



Enhancing sexual and reproductive health services for rural women in uMkhambathini: A Framework for Localized Reproductive Health and Support Structure (FLRHSS)

Philani Goodman Kuluse¹  & Lungile Prudence Zondi¹ 

¹ School of Social Sciences, University of KwaZulu-Natal, South Africa.

ABSTRACT

Access to Sexual and Reproductive Health (SRH) services remains a significant challenge for women living in rural areas of South Africa, where structural and socio-cultural barriers limit effective use of healthcare. This study examined the availability and accessibility of SRH services in the uMkhambathini Local Municipality, focusing on factors such as inadequate infrastructure, shortages of healthcare staff, and transportation difficulties. It also explored how gender roles, traditional beliefs, and stigma affect women's decisions to seek care and their ability to exercise reproductive autonomy. Data were gathered from 30 rural women, guided by Gender Theory, Critical Medical Anthropology, and Social Constructivism, to provide a deeper understanding of the complex social influences on SRH access. Findings reveal how these intersecting obstacles restrict women's reproductive rights and perpetuate inequalities. To address these issues, the study introduces the Framework for Localized Reproductive Health and Support Structure (FLRHSS), a community-focused approach designed to improve healthcare delivery by strengthening local engagement, enhancing healthcare provider training, and addressing economic and cultural factors. This framework supports South Africa's constitutional rights and national development goals by emphasizing that fair access to reproductive healthcare is essential to democratic inclusion. The study contributes to ongoing efforts to reform health systems and promote gender equity in rural settings.

Keywords: Sexual and reproductive health (SRH), rural women, FLRHSS model, community health interventions, healthcare policy

INTRODUCTION

Despite global progress, access to sexual and reproductive health (SRH) services remains a pressing challenge in many African countries. However, in recent years, national leaders have increasingly recognized the importance of SRH and have taken meaningful steps to address care gaps. Heads of state play a pivotal role in advancing SRH by shaping national health agendas, mobilizing resources, and promoting gender-inclusive health programs. Their leadership significantly influences the integration of SRH services into national healthcare systems, including greater attention to men's reproductive health. For instance, in Rwanda, President Paul Kagame has championed universal healthcare coverage, which includes

CORRESPONDENCE – Philani Goodman Kuluse Email: KuluseP@ukzn.ac.za

PUBLICATION HISTORY - Received : 12th August, 2025 | Accepted: 18th December, 2025 | Published: 27th February, 2026.

TO CITE THIS ARTICLE – Kuluse, Philani Goodman, and Lungile Prudence Zondi. "Enhancing sexual and reproductive health services for rural women in uMkhambathini: A framework for localized Reproductive Health and Support Structure (FLRHSS)." *E-Journal of Humanities, Arts and Social Sciences* 7, no.1 (2026): 220 - 234. <https://doi.org/10.38159/ehass.20267116>

COPYRIGHT AND LICENSING - © 2026 The Author(s). Published and Maintained by Noyam Journals.

This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>).

access to family planning and SRH services for both men and women, contributing to increased contraceptive use and a reduction in maternal mortality.¹ Similarly, in Ethiopia, former Prime Minister Hailemariam Desalegn encouraged male involvement in family planning by promoting men's participation in antenatal visits alongside their partners.² In South Africa, President Cyril Ramaphosa has supported HIV prevention efforts, such as voluntary medical male circumcision, which has played a role in reducing HIV transmission rates among men.³ Beyond national efforts, regional bodies like the African Union (AU) have provided platforms for collective action. Through frameworks such as the Maputo Plan of Action, African leaders have endorsed comprehensive SRH services and emphasized shared responsibility in reproductive health.⁴ While these efforts mark important progress, challenges persist, including inconsistent political will and entrenched gender norms that limit effective implementation. Strengthening political commitment and aligning policies with cultural and social realities remain critical for the long-term success of SRH initiatives across the continent.

Identifying and implementing effective solutions to enhance sexual and reproductive health and rights (SRHR) is essential to advancing public health, promoting gender equity, and supporting the Sustainable Development Goals. Comprehensive access to SRHR services contributes to improved health outcomes by reducing maternal and infant mortality, limiting the spread of sexually transmitted infections, and enabling individuals to make informed reproductive choices. In low- and middle-income contexts, particularly within sub-Saharan Africa, systemic barriers such as limited access to healthcare, sociocultural norms, and gender-based inequalities continue to restrict women's and girls' access to these vital services. These challenges often reinforce intergenerational cycles of poverty and social marginalization. Therefore, addressing SRHR demands requires context-sensitive, inclusive approaches prioritizing the lived realities of those most affected, especially rural women. Policy reform, community-based engagement, and the integration of SRHR into public healthcare systems are necessary to ensure equitable access for all individuals, regardless of gender, socioeconomic background, or geographic location. Enhancing SRHR is not only a matter of health but a foundational step toward broader societal advancement, including educational attainment, economic empowerment, and the protection of human rights.

This paper is problematized around access to SRH services in rural South Africa. The paper argues that SRH remains a pressing public health and social equity concern, particularly within underserved regions such as the uMkhambathini Local Municipality in KwaZulu-Natal. This study investigates two interrelated dimensions of this problem: structural impediments to SRH service access and cultural and social constraints on service utilization. On a structural level, rural women in uMkhambathini face significant challenges, including long travel distances to health facilities, limited or unaffordable transportation, persistent staff shortages, and inadequately resourced clinics. These issues are compounded by broader socio-economic conditions such as poverty, unemployment, and limited access to information, which collectively restrict women's ability to seek timely and adequate reproductive healthcare. Concurrently, the study examines the entrenched cultural norms, traditional belief systems, and gendered power dynamics that shape reproductive health decisions. Stigma surrounding sexuality, especially in relation to contraceptive use, teenage pregnancy, and HIV, discourages women, particularly unmarried or young women, from accessing available services. Within households, patriarchal authority often limits women's autonomy in making health-related decisions. The convergence of these systemic and socio-cultural barriers underscores the urgent need for a localized, gender-responsive framework for SRH service delivery. In the context of uMkhambathini, addressing these challenges is not only a healthcare imperative but also a constitutional obligation to uphold the rights, dignity, and well-being of rural women within South Africa's democratic and developmental agenda.

¹ Christina Tafadzwa Dzimiri, *The Use of the Female Condom as an HIV Prevention Technology: Perceptions of Female Students at the University of Venda, Limpopo Province, South Africa* (University of Johannesburg (South Africa), 2022).

² J. Cleland, M. M. Ali, and I. H. Shah, *The Global Contraceptive Landscape: An Unfinished Agenda* (Population Council, 2018).

³ Dzimiri, *The Use of the Female Condom as an HIV Prevention Technology: Perceptions of Female Students at the University of Venda, Limpopo Province, South Africa*.

⁴ African Union, "Maputo Plan of Action 2016–2030 for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights," 2015, <https://au.int/en/documents/20150630/maputo-plan-action-2016-2030>.

LITERATURE REVIEW

Access to healthcare in rural African communities remains deeply intertwined with broader social and economic inequalities, significantly shaping health outcomes. In regions such as uMkhambathini, the intersection of entrenched cultural norms and socioeconomic challenges erects formidable barriers to equitable healthcare access. Cultural beliefs profoundly influence community attitudes toward medical interventions, particularly in SRH, where traditional practices maintain a stronghold. The continued reliance on traditional medicine in rural areas, largely due to cost and accessibility factors, contrasts with the dominance of biomedical services in urban centers, exposing a stark geographic and cultural divide in healthcare utilization.⁵ Compounding this divide, restrictive gender roles often limit women's autonomy in reproductive decision-making, thereby reinforcing systemic power imbalances that obstruct access to necessary care.⁶ Notably, improvements in women's socioeconomic status, educational attainment, and workforce participation are positively correlated with greater agency in reproductive health decisions.⁷ Despite such progress, healthcare delivery systems frequently overlook the complex sociocultural realities that shape health-seeking behaviors, highlighting the critical need for culturally responsive care models.⁸ Furthermore, maternal and child health programs often emphasize child survival while neglecting broader maternal health concerns, such as infertility and unintended pregnancies, reinforcing narrow societal views that reduce women to their reproductive functions rather than addressing their comprehensive health needs.⁹ This gap underscores an urgent imperative for integrated reproductive health strategies that centralize women's holistic well-being within healthcare policy and practice.¹⁰ Such strategies are vital for transforming health systems into equitable, culturally sensitive entities aligned with the lived experiences of rural women.

Beyond cultural and economic factors, access to healthcare is impeded by a spectrum of socio-cultural and structural barriers, including stigma, discrimination, misconceptions, social stratification, and low health literacy. These challenges are particularly acute in marginalized and rural populations where systemic inequities exacerbate health disparities. Stigma remains a pervasive obstacle within healthcare settings, deterring both patients and providers from engaging openly with health issues that carry social taboos.¹¹ Highlight how fear of judgment leads healthcare workers to conceal conditions or avoid seeking care, further perpetuating silence and delayed treatment. Closely related, discrimination often rooted in biases related to race, gender, disability, or class undermines trust in healthcare systems and contributes to adverse health outcomes such as anxiety and hypertension.¹² Despite ongoing interventions, including training and policy reforms, discrimination continues to hinder equitable healthcare delivery.

Cultural misconceptions also substantially hinder healthcare utilization, especially in rural settings where traditional worldviews dominate understandings of disease causation and treatment.¹³ Argue that these misconceptions, often lacking a scientific basis, generate resistance to biomedical care. For example, in Zambia, cultural misunderstandings about mental illness perpetuate stigma and prevent sufferers from accessing treatment.¹⁴ Similarly, Indigenous populations in Australia face ongoing barriers to healthcare

⁵ Anthony A Elujoba, O M Odeleye, and C M Ogunyemi, "Traditional Medicine Development for Medical and Dental Primary Health Care Delivery System in Africa.," *African Journal of Traditional, Complementary and Alternative Medicines* 2, no. 1 (2005): 46–61.

⁶ Mihiretu Alemayehu and Mengistu Meskele, "Health Care Decision Making Autonomy of Women from Rural Districts of Southern Ethiopia: A Community Based Cross-Sectional Study," *International Journal of Women's Health*, 2017, 213–21.

⁷ Mohammad Mumtaz Khan et al., "Effect of Socio-Economic, Cultural and Demographic Factors on Woman Reproductive Health.," 2009.

⁸ Osío, J. B. (2023). Unveiling the intersection: anthropological insights into health disparities and well-being. *Social Science Chronicle*, 2(1).

⁹ World Health Organization, "Maternal and Child Health: Priorities and Challenges," 2020; E. Foley, J. Smith, and A. Brown, "Women's Reproductive Health: Beyond Biological Roles," *Global Health Perspectives* 18, no. 2 (2022): 112–20; National Department of Health, "Integrating Women's Reproductive Health into Healthcare Policy," 2021.

¹⁰ Laura Nyblade et al., "Stigma in Health Facilities: Why It Matters and How We Can Change It," *BMC Medicine* 17, no. 1 (2019): 25.

¹¹ Nyblade et al., "Stigma in Health Facilities: Why It Matters and How We Can Change It."

¹² Brandon Togioka and Emily Young, "Diversity and Discrimination in Health Care," *StatPearls*, 2024.

¹³ N. S. Kasongo, "Experiences of Women with Depression on Rehabilitation Counselling in Mkushi District of Zambia" (The University of Zambia, 2022).

¹⁴ Kasongo, "Experiences of Women with Depression on Rehabilitation Counselling in Mkushi District of Zambia."

access rooted in historical colonization and cultural disconnection.¹⁵ These examples illustrate the need for culturally sensitive health education initiatives that bridge traditional beliefs and contemporary healthcare practices.

Social stratification further entrenches healthcare inequities by limiting resource distribution and access opportunities. Wealthier and urban populations typically experience superior healthcare access, while rural and economically marginalized women suffer systemic exclusion due to entrenched gender norms, economic dependency, and geographic isolation.¹⁶ These structural inequalities manifest in poorer health outcomes for women, perpetuating cycles of disadvantage. Health literacy, defined as the ability to understand and utilize health information, is closely tied to these inequities. Women with limited literacy face heightened difficulties navigating healthcare systems, comprehending treatment options, and communicating with providers. In patriarchal societies, restricted educational opportunities exacerbate these challenges, resulting in delayed care and worse health outcomes.¹⁷ Addressing health literacy gaps requires focused empowerment initiatives that equip marginalized women with the knowledge and skills to advocate for their health needs.

Globally, SRHR disparities continue to impede development efforts, demanding targeted policies and programs. Emphasizes the importance of integrating basic healthcare services into broader health systems, especially in underserved regions. While many developing countries have made strides in establishing foundational SRHR frameworks, challenges remain in achieving universal and equitable access. For instance, Vietnam has demonstrated strong political commitment to adolescent and youth SRH through ratifying numerous international treaties and implementing national strategies such as the Youth Development Strategy (2011-2020) and the National Population and Reproductive Health Strategy (2011-2020).¹⁸ Nonetheless, rural and remote areas continue to face gaps in SRH education and service availability, underscoring the need to reassess policies to better align with the Sustainable Development Goals and the 2030 Agenda. Likewise, India's Ministry of Health and Family Welfare has prioritized adolescent health through comprehensive strategies addressing nutrition, SRH, substance abuse, mental health, and violence.¹⁹ The Rashtriya Kishor Swasthya Karyakram (RKSK), launched in 2014, expanded adolescent health services but continues to face infrastructural limitations and cultural resistance, particularly parental discomfort with SRH education for daughters. Despite progress in school-based programs, further oversight and culturally sensitive approaches remain necessary, especially in religious education.

THEORETICAL FRAMEWORKS

This paper is grounded in three interrelated theoretical frameworks: Gender Theory, Critical Medical Anthropology, and Social Constructivism. Gender Theory provides insight into how power relations and socially constructed roles influence access to sexual and reproductive health and rights (SRHR). It highlights how entrenched gender norms can limit women's autonomy in reproductive decision-making and shape health system structures and provider attitudes.²⁰ Critical Medical Anthropology adds a structural dimension, interrogating how broader socio-economic forces, political systems, and institutional inequalities shape reproductive health outcomes, particularly in under-resourced rural settings.²¹ This

¹⁵ Kathomi Gatwiri, Darlene Rotumah, and Elizabeth Rix, "BlackLivesMatter in Healthcare: Racism and Implications for Health Inequity among Aboriginal and Torres Strait Islander Peoples in Australia," *International Journal of Environmental Research and Public Health* 18, no. 9 (2021): 4399.

¹⁶ Sunday A Adedini, Oluwaseyi D Somefun, and Clifford Odimegwu, "Gender Inequality and Maternal and Child Healthcare Utilization in Sub-Saharan Africa," *Gender and Behaviour* 12, no. 4 (2014): 6050–70.

¹⁷ Rafia S Rasu et al., "Health Literacy Impact on National Healthcare Utilization and Expenditure," *International Journal of Health Policy and Management* 4, no. 11 (2015): 747.

¹⁸ Hoang Khanh Chi et al., "The Content and Implementation of Policies and Programs on Adolescent Sexual and Reproductive Health in Vietnam: Results and Challenges," *Health Services Insights* 14 (2021): 11786329211037500.

¹⁹ Jayantil Satia, "Challenges for Adolescent Health Programs: What Is Needed?," *Indian Journal of Community Medicine* (Medknow, 2018).

²⁰ J. Butler, *Gender Trouble: Feminism and the Subversion of Identity* (New York: Routledge, 1990); R. W. Connell, *Gender*, 2nd ed. (Polity Press, 2012).

²¹ H. A. Baer, M. Singer, and I. Susser, *Medical Anthropology and the World System: Critical Perspectives*, 3rd ed. (Praeger, 2013).

theory shifts the analytical focus from individual behaviours to the systemic barriers that perpetuate reproductive injustice, such as poverty, marginalisation, and restricted health infrastructure. Social Constructivism complements these perspectives by emphasizing how reproductive health meanings such as fertility, contraception, and motherhood are culturally and contextually constructed through social interaction.²² This framework is particularly relevant in communities where traditional beliefs and localized knowledge systems shape health-seeking behaviours and engagement with biomedical services.²³ These theories offer a nuanced understanding of SRHR by situating individual experiences within broader social, cultural, and structural contexts. Their combined application supports the development of contextually relevant, equitable, and gender-sensitive healthcare interventions for rural women.

METHODOLOGY

This study adopted an interpretivist paradigm and a phenomenological design to explore the lived experiences of AmaZulu women accessing SRH services in eNkanyezini, uMkhambathini. The interpretivist approach allowed for an in-depth understanding of how participants make sense of their reproductive health realities. At the same time, the focus was on the phenomenological method for capturing these experiences from participants' perspectives.²⁴ Over ten months, the study used purposive and snowball sampling to recruit 30 AmaZulu women aged 18–49 who had lived in the area for at least 10 years and had experienced challenges in accessing SRH services. Purposive sampling ensured the selection of information-rich cases.²⁵ Snowball sampling helped access participants within social networks.²⁶ A pilot study involving 8 participants refined data-collection tools for cultural and contextual relevance. Five focus group discussions (FGDs) with six participants were conducted in isiZulu to facilitate open communication. A trained female assistant fluent in isiZulu led the discussions, which lasted about 60 minutes and prioritized participant comfort and confidentiality.²⁷ The researcher and assistant collaboratively reviewed and translated the transcripts to preserve cultural accuracy. Ethical approval was granted by the Humanities and Social Sciences Research Ethics Committee at the University of KwaZulu-Natal. Informed consent was obtained in both isiZulu and English, with participants assured of confidentiality, anonymity, and the right to withdraw without consequence. Pseudonyms and secure data handling ensured ethical integrity. Though not generalizable, the findings offer transferable insights. Trustworthiness was maintained through clear inclusion criteria, a transparent methodology, and grounded analysis grounded in participants' lived experiences, ensuring the data authentically reflected their SRH realities. Ethical Approval was granted by the University of KwaZulu-Natal's Humanities and Social Science Research Ethics Committee (HSSREC/00005485/2023).

PRESENTATION OF FINDINGS

The findings reveal that structural barriers significantly constrain women's access to sexual and reproductive health (SRH) services in the rural context of uMkhambathini. Economic limitations emerge prominently, with participants identifying unemployment, unaffordability of private healthcare, and transportation costs as pervasive obstacles restricting their healthcare choices.

²² P. L. Berger and T. Luckmann, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* (Anchor Books, 1966).

²³ Anne HAMmArsTröm, "A Tool for Developing Gender Research in Medicine: Examples from the Medical Literature on Work Life," *Gender Medicine* 4 (2007): S123–32.

²⁴ C. Marshall and G. B. Rossmann, *Designing Qualitative Research*, 6th ed. (SAGE Publications, 2014); U. Flick, *An Introduction to Qualitative Research*, 7th ed. (London: (7th ed.). SAGE Publications., 2022)..

²⁵ Lawrence A Palinkas et al., "Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research," *Administration and Policy in Mental Health and Mental Health Services Research* 42, no. 5 (2015): 533–44.

²⁶ Chaim Noy, "Sampling Knowledge: The Hermeneutics of Snowball Sampling in Qualitative Research," *International Journal of Social Research Methodology* 11, no. 4 (2008): 327–44.

²⁷ R., Hayman and S. Sierra, "Focus Group Discussions on Development Research," *INTRAC Praxis Note* 57 (2010); Greg Guest, Emily Namey, and Kevin McKenna, "How Many Focus Groups Are Enough? Building an Evidence Base for Nonprobability Sample Sizes," *Field Methods* 29, no. 1 (February 24, 2017): 3–22, <https://doi.org/10.1177/1525822X16639015>..

Participant accounts illustrate this economic vulnerability:

“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 of transport and medicine.” (Participant 4)

Gendered power relations within households further exacerbate these barriers, as decision-making authority predominantly resides with male partners, thereby curtailing women’s autonomy in seeking care. Additionally, socio-cultural and religious frameworks, including traditional healing practices and affiliations with faiths such as the Nazareth church and Jehovah’s Witnesses, actively shape women’s perceptions and engagement with SRH services. Such affiliations often discourage the use of biomedical interventions, particularly contraceptive methods and abortion services. Internalized societal norms around shame and stigma further deter women from accessing care. Misinformation about contraceptive use and reproductive health is widespread, reinforcing feelings of fear and judgment. Moreover, infrastructural inadequacies such as long wait times, overcrowding, lack of privacy, and perceived hostility or judgment from healthcare personnel disincentivize timely and repeated use of SRH facilities.

Structural and Socio-cultural Inhibitions

The emic narratives/daily realities of rural women at uMkhambathini highlight the importance of understanding socio-cultural norms and structural determinants that mediate health-seeking behavior in this setting. Cultural interpretations of illness and health are deeply embedded and can serve as barriers and sources of resilience in healthcare engagement.²⁸ Moreover, social determinants such as socioeconomic status, education, social capital, and political economy shape health inequities by influencing access to resources and services.²⁹ These determinants frame the lived experiences of rural women navigating SRH care.

Stigma, Discrimination, and Healthcare Experiences

Stigma emerges as a critical impediment to healthcare access, exerting influence across multiple socio-ecological levels, consistent with the Health Stigma and Discrimination Framework.³⁰ Stigma manifests in interpersonal interactions, institutional practices, and internalized shame, cumulatively obstructing SRH service utilization.

Participants reported direct experiences of stigma and breaches of confidentiality by healthcare workers:

“Personally, people, especially nurses, ask many 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)

Domestic labor responsibilities further constrain healthcare access:

“Remember that being a housewife comes with many challenges... your chores take up time, even when you are feeling sick; our minds have been trained to dismiss that thinking because no one pays attention to your health needs.”

The narratives also reveal pervasive distrust related to confidentiality and provider judgment:

“Our clinic staff are very judgemental, we wouldn’t even ask about SRH services in detail, it is a hard shame.” (Participant 11)

²⁸ Quynh Lê, “Cultural Meaning in Health Communication,” *Health (San Francisco)*, 2006, 13–15.

²⁹ Mauricio Lima Barreto, “Health Inequalities: A Global Perspective,” *Ciencia & Saude Coletiva* 22 (2017): 2097–2108; Lê, “Cultural Meaning in Health Communication.”

³⁰ Anne L. Stangl et al., “The Health Stigma and Discrimination Framework: A Global, Crosscutting Framework to Inform Research, Intervention Development, and Policy on Health-Related Stigmas,” *BMC Medicine* 17, no. 1 (December 15, 2019): 31, <https://doi.org/10.1186/s12916-019-1271-3>.

“There is no client-patient confidentiality there; shame.” (Participant 13)

“The same people required to help us talk negatively about us or discuss us.” (Participant 15)

These testimonies reflect entrenched patterns of stigma, stereotyping, and discrimination that serve as formidable barriers to SRH access, underscoring how social prejudices are reproduced within healthcare settings.³¹

The findings demonstrate that stigma and resource scarcity synergistically undermine SRH service delivery and utilization. Negative attitudes and behaviors of healthcare workers rooted in societal stigma create environments hostile to patient disclosure and engagement. Concurrently, systemic challenges such as inadequate staffing and limited medical supplies exacerbate service gaps. This multifaceted dynamic necessitates comprehensive interventions that address both structural deficits and socio-cultural factors, underscoring the urgent need to cultivate culturally sensitive, gender-responsive, and stigma-reducing healthcare environments. Only through such integrative approaches can equitable SRH access and improved health outcomes for rural women in uMkhambathini be realized.



Figure 1: Barriers to SRH in uMkhambathini
Own source (2025)

³¹ David Marx and Sei Jin Ko, “Stereotypes and Prejudice,” in *Oxford Research Encyclopedia of Psychology*, 2019.

This diagram illustrates the multifaceted barriers restricting access to Sexual and Reproductive Health (SRH) services for rural women in uMkhambathini. The central issue, Restricted SRH Service Access, is influenced by four main categories of obstacles.

- Structural Barriers include economic hardships like unemployment and transport costs, poor infrastructure leading to long waits and lack of privacy, and an inadequate healthcare workforce.
- Simultaneously, Gendered Power Relations in households, where men hold decision-making authority, curtail women's autonomy over their own health choices.
- Socio-Cultural and Religious Influences, such as traditional healing practices and faith-based or cultural norms, also shape access to services.
- Finally, Stigma and Discrimination create significant hurdles, manifesting as interpersonal stigma, institutional bias, internalized shame, and fears of gossip or confidentiality breaches. Together, these interconnected factors create a complex web of challenges that severely limit women's ability to access essential SRH care.

DISCUSSION

The findings from uMkhambathini reveal a complex interplay of structural, cultural, and systemic barriers that severely constrain rural women's access to sexual and reproductive health (SRH) services. Central to these challenges is the conduct and attitude of healthcare workers, which profoundly shapes patients' experiences. Participants consistently reported judgmental, dismissive, and unprofessional behaviour, particularly in public health facilities. Breaches of confidentiality, derogatory remarks, and a pervasive atmosphere of surveillance emerged as recurring themes. For many women, merely inquiring about SRH services exposed them to moral scrutiny and social censure, discouraging engagement even when health needs were urgent. Some healthcare workers reportedly discussed patients' private health matters with others in the community, representing a significant violation of professional ethics. These breaches of trust inflicted emotional harm and fostered a climate of fear around healthcare engagement. Stigmatization was especially acute for unmarried women, survivors of sexual violence, and those seeking services related to contraception or abortion, reinforcing silence around adolescent pregnancy, HIV, and sexual trauma and prompting avoidance of formal healthcare.³²

Gender Theory provides a lens for interpreting these dynamics, emphasizing how socially constructed gender roles produce and sustain power inequalities that constrain women's autonomy in health-related decision-making.³³ Participants' experiences of judgment and limited agency in SRH decisions illustrate how patriarchal norms are embedded in both interpersonal and institutional contexts, shaping behaviors, expectations, and access to care. For instance, male partners' control over clinic visits and contraceptive use exemplifies the gendered power hierarchies described in feminist scholarship, where women's reproductive choices are circumscribed by socially sanctioned male authority.³⁴

This pattern aligns with scholarship emphasizing that healthcare workers' attitudes are pivotal in shaping service uptake. Compassionate and respectful care fosters trust and encourages utilization, whereas judgmental attitudes undermine patient satisfaction and morale while contributing to staff burnout.³⁵ In rural communities like uMkhambathini, where social proximity between healthcare workers and patients is common, negative professional conduct often extends into everyday interactions, reinforcing stigma through gossip and informal commentary.³⁶ Critical Medical Anthropology (CMA) contextualizes these findings within broader structural and systemic forces, highlighting how institutional constraints such as

³² Nyblade et al., "Stigma in Health Facilities: Why It Matters and How We Can Change It"; Togioka and Young, "Diversity and Discrimination in Health Care."

³³ J. Butler, *Gender Trouble: Feminism and the Subversion of Identity* (Routledge, 1990); Raewyn Connell, "Gender, Health and Theory: Conceptualizing the Issue, in Local and World Perspective," *Social Science & Medicine* 74, no. 11 (June 2012): 1675–83, <https://doi.org/10.1016/j.socscimed.2011.06.006>.

³⁴ Alemayehu and Meskele, "Health Care Decision Making Autonomy of Women from Rural Districts of Southern Ethiopia: A Community Based Cross-Sectional Study"; Khan et al., "Effect of Socio-Economic, Cultural and Demographic Factors on Woman Reproductive Health."

³⁵ Foley, Smith, and Brown, "Women's Reproductive Health: Beyond Biological Roles."

³⁶ Nyblade et al., "Stigma in Health Facilities: Why It Matters and How We Can Change It."

understaffing, resource scarcity, and overcrowded clinics intersect with social inequalities to produce health disparities.³⁷ CMA underscores that stigma and discrimination are not merely interpersonal failings but are embedded within political, economic, and organizational structures that disadvantage marginalized groups.

Systemic inadequacies further compound these barriers. Clinics in uMkhambathini are frequently under-resourced, with chronic staff shortages and limited medical supplies.³⁸ Women, particularly those with caregiving responsibilities or living in remote areas, must navigate long distances and endure extended waiting times. The absence of private spaces for sensitive consultations undermines both dignity and safety. Economic hardship intensifies these obstacles; many women lack the means to afford transport or private alternatives, leaving public clinics as the only feasible option despite their shortcomings.³⁹ Consequently, accessing SRH services becomes both physically demanding and emotionally taxing, often resulting in delayed or forgone care.

Social Constructivism offers a complementary lens by illustrating how knowledge, beliefs, and meanings around health are socially produced and shared. Participants' reliance on community narratives and traditional beliefs shaped their perceptions of SRH services, often generating misconceptions and mistrust.⁴⁰ Contraceptive use, abortion, and open discussions about sexuality were frequently framed as morally or spiritually impermissible, reflecting socially constructed norms that inhibit autonomous decision-making. These socially mediated perceptions intersect with stigma, fear, and low health literacy to restrict engagement with biomedical services.⁴¹

Intrahousehold gender dynamics, coupled with restrictive cultural and religious ideologies, further limit women's agency in SRH decisions. Traditional healing practices and religious doctrines, such as those associated with the Nazareth Church or Jehovah's Witnesses, often discourage biomedical engagement, particularly in matters of contraception, abortion, and adolescent sexual health.⁴² Gender Theory and CMA converge here, demonstrating that both socially constructed gender norms and systemic power relations reinforce barriers, producing unequal access to care and adverse health outcomes.

Limited health literacy compounds these challenges, as many women lack knowledge of available SRH services or clear pathways to access them.⁴³ Health literacy gaps reflect broader educational and socioeconomic inequities, with patriarchal structures often limiting women's opportunities for formal education and independent decision-making.⁴⁴ Social Constructivism helps explain how misinformation circulates within communities, shaping collective understandings of health and reinforcing behavioral norms that deter service utilization.

Addressing these interrelated barriers requires a holistic, theory-informed approach. First, healthcare providers must receive comprehensive training in ethics, confidentiality, and non-judgmental care, along with accountability mechanisms and patient feedback systems, to ensure respectful service delivery.⁴⁵ Second, infrastructure improvements are essential, including increased staffing, adequate

³⁷ J B Osío, "Unveiling the Intersection: Anthropological Insights into Health Disparities and Well-Being," *Social Science Chronicle* 2, no. 1 (2023); World Health Organization, "Maternal and Child Health: Priorities and Challenges."

³⁸ World Health Organization, "Maternal and Child Health: Priorities and Challenges"; National Department of Health, "Integrating Women's Reproductive Health into Healthcare Policy."

³⁹ Khan et al., "Effect of Socio-Economic, Cultural and Demographic Factors on Woman Reproductive Health."; Alemayehu and Meskele, "Health Care Decision Making Autonomy of Women from Rural Districts of Southern Ethiopia: A Community Based Cross-Sectional Study."

⁴⁰ Elujoba, Odeleye, and Ogunyemi, "Traditional Medicine Development for Medical and Dental Primary Health Care Delivery System in Africa."; Osío, "Unveiling the Intersection: Anthropological Insights into Health Disparities and Well-Being."

⁴¹ Rasu et al., "Health Literacy Impact on National Healthcare Utilization and Expenditure"; Kasongo, "Experiences of Women with Depression on Rehabilitation Counselling in Mkushi District of Zambia."

⁴² Elujoba, Odeleye, and Ogunyemi, "Traditional Medicine Development for Medical and Dental Primary Health Care Delivery System in Africa."; Gatwiri, Rotumah, and Rix, "BlackLivesMatter in Healthcare: Racism and Implications for Health Inequity among Aboriginal and Torres Strait Islander Peoples in Australia."

⁴³ Rasu et al., "Health Literacy Impact on National Healthcare Utilization and Expenditure"; Kasongo, "Experiences of Women with Depression on Rehabilitation Counselling in Mkushi District of Zambia."

⁴⁴ M. F. Fathalla, "Reproductive Health and Women's Rights," *International Journal of Gynecology & Obstetrics* 46, no. 1 (1994): 1-7; Alemayehu and Meskele, "Health Care Decision Making Autonomy of Women from Rural Districts of Southern Ethiopia: A Community Based Cross-Sectional Study."

⁴⁵ Nyblade et al., "Stigma in Health Facilities: Why It Matters and How We Can Change It."

medical supplies, and private consultation spaces to protect dignity and privacy.⁴⁶ Third, culturally sensitive, community-based education initiatives must engage local leaders, religious figures, and traditional healers to dismantle harmful narratives, correct misinformation, and promote open dialogue on SRH.⁴⁷ Fourth, gender-responsive interventions are vital. Empowering women to make autonomous health decisions requires reshaping household power dynamics and community norms, potentially through male-inclusive education, advocacy, and policy reform.⁴⁸ By integrating insights from Gender Theory, CMA, and Social Constructivism, these strategies can address both the structural and sociocultural determinants of health, creating an enabling environment that supports equitable access to SRH services in rural contexts.

RECOMMENDATIONS

This paper contributes to the FLRHSS framework for localizing sexual and reproductive health (SRH) services in rural settings. Grounded in the study’s findings, which reveal key challenges such as limited access to SRH services, pervasive social stigma, and healthcare system inefficiencies, the framework seeks to enhance SRH accessibility for women in rural communities, particularly in uMkhambathini eNkanyezini. By integrating cultural sensitivity, social determinants, and health system improvements, the FLRHSS is informed by the Anthropology of Women and Feminist Anthropology, emphasizing a gender-sensitive approach that uplifts marginalized rural women. Additionally, the framework draws on the four stages of healthcare engagement, offering localized, context-specific solutions to address systemic and cultural barriers to SRH service delivery.

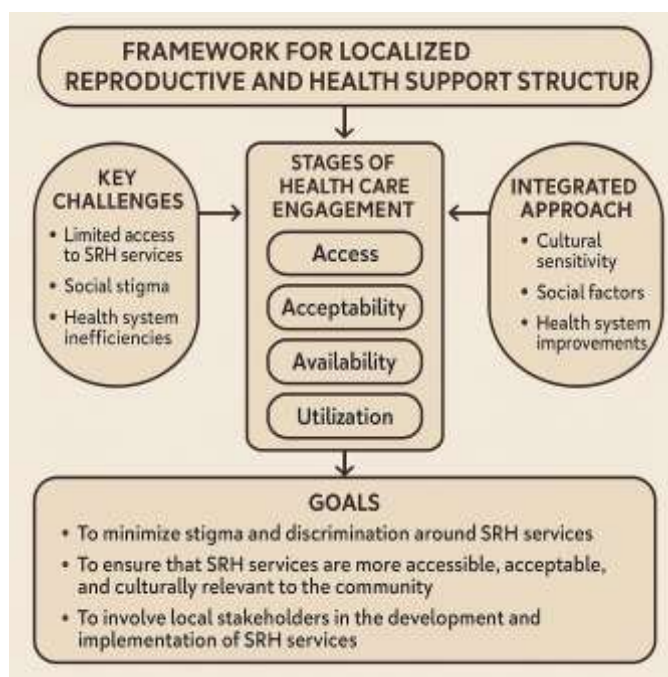


Figure 2: Represents a Framework for localized reproductive and health support structure
Own source (2025)

The contributed FLRHSS framework is deeply informed and strengthened by Gender Theory, Critical Medical Anthropology, and Social Constructivism. Gender Theory highlights the importance of addressing patriarchal power dynamics that limit women’s autonomy over their sexual and reproductive

⁴⁶ World Health Organization, “Maternal and Child Health: Priorities and Challenges”; National Department of Health, “Integrating Women’s Reproductive Health into Healthcare Policy.”

⁴⁷ Elujoba, Odeleye, and Ogunyemi, “Traditional Medicine Development for Medical and Dental Primary Health Care Delivery System in Africa”; Gatwiri, Rotumah, and Rix, “BlackLivesMatter in Healthcare: Racism and Implications for Health Inequity among Aboriginal and Torres Strait Islander Peoples in Australia.”

⁴⁸ Connell, *Gender*; Butler, *Gender Trouble: Feminism and the Subversion of Identity*.

health, guiding the framework to adopt a gender-sensitive approach that empowers rural women. Critical Medical Anthropology highlights the broader structural and institutional factors, such as poverty, healthcare inequities, and systemic stigma, that shape women's access to care, ensuring the framework tackles these root causes beyond individual behaviors. Meanwhile, Social Constructivism underscores how cultural beliefs, social norms, and stigma around SRH are socially constructed within communities, reinforcing the need for localized, culturally sensitive interventions. Together, these theories provide a multidimensional lens that enables the FLRHSS to offer holistic, context-specific solutions that effectively address the intertwined social, cultural, and systemic barriers that women in rural areas like uMkhambathini eNkanyezini face.

Goals of the FLRHSS are to:

- Reduce stigma and discrimination related to sexual and reproductive health services.
- Make SRH services accessible, culturally appropriate, and acceptable to local communities.
- Engage local community members and leaders in designing and delivering SRH programs.
- Enhance rural healthcare facilities by improving resources, infrastructure, and staff training.
- Support community-led outreach efforts to raise awareness and encourage women to use SRH services.

Implementation Guidance for Comprehensive SRH Services

Stage 1: Encouraging Women to Seek Care

- Hire and train healthcare workers who understand local culture and community needs.
- Improve clinic workflows to shorten wait times and reduce overcrowding.
- Keep essential SRH medicines consistently available.
- Use community gatherings and peer-led education to address stigma and raise awareness.
- Set up reliable referral networks and patient follow-up systems across clinics.

Stage 2: Building Community Support for SRH

- Develop outreach programs that respect local customs, are age-appropriate, and use the local language.
- Use schools, religious centers, and traditional meetings to share information.
- Partner with trusted figures like community leaders and traditional healers to challenge misconceptions.
- Focus on reaching vulnerable groups such as young mothers and adolescents with tailored messages.

Stage 3: Expanding Local SRH Services

- Upgrade clinics with better facilities and ensure steady supplies.
- Deploy mobile clinics to reach distant communities regularly.
- Train local residents as health educators and counselors to provide culturally relevant support.
- Work with NGOs and community groups to secure resources and maintain programs.

Stage 4: Improving Service Quality and Respectful Care

- Train healthcare staff on gender sensitivity, cultural awareness, and respectful communication.
- Provide care that addresses physical, mental, and emotional health needs.
- Establish health committees involving community members to enhance transparency and accountability.
- Include mental health services, regularly gather patient feedback, and track local data to guide improvements and reduce stigma.

Implementing the FLRHSS framework aligns with the foundational principles of South Africa's Constitution (No. 108 of 1996), which enshrines the right to access healthcare services as a fundamental human right. Section 27(1)(a) of the Constitution explicitly guarantees everyone the right to access healthcare services, including reproductive health, positioning this as a legal imperative for equitable service delivery. Moreover, the National Development Plan (NDP) 2030 underscores the urgent need to reduce inequality and improve healthcare outcomes by strengthening primary health care systems and addressing socio-economic determinants of health. The plan's vision to build a more inclusive, accessible healthcare system necessitates frameworks such as FLRHSS targeting marginalized rural populations. Similarly, the National Health Insurance (NHI) scheme envisages a universal health coverage model that eliminates disparities in healthcare access, particularly in under-resourced rural areas. Effective implementation of this framework, therefore, not only fulfills constitutional mandates but also operationalizes the strategic goals of the NDP and NHI by addressing barriers like stigma, infrastructural deficits, and gendered social constraints. The framework advances South Africa's commitment to healthcare as a social right by embedding culturally sensitive, community-driven approaches into the health system. It promotes a more just and equitable society, ensuring that rural women's sexual and reproductive health needs are not overlooked or marginalized.

The contributed framework asserts that rural women should not be viewed merely as data points contributing to health statistics; instead, their lived experiences and access to care must be recognized as critical indicators of health systems' inclusivity, responsiveness, and equity. Marginalized in both geography and policy, rural women often face compounded barriers to sexual and reproductive health (SRH) services ranging from physical inaccessibility and social stigma to systemic neglect and gender-based discrimination. Their consistent exclusion from meaningful policy engagement reflects a broader failure of health systems to account for context-specific realities. When rural women are unable to access timely, respectful, and confidential SRH care, it is not simply a service delivery gap; it is evidence of structural inequality embedded within the health system itself. Recognizing rural women as central to assessing health system effectiveness compels implementers to go beyond superficial metrics and interrogate whether services genuinely reach those most at risk. Thus, the framework insists that achieving universal health coverage, gender equity, and constitutional rights in South Africa demands a deliberate focus on the experiences of rural women not only to fulfill legal and policy commitments, but to transform health systems from exclusionary to inclusive, from distant to responsive, and from statistical to human-centered.

Drawing on Gender Theory and Critical Medical Anthropology, the push for maximized and equitable healthcare systems in post-apartheid South Africa must confront the gendered hierarchies and socio-political determinants that continue to shape rural women's access to care. Gender Theory compels us to examine how social roles, power relations, and institutional norms systematically disadvantage women, especially in patriarchal rural contexts where health decisions are often mediated through male authority. Within this lens, rural women are not just passive recipients of healthcare but active agents whose health choices are constrained by unequal access to resources, decision-making power, and mobility. Critical Medical Anthropology further illuminates how structural violence manifested through under-resourced clinics, stigmatizing service environments, and policy neglect reproduces historical injustices under the guise of neutrality. In South Africa's democratic dispensation, where the Constitution guarantees the right to health and equality (Section 27 & 9), these inequities represent not just service failures, but a more profound betrayal of the state's transformative promises. Therefore, to realise a truly inclusive health system, policy and implementation must be grounded in gender-aware and structurally conscious approaches that confront visible and invisible barriers to care. This includes not only addressing the supply side of healthcare but also challenging the embedded social norms and institutional biases that continue to marginalize rural women in the very system meant to protect them.

CONCLUSION

This research paper introduces the Framework for Localized Reproductive Health and Support Structure (FLRHSS), a community-focused model designed to improve access to SRH in rural South Africa. By

strengthening local engagement, enhancing healthcare provider training, and addressing economic and cultural barriers, the framework aligns with constitutional rights and national development goals, promoting equitable and inclusive healthcare.

Findings reveal that women in areas like uMkhambathini and eNkanyezini continue to face intersecting challenges, including household power dynamics, long distances to clinics, inconsistent service delivery, stigma, and restrictive cultural or religious norms that undermine reproductive rights. Effective SRH access cannot rely solely on policy declarations; it requires culturally sensitive, ethically grounded, and community-centered interventions.

The FLRHSS provides a strategic pathway for reconfiguring rural healthcare delivery, prioritizing confidentiality, respectful care, and meaningful community participation. Achieving equitable SRH access is a matter of social justice, demanding that rural women’s agency and dignity be placed at the center of health system reform. When reproductive healthcare is responsive to their realities, it reflects not only service provision but the fulfilment of South Africa’s democratic and constitutional promises.

BIBLIOGRAPHY

- Adedini, Sunday A, Oluwaseyi D Somefun, and Clifford Odimegwu. “Gender Inequality and Maternal and Child Healthcare Utilization in Sub-Saharan Africa.” *Gender and Behaviour* 12, no. 4 (2014): 6050–70.
- African Union. “Maputo Plan of Action 2016–2030 for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights,” 2015.
<https://au.int/en/documents/20150630/maputo-plan-action-2016-2030>.
- Alemayehu, Mihiretu, and Mengistu Meskele. “Health Care Decision Making Autonomy of Women from Rural Districts of Southern Ethiopia: A Community-Based Cross-Sectional Study.” *International Journal of Women’s Health*, 2017, 213–21.
- Baer, H. A., M. Singer, and I. Susser. *Medical Anthropology and the World System: Critical Perspectives*. 3rd ed. Praeger, 2013.
- Barreto, Mauricio Lima. “Health Inequalities: A Global Perspective.” *Ciencia & Saude Coletiva* 22 (2017): 2097–2108.
- Berger, P. L., and T. Luckmann. *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. Anchor Books, 1966.
- Butler, J. *Gender Trouble: Feminism and the Subversion of Identity*. Routledge, 1990.
———. *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge, 1990.
- Cleland, J., M. M. Ali, and I. H. Shah. *The Global Contraceptive Landscape: An Unfinished Agenda*. Population Council, 2018.
- Connell, R. W. *Gender*. 2nd ed. Polity Press, 2012.
- Connell, Raewyn. “Gender, Health and Theory: Conceptualizing the Issue, in Local and World Perspective.” *Social Science & Medicine* 74, no. 11 (June 2012): 1675–83.
<https://doi.org/10.1016/j.socscimed.2011.06.006>.
- Dzimiri, Christina Tafadzwa. *The Use of the Female Condom as an HIV Prevention Technology: Perceptions of Female Students at the University of Venda, Limpopo Province, South Africa*. University of Johannesburg (South Africa), 2022.
- Elujoba, Anthony A, O M Odeleye, and C M Ogunyemi. “Traditional Medicine Development for Medical and Dental Primary Health Care Delivery System in Africa.” *African Journal of Traditional, Complementary and Alternative Medicines* 2, no. 1 (2005): 46–61.
- Fathalla, M. F. “Reproductive Health and Women’s Rights.” *International Journal of Gynecology & Obstetrics* 46, no. 1 (1994): 1–7.
- Flick, U. *An Introduction to Qualitative Research*. 7th ed. London: (7th ed.). SAGE Publications., 2022.
- Foley, E., J. Smith, and A. Brown. “Women’s Reproductive Health: Beyond Biological Roles.” *Global Health Perspectives* 18, no. 2 (2022): 112–20.
- Gatwiri, Kathomi, Darlene Rotumah, and Elizabeth Rix. “BlackLivesMatter in Healthcare: Racism and Implications for Health Inequity among Aboriginal and Torres Strait Islander Peoples in Australia.”

- International Journal of Environmental Research and Public Health* 18, no. 9 (2021): 4399.
- Guest, Greg, Emily Namey, and Kevin McKenna. "How Many Focus Groups Are Enough? Building an Evidence Base for Nonprobability Sample Sizes." *Field Methods* 29, no. 1 (February 24, 2017): 3–22. <https://doi.org/10.1177/1525822X16639015>.
- Halisçelik, Ergül, and Mehmet Ali Soytas. "Sustainable Development from Millennium 2015 to Sustainable Development Goals 2030." *Sustainable Development* 27, no. 4 (July 22, 2019): 545–72. <https://doi.org/10.1002/sd.1921>.
- HAMmArsTröm, Anne. "A Tool for Developing Gender Research in Medicine: Examples from the Medical Literature on Work Life." *Gender Medicine* 4 (2007): S123–32.
- Hayman, R., and S. Sierra. "Focus Group Discussions on Development Research." *INTRAC Praxis Note* 57 (2010).
- Kasongo, N. S. "Experiences of Women with Depression on Rehabilitation Counselling in Mkushi District of Zambia ." The University of Zambia, 2022.
- Khan, Mohammad Mumtaz, Mohammad Iqbal Zafar, Tanvir Ali, and Ashfaq Ahmad. "Effect of Socio-Economic, Cultural and Demographic Factors on Woman Reproductive Health.," 2009.
- Khanh Chi, Hoang, Hua Thanh Thuy, Luu Thi Kim Oanh, Tran Quynh Anh, Nguyen Duc Vinh, Nghiem Thi Xuan Hanh, and Nguyen Thanh Huong. "The Content and Implementation of Policies and Programs on Adolescent Sexual and Reproductive Health in Vietnam: Results and Challenges." *Health Services Insights* 14 (2021): 11786329211037500.
- Lê, Quynh. "Cultural Meaning in Health Communication." *Health (San Francisco)*, 2006, 13–15.
- Marshall, C., and G. B. Rossman. *Designing Qualitative Research* . 6th ed. SAGE Publications, 2014.
- Marx, David, and Sei Jin Ko. "Stereotypes and Prejudice." In *Oxford Research Encyclopedia of Psychology*, 2019.
- National Department of Health. "Integrating Women's Reproductive Health into Healthcare Policy," 2021.
- Noy, Chaim. "Sampling Knowledge: The Hermeneutics of Snowball Sampling in Qualitative Research." *International Journal of Social Research Methodology* 11, no. 4 (2008): 327–44.
- Nyblade, Laura, Melissa A Stockton, Kayla Giger, Virginia Bond, Maria L Ekstrand, Roger Mc Lean, Ellen M H Mitchell, La Ron E Nelson, Jaime C Sapag, and Taweessap Siraprapasiri. "Stigma in Health Facilities: Why It Matters and How We Can Change It." *BMC Medicine* 17, no. 1 (2019): 25.
- Osío, J B. "Unveiling the Intersection: Anthropological Insights into Health Disparities and Well-Being." *Social Science Chronicle* 2, no. 1 (2023).
- Palinkas, Lawrence A, Sarah M Horwitz, Carla A Green, Jennifer P Wisdom, Naihua Duan, and Kimberly Hoagwood. "Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research." *Administration and Policy in Mental Health and Mental Health Services Research* 42, no. 5 (2015): 533–44.
- Rasu, Rafia S, Walter Agbor Bawa, Richard Suminski, Kathleen Snella, and Bradley Warady. "Health Literacy Impact on National Healthcare Utilization and Expenditure." *International Journal of Health Policy and Management* 4, no. 11 (2015): 747.
- Satia, Jayantilal. "Challenges for Adolescent Health Programs: What Is Needed?" *Indian Journal of Community Medicine*. Medknow, 2018.
- Stangl, Anne L., Valerie A. Earnshaw, Carmen H. Logie, Wim van Brakel, Leickness C. Simbayi, Iman Barré, and John F. Dovidio. "The Health Stigma and Discrimination Framework: A Global, Crosscutting Framework to Inform Research, Intervention Development, and Policy on Health-Related Stigmas." *BMC Medicine* 17, no. 1 (December 15, 2019): 31. <https://doi.org/10.1186/s12916-019-1271-3>.
- Togioka, Brandon, and Emily Young. "Diversity and Discrimination in Health Care." *StatPearls*, 2024.
- World Health Organization. "Maternal and Child Health: Priorities and Challenges," 2020.

ABOUT AUTHORS

Dr Philani Goodman Kuluse is an emerging scholar in Medical Anthropology; his research interest is centred on sexual reproductive health.

Dr. Lungile Prudence Zondi is a Senior lecturer in Anthropology at the University of KwaZulu-Natal, Pietermaritzburg Campus. Her academic work is dedicated to exploring and addressing the complex social issues marginalized communities face in South Africa, focusing on improving health and wellbeing through culturally informed research.

Author Contributions All authors contributed to the manuscript conception and design. [Dr Philani Kuluse and Dr Lungile Prudence Zondi] performed data collection and analysis. All authors wrote and revised the first draft of the manuscript, and all authors read and approved the final manuscript.

Funding: The authors declare that no funds, grants, or other support were received during the preparation of this manuscript.

Declaration: This paper is extracted from a Ph.D thesis in Medical Anthropology that has been recently passed.