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“They are being made into like baby-making machines”

A study of the impact of gender structures and norms on family planning for Xhosa women in rural Zithulele, South Africa.

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Abstract

Women in rural areas of South Africa battle with many structural issues, including unemployment, education and accessibility to health services, greatly delimiting family planning. However, socially constructed and internalized gender norms pose an additional and potentially greater barrier to family planning in traditional and patriarchal settings. This thesis aims to contribute to the growing research on the relation of gendered structures and norms to family planning outcomes. It explores how gender stratified systems and structural determinants exasperate such norms for pregnant women. A case-study was conducted in rural Zithulele, based on theoretical concepts from public health, feminism, constructivism and development studies, to conduct semi-structured interviews with pregnant Xhosa mothers. It follows a gendered health framework to determine localized socio-economic and family planning outcomes, finding that there are a number of deeply gendered structural determinants, which interplay with gender norms pertaining to masculinity, femininity and contraception, creating restrictive and gender-biased settings limiting women's family planning options. The found consequences include limited knowledge on family planning and contraceptive side-effects, discontent with pregnancies and not finishing secondary schooling, which affect the long-term socio-economic status and family planning options for individual Xhosa women in rural South Africa.

Key Words: gender norms, gender roles, family planning, South Africa, rural, sexual health and reproductive rights, structural determinants of health,

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Abbreviations

Eastern Cape	EC
Gender and Development	GAD
Gender Based Violence	GBV
Human Immunodeficiency Virus	HIV
Intrauterine-Device	IUD
Sexual and Reproductive Health and Rights	SRHR
Sexual and Reproductive Health	SRH
South Africa	SA
Sub-Saharan Africa	SSA
Waiting Mother's Accommodation	WMA

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1. Introduction

Effective family planning has numerous positive effects, from decreased maternal and child mortality, less (unsafe) abortions to long-term economic gains and female empowerment (Chersich et al., 2017; UNFPA-ESARO, n.d.). Despite international commitment to the sustainable development goals[1] or Family Planning 2020[2], targeting gender equality, global health and rights-based family planning, this domain is still marked with an unmet need for contraceptives, restrictive policies and harmful norms worldwide.

The latter is the focus of this thesis. Family planning is understood as the right of individuals or couples to decide the spacing and number of children, through affordable and quality healthcare and counseling, including access to information and contraceptives (UNFPA-ESARO, n.d.). It is a highly gendered topic, in which gender roles dominate and relate to biological sex. Few other aspects in life affect sexual and reproductive health and rights (SRHR), socio-economic status and well-being as much as harmful and restrictive norms (Lundgren et al., 2019: 237). Norms have the power to improve or aggravate health challenges (Pulerwitz et al., 2019a), furthering gender inequality and restricting access to family planning. However, they do not act by themselves, but must be seen in conjunction with existing structural determinants, underlying and facilitating gendered differences.

Research on norms is slowly gaining attention in development in connection to family planning and has been studied in relation to SRHR. To understand family planning outcomes, gender norms are indispensable, because of the influence they have on power relations and gender hierarchies (Pulerwitz et al., 2019a). Gender norms in public health and especially in family planning in South Africa (SA) are important because they sustain deeply gendered power hierarchies and inequalities that exist in the country (Cold-Ravnkilde, 2019; Lundgren et al., 2020). Consequently, there remains "immense potential for social norms research […] in South Africa" (Ganz et al., 2017: 30).

[1] The Sustainable Development Goals (SDG's) are 17 global goals to reach by 2030 set by the United Nations in 2015. It links governments, private sector, civil society, and citizens to reach the goals, with special attention to the poorest countries, to find and implement solutions. (UN-ECOSOC, n.d.)

[2] The 2012 Family Planning Summit in London led to the Family Planning 2020 (FP2020) initiative to have 120 million more women using family planning by 2020, addressing the unmet need for family planning in the 69 poorest countries, ensuring a right-based approach (Brown et al., 2014; Stover & Sonneveldt, 2017). South Africa signed this agreement. There has been clear advancement of family planning in many countries (Stover & Sonneveldt, 2017), yet also wide-spread critique of forced and coerced family planning in developing countries (Wilson, 2018). FP2020 is supported by many international organizations and foundations (FP2020, n.d.).

Yet the impact of gendered structures and norms on family planning is context specific and mostly localized (Weber et al., 2019), meaning it must be explored as a case-study. In this instance, the localized focus in on Xhosa[3] women in the deeply rural Ginyintsimbi location, colloquially known as Zithulele[4], in the Eastern Cape (EC) of SA. The region is one of the poorest rural areas in the country, marked by limited infrastructure and high unemployment (Zithulele Hospital, n.d.), suggesting that everyday struggles for women are abundant. It is a culturally rich region, with many female-headed households, yet patriarchal structures remain. As an under-researched and remote location, this makes it an interesting setting to question family planning.

The impact of gendered structures and norms on family planning shall be uncovered and problematized through an analytical health framework situated within Gender and Development (GAD). This topic is deeply embedded in development debates cutting across global public health, rural development, gender disparities and socio-structural dilemmas in emerging economies. It raises and encourages debate relevant for the entire development community.

1.1. Research Problem, Aim and Question

The research problem came from a conglomeration of contradicting findings observed during my internship in Zithulele: High Human-Immunodeficiency-Virus (HIV) rates, yet low condom use; hormonal injectable popularity, yet low use of other methods; and many female-headed household yet strong patriarchal settings. To unravel these contradicting problems and what influences women in their family planning, this research sets out to understand if and how norms are a crucial factor and how structural determinants may exacerbate them. Gender norms are rules on acceptable behavior for men and women, created and maintained through social interactions (Weber et al., 2019: 2455), but both concepts of structural determinants and norms will be elaborated on in the theoretical framework. The specific focus on family planning and contraception was chosen because it is directly tied to, and could prevent HIV, unwanted pregnancies, unsafe abortions, maternal or child mortality (Chersich et al., 2017). The focus is motivated by research presenting that despite norms being quite static (Adams et al., 2013), family planning offers women the perception and opportunity of being more empowered, even

[3] The Xhosa are an ethnic group and part of the Bantu-speaking people in SA (Carver, 2007-2008). Xhosa are primarily located in the Eastern Cape; however also live in other provinces (Ibid.). The spoken language is isiXhosa, one of the dominant mother tongues in SA.
[4] From here on forth referred to as Zithulele.

in patriarchal systems (Paek et al., 2008: 464). Further, the connection of structures, norms and overarching family planning (to the best of my knowledge) has not been researched in rural SA.

The aim of this paper is to uncover how socially constructed gender norms, in interaction with structures, impact the lived experience of women regarding reproductive behavior, specifically family planning and socio-economic outcomes. This thesis questions how gender norms fit into a gender system, whilst highlighting structural barriers. This thesis does not aim to find a solution or a project intervention but to add to existing debate on the relevance of structures and norms in family planning. The guiding research question is:

What localized gendered structures and gender norms exist for Xhosa women in rural Zithulele, South Africa and how do these impact family planning?

1.2. Research Motivation: Contribution to Literature

This thesis adds to the debate that norms, specifically gender norms, critically influence sexual health (WHO, 2010: 3). Research presents that norms limit access to family planning, as "inequitable gender norms act as social constraints that decrease women's ability to engage in healthy reproductive behaviors and/or seek services for their reproductive health needs" (Okigbo et al., 2018: 14). There is increasing attention and adaptation of social norm analysis and interventions for health outcomes (see Cislaghi & Heise, 2019; Weber et al., 2019). However, research is still emerging on the connection of norms and family planning and is not always connected to underlying structural issues. The following presents how this thesis contributes to the sparsely spread, existing research on this topic.

When it comes to norms and family planning much attention is paid to the role of men and patriarchy, especially in Africa (as literature in this theme is still emerging, a geographical focus had to be taken, which by no means imposes a continent-wide comparison or conflates intra-African regional differences, as country contexts vary greatly). Paek et al. (2008: 463) in Uganda discuss that most Africans have "patriarchal, patrilineal, and male-dominant societies" and especially in southern African countries, where traditional gender norms are more important, male authority is supported and sets conditions in which villages are less likely to use family planning options. In line with male authority their "domination in decision-making functions as barriers to the use of modern contraceptives" (Schuler et al., 2011: 102) and reiterates the importance of questioning masculinity. Simultaneously, men are drivers for high fertility because they have control over condom and hormonal contraceptive use and need to

father children prior to marriage to mark their entry to adulthood (Frost & Nii-Amoo Dodoo, 2009). Lastly, the intersection of patriarchy with pregnancy and childbearing norms, sustains men's power in all realms, whilst restricting women's (reproductive) power (Kane et al., 2016: 9).

By studying gender norms this thesis aims to question male-dominated hierarchies and how these influence family planning in SA. Existing research presents a gap, enabling to inquire more in-depth about contraception as part of family planning and opposing femininity in juxtaposition to the dominating man narrative, such as Geleta et al.'s study (2015). There is an "urgency" to research gender inequalities in relation to health outcomes (George et al., 2019: 2369), which this thesis aspires to do with focus on family planning. Because this research examines a predominantly Xhosa area, it hopes to add to the important understanding of culture in this thematic field, which Mayaki and Kouabenan (2015) previously pinpointed.

Yet as indicated, norms intersect with structures and social factors (Schuler et al., 2011; Weber et al., 2019). Previous research on the interaction of structures, norms and family planning indicated that education gives women control over family planning. Norms influenced behavior on contraception methods amongst non-schooled women, versus women with formal education who were less swayed by norms, indicating that education gives women greater control over family planning (Mayaki & Kouabenan, 2015). Schuler et al. (2011) highlight the importance of women in the economy and increased access to education for family planning in combination with norms. Gendered control of access to healthcare or information (Adams et al., 2013; Geleta et al., 2015) was repeated as a barrier to family planning. Consequently, this research wishes not only to contribute to what gender norms exist but what structural aspects underline these norms in a context specific setting and perpetuate gendered hurdles for women. Due to the limited research done in Zithulele, with many underlying problems of poverty and remoteness, this thesis hopes to provide evidence for the increased relevance and understanding of family planning, gender structures and norms in the EC and how they interact.

2. Situating the research

After highlighting the importance of structures and gender norms above the following will examine gender, sex and health in SA, the country's history towards family planning, and current formal norms, including policies and lastly follow with an introduction on the Zithulele location.

2.1. Gender, Sex and Health in South Africa

To understand the cultural context of Zithulele the gendered dimensions, specifically which gendered practices exist in SA and in Xhosa culture, must be understood.

Great influence on women's lives comes from male partners. Men in most societies possess greater control and power in (sexual) relationships (Strebel et al., 2006). SA is no exception, as studies indicate that the history of the country asserted dominant, traditional men, whose masculinity is heterosexist, patriarchal and encourages sexual success with women, supported by authorities, including former president Jacob Zuma (Morrell et al., 2012). This aligns with studies done on HIV prevalence, sexual-risk behavior or condom use, finding persistent male dominance and is further mirrored in studies on norms in the country.

Colvin's (2017) article reviews health interventions targeting men. He finds that South Africans endorse hegemonic masculinity[5] and patriarchal beliefs are pervasive and unchanging in many communities. There is perceived cultural prohibition to talk about sex between women and men and based on patriarchal norms and ideals of masculinity it is more difficult, especially for HIV-positive men, to practice safe sex. Further studies discuss how HIV, masculinity, and norms interplay. Several studies on gender, roles and sex were conducted in KwaZulu-Natal.[6] Fladseth et al. (2015) investigate condom use in KwaZulu-Natal using gender norms and find that in order to reduce gender inequity and HIV in rural SA, education is crucial, and further that HIV status was a determinant in condom use. Moreover, women in KwaZulu-Natal are not considered to have had a child, if they have not given birth to a boy (Ndinda et al., 2017). Varga (2003) presents the effects gender roles have on SRHR. Girls gain respectability if they are sexually active, remain sexual fidelity and they retain responsibilities towards contraception.

[5] Hegemonic masculinity is understood as a "form of masculinity that legitimates the subordination of women" which is "through a complex web of processes that extend into the organization of private life and cultural arrangements" (Jewkes & Morrell, 2010: 3).
[6] A neighboring province to the EC.

Men, conversely, have predominant sexual decision-making power and choice of sexual behavior, including a natural *need* for sex and *right* to initiate it.

This is echoed by Gottert et al. (2016) who find that South African men define sexual prowess as a personal achievement, but also that cultural adherence to gender norms and consequential strains associated with these, impact HIV and gender based violence (GBV) epidemics, specifically in rural Mpumalanga.[7] Pulerwitz et al. (2019b) also examine gender norms' influence on HIV testing and antiretroviral treatment. They find that men are often 'primary decision-makers' and can discipline their women. Women conversely are caregivers, yet more likely to get HIV tested. Overall, women and men in their study supported inequitable gender norms associated with negative outcomes (Ibid.).

Pettifor et al. (2004) present that multiple partnerships simultaneously are encouraged for men, whilst women are to be monogamous. In the same context there is more male control over sexual decisions, forced and coercive sex, whereas women often have no right to refuse. Varga (2003) reinforces this, noting that men can accept or reject paternity, whereas women are expected to enter motherhood, especially in traditional, rural areas.

Highlighting traditional beliefs in rural areas is relevant for Zithulele, where many cultural practices persist. One example is *lobola* (bridewealth) which is a formalized payment by men to a wife, widely practiced in Xhosa communities. Nowadays, it leaves many couples unmarried, because in order to raise *lobola* many men work in other provinces to earn money, or they do not manage to raise the money, creating female-headed households (Morrell et al., 2012). Mkhwanazi (2009) mentions the connection of teenage pregnancies with matriarchal households, and Strebel et al. (2006) argue matriarchal households break gender and cultural roles, as women gain more power in relationships and communities. Comparably, *ulwaluko*, is the Xhosa passage to manhood, in which boys become men through several weeks of traditional rituals. Men would rather "face death" than being a failure (Ntozini 2015: 136). Crying during the circumcision ritual is seen as weak femininity or "regression to childhood" (Ntozini & Ngqangweni, 2016: 1310).

The literature provides insight that gender plays an important role in SA and shows clear male dominance. Growing up in such "hegemonic societies" often leads "gender norms [to] reinforce ideals of male strength and control as well as female vulnerability" (Pulerwitz, 2019a: 7). Other

[7] Another province in SA, located North-East of KwaZulu-Natal.

reoccurring themes in SA were HIV, education and traditional practices. However, whilst research in SA with gender norms touches upon family planning it does not make it a specific focus, highlighting this thesis' contribution to current research.

2.2. South Africa's History on Family Planning

In order to understand Zithulele's family planning, the debate must be placed historically. SA was ruled by apartheid from 1948 to 1994.[8] From the beginning apartheid believed in the superiority of the white race. The government was scared that growing non-whites could jeopardize white political power, thus pushing white immigration and reproduction with family planning services, whilst rural, black populations had almost no access (Norling, 2018).

However, Malthusianism[9] arrived in SA in the 1950s, which led to a rush in contraception promotion (Norling, 2018). Poor, black people became the scapegoat for development issues, with a mission to limit reproduction. Black women were predominantly offered Depo-Provera[10], despite government knowledge linking it to cancer-causing effects, whilst white women used other options (Kaufman, 2000; Norling, 2018). With growing concern over black reproduction, the government started offering more family planning services in the 1970s, including in black urban areas and mobile clinics in rural areas and 'homelands'[11] (Norling, 2018: 370). Notably they offered contraception for free at these clinics, giving access to poorer women who desired it, however the linkage to white fear and control of black Africans was clear (Kaufman, 2000: 105). The 1970s were marked by national desire to provide contraception to reduce the black population and encourage white population growth (Ndinda et al., 2017). For some black women to be hired, contraception became a precondition and medical staff administered injections directly post-partum without explanation or permission (Kaufman, 2000). And it 'worked': contraception usage amongst black women increased in the

[8] During apartheid people were separated politically, economically and even residentially based on race (Norling, 2018). This separation was violent, inhumane and deeply rooted in all aspects of society including family planning. The record of this time is imperfect, especially for the black and colored population. For example, black South African's death was not even officially registered (Ibid.: 372).

[9] Malthusianism blames overpopulation and women's sexual behavior for global development problems, including climate change, hunger, poverty (Wilson, 2017). In this argumentation it is often developing countries and women here who are responsible for the problems. For most of the 20th century SRH(R) and family planning were discussed in the Malthusian matter of population control, instead of a rights-based approach.

[10] A hormonal injectable, see further Appendix A.

[11] Homelands, also known as Bantustans, were a designed ethnic device created by the apartheid government. Black Africans were assigned a Bantustan, based on their language (Kaufman, 2000) and were grouped as 'autonomous' nations. It allowed for "separate development" (Ibid.: 106) but enabled the white population to have a pool of black labor, creating precedent of labor migration of black men in the country. Parts of the Eastern Cape, including Zithulele, belonged to the Transkei, an area of Xhosa people, which was operated through self-governance and was nominally independent (Carver, 2007-2008) from 1976 – 1994.

1970s and 1980s (Norling, 2018) and fertility rates were lower than in any other sub-Saharan country at the time (Kaufman, 2000). Still, this "dubious program" had "genocidal undertones" as Kaufman (2000: 105) states.

With apartheid only in the recent past, scars across the country remain. There is collective remembrance of black African population control, whilst whites were encouraged to reproduce (Ndinda et al., 2017). Black women carried "the brunt of apartheids evils" (Sen & Östlin, 2007: 120). And even now it is argued that black South Africans have "a reluctance to use contraceptives for reasons related to the apartheid-era political climate" (Varga, 2003: 169). The connotations of suppression and control, which women might feel when using contraception, cannot be forgotten when discussing family planning.

2.3. Modern Family Planning Regulations

Today modern contraception in SA reaches one of the highest levels of usage in Africa (Lince-Deroche et al., 2015). Family Planning is personal and thus statistics cannot create viable comparisons, however one can regard contraception usage, which is part of family planning.

Injectables are the most popular choice across Sub-Saharan Africa (SSA) and in SA (Tsui et al., 2017), despite continued known hazards, such as potential increase of HIV risk (DoH 2012a: 11). In the Western world injectables are generally uncommon, except for in poorer, marginalized communities (Chersich et al., 2017). These quantifiable trends are reflected in the EC. The province did second highest nationally with 50.7% contraceptive usage (Ibid.). Injectables (2 or 3 months) are the most popular with one third of women (aged 15-49) using this method, yet discontinuation or delaying injections is prevalent and almost half of all women were late to follow-up appointments (Chersich et al., 2017; NDoH et al., 2019: 104). Research found that 36% of those who were late in the EC were refused a reinjection by the nursing staff (Lince-Deroche et al., 2015). (*Overview of contraception methods see Appendix A).*

Further, SA has high rates of teenage pregnancy, where half of all women aged 20-24 were previously pregnant, mostly premarital and unwanted, especially in poor, rural areas (Lince-Deroche et al., 2015: 73; Margherio, 2019; Mkhwanazi, 2010). It is argued that the eco-political situation post-apartheid led to many pre-marital, adolescent pregnancies specifically in the Transkei, where Zithulele is located (Makiwane, 1998).

Liberal laws influence contraceptive prevalence, they reduce the risk of using traditional methods and increase chances of women using (modern) contraception (Finlay & James, 2017).

SA has been recognized to have "one of the world's most progressive constitution[s], policies, laws and institutional frameworks" (Cold-Ravnkilde, 2019: 212). There are many relevant legal documents, which are the *formal norms* framing family planning.[12] Most recent and relevant are the *National Contraception and Fertility Planning Policy and Service Delivery Guidelines* (DoH, 2012b) and *National Contraception Clinical Guidelines* (DoH, 2012a) based on the London Family Planning Summit. The goal is that "everyone should have access to accurate, unbiased information about all available methods in order to make an informed choice" (DoH, 2012a: 8). Simultaneously the guidelines show awareness of surrounding issues, including socio-economic status; rural versus urban areas; educational level; partner, family and community expectations and individual knowledge (DoH, 2012b). It is said that these progressive policies come from the "collective struggle of women during the transition from apartheid to democracy" (Cold-Ravnkilde, 2019: 212).

It should also be noted that SA, despite its legal framework, battles with high GBV levels and some of the world's highest rape-rates, framed as a consequence of apartheid, labor migration and persistent patriarchy (Cold-Ravnkilde, 2019; Jewkes & Morrell, 2010). Lince-Deroche et al. (2015) show that GBV can be a barrier to contraceptive use, and consequently family planning, and is based on structural inequalities and discriminatory norms. Whilst the foundations for equitable family planning services are provided, many challenges remain.

[12] These include the *Patients' Rights Charter*, promoting the right of access to healthcare, *Adolescent & Youth Health Policy* (2016-2020) which include youth as key priority in SRH and the *Guidelines for Maternity Care in South Africa* (2015), outlining maternal, antenatal and obstetric services in healthcare.

2.4. Zithulele: The Location of the Study

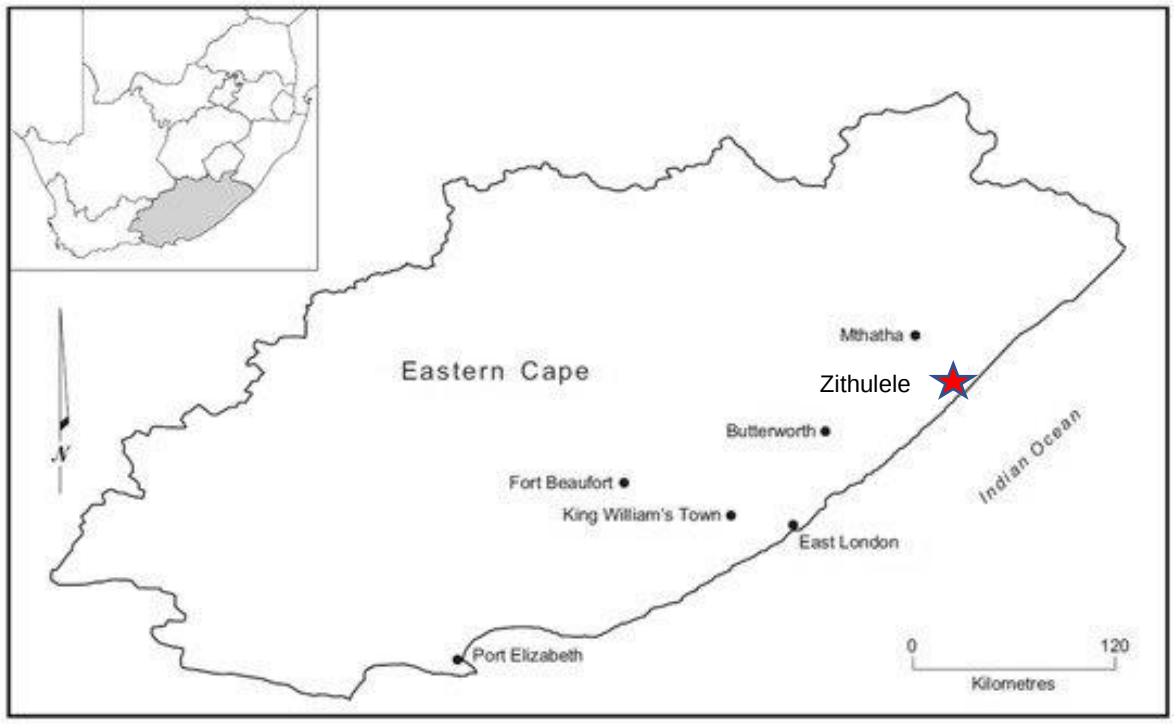

Figure 1 Location of Zithulele in the Eastern Cape (Roberts & Shackleton 2018, modified by Author, 2020)

In the previous section of the chapter formal norms or laws, as well as the history, gender and sex in SA were discussed. The following will turn to Zithulele (for location *see Figure 1*) to describe complex, underlying problems here. It would be negligent to point at family planning and not explicitly state that Zithulele has a burden of other issues it must combat, that simultaneously influence family planning.

HIV is a challenge for women around Zithulele, as every third woman is HIV-positive (NDoH, 2019: 232). Researchers have gone so far to call it a "heterosexual HIV epidemic", as most new HIV infections are found amongst heterosexuals, predominantly among black South Africans in poor communities, such as the wider EC (Speizer et al., 2018: 95-96). This should make condom use exceptionally prevalent. However, despite one third of sexually active women viewing themselves at high risk of a HIV infection, only 11.5% of the population uses a male condom (Chersich et al., 2017; NDoH et al., 2019: 104.). Chersich et al. (2017) further shows that health workers have misconceptions about HIV-positive women, antiretrovirals and contraception, where these women are less likely to obtain oral contraceptives or intra-uterine devices (IUDs), consequently limiting family planning options.

This connects to general problems documented in accessing healthcare in the EC. Whilst the province has some larger cities[13], much is rural like Zithulele. Limited infrastructure and expensive 'taxis'[14] remain a problem and 49% of women (including larger cities) reported difficulties accessing healthcare (NDoH et al., 2019: 250).

Lastly, Zithulele perfectly presents how deeply unequal SA is (see Stats SA, 2020; World Bank, n.d.). Whilst SA is a rising economy, some regions remain in dire poverty. Education attainment for women in the EC is low and most do not finish secondary school (Stats SA, 2012: 49). The lack of education is mirrored in the labor market, with extremely high unemployment rates, especially in rural areas (Ibid.: 47). Next to formal regulations and laws, this chapter aims to visualize that overarching health and structural issues are additional challenges for women around Zithulele to access family planning.

[13] Including East London, Port Elizabeth and Mthatha.
[14] A type of mini-bus and only form of public transport available in Zithulele.

3. Theoretical Framework

The theoretical framework builds on Gita Sen and Piroska Östlin's (2007) "*Framework for the role of gender as a social determinant of health*" (*Appendix B*). This framework originates from feminist theoretical debates on GAD and explains how gendered, inequitable health outcomes develop.

Albeit this thesis leans on this framework, the focus is narrowed, to address family planning and norms, constructing a "*framework for the role of gender as a determinant of family planning."* Sen and Östlin's argumentation was chosen as it presents that inequitable health outcomes, in this case family planning outcomes, seldomly can be explained on their own. There are structural and normative challenges, placed in gender hierarchies. This chapter explains the theoretical origins of the framework and its building blocks, starting with the gender system and gender stratification, presenting that gender is a key social determinant of health. Then two facets of this system, gendered structural determinants and gender norms, will be explained. Lastly, it will combine the theoretical concepts before presenting how they interact.

3.1. Feminism and GAD

This framework is inspired by Gita Sen's work, a key author and activist in feminism, GAD and DAWN.[15] Sen and Grown's (1987: 18-19) understanding of feminism is adopted as the "opposition to gender oppression and hierarchy", but with emphasis that there is no universal understanding of feminism, as the 'needs' of feminism vary for different women in different contexts. Using a feminist lens uncovers invisible power structures and creates a framework to resist the oppression of women in any sense and actively challenge gender power relations (Harcourt, 2009).

Sen and Grown (1987) question many early development projects targeting women that only pointed at insufficient participation, or practical needs, rather than the biases towards women, ignoring the social and political sphere in which women existed (Rai, 2011: 29). This is one of the ideas on which GAD builds, and in which this thesis frames itself. It aims not to see women

[15] Development Alternatives for Women in a New Era (DAWN) is an influential network of feminist activists and researchers from the global South, all working towards eliminating gender inequality. It questions Western orientated development processes and thus gears development from the world's poor people for the world's poor people, but especially from / to women (Sen & Grown, 1987). The aim is to aspire for a world free from gender, class, race and nation, breaking "down hierarchies, power and distrust" (Ibid.: 19).

as independent objects, but in relation to the world around them. Benería and Sen (1982) state the focus should be on the systematic effects which women in different classes and positions face, because gender is constructed and seen in relation to society.

When only focusing on women as objects and their practical needs, there is a deeply rooted failure to "challenges existing structures and hierarchies of domination and subordination that essentially define women" (Sen & Durano, 2014: 14). GAD and Sen aim to challenge this inequity, oppression and subordination (Benería & Sen, 1982; Lee et al., 2019). In GAD the question becomes how and where "women have been systematically subordinated" and refocuses on gender as an analytical category (Moser, 1989: 1800).

3.2. Gender Systems: Gender as a Social Stratifier and Determinant of Health

The first stage in Sen and Östlin's (2007) framework is the notion of a gender system. This system uses existing hierarchies "to generate and intensify inequalities" (Benería & Sen, 1982: 162). It is based on the difference of gender as a defining category of marginalization and exclusion. Therefore it "govern[s] how people live, and what they believe, and claim to know about what it means to be a girl or a boy" (Sen & Östlin, 2011: 65).

The system highlights the need to see society and its features as gendered, including land, property, economy, reproduction, migration and education (Sen & Durano, 2014; Sen & Östlin, 2011: 65). It is composed of entities keeping hierarchies and inequalities in place, including structures, norms and agents, and operates through regulations and relations that subordinate women. Aligning with GAD it questions how women in many societies are "objects rather than subjects (or agents)" (Sen & Östlin, 2011: 65). This system is visible and operates at a global level, as women (in most societies) are subordinated based on their gender. However, Sen and Östlin (2011), state that societal features vary across different locations, including gender roles. Therefore, the operationalization of gender systems is context dependent, questioning local gender norms and behavior, gendered structural determinants, how these entities interact and what consequences they bear.

Sen and Östlin (2007) establish that based on the gender system, gender is a stratifier and, along with other stratifiers, a key social determinant of health. This concept originated in public health discourse, where health is influenced by social determinants, which are the "conditions in which

people are born, grow, live, work and age" (CSDH, 2008: 1). By tackling these aspects of poor and unequal health, one addresses the need for health equity.[16]

Other forms of stratification can be race, caste, or economic class, which interact with gender (Sen & Östlin, 2007). It would be foolish to not point out additional stratifiers in this thesis, such as the poverty in Zithulele and being of black, Xhosa ethnicity, as these shape lived experiences. They are important factors, yet for the scope of this thesis, the framework and analysis will concentrate on gender, thereby allowing the pinpointing of gender hierarchies and placing the debate in the GAD approach (Moser, 1989; Ridgeway & Smith-Lovin, 1999).

Reiterating that the gender system is the differentiation of male and female that justifies inequality and creates hierarchies based on gender (Benería & Sen, 1982; Ridgeway & Smith-Lovin, 1999), the following established the dichotomy of sex versus gender. Sex is the biological marker of each human, that defines reproductive capacity, whilst gender is socially conscribed attributes and roles. Construction of gender is culturally dependent and globally diverse (Sen & Mukherjee, 2014). As Connell and Pearse (2015: 17) point out "being a man or a woman […] is not a pre-determined state. It is a *becoming.*" Gender is fluid and can change over time and space and is "lived differently in different places, bodies and locations" (Harcourt, 2009: 14). Each person understands their identity in relation to the society around them.

Biological sex is important in the discussion on family planning. There are many sex-specific health outcomes, such as cancers, specific hormones, or pregnancy (Heise et al., 2019: 2443). This is important to keep in mind when it comes to family planning, as contraception and childbearing are ascribed to women's bodies. Despite male options being available, women are predominantly responsible for birth control globally. Kimport (2018) appropriately calls this the "feminization of contraception". It is in family planning, that female bodies are brought into gendered social processes, arguing for innate nature such as reproduction, crossing the boundary of the sex versus gender debate, and show how they interrelate (Connell & Pearse, 2015, John et al., 2017). It is also in sexuality and reproduction where women's bodies become a "site of the most direct forms of control" (Sen & Durano, 2014: 15).

[16] Equity is giving individuals what they personally need to have the same position as everyone else, whereas equality is giving everyone the same. The WHO defines equity as "the absence of avoidable or remediable differences among groups of people" that help "void or overcome inequalities that infringe on fairness and human rights norms." (WHO, n.d.)

Returning to inequitable health, gender often restricts resources and access to goods or services. Because gender is socially constructed and based on community knowledge, it comes with locally prescribed roles of gender-appropriate behavior, presenting "exemplary masculinities and femininities" (Connell & Pearse, 2015: 17). These gender roles occur with "*having, being, knowing* and *doing"* female versus male, where gender acts to "differentiate, stratify, subordinate, and hierarchise people" (Sen & Östlin, 2007: 12). In these gender hierarchies, males predominantly hold power over females. Using gender as an analysis tool can capture hierarchies, as in the inception of wider GAD debates. In a system that differentiates on people's gender, stratification is created to match prescribed roles, as gender is fundamental in directing everyday actions and objectives and compromises all aspects of life. Gender delimits who has access to what, how a person lives, works and ages, and thus is a social determinant of health. Using a gender lens on everything challenges underlining power relations, including structures, norms, and agents.

3.2.1. Power in Gender Systems

Whilst this thesis does not problematize power, per se, it is relevant to address it, as social hierarchies in the gender system imply social relations of power (Sen & Östlin, 2007). By using gender as an analytical category, it enables one to ask *how* hierarchies and differences are produced in power relations (Locher & Prügle, 2001a). For feminists' power is constantly inherent (Ibid.) and this view is adopted here.

With gender distinctions it is inevitable that there are power relations between men and women (Jaquette, 2013). There are some gender needs (such as structural barriers) that are immediate. However, GAD pinpoints the ability to alter power relations (Sharp et al., 2003). Thus, Sen and Östlin (2007) hint at two understandings of power – *power over* and *power to* (Boudet et al., 2012: 20). Power over, is visible in the form of discrimination and bias that result in inequalities and injustice or social power relations (Sen & Östlin, 2007: 7). In places where strong gender systems exist, men and masculine behavior are favored over women and femininity and create hegemonic masculinities and systems of power in which women are placed in subordinate positions (Sen & Östlin, 2007). In this paper heteronormative understandings and male-female dichotomies are applied, based on the context of SA.[17]

[17] I would like to point out that there is no question that there are more than two genders and identification across these boundaries, however in areas where heteronormativity is valued and patriarchy is normalized often (not always) "non-conventional gender identities are deeply disfavored" (Heise et al., 2019: 2441). In SA

However, by using gender as an analytical tool, it is also possible to fight against power relations and not inscribe women as victims (Sen & Östlin, 2007). This is "individual empowerment", which can create transformation (Ibid.: 57). Women and their bodies in family planning are not just objects but partake in social agency and are active participants in social processes (Connell & Pearse, 2015). Aligning with GAD, women are agents of resistance, and norm-change is an effective weapon against power systems (Jaquette, 2013). Thus, women maintain but also transform norms.

3.3. Structural Determinants of Health

Sen and Östlin (2007) then turn to structural determinants, and their interaction with gender as a stratifier. In their view, gender systems comprise gendered structural determinants or women's practical needs. These are necessary to eliminate subordinate positions (Moser, 1989), because in existing socio-economic processes women do not have the same resources or control as men (Sen & Grown, 1987; Sen & Östlin, 2011).

Socio-economic structures outside of health systems, negatively impact health outcomes. These structures interact with gendered stratification, meaning structural issues which disproportionately affect women, causing inequitable health. Sen and Östlin (2007) point out that the gender system is slow to change, but can when structural barriers shift, which they call structural processes. To understand these structural issues two examples are presented. There are structural barriers in education, such as school fees or security, which more likely impact females, due to preferential treatment in the gender system of males. Consequently, women have less access to formal education, causing lower socio-economic standing and negative health outcomes (Skolnik, 2016). Sen and Östlin (2007) also highlight demographic transitions as positive for health outcomes and including family planning programs is tied to gains in other determinants. As structures change, the interaction within the gender system is crucial and can strengthen or weaken gender inequity/inequality (Ibid.). In the GAD approach the removal of structural obstacles is essential for gender equality.

Sen and Östlin (2007) find the processes of transition, such as rising literacy and globalization important, yet to record changes in structural determinants would require a longitudinal study

homosexuality is widely accepted, gay and lesbians can marry and father/adopt children, however in traditional settings, for example through *ulwaluko*, it is assumed that men are heterosexual and masculine, if they do not conform to these cultural expectations they often become marginalized (Ntozini & Ngqangweni, 2016). SA has very liberal policies towards LGBTQ+ and against discrimination, yet parts of society remain homophobic and heterosexist, and heteronormativity is common (Henderson & Shefer, 2008: 2). It is a common critique to the GAD approach to categories in heterosexual dimensions (Tripathy, 2010) and I acknowledge this limitation.

and cannot be covered in this thesis' scope. Structural determinants will be observed, to present static findings. The focus will be derived partly from Sen and Östlin, looking at literacy; education and health systems, as well as based on findings in the coding process.

3.4. Social Norms as an Intermediary Factor

Sen and Östlin (2007) see the interplay between structural determinants and health outcomes intensified by intermediary factors. It is important to combine structural issues with norms, because "improving women's education and health does not translate into empowerment" and equity, if corresponding "sexual and reproductive rights" and local acceptance of these do not exist (Sen & Mukherjee, 2014: 191). This is because gender systems and determinants are not just structural but operate in and through other factors. Sen and Östlin (2007) outline four categories of intermediary factors[18], however based on time and financial means available for this thesis, the scope had to be reduced. Here the framework concentrates solely on gender norms, as they are a vital determinant of social stratification (Sen & Östlin, 2007: 28).

Gender norms are first and foremost social norms or socially constructed ideals and rules to follow on how to behave. People "follow rules and norms [and] are guided by […] various social practices" around them (Locher & Prügl, 2001a: 114). For groups to maintain a stable social order, there must be predictability of behavior and guiding expectations to create routines (Fine, 2001: 139). Norms are different from attitudes and beliefs because norms directly govern behavior (Ganz et al., 2017). This can be done through formal or informal norms. People are mostly aware of *formal norms*, including laws and regulations, versus *informal social norms* that rule behavior outside of these formal systems (Sen & Östlin, 2007: 28). Simply put "social norms are the informal, mostly unwritten, rules that define acceptable, appropriate, and obligatory actions in a given group or society" (Cislaghi & Heise, 2018: 2). Some formal norms in SA were outlined in section 2.3, but the focus of this research is social norms, specifically gender norms.

3.5. Gender Norms

Placed within a gendered system, all social norms are gendered and therefore gender norms. To understand gender norms the definition of Keleher and Franklin (2008: 43) is adopted where gender norms are "powerful, pervasive values and attitudes, about gender-based social roles

[18] 1) discriminatory values, norms, practices, and behaviors, 2) differential exposures and vulnerabilities to diseases, disabilities, and injuries, 3) biases in health systems and 4) biases in health research (Sen & Östlin, 2007)

and behaviors that are deeply embedded in social structures." As with social norms, gender norms' construction is through social relations. This can include households, communities, and wider society, often reproducing inequitable outcomes and dynamics for women (CSDH, 2008; Keleher & Franklin, 2008).

Gender norms aid the creation of a gendered system and are part of a patriarchal hierarchy. This means that gender norms are a form of power that enables and constrains women's position, especially in reproductive health. Power is enacted on women in the form of regulations, decisions and expectations, and thereby affect social relations and subordination (Sen & Durano, 2014).

Norms are unwritten, fluid and may change over time. They can create powerful ideals of manhood, womanhood, masculinity and femininity, which are internalized, and make men or women believe in their superior or subordinate status (Sen & Östlin, 2007: 29). Specifically, patriarchal gender norms favor masculinity and deny opportunities and resources to women (Lundgren et al., 2019). This aligns with GAD, as social constructions of gender create roles and expectations, but also opportunities for resistance (Rathgeber, 1990 in Lee et al., 2019). Research presents that "social norms can either help or hinder the individual's capacity" for agency, as with increased agency women are more likely to move from compliance of restrictive gender norms to challenge them (Boudet et al., 2012: 13-14).

3.6. Analytical Framework

Sen and Östlin (2007) see an interplay of gender systems and structural processes, which produce gendered structural determinants, which in combination with intermediary factors, including norms, leads to inequitable health and socio-economic outcomes. Their framework looks at public health outcomes in general. As described throughout the components above, the framework was limited for the scope of this thesis, and therefore is adapted to research gender norms and family planning. Many other factors would have been interesting to include but require monitoring over longer periods of time. Norms were picked because they are observable, yet also relevant and never researched in this location.

In the gender system, gender acts as a stratifier, differentiating male and female and building power hierarchies and relations. It is a structural determinant in limiting access to resources and acts as a barrier. Following the GAD analysis, one must always focus on underlining issues of gender disparity, as only focusing on structural disparity cannot resolve issues (Lee at al., 2019:

97). Consequently, norms reinforce inequalities and determinants and in turn results in inequitable health outcomes, specifically family planning and socio-economic consequences for women. There are feedback effects from outcomes and consequences back to determinants and norms and the framework presents how deeply interrelated family planning is to the social context. The modified framework *(see Figure 2)* allows to see an overarching picture of family planning in a localized setting.

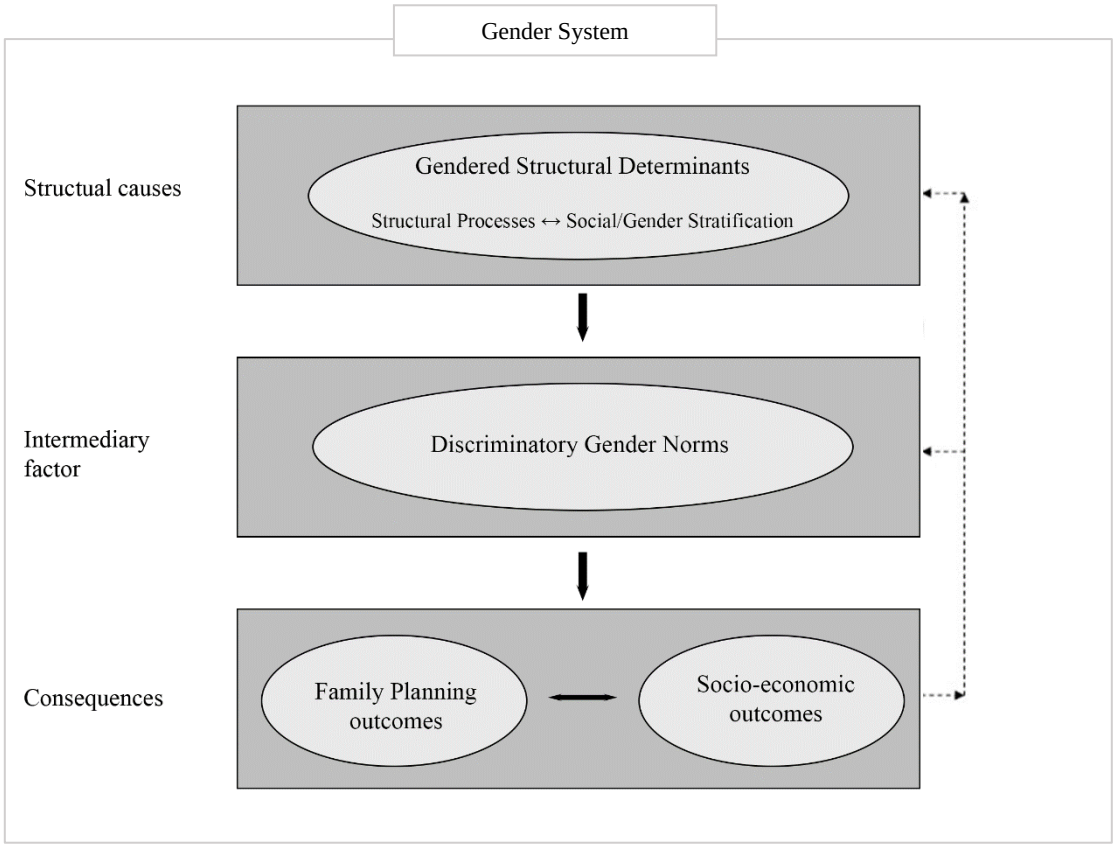

Figure 2 Framework for the role of gender as a determinant of family planning (Author, 2020)

4. Methodology

4.1. A Feminist-Constructivist Standpoint

Based on the theoretical framework a feminist-constructivist ontology was taken. In a constructivist view I understand that social phenomena are created from perceptions and actions of actors in society. Culture and surroundings are in a "continuous state of construction and reconstruction" (Bryman, 2012: 34). Adopting a constructivist view indicates the importance of social construction of norms and how "historical and cultural norms […] operate in individuals' lives" (Creswell & Porth, 2018: 60). To critique existing, predominantly male-created (Tickner, 2005), knowledge of the world, I adopt a relational, feminist ontology. Based on Tickner (2005: 2177) the '*ontology of social relations*' is what allows feminists to question unequal social structures.

I follow an interpretivist epistemology in which truth is developed based on social interactions (Bryman, 2012). In constructivist epistemology, knowledge is self-constructed and interpretation intrinsic (Jung, 2019). Constructivists rely on the participants' view on situations (Creswell & Porth, 2018) which aligns with feminists' epistemological standpoint, giving attention to lived experiences of women, where knowledge comes from a range of locations and people (Tickner, 2005). This integrates with Xhosa culture, which emphasizes storytelling and traditions passed down along generations.

I shortly acknowledge how this ontology and epistemology enters a debate between constructivism and feminism. Feminists and constructivists agree that gender as well as norms are socially constructed (Locher & Prügl, 2011b). I am interested in norms, but also how they reflect the categorization of people through hierarchies, therefore I acknowledge the theoretical disagreement on the question of power. Power is outside the social realm for constructivists, whereas for feminists' power is inherent. I will see power as constantly present, allowing me to assume hierarchies and relationships based on power. Consequently, ideas and knowledge of the world are relational and generated by interactions.

4.2. Research Design

A qualitative approach was most appropriate, as it allows to capture and interpret personal perspectives. To research lived experiences in an under-researched area and the complexity of one remote location, a case-study design was chosen (Bryman, 2012). In a feminist approach,

the knowledge produced here, makes no claims to have universal applicability to all women (or men) (Rose, 1997: 307) or even for the wider EC, based on limited sample size.

4.3. Research Methods

The following outlines the methodological tools used for this thesis, including recruitment, ethics, data collection and analysis.

4.3.1. Access to the Field

Zithulele is the location of a deeply rural hospital[19], with no surrounding village-structures but scattered houses, meaning research here presented obstacles in accessing the field. Public 'taxis' were deemed unsafe to use, access to cars was limited and required a driver. It could take up to 8.5 hours to reach three people with random sampling, meaning chosen locations could be unwilling to participate, not at home or crossing ethical boundaries by approaching houses without consent. In order to give voice to those more marginalized (Hesse-Biber & Leavy, 2007) it was necessary to talk to women who came from more rural pockets than women in Zithulele, where many speak English, are employed and have finished secondary schooling.

Thus, a localized solution was found. Approximately 90% of all women in the catchment area of Zithulele Hospital come here to give birth and present a wide range of age, location and background. The hospital administrates the "Waiting Mother's Accommodation" (WMA). Its purpose is to allow pregnant women to arrive prior to giving birth and stay up to three weeks. The WMA is separate from the hospital, and not on medical grounds. Women are at full gestation but *not* in labor. The mothers have space and time but due to limited facilities do not have much entertainment. It was considered ethical to conduct research here, from the patient-comfort perspective from Zithulele doctors. Recruiting women here gave me access to women going to 13 different local clinics and who have different information on family planning. Further coming to the hospital presumes these women had some consultation concerning SRH(R). This allowed the questioning of contraceptive use, knowledge attainment and influences on family planning.

[19] Zithulele Hospital is a district Hospital, with 147 beds, which is the primary healthcare service for approximately 130.000 people (Zithulele Hospital, n.d.)

4.3.2. Participant Recruitment

Following criteria for recruitment was established. The participant must…

a) … be between 18 and 45 years old.

b) … be an expectant mother.

c) … currently reside in the WMA.

d) … voluntarily agree to participate.

The sampling took place in the WMA, choosing women on the basis that they were interested and gave informed consent. Therefore, it was purposeful sampling. The interviews took place in a separate kitchen area, which was a quiet, private and neutral environment. The sampling took place over 4 weeks. I had direct contact with doctors in case women were showing symptoms of distress or labor. I chose to only study women, in a setting where they are alone, allowing in-depth conversations without pressure from partners (Speizer et al., 2018).

A total of 19 interviews were conducted, which fulfilled saturation. Of these, 17 were used for analysis, as one woman was only visiting Zithulele and one recording had a technical malfunction. The age ranged from 18-35, and women had 1-5 children. The geographical space covered 8 out of 13 clinics of the Zithulele Hospital catchment area. Further information on participants is available in Appendix C.

I further conducted purposeful sampling of medical staff as key informants about cultural and medical setting, basing recruitment on availability and voluntary participation. Four interviews were held, all conducted in English. An overview of informants is found in Appendix D.

4.3.3. Ethical Considerations

Ethical consent for this study was given by Walter Sisulu University's Family Medicine Department in Mthata (*Appendix E*) and LUMID's ethics board (*Appendix F*). For access into the community, local gatekeepers were informed. The head of clinical services, Dr. Ben Gaunt, and a practicing doctor, Dr. Karl le Roux, agreed to support this research and recruiting method. These gatekeepers likely never met any of the women before and thus did not create pressure for them to participate. By having no direct attachment to the staff there is no coerciveness to the participants. It was decided to not give monetary compensation to participants but rather provide snacks and drinks, to not coerce participation.

I made sure participants were aware of their role and rights, with every opportunity to quit, take a break or ask questions (Hesse-Biber & Leavy, 2007). The study was explained verbally during recruitment. Each participant was given an information sheet and consent form in isiXhosa (*Appendix G*). If the participant was illiterate the translator read the consent form, gathered oral consent and asked for a signature. Each participant was assigned a personal identifier (PID) which was continuously used during transcription and analysis. During the writing process, PID's were converted to random, Xhosa pseudonyms, which anonymizes and protects the confidentiality of the participants (Creswell & Porth, 2018) and conveys a more personal lived experience for the reader than relating to a number. There is no public record of names, nor will any answer be identifiable to an individual, to keep confidentiality and anonymity. All recordings are kept on a password-protected external hard-drive. Key informants were informed of the study, consent gathered (*Appendix H*) and during the writing process pseudonyms were assigned to ensure confidentiality. After the writing process key informants were contacted to ensure agreement of used quotes.

To ensure credibility and that this study investigates the intended questions, I used methods established in qualitative investigations. I assume interviewees were honest, and through opportunities to refuse the interview, hoped to gather participants who were genuinely willing to participate. I presented initial findings to the Zithulele community and will share the final paper.

4.3.4. Data Collection

I created a semi-structured interview guide based on previous research, inquiring about family planning, contraception, culture, and societal relations (*Appendix I*). Semi-structured interviews allowed women to answer on their own terms and comfort (May, 2011). I wanted to capture the *experience* of women which is why a small sample with a flexible interview guide was used to explore processes and personal stories (Hesse-Bieber & Leavy, 2007). The interview guide was given to the translator prior to the interviews to ensure that language was comprehendible, translatable and relevant. A pilot interview was conducted on the same terms and conditions as designed, in order to ensure smooth translation, interview flow and relevant questions. After the pilot, I made changes accordingly. The pilot was not included in analysis.

The translator and I explained the study to the women in the WMA. Once participation was agreed, the interview was held in the WMA kitchen. If the kitchen was not available an alternative location, with similar characteristics, was found. The study was explained, and

consent gathered, as stipulated above. To create a relaxed atmosphere, all sat in a circle with snacks and drinks.

Based on a semi-structured format, I always probed with further questions, and silent probing (Hesse-Biber & Leavy, 2007). I remained quiet to allow my participant to expand on her story, but also offer reassurance or a break when it got emotional. Based on the feminist standpoint, interviews and research should not exploit but there must be given something in return, creating collaborative research (Bryman, 2012; Creswell & Porth, 2018). I ended each interview with an overview of the contraception options available (*Appendix A*) and answering questions, hoping for a knowledge exchange.

Further I created a semi-structured interview guide for key informants, based on the same topics (*Appendix J*).

4.3.5. Translation

There is a "relationship between language and social experience" which means not knowing the language is a barrier in cross-cultural research (McLean, 2008: 785). I worked with a local translator from Zithulele. She was paid the same wage as her formal employment which was 40 Rand[20] per hour. Interviews were held in isiXhosa and translation was concurrently, unless participants wished to speak English. In concurrent translation, answers are directly translated back to English, if possible word-for-word. This was time-costly, as surely "people lost the rhythm" of conversation (Desai & Potter, 2006: 175), yet made sense in the setting and with financial constraints. Because translation was concurrent, I could start transcribing whilst in SA. This helped me to keep account of my research process and with 'hunches' about data (Hesse-Biber & Leavy, 2007: 145). Following a 'hunch' I added a question about spiritual beliefs, after this was reoccurring in the first five interviews.

As a white, European woman with no children I considered myself an "outsider", whilst my translator, a Xhosa mother herself, was able to gain an "insider-status" and acted as a local gatekeeper, building rapport with participants (Hesse-Biber & Leavy, 2007: 140). She did not know any interviewees, creating no pressure from personal relations. I knew translation would not always be word-for-word, but as the translator was local and the interview guide previously discussed, I trusted that she "convey[ed] expressions and ideas from another linguistic scheme and cultural environment" to our common understanding and defined aspects if there was

[20] Equivalent to 21 SEK.

uncertainty, opening a door to cross-cultural understanding (McLean, 2008: 786). In the four weeks of data collection, the translator had to take a leave of absence, thus for one interview another translator was hired, who was also a local Xhosa woman working as a translator in the hospital. The same terms were applied.

4.3.6. Data Analysis

After each interview I recorded characteristics such as age, education and, profession, followed by reflections on the interview, including disposition to talk, non-verbal signs and difficult passages to remember participants during analysis.

Thirteen interviews were transcribed manually, for the remaining four and the key informant interviews the website *otter.ai* was utilized. Here audio is uploaded and transcribed. No personal names were mentioned in the interviews uploaded, making participants anonymous. Further, the interviews were deleted as soon as transcribed, leaving no record by AISence according to the privacy guidelines (Otter.ai Inc, 2020).

The data was analyzed and coded using Nvivo12. I re-read all transcriptions and characteristics, as Bryman (2012) suggests. I started noticing recurring themes, which were broadly characterized as 'contraception', 'masculinity' and 'marriage'/ 'femininity'. Creswell and Porth (2018) state that in constructivism, the inquiry develops a pattern of meaning. By letting the participants explain their viewpoint, I adopted an inductive approach to my interpretation. I realized that many of the coded findings indicated 'behavioral rules', which is how the inductive finding of norms occurred. I further referenced general categories of 'consequences' and 'government' (later 'structural determinants'). Within each coded 'node' in Nvivo12 I added sub-codes. From there I used axial coding, which allowed me to focus on nuances (Hammett et al., 2015: 260) and adding theoretical input to analyze the data.

4.4. Reflexivity

In feminist-constructivist understanding I must be self-consciousness during research and consider how my background, personal, cultural and historical experiences shaped my interpretation (Creswell & Porth, 2018; Rose, 1997). Hammett et al. (2015: 47) highlight the importance of understanding political context, including SA's violent apartheid history. I was aware of my power during the research, being white and of a higher socio-economic background. Despite me reinforcing opportunities to decline questions, my translator reminded participants that they did not *have* to answer just because I am white. I was able to travel to SA,

have the education to conduct research and visible material inequalities that separated me from the women I interviewed (Rose, 1997). I was younger than most participants, and could not relate to medical burdens, including HIV, Tuberculosis or even childbirth. I understood that it would be difficult to build trust, and many would see me as "detached, arrogant or fleetingly present" (Sultana, 2007: 381) – all valid critique.

Intrinsically I had power, which Staeheli and Lawson (1995 in Rose, 1997: 307) problematizes as when

> western feminists enter developing settings, they cannot escape the power relations that exist between those societies or between themselves as academics and their research subjects, even when they wish to do so.

This meant the interviews were based on an unequal power-relation, ruled by me (Creswell & Porth, 2018). I spent a lot of time reflecting and criticizing the 'need' for me to do research in a developing country and found comfort in Sultana (2007: 375) who said that this type of "fieldwork can be productive and liberating". In order to ensure a more equal relationship and avoid exploitation, I attempted to 'level' the relationships, such as having a community member with me, and sharing my own experiences around contraception, when it seemed appropriate, because as Hesse-Biber and Leavy (2007) explain similar problems can bridge the insider/outsider dichotomy. I hoped that the contraceptive-knowledge exchange would lead to mutual learning and be beneficial. And lastly, I hoped to build trust, which in some cases succeeded and women told me their stories, and in others I had to accept yes/no answers. I appreciated those answers, because it showed that women, by declining questions, used their agency and leveled our power field.

I also must reflect on feminism itself because my definition might vary from my participants. By focusing on GAD, I entered a debate in which western feminist are criticized for delimiting women as "too weak to challenge their culture" (Tripathy, 2010: 116). Avishai et al. (2012: 395) question how one interprets "spaces and communities that feminism considers conservative, misogynist and/or antifeminist." I am privileged to access information and education about family planning, deemed natural in a Western worldview. Thus, whilst the context of feminism and worldviews might differ, one must remember that perception and behavior is influenced by respective cultures and normative contexts (Heise et al., 2019: 2448). Feminist agency is found in the actions of incredibly strong women in this study (who I do not

consider ‘too weak to challenge their culture’), to attain information or oppose norms and I learned a lot on the extent of feminist actions whilst being exposed to new meanings.

4.5. Limitations

In a feminist approach it was a small sample size, without the intention to generalize, thus some findings might not be reflective or miss out on aspects due to limited scope. I concentrated on pregnant women, therefore, patterns might be different for women without children or in menopause. Men were not included, and findings were not verified through the male counter-standpoint.

I had a limited amount of time available in SA and may have interpreted findings with a Western-view and not considered all internal country aspects. My power in the interview may have created a dynamic in which women were less comfortable to speak freely. Still, I noticed that many women were excited to talk to me, prepared questions about contraception, HIV and family planning and were willing to share stories about their life. Yet I want to reflect on my power as a limitation because of my (feminist) concern with the representation of my participants (Hesse-Biber & Leavy, 2007). Lastly, I note that working in a cross-cultural setting with a language barrier, means some contextual meaning may have been lost in translation.

5. Findings: Gendered Structural Determinants

5.1. Health Services

Based on Sen and Östlin's framework, the first conceptual piece is gendered structural determinants and answers *what gendered structures exist.* In 2012 the need for improved access, quality and supply was already outlined (DoH, 2012b). Yet questions of availability, accessibility and quality presented themselves during the interviews, including government-caused stock-out issues. One of the participants, Thandiwe, noticed

> the problem is, that our closest clinics are always out of stock. Of everything. I don't know if maybe the government is neglecting those clinics or not, that's why most people become pregnant.

People switch between methods when one is not in stock (Nomble) and Aphiwe said shops are often out of condoms. This is resonated in the concerns of medical staff. Dr. Agetha Visser questioned how

> we're supposed to offer it, but we don't have stock. Cause apparently, we don't even offer that. So, we cannot even talk about trying to educate women about different options and then you finally convinced somebody about a method that will work better. But then we don't have it available.

Between limited options and stock, the women in the EC are not prioritized in governmental policies. Still, contraception is free, making family planning available financially.

In line with findings that women in SA struggle to access healthcare (NDoH et al., 2019), accessibility challenges were mentioned. Marmot (2005) specifically pinpoints transport as crucial. Even reaching healthcare can be time consuming as Head Nurse Anathi Genge explained, including participant Sisipho walking 3 hours to reach the nearest clinic. Simultaneously,

> …clinics kind of limit access at times to people who try and access them by either closing early or you know, saying: "Oh today's a vaccination day only and we're not doing contraception." They are understaffed and under-resourced. (Dr. Annika Smith)

It critically presents gender as a stratifier as women carry the burden of canceled consultation, prescription and potential unwanted pregnancy, when healthcare services deny access.

Questionable quality was observed, likely due to limited funds. Some clinics do not have the necessary lights or speculums to insert IUDs, yet most contraception happens directly at clinics (Smith). Unfortunately, other research in SA also found that even when IUDs are offered, healthcare workers may not be familiar with them or know how to insert them (Holt et al., 2012). Whilst there are many rights in the country's constitution, there is a "wide chasm" to the reality of women's experiences in public health services (Mbali & Mthembu, 2012: 12).

5.2. Education

Most women in this study did not finish secondary education (*see Table 1*). This limits access to available resources. Thandiwe pointed out posters on clinic walls explaining contraception. In theory exposure to contraceptive messages, increases women's likelihood of using any method (Paek et al., 2008). However, "the problem is the literacy rates are not great. So that's why posters are not so great out here" (Smith). Measures implemented by the government are less effective if fundamental literacy skills are missing. The quality of information is engrained in structural issues, which limit and constrain family planning options for women. However, as Sen and Östlin (2007) point out there is room for individual agency. Women want to finish their education, such as Aphiwe: "I'm not sure when I want to be pregnant because I want to finish school first, before having a third child."

Age (in years)	
18-21	3
22-25	5
26- 29	3
30-33	4
34 -35	2
Transport method[1]	
Walking	10
Taxi	4
Travel Time to Clinic [2]	
< under 30min	3
30 min - 1h	8
1h -2h	1
2h – 3h	1
3h+	2
Finished education [3]	
yes	0
no	16
Currently employed	
Yes	5
No	12
Current pregnancy number	
1st pregnancy	3
2nd pregnancy	7
3rd pregnancy	2
4th pregnancy	3
5th pregnancy	2
Relationship status	
boyfriend	7
married	8
widowed	2

[1] Missing data from 3 participants
[2] Missing data from 2 participants
[3] Missing data from 1 participant

Table 1 Socio-Demographic information of participants (Author, 2020)

5.3. Employment

Further, education has direct effects on employment. Barriers for women to enter business in male dominated structures already exist (Keleher & Franklin, 2008), however with limited education this entrance becomes more difficult. Only five women were currently employed, though indicated they might not be able to return to these jobs after pregnancy. This forces women to look for other income, such as 18-year old Sisipho, who was having her second child

and planning for one more, to receive the governments' child support grant[21] to "help out" in the household. This is not unusual as "the bottom 60% of households depend more on social grants and less on income from the labor market" (Stats SA, 2020). Whilst only two women were aware of government policies in relation to family planning, the government does have influence. The example of social grants shows how intertwined socio-economic circumstances are with formal and informal norms and the pressure these create for women. Structural barriers become more visible in worse-off socio-economic locations. Many of these issues are exemplified in the "Zithulele / Eastern Cape contextual problem, that we're sitting with. In the Eastern Cape rather than the national", Visser points out, presenting that determinants are heavily province dependent. Poorer women are not left without choice but are often at the bottom of the gendered structural gradient.

5.4. Religion

Lastly, women in this study indicated faith-based beliefs, either church or traditional spirits.[22] Fudiswa, Aphiwe, Bongani and Babalwa, said children are a gift from god and the church encourages many children. There is a degree of fatalism, influencing women's stance on family planning, as they themselves cannot plan a pregnancy, but higher powers cause it, delimiting females to their reproductive sex (Jones et al., 2016). Simultaneously the church preaches against having children before marriage (Lindelwa, Nobomi, Aphiwe), pushing ideals of female purity.

According to Buhle spirits also stress the importance of children. Spiritual belief influences fertility as "they will say there are bad spirits or evil spirits if you can't get pregnant. Those spirits are the ones that causes you not to be pregnant" (Zintle). Fatalism is associated with infertility as well (Jones et al., 2016). This reinforces ideas of higher power creating a framework in which women believe family planning is not in their hands, making faith a gendered structural obstacle and determinant.

[21] Child Support Grant: Given to you if needy, in order to help raise the child you look after. In order to qualify one must be the child's primary caregiver, be a South African Citizen or permanent resident and not earn more than R48 000 (26 416 SEK) per year if single. If married, the combined income should not be above R96 000 (52 832 SEK) per year. The child must be under 18, not cared for in a state institution and live with the primary caregiver. The grant gives R420 (231 SEK) a month and one cannot receive it for more than 6 children. (SASSA, 2014) It is often difficult for poor and rural families to apply for this grant as there must be official identity -, earning-, marriage- documents provided which many do not have.

[22] Traditional, spiritual beliefs include a conviction that ancestors return in the form of spirits and communicate with descendants and influence their lives. "Ancestor worship is a central part of Xhosa spirituality." (Carver, 2007-2008: 43)

6. Norms

The norms found in this research are presented in *Table 2* and overlap with previous findings (see section 1.2 and 2.1). This section answers *what localized gender norms exist for Xhosa women regarding family planning*. All norms assume gendered stratification, as roles are assigned on socially constructed gender ideals and enhance effects of gendered structural determinants. They portray a 'successful' man and attribute value to masculinity, and a 'good wife / mother / daughter', which enable restrictive contraception norms. The gender-appropriate behavior, deeply reinforces the gender system and creates gender hierarchies.

Masculinity
Son Bias
Men can cheat and have no child-responsibility
Men are the head of the household
Marriage
Women should not have children before marriage
Women must obey family's expectation
Women must obey in-law's expectation
Married women must have many children
Contraception
Contraception is not publicly discussed
Condoms are dismayed
Contraception usage is monitored

Table 2 Overview Norms (Author, 2020)

6.1. Masculinity Norms

It became apparent that norms about masculinity had a decisive influence on women's family planning. Masculinity and femininity norms are important, because of the hierarchy and gender system they represent, which denounces feminine as inferior to masculine (Heise et al., 2019).

6.1.1. Son Bias

Sixteen out of seventeen participants stated either they or their partner wanted a son. This corresponds with a global son-bias (Adams et al., 2013; Marcus et al., 2015). Especially Xhosa prefer their first child to be a boy as Nofoto explained. This is because the boy is "a father of a child" (Nofoto), carries on the name and home (Zintle, Vuyokazi), and supports their mother financially as they can find work (Lindelwa, Sisipho). As economic opportunities are gendered, parents believe it more worthwhile to have boys as they can deliver financial returns (Marcus et al., 2015; Weber et al., 2019). In a way women produce the labor force to maintain households, agriculture and land (Sen & Benería, 1982). Girls are devalued or a financial drain,

as “girls don’t always support their mom unfortunately” (Lindelwa) and in Xhosa culture join the husband’s household upon marriage, whilst sons bring extra workforce to the house.

It was said that having a son is important in marriage and out-of-wedlock (Funeka, Nobomi), and husbands, boyfriends and male relatives all desire a boy (Bongani, Vuyokazi). This creates pressure and might coerce women to have more children in order to have a boy. Aphiwe said she was not happy about having a girl, worrying that a girl might become a victim or be raped. This is a valid concern as the region battles with sexual harassment (Visser). Fear of GBV is exasperated in patriarchal societies (McLlwaine, 2013) and sexual violence often expresses gender powers (Sen & Durano, 2014: 17).

Pressure and power are exercised from birth, if there is higher value associated with the male gender. Parental behavior might change when the sex is known and with it “norms and other aspects of the gender system begin to shape the [child’s] life prospects” (Heise et al., 2019: 2441). Children retain the messages of “what is valued, who has power, and how to behave” (Ibid.). The enforcement and internalization of gender norms and consequential health outcomes even during adolescence thus has long-term consequences (Weber et al., 2019), creating a cycle that values males more and pressures women to ‘produce’ male heirs.

6.1.2. Men can cheat and have no child-responsibility

Women were aware of their husbands being “in a relationship with many girls” (Babalwa). Infidelity was normalized, as “you can’t just take a man and stop him to go outside” (Nofoto). This is a common norm of masculinity where men have freedom of sexual partners (Marcus et al., 2015). Yet, when the husband is away “doing different things” (Vuyokazi) with multiple partners, it adds to the fear and risk of HIV. High female HIV-rates in the EC, can be partly explained by infidelity.

> The reason why we got as many unwanted pregnancies and our HIV rate is like through the roof around here, because what happens is the men then, most of them work in Jo’burg or Cape Town, there they have their mistresses and when they come home, the wife is here, has been here with the family and when the husband comes in no one actually says […] get tested. (Genge)

However, high HIV-rates also present a bigger issue, because when men do not acknowledge their (HIV) health needs, this is mirrored in women repressing these needs, including HIV or family planning (Sen & Östlin, 2007). Due to normalized multi-partner conduct, it is easier and

acceptable for men to denounce paternity, assuming no responsibility until after birth (Nomble) or leave entirely (Nosipho).

Men enjoy freedom and power to decide their reproductive desires and it is socially accepted. The cultural ideal linking risky sexual practices with controlling behavior over women, is typical for hegemonic masculinity (Jewekes & Morrell, 2010). Yet as these characteristics underline the idea of hegemonic males, there is an expectation and pressure to behave this way. Speizer et al. (2018) study that men in poorer, black South African communities are expected to have multiple sex partners, and the "ideal black African manhood emphasizes toughness, strength and expression of prodigious sexual success" (Jewkes & Morrell, 2010: 1). These ideals are reflected in Xhosa culture through *ulwaluko* ceremonies, where men fear that if they do not achieve local masculinity standards, they are bullied and ridiculed (Heise et al., 2019; Ntozini & Ngqangweni, 2016). In GAD perspective, not all men benefit from patriarchal arrangements (Sharp et al., 2003) and harmful gender norms for males must also be addressed.

6.1.3. Men are the head of the household

In Xhosa culture, men are the head of the household, have power, make (financial) decisions and women are raised to know that men have the "final say or only say" (Genge, Vuyokazi), presenting a clear power hierarchy. If males are the "family provider", they become ultimate decision makers (Marcus et al., 2015: 9) as often in poorer socio-economic circumstances money means power. Especially younger mothers have little power to voice opinions. This gendered power dynamic moves to relationships when boyfriends make most decisions (Cebisa), then husbands (Nomble), because when a woman lives with a man, he makes the decisions (Bongani). This acceptance of male dominance shows when women including Nosipho get "pregnant to satisfy the man that I'm staying with." Women may comply because of fear of negative consequences if they do not (Marcus et al., 2015). Women in this context are financially dependent and will submit to negative norms, because it is "crucial to their own survival and that of their children" (Sen & Östlin, 2007:29). As decision-makers men have all the power in relationships, as some participants stated. This may include decisions about when and how many children to have, potentially deciding family planning for women, which Herbert (2015) points out is visible in highly gender-stratified societies, such as SA.

6.2. Marriage Norms

Marriage is highly valued in Xhosa culture. Marriage is a sign of 'successful' womanhood and femininity, in which women attain recognition for reproduction, household and wife duties, yet comes with norms and expectations on respectable femininity.

6.2.1. Women should not have children before marriage

"A lady" Vuyokazi said, resonated by Bongani, would save herself for marriage, to be desirable to men. This aligns with global ideals of virginity before marriage but is also engrained in Xhosa culture (Bongani). Nosipho could not get married with her partner of thirteen years because she had children before their union, whilst Babalwa was chased away years into their marriage when her partner found out she had children before. Husbands do not have to provide for the women's children with other partners (Babalwa), increasing women's restrictive financial dependency.

Women comply because of community approval or disapproval, even if they do not agree or understand (Marcus et al., 2015). Nofoto explained:

> Since I am not with my husband, I don't think it's a good idea to have different childrens cause if you are not on a marriage sometimes you get different childrens to different fathers. So that's not good.

Having children out of wedlock is considered a "disgrace" (Visser). There is a dichotomy on the norm that men should and can have children with multiple partners whilst the opposite is applicable for women. This "sexual double standard" as Heise et al. (2019: 2445) call it, has the "objective of controlling women and offspring" and is a fundamental aspect of heteronormativity. It places women with a double burden to be sexually available yet not produce offspring, making access to contraception vital.

6.2.2. Women must obey family's expectation

Traditional, arranged marriages, including *lobola*, are common around Zithulele. Often women do not know future partners, as it is arranged between families. Babalwa had an arranged marriage and "she didn't want to agree to get married, but she was obeying her parent's decision for her to get married, because she didn't want to disappoint them." Bridewealth payment often gives men power, formalizing norms through traditional marriage, making them into cultural practices and creating pressure, by those who should protect young women, including parents

(Barker, 2006 in Sen & Östlin, 2007; Frost & Nii-Amoo Dodoo, 2009). Parents may have lower aspirations for girls' future, but *lobola* can help the family financially. Bongani pointed out how it is expected of women to be married off so her family can receive cows.[23]

Simultaneously there is an expectation from the family to birth children, for example Vuyokazi's mom started telling her she should have a child, because she was already 24 years old and everyone around her was having children, and "once you have a boyfriend, the next thing you're expecting having a child." She must fulfill expectations and prove fertility. This can be beneficial for the entire family as "when you get pregnant according to our culture, your family go to the boy's family to ask for that family to pay damages, since their boy impregnated you" (Bongani). Financial productivity is, again, a motivation.

6.2.3. Women must obey in-law's expectation

Women move to their partner's location and reside with in-laws, even if they do not want to, it is not nice there (Babalwa) and "his home is not the right home" (Nomble). An impregnated woman is seen as a win-win for her family and the in-laws as Bongani and Nomble explain, as your family gets paid damages but after birth you go work for the in-laws, do chores and take care of children in that household. This work provides a well-functioning household and training to be a better wife and mother, ideals of femininity (Marcus et al., 2015). This ties into problematics of deeply gendered, informal, domestic work. Women worldwide do most domestic work, and this unpaid and undervalued labor accentuates gender disparities. Despite the "clear distinction" of biological *re*production and household production, as well as "childbearing and childrearing", the concepts are conflated as "biologically determined tasks" rather than socially constructed roles (Benería & Sen, 1982: 166).

Women are expected to obey in-law's regulations and bear children to the family name. Vuyokazi explained:

> The family that you're married to they always expect that you bear children. You bear children so if you ever maybe go my mother-in-law: "I would like to use a contraceptive" then they'll be like I'm crazy: "When are you going to give birth to my grandchildren?!"

[23] Cattle are important in Xhosa tradition and wealth is often measured in cattle (Caver, 2007-2008: 43)

Women are not allowed to use contraception by their in-laws, so they have a secret, separate clinic record book which they hide in order to receive contraceptives (Smith), showing resistance to restrictive settings.

6.2.4. Married women must have many children

Once married, women must birth many children. In Xhosa culture marriage is validated by having a child, preferable in the first year, regardless of children prior (Vuyokazi, Genge). Women must fulfill expectation: "your husband wants you to have many children, maybe ten kids" (Bongani). Consequently, women are hesitant about contraception, especially tubal ligations because "the problem is that if you can get married you might regret it, want another child or maybe your husband would want you to give him a child" (Cebisa). Women

> …don't really have control over what they do. […] So obviously if you're married part of your responsibility is to produce offspring for your husband. So you don't really have a choice of how many children, you've got, that's a decision that you - Well, I mean, that's the decision that your husband makes for you. (Visser).

With social expectations and pressure, women accept these conditions and consider their loss of control as a trade-off for economic support (Sen & Östlin, 2007). Herbert (2015) found that having many children is also tied to the social status of motherhood in SSA, thus having children can help women gain status and potentially power in the community.

6.3. Contraception Norms

Contraception norms are crucial to family planning yet are deeply affected by expectations outlined above. It was especially here that the role of women reinforcing norms and submitting to power structures became visible. Bongani only used contraception because she felt "obligated". There is little room for resistance, as persistent hierarchies influence decisions to (un)follow norms (Pulerwitz et al., 2019a).

6.3.1. Contraception is not publicly discussed

In Xhosa culture public conversation about contraception is a taboo. Visser explained that it is common to grow up with the wider family all living in one rondaval[24] without divisions. It is normal to watch family members have sex, yet "it's not something's worth mentioning or talking about so it's- it's part of life" (Visser). Once the younger generation starts having sex, they have

[24] Rondavels are the most common form of housing in the region, which is a one-room round house.

“never been counseled” by parents or relatives. Visser says “there's no sexual education. Like parents, don't talk to the children about at all, it feels like it's something that they discover on, on media, just somehow it just happens.”

Theoretically “sex is normal and healthy and an essential feature of life for all ages” (Jewkes & Morrell, 2010: 4), however in Zithulele communication is lacking. Women said they never discussed contraception with their mothers (Babalwa, Cebisa, Lindelwa, Nomble, Nosipho, Vuyokazi, Funeka, Fudiswa), because she “doesn’t know a lot of things” (Nofoto) or is uneducated (Nobomi, Thandiwe). It is also not discussed with aunts (Nofoto), friends (Babalwa, Nosipho, Nobomi, Fudiswa), sisters or cousins (Nomble, Funeka) or at school (Nomble, Nosipho, Funeka). Gendered conduct is “policed by parents and peers” (Heise et al., 2019: 2441) and the lack of communication governs behavior, because in SA “cultural norms dictate that parents do not talk with their children about sex” (Holt et al., 2012: 291).

The fragmented information came from word of mouth and had one subject: injectable. Information received was ‘use the injectable’ (Lindelwa, Buhle), ‘Nur-isterate is the better/right one’ (Sisipho, Vuyokazi, Funeka), someone told them ‘Petogen/ Depo is good’ (Bongani, Nosipho), maybe both (Nomble). But most “never learned about contraceptives, I just hear people talking about them. I've never had anyone teaching me about how they work” (Lulama). Because of the idea of male virility and female purity, women are not supposed to know and talk about sex (Heise et al., 2019: 2445), which includes protection.

6.3.2. Condoms are dismayed

Nobomi said “you can’t put a sweet in a paper” and illustrates men’s views on condoms. Despite condoms protecting against sexually transmitted infections and HIV, in a high HIV region, many women said they do not use these because their partners dislike them. Condoms are considered a taboo. Nurses have to “force” condoms on women because

> …females don’t necessarily have a say when it comes to their sexual life in a sense of a girlfriend cannot say to a boyfriend “let’s use a condom”. So, they don’t even go there, so, whenever you ask them why aren’t you using a condom the thing is like he doesn’t wanna use it, and it stops there, there is no conversation further than that. (Genge)

Women are unable to use them simply because they are not allowed to (Smith). Men refuse it (Nomble, Lulama, Nobomi) and say they do not like it (Funeka). Expectations exists that for

sex to be pleasurable, it must be "flesh-to-flesh" (Jewkes & Morrell, 2010: 6). Often this is motivated by the desire for more children (Lindelwa, Nosipho). Sometimes women "will ask him to use a condom, and they will break it and you will find yourself pregnant" (Thandiwe). The internalization of condom-refusal caused Buhle to fear condoms and left Nosipho uncomfortable. Aphiwe's partner's response (refusal) to condoms made it

> …difficult for me very much, sometimes I cry. And if I knew before we got married, that I was HIV positive, I wouldn't have agreed to get married. And the fact that he is HIV negative, which means he will get HIV from me and when we're about to have sex I don't feel good.

Women's sexual power and pleasure are compromised, as condom use is always "contingent on power relations" (Sen, 2010: 144). With social disapproval and moral obligations including childbearing, women do not have the bargaining power to enforce condom use.

6.3.3. Contraception usage is monitored

Ironically, whilst men are 'allowed' to have affairs, the opposite is true for women. Participants explained that their partners assumed they were using contraception to have sexual affairs. Nofoto was asked: "Why you want us to use a condom? Or maybe you are sick!" Men assume women are having affairs if she continues contraception while he is working in other provinces (Nomble).

Consequently, men often decide a woman's contraceptives or rule against her decision. Zintle's husband did not want her using contraception nor did Lindelwa's, because he wanted a child, and "at first I did want to use contraceptives but I told myself we've been dating for a very long time and I haven't been pregnant so I didn't have a problem giving him a child." Women do not like making decisions without consulting their partners first (Bongani), especially surrounding tubal ligations (Visser), because of fear of infidelity claims or pressure for more children. Masculine power shines through when it comes to contraceptive choices.

However, following a GAD analysis, women can resist norms. Women have a

> …small box for contraception they have to hide from their husbands because they feel like they are being made into like baby-making machines but we can't really run away from it for us it's a culture. (Genge)

Despite the subordination of women's needs and desires, there is resistance to gendered hierarchies. Such as Vuyokazi saying she "veeeeery prepared to lie to the husband." Women can be active agents of change.

7. Analysis of consequences on family planning

Following the framework, the analysis focuses on the outcomes of the gender system made up of gendered structural determinants and gender norms. Through examination of structures and norms, the interaction of prescribed roles concerning family planning, childbearing and contraception become visible. The consequences are highly gendered, creating a range of socio-economic and family planning outcomes and answer *how localized gendered structures and gender norms impact family planning for women. Figure 3* presents the dynamic of this case study.

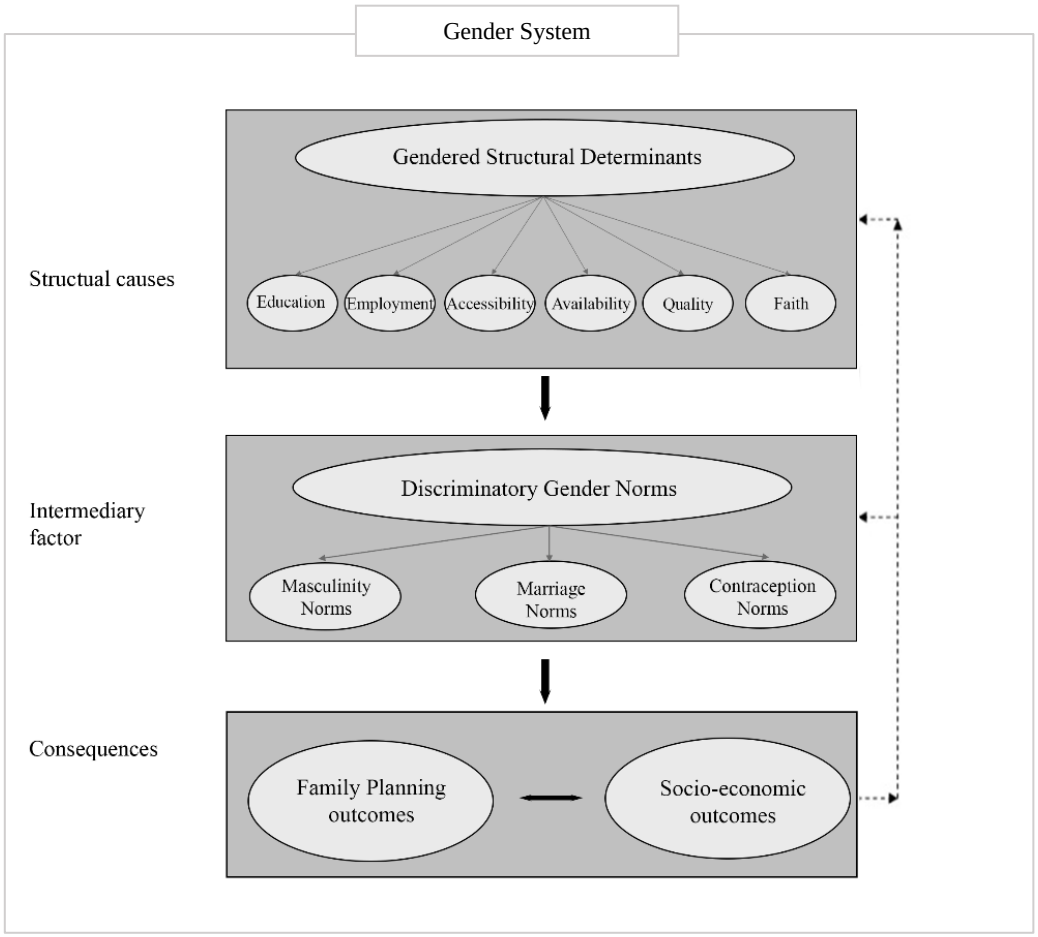

Figure 3 Detailed framework for the role of gender as a determinant of family planning (Author, 2020)

7.1. General lack of knowledge of family planning

Babalwa said: “No I don’t know anything” and presents a reoccuring theme. Nomble explained: “I have so many children, its because I didn’t have information.” It became visible that women

have a significant knowledge gap when it comes to contraception and family planning, causing (unwanted) pregnancies. This is due to the lack of public discussion and contraception being socially controlled.

Healthcare workers in rural areas do incredible work, but there are structural problematics, including healthcare services interacting with gendered assumptions. Genge explained that many healthcare workers think the pill is easily forgotten by women. Community Health Worker Khanyiswa Sokhasi asked if it is important to take the pill at the same time or you could miss it or take it later and still be safe, presenting the depth of misinformation. Simultaneously men observe, disapprove and control contraception and this can have negative consequences for women. Without access to sex-education in limited schooling and women's socio-interactional surrounding, the lack of conversation is problematic. Society creates gendered barriers for women to access knowledge.

Women were aware they had limited knowledge (Cebisa). A common mistake was conflating Depo, Nur-isterate and Petogen (Lindelwa, Sisipho). Another word-of-mouth was "when you've got an implant, with people saying that it moves in your body, makes you go crazy" (Vuyokazi). Implanon[25] was first rolled out by the government but then mass-removed based on superstition and lack of prior counseling. Misinformation about condoms was prevalent, such as confusion that condoms can break (Lulama). Some traditional medicine practices prevail:

> … they use the hair from the tail of an ox - so I don't trust that because they do it like this thing that I'm putting around my neck, but they put it around the waist […] Other people say its helping them to not fall pregnant. (Nobomi)

The lack of knowledge on contraception can increase the amount of unwanted pregnancies, whereas the general lack of education creates long-term socio-economic consequences.

7.2. Limited side-effect knowledge

Women show a knowledge gap and discontent on the side-effects of contraception. This caused women to discontinue contraceptives, instead of discussing it with medical staff. Side-effects included headaches, heavy or no menstruation, back or abdominal pain – 'normal' side-effects for hormonal contraception. The lack of public discussion about contraception as well as its

[25] Contraceptive Implant, see further Appendix A.

side-effects is a huge factor for health outcomes. Vuyokazi explained after not having her menstruration for two years:

> …she used the oral contraceptives and ehm she was only using the red ones, because she believed if she drinks the red ones that will make her bleed but that didn't happen. And then she ended up going to a doctor and the doctor checked and said that her womb was like tired, like dirty so it needed to be cleaned.

It was visible that sudden discontinuation often led to more pregnancies. Yet "women don't complain" (Genge). This might be based on the expectation that they should dismiss their medical needs (section 6.1.2) or that women are seen as "fragile and overemotional" by overworked healthcare, as women's complaints are often dismissed as psychosomatic (Heise et al., 2019: 2447). In a medical perspective, women complain mostly when

> …they don't bleed. Then it's this conception, that if they don't go to their menstrual period then the blood collects[…] like in the back of the body like, then they believe that they get lower back pain because of that, so they stop because they want their period back. (Genge)

Genge said women complain quickly about other types of contraception, but "injectables equals contraception in this community, so they don't complain about it they just use it because that's what contraception is." Beekle and McCabe (2006) explain that discontinuation and non-use of contraceptives is based on fear of side-effects. Further, stigma (families or partners finding out) and embarrassment (constant menstruation) are also relevant (Herbert, 2015). Both fear and misinformation must be addressed, through inclusive sex-education and medical counseling, otherwise discontinuation and concern have negative health outcomes with unwanted pregnancies and drug experimentation to gain menstruation back.

7.3. Women are unhappy about (first) pregnancies

Women experience pressure to conform to certain reproductive behaviour. This includes having no children before marriage, many children in marriage, responsibilities for families/in-laws and childcare. Undisputed norms left women deeply unhappy about their first pregnancies, saying it was not nice (Sisipho), difficult (Nosipho, Aphiwe) or thinking it was a "mistake. A very big mistake" (Lulama). Many showed discontent on later pregnancies. Some women did not want to talk about their (first) pregnancies and cried during the interviews. The pregnancies are often not the woman's choice but an expected duty she must fulfill, including participants

having children to satisfy men. Nosipho states “I decided that in my life I want to have two kids, but the three other ones they just happened.” There is a huge finacial and moral obligation to raising five children instead of two. The socio-economic outcomes of bearing children places a burden (often solely) on women’s shoulders. It affects her family planning and is connected to wider (mental) health.

7.4. Contraception and childbearing are women’s responsibility

Women are not given enough family planning information, and nonetheless it is their responsibility to choose contraceptives. Women described that when visiting a clinic, they are not explained an option, they are just asked what they want and that is what they receive. The responsibility to attain knowledge is on the individual, which contradicts that it is not publicly discussed nor explained by healthcare. These issues are underlined by poverty in the region as gender norms interrelate with poverty, restricting where women can use limited resources (Marcus et al., 2015: 9).

This sole responsibility was further visible in the interview setting. Women were at full gestation and were alone, as Nofoto explained:

> The guy’s not here. In the hospital. So, I have to be chosen to have a children or not. Not just to say like “No, my boyfriend want a child, then I have to give him” No. It’s not like to buy a sweet and give him. You must know that you will be alone for that 9 months, maternity, if the guy is not here with you. Even if the guy don’t want to support you, you will be alone.

The socio-economic burden of childcaring is immense. The challenges are static gender norms, where femininity is equated to procreation, obedience and nurturing (Adams et al., 2013: 9), reflecting gendered power hierarchies. The expectation and result of the gender system is that women are pushed into childbearing yet carry consequences alone.

7.5. Women do not finish school

Participants were told in school or by others to use contraception to not fall pregnant whilst enrolled (Fudiswa, Aphiwe, Buhle, Funeka). Yet none of the women finished school, some due to financial restrictions and some became pregnant. There is a high rate of teenage pregnancy (Visser) as in all of SA. Even with little stigma attached to teen pregnancy, it is difficult to continue schooling after birth (Sen & Östlin, 2007). Women fall pregnant in school and then it is especially hard for them, as Nofoto presented:

> Oh it was very, very, very difficult to me. Because I was at school. And then my father was every time he told me: "I'm gonna send you back where you come cause you come from school with a child. No, you are not allowed to stay here with a child."

There is shame, fear and responsibility on women's shoulders, which impacts their educational chances.

Because women often have children whilst enrolled, they have less chances of formal employment, making them financially dependent on men and more willing to oblige by men's decisions, including not using contraception or having more children. Financial dependency and poverty decrease the likelihood of women accessing clinics (Marcus et al., 2015), combined with accessibility and availability challenges in rural areas, it gives women little opportunity to access family planning tools. It is a cycle, in which gendered structural determinants impact family planning and socio-economic standing and are continuously reinforced by norms.

7.6. Injectable is the go-to

As indicated injectables are popular, because women lack information and over-worked healthcare do not have the time to explain. Women arrive at clinics, are asked what they want and leave (Vuyokazi). Nomble said "they didn't explain how it works in my body they just injected me", echoed by Lulama. The prevalence is easily explained: convenience, cost-effectiveness and acceptability (Chersich, et al., 2017: 307). As Visser asks: "How do you contextually, with 10 women waiting, you've got 10 minutes, you need to give contraception to 10 women. I mean how are you gonna get informed consent. Impossible." It leaves women in the limbo of only hearing names without knowing the consequences to fertility, menstruation or side-effects. With the word of mouth being injectables, together with structural challenges such as convenience for understaffed clinics and stock, women keep using injectables. As Lulama said: "I heard about the name and I used it." Women trust the injectable, for them contraception equals Nur-isterate or Petogen (Visser, Genge). Here one might speculate that there is historical remembrance as indicated in chapter 2.2 and therefore reluctance to try other options.

However, injectables still bear a potential increased risk of HIV acquisition (Polis et al., 2014), in a region where condom use is constrained, men have multiple sexual partners and HIV is prevalent. Nonetheless, injectables present an effective contraceptive that can give women power to practice family planning without men's control.

8. Conclusion

This research set out to understand *what localized gendered structures and gender norms exist for Xhosa women in rural Zithulele, South Africa and how do these affect family planning*. By adapting a gendered public health framework towards family planning, it was uncovered that many structural barriers and deeply gendered norms persist in Xhosa culture in Zithulele.

The research shows that underlying structures include incomplete education, unemployment and financial dependency, health service struggles and faith-based fatalism. All of these by themselves pose barriers for women to fairly access and practice family planning. They are, however, exasperated by norms influencing ideals about masculinity, femininity and contraception, all of which influence women's family planning and socio-economic standing in the long-term, as they do not finish school, become financially dependent and 'baby-making machines'. The findings speak to GAD, as gender acts as a stratification, allowing inequality based on socially constructed difference. The structural determinants, norms and outcomes all present that women are part of a patriarchal system and hierarchy in which men are more valued and women must fulfill obligations and expectations regarding family planning. By adhering to norms, women reinforce this gendered system in which men have more power and influence, especially over women's reproduction.

Consequently, women are often pressured into reproducing. They have limited access and availability in rural areas to family planning services and many normative rules to follow which delimit their choice to decide when, where and why to have children and which contraceptive to use. However, as indicated, whilst structural barriers exist and norms persist, there is room for resistance.

8.1. Further Research

This thesis opens a road to further research. I suggest a systematic analysis of power and agency against restrictive gender norms, as I showed that acts of power and resistance are apparent. I see a comparison of Zithulele to the wider EC as necessary, as my interview with PID18, who was from Port Elisabeth (and therefore excluded from analysis), showed that her experiences differed in terms of education, employment and contraceptive knowledge. She was only in Zithulele as her boyfriend's family lived here and cried when explaining the restrictive and traditional settings around Zithulele. It points towards a difference between rural and urban gender systems.

Studying men's perspective could be interesting, as well as how and where norms are reinforced. Further research needs to account for GBV and abortion stigmas in relation to norms and family planning, the latter is legal in SA, but doctors can decide on performing. Lastly, the issue of infertility should be explored further, as I only addressed it in relation to faith, yet impacts women if they cannot fulfill reproductive expectations.

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Appendix A - Contraception Options

Contraception Options available in South Africa and Zithulele.

Table from: WHO (World Health Organization). (2018). *Family Planning / Contraception*. [online] Available at: https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception [Accessed 02.05.2020]

Edited with information from:

- DoH (Department of Health)- Republic of South Africa. (2012a). *National Contraception Clinical Guidelines.* Pretoria: Department of Health.
- Information from Zithulele Pharmacy.

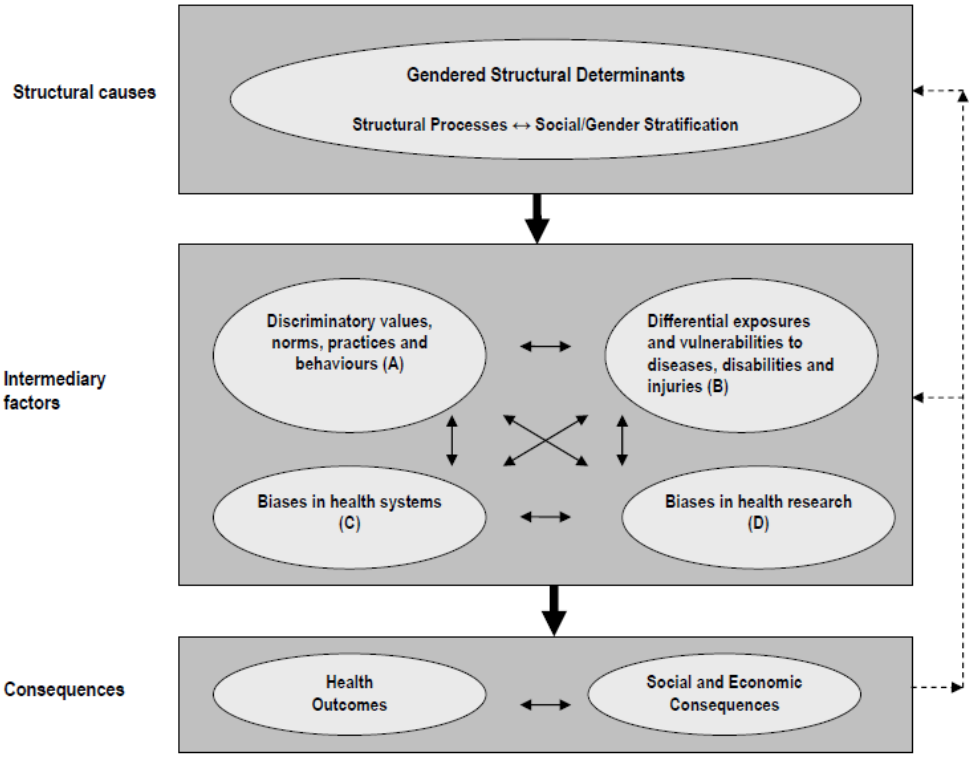
Method	Zithulele Options	Description	How it works	Effectiveness to prevent pregnancy	Comments
Oral contraceptives (COCs) or "the pill"	COCs are available at all levels of service provision. Following were in stock during interview period. Trigestrel (COP) Famynor (COP) Oralcon (COP)	Contains two hormones (estrogen and progestogen)	Prevents the release of eggs from the ovaries (ovulation)	>99% with correct and consistent use 92% as commonly used	Reduces risk of endometrial and ovarian cancer
Progestogen-only pills (POPs) or "the minipill"	POP's are available at all levels of care in South Africa. Not in stock during interviews at Zithulele Pharmacy.	Contains only progestogen hormone, not estrogen	Thickens cervical mucous to block sperm and egg from meeting and prevents ovulation	99% with correct and consistent use	Can be used while breastfeeding; must be taken at the same time each day
Implants	Implanon NXT (effective for 3 years)	Small, flexible rods or capsules placed under the skin of the upper arm; contains progestogen hormone only	Thickens cervical mucous to block sperm and egg from meeting and prevents ovulation	>99%	Healthcare provider must insert and remove; can be used for 3–5 years depending on implant; irregular vaginal bleeding common but not harmful

Progestogen only injectables	Depot Medroxyprogesterone Acetate (DMPA) – known as **Depo, Depo-Provera or Petogen** (12 weeks) Norethisterone Enanthate (NET-EN) – Known as **Nur-Isterate or Nuri** (8 weeks)	Injected into the muscle or under the skin every 2 or 3 months, depending on product	Thickens cervical mucous to block sperm and egg from meeting and prevents ovulation	>99% with correct and consistent use	Delayed return to fertility (about 1–4 months on the average) after use; irregular vaginal bleeding common, but not harmful
Intrauterine device (IUD): copper containing	In Zithulele - NOCA T380 (5 years) Other option is CuT380 IUD registered for 10 years in SA.	Small flexible plastic device containing copper sleeves or wire that is inserted into the uterus	Copper component damages sperm and prevents it from meeting the egg	>99%	Longer and heavier periods during first months of use are common but not harmful; can also be used as emergency contraception
Intrauterine device (IUD) levonorgestrel	The method is currently only available to clients in the private sector and some secondary and tertiary institutions.	A T-shaped plastic device inserted into the uterus that steadily releases small amounts of levonorgestrel each day	Thickens cervical mucous to block sperm and egg from meeting	>99%	Decreases amount of blood lost with menstruation over time; Reduces menstrual cramps and symptoms of endometriosis; amenorrhea (no menstrual bleeding) in a group of users
Male condoms	Male condoms are available, free of charge, at all levels of service delivery. Often freely available at suspensers around Zithulele Hospital and clinics.	Sheaths or coverings that fit over a man's erect penis	Forms a barrier to prevent sperm and egg from meeting	98% with correct and consistent use	Also protects against sexually transmitted infections, including HIV

Female condoms	The female condom is available at selected public health facilities throughout the country. It is also available at some retail outlets. Not currently available during time of interviews.	Sheaths, or linings, that fit loosely inside a woman's vagina, made of thin, transparent, soft plastic film	Forms a barrier to prevent sperm and egg from meeting	90% with correct and consistent use	Also protects against sexually transmitted infections, including HIV
Male sterilization (vasectomy)		Permanent contraception to block or cut the vas deferens tubes that carry sperm from the testicles	Keeps sperm out of ejaculated semen	>99% after 3 months semen evaluation	3 months delay in taking effect while stored sperm is still present; does not affect male sexual performance; voluntary and informed choice is essential
Female sterilization (tubal ligation)		Permanent contraception to block or cut the fallopian tubes	Eggs are blocked from meeting sperm	>99%	Voluntary and informed choice is essential
Emergency contraception pills (ulipristal acetate 30 mg or levonorgestrel 1.5 mg)	Currently two types of progestogen only ECP are registered and packaged specifically for emergency contraception in South Africa. Both are available over the counter in pharmacies Escapelle (Levonorgestrel hormone) available at Zithulele during time of interviews.	Pills taken to prevent pregnancy up to 5 days after unprotected sex	Delays ovulation	If all 100 women used progestin-only emergency contraception, one would likely become pregnant.	Does not disrupt an already existing pregnancy

Appendix B – Sen and Östlin's Framework

Figure 1: Framework for the role of gender as a social determinant of health



Note: The dashed lines represent feedback effects

Appendix C - Overview Research Participants

Date of Interview	Length of Interview	Personal Identifier (PID)	Pseudonym Name	Age	Clinic	Partner relationship	# of children (Inc. current)	Currently employed	Education finished
17.10.2019	44min	PILOT **(not used in analysis)**	/	20	Wilo	boyfriend	2	no	no
21.10.2019	29 min	PID01	Fudiswa	23	Wilo	boyfriend	2	no	no
21.10.2019	27 min	PID02	Nofoto	30	Mqanduli	widowed	3	yes	no
22.10.2019	36 min	PID03	Babalwa	26	Mpame	married	3	no	no
22.10.2019		PID04	**EXCLUDED DUE TO TECHNICAL ISSUES DURING RECORDING**						
23.10.2019	38 min	PID05	Cebisa	23	Mpuzi	boyfriend	2	no	no
28.10.2019	1h 09 min	PID06	Lindelwa	21	Mpuzi	widowed	1	no	no
28.10.2019	23 min	PID07	Sisipho	18	Wilo	boyfriend	2	no	no
29.10.2019	1h 17 min	PID08	Bongani	31	Ngcwanguba	married	4	no	?
30.10.2019	1h 04 min	PID09	Nomble	35	Ngcwanguba	married	5	no	no
30.10.2019	53 min	PID10	Nosipho	35	Tshezi	boyfriend	5	no	no
3.11.2019	1h 21 min	PID11	Vuyokazi	28	Ntlangaza	married	2	yes	no
7.11.2019	1h 09 min	PID12	Aphiwe	28	Ngcwanguba	married	2	yes	no
8.11.2019	47 min	PID13	Buhle	23	Ntlangaza	married	1	no	no
11.11.2019	49 min	PID14	Funeka	23	Ngcwanguba	boyfriend	2	yes	no
12.11.2019	42 min	PID15	Lulama	22	Jalamba	boyfriend	2	no	no
13.11.2019	44 min	PID16	Nobomi	31	Mpuzi	married	4	no	no
14.11.2019	44 min	PID17	Thandiwe	33	Wilo	boyfriend	4	yes	no
14.11.2019		PID18	**EXCLUDED AS DURING INTERVIEW DISCOVERED NOT FROM ZITHULELE BUT PORT ELIZABETH**						
15.11.2019	38 min	PID19	Zintle	21	Phame	married	1	no	no

Appendix D - Overview Key Informants

Date	Length	Key Informant Name	Occupation
22.10.2019	21 min	Dr. Annika Smith*	Doctor at Zithulele for 5+ years
25.10.2019	48 min	Dr. Agetha Visser*	Doctor at Zithulele for 7+ years
15.11.2019	6 min + informal conversation after	Ms. Khanyiswa Sokhasi*	Community Health Worker
14.11.2019	23 min	Ms. Anathi Genge*	Head Nurse at Clinic

*Pseudonym for anonymity and confidentiality

Appendix E - Ethical approval Walter Sisulu University

WSU
Walter Sisulu University

FACULTY OF HEALTH SCIENCES
POSTGRADUATE EDUCATION, TRAINING, RESEARCH AND ETHICS UNIT

HUMAN RESEARCH COMMITTEE
CLEARANCE CERTIFICATE

PROTOCOL NUMBER	: 074/2019
PROJECT	: AN EXPLORATION OF CHOICE FOR FAMILY PLANNING AND CONTRACEPTIVE METHODS AMONG MOTHERS IN THE RURAL ZITHULELE HOSPITAL (EASTERN CAPE, SOUTH AFRICA) CATCHMENT ARE
INVESTIGATOR(S)	: HANNAH HÖLSCHER
DEPARTMENT	: HUMAN GEOGRAPHY – LUND UNIVERSITY, SWEDEN
DATE CONSIDERED	: 17 OCTOBER 2019
DECISION OF THE COMMITTEE	: APPROVED

N.B You are required to provide the committee with a progress or outcome report of the research after every 6 months. The committee expects a report on any changes in the protocol as well as any untoward events that may occur at any time during the study as soon as they occur.

WALTER SISULU UNIVERSITY
ACADEMIC HEALTH SERVICE COMPLEX OF THE EASTERN CAPE
POSTGRADUATE EDUCATION AND TRAINING
FACULTY OF HEALTH SCIENCES
WALTER SISULU UNIVERSITY
P/BAG X 1, WSU, 5117, E.C
TEL: (047) 502 2100 / FAX: (047) 502 2101

DR T APALATA
CHAIRPERSON

18 – 10 – 2019
DATE

DECLARATION OF INVESTIGATOR(S)

(To be completed in duplicate and one copy returned to the Research Officer at Office L311, 3rd Floor, Old Library Building, NMD Campus, WSU)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Research Ethics Committee. I/We agree to a completion of a yearly progress report.

Hölscher

21.10.2019

N. B. Please quote the protocol number in all enquiries.

Appendix F - Ethical approval LUMID

ETHICAL APPROVAL

16.09.2019

Hannah Hölscher

LUND UNIVERSITY

Department of Human Geography
Lund University Master Programme in
International Development and Managment

The Direction of Lund University's Master of Science in International Development and Management has approved the proposal by **Hannah Hölscher** to conduct field research in South Africa with the title **"A qualitative exploration of choice for family planning and contraceptive methods among mothers in the rural Zithulele Hospital (Eastern Cape, South Africa) catchment area**".

Her research proposal, consent form and interview guide were examined and with no further ethical issues was given approval by the Director of Studies.

Maria Andrea Nardi

PhD/Director of Studies
LUMID - Master's in International Development and Management
Department of Human Geography
Lund University
Sölvegatan 10, office 320
223 62 Lund, Sweden
Tel.: +46(0)46 222 8422
Mobile: +46(0)7 694 727 41
maria_andrea.nardi@rwi.lu.se

Appendix G - Information Sheet and Consent Form Research Participants
English

Background Information Sheet

The Researcher

My name is Hannah Hölscher, I am from Germany and I am a Master's student researching contraceptive choices in Zithulele Hospital's catchment area. I study International Development and Management at Lund University in Sweden. Further I am volunteering here in Zithulele with Philani, Matneral, Child Health and Nutrition Project as well as the Zithulele Training and Research Center and live here for three months.

Here is my **Contact Information**:

Whatsapp +4915789198663
Email: ha8052ho-s@student.lu.se
For any questions or concerns you can contact me at any point.

This Study and Your Input

For my Master at Lund University I need to conduct a thesis, which is a prolonged research paper. For my study I want to explore the choices women have to contraception here around Zithulele. This includes any type of family planning you may see as relevant. I want to learn from you and understand your perspective. There are no right or wrong answers and I am only here to listen. It is all about what you have experienced. I hope to gather an overview of how women feel with their family planning options. By agreeing to this study, you agree to an hour-long interview, which will be audio-recorded. You will be asked to talk about your children, family, partner and your current contraceptive method and knowledge. You can stop the interview at any point or take a break if you feel uncomfortable. Please let me know if this becomes too personal for you. After your interview we will be using the audio-recording to transcribe your answers to paper and use these in a published Lund University Paper

Your participation is entirely **voluntary**, your refusal to not participate will not involve any penalty. Any choice to stop the interview at any given point will not involve any penalty.

I do not see any foreseeable risks, discomforts or side-effects to this study. If at any point the questions are too personal for you, we can stop the interview at any point without any penalty.

Confidentiality

Your name will never be published in any context. I will record this interview so I can translate it from isiXhosa to English for my paper, but your name will only be seen by myself and my translator. You will be given a number code, to which you will be referred to. No one will be able to follow your name with your answers, identify you or anyone you mention in the course of the interview.

Reimbursement

Participation in this interview is voluntary, you will not receive reimbursement for your time. I will provide you with refreshments and a snack.

Consent for Participation in Interview Research

I hereby declare that I voluntarily participate in the research project conducted by Hannah Hölscher from Lund University and voluntarily allow her to interview me.

1. I confirm that I am 18 years and older.
2. My participation in this project is entirely voluntary. I understand that I may withdraw and discontinue participation at any time without penalty.
3. I understand that I will not receive any reimbursement for my participation in this study.
4. I have had the study explained to me in writing and I have had the opportunity to ask questions about the study.
5. I have understood that the purpose of this study is to talk about my contraceptive choices.
6. I agree to this interview being audio-recorded and both Hannah Hölscher and her translator being present. I understand if I now decline the audio-recording, I will not be able to participate in this study.
7. I understand that all information that I provide during this interview will be treated confidentially and my personal information not shared.
8. I understand that in the report on the results of this research my identity will remain anonymous. I understand that my name will be coded into a number, disguising any details of this interview, which may reveal my identity or the identity of the people I speak about.
9. I understand that Hannah Hölscher may used anonymous extracts from this interview in her Master thesis at Lund University.
10. I understand that signed this consent form and original audio recordings will be retained in an external hard drive, which will only be accessible by Hannah Hölscher and if need be by Lund University, until June 2022.
11. I understand that at I may contact Hannah Hölscher at a later point, should I feel I still have questions.
12. I have been given a copy of the information sheet and this consent form.

_____ _____

Signature of research participant Date

_____ _____

Signature of researcher Date

isiXhosa

Information Sheet isiXhosa/ **Iphepha lolwazi**

Umphandi

Igama lam ndingu Hannah Hölscher, ndisuka e Germany ndingumfundi we Masters ndenza uphando ngokuzikhethela izinto zokucwangcisa kwingingqi yesibhedlele sase Zithulele. Ndifundela i International Development and Management kwiYunivesithi yase Lund kwilizwe lase Sweden.

Ndilivolontiya apha eZithulele e Philani, Maternal, Child Health and Nutrition Project kunye ne Zithulele Training and Research Center ndihlala apha ixeshana elingange nyanga ezintathu.

Nazi iinkcukacha zam zonxebelelwano:

Whatsapp: +4915789198663
Email: ha8052ho-s@student.lu.se
Xa unemibuzo okanye inkxalabo unganxibelelana nam nani na.

Esi sifundo kunye negalelo lakho:

Kwi Master yam kwiYunivesithi yase Lund ndidinga ukuqhuba ithisisi, eliphepha elingapheliyo lophando. Kwisifundo sam ndifuna ukuphononongа ukuzikhethela kwabafazi kwizinto zokucwangcisa apha eZithulele jikelele. Oku kuquka naluphi uhlobo lwezinto zokucwangcisa olubona lufanelekile. Ndifuna ukufunda kuwe ndiqonde umbono wakho. Akho mpendulo zilungileyo nezingalunganga ndilapha ukuzomanela kuphela. Imalunga nezinto ozibonileyo. Ndinethemba lokuqokelela imbonakalo yendlela abavakalelwa ngayo abasetyhini ngezinto zokucwangcisa. Ngokuvuma kwesi sifundo uza kuba nodliwano-ndlebe oluza kuthatha ixesha elingange yure enye, oluza kushicilelwa ngesi shicilelo-zwi.

Uza kucelwa uthethe ngabantwana bakho, usapho, umlingane kunye nendlela oyisebenzisayo yokucwangcisa ngalo mzuzu nolwazi lwakho ngayo. Ungalumisa uvavanyo nanini na okanye uphumle xa uziva ungakhululekanga. Ndicela undixelele ukuba ingena nzulu kuwe. Emveni kovavanyo lwakho siza kuthatha ushicilelo lwakho kubhalwe phantsi iimpendulo zakho kwaye zisetyenziswe kwiphepha elikhutshiweyo kwiYunivesithi yase Lund.

Ukuthatha kwakho inxaxheba kuku zikhethela, ukwala kwakho ukuthatha inxaxheba akuyi kubakho sohlwayo.

Andiboni kukho mingciphekho, ukungakhululeki, okanye izizamva kwesi sifundo. Ukuba ngalo naliphi na ixesha imibuzo ingene kakhulu kuwe singalumisa uvavanyo nanini na ungasayi kuchatshazelwa nanjani na.

Ubumfihlo bakho

Igama lakho aliseyi kupapashwe nakweyiphi into. Ndiza kulushicilela olu vavanyo ukuze lutolikwe ukusuka kwisiXhosa ukuya kwisiNgesi, igama lakho liza kubonwa ndim netoliki. Uza kunikwa inombolo yekhowdi oza kubizwa ngayo. Akukho mntu uza kukwazi ukulandelela igama lakho neempendulo zakho, azi wena okanye umntu ombizileyo kudliwano-ndlebe.

Intlawulo

Ukuthabatha kwakho inxaxheba kolu dliwano-ndlebe kukuzithandela, akukho mbuyekezo oza kuyizuza ngexesha lakho. Ndiza kuthengela umthamo nento eselwayo.

Imvume yomthathi-nxaxheba kudliwano-ndlebe.

Ndiyavuma ukuthabatha inxaxheba ngokuzithandela kwiprojekthi yo phando equlunqwe ngu Hannah Hölscher osuka eYunivesithi yase Lund kwaye ndiyathanda ukumvumela andenze udliwanondlebe.

1. Ndiyaqinisekisa ndineminyaka elishumi elinesibhozo nangaphezulu.
2. Ukuthatha kwam inxaxheba kule projekti ndikwenza ngokuzithandela. Ndiyaqonda ndingakhetha ukuyeka kuphando nanini na andiyi kohlwaya okanye ndicalulwe nangayiphi indlela.
3. Ndiyaqonda akukho mbuyekezo endiza uyizuza ngokuthabatha inxaxheba kolu phando. Ndilicaciselwe uphando lubhalwe phantsi ndalinikwa nethuba lokubuza imibuzo ngophando.
4. Ndiyaqonda injongo yesi sifundo kukuncokola ngolobo lokucwangcisa inzala endizikhethele lona.
5. Ndiyavuma kolu dliwano-ndlebe lushicilelwe ngesi shicilelo mazwi bekhona u Hannah Hölscher netoliki yakhe. Ndiyaqonda ukuba ndiyala ukushicilelwa ilizwi, ondi zoba nako ukuthabatha inxaxheba kwesi sifundo.
6. Ndiyaqonda ukuba zonke iinkcukacha endinikeza ngazo ngexesha lodliwano-ndlebe ziza kugcinwa ziyimfihlo nezinto ebendi zithetha ngam akuzo kwabelwana ngazo.
7. Ndiyaqonda kwisiphumo seripoti yophando igama lam aliyikuvela. Ndiyaqonda igama lam liza kwenziwa ikhowdi yamanani, ukufihla naziphi na inkcukacha zolu dliwano-ndlebe, ekunokwenzeka ziveze mna okanye obantu endithetha ngabo.
8. Ndiyaqonda u Hannah Hölscher usebenzisa izinto zokufihla kolu udliwanondlebe kwithesisi ye Masters yakhe eYunivesithi yase Lund.
9. Ndiyaqonda ifomu yemvume etyikityweyo namazwi ashicilelweyo ziza kugcinwa zikhutshelwe kwihard drive ezakufunyanwa ngu Hannah Hölscher kuphela kwaye ukuba iyadingeka nakwi Yunivesithi yase Lund kude kube ngunyaka ka 2022.
10. Ndiyaqonda ukuba ndinganxibelelana no Hannah Hölscher emveni kwexesha, ukuba ndiziva ndise nemibuzo.
11. Ndiyinikiwe ikopi yeenkcukacha kunye nefomu yemvume.

_____ _____

Utyikityo lomthathi nxaxheba wophando Umhla

_____ _____

Utyikityo lomphandi Umhla

Appendix H – Information Sheet and Consent Form Key Informants

Key Informant Interviews - Background Information Sheet

The Researcher

My name is Hannah Hölscher, I am from Germany and I am a Master's student researching family planning and contraceptive choices in Zithulele Hospital's catchment area. I study International Development and Management at Lund University in Sweden. Further I am volunteering here in Zithulele with Philani, Matneral, Child Health and Nutrition Project as well as the Zithulele Training and Research Center and live here for three months.

Here is my **Contact Information**:

Whatsapp +4915789198663
Email: ha8052ho-s@student.lu.se
For any questions or concerns you can contact me at any point.

This Study and Your Input

For my Master at Lund University I need to conduct a thesis, which is a prolonged research paper. For my study I want to explore the *choices* women have to family planning and contraception here around Zithulele. In particular, I am interviewing mother's in the Zithulele Waiting Mothers Accommodation, as these women are in the midst of family planning choices. You have been asked to participate in this study as a key informant. Through your additional knowledge on the local culture, medical background, personal and specific knowledge on this topic and situatedness within this community, I hope to understand the complexity of this issue from more than one perspective. There are no right or wrong answers and I hope to gather an overview of family planning options from your expert opinion.

By agreeing to this study, you agree to a 30-minute-long interview, which will be audio-recorded. The interview can be stopped at any point or you can take a break if you feel uncomfortable with certain questions. After your interview we will be using the audio-recording to transcribe your answers to paper and use these in a published Lund University Paper.

Your participation is entirely **voluntary**, your refusal to not participate will not involve any penalty. Any choice to stop the interview at any given point will not involve any penalty.

I do not see any foreseeable risks, discomforts or side-effects to this study. If any issue arises, we can stop the interview at any point without any penalty.

Confidentiality

On the consent form you may choose whether you would like your name published or not. Should you be willing to have your answers published with your name, you will be sent the exact quotes, to verify the statements from your side. Should you choose to remain anonymous, then your name will never be published in any context, and your name will only be seen by myself. You will be assigned a personal identifier / Number to remain anonymous, but your position within the community may be described to attach credibility to your answers.

Reimbursement

You will not receive reimbursement for the time spent in this interview, but refreshments and snacks will be offered.

Consent for Participation in Interview Research as Key Informant

I hereby declare that I voluntarily participate in the research project conducted by Hannah Hölscher from Lund University and voluntarily allow her to interview me.

13. I confirm that I am 18 years and older.
14. My participation in this project is entirely voluntary. I understand that I may withdraw and discontinue participation at any time without penalty.
15. I understand that I will not receive reimbursement for my time in this interview.
16. I have had the study explained to me in writing and I have had the opportunity to ask questions about the study.
17. I have understood that the purpose of this study is to talk about my knowledge of family planning and contraception in the Zithulele catchment area.
18. I agree to this interview being audio-recorded by Hannah Hölscher. I understand if I now decline the audio-recording, I will not be able to participate in this study.
19. I understand that signed this consent form and original audio recordings will be retained in an external hard drive, which will only be accessible by Hannah Hölscher and if need be by Lund University, until June 2022.
20. I understand that at I may contact Hannah Hölscher at a later point, should I feel I still have questions.
21. I have been given a copy of the information sheet and this consent form.

Please choose <u>one</u> of the following:

□ **1.** I hereby allow Hannah Hölscher to publish my name in her thesis as a key informant to this research.

1. I allow Hannah Hölscher to use my name and job title in relation to quotes and information provided by me.
2. I understand that Hannah Hölscher will send me a draft of these quotations and references to verify my statements.

□ **2.** I hereby choose to remain anonymous and wish for all my personal information to be treated confidentially.

1. I understand that all information that I provide during this interview will be treated confidentially and my personal information not shared.
2. I understand that in the report on the results of this research my identity will remain anonymous. I understand that my name will be coded into a number, disguising any details of this interview, which may reveal my identity or the identity of the people I speak about.
3. I understand that Hannah Hölscher may used anonymous extracts from this interview in her Master thesis at Lund University.
4. I understand that Hannah Hölscher may describe my position within the community to refer credibility to the information.

_____ _____

Signature of research participant Date

_____ _____

Signature of researcher Date

Appendix I - Interview Guide Research Participants

Please tell me all the things you can think of, whether they seem big and important or small and unimportant to you, I want to hear everything you have to say on this topic. That being said if you are uncomfortable, just let me know, we can stop or take a break at any point. This interview is divided in 8 sections and will take about an hour. This is Ncumisa and she will be translating your answers for me and I might follow up if I think something is unclear for me. We will be recording this interview on this device. Depending on your answers, the the estimated time might change All information will remain anonymous and you can stop at any time.

1. **General Information**

I want to understand a bit more about your background.
Can you tell me a bit about yourself?

How old are you?

What do you normally do? (Job, School, etc.?)

Can you tell me about where you live?

How do you get to a clinic?

Can you tell me about your family?

Do you have a partner, boyfriend or husband? Can you tell me about them?

2. **Family planning history**

Now I want to talk about family planning, your family and your children. Are you comfortable answering questions about this?
Can you tell me about your children?

Can you tell me about your first pregnancy?

Do you want to have more children?

Does the gender of the child play an important role to you / your family?

How do you decide how many children you want to have?

How did you choose when do have children?

3. **Contraception History**

I want to now talk about contraception methods. With contraception I mean the deliberate prevention of becoming pregnant with medical or traditional methods.

Can you tell me about what contraception methods you have used at any point in your life?

Where did you learn about them?

Did you like these? Why?

Why did you take them?

Can you tell me if you have ever had side-effects / complications from contraception?

If you have ever used a hormonal injectable, can you tell me how that was for you?

What is your experience with condoms?

Have you ever used a pull-out method, so ending sex early?

What do you know about the Morning-After-Pill / Plan B / Emergency contraception pills?

[*depending if participant seems comfortable and open to talking*] If someone were to fall pregnant and didn't want the child, do they have any options to end a pregnancy early in this region?

4. **Wider community Discussion**

I want to learn more about your community and how you talk about family planning and contraception there.

Does Xhosa culture say anything about family planning and contraception?

What does the government say about family planning and contraception?

Can you tell me what your local chief says about family planning and contraception?

Do you go to church? Can you tell me about what your religions says about family planning/ having children / contraception? (**after Interview 5 added*: Do you believe in spirits? Do they say anything about family planning / having children?)

What has the local clinic told you about family planning and contraception?

What have doctors at Zithulele hospital told you about family planning and contraception?

5. **Closer Community Discussion**

In the following I want to talk about your family and who you talk to in your personal surroundings.

Can you tell me what your mother told you about family planning and contraception?

Can you tell me what you and your friends discuss about family planning and contraception?

Do you talk to anyone else about having children or contraception?

How does your household run? / Who is the head of the household?

[if in relationship] In general, who makes decisions in your relationship?

Do you discuss contraception with your partner?

Do you discuss the possibility of children with your partner?

Do you discuss condom use with your sexual partner?

Who possess financial power to purchase in your household?

Do you feel like you have power in your community?

6. **Ending**

This is the last section, and I want to know about your feelings and any other thoughts and choices of family planning and contraception.

Do you feel like you have had a choice in how many children to have and when?

Do you feel like you had enough information on contraception?

Do you feel like you had a choice in what contraception to take?

At this point I would like to end the interview. Do you have any questions for me?

We normally spent a few minutes talking about the options available, if your curious. [go over options] Thank you for your time, your input has been invaluable to this study! You have my contact information should you have any questions in the future.

Appendix J - Interview Guide Key Informants

During this interview, please tell me all the things you can think of, whether they seem important or unimportant. I want to learn from you and gather as much background information on this topic and on the local knowledge as possible. This interview is divided in 8 sections and will roughly take 30 minutes. For each section I will give you some background information. If at any point you feel uncomfortable answering a question, please let me know and we can take a break or end this interview.

1. **General Information**

In this section I want to gather some background information on you and understand what you do.

[What is your name?] **if consent is given to use name*.

How old are you?

What do you do as an occupation?

How long have you been in Zithulele?

What is your previous relationship to the topic of family planning and contraception?

2. **Family Planning**

Now I want to talk about family planning in Zithulele Hospital's catchment area. I am defining family planning according to the World Health Organization as determining the number and spacing of children through some method of birth control.

In your expert opinion, how is family planning done in this region?

What do you know about the baby's sex being important in local culture?

3. **Contraception**

This section discussed contraception in this region. I am defining contraception as the deliberate prevention of impregnation with medical or traditional methods.

What do you know about contraception for women in this region?

There is a dominance of hormonal injectables in this region, can you tell me what you know about this.

There is a lack of condom usage in many households here, can you tell me why you think that is.

Can you tell me what you know about the Morning-After-Pill in this region?

Can you tell me what you know about abortions, whether legal or illegal, in this region?

4. **Community**

In this section I want to learn how external powers influence family planning and contraception.

What do you know about local chiefs and their opinion on family planning and contraception?

What do you know about local religion's opinion on family planning and contraception?

What do you know what local clinics say and do about family planning and contraception?

What do you or other medical staff at Zithulele Hospital / Philani / ZTRC say about family planning and contraception to women?

5. **Relationship**

This section is about local relationships impacting the discourse on family planning and contraception.

What do you know of family discourse in households here in terms of family planning and contraception?

How is financial power divided in this region, in your opinion?

6. **Power / Gender**

This section looks at power, but I want to ask you more about gender relations.

In your opinion do women have power here and does it change with maternity status?

In your opinion do men get involved in family planning and contraception?

7. **Ending**

This last section asks about choices and I just want your opinion here.

Do you think women are given a choice when it comes to family planning in this region?

Do you think women are given a choice when it comes to method of contraception in this region?