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"The Period, The Problem"

An investigation on mothers' menstrual health in rural Zithulele, Eastern Cape, South Africa

Author: Emilia Modigh
Supervisor: Agnes Andersson Djurfeldt

Abstract

Poor menstrual health (MH) harms women in various ways globally, and therefore maintaining sufficient MH is vital. However, MH is not considered as a Human Right and is generally unprioritized, especially in resource poor areas. There is a prominent research gap on MH and in particular among women in different ages in rural areas. This study therefore aims to investigate the MH among mothers, in varying ages, in rural Zithulele, South Africa. Specifically, how menstruation is perceived among the mothers, in what way and why stigmatic perceptions affect their menstrual practices and how these perceptions and practices combined impact the mothers' daily lives will be examined.

To gather the women's perspective, a qualitative case study using semi-structured interviews with a feminist and intersectional standpoint was used. Findings revealed the existence of a duality of emotion among the mothers regarding their menstruation, it is seen as stigmatic and natural simultaneously. These stigmatic perceptions influence the mothers' practices to hide their menstrual mark (i.e. blood). These practices and perceptions combined impact the mothers' wellbeing and limit their possibility to improve their MH. The result does not differ due to age, income or education-levels among the mothers, demonstrating menstruation as a cross-sectional issue.

Key words: Menstrual Health, Menstruation, Mothers, Rural, South Africa, Theory of Practice, Stigma, Menstrual stigma

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List of Abbreviations

EC	Eastern Cape
HIV	Human Immunodeficiency Virus
MH	Menstrual Health
MHM	Menstrual Hygiene Management
NGO	Non-Government Organization
PID	Participant Identification Number
R	The currency Rand in South Africa
SDG's	Sustainable Development Goals
SDIF	Sanitary Dignity Implementation Framework
SRHR	Sexual and Reproductive Health and Rights
VAT	Value Added Tax
WASH	Water, Sanitation & Hygiene
WSU	Walter Sisulu University
ZTRC	Zithulele Training & Research Center

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1. Introduction

Almost all women in their reproductive age get their menstruation[1]. The arrival of the period, every month, manifests the functionality and health of the female body. During a woman's lifetime she generally manages her period for 3000 days and thus, managing menstruation is something that women spend a substantial amount of time on. Poor menstrual management practices lead to severe health issues, which has been captured in the concept of Menstrual Hygiene Management[2] (MHM). The circumstances for managing menstruation differs significantly around the world, where the quality in rural and resource poor areas are considered as notably worse than in urban areas (SIDA, 2016; Hekster – Punzi, 2019; Ahmed – Yesmin, 2008; Kuhlmann et al., 2017; Zivi, 2020). Moreover, the stigma and taboo against menstruation restrict women's lives tremendously, which often undermines gender equality and constitutes discrimination. Due to this stigma women can be kept from food preparation, consumption, socializing, religious activities or be completely isolated during the bleeding period. This is generally a consequence of women being considered to be impure during their menstruation and by touching people or objects their 'polluting touch' can spread the impurity (Menstrual Hygiene Day, a, n.d.; Mahon – Fernandes, 2010; Phillips-Howard et al., 2018).

The hardware (practical-based) and software (social-based) sides of MHM are interdependent. Having good access to hardware in the form of sanitary products does not exclude the possibility of women being restricted from participating in certain activities. Equally, having proper knowledge but missing sufficient sanitation facilities will not support the women in maintaining good MHM either. The concept Menstrual Health (MH) recognizes this by incorporating the MHM definition and additionally include; "that [women and adolescent girls] understand the basic facts linked to the menstrual cycle and how to manage it with dignity and without discomfort or fear" (Hennegan et al., 2019:4) and contains the "broader systemic factors that link menstruation with health, well-being, gender, education, equity, empowerment, and rights" (Geertz et al., 2016:5). This broadening of the concept recognizes the importance of understanding MH beyond the practical Water, Sanitation and Hygiene (WASH)-perspective

[1] Whilst using the terms 'women' and 'girls' when referring to menstruating people, this thesis acknowledge that the menstruating population also include people who do not identify as female.

[2] Menstrual Hygiene Management is defined as: "women and adolescent girls using a clean menstrual management material to absorb and collect blood, that can be changed in privacy as often as necessary for the duration of the period, using soap and water for washing the body as required and having access to facilities to dispose of used menstrual management materials sustainably" (SIDA, 2016:1).

and including it in the Sexual and Reproductive Health and Rights (SRHR) spectra where harmful norms can be questioned and raise the opportunity for women to make informed and independent decisions about their health and body (Hekster – Punzi, 2019). This paradigm shift has allowed MH to become increasingly recognized as a human right and a development issue (Menstrual Hygiene Day, a, n.d.). However, the improvement rate of MH is slow, and women suffer daily, especially in rural areas, from not having the basic knowledge, practices or materials to manage their menstruation safely and with dignity (SIDA, 2016; Hekster – Punzi, 2019). Furthermore, compromised MH has a negative effect on women's health, education and wellbeing (Phillips-Howard et al., 2018). In order to make sure that future MH interventions and research are effective in accomplishing improvement it is vital to ensure the normalization of MH among the whole menstruating population. This can only be done by including women of all stages in life, and research regarding the contexts, challenges, perceptions and potential myths that affect various women's MH is needed (Chothe et al., 2014; UNFPA et al., 2018).

The need of more research in rural areas and the intersectional importance of including women of all stages in life in research, rationalizes why this study focuses on mothers' MH in rural Zithulele, Eastern Cape (EC), South Africa. Mothers being women of ranging ages reflects the relevance of them as a study group[3] to add on to the lacking research of their MH.

1.1 Objective of The Study

The aim of this study is to investigate perceptions and practices related to menstruation and MH and how they affect mothers in Zithulele.

1.2 Research Questions

1: How is menstruation perceived among mothers in Zithulele?

2: How and why does the stigmatic perception of menstruation affect menstrual health practices among the mothers?

3: How and why do menstrual practices and perceptions, arising from stigma, affect the mothers' daily lives?

[3] Further reasoning behind choosing mothers as the study group can be seen in section 2.

2. Literature Review & Research Rationale

MH is vital globally because menstruation is experienced by women in all stages of life everywhere (Chrisler – Johnston-Robledo, 2002). To ensure adequate and safe MH, access to water, sanitation and hygiene services, as well as, sanitation products or rags that can absorb menstrual blood, are needed. Somewhere to dry or to dispose these materials and a private place to change them, is also required. Good practices, education on the basics of menstruation and how to manage it with dignity need to be provided (Tacoli, 2012; SIDA, 2016; Hennegan et al., 2019). All of which are lacking worldwide (Menstrual Hygiene Day, a, n.d.). In Western societies the concept of menstruation is medicalized, and it is generally seen as something that should be handled discreetly. From this perspective the menarche[4] is not a sign of womanhood but a 'hygienic crisis', where women are encouraged to see their menstruation as something 'wrong' that can be solved and become 'right' (Bobel, 2018).

By contrast, in many countries in the Global South, stigmas and taboos surround menstruation. For example, in some rural regions of Nepal, the tradition 'Chaupadi' banishes menstruating women into strict isolation in sheds or huts because they are viewed as unclean (Stacke, 2017). This case demonstrates how menstruation manifests differently globally, with dominating negative attitudes towards it (Menstrual Hygiene Day, a, n.d.). Further, in many low-income settings girls have no idea of what menstruation is before and during their menarche. Not having the information or ability to safeguard MH can lead to physical issues such as vaginal infections which can result in death. This also affects girls and women's wellbeing drastically where odors or blood-stained clothes can reinforce negative attitudes towards them leading to psychological and social issues connected to sexuality, body image, reproductive functions, gender identity and social status. As a consequence of these attitudes, women in resource poor areas are prone to more violence and discrimination (Sommer et al., 2017; Johnston-Robeldo – Stubbs, 2013; Zivi, 2020). All of which, restricts women to engage in daily life activities and undermines gender equality (Hennegan et al, 2019; Menstrual Hygiene Day, a, n.d.).

Even though MH is a global issue it was not mentioned in the Millennium Development Goals and can only be found indirectly in the Sustainable Development Goals (SDGs) (Tellier –

[4] "The first occurrence of menstruation … that marks the beginning of menstrual cycling and is considered the start of a woman's reproductive span" (Valeggia - Núñez-de la Mora, 2015:299).

Hyttel, 2017). Moreover, there has historically been a WASH focus on menstrual research and interventions, limiting the inclusion of the perceptions about it (Phillips-Howard et al., 2018). The recent broadening of the understanding of menstruation, together with the emergence of MH paved the way for more research on the software issues, such as the feelings toward menstruation (Rembeck et al., 2007), the knowledge and attitudes regarding it (Kapoor – Khari, 2016), the stigma related to menstruation (Sahin, 2015) and seeing it as a cross-sectional phenomenon (Johnston-Robeldo – Stubbs, 2013). Even though the phenomenon of menstruation has broadened, the dominating focus in terms of research and interventions is on the hardware and WASH-related side of menstruation (Sommer et al., 2015). For example, many recent studies have been done on the use and function of the menstrual cup (Zulaika et al., 2019; Huang – Huang, 2019). In South Africa a study in Durban, KwaZulu-Natal, the neighboring province to EC, focusing on disposal and sanitation practices was conducted (Scorgie et al., 2016). However, product provision cannot challenge the societal issues like stigma that face the menstruating population (Thomson et al., 2019).

Researchers therefore advocate the need for broader studies on softer subjects such as knowledge, social environment and stigma surrounding MH in combination with the hardware perspective (Bezruki et al., 2020; Sommer et al., 2015). This idea is starting to be reflected in global polices since the UN Human Rights Council in September 2018 adopted a resolution that calls upon states to "address the widespread stigma and shame surrounding menstruation and menstrual hygiene." The Resolution describes how this can be done by, for example, ensuring information, addressing negative norms and universal access to sanitary products as well as secure disposal of these (Menstrual Hygiene Day, b, n.d.). Broadening menstrual improvement efforts are greatly welcomed as MH is a cross-cutting issue that has a great impact on women's and girls' daily lives and future, and thus, using a holistic approach including both the hardware and software perspectives of menstruation is vital when studying the issue (Geertz, 2016; Bobel, 2019).

The focus of previous softer studies globally has mainly been on adolescent girls in school settings (Bobel, 2019; Sommer et al., 2015). This correlates with the previous research on menstruation in rural areas, where girls in schools has been mostly researched (Kuhlmann et al., 2017; Chothe et al., 2014; Mason et al., 2013), as well as on how the stigma of menstruation hinders teenagers from conducting daily activates in rural areas (Kothari, 2010; Shanbhag et al., 2012). The majority of these studies have further been conducted in rural India (Kaur et al.,

2018; Tiwari, 2018; Kamath et al., 2013). Although more studies on MH in rural settings in Sub-Saharan Africa have emerged, they have not concentrated on South Africa (Tellier – Hyttel, 2017; Sommer et al. 2016). In South Africa one study of South African women belonging to the Xhosa ethnic group in rural EC focusing on traditional activities concerning menstruation was conducted (Padmanabhanunni et al., 2017). However, due to the lack of information regarding how menstruation is managed and perceived in low-income settings (Foster et al., 2016), there is a consensus that more research on vulnerable communities in East and Southern Africa, such as the rural areas, are of great relevance. Compared to other countries in the Global South, there is significantly less menstrual research done in South Africa, especially in the resource poor regions (UNFPA et al., 2018; Padmanabhanunni et al., 2017).

A systematic search of 78 studies covering 35 countries regarding women's MH experiences was conducted by Hennegan et al. (2019:2) with the aim to appraise the coverage and quality of existing research resulted in that "the experiences of adolescent girls were most strongly represented, and we achieved early saturation for this group". Hennegan et al. (2019) concluded an absence of studies focused on adult women, women in different stages of life, and those from certain geographical areas. Other literature has noted the need of using a life-cycle approach as well, where women of all ages are included in the MH research and interventions (UNFPA et al., 2018; Geertz, 2016). Accordingly, Sommer et al. (2017) note that a focus on adolescents has resulted in a lack of attention for studies on older women and mothers regarding their knowledge, opinions and practice of MH and that there is a significant empirical gap for studies regarding this.

The focus of research and interventions on adolescences' MH in school environments is of course of fundamental value. However, to include a wider spectrum of women is necessary since different women present different needs to ensure their personal MH and the challenges they face in doing this differs significantly. This can depend on factors such as geographical location, economic status, social norms, customs and age (Sommer et al., 2017; Menstrual Hygiene Day, a, n.d.). For example, a cross-sectional study with 3,952 women in rural India revealed that MH practices differed vastly between women in different life stages. Unmarried youths were more likely to use disposable pads or tampons than established married women who instead reused cloths (Baker et al., 2017). To contribute to the widening of this intersectional perspective, this study focuses on mothers' MH. To the best of the author's knowledge there are no previous studies concentrating only on mothers and whenever mothers

are included in the previous MH research it is with the sole focus on their relationship with their daughters (Devaney, 2016). Examples include how they talk about menstrual practices between mother and daughter (Zakaria et al., 2019), and what the mother's perception is about her daughter's menstruation (Ouedraogo et al., 2016). However, as mothers are the main influencers for their daughters, the perception and management of a mother's menstruation directly affects her daughter's MH (Alberda, 2018; Geertz et al., 2016). Maternal health is additionally considered vital globally, and badly managed MH has direct negative impacts on the mothers' health, as to all women (WHO, 2005; UNFPA et al., 2018). In conclusion, a study in rural South Africa focusing on mothers of differing ages, regarding their MH perception and practices covering both the software and hardware side of menstruation fills several empirical gaps of direct and indirect relevance to SRHR and broader gender aspects of development.

3. Theoretical Framework & Definitions of Key Concepts

In this section the theoretical framework and key concepts used for the analysis will be presented. Mainly, Pierre Bourdieu's Theory of Practice and the concept of stigma will be applied to investigate the perceptions and practices related to menstruation and how they affect the mothers. The Theory of Practice explains how and why people perceive certain things and practice in certain ways by internalizing their surroundings (where stigma is present) and how their practices, in turn, affect their surroundings.

3.1 Broad Theoretical Standpoints

A feminist standpoint is used in this study, which involves attending to women's stories as told by them, and to the unique and complex experiences of the participants (Harding, 2004). Moreover, a gender lens is applied throughout this study. Using a gender lens when analyzing material can help identify and visualize potential challenges or opportunities that otherwise would be hidden. These include the socially constructed differences between men and women, but also between different women, and the intersectional recognition that they have different preconditions in terms of capital, demographics and labor (Chant, 2013; Chant – Datu, 2011). These perspectives are vital to include in order to understand and contextualize the perceptions and practices that the mothers have on MH.

3.2 Pierre Bourdieu´s Theory of Practice

To understand how and why the interviewed mothers in Zithulele perceive and practically manage their period Bourdieu's Theory of Practice will be applied. The theory focuses on how norms and perceptions are internalized and translated into practice. Thus, it acknowledges both the hardware (practices) and software (perceptions) of MH, making it a relevant theory for this study. The theory contains four key concepts; habitus, practice, field, and different 'forms' of capital including cultural, economic, social and symbolic capital (Bourdieu, 1977).

3.2.1 Habitus

According to Bourdieu habitus is the social structure and history within individuals. These two aspects influence an individual's behavior, how they perceive the world and their surroundings,

as well as, what aspirations they have and what choices they make. These internal social structures and history shape, through interactions and discussions, external social structures. The habitus is created in the childhood, where for example a person's parents' social position (how they think, feel, act and behave) influences the child (Power, 1999; Bourdieu, 1977; Walther, 2014). The habitus therefore reflects the social conditions in which one is formed, this creation of a person's "commonsense understanding of the world" is done almost completely unconscious and unquestioned (Reed-Danahay, 2018:2). This means that the habitus of people growing up in rural areas are likely to be more similar than to people growing up in urban areas (Bourdieu, 1977; Walther, 2014). Thus, "habitus is not only the product of structures and producer of practices, but it is also the reproducer of structures" (Power, 1999:49). One continually acts along the social conditions that produced the habitus and therefore reinforces one's social position (Bourdieu, 1977; Chang et al., 2016). In conclusion, the habitus shapes how we behave and act, in other words our perceptions and practices. However, individuals can still act in ways that are not consistent with their habitus (Chang et al., 2016; Maton, 2014). In a study of MH practices and perceptions which may be largely unreflected, habitus is a useful concept since it for example can explain why bad practices or stigmatic perceptions can stagnate for generations. Finally, habitus is a relational concept and needs to be understood together with the other key concepts of field, capital and practice (Maton, 2014).

3.2.2 Field

The field is, according to Bourdieu, where the habitus is constructed and reinforced such as social spaces where we act and interact, in other words, arenas of practice. Examples of fields are the intellectual, the science and the educational field (Bourdieu, 1977; Power, 1999). These fields are filled with specific rules referred to as 'doxa' created by the ways in which people act and interact. Doxa regulates what is doable and thinkable for people and is "internalized by agents in order to demonstrate appropriate practices and strategies" (Maton, 2014; Walther, 2014:8). Thus, "involvement in a field shapes the habitus, which in turn shapes the perceptions and actions" (Crossley, 2001:101), that leads to the reinforcements of the field's rules (doxa) (Walther, 2014). The habitus and the field reinforce each other and together strengthen the doxa which provide the rules of the game in the certain field (Bourdieu & Wacquant 1992). Habitus and doxa are therefore a part of the field while simultaneously creating it. How one is coping within the field is decided by one's status within it and everyone wants to maximize their position within the fields, which results in struggles of power (Chang et al., 2016; Maton, 2014).

However, the field and habitus do not always match. When you are uncomfortable or feel like a “fish out of water” your habitus does not fit the specific field you are in (Maton, 2014:56). This is referred to as ‘hysteresis effect’ where the habitus does not correlate with the field or the doxa, thus a person lacks the ‘feel for the game’. Meaning that the habitus does not adjust to the present social context. A well cited example of this is inter-generational disagreements, where there are “different understandings of which practice is ‘reasonable’ for one generation versus ‘scandalous’ or ‘unthinkable’ for the other generation” because their habitus has “been developed in different points in time leading to different understandings” (Walther, 2014:13). People generally drift toward fields and positions within these fields where they feel secure and like a “fish in water” (Maton, 2014:56).

Since menstruation is an overarching concept which essentially enters and intersects all the fields that the menstruating individual enters. Several fields will be considered in this thesis, such as the family, household, school, community and health care fields.

3.2.3 Capital

Different fields recognize specific sorts of capital and Bourdieu presents four main types of capital (Bourdieu – Wacquant, 1992; Powell, 1999). The *economic* which refers to monetary wealth and can easily be transformed into other capitals, such as buying a book and receiving cultural capital. The economic capital can be connected to the hardware of MH, i.e. affordability of sanitary products. The *cultural* capital is one’s intellectual qualifications, it can manifest in books, instruments or academic qualifications (Walther, 2014). One’s knowledge of certain issues, such as menstrual functions and practices is determined by the level of cultural capital. The *social* capital is the network of relationships such as family and firends. These relationships can give access to material and immaterial resources as well as information and knowledge (Power, 1999; Bourdieu, 1986). The level of social capital determines if a woman can get menstrual information from family and friends. Furthermore, if women do not follow the doxa on menstruation in a certain field, their social capital might decrease. Finally, *Symbolic* capital is what economic, social and cultural capital transforms into in a social field and is therefore not an independent capital. It determines one’s position in the social field and if one can enter another. It is related to reputation and respect; thus, more capital means more power in a certain field (Walther, 2014). The menstrual stigma can limit all types of capital for a woman and in turn decrease her symbolic capital, leaving her less valued and respected (Zivi, 2020).

3.2.4 Practice

Practice is the outcome of the relationship between habitus, capital and field (see Fig. 1) (Power, 1999). In particular, practice is the result of the field and the rules that apply there (doxa) together with habitus. Habitus ensures the collective belief in the doxa and that people act according to these. Their position within the field is decided by one's capital (Walther, 2014). An individual's practices are formed by the "expectations of the outcomes of a given course of action" which is through the habitus based on "experience of past outcomes". Indicating that individuals tend to learn from their previous practices (Maton, 2014:57).

Fig. 1 Formula of Interplay (Bourdieu, 1984:101).

[(habitus) (capital) + field] = Practice

More recently in Masculine Domination (2001) Bourdieu discuss the Theory of Practice in relation to gender. Bourdieu argues that gender is a constant dimension of social action and habitus which in turn influences people's interactions and relations constantly (Skeggs, 2004). It is with the inclusion of this gender perspective that the Theory of Practice will be understood in this study.

3.3 Stigma

The most prominent researcher within stigma theory is Ervin Goffman who, with his book Stigma: Notes on the Management of Spoiled Identity (1963), has guided the research on stigma until today. According to Goffman (1963), stigma is a mark, stain or defect of the character or the body that influences one's identity or appearance. Goffman developed three determinants that need to be fulfilled in order for something to be defined as a stigma. These are "abominations of the body" such as scars or malformations, "blemishes of individual character" for example addictive behaviors, and finally "tribal" characteristics or social markers linked to marginalized groups including gender, race or sexual orientations (Goffman, 1963:4; Johnston-Robledo – Chrisler, 2011). Those that do not have any of these determinants are viewed as 'normal'[5] and have an unproblematic relation to their identities and bodies (Goffman, 1963). Relating to the Theory of Practice, to pass as 'normal' one must act and practice in accordance

[5] When the term 'normal' is used from here on it is referred to Goffman's (1963) definition of it.

to the doxa of a field, even if it is stigmatic, leaving the doxa to continually be stigmatic (Walther, 2014).

3.3.1 Menstrual Stigma

Menstruation is often described as stigmatic within and outside the research spectra (Goddard – Pritzkat, 2019). Previous menstrual stigma studies have been conducted on how others perceive women when they are on their period (Roberts et al., 2002), studies on attitudes towards sanitary products (Rozin et al., 1999), or how women think others perceive them when they are on their period (Kowlaski – Chapple, 2000) have also been undertaken. Ingrid Johnston-Robledo and Joan C. Chrisler (2011) tested if menstruation theoretically can be defined as a source of social stigma. To test this, they used Goffman's three determinants of stigma and investigated if it corresponded with menstruation. They concluded that menstruation should be defined, understood and tackled as a source of social stigma. Firstly, because menstrual blood is like other bodily fluids considered as an *abomination,* secondly a menstrual blood stain can be viewed as a *blemish* because it is unwanted. Finally, Johnston – Robledo and Chrisler (2011:10) argue that "because only girls and women menstruate, menstrual blood also marks a *tribal* identity of femaleness". Although menstrual stigma manifests differently in various contexts with regards to religious and cultural ideas, the "dominant discourses" portray menstruation as something stigmatized, dirty and shameful through traditions, jokes and advertisements. This results in the idea of women as "less rational, less capable, less entitled to appearing in the public" when showing signs of menstruation (Zivi, 2020:120; Chrisler – Johnston – Robledo, 2018). Resulting, in terms of the Theory of Practice, in less symbolic capital (Walther, 2014).

Johnston-Robledo and Chrisler present some of the many consequences of menstrual stigma. The negative effects it has on women's health, well-being and social status is discussed. They especially note the self-consciousness associated with others knowing women's menstrual status and the time-consuming self-monitoring for leaks and odors this brings (Johnston-Robledo – Chrisler, 2011). The positive consequences are also discussed, but even more in their later work where they highlight that menstruation can, for some women be a source of pride, well-being, and a sign of maturity. However, the duality of being proud of something that is constantly implied as negative is complicated (Johnston-Robledo – Chrisler, 2011; Chrisler – Johnston – Robledo, 2018). Due to the stigma being overarching and prevalent in different

contexts, being rich or having higher education does not hinder menstruating women from being stigmatized (Geertz et al., 2016; Zivi, 2020). Therefore, in relation to menstrual stigma, cultural or social capital as defined by Bourdieu (1977) may not be able to mitigate a generalized stigma. Johnston-Robledo and Chrisler (2011:11) further highlight menstruation as a "more hidden than a visible stigma" because women "go to a great deal of effort to conceal it". They argue that menstrual sanitary products are designed to be handled discreetly and that menstrual stigma generally is created in the silence, meaning that menstruation is constantly an avoided and unprioritized subject.

3.3.2 Self-Stigma

The idea of menstruation as a hidden stigma correlates well with the concept of internalized or self-stigma[6]. Stigma is usually understood as two-parted, including public and self-stigma. Public stigma entails people's negative attitudes toward persons with 'abnormal' characteristics, which often result in the creation of stereotypes, prejudice and discriminatory actions. Self-stigma is the result of these public stigmas being enacted, personally experienced and internalized in the sense that these ideas are endorsed as true (Goffman, 1963; Rao et al., 2012). The creation of self-stigma is usually explained by the three A's of self-stigma. The first A stands for *Awareness* meaning that a person must be aware of the prejudices against the certain characteristic. The second A is *Agreement* when the person with abnormal characteristics believe the prejudice about them. Finally, the third A stands for the *Application* of these negative attitudes to oneself (Corrigan et al., 2011; Corrigan et al., 2009).

The idea of self-stigmatization acknowledges that being a part of a society where one is defined as abnormal, or in Goffman's (1963) words 'discreditable', will make one internalize these public perceptions and feel inadequate and shameful. Studies have shown that even small amounts of self-stigmatization can be very harmful (Balfe et al., 2010; Draplaski et al., 2013). However, if discreditable people can hide their abominations, blemishes and 'tribalness' and in turn manage their shameful characteristic they can pass as 'normal'. If they do not try to conceal it, they will be even more stigmatized. This draws on the idea of concealability, entailing that the more visible the mark is the more stigmatized the individual becomes. This results in a constant worry over managing and hiding the discredited characteristic, which relates to

[6] Internalized stigma and self-stigma are used interchangeably within the research spectra (Fox et al., 2017).

Johnston-Robeldo and Chrisler's (2011) discussion on the constant self-monitoring to manage menstrual stigma (Chrisler – Johnston – Robledo, 2018; Balfe et al., 2010; Goffman, 1963). Relating back to Bourdieu (1977), where one can pass as 'normal' if one's habitus and practices follow the doxa of a specific field. The concern of others seeing one's abnormality is defined as 'felt stigma' by Scrambler (2009) which essentially is the fear of 'enacted stigma'. 'Enacted stigma' being the obvious discrimination of someone because of their stigmatized characteristic, such as menstruating women not being allowed to cook. The felt stigma is enough for people to change their behavior in order to cope (Balfe et al., 2010; Crawford et al., 2014). This can lead to avoidance of situations where one accidently might display the stigmatized characteristics, such as avoidance of seeking help for medical issues related to the characteristic. It can also lead to the understanding that one deserves the negative treatment that comes with being stigmatized (Corrigan et al., 2009; Matthews et al., 2017). In most research on self-stigma it is described as a path to negative effects, however in some rare cases, it empowers people to change their current situation (Corrigan – Watson, 2002; Watson et al., 2013).

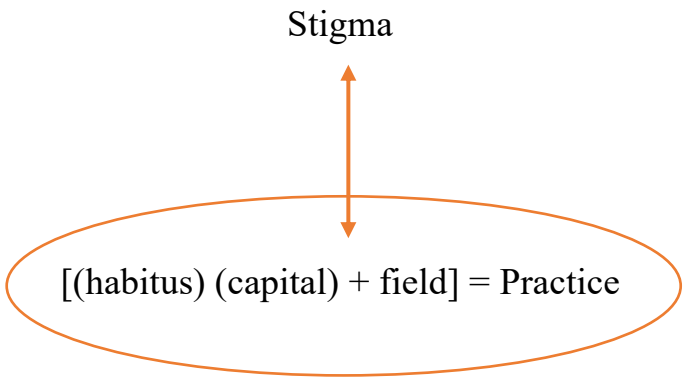
Previous research on self-stigma has and still is mostly conducted on mental illness (Link et al., 2001; Draplaski et al., 2013; Armstrong – Brandon, 2020). A diversion in the spectra has occurred and research on internalized stigma of HIV (Rao et al., 2012), sexual orientation (Feinstein et al., 2012), alcohol abuse (Schomerus et al., 2011) and 'fat-stigma' have been done (Wong et al., 2019). There are some theoretical models created to analyze self-stigma (Quinn – Earnshaw, 2014; Lannin et al., 2015), however these have mostly been developed to analyze the prevalence of mental illness stigma (Watson et al., 2013; Masuch et al., 2019). Since measuring the prevalence of self-stigma is not the aim of the study, these models will not be used, purely the concept of self-stigma.

3.4 Operationalization

In order to investigate menstrual practices and perceptions and their impact among mothers in Zithulele the theoretical groundings discussed above will lead the analysis. More specifically, in the backdrop of menstruation defined as a stigma and the consequences of this presented by Johnston – Robledo and Chrisler (2011), the concepts of public and self-stigma will be used. Self-stigma links elegantly with Bourdieu's Theory of Practice, especially Bourdieu's concepts of habitus and doxa. Since habitus is understood as the concept where a person constantly

reinforces one's own and the surrounding's beliefs by following the doxa of a certain field (e.g. internalizing the public stigma) which affect one's practices. Fig 2. Demonstrates how stigma is constantly present and affects the habitus, capital, field and practices as well as how they, in turn, reinforce and affect the stigma.

Fig. 2 Formula of Interplay (Bourdieu, 1984:101) Modified by Author.



Noting that Bourdieu's Theory of Practice and Goffman's Stigma-theory is created in Western contexts, the more recent work discussed above when elaborating on the theories have been taken from different parts of the world, including the Global South. The study's feminist standpoint enables an openness towards the participants stories in their socio-cultural context (Harding, 2004; Chrisler – Johnston - Robledo, 2018). The use of a gender lens throughout will give way for what challenges and opportunities that face the mothers in their specific context (Chant, 2013).

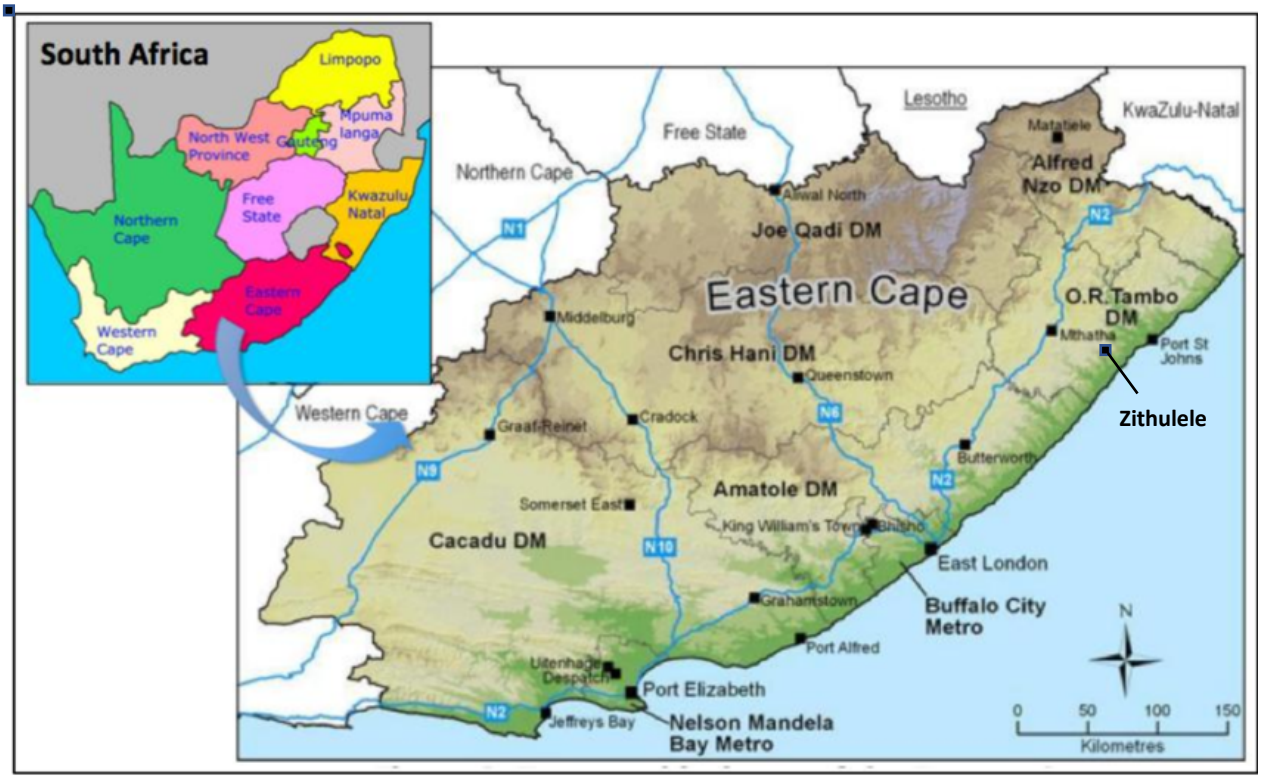
4. Contextualization

In this section the cultural, social and geographic background of the research setting will be presented. Followed by an account of the MH situation in South Africa, EC and Zithulele.

4.1 Zithulele, Eastern Cape, South Africa

The EC region consists mostly of rural settings except for a few more populated areas such as the cities of East London and Port Elizabeth. With limited resources and infrastructure throughout EC, it is difficult to conduct research in EC, resulting in a lack of sufficient demographic data and indicators of its rural parts. This study's research setting, Zithulele, is one of these rural areas in EC and more specifically in the OR Tambo District (see Fig. 3) (Zithulele Research, b, n.d.). In Zithulele, a rural hospital is located and several Non-Governmental Organizations (NGOs) that works with community development. Nevertheless, Zithulele is one of the poorest areas in the country (Zithulele Research, a, n.d.).

Fig 3. Map of the Eastern Cape Province, South Africa (Sibanda - Mutengwa, 2016), Modified by Author.



Apartheid, where black and colored South Africans, amongst others, were systematically banned and limited from accessing rights, infrastructure, education systems and health care, has left significant remnants in the area. South Africa is one of the most unequal countries in the world with a Gini Index[7] of 63. Out of the 7 million people inhabiting the EC 86% are Black African and 8% Colored (The World Bank, 2014; Republic of South Africa, 2012). In EC the lack of infrastructure initiatives, transportation routes and public transportation is prevalent, and the main source of travel is done via taxis. Maintenance, sanitation and health care services is still vastly limited (Bähre, 2007; Scorgie et al., 2016; STATSSA, 2018a). This has left EC covered by widespread vulnerability, as well as high rates of malnutrition, infant mortality, HIV/Aids and Tuberculosis (Young – Gaunt, 2014; Zithulele Research, a, n.d.). The lack of education is also prevalent in the region (Republic of South Africa, 2012). High unemployment rates have led to a significant out-migration among men to larger cities which has contributed to many female-headed households. With an average household size of 3,9 persons. The unemployment rates have left a significant part of the households relying on social grants and remittances for survival (STATSSA, 2019a; STATSSA, 2018a; STATSSA, 2018b). Households live in general off about R2000 (US$180) a month (STATSSA, 2019b). Moreover, traditional dwellings, made of mud or clay defines the majority's living structures in Zithulele and there is a huge lack of electricity and disposal systems. The outside located long drop toilets[8] and bucket toilets are most prominent in Zithulele and there is limited access to water and sanitation services (Zithulele Hospital, n.d.; Republic of South Africa 2012).

IsiXhosa is the mother tongue for more than three quarters of the inhabitants in EC. The Xhosa ethnic or cultural group is mainly based in EC and is one of the largest groups in South Africa (Padmanabhanunni et al., 2017; South Africa Online, 2019; Republic of South Africa, 2012). The area is structured as a patriarchal society which affect most activities and beliefs. Age hierarchies are also deeply prevalent and respect for the elders is of great importance (Rice, 2015; Madiba – Ngwenya, 2017; Personal communication, Head Nurse, Kuselwa Fonya, 2019-11-14).

[7] "Gini index measures the extent to which the distribution of income (or, in some cases, consumption expenditure) among individuals or households within an economy deviates from a perfectly equal distribution" (The World Bank, 2014).
[8] Long-drop toilet or pit latrines are toilets that collects feces in a dug hole in the ground (BBC, 2018).

4.2 Menstrual Health in Zithulele, The Eastern Cape & South Africa

The rising amount of literature concerning MH in rural Sub-Saharan Africa mentioned in Section 2, is reflected in the region's policies. For example, the UNFPA together with the East and Southern Africa Regional Office (ESARO) and the Department of Women in the Presidency of the Republic of South Africa cohosted the first East and Southern African symposium on MHM 2018 in Johannesburg (UNFPA et al., 2018). The South African government recognizes the importance of MH through committing to initiatives such as 'Menstrual Hygiene Day', a global advocacy platform aiming to improve MHM globally and in April 2019 the VAT (Value Added Tax) on sanitary products was revoked. However, the main focus of the South African government, similar to the research spectra, has been on the MH of adolescences in school settings, as for example, in January 2019 The National Student Financial Aid Scheme allocated R275 (US$16) among 800 000 students for personal hygiene. In April 2019 the Department of Women of the South African Government launched the National Sanitary Dignity Implementation Framework (SDIF) in Makana, EC. SDIF seeks to provide sanitary products to vulnerable persons (Gajadhar, 2019). These new initiatives reflect how severe the issue is in the country and especially in the EC and rural areas. Resulting in women's lives being restricted due to stigma, lack of sanitary products and fundamental services, where for example the insufficient and expensive transportation possibilities limit women's access to sanitary products (Padmanabhanunnia, et al., 2018).

Moreover, the Head Nurse Kuselwa Fonya at the local clinic in Zithulele, Pumalanga Clinic (Personal communication , 2019-11-14) explains that there are no sanitary products to hand out at the clinic, in fact they do not even have pads to provide after conducting vaginal examinations on patients, which Head Nurse Fonya argues is the "biggest headache of my life". Another huge issue in Zithulele explained by Zonke Banjwa (Personal communication, 2019-10-16) a MH Educator and Activist in the area, is the lacking information about menstruation and how to manage it. Menstruation is generally not discussed, not even within the family. Girls are often scared to ask for money to buy sanitary products and uncomfortable to go to school during their period. Head Nurse Fonya also argues that menstruation is not discussed within families and that parents often assume that the children learn about it in school which is not always the case. She further explains that there is widespread misinformation about menstruation in Zithulele and that there is a lack of interest regarding it. Information about menstruation and its functions

is not given by the local clinic. They provide solutions to the patients' menstrual issue, but it is not discussed in a deeper matter. Additionally, these discussions are difficult to have because being a young nurse with the authority that comes with the job creates a power dissymmetry between Head Nurse Fonya and the older patients, due to the age hierarchies in Zithulele. Moreover, since menstruation often correlates with sex, it is still a "touchy subject" (Personal communication, 2019-11-14). This view of menstruation together with Zithulele being a part of a patriarchal country, with women who got "a very submissive demeanor about them" (Madiba – Ngwenya, 2017; Personal communication, Head Nurse, Kuselwa Fonya, 2019-11-14), leads to that MH is not prioritized and seen as taboo. Finally, women's menstrual experience is the result of the sanitation services provided and existing believes and practices concerning menstruation in a certain area (Scorgie et al., 2016).

5. Methodological Discussion

In this section the study's research design and strategy will be presented, as well as the ontological and epistemological stance and methodological choices such as data collection methods and the method of analysis. Finally, a critical evaluation and limitations of the study as well as ethical considerations will be presented.

5.1 Research Strategy & Design

In order to fulfill the aim of the study in gaining the mothers' perspective of their experience regarding their menstruation, the study has a qualitative research strategy. Qualitative strategies are fitting to use when the purpose is to comprehend certain participants thoughts about an issue and further offers a more detailed understanding of the topic than quantitative. The research design is a single case study of mothers' MH in rural Zithulele, where in-depth field research was conducted focusing on getting the mothers' perceptions regarding their menstruation (Creswell – Poth, 2018; Bryman, 2012).

5.2 Ontological and Epistemological Stance

The ontological position of this study is constructionist where individuals' interactions create social properties which are not understood as detached from the individuals involved in their construction. This correlates well with the theoretical framework presented, especially Bourdieu's Theory of Practice, which emphasizes the interaction between individuals through habitus and the outcome of this interaction in the concept of practice. The epistemological position is further interpretivist, meaning that, the understanding of the social world will be reached through an examination of the participants' understanding of the world they inhabit (Bryman, 2012), in this case through how the mothers perceive and understand their menstruation. Focus will be on the specific context in which the research group live, in order to understand the cultural as well as historical background of the participants (Creswell – Poth, 2018). Furthermore, a feminist standpoint is used throughout the study as mentioned in Section 3.1, where the focus is to understand the women's stories as told by them and acknowledge the uniqueness of their experiences (Harding, 2004).

5.3 Access

To get initial access to the interview participants, I got help from three local Xhosa women who were employed by Zithulele Research and Training Center (ZRTC)[9]. One Xhosa woman in particular, who was employed as a Research Administrator became the main gatekeeper. She was well integrated in the local society and had great knowledge of the research conducted in the area as well as of this research (Creswell – Poth, 2018; Murray – Overton, 2014). I was a Research Intern at the ZTRC prior and during the data collection and was therefore able to use the ZTRCs insights and understanding of the local context, which was vital in order to ensure cultural sensitivity of the research. To have a gatekeeper that truly believed in my research and simultaneously wanted the best for her local surroundings was beneficial, considering that the gatekeeper can influence the research in different ways. After introducing the initial participants for the interviews she became more of a 'cultural mentor' and could guide and give context when needed (Murray – Overton, 2014; Hammett, et al., 2014).

5.4 Data Collection

To gather data, semi-structured open-ended interviews have been conducted, summarized in Table 1. The open-ended method was chosen to provide in-depth information regarding the participants' experiences and opinions of menstruation, which is of great value when discussing sensitive topics (Turner, 2010; UNICEF, 2019). Due to this sensitivity of the subject the interviews were conducted in person, allowing the participants' emotional expressions to be observed (Bryman, 2012). Secondary material in the form of reports and journal articles were used to contextualize the background of the study area, menstruation as phenomenon, as well as, the theoretical framework and the literature review to provide a research rationale.

[9] A local research NGO conducting various of research projects in the area, mainly on the underrepresented population (Zithulele, 2019b).

Table 1. List of Interviews

Interview Type	Number of Interviews & Participants
Semi-structured Key Informant Interviews	2
Individual Semi-structured Interviews	25
Total	27

Interview guides (Appendix 3, 4 & 5) were derived through the 'Integrated model of menstrual experience' (Appendix 1) which has been developed by Hennegan et al. (2019) after extensive systematic search and review on qualitative studies on MH. The model helped identify important themes to reflect on when discussing MH. In order to identify potential barriers and challenges for mothers managing their MH the Health Stigma and Discrimination Framework (Appendix 2) was used when preparing the interview guide. It is a global, crosscutting framework developed by Stangl et al. (2019) which informs research, development interventions and policy on health-related stigma. Demographic and background questions were asked at the beginning of the interview as an ice breaker but also to get an understanding of the living conditions of the participants. These were then followed by more specific questions regarding the mother's MH practices and perceptions. The key informant interviews were also initiated with background questions to make them feel more comfortable and to get a better understanding on their position as specialists. To determine potential flaws or limitations within the interview guide a pilot interview was conducted (Turner, 2010). Since no changes were made to the interview guide after the pilot had been conducted and the pilot participant had the requirements needed to join the study, the pilot interview was included in the output and analyzed. The dates of all the conducted interviews can be seen in Appendix 9.

The interviews varied from 20 minutes to 1 hour and 10 minutes. I carried out the interviews alone in English without a translator even though the most commonly spoken language in the area is isiXhosa. This decision was made for several reasons. Firstly, the topic concerning menstruation is commonly seen as a private matter and having a translator as an additional person in the room might have made the participants uncomfortable and less likely to open up (Hammett et al., 2014). Accordingly, a few of the participants argued that they would not have been able to be as open as they were about their menstruation if another person was in the room.

Secondly, the cost of paying for a translator as well as the time and effort that is needed for making appointments for not only two, but three people was considered as problematic (Hammett et al., 2014). Doing this would have pressured the economic situation as well as the strict time schedule to gather material. Thirdly, when using a translator, one needs to consider and reflect upon that person's positionality in addition to one's own (Hammett et al., 2014), which is challenging enough. Additionally, it is difficult to ensure the accuracy of the translation when using a translator, especially in isiXhosa because it is not a written language. However, it is important to note that neither the researcher nor the participants conducted the interviews in their mother tongue which could limit the study's output. Even more so, when the topic is sensitive, since this can be difficult enough to discuss in ones' first language. An attempt to tackle this was done by asking the participants the same kind of question in different forms and parts of the interview (Bryman, 2012), with the hope that if the answers were not elaborated on by the participants the first time, they would be the second time.

5.5 Sample & Profile of Participants

To keep the focus of the study, the following criteria were used when selecting respondents. Participants included in the study needed to;

(i) be mother; meaning being a woman that has given birth to at least one child and taken care of it. This requirement is needed in order for the participants to be able to give the perspective on MH from the biological conditions of being a mother as well as the social relationship of motherhood.

(ii) be over 18 years old. This requirement was included in order not to compromise any underaged in the study and to get the adult perspective of MH in the area.

(iii) speak and understand English. This was important in order for the participant to be interviewed as well as understand the consent form.

(iv) live in Zithulele, considering that it is the focus area of the study.

(v) identify as being part of the Xhosa culture. In order to get the local perspective of the area and not include women that have moved from other parts of South Africa or abroad to the area.

Purposive snowballing was used as sampling method which encourages people of interest or interviewees to share contact information of persons in their surroundings that match the sample criteria (Creswell – Poth, 2018). Snowballing was used since to bluntly recruit people to a study

on MH could be perceived as invasive. If, however a potential participant was contacted by a friend the approach could be less interfering. Additionally, using purposive snowballing ensured that the interviewed mothers' age differed, which was essential in order to include women of wide-ranging ages. After the interviews when the participants were asked to enquire for potential participants to join the study they were provided with a form (Appendix 8) with information of the criteria that the participants needed to fulfill. This was a successful sampling method, because the participants that had finished the interviews had a good idea of what level of English proficiency was needed to participate and could ask persons with sufficient English knowledge to partake. Resulting in that all participant had the level of English proficiency needed for the study. Initially 8-12 participants were planned to be interviewed, but thanks to the snowball sampling more participants from the area were contacted. The number ended up being a total of 25 interviews where information saturation was reached after 24. The key informants were purposively sampled after informal conversations with ZTRC staff, where the aim was to find people that professionally or voluntary worked with menstruation in Zithulele. Two key informant interviews were conducted, one with the Head Nurse Kuselwa Fonya of the Pumalanga Clinic, the local clinic in Zithulele and one with Zonke Banjwa a MH educator and Activist in Zithulele.

5.6 Data Management Analysis

The interviews were audio recorded and transcribed by me ad verbatim in order for the answers to be analyzed thoroughly. The interviews were securely stored with password protection. The participants names were not recorded, and each recorded interview was linked to a participant identification number (PID). Each participant is referred to with a PID in the data and output as a result of the ethical agreement with Walter Sisulu University (WSU) elaborated on in Section 5.8. Although the analysis of the material was initiated during the interview phase, the coding process paved the way for a more systematic analysis of the material. In analyzing the transcripts, initial themes were deductively created (Bryman, 2012). Going through the interviews, thematic analysis was used, where familiarization with the material was done and later the data was grouped in recurring themes and subthemes. Thematic analysis is often used in analyzing what is actually said, which fits this study well (Creswell – Poth, 2018; Nowell et al., 2017).

5.7 Measures to Ensure Trustworthiness & Limitations of The Study

Considering that the study focuses on the mothers' experiences and 'their truth' assessing their credibility and the credibility of the study can be difficult. However, cross-referencing statements with secondary data sources have been made, as well as continuous conversations with the ZTRC staff. The findings have additionally been presented at the ZTRC to doctors, nurses and other health care workers serving Zithulele community, where feedback was gathered and taken into account, which enhances the credibility of the study (Bryman, 2012).

Since this is a qualitative study focusing on a small in-depth group, the qualitative findings represent the 'contextual uniqueness and significance' of this certain topic in this specific area (Bryman, 2012:392). The participants interviewed have shared their subjective view on their situation which affects the transferability and generalization. To tackle this, the contextualization (Section 4) provides necessary information of the studied social context. This can in turn inform other researchers about the actual context of this particular research and assist in deciding whether these findings are applicable to other contexts or not (Bryman, 2012). Additionally, replicating a social setting is impossible and one must be aware of the changes regarding the phenomena of menstruation since it is influenced by the social structure, norms and ideas, which is changing rapidly in South Africa (see Section 4.2) (Bryman, 2012).

The sample being small (n=25), with not many participants for each age group limits the quality of statements being made of the perceptions within certain ages. More participants would have been needed in order to rule out potential additional factors, besides age for a certain outcome. However, the range of ages included in the study gave it broadness. No quantitative surveys were conducted for this study even though it would have given it a larger sample. This decision was made partly because of time constraints and the language barrier, since translation of the surveys to isiXhosa would have been needed. More importantly because menstruation is a sensitive topic which requires a level of confidence from the participant when answering questions about it, which in in-depth interviews can be established through the trust between the researcher and interviewee. The answers in a survey could therefore have been misguiding (Bryman, 2012). Moreover, focus groups were decided not to be used after discussion with the local supervisor and gatekeeper due to the sensitivity of the topic.

The dependability is ensured by using an auditing approach, where records of every part of the research process has been kept in an accessible manner; such as the transcriptions and data analysis decisions (Bryman, 2012). This falls naturally in the writing of a Master's thesis since one is assigned one supervisor and one peer review group which are appointed to establish how far these procedures are followed. This audit trail further strengthens the confirmability of the study. Being aware that complete objectivity is not possible within social research, the audit trail which highlights every step of data analysis that was made in order to provide a rationale for the decisions made, helps establish that the study findings accurately portray the participants' responses (Bryman, 2012).

As briefly touched upon in Section 5.5 and which can be seen in the demographics of the participants in Section 6.1, one could argue that the participants are 'unusually modernized' with the level of education, income, and language knowledge in comparison to others in the area, considering that the lack of education is extremely prevalent in the region (Republic of South Africa, 2012). Using snowballing as a method of sampling could additionally have swayed the outcome so that a certain category of women with similar background were included in the study. Although, the purpose of the study was not to interview women in a certain socioeconomic group, rather mothers in the area over 18 years old, to get a greater understanding of how they practice and perceive their menstruation. However, this limitation should be acknowledged when reading the study.

5.8 Ethical Considerations & Reflexivity

Qualitative studies are greatly influenced by the researcher (Bryman, 2012). Being an interpretivist study the recognition that one's background (historical, personal and cultural experience) will impact the interpretation of the data and result is important (Creswell- Poth, 2018). To reflect over one's positionality and to present the researchers stance is vital if other researchers want to conduct a similar study (Bryman, 2012).

Being female was helpful when interviewing female participants about a private matter like menstruation, especially in Zithulele, where menstruation is seen as an issue concerning solely women (Hartsock, 1987, Personal communication, Head Nurse, Kuselwa Fonya, 2019-11-14). This was something one participant explicitly commented on;

> … it's like I've been talking to you for years and when I first saw you I didn't saw a stranger… because you are also a girl and you also experience the same thing as I am experiencing (PID11).

However, being white, Western and young in a country with racial division lingering from the aftermath of apartheid and with age hierarchy that impacts the social context, made the data collection more challenging. Some of the participants acknowledged this difference and noted how the discussion on menstruation could help manage it, where one stated "We are different me and you it's not the same, we are the same blood but the different color" (PID09). To further minimize the "bracketing" between me and the participants I shared personal experiences about myself and my menstruation (Creswell – Poth, 2018:381), where we could meet in commonalities of perception and practices regarding menstruation. To somewhat tackle the power differences between me as a white, Western young female researcher and the interviewees, a feminist standpoint was adopted, where the interview was seen as a conversation with the exchange of information (Sultana, 2007). This became quite natural for this research because the topic often became a source of laughter, which relived much of the existing tension. Feminist methodologies moreover highlight the importance of mutual learning when conducting interviews (Sultana, 2007). This was also a natural part of the interviews, where certain practices or phenomena such as how to use a tampon or what happens when the period arrives was encouraged by the participants to be explained. Where one noted;

> Knowing what or like the purpose of your research, I'm more comfortable with you talking about it because, I also feel like there is so much that we do not know, like for instance I did not know like where was this blood coming from but now I know so, it's like you getting some info from me and I'm also getting some info from you (PID24).

The participants were further not viewed as 'powerless' but rather as people that had agency and power over the study (Hammett et al., 2014). The fact that I had lived and worked in the area for two months prior to the data collection and approached the study context slowly (Creswell – Poth, 2018), made the relation between me and the participant more natural and not so clinical and research oriented (Bryman, 2012). The participants accordingly expressed that they felt more relaxed in the interviews because I had been in the area for a while. Furthermore, the interviews had a better flow because the participants could refer to local sites or occurrences without having to further explain them.

Although these measures taken are all helpful, following ethical guidelines can further counter power differences and promote moral and mutual relations as well as a respectful research and minimize potential harm (Sultana, 2007). Considering that the topic is private and could be viewed as socially and culturally sensitive, possible discomfort among the interviewees could have occurred. However, a written participant information and consent form was presented, read and signed by all participants before the interviews started (Appendix 6 & 7). This was done in order to make sure that the participants felt comfortable with the topic and the questions of the study. The form disclosed that the interviews were completely voluntary and anonymous and that the participants were free to skip questions, pause or stop the interview without any consequences. The form moreover explained that the participants were free to have the interview removed from the record or the research at a later stage if they would prefer. The interviews were conducted in one of the office rooms of ZTRC in a private environment. All the interviews were audio recorded. To make sure that the participants still wanted to go through with the interview while being recorded, even if it was stated in the consent form, they were asked to give their verbal consent prior to the start of the interview. As stated on the information sheet, the participants could at any time withdraw their participation in the study if they wanted to. The participants received a R150 (US$9) voucher of airtime as a gratitude for their time. This was decided after conversations with researchers and employees at the ZTRC who argued that this was a reasonable compensation. Finally, the study has received ethical approval from Lund University as well as the WSU, Eastern Cape, South Africa (Appendix 10 and 11). It is further vital to maintain the ethical perspective not only in the preparation of but also throughout the interview and research process (Kvale, 1996). Accordingly, the WSU demanded a progress report on the current state of the research in late April 2020 to ensure that ethical guidelines were still followed, which they were considered to be.

6. Findings & Analysis

In this section some demographic data is initially presented as a contextualization for the analysis, followed by the results and analysis of the study findings.

6.1 Contextualizing the Analysis

The main demographic findings, summarized in Table 2 and 3, assist in comprehending the mothers' reasoning and living situation.

Table 2. Demographic Results from Interviews: Age, Household Size and Monthly Income.

Demographics	**Average (Mean)**	**Median**	**Range**
Age	33	32	22 - 47
Household Size	5	5	1 - 17
Monthly Income	R4160 (US$270)	R3000 (US$195)	R250 (US$16) - R14500 (US$939)

The range in the mothers' ages was vast and the variation of the number of people in the household was substantial. The mothers' socio-economic status and their ability to buy sanitary products to ensure MH, can be linked to monthly income, where lower income households generally lead to poorer MHM (UNFPA, 2019). A majority of the mothers explained that social grants such as pension and child support grants were a significant part of their income and salaries were therefore generally quite low among them. The number of people sharing the same income were mostly more than the number of people in the household since many families in Zithulele are spread over different cites, due to lack of job opportunities (STATSSA, 2019, a). Further, a majority of the mothers claimed to have a significant saying on how their income should be spent.

Table 3. Demographic Results from Interviews: Level of Education Attained and Occupation

Education	**Number of Participants**
Finished grade 12	8
Educated beyond grade 12	10
Finished grade 11 (failed grade 12)	4
Finished grade 4	1
No education	1
Unknown	1
Occupation	**Number of Participants**
Unemployed	4
Employed	21

MHM has been reported to be worse in households with lower educational levels and poor MHM generally result in school absenteeism and dropouts (Tegegne – Sisay, 2014). However, the majority of the respondents had finished grade 12 and a significant group had conducted further studies (see Table 3), indicating low dropout rates among the women. The most common higher educations were in nursing, social work, business administration and as pharmacy assistants. Table 3 further demonstrate that a strong majority of the mothers are employed, which is unusual in Zithulele with its high unemployment rates (Zithulele Research, a, n.d.), discussed in Section 5.7. Most of the participants' occupation was as domestic workers, translators, pre-school assistants or teachers, or in assistant positions within the hospital. To have positions or education within the health care field could potentially give the mothers more MH information. However, this does not seem to be the case, since menstruation is not even discussed in detail at the local clinic (Personal communication, Head Nurse, Kuselwa Fonya, 2019-11-14).

To better understand under what conditions the mothers manage their menstruation, data was gathered on use of sanitary products and disposal practices, as summarized in Table 4. Besides being essential to survive and maintain good health, water access is vital to ensure MH (SIDA, 2016). The largest number of respondents (11) had access to a JoJo-tank[10] close to the house[11],

[10] Large tanks that collect store rainwater (Jojo, 2020).
[11] If there is lack of rain, some of those with access to Jojo-tanks use the communal taps (5) and some of those with access to Jojo tanks fetch water from the river for the same reason (3).

while the rest used a JoJo tank at their workplace (2), communal taps (7) or the river[12] (5). A majority did not express any issues with the fetching of water or saw it as time-consuming.

Table 4. Use of Sanitary Products and Disposal Practices for Sanitary Products

Sanitary Product Use	**Number of Participants**
Disposable sanitary pads	23
Tampons	2
Disposal Practices	**Number of Participants**
Use the recycling center established by the NGO Jabulani	1
Use bins provided by the NGO Jabulani	2
Burn rubbish in the garden	15
Put rubbish in dug holes in garden	7

Sanitary products are a significant part to maintain MH (SIDA, 2016). Among the mothers, a clear majority used pads, except for two that used tampons (see Table 4). Disposal systems, which are essential for ensuring MH (SIDA, 2016), were considered to be lacking and especially sustainable ways of disposing sanitary pads.

Photo 1: Zithulele; a traditional mud dwelling in the middle, a green Jojo-tank in front of it, an outdoor long drop toilet to the right and rests of burned trash to the left (Author, 09-2019).

[12] With varying walking distance from five to twenty minutes one way.

This section has highlighted an impression of who the interviewed mothers are and their current MH situation. At a first glance, in term of income, employment, education and water access, the mothers are quite well off when it comes to what is needed to sustain MH. However, even if these mothers have an income it is generally not very high considering that they are expected to share it with a number of household members. Moreover, the lack of sustainable ways of disposing sanitary products is an obstacle in ensuring MH.

6.2 Analysis

In this section the data will be analyzed using the theoretical framework outlined above, to answer the three research questions presented in the introduction of the thesis.

6.2.1 The Mothers' Perception of Menstruation in Zithulele

In Zithulele the mothers generally have a conflicting relationship with their monthly bleeding. In negative terms menstruation is seen as something uncomfortable and dirty. "The dead blood come out and then I'm clean" (PID11). Some mothers even express hate toward their menstruation and almost every mother felt ashamed and sad when they reached menarche. Some further reflect on how big of an issue menstruation is in Zithulele; "When you talk about menstruation it touches my heart because we are really struggling when it comes to that" (PID22). In positive terms some mothers see it as natural; "I just think it's a natural thing, it's meant to happen" (PID06), although most mothers have these perceptions combined.

It is considered as a difficult topic to discuss, especially between younger and older women as well as with men. If a woman does not have a sister or mother, it is increasingly difficult for her to attain menstrual information. According to almost all the mothers there is a "culture of silence" (Personal communication, MH Educator, Zonke Banjwa, 2019-10-16) regarding menstruation in Zithulele; "In my culture you don't talk about menstruation" (PID05). This silence relates to what Head Nurse Fonya expressed when she described the lack of interest for menstruation in Section 4.2 (Personal communication, 2019-11-14). Furthermore, the same mothers who argue that menstruation is not talked about in Zithulele, also state that they are comfortable talking about it. This of course is contradictory, however, it shows how the mothers unconsciously act and conform to the doxa related to menstruation in various fields. To

summarize, menstruation is not a widely discussed topic and the mothers express a duality of emotions regarding it, although negative attitudes are somewhat more prevalent.

6.2.2 The Effect of Stigmatic Perceptions on Mothers' Menstrual Health Practices

In this section the concept of menstruation as stigmatic and its effect on mothers' MH practices in Zithulele are discussed using concepts from the theoretical framework.

The Culture of Silence

Menstruation is a hidden social stigma in Zithulele as suggested by the quote below:

> It's a struggle because you know we are from this deep rural area our parents are limiting us when it comes to education [about menstruation]. So, if you see that it's time for you to go to periods, you are stressed, you don't know who to tell because you think that your parents may say that you slept with a man or something like that. So, you end up not talking about it, just doing some research from friends at school. The information that you obtain from friends is not the valid information that you may chose (PID22).

The public stigma of menstruation (as shameful and dirty) is enacted among the mothers, which manifests in their reluctance to discuss it. Thus, the mothers are aware of the negative attitudes, they accept them as true and apply them to themselves when they feel dirty. The three A's of self-stigma are therefore fulfilled, demonstrating that self-stigmatization is conducted among the mothers (Corrigan et al., 2011; Corrigan et al., 2009). The 'culture of silence' is also portrayed in the quote and highlights the lack of social capital within the family and household fields surrounding menstruation as conversation among family and friends about menstruation is limited. This has serious impacts on the mothers' menstrual practices, since social capital can provide, material and immaterial resources as well as information. The mothers express that one instead learns how to manage menstruation by seeing how others do it or overhear in conversations. Thus, bad practices could be reinforced, and misinterpretations could easily happen. When menstrual advice is given from family and friends the reason why menstruation exists is not reveled, it is mainly stated that the girl is fertile.

> It's like one of those well-known but not really known things. It's like everyone knows that at some stage a girl is supposed to go through the menstrual period, and this means that they're fertile, they're ready to have kids. So, that's all they feel they need to know (Personal communication, Head Nurse, Kuselwa Fonya, 2019-11-14).

Additionally, ‘felt stigma’ such as the ‘culture of silence’, is enough for people to change their practices (Balfe et al., 2010; Crawford et al., 2014).

One of the mothers’ biggest concerns regarding menstruation is the anxiety of others knowing that they are on their period. This is not surprising since they learn in various fields (school, family and community) from a young age that menstruation should not be talked about, which is adopted by their habitus. By not discussing it they constantly reinforce the silence around it, since habitus is both the product and reproducer of structures (Power, 1999). This results in the strengthening of the doxa in fields, meaning that certain norms are constantly taken for granted, which in this case is menstruation as something stigmatized that should be hidden. The habitus further produce practices, which in this case would mean hiding the ‘abnormal’ menstruation. These practices further affect the people’s perceptions about menstruation within the field, which are then reinforced (Power, 1999). According to the Theory of Practice, individuals tend to learn from the outcome of their previous actions (Maton, 2014). Applying this to this data, mothers with stigmatic menstrual experiences (i.e. having had a visible blood stain or a shameful menarche experience) will do whatever it takes to avoid the same or another negative outcome. Many of the mothers, therefore, want to avoid menstruation to not have to worry about it. One of them therefore uses contraception to skip her menstruation (PID17). To hide the stigmatic mark successfully makes the mothers appear ‘normal’. “They didn’t know that I was on period, so, they treat me the same” (PID09). It is further well integrated in the women’s habitus to at all cost conceal the stigmatic menstrual blood.

Disposal Practices

Menstruation as a social stigma impacts the priorities made in a community, such as the lack of disposal systems (Geertz et al., 2016; Zivi, 2020). The insufficient disposal systems in Zithulele affect the mothers’ disposal practices of sanitary products. Some of the mothers washed their pad and then threw it in a hole in the garden which later was burnt or buried, and others washed their pad, dissolved it in water and spread it out in the garden.

> … what if maybe someone see that there is blood there, there is pad with blood, what if a person saw it? … So, I decided to wash it [the pad] then mix it with water and throw it, cause I don’t want my blood to lie around (PID23).

These practices are not considered difficult or time-consuming among the mothers, which is not surprising considering that it is embedded in their habitus and the doxa of certain fields and therefore unquestionable. To not dispose sanitary products in the 'right' way is further shameful; "It's always uncomfortably if you see a used pad lying around. You're always worried 'are they thinking that it was me who throwed it away'" (PID01).

Stigma & Lack of Menstrual Health Education

According to the mothers, MH knowledge is drastically lacking in the school, household and community field in Zithulele. Due to not having cultural or social capital regarding menstrual information, almost all of the mothers were clueless when they reached menarche. Many thought they were wounded, and it was always described as scary and shameful. Some received menstrual education in school, but there were often circumstances limiting their learning, such as having male teachers. This made them reluctant to listen or ask questions due to menstrual stigma. The majority of the mothers did at the time of this study not know what biologically happens when their period comes or what menopause is, even if some of them had reached it. This was prevalent among mothers with various age, income and education levels. Demonstrating the knowledge gap regarding menstruation in general and specifically in the education field, it was found that women with higher education levels were not more informed about menstruation. Additionally, it was found that more economic capital does not necessarily lead to more knowledge regarding MH among the mothers.

Due to menstrual education being essential to establish and maintain good MH practices (Hennegan et al., 2019), the lack of it affects the quality of the mothers' practices. It could further be argued that their habitus and the doxa in certain fields, unconsciously limits them to seek more information about menstruation, even if they express that they want to; "Even when you have like a smartphone it's not something that you think about like 'let me read up on it [menstruation]'" (PID24). This lack of adequate education has led to widespread misinformation about menstruation among the mothers, where menstrual issues that are generally common, are seen by the individual as abnormal. "I didn't know that periods were normal. I thought when you're having periods it's because you've started having sex when you're still young" (PID04). The mothers' lacking knowledge and misinformation about menstruation further impact the coming generations' MH practices and in turn the doxa in certain fields. The mothers' habitus directly impact their children's habitus, since mothers are

the greatest menstrual influencers (Geertz et al., 2016). Accordingly, almost all mothers expressed that they were discussing menstruation with their daughters.

Even the menstrual information given to mothers in the health care field is lacking and it is generally not discussed in-depth (Personal communication, Head Nurse, Kuselwa Fonya, 2019-11-14). Every mother except one (PID15) argued that their period changed after giving birth in terms of more severe cramps, less cramps or heavier flow. A majority claimed that they did not get information about this potential change from the hospital. This left many confused and guessing like PID23 "… we believe that that pains goes away after you give birth when you are menstruating". The concept of guessing is brought up several times by the mothers and when correct information in a resource poor area like Zithulele is limited, it enables alternative ideas to flourish. This together with the notion of menstrual stigma is portrayed in traditional myths on menstruation in Zithulele. One should not eat dairy products or eggs nor sit close to males or another woman having her period during menstruation. These practices are said to increase the menstrual flow, which is an unwanted outcome. Moreover, one should not visit the cattle crawl during menstruation, because it can give the cattle miscarriages. However, most mothers argue that these rules are not followed by everyone anymore and are mostly shared by the older generations. Bourdieu's hysteresis effect can explain this, that one practice can be sensible for one generation and simultaneously unthinkable for the other (Walther, 2014). However, since myths can be considered as cultural capital (Bourdieu, 1977), the restrictions toward menstruating women, even if they are not followed by everyone, has relevance. Since cultural capital is valuable within a field, following or acknowledging these practices is important, because enhancing one's cultural capital can in turn validate or advance one's social position by boosting one's symbolic capital (Bourdieu, 1977).

This knowledge gap regarding menstruation limits the mothers to try new methods or other sanitary products. However, most mothers are satisfied with their menstrual practices and products that they use and do not express any will to change these. A significant amount of them had not heard of any other sanitary products than sanitary pads and cloths. The majority of the ones that had heard of tampons were genuinely scared of them; "No, I don't want anything to come inside me! I'm afraid of it" (PID17). One reason why this fear is expressed could be the lacking cultural capital and knowledge about it; "I'm not sure if I can be able to use it because there is certain ways to use those things and I never see anyone using them [tampons]" (PID06). The high price of sanitary products is further expressed as a huge issue

among the mothers. Living far from supermarkets, with high prices of transportation and an overall lack of economic capital affects the women's physical access to sanitary products; "…you can't just go to the big shop only for pads, it will cost you because you have to find a transport" (PID04). In a small 'Spaza' shop in the village pads are sold, however, the prices are significantly higher than in supermarkets and the local clinic does not have any sanitary products to hand out either (Personal communication, Head Nurse, Kuselwa Fonya, 2019-11-14). A majority of the mothers, therefore, want lower prices and easier access to sanitary pads; "It's not like you got a choice of not using it, it's like it's a must I must have pads I must have my tampons. But the pricing I do not understand the concept behind it" (PID24).

Individuals can, as noted, act inconsistently with their habitus (Chang et al., 2016), which explains why a few mothers perform more empowering practices; "When I changing it [the pad], I'm not going to the private room, I change in front of them [her children] so that they can know that it's not a sin to use it" (PID17). Social stigma does not always have to result in self-stigmatization, it can be a driving force and manifest in 'revenge' toward bad practices in the past. This made the 28-year-old PID22 start gathering sanitary pads and donate to local schoolgirls and made Zonke Banjwa, one of the key informants of this study, to become a menstrual activist and educator (Personal communication, MH Educator, 2019-10-16).

In conclusion, stigmatic perceptions affect the mothers' MH practice in various ways despite age, wealth or education level, demonstrating that the MH software and hardware are interrelated. Further, the lack of priority of menstruation in the school, household and family field is manifested in a 'culture of silence' which directly impacts the mother's MH knowledge and practice. This in turn is internalized in their habitus affecting the doxas of various fields, impacting future generations' MH practices.

6.2.3 The Effect of Menstrual Practices & Perceptions on The Mothers' Daily Lives

This section aims to answer how and why the menstrual practices and perceptions arising from stigma in Zithulele, described in previous sections, together affect the mother's daily lives. Mainly its effect on; self-monitoring behavior, mobility and social interactions, physical and psychological wellbeing as well as health seeking behavior will be presented.

Self-monitoring

The mothers conduct several practices to conceal the stigmatic fact that they are menstruating and in turn follow the doxa around menstruation in their current field of interaction. The most apparent of these practices is self-monitoring, constantly checking for blood stains on their clothes.

> …if you want to stand up "you have something" and your confidence, your mood drop, the whole day you will be sitting like this and thinking that you have a stain even though you don't have that stain (PID22).

This self-monitoring is in the quote below described as 'nothing', which is what a lot of the practices done by the mothers to manage their menstruation and be 'normal' is referred to as.

> … to my daily life like there is nothing changes. I only have to, I have to keep on checking [for stains] (PID04).

Limiting Mobility & Social Contacts

Although, many of the mothers are uncomfortable during their period, a large majority still attend work during it; "I go, I can't stay at home but my body does not feel comfortable" (PID13). Going to work during the period is described as challenging, but it is done in order to stay 'normal' and secure financial income; "I have cramps, I have heavy flow, I'm on my mood swings, because when I'm at work, I'm at work, my mood swings don't matter (PID07). The mothers state that they still went to school during their period and only a few mentioned that they skipped some days due to cramps or fear of spotting their clothes.

Some, however, witness that the menstruation affects their availability to travel, which in a sparsely built rural area like Zithulele is hard to avoid. "It does affect me, because where I'm going to bath during the day? Because I'm using pads, what I'm gonna do? So, I get worried, but in the same time I have to go" (PID04). Yet, there are some mothers that stay at home because of their menstruation, but they are in a clear minority. To potentially have a stigmatized mark on their clothes makes some of the women reluctant to go to social gatherings, since stigma is enough to avoid certain places and situations (Corrigan et al., 2009).

> I didn't like mixing with people when I'm menstruation because I always feel uncomfortable … I'm afraid maybe someone at the back can see that I'm on periods … I'm ashamed of what the people will see if I'm on periods (PID23).

The menstruation further affects the mothers' relationships in Zithulele, particularly to men. Since men are present in almost all the fields that the mothers enter, their habitus impact the doxas regarding menstruation within these fields. The mothers state that men generally think there is something wrong and abnormal with menstruation and that they do not understand it. Some argue that men should not be affiliated with menstruation; "The periods is the chat for us, it's not for men" (PID18). Several argue that the men do not take the mothers' menstruation seriously and assume that they are using it as an excuse to avoid having sex with them; "They think that it's something that we use to escape to sleep with them" (PID24). However, MH Educator Banjwa argue that including everyone in society in menstrual education is essential for sustainable improvement (Personal communication, 2019-10-16), since everyone's habitus constantly reinforcing the stigmatic surroundings.

Psychological & Physical Problems Related to Menstrual Stigma

The stress due to lack of menstrual information is prevalent among the mothers; "you're stressing about things that, like, you just don't know how it works." (PID24). The lack of cultural and social capital regarding menstruation in the education, household, and family field, leads to insufficient information among the mothers regarding the biological menstrual functions. This causes severe consequences in the mothers' lives, such as unwanted pregnancies. A 47-year-old mother (PID09) states that she got accidently pregnant solely for the reason that she was told to not have sex during her period since she could fall pregnant. This led her to believe that she could have sex without getting pregnant the rest of the month. Head Nurse Fonya notes that women get accidently pregnant when they stop taking their contraceptives to get their menstruation back in order to know that it is still functioning; "It's a sort of thing that 'No I was trying to get my bleeding back' and then boom… Sorry, shit happens" (Personal communication, 2019-11-14).

Severe physical menstrual issues such as cramps, headaches, rashes and nausea were common among the mothers. The misinformation as a result of the menstrual stigma and lacking social and cultural capital limit the mothers' awareness on how these discomforts can alter between

them, where some women can have minor cramps while others have Endometriosis[13]. Since this nor menstruation in general not is discussed in detail, the women are expected to manage their period and daily life activities the same way, even though they have differing menstrual symptoms amongst them. Thus, there is a lack of sensitivity toward seeing each mother's menstrual experience, which results in increasingly tough living circumstances when suffering from conditions like Endometriosis. The self-stigmatization of menstruation additionally has negative effects on the mothers' psychological wellbeing. When the negative thoughts are constantly reinforced as true, through the habitus and doxa, a vicious cycle is created which harms their mental health. Moreover, showing a stigmatic mark can be translated into a loss of symbolic capital, meaning a loss in respect and worse reputation which is deeply unwanted and harms ones living conditions. Some of the mothers mention that they get less sleep because they have to discretely manage their menstruation. For example, waking up during the night to make sure that there is no blood in the bed. "It affects me because I'll always have to wake very early in the morning to take that bucket [used for peeing] out before anyone can see that blood" (PID01).

Health Seeking Behavior

Menstrual stigma does not hinder the women to visit health care facilities when they have menstrual problems.

> It's not a matter of maybe they're scared to ask about it [the menstruation] … it's just the matter of it's not really that important up until something irregular happens … they're very quick to go and seek help when it comes to their menstrual cycle … anything that has to do with this area with them they are very quick the females (Personal communication, Head Nurse, Kuselwa Fonya, 2019-11-14).

Head Nurse Fonya argues that the reason why the women are willing to discuss their period in the health care field is because family and reproduction is a fundamental part of the culture, thus maintaining good reproductivity is essential. "…in our culture as soon as you get married, it doesn't matter how many kids you have had before you need to have a kid in the marriage it's like you're validating the marriage" (Personal communication, 2019-11-14). One mother explains how she is afraid to tell a male doctor that she is menstruating, not because he is a

[13] "A condition where tissue similar to the lining of the womb starts to grow in other places, such as the ovaries and fallopian tubes" usually resulting in extremely severe pain while menstruating. This pain is constantly there, limiting the practices of talking and thinking, making it difficult to move and function normally as well as sleep. It could further lead to depression and surgery is a common treatment (NHS, 2019).

doctor but because he is a man; "…because that doctor was a man and … I can't tell him that I'm in periods and I'm afraid" (PID09). This reasoning is paradoxical since in the other fields where reproduction is essential such as the family or household, menstruation is deeply stigmatic, even though it is fundamental for reproductivity. What can explain this inconsistency is that different fields have different rules and norms (doxas). Since children are essential to the family (Personal communication, Head Nurse, Kuselwa Fonya, 2019-11-14; Bimha – Chadwick, 2016; WHO, 2010), and menstrual stigma being mostly hidden and internalized, the negative symbolic stigma of not being able to reproduce might outweigh that of menstruation disclosure. Additionally, discussions in clinics also have social structures such as the magnified menstrual stigma perceived from men which can intersect the health care fields. Another factor that can explain this paradox is the lack of cultural capital of knowledge regarding the menstruations' function and its relation to reproduction in the family or household field.

To summarize, it is clear that the stigma surrounding menstruation has a vast impact on the mothers' daily lives both psychologically and physically, living in a rural resource poor area like Zithulele makes these constraints even more severe. Due to the doxa being unquestionable, it is not surprising that the mothers are not questioning practices and perceptions surrounding menstruation even if they impact their daily life negatively; "I live with it [the menstruation] that's, I'm not comfortable I'm really not comfortable" (PID23). This quote clarifies the attitude of coping with menstruation and its consequences. Because menstruation is not talked about the women do not reflect on changing their menstrual practices or attitudes toward it. This further strengthens the prevailing doxa and in turn affects their surroundings' and future generations' habitus and practices.

7. Conclusion

In this section a summary of the results and empirical conclusions will be presented as well as the theoretical conclusions and the implications for future policy and research.

The interviewed mothers perceive menstruation as something negative and positive simultaneously, resulting in a love-hate relationship to their monthly bleeding. This is reflected in the clash of menstruation as something natural enabling women to have children and the menstrual stigma in Zithulele. The 'culture of silence' prevailing over Zithulele regarding menstruation, correlates with Johnston-Robledo and Chrisler's (2011) conceptualization of menstruation as a hidden stigma. This was the most prominent underlying reason for poor MH among the mothers, due to its impact on the amount and quality of education as well as the information and misinformation shared about menstruation among both men and women. It also enhances the lacking priorities in Zithulele in terms of menstruation, such as the absence of disposal solutions for sanitary pads and affordable sanitary products, as well as, adequate menstrual information from the health care field, all of which correlates well with the main consequences of menstrual stigma.

It is further clear, through the application of the theoretical framework, that the menstrual stigma in combination with the resulting menstrual practices impact the mothers' daily lives and MH negatively. Since mothers are the main menstrual influencers their habitus impact their children's habitus leading to a vicious cycle of insufficient MH. This interrelation and reinforcement of perceptions and practices clearly demonstrates how the menstrual software impact the hardware, but also how the hardware impacts the software. This further notes the importance of seeing these concepts interdependently, as it has been argued by the emerging MH literature (Sommer et al., 2017). The usage of the Theory of Practice further enabled the understanding of how the menstrual stigma is created and constantly reinforced, with the habitus following the certain doxa of a field. Furthermore, how this in turn affect people's perceptions and practices and by doing that constantly reinforce the process. Enforcing the idea of menstruation as a crosscutting issue affecting women's lives in several ways and levels, intersecting all the fields in which the women are interacting in, as suggested by the literature reviewed in this thesis. Moreover, it is found that the menstrual practices and perceptions among the mothers do not differ considerably between ages, even though there is a 25-year

span between the oldest and youngest interviewees. Thus, most mothers have experienced similar menstrual processes from menarche to current age. The income and education level do not offer any differences in practices or perceptions regarding menstruation among the mothers either, recognizing the idea of menstruation being a cross-sectional issue even from an intersectional perspective. Additionally, the menstrual stigma enhances the lack of cultural and social capital within various fields, which in turn affect the possibility of women improving their MH.

By adding to the lacking literature on MH in general and among women in all ages in particular, as well as in rural areas and in Sub-Saharan Africa and South Africa. This thesis is part of the wider effort of making MH an attractive topic for further studies and priority in global policy. Considering that MH today is not defined as a Human Right, not mentioned specifically in the SDGs and not part of the SRHR spectra, more studies that highlight the crosscutting impact of menstruation are needed. To enable more sustainable solutions and improvement efforts, it is clear that education, information, and conversations about menstruation is vital. Additionally, including everyone in society in menstrual education, concerning hardware and software, is essential for sustainable improvement. Further studies should continue doing research on women of all ages and with intersectional perspectives, to highlight all the various ways that insufficient MH affect women differently. Finally, it is of great significance for sustainable improvement efforts to increase the understanding of the MH situation in deeper rural areas. To conduct more studies in rural areas while simultaneously recognizing the diversity among these is therefore desirable.

8. References

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9. Appendices

Appendix 1. Integrated Model of Menstrual Experience

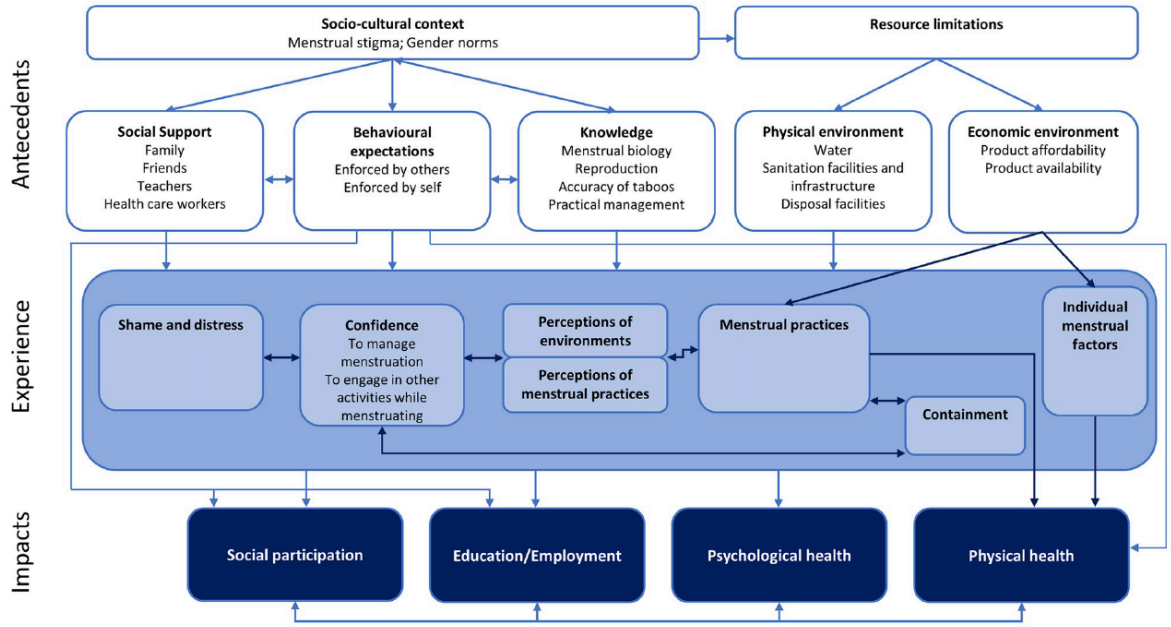
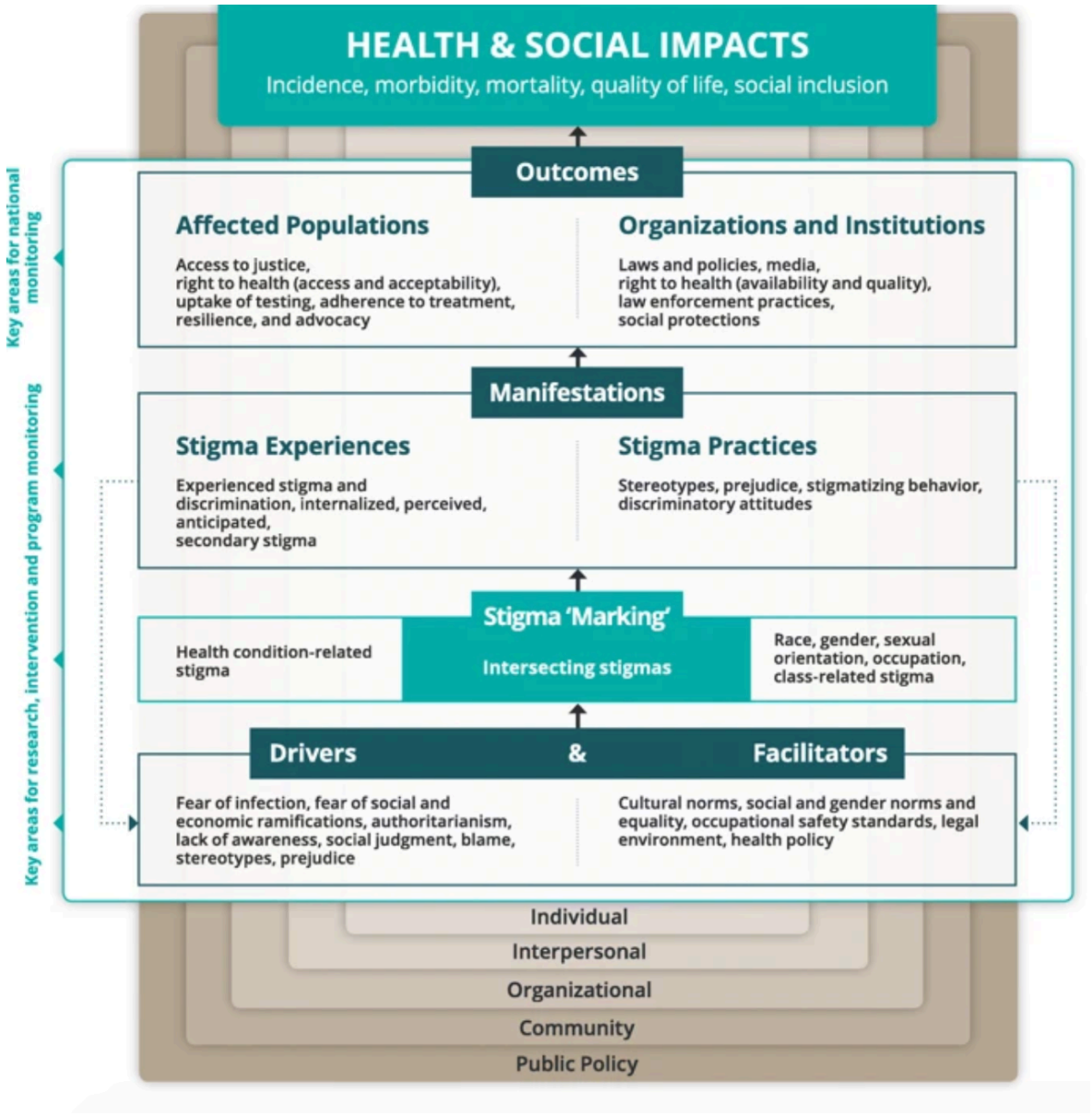


Fig 2. Integrated model of menstrual experience. Bolded headings capture themes, with subthemes presented below in unbolded text. Arrows depict directional and bidirectional relationships between themes.

Hennegan et al., 2019:13.

Appendix 2. The Health Stigma and Discrimination Framework



Stangl et al., 2019:3.

Appendix 3. Interview Guide for Participants: Mothers

(i) Introduction

Thank you for agreeing to meet with me and for participating in this interview. First, I will tell you a little bit about myself and the study I am conducting and after that we will go through the consent form and then the interview starts. Sounds good?

(i) Who I am

I am Emilia Modigh and I am a master's student form Sweden I am also interning here at the Zithulele Research and Training Center.

(ii) What I am doing

I am conducting research as a part of my studies. The research is about the menstrual health among mothers, so their practices, knowledge and opinions of menstruation. The period is something almost all women have to take care of, including myself. It is an important and often unprioritized thing over the world. Where much focus has been on youths in schools but almost nothing about older women or mothers. ***This study therefore aims to get the mothers point of view of their period.*** *Their practices and opinions regarding it here in Zithulele. Which can hopefully open up to more understanding of menstrual practices in general. The questions of this study*

(iii) Go through consent form

(iv) Start the interview

The questions in this interview are about your period in general, what you think about it and your usage of menstrual products. I am really interested in your answers and please answer anything that pops up in your mind when you hear the question, whether you think it's important or not. And feel free to stop me or the interview at any time.

Section 1: Introduction & Icebreaker

Firstly, I just want to ask some questions about you and your background.

1. Tell me a bit about yourself.

Probs[14]

- How old are you?
- Where do you live? How long have you lived here for?
- Do you have a job? What?

2. … and about your family.

Probs

- How many children do you have? Are they boys or girls?
- How many live in your household? Who?

[14] Probs stands for probing questions, which encourage participants to reflect more deeply on the meaning of their comments. These questions are also useful at getting people to think about the cause or root of the problem you are investigating

Section 2: Resource limitations & Facilities
2.1 Physical environment & economic environment

3. Do you have an education?
   5.1 [If yes] What academic level are you on?

4. What is your monthly income including grants?
5. How many people share this income?
6. Who decides what to buy for the money?

7. Do you have access to running water?

Probs

- [if no]: Where do you get your water form?

8. Do you have access to any disposal system?

Probs

- [If yes]: How does it work?
- [If no]: What do you do with your trash?

Section 3. Socio cultural context
3.1 Knowledge & Practice

Okay, that's the background questions, now we will talk a bit about your period

9. Tell me about your experience with your own period

Probs

- How did you learn about how to practically take care of your period?
- Who taught you?
- Do you still get your period?

10. What do you think happens in the body when your period comes?

Probs

- Where did you learn that?

11. Tell me about one regular day when you are on your period.

12. How do you practically manage your period?

Probs

- What kind of menstrual product do you use?
  [Name examples if needed: commercial pads? Cloths? Tampons? Menstrual cup? Other?]
- Have you always used the same product?
- Why do you use that specific menstrual product?
- Are you satisfied with that product?

13. Do you have a chance to choose from different products?

Probs

- Where do you get the products form?
- Is it easy to get menstrual products?
- Is it expensive or cheap?

14. What do you do with used menstrual product?

Probs

- [If dispose]: Where and how do you dispose it?
- [If wash it]: How do you wash it? [name examples if needed: soap or water]
- [If wash it]: How and where do you dry it?
- Are there any issues with [disposing/washing or other suggested] the product?

15. Do you wash or clean yourself differently when you are on your period?

Probs

- Why?
- How?

16. How much time do you spend on managing your period per day during your period?

Probs

- *How does that affect your day or daily routines?*

17. What is it like to get your period after giving birth?

Probs

- Do you use different menstruation products after you had a child?
- [if no]: Does that product works equally as good as before?

2.2 Behavioral expectations: Beliefs & Cultural traditions

18. How does your period affect you? If it does in any way.

Probs

- Does the period restrict you in any way?
- Do you manage all your employment and or household tasks during the day when you are on your period?
- Do you socially interact (with other people) during your period?

19. Tell me how you act when you are on your period

Probs

- Are there any differences from when you are not on your period?

20. Would you say you are treated differently when you are on your period compared to when you are not menstruating?

Probs

- [If yes]: How and by whom?

21. Have you experienced any complications during your period?

Probs

- Cramps, diseases, pain?
- How do you generally deal with pain/cramps?
- Have you ever seen a doctor or nurse because of issues with your period?

22. How do you feel about your period? What pops up in your head when you think about it?

Probs

- Positive/ negative feelings, more confident / less? shame, pride?
- Why do you think you feel like this?

23. What do you think men or boys think about menstruation?

Probs

- Why?

24. Does Xhosa culture say anything about menstruation? Or how to act during it?

25. Does menstruation carry any meaning or symbolism to you?

2.3 Social support: Community & family support

26. Do you talk to anyone about your period?

Probs

- Family?
- Partner?
- Friends?
- Your children?
- What do you talk about?

27. Do you talk to anyone at the clinic or hospital about your period?

Probs

- About what?

28. How do you feel about talking with others about your period?

29. How do you feel about talking to me about your period today?

30. Have you ever felt that you needed more information about your period?

Probs

- Did you get the information you needed?
- From whom? Or from where?

31. *Remember how I asked you to describe one day on your period in the beginning?*

Picture now instead how a day on your period would be if you would have all the resources that you wanted, such as money and products and such.

32.

Would that story be different form the one you told in the beginning?
If so, can you describe how?

Probs

- How can this be achieved?

33. Do you think things need to change regarding menstrual health in Zithulele?

Probs

- What and why?
- Is there anything you can do?

Now we are all done! Thank you so much for participating!

Do you have any questions for me?

Appendix 4. Interview Guide for Key informant: Head Nurse Kuselwa Fonya at the Local Clinic in Zithulele, Pumalanga Clinic

Thank you for agreeing to meet with me and for participating in this interview. First, I will tell you a little bit about the study I am conducting and after that we will go through the consent form and then the interview starts. Sounds good?

1. Tell me a bit about yourself.

Probs

- Where do you live? How long have you lived there for?
- What do you work with? What is your position?

2. What kind of experience do you have with menstruation as a [doctor, nurse etc.] here in the community?

Probs

- Do you discuss menstrual practices with women? What is said?
- Do women seek for care because of menstruation? What questions is asked?
- Any health issues in particular?
- Cramps? UTIs?

3. How are health professionals currently able to address these issues as a result of menstruation?

4. In your view what are the most important issues related to menstruation in the community?

5. Do you think community members experiencing barriers to ask for/seek for help regarding issues concerning menstruation?

6. Do you think women know about how to manage their menstruation in the area?

7. Is there anything that needs to be improved in the terms of what we have discussed?

8. Is there anything else you would like to add?

Appendix 5. Interview Guide for Key informant: Zonke Banjwa, MH Educator and Activist in Zithulele

Thank you for agreeing to meet with me and for participating in this interview. First, I will tell you a little bit about the study I am conducting and after that we will go through the consent form and then the interview starts. Sounds good?

1. Tell me a bit about yourself.

Probs

- Where do you live? How long have you lived here for?
- What do you work with?/ What is your position?

2. Tell me about your work with menstruation

Probs

- How did you get the idea?
- For how long did you work with it?
- Was there anyone else working with it other than you?
- Do you know if something like this has been done in the area before?

3. How did people in the classroom generally react when you started talking about menstruation?

   Probs

   - Girls? Boys? Teachers? Parents?

4. Have you encountered any difficulties when working with this?

   Probs

   - What kind?

5. How do you think women and girls generally manage their menstruation in the area?

   Probs

   - What menstrual products do you think is mostly used in the area?
   - How do women/girls dispose menstrual products?
   - How do women keep clean?

6. What do you think the biggest struggle is for women/girls when managing their menstruation?

7. Are women and girls treated differently when they are on their period?
   - Does the period restrict them in any way?
   - Do they generally socially interact (with other people) during their period?
   - Do they manage all their employment and household tasks during the day when they are on their period?

8. Do you know if Xhosa culture says anything about menstruation? Or how to act during it?

9. Where do women/girls turn if they have any struggles with their period?

Probs

- Medical issues, cramps or questions?

10. Can you tell me what you think is lacking in terms of menstrual health in Zithulele and what is working well?

11. Is there anything else you would like to add?

Appendix 6. Information Sheet and Consent Form for Participants: Mothers

An investigation study on mothers' menstrual health in Zithulele, Eastern Cape, South Africa

Who I am
I am Emilia Modigh and I am a master's student in international development and management at Lund University in Sweden I am also volunteering here at the Zithulele Research and Training Center.

What I am doing
I am conducting research which is part of my master's degree. The research involves a study to understand the practices, knowledge and opinions of menstruation among mothers. The period is something almost all women have to take care of, including myself. It is an important and often unprioritized thing over the world. Where much focus has been on youths in schools but almost nothing about older women or mothers. This study therefore aims to get the mothers point of view of their period. Their practices and opinions regarding it here in Zithulele. Which can hopefully open up to more understanding of menstrual practices in general.

Your participation
I am asking you whether you will allow me to conduct one interview for approximately one hour with you about your knowledge, practices and opinion of your period. You are being invited to take part in this research because I feel that your experience as a mother in Zithulele can contribute much to our understanding and knowledge of menstrual health.

Please understand that **your participation is voluntary,** and you are not being forced to take part in this study. The choice of whether to participate or not, is yours alone. If you choose not to take part, you will not be affected in any way. If you agree to participate, you may stop participating in the research at any time and tell me that you don't want to go continue. If you do this, there will be no penalties.

Confidentiality
I am asking you to give your permission to tape-record the interview so that I can accurately record what is said. If you do not want to be recorded, you may stop participating in the research at any time. Your answers will be stored electronically in a secure environment and used for research. I will not record your name anywhere and no one will be able to connect you to the answers you give. Your answers will be linked to a code number and I will refer to you in this way in the data, any publication, report or other research output. Your answer can come to be quoted; however, these quotes will also be linked to a code number and therefore completely anonymous.

Risks/discomforts
At the present time, I do not see any risk of harm from your participation. The risks associated with participation in this study are no greater than those encountered in daily life. However, if you feel uncomfortable talking about some of the topics you do not need to answer. You do not have to give me any reason for not responding to any question, or for refusing to take part in the interview.

Benefits
There are no immediate benefits to you from participating in this study. However, this study will be helpful in that I hope it will promote understanding of the importance of menstrual health for mothers. If you would like to read the finished study, you are more than welcome to leave your e-mail address.

Reimbursements/compensation
You will receive 150 RAND worth of airtime as a thank you for your time.

Contact details of researcher
If you have concerns or questions about the research you may message, call or email me:

Researcher: Emilia Modigh
Whatsapp: +4670 755 8563 Phone number: 074 692 2882 Email: emiliamodigh@gmail.com
Supervisor: Agnes Andersson Djurfeldt
Email: agnes.andersson_djurfeldt@keg.lu.se

Consent for participation in research interview
A qualitative study on mothers' menstrual health in rural Zithulele, Eastern Cape, South Africa

1. I have been given sufficient information about this research project and I understand my role. The purpose of my participation as a participant in this project and the future management of my data has been explained to me and is clear.

2. My participation as a participant in this project is voluntary. There is no explicit or implicit coercion whatsoever to participate.

3. I allow the researcher to take notes during the interview. I also allow the recording of the interview by audio tape. It is clear to me that in case I do not want the interview to be taped I am fully entitled to withdraw from participation.

4. I understand that my words may be quoted directly. However, confidentiality and anonymity of records will be maintained and that my name and identity will not be revealed to anyone but the researcher.

5. I have the right not to answer questions and if I feel uncomfortable in any way during the interview session, I have the right to withdraw from the interview without penalty.

6. I understand that this is a research project whose purpose is not necessarily to benefit me personally in the immediate or short term.

7. I understand that I am free to contact the researcher to seek further clarification and information.

8. A copy of this informed consent declaration will be given to me co-signed by the researcher

I, _____ (full name of participant) **have read and understood the points and statements of this form. I have had all my questions answered to my satisfaction, I have not been pressured in any way and I voluntarily agree to participate in the above-mentioned project.**

……. …….
Signature of participant **Date**

I, _____ (full name of researcher) **confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.**

……. …….
Signature of researcher **Date**

Appendix 7. Information Sheet and Consent Form for Key Informants

An investigation study on mothers' menstrual health in Zithulele, Eastern Cape, South Africa

Who I am
I am Emilia Modigh and I am a master's student in international development and management at Lund University in Sweden I am also volunteering here at the Zithulele Research and Training Center.

What I am doing
I am conducting research which is part of my master's degree. The research involves a study to understand the practices, knowledge and opinions of menstruation among mothers. The period is something almost all women have to take care of, including myself. It is an important and often unprioritized thing over the world. Where much focus has been on youths in schools but almost nothing about older women or mothers. This study therefore aims to get the mothers point of view of their period. Their practices and opinions regarding it here in Zithulele. Which can hopefully open up to more understanding of menstrual practices in general.

Your participation
I am asking you whether you will allow me to conduct one interview for approximately one hour with you about your knowledge, practices and opinion of your period. You are being invited to take part in this research because I feel that your experience as a mother in Zithulele can contribute much to our understanding and knowledge of menstrual health.

Please understand that **your participation is voluntary,** and you are not being forced to take part in this study. The choice of whether to participate or not, is yours alone. If you choose not to take part, you will not be affected in any way. If you agree to participate, you may stop participating in the research at any time and tell me that you don't want to go continue. If you do this, there will be no penalties.

Confidentiality
I am asking you to give your permission to tape-record the interview so that I can accurately record what is said. If you do not want to be recorded, you may stop participating in the research at any time. Your answers will be stored electronically in a secure environment and used for research. I will not record your name anywhere and no one will be able to connect you to the answers you give. Your answers will be linked to a code number and I will refer to you in this way in the data, any publication, report or other research output. Your answer can come to be quoted; however, these quotes will also be linked to a code number and therefore completely anonymous.

Risks/discomforts
At the present time, I do not see any risk of harm from your participation. The risks associated with participation in this study are no greater than those encountered in daily life. However, if you feel uncomfortable talking about some of the topics you do not need to answer. You do not have to give me any reason for not responding to any question, or for refusing to take part in the interview.

Benefits
There are no immediate benefits to you from participating in this study. However, this study will be helpful in that I hope it will promote understanding of the importance of menstrual health for mothers. If you would like to read the finished study, you are more than welcome to leave your e-mail address.

Reimbursements/compensation
You will receive 100 RAND worth of airtime as a thank you for your time.

Contact details of researcher
If you have concerns or questions about the research you may message, call or email me:

Researcher: Emilia Modigh
Whatsapp: +4670 755 8563 Phone number: 074 692 2882 Email: emiliamodigh@gmail.com
Supervisor: Agnes Andersson Djurfeldt
Email: agnes.andersson_djurfeldt@keg.lu.se

A qualitative study on mothers' menstrual health in rural Zithulele, Eastern Cape, South Africa

1. I have been given sufficient information about this research project and I understand my role. The purpose of my participation as a participant in this project and the future management of my data has been explained to me and is clear.

2. My participation as a participant in this project is voluntary. There is no explicit or implicit coercion whatsoever to participate.

3. I allow the researcher to take notes during the interview. I also allow the recording of the interview by audio tape. It is clear to me that in case I do not want the interview to be taped I am fully entitled to withdraw from participation.

4. I have the right not to answer questions and if I feel uncomfortable in any way during the interview session, I have the right to withdraw from the interview without penalty.

5. I understand that this is a research project whose purpose is not necessarily to benefit me personally in the immediate or short term.

6. I understand that I am free to contact the researcher to seek further clarification and information.

7. A copy of this informed consent declaration will be given to me co-signed by the researcher

8. I understand that my words may be quoted directly. However, If I wish confidentiality and anonymity of records will be maintained and that my name and identity will not be revealed to anyone but the researcher. If I do not wish to be anonyms my name will be used in the study.

8.b I wish to be anonymous in this study ☐

I, _____ (full name of participant) **have read and understood the points and statements of this form. I have had all my questions answered to my satisfaction, I have not been pressured in any way and I voluntarily agree to participate in the above-mentioned project.**

……. …….
Signature of participant **Date**

I, _____ (full name of researcher) **confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.**

……. …….
Signature of researcher **Date**

Appendix 8. Snowballing Form

A qualitative study on mothers' menstrual health in Zithulele, Eastern Cape, South Africa

In order to participate you have to:

- *be a mother*
- *be 18 years old or older*
- *live in the Zithulele area*
- *speak English (because the interview will be held in English)*

The interview will be held at the Zithulele Research and Traning center and will last for approximately one hour.

I am happy that you are interested in participating in this study, ***please fill in the information below and come by with it to the Research and Training Center office or send me the information via Whatsapp/text.***

Kind Regards
Emilia Modigh
Whatsapp: +4670 755 8563
SAPhone number: 074 692 2882 (for text or phone calls)

Name: ……..…….

Age: ……..…

Address: ……..…….

Telephone number/Whatsapp: ……..…….

Additional telephone number/Whatsapp: ……..……

Which day during the week would suit you best for an interview?

What time during the day would suit you best for an interview?

Appendix 9. Interview Dates

Date	Interview PID
19/10–2019	Key Informant Zonke Banjwa, MH Educator and Activist in Zithulele
19/10–2019	PID01
21/10–2019	PID02
22/10–2019	PID03
23/10–2019	PID04
23/10–2019	PID05
23/10–2019	PID06
23/10–2019	PID07
25/10–2019	PID08
25/10–2019	PID09
25/10–2019	PID10
29/10–2019	PID11
29/10–2019	PID12
30/10–2019	PID13
30/10–2019	PID14
30/10–2019	PID15
01/11–2019	PID16
01/11–2019	PID17
04/11–2019	PID18
04/11–2019	PID19
04/11–2019	PID20
06/11–2019	PID21
11/11–2019	PID22
13/11–2019	PID23
13/11–2019	PID24
14/11–2019	Key Informant: Head Nurse Kuselwa Fonya at the local clinic in Zithulele, Pumalanga Clinic
14/11–2019	PID25

Appendix 10. Ethical Approval from Walter Sisulu University, Faculty of Health Science

WSU
Walter Sisulu University

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

HUMAN RESEARCH COMMITTEE
CLEARANCE CERTIFICATE

PROTOCOL NUMBER	: 075/2019
PROJECT	: AN INVESTIGATION ON MOTHERS' MENSTRUAL HEALTH IN RURAL ZITHULELE, EASTERN CAPE, SOUTH AFRICA
INVESTIGATOR(S)	: MISS EMILIA MODIGH
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.

21-10-2019

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

Appendix 11. Ethical Approval from Lund University, Department of Human Geography

ETHICAL APPROVAL

16.09.2019

Emilia Modigh

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 **Emilia Modigh** to conduct field research in South Africa with the title "**A qualitative study on mothers' menstrual health in rural Zithulele, Eastern Cape, South Africa**".

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