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"We are a Family That Doesn't Have Much Every Day, so we Eat What we Get": The Bodily Health of a Group of Rural Women Living in South Africa

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"We are a Family That Doesn't Have Much Every Day, so we Eat What we Get": The Bodily Health of a Group of Rural Women Living In South Africa

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Abstract

South Africa's health system continues to exhibit stark inequalities, with the well-being of individuals inextricably linked to their geographic location and social position. This study explored the concept of bodily health from the perspective of women living in rural areas, employing the human capabilities approach as a theoretical framework. Using a qualitative, exploratory approach, semi-structured individual interviews were conducted with 45 participants, including parents, caregivers, and key stakeholders, in two rural towns in South Africa. Participants' understanding of health varied, and they highlighted the inadequacy of healthcare services available to them. The findings reveal the multifaceted nature of rural health, where factors such as the proximity of healthcare facilities, the availability of medical personnel and supplies, and the level of trust in the healthcare system all play a crucial role in shaping individuals' experiences and perceptions of bodily health. Collaborative efforts among diverse stakeholders are necessary to develop and implement comprehensive approaches that ensure equitable access to quality healthcare and nutrition in rural areas, ultimately fostering the well-being of individuals and families. This study underscores the importance of a capabilities-oriented perspective in understanding and addressing the complex realities of rural health in South Africa, where the interplay of geography, socioeconomic status, and intersectional identities profoundly shapes the pursuit of optimal bodily health.

Keywords: food insecurity; human capabilities approach; rural healthcare; rural women's health, South Africa

« Nous sommes une famille qui n'a pas grand-chose chaque jour, alors nous mangeons ce que nous recevons » : la santé corporelle d'un groupe de femmes rurales vivant en Afrique du Sud

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Résumé

Le système de santé sud-africain continue de présenter de fortes inégalités, le bien-être des individus étant inextricablement lié à leur situation géographique et à leur position sociale. Cette étude a exploré le concept de santé corporelle du point de vue des femmes vivant dans les zones rurales, en utilisant l'approche des capacités humaines comme cadre théorique. À l'aide d'une approche qualitative et exploratoire, des entretiens individuels semi-structurés ont été menés auprès de 45 participants, dont des parents, des soignants et des parties prenantes clés, dans deux villes rurales d'Afrique du Sud. La compréhension de la santé par les participants variait et ils ont souligné l'insuffisance des services de santé mis à leur disposition. Les résultats révèlent la nature multidimensionnelle de la santé rurale, où des facteurs tels que la proximité des établissements de santé, la disponibilité du personnel et des fournitures médicales et le niveau de confiance dans le système de santé jouent un rôle crucial dans la formation des expériences et des perceptions des individus en matière de santé corporelle. Des efforts de collaboration entre diverses parties prenantes sont nécessaires pour développer et mettre en œuvre des approches globales garantissant un accès équitable à des soins de santé et à une nutrition de qualité dans les zones rurales, favorisant à terme le bien-être des individus et des familles. Cette étude souligne l'importance d'une perspective axée sur les capacités pour comprendre et aborder les réalités complexes de la santé rurale en Afrique du Sud, où l'interaction de la géographie, du statut socio-économique et des identités intersectionnelles façonne profondément la recherche d'une santé corporelle optimale.

Mots-clés : insécurité alimentaire, approche des capacités humaines, soins de santé ruraux, santé des femmes rurales, Afrique du Sud

1.0 Introduction

A legacy of social, emotional, and physical health challenges exists in South Africa that lives on from the former apartheid government, a political regime that oppressed and disempowered black South Africans. (Pillay, 2019). South Africa is an unequal country, with a Gini coefficient of 63.0 (World Bank Group, 2019), meaning that the country's resources are unequally distributed. Unfortunately, Black women in South Africa bear the brunt of this financial inequality. (Statistics South Africa, 2019) and those living in rural areas are even more likely to experience food insecurity than those in urban areas (De Cock et al., 2013; Ndhleve et al., 2013). In many cultures, women are viewed as secondary in relation to male family members resulting in them often being the last to eat (Lewis, 2015; Nussbaum, 2000). Women and young–adolescent girls are particularly vulnerable to hunger and malnutrition. (Lewis, 2015; Thow et al., 2018). Almost half of all South Africans are living in extreme poverty with 46.1% of males and 52% of females living below the breadline—R992 or less per month (Statistics South Africa, 2018).

In addition to poverty being a barrier to attaining nutritious food (Thow et al., 2018), when seeking healthcare (Gordon et al., 2020; Harris et al., 2011)

The costs often deter people from seeking help (David et al., 2018; Harris et al., 2011). It is evident that those living in rural communities experience inequality more significantly (David et al., 2018), with many communities unable to access medical doctors when they are needed, relying solely on community health workers or nurses (Health Systems Trust, 2022; Rispel et al., 2018). Although efforts to retain doctors and healthcare professionals are in place, many professionals drift toward urban areas (Strategic Plan for the Prevention and Control of Non-Communicable Diseases 2013-2017, n.d.; Gumede et al., 2021; National Department of Health, 2022).

In the years leading up to 2000, HIV claimed the lives of millions of South Africans; as a result, the prevention and treatment of HIV/AIDS and TB have become a primary concern, as it is still South Africa's largest contributor towards mortality. (Strategic plan for the prevention and control of non-communicable diseases 2013-2017, n.d.). Nevertheless, while HIV and TB are the leading causes of death in South Africa, non-communicable diseases (NCDs) are on the rise (Samodien et al., 2021) largely attributed to lifestyle, diet, inactivity, and substance abuse. These NCDs include diabetes, hypertension, and obesity (Lalkhen & Mash, 2015; Samodien et al., 2021), and the co-occurrence of all these NCDs places an additional financial burden on South Africa's overburdened and under-resourced health system (Delobelle, 2013; National Department of Health, 2022).

Being poor and living in a rural area is an added barrier that negatively impacts the physical health and longevity of a population. (National Department of Health, 2022). Multiple dimensions of health and well-being must be accounted for when attempting to gauge the health and well-being of a population (Manderson & Jewett, 2023; Schneider et al., 2009) rather than measuring the well-being of a nation based purely on the gross national product. Literature concerning the South African context highlights a link between (a) poverty, (b) food insecurity, (c) difficulties accessing health care, and (d) NCDs (David et al., 2018; Nussbaum, 2007). Therefore, this article intends to frame food security and access to healthcare from the perspective of a capability to reach a state of bodily health, as described by Martha Nussbaum.

The study aimed to establish whether women in rural towns of South Africa have the functioning and capability of "bodily health". The study had three research questions:

1. What do women living in rural areas in South Africa perceive health to be?
2. How do women living in rural areas express their status of food security?
3. How do women living in rural areas experience the health system?

1.1 The Human Capabilities Approach

The human capabilities approach theoretical framework focuses on human abilities, situations, and resources. Comparatively, it may assess similarities and contrasts between persons or groups to identify gaps concerning capabilities, which, in turn, allows for individuals to be viewed within context. This is crucial for health and well-being since it allows you to compare an individual's or group's well-being to others or to a prior period. Nussbaum seeks an objective well-being account by concentrating on individual capacities and capabilities. She suggests that focusing on whether people can do and experience certain things, rather than just how they feel, is a better way to understand well-being (Jayawickreme & Pawelski, 2013) This approach helps avoid the issue of people wanting things that might be harmful to them. Nussbaum's human capabilities approach (HCA) is therefore a complex theoretical framework providing an evaluative account of individual and societal well-being that is especially pertinent to health because it sets standards for what should be good health and well-being. Furthermore, HCA is a broad account of the requirements for well-being; it is not a theory of good health but has clear implications for health policy and the intention of ensuring everyone has good health (Navaro, 2020).

1.2 Framing Health in a Human Capabilities Approach

Nussbaum identifies a list of central human capabilities that all people have a moral entitlement to and focuses on increasing people's valuable 'beings and doings'. These central human capabilities include (a) bodily life; (b) health, bodily integrity; (c) sense, imagination, and thought; (d) emotions; (e) practical reasoning; (f) affiliation; (g) other species; (h) play; and (i) control over one's environment (Stewart, 2013). These capabilities form the core of Nussbaum's approach to human development and well-being. She argues that a just society should aim to bring all individuals above a threshold level—or standard or normative level—in each of these capabilities (DeHaan et al., 2016).

Nussbaum considers health as "a holistic state of physical and psychological integrity" (Nussbaum, 2000, p. 76), and identifies seven specific 'health enabling' capabilities:

1. Being able to have good health: This is not defined simply as the absence of illness, but, given that she considers health to be holistic, as a state of integral well-being.
2. Being able to have adequate nourishment.
3. Being able to have adequate shelter.
4. Being able to have adequate medical care.
5. Being able to seek to avoid premature morbidity: Not all ill health can be avoided, but she notes that those with various disabilities are often more vulnerable to illness and will therefore require more assistance and interventions to reach the capability of bodily health.

6. Being able to care for the health of others.
7. Being able to have physical and emotional well-being: The relation between these is complex, as psychological states often affect physical health and vice versa (Tengland, 2020).

Bodily health is defined by Nussbaum as the ability to experience and engage in the world through the senses, to have good health and physical vitality, and to be able to move freely from place to place (Venkatapuram, 2011). Health is seen in terms of normative function and personal goals meaning that health is not just a personal matter, but a fundamental entitlement that society should strive to secure for all individuals (Venkatapuram, 2011). The normative aspect here is that good health is seen as universally valuable and necessary for a life of human dignity (Sovová, 2017). Health functions as a foundational capability that enables the realization of other capabilities. For instance, without good health one's ability to engage in education, work, or social relationships may be severely limited. This interconnectedness highlights the normative role of health in facilitating overall human development and well-being. (Pettigrew et al., 2015). The human capabilities approach allows for comparisons of health across individuals and groups. This comparative aspect introduces a normative dimension by which health disparities can be identified and addressed. Nussbaum's approach recognizes that health capabilities are shaped by social, economic, and political factors. This acknowledgement of social determinants implies a normative obligation for societies to address systemic inequalities that impact health outcomes (Venkatapuram, 2011).

The human capabilities approach (HCA) emphasizes the complex relationship between health and physiological well-being in South Africa, particularly in the context of the country's unique ‘double burden’ of sickness (Aikins, et al., 2010). In rich metropolitan regions, diseases like Type 2 diabetes, hypertension, and obesity are prevalent due to lifestyle diseases linked to economic stability and social status. These lifestyle diseases often stem from unhealthy diets, inactive office employment, and high-stress executive positions. Conversely, in underdeveloped urban townships and rural regions, diseases like kwashiorkor, anaemia, and TB are common due to inadequate living conditions (Godongwana et al., 2021). The social systems and class divide of South Africa reflect these different illness patterns, leading to notable differences in access to treatment and preventative actions. For instance, an affluent person with Type 2 diabetes in Cape Town could have access to dietitians, expensive drugs, and specialized endocrinologists, while someone living in a rural Limpopo region with malnutrition-related sickness might find it difficult to get even minimum basic healthcare treatments.

Nussbaum's focus on the link between capacities and the minute elements in social justice might help one to clearly see how health results from these elements. According to Nussbaum's views, health is not simply an inherent ability; she also refers to ‘healthy functioning’, a goal condition of being that has to be considered with respect to the rest of fundamental capacities (Venkatapuram, 2011). This means that health is an integrated state which cannot be separated from an individual's whole life and activities. The concept of ‘an adequate level of health’ should be interpreted not just as a mere ‘ability’, but rather as one of the essential prerequisites for human functioning. In terms of health, a certain high standard of health is liberal, and it can only be achieved by simplifying and reshaping life. Some people in developing countries, especially young women, devote a substantial amount of their time to collecting water from distant locations. In addition to the burden of bearing water on their bodies and the continuous movements they must make, these collected waters

might not be clean enough to use, or even not enough to provide (Nussbaum, 2006). As such, a high standard of health would need to expand their capabilities and reduce factors that may defeat their functions. Capabilities and health, respectively—or bodily health—do not necessarily encompass or guarantee each other. It is possible to have health and wellness but not have certain capabilities, or, in Amartya Sen's words, not have the freedom to act upon certain choices. In South Africa, choices to be and do are limited for certain women.

1.3 Women's Health in Rural South Africa

South Africa is geographically segregated among rural regions and urban centres, with rural women being seen as the most vulnerable demographic. They confront a multitude of challenges including (a) poverty, (b) overcrowding, (c) unemployment, (d) elevated illiteracy rates, (e) underdeveloped infrastructure, (f) significant levels of sickness and mortality, (g) educational achievements, and, (h) persistent hunger (Amusan, 2020; Govender & Qwaba, 2022). Rural women's growth is sometimes hindered by prevalent issues such as crime, adolescent pregnancy, unwanted pregnancy, and HIV infection. This is particularly true for females residing near male hostels, mines, plantations, and squatter settlements. The influence of society, culture, and the position of women within families and communities has a notable impact on their ability to receive healthcare and nutritious food, which is perceived as a hindrance to the advancement of women's health (Aubel et al., 2021). In South Africa, the health system is comparable to that of many other nations. However, those residing in rural regions face more difficulties in receiving healthcare services compared to those living in metropolitan areas. The inclusion of gender as a factor introduces intricacy to the matter and intensifies the disparities both within and across households.

Poverty in rural South Africa limits access to healthcare services and transport, creating a vicious cycle of poverty and out-of-pocket expenses. Even when services are nominally free, hidden costs like transport and work time can prevent rural women from accessing care. The great distances rural women in South Africa must travel to receive healthcare presents major obstacles. According to Versteeg and Gaede (2011), residents of certain remote communities might have to spend up to five hours getting to the closest clinic. Low education levels affect health literacy, with less educated women less likely to use maternal health services. Low health literacy is associated with poorer understanding of HIV prevention and treatment, contributing to higher HIV rates in these areas (Wawrzyniak et al., 2013). Persistent educational inequalities between rural and urban areas in South Africa have long-term impacts on health outcomes. Gender inequality reduces women's decision-making power, with gender-based violence and unequal power dynamics limiting their ability to make decisions about their own health, including accessing contraception and HIV testing (Chang, 2020).

According to Harris et al. (2011), rural women delayed seeking of prenatal treatment was mostly influenced by distance. Restricted means of mobility: public transit in rural South Africa is sometimes nonexistent, sporadic, or unreliable. According to Moshabela et al. (2020), many rural women must travel great distances to access medical services or pay for costly private transportation (Ngene et al., 2023). For pregnant women, or those with young children especially, this is rather difficult. Goudge et al. (2009) underlined how limited choices for travel could result in delayed seeking of treatment and worse health results. Bad road infrastructure: Rural South Africa's roads' state can seriously hinder access to healthcare. Particularly in wet seasons, Tanser et al. (2006) employed GIS mapping to demonstrate how bad road conditions extend travel times to health

institutions. In remote locations, road quality was reported by McLaren et al. (2014) to be a major factor influencing mother health service use.

In this research, the perceptions of health from the participant's perspective are important when defining and evaluating their state of health. Meaning, this perspective does not necessarily view health from the dominant view of society at large, as it does not always resonate with social justice (Robeyns, 2017). Rather, it considers the voices of the participants and their position in society: (a) 'individual' what the person can do considering their capacities and restrictions—do they have a disability that prevents them from carrying out a task?; (b) social positioning in their context based on race, class, and gender; (c) the material resources available to the person; and (d) nature and environment. These aspects will touch on more social indicators of life, health, and well-being of society, such as maternal mortality, premature death, the average lifespan of the nation and nourishment (Robeyns, 2017). In the case of this study, the HCA provided a lens to frame the lives of black females living in a rural area in Post-Apartheid South Africa, who are oppressed or disadvantaged because of race, class, gender, and geographical positioning (Cho et al., 2013; Statistics South Africa, 2019)

2.0 Materials and Methods

The study used qualitative methods and took an exploratory approach whereby semi-structured individual interviews were conducted (Creswell & Creswell, 2018). The interview schedule was drawn up based on the definition of bodily health from the HCA by Martha Nussbaum. Participants' understandings and experiences were examined as the study aimed to understand the capability and functioning of bodily health among women in rural areas in South Africa as defined by Nussbaum (Nussbaum, 2011; Venkatapuram, 2011).

The two rural areas located in South Africa were purposively selected based on convenience: Calvinia, a farming town located in the Northern Cape Province, and Lamberts Bay, a fishing community in the Western Cape Province. A 2011 census survey conducted in South Africa indicated that both the towns had a small population with Lambert's Bay having a total of 6,120 residents and Calvinia having a total of 9,680 residents. That said, unemployment and poor public service delivery is a major concern across both communities, which brings about additional challenges that include crime and substance abuse (Nel et al., 2011; Nthane, 2015).

The final sample consisted of 45 participants from both Lamberts Bay (17 individuals) and Calvinia (31 individuals). Participants consisted of parents and/or caregivers, and stakeholders, who agreed to share their understanding and knowledge on bodily health within their personal lives and the community. Parents/caregiver participants were considered eligible to participate if they had at least one child 17 years old or younger. Stakeholders were comprised of social workers, dieticians, nurses, community health workers, and police officials. Overall, the study consisted of 11 stakeholders and 35 parents who were interviewed during the data collection phase. Parent participants were recruited through purposive random sampling (Creswell & Creswell, 2018) via non-governmental organisations (NGOs) and street intercept.

Researchers gained access to stakeholders through the permission of local clinics, a police station, and a private health facility accessing the local social workers, police officers, and individuals in the health profession such as dieticians. The study utilised two semi-structured interview schedules, one for parents and one for stakeholders. The parents' interview schedule consisted of 24 questions aimed at parents' understanding of health, what it means to be

healthy and their options and affordability for accessing what they perceive to be healthy foods. Stakeholders' semi-structured interview schedule consisted of 11 questions focused on available social and health services and food access in the local community. Interviews with parents ranged between 15–40 minutes, and interviews with stakeholders ranged between 40–60 minutes. Questions were asked as guided by the interview schedule, followed by probing questions based on participants' responses. Interviews were conducted in English and Afrikaans. Interview schedules were translated into Afrikaans and then backtranslated to ensure quality, accuracy, and compatibility to the original interview schedule. All interviews were audio-recorded with the permission of participants and transcribed. All Afrikaans interviews were translated into English during the transcribing phase.

The interviews were analysed using inductive thematic analysis as stipulated by This analysis comprised of six steps, namely: (a) familiarising yourself with your data; (b) generating initial codes; (c) searching for themes; (d) reviewing themes; (e) defining and naming themes; and (f) producing the report.

Ethics was obtained from the University of the Western Cape and was strictly adhered to by ensuring that all participants received an explanation of the purpose of the study and were informed that their participation was completely voluntary in a language they understood and/or preferred. Informed consent and assent were obtained from all participants. Confidentiality and anonymity were ensured by removing participant identifiers, such as their names and keeping their information and data in a password-secured computer that can only be accessed by the researchers.

3.0 Results

3.1 Demographics

Forty-six parents and stakeholders from Calvinia, in the Northern Cape and Lamberts, in the Western Cape, participated in the study. Of the engaged participants, 77% were parents with a child 17 years old or younger, and 23% were stakeholders working within the communities as social workers, dieticians, nurses, community health workers or police officials.

3.2 Identified Themes

Three patterns emerged around ‘bodily health' with theme one presenting as: ‘All I have is high blood pressure’ perceptions and understandings of health where participants expressed their beliefs and understandings of health. Food (in)security was highlighted in theme two, titled: Food Security for the Poor? The last theme provides narratives around the participants' experiences of the health system in rural areas.

‘All I have is high blood pressure’—perceptions and understandings of health.

The understandings of health varied among the reporting women, with some having described that being healthy means not having to visit the clinic, whereas others stated the opposite, explaining that they are healthy because they go for regular check-ups. Another understanding of health was from that of a spiritual perspective. Here a mother describes her health, and the health of her child as connected to a dyad of both God and practical health-seeking behaviour. She explains that she and her child are healthy, attributing her health to spiritual reasons:

> I am healthy...through the Lord's grace I am healthy. Whereas she locates the source of her children's health in modern medicine: The children are healthy, because they go every month, the little one attends clinic if there is a problem or if I see you not well then, I take her immediately to the clinic, the same with my son (Female, 22 years old, Grade 8).

Some participants believed (good) health is 'only' having a single illness: “All that I have is high blood pressure [in addition, the participant described her daughter as being healthy, however, when asked why she believes her daughter to be healthy, she responded] she doesn't take any medication” (Female, 46 years old, Grade 7).

Poor health was attributed to multiple reasons, including preventable or poor lifestyle behaviours: “I think I am very unhealthy, because I smoke...I am unfit, I had some sort of sickness until my pregnancy, I needed blood” (Female, 24 years old, Grade 12).

Furthermore, the participant described the health of her child as good, which is conflicting, as she states that they do not eat healthily as a family due to financial constraints: “We are a family that doesn't have much every day, so we eat what we get. For example, slap chips and eggs, which is very unhealthy for your body. We don't eat food that we're supposed to eat.”

Another participant expresses a dislike towards healthcare facilities which materialises into poor health-seeking behaviours. However, the participant views her children as healthy, due to them not having been to the clinic. Most health practitioners would view this as the mother behaving neglectfully towards her children's health: “I don't like the clinic...my children were not in a clinic yet. The middle child was [there] when he was younger, but I can't say I have sick children” (Female, 42 years old, Grade 4).

3.3 Food Security for the Poor?

In this context food insecurity and hunger were linked to poverty, with participants frequently stating that being poor has resulted in being unable to eat or provide healthy food for their families. Participants expressed an awareness of their diets being unhealthy. In the extract below a mother indicates how challenging it can be to provide food for her family: “[It's] very hard, because I don't have money every day” (Female, 46 years old, Grade 8).

A young mother describes her desire to cook healthy meals; however, she is only able to buy vegetables twice monthly. While the participant understands the importance of consuming vegetables frequently, it is not an option for her.

> Look we don't eat healthy every day but that which we have we must eat, you understand? We can't really just buy healthy food we have to buy what we can afford...if we buy veg or carrots but we can't maybe buy that every day you understand? If I maybe bought it this month then I can't buy it again in the middle of the month but at least I eat it once or twice in the month (Female, 22 years old, Grade 8).

A similar narrative below sketches vegetables as a food for those who are ‘privileged’ where vegetables are depicted as a luxury, rather than what they are

—a basic dietary requirement. “Vegetables isn't what I can always afford...I buy them food, for example we are not shall I say, not poor, but we are not privileged to buy expensive food” (Female, 41 years old, Grade 5).

Another participant responded in the affirmative when asked whether or not the food she eats is healthy, reasoning that “because the food never made me sick yet.” Interestingly, she continues to explain that the type of foods she and her children eat, consists largely of starch: “We eat what we have, like potatoes and rice. Things we can afford...vegetables we don't eat so much of” (Female, 42 years old, Grade 4).

While a participant described herself and her children as being healthy, she illustrates a household that is food insecure when asked about what she and her children eat: “Bread, coffee and porridge is life. I don't eat a lot. [When asked what food options are available to them, she answers by stating that] bread is not so expensive” (Female, 34 years old, Grade 9).

When one of the participants was asked whether she eats healthily, she responded: “I don't think so, because I eat a lot of fatty food”. Inconsistently, when asked whether her children eat healthily, she responded by saying: “Yes, they also eat healthy with me” (Female, 22 years old, Grade 8).

At the community level, a stakeholder highlighted a need for consistent food provision—a sustainable soup kitchen—for those in need, which is illustrative of not only individuals being deprived in relation to nutrition, but that this is a larger problem. *“*Sustainable soup kitchen [*sic*], we have them come and go, it really[is] a big issue for people who are unemployed, and they just do not have money for food” (Female, 36 years old, nutritionist).

3.4 Health Services in Rural Towns ‘We're so Used to Having Just This...’

Adequate healthcare is a basic human right; however, the narratives of the participants and stakeholders depicts a state where a single general practitioner (GP) must provide services to an entire town. The narratives below depict both health systems in these rural areas as fractured, under resourced, and overburdened.

When asked about the services available in their community, participants stated that they survive with the little that they have.

> It's the local clinic, we call it the community health centre and then we have got one general practitioner—Doctor Heinrich and then we have got the… what do you call them? Community health visitors—something like that. That's basically all we have, yeah (Female, 60 years old, social worker).

The narrative illustrates a sense of learnt helplessness by stating how accustomed the community has become to the lack of resources and staff. The social worker unpacks how dire the circumstances will be in the absence of the current GP nearing retirement.

> We're so used to having just this, so we don't really know what we [are] missing...if the GP is not here then here's no doctor and he really struggles to get a locum because of the younger doctors, he is almost

> 60...he still does house calls which you don't get. When someone dies, he is the one who comes for the death certificate but if his not here, he's on holiday or away for a week then we really have a problem then we all have to go to Klein William hospital, from there we are referred to wherever (Female, 60 years old, social worker).

The vignette below illustrates the difficulty in accessing tertiary healthcare for those who live in rural areas. Patients are forced to wait long hours and travel vast distances because of the distance between rural communities and tertiary healthcare facilities.

> I'm sure it's just—you have to be patient; you know because you have to sit there and wait...This one client of mine she has to go for chemo, by one o'clock tonight, the police will come and fetch her then she has to sit at the police station till her mobile transport comes the bus—that's round about three o clock, then they take her to Tygerberg then she has to sit there the whole day have her chemo and then if she's lucky, tomorrow round about twelve o clock, she will be home. So, it takes twenty-four hours for her treatment, ya. The service is there but it's very long and hard (Female, 60 years old, social worker).

A young mother had a negative experience when visiting the clinic in her area after her son had fallen ill. The town is restricted in the sense that they rely on one doctor, and she was forced to visit his private practice after continuously visiting the clinic.

> I was at the clinic a few times, actually a lot of times, not only a few times a lot of times and they couldn't tell me what was wrong with him. The clinic doctor that is the doctor in Lamberts Bay...and every time I go to him, to the doctor...later on I couldn't afford [to go to] the doctor anymore, so I went to the clinic, so they just sent me to the same doctor again because he's also the clinics doctor (Female, 26 years old, certificate).

Furthermore, education and awareness on sexual and reproductive health was considered to be limited. This is highlighted by the information from a maternal adolescent who describes her experience of giving birth at home, stating that both she and her parents were unaware of her pregnancy. Had the participant been better educated on the topic of sexual reproductive and maternal health, she may have been more conscious of the changes happening in her body and potentially received basic antenatal care.

> Nobody actually knew I was pregnant because I wasn't showing. I also never knew I was pregnant...I didn't know what pains I was getting, so I asked my sister—my older sister so she tried to help, but I couldn't sleep and then I called my mom, and my dad asked where I am getting the pains, so I said in my stomach. So, she said I must push and when I

> pushed...my mother caught her, and my father called the hospital and so they came to fetch me (Female, 19 years-old).

An elderly patient describes the process of seeking health care at a public health facility as 'hard', as younger people do not consider age and no systems are emplaced to expedite treatment for the elderly.

> Here's just one doctor in this place, and one day hospital. So, it goes, there's a slow line, a slow line...It actually makes it hard because if you came this morning then I can't go in before you, even if I am older than you. Because you can tell me 'Aunty I'm sitting here before you,' yes (Female, 63 years old, Grade 8).

Furthermore, the study also indicated some challenges with the staff at the clinic as well as the shortage of medicine at the clinic that made people wait for long periods to get their medication. One of the stakeholders described this in the following manner:

> The staff at the clinic is a bit weak. The clinic does not always have medication that people need, like my father is waiting two weeks now for his tablets and he needs it, so the medication is not always available (Female, 36 years old, Grade 12, youth and child worker).

When asked what would help improve the current state of health, a social worker responded by saying that the community needs individuals from the Department of Health who are trained in assisting children and adolescents. She describes a more decentralised approach where these workers assist the population group in multiple spaces not limited to spaces associated with the Department of Health.

> At our Department of Health, we need more child and youth care workers, because the child and youth care workers is [*sic*] the workers who are every day in the community, they go into the house and help with school work, they help with cleaning the house, not cleaning the house themselves they learn people [*sic*] how to use their skills and that kind of stuff and prevention and awareness services (Female, 60 years old, social worker).

4.0 Discussion

This study explored the bodily health capabilities of women living in rural areas of South Africa, using Martha Nussbaum's human capabilities approach as a theoretical framework. Nussbaum defines bodily health as a central human capability, including "being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter" (Nussbaum, 2006, p. 117). The findings reveal significant gaps between this ideal and the lived experiences of the participants across multiple dimensions of bodily health.

Many of the reporting women depicted a state of health that conflicted with this capability. There was also a lack of consensus of perceptions around 'what health is', indicating that the concept of health is not only complex but

contextual. Several of the views expressed around health and being healthy differ from the reductionist biomedical perspective—illness and symptoms arise from an underlying problem found within the body—as many negative health contributors are expressed by participants because of social circumstances (Anjum et al., 2020). Even so, biomedical perspectives do not account for social issues of inequality that impact health (Alaba & Chola, 2013; Biney et al., 2020) which play a major role on health perspectives and constructions of health.

Interestingly, an understanding of being physically healthy was attributed to spirituality, where God was described as the source of good health. While spiritual understandings of health are not a major focus in health research, evidence indicates that people make meaning of their state of health through spirituality and that doing so can add value to their overall state of well-being (Bożek et al., 2020; Koenig, 2012).

Furthermore, poor health-seeking behaviour can be linked to low levels of education (Abubakar et al., 2013). This theory can be seen in the case of a mother with an education level of Grade 4 who reports that she does not like the clinic, nor does she take her children to the clinic. The reasoning behind her children's health is contrary to what is perceived as ‘good health-seeking behaviour' based on her inaction in seeking health care (Latunji & Akinyemi, 2018). Thus, suggesting that participants in this study who had lower education levels were less likely to seek health services. This highlights the role of education in capabilities (Nussbaum, 2006; Nussbaum, 2007).

Perceptions of health indicated that issues such as high blood pressure could be seen as being minimised by using the word 'only' as a precursor to the disease, similar to the findings of van Koningsbruggen et al. (2009) who discussed the role of self-affirmation in reducing the threat of disease or poor health. High blood pressure is accountable for 13% of global mortality each year (National Department of Health, 2022) however, it was not relayed as a potentially life-threatening illness. For some, they were not aware of what illness they had, stating they had a sickness, but could not give it a name. This may be an indication of not having the capability capacity for the individual to take control of one's own health. It has been suggested that greater focus must be placed on health promotion in society so that individuals may take ownership of their own health (Resnik, 2007). The aforementioned is suggested in the hopes of preventing individuals from developing or contracting many of the health burdens across society.

Many of the reporting women not having completed their high school education; being unemployed; and relying solely on a government grant, it can therefore be deduced that the women are potentially deprived of the opportunity to reach a state of ‘bodily health' (Ndhleve et al., 2013). Participants expressed only being able to buy vegetables once a month and mostly relying on starch food products like bread. Food security differed from a state of hunger and having no money for food to not being able to afford healthy options or vegetables. Food security does occur on a continuum ranging in severity (Ndhleve et al., 2013), which has been mirrored in the narratives provided, however, most express having some access to food. The narratives around poor food access align with the findings that 54% of South Africans experience food insecurity (Thow et al., 2018).

Encounters with the health system were not depicted in a positive light with descriptions of long waiting periods, instances where medication is not available, and a shortage of staff—particularly general practitioners. The reports are reflective of the challenges that the Department of Health grapple with particularly in rural communities of South Africa (David et al., 2018; Rispel et

al., 2018). In addition, participants expressed having very few tertiary hospitals nearby and therefore needing to travel far distances to receive basic health care like chemotherapy or therapeutic interventions.

The context of health and the health system in South Africa, still in the present day, is unequal due to the social, political, and fiscal landscape across various populations (de Villiers, 2021; van Rensburg, 2014). South Africa has a rich history of removing humanity from health care that can be traced back to Steve Biko's death in 1977 from a head injury neglected by doctors during Apartheid (Ataguba & Alaba, 2012; Peterson, 2018). Leading to the more recent, Life Esidimeni massacre that claimed the lives of 143 due to cruelty and indifference towards patients' humanity (Dhai, 2018). To maintain social justice for everyone, issues of social positioning within a post-apartheid society—being poor, female, and/or living in a rural community— (Cho et al., 2013; Lewis, 2015) must be accounted for in order for various individual's health capabilities to be enhanced.

The narratives expressed around the lack of food security and poor experiences of health care serve as barriers towards the human right of health, contradictory to the goals and milestones of the 2030 National Development Plan that aims to achieve household food security and affordable quality health care (National Planning Commission, 2011). It also opposes the third Sustainable Development Goal of ensuring health and promoting well-being (United Nations, 2022). Nutritious and healthy food should be endorsed and made affordable in rural communities, as they rely largely on ‘small shops' that can range from 10% to 60% more costly when buying healthy food (Igumbor et al., 2012). The aforementioned may have impacted the results where there is an inability to eat healthy and nutritious food.

Some of the limitations of this research include that it cannot be generalised as it is comprised of subjective expressions of a cohort of rural women. An implication for this research is that it may enlighten researchers around some of the idiosyncratic and contextual health conceptions, misconceptions and challenges that rural woman in South Africa face. It is also suggested that the concept of 'bodily health' is explored in relation to the family through a HCA. Furthermore, this research does not illustrate how rural men, or rural children perceive bodily health or experience food insecurity. The accounts allow for an understanding that shifts from the normative or scientific positioning of health.

This study proposes the collaboration of different stakeholders in developing and implementing different approaches to ensuring access to health care, nutrition and good health for vulnerable populations. It is essential for different stakeholders to come up with equitable policies and action plans to redress the imbalances in access to healthcare resources and infrastructure in South African communities and emplace strategies that retain health staff in these areas.

Integrating affordable or free telehealth services can enhance healthcare access for rural residents, potentially improving health-seeking behaviour. It can assist in overcoming geographic barriers, such as a lack of money for transport, poor public infrastructure and long distances to healthcare facilities, by providing remote consultations and monitoring (Shah et al. 2020). This increased accessibility could potentially lead to earlier diagnosis and treatment, improving health outcomes.

There is an increased need for nutrition interventions such as projects educating women about nutrition and the promotion of sustainable ways to ensure that families have access to a healthy diet. Therefore, it is recommended that people living in rural areas who may be vulnerable to food insecurity are educated about nutrition and receive the necessary support to ensure sustainability by

encouraging families to have vegetable gardens in their backyards. This can include providing families with seeds to start these vegetable gardens. It is also recommended that eating plans be developed with consideration of contextual and individual factors such as unemployed women living in a rural area who rely solely on the state-funded child support grant. There is also a need to develop interventions to enhance rural women's capabilities particularly around bodily health by promoting 'health ownership', self-care education and over-all health.

5.0 Conclusions

The purpose of this study was to explore whether women in rural towns of South Africa have the functioning and capability of 'bodily health'. A gap in the body of knowledge was indicated in the field of health and food security from a human capabilities approach. The study found that the participants had varying beliefs around 'what health is' and 'what it means to be healthy' with the reporting women voicing very personal understandings and perceptions of health. The study also highlighted that physical health was attributed to spirituality with respondents describing their spirituality as a source of good health. It is also evident from the study that the community had limited knowledge of the importance of health-seeking behaviour and the severity of some of the diseases or conditions that they have. This was evidenced by some of the participants not taking their children to the clinic and some reducing the threat of the disease when describing it. The cohort of rural women living in South Africa do not have sufficient access to nutritious food even though they would like to change their diets. Further, the study indicated that the health system in rural areas lack human and material resources and that they do not have tertiary hospitals that offer the care that many patients need. In applying Nussbaum's capabilities approach significant gaps between the ideal of bodily health as a universal human entitlement and the lived realities of rural South African women are revealed. While some capability for health exists, numerous intersecting factors constrain participants' real freedom to achieve good health and nutrition. This framework highlights the need for multidimensional interventions addressing various capability inputs—from nutrition education to healthcare infrastructure to women's empowerment to meaningfully expand health capabilities in this context. Further research exploring how to cultivate health agency and expand the choice sets available to rural women could help inform more capability-enhancing health and development initiatives.

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