RANGEEN KHIDKI

Drop The Shame:

Conversations around menstruation, contraception and abortion in Kolkata

Acknowledgements

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List of Acronyms

1. WASH - Water, Sanitation and Hygiene
2. UNICEF - United Nations Children's Fund
3. WSSCC - Water Supply and Sanitation Collaborative Council
4. MHM - Menstrual Health Management
5. CWF - Civilian Welfare Foundation
6. RKF - Rangeen Khidki Foundation
7. IUD- Intrauterine device
8. FGC- Focussed group conversations
9. PCOS- Polycystic Ovarian Syndrome
10. GDP- Gross Domestic Product
11. OB/GYN- Obstetrician/ Gynecologist

Introduction: Rationale, Objectives and Key Findings

Menstrual health care and management in our country is a subject of immense taboo and shame which often takes away opportunity of growth and equality from young girls, women and other menstruators. Through our work, we have felt the need of having structured data and studies on various aspects of sexual and reproductive health, especially mesntrual health, contraceptive care and safe abortion rights. While there have been studies conducted on the state of Menstrual Health management in different parts of the country, there isn't much data on the same in the context of West Bengal. There is a dearth of literature on the state of Menstrual Health management in the state of West Bengal, even in the city of Kolkata. This often makes it challenging to design interventions or establish linkages with existing government schemes because the field reality may be far removed from the context in which the interventions or policy has been designed.

While there have been multiple national reports like The Water Supply and Sanitation Collaborative Council's (WSSCC) 2020, Youth Ki Awaaz and the Water Supply and Sanitation Collaborative Council study 2020, Dasra's Spot on! In 2014, but it has been challenging to find specific data points or narratives pertaining to West Bengal.

As an organization working in the sphere of advocacy and capacity building, Rangeen Khidki Foundation (RKF) takes a rights-based approach to matters of sexual and reproductive health and rights. Thus, our initiative was aimed at collating ground realities and lived experiences with a qualitative focus to gauge a nuanced understanding of both the existing levels of awareness as well as challenges pertaining to menstrual health, contraception and abortions in our chosen sites across the city. This is an attempt to fill in the gap of not enough data being available on the public domain. There are four thematic categories that has been used to collate our findings:
Knowledge of menstrual healthcare,
Knowledge and perception towards alternate and sustainable products,
Knowledge and usage of contraception and abortion rights.

Objectives:

01 To examine conditions of existing sanitation facilities and their impact on Menstrual hygiene.

02 To ascertain access to menstrual products and knowledge of usage and disposal as per financial affordability and convenience.

03 To analyze awareness of menstrual and reproductive health, including menstrual health problems and remedies and treatments available for the same.

04 To delve into knowledge of and access to contraceptives, and understanding of the legality of abortion in India.

Narratives Collection Process:

We used a semi structured form of group conversations in 6 communities in the city of Kolkata between the months of October and December 2020 and held separate group conversations with adolescent girls and young women.

Thus, we opted for a mixed methodology. As Ashley Castleberry and Amanda Nolen write in their paper in Currents in Pharmacy Teaching and Learning on “Thematic analysis of qualitative research data : Is it as easy as it sounds?” (Castleberry and Nolen, 2018) - qualitative analysis allows researchers to identify specific local contexts and gain an understanding of respondents' beliefs and practices. Quantitative data, on the other hand, points towards frequency and intensity of certain behaviour patterns or consumption choices. A combination of both allows us to take a holistic approach to our research questions while factoring in different behavioural determinants across demographic groups.

The approach we used included -

Focused group conversations

Online survey

- A series of focussed group conversations conducted in different locations across Kolkata. The conversation, conducted in small groups, allowed us to discuss several aspects of our research questions, in great details, while also answering questions that our respondents had for us, and clarifying their doubts and queries regarding issues that were being brought up for conversation.

- An online survey, which has proven to be a very valuable research tool in the midst of the coronavirus pandemic enabled us to remotely reach out to a number of respondents from different demographic backgrounds, and do a quantitative assessment of their responses to our survey questions which were framed in conjunction with the topics of conversation covered in the focus group conversations.

Given the pandemic, the data collection process has been challenging and time consuming. A lot of emphasis was placed on following safety protocols and ethical considerations when conducting these discussions. We covered three urban slums (Bagmari, Peyerabagan, Panchanantala) and three red light areas (Sonagachhi, Kalighat, Bowbazar) in Kolkata. While all the locations we visited were primarily home to families and individuals from low-income backgrounds, there were discrepancies across them and even within particular groups. We also rolled out an online survey to achieve responses from varied socio-economic backgrounds in and around Kolkata.

A significant limitation to our study was the fact that we couldn't collect more qualitative data from respondents belonging to a diverse range of socio-economic backgrounds. This was partly due to a paucity of time and also the restrictions imposed by the COVID-19 pandemic. However, we have been able to make inferences from the quantitative data collected through the online survey. Additionally, the pandemic also meant that we were unable to cover more ground and access a larger number of locations for the field study, which could have added more valuable insights in terms of our findings.

Furthermore, the study sites we visited were quite populous which meant that each focus group had at least 10 respondents and in some groups it went to more than that. Cross communication and logistical issues such as noises in the surroundings affected the quality of parts of some recordings, but fortunately we had our field notes to supplement the same.

Please note that this is not a comprehensive standard research study or research exercise. This was an attempt by our team to collate field realities and lived experiences and try to indicate that there is a need to conduct professional research in this space.

Knowledge of menstrual cycle, menstrual healthcare and existing stigma:

In our conversations with both adolescents and young women across 6 communities, the understanding of the physiological phenomenon of menstruation was low. *Respondents shared the different terms that is used to refer to periods including 'shorir kharap' (meaning illness), menses, mashik (meaning monthly), 'badha poreche' (meaning something that has been obstructed), lal jhanda (red flag).* Most of these euphemisms are used to avoid using the actual name of the process and therefore avoid the stigma associated.

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Young girls, given that they have exposure to the internet along with education, have some access to information on this process if not completely. But women have made statements like "*na amra bujhina eta keno hoye." [No we don't understand why this (periods) happens]* or *"Bachcha howar shathe shomporko achhe.." (It is related to bearing kids)* but not one respondent has been able to explain what the process entails or why it happens. There is an association of period with impurity. Women across the communities perceive menstrual flow as 'bodrokto' or dirty blood.

Given that the understanding of the menstrual process wasn't very clear for many of our respondents, especially the older people, they were also uncertain about health problems associated with it. There were several instances in the conversations where girls and women mentioned living with excruciatingly painful cramps or irregular cycles but were uncertain about seeing it necessary to see a doctor. *A 15 year old girl mentioned, "Mera toh bohot pain hota hain, kabhi nahin ja paate the," (I have terrible pain and wouldn't be able to go)* when asked about missing school or college on account of periods. A sex worker from one of the red light areas expressed that the cramps and pain make it difficult to be functional during periods. "Oi kodin kaaj korte oshubidhe toh hoye kintu upaye ki," (It is difficult to work during those days, but what option do we have?).

As for consulting a doctor regarding problems pertaining to menstrual health, only three out of all our respondents in the focus group conversations said they'd done it once. In the online survey, 9% of our respondents shared that they go for regular checkups, while 41% of them said they'd seen an OB/GYN more than a year back, while 37% shared that they'd never seen one.

While school, college, and household work continue as usual during periods, what is off-limits is religious rituals and worship. In all our locations, across both age groups, every respondent said that they would stay away from places of worship during periods. When asked why this was followed as a custom, the most common response was that during menstruation, they are impure. Many of the respondents also said that they don't wash their hair during the time. Most of them attributed these customs that have been passed down in their families for generations.

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Knowledge on alternative Products, Sustainability and Attitudinal Barriers:

Maximum of our respondents shared that they used sanitary pads for flow management. As we learnt from the younger girls, visiting their ancestral homes in their villages (desher bari) would make it difficult to avail pads with very few shops, mostly managed by men. Using old cloth would be the only option then unless they could carry pads with them. A few girls did mention that they have tried using menstrual cups alongside pads. Besides this, when we told them about cloth pads, and menstrual cups, these were very new to all our respondents. Even as we explained to them how the products work, and can prove to be quite cost-effective, most of our respondents did not want to try them.

The primary concerns with these products mentioned by the respondents -

- They were new, while the regular sanitary napkins had been familiar to them for a long time.
- The menstrual cups need to be boiled in hot water before and after use, which was seen as a logistical hassle. Also, the idea of inserting a cup in one's vagina seemed uncomfortable to people who didn't want to use the cup. This was a concern among the younger girls. For instance, in one area, one of our younger respondents saw the cup and said, "*Eta toh dekhei kirom ekta lagche" (Can be roughly translated into, "this looks uncomfortable").*
- The cloth pads turned out to be more popular with all our groups, but those who didn't want to use it said that having to wash and dry them would prove to be difficult. Being able to dispose of the pads after use seemed like a more convenient option. Some respondents felt that it would be difficult to maintain reusable cloth pads. "*Kapor er pad toh dhowa ekta shomoshya. Dhuye melbo kothaye?" (Cloth pads will be a hassle to clean. Where will we dry them after washing?)* In fact, the girl who found the menstrual cups to be uncomfortable looking, said , "*Eta dekhe bhalo lagche. Hoye toh byabohar korte pari., (This looks good. Might be able to use it)* in reference to the cloth pads.

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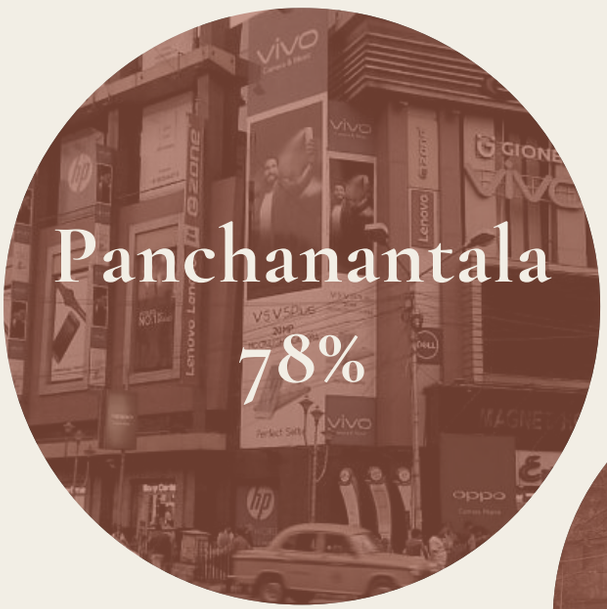
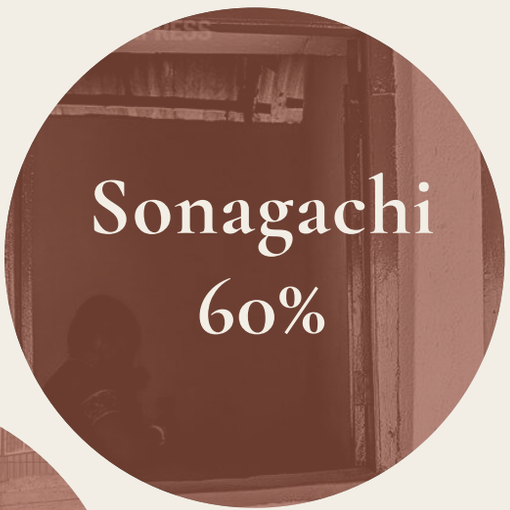
In contrast, 67% of our online survey respondents knew about cloth pads, while 80% of them knew about menstrual cups. Interestingly enough, only 14% and 13% of them had used a cloth pad or a menstrual cup, respectively. Others stuck to using sanitary napkins or tampons.

The fact that most of these communities share their latrines and washrooms, privacy required in washing or maintaining hygiene is challenging which is needed especially when using reusable menstrual products.

Percentage of respondents using a shared Washroom by location-





Knowledge on contraception methods and usage:

More than 80% of the younger girls knew about condoms, from television or the internet, or conversations within peer groups. They were initially hesitant to talk about it. While the presence of other NGOs in some places entailed some amount of awareness regarding phenomena such as pregnancy and the need for safe sex practices, these ideas weren't known in great detail to the younger girls.

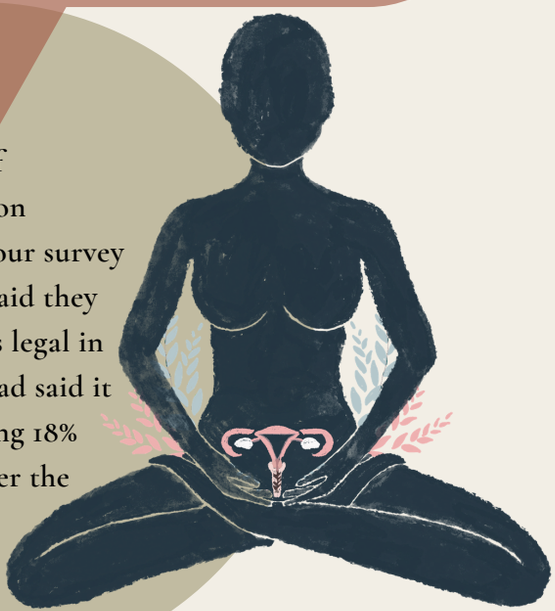
What significantly differed for us between our survey and focus group conversation responses was answers to questions about reproductive and sexual health. 37% of our respondents regularly used some form of birth control while engaging in sexual activity, wth male condoms and oral birth control pills being the most common. Even then, 24% of them claimed not to use it. Of the remaining respondents, some claimed to use it occasionally, while a few others said they weren't sexually active. Some people shared the fact of greater pleasure as a reason for not using it, while some said that they "*just didn't" or they've had partners who refused.* The latter was a very common response that we got from our focus group conversation respondents. While the women who do sex work said that they use condoms with customers, none of them seemd to use it with their partners as they felt they trusted their partners and did not need to use any contraceptive. In some cases partners of all the women refused to wear condoms even if the women would want them too. There were also respondents who knew about oral birth control pills, but nobody claimed to have used it.

Amongst the relatively younger women in the older age group, many of them wore IUDs which are inserted in the vagina after childbirth as a reversible birth control measure. These can be removed after a few years, or even months. However, we learnt that as a population control measure, many government hospitals refused to remove intrauterine contraceptive devices before a period of at least 3 years after childbirth, even if the woman wants it removed. Respondents have mentioned that they believe oral contraceptives have severely affected her menstrual cycle. There was a concern for gaining weight on using contraceptive pills.

Knowledge and perceptions about abortions:

“Amar kono boktobyo nei, je jeta thik mone korbe, shei bhabe korbe,” (I don’t have an opinion, people would do what they think is right)

The last subject of conversation was on abortions. 72% of our survey respondents had said they believe abortion is legal in India, while 10% had said it isn’t. The remaining 18% chose not to answer the question.



When we asked our focus group conversation respondents, the question of legality hardly seemed to hold relevance for them. In some areas, most of the women were of the opinion that it should not be permissible, while some others chose not to take a stand. In some places, women expressed their opposition to it, while the remaining said it has to be a woman’s choice since bearing the child will be her responsibility. When asked if they know about the process of abortion, a woman had answered saying, *"Medical e jete hoye. Clear korar oshudh hoye ba operation-o hoye." (You need to go to Kolkata Medical College and Hospital. A surgery is undertaken or else there are also medicines available for ‘washing’ out the contents of the uterus.)*

When further questioned on what they think the law had to say about abortion, another woman replied, *"Amar ekta meye achhe ba duto, ami aar bachcha chayi na, toh shekhane aayin ki korbe?" (If I have a daughter or two, and I don't want more kids, what can the law do therein?).*

Shishur bechey thakar adhikar niye newa jaye na," (We can't take away a baby's right to life) is what some respondents said in explaining her stance on the issue. It is important to note here that how respondent has chosen to refer to the unborn fetus as a ‘baby’.

We’ve also had women who accepted that even though they wouldn’t personally approve of it or do it, every woman should decide for herself. *“Amar kono boktobyo nei, je jeta thik mone korbe, shei bhabe korbe,” (I don’t have an opinion, people would do what they think is right)* Another response was, “Amar mone hoye na eta shothik, kintu onnyo kauke korte hole amar toh kichu bolar kono jayega nei,” (I don’t think it’s correct but if someone else has to do it then it’s not my place to say anything). There has been some ambivalence and divide in terms of responses in these areas where women engaged in sex work and the areas with women did not engage in any profession.

Contrarily, in some communities, maximum respondents said they are opposed to abortions. This was persistent across many of the study sites. Interestingly, one of our respondents in Peyarabagan had described abortion as *“bachcha noshto”*. Many women therein thought of it as an “*oporadh*” or an offense, expressing the belief that it’s probably not legal. One woman said, “*maane ekta bhul hoye gelo dekhlo je baccha boro ache toh jodi ese jaaye kono karone toh tokhon amra ki korbo, emni toh parchina tokhon to badho hoye korte..” (If something happens by mistake, someone has an old kid, and it happens then what can we do, we might be compelled to..)* in response to which another woman said,”*Eta kintu thik noye.” (But this isn’t right)* The idea that abortion is “not right” because one is taking away a baby’s life was more strongly prevalent considerations about a woman’s right to choose the fate of her body. Even with some people who were willing to concede that a woman should have the right to choose whether or not she wants to keep her baby, the conversations were happening euphemistically without people referring to abortions directly or speaking with much clarity.

Our key take-aways:

Knowledge of menstrual cycle, menstrual healthcare and existing stigma:

While our study, on the whole, offered myriad insights on various aspects of menstrual health, and especially the challenges encountered by people in the communities whose members we interacted with, certain findings called for further examination. We took the liberty of drawing inferences from the findings based on our experiences of working in these communities and extended conversations with the respondents before and after this exercise.

In our experience with working in the space of menstrual health and care, we believe the first step to ensure bodily autonomy and informed decision making about one's own body starts with access to correct information from reliable sources. Our respondents, especially the young girls have mostly been accessing information about their own bodies on the internet. Schools which teach biology are not currently the spaces where they can get this information. Across all three study sites wherein we interacted with younger respondents, despite initial hesitation in talking about certain subjects, there was knowledge about things such as contraceptive use. Even with the evolution of technology and the internet making information more easily accessible, the flow of information doesn't happen with uniformity because:

- It is difficult to regulate the information available on a space such as the internet. Answers to every kind of medical question is present across platforms ranging from WebMD to Reddit but that also makes it that much more difficult to verify the authenticity of our sources. The most effective means of countering misinformation is obviously through schools and homes which leads us to the second problem in this regard.
- The existing customs and rituals followed in the family/home set ups have a major impact on how the adolescents view menstruation. There is a constant contradiction in what they read on the internet and what they see or are told at home. As the foremost sites of psychosocial conditioning, the school and family play an instrumental role in shaping individual attitudes and perceptions. The community environment also adds to this. For a genuine increase in awareness and sensitization to happen in the sphere of menstrual health, all of these institutions need to be simultaneously engaged in the process.

Knowledge on alternative Products, Sustainability and Attitudinal Barriers:

In the recent past, there has been an influx of information by multiple initiatives on reusable and sustainable menstrual products and we have realised during our work that any acceptance to products are dependent on a multitude of factors. The issue at hand is clearly not just one of accessibility and awareness but also comfort and familiarity. Individuals who've grown up using a particular kind of product seem less likely to switch to an alternative at a later stage.

Also, while sanitary napkins are easily available at any pharmacy in and around Kolkata, cloth pads and menstrual cups need to be ordered online for use. Sanitary napkins are usually very extensively marketed as the safest and healthiest menstrual hygiene product Most big sanitary napkin brands also spend a lot of resources on advertising which substantially increases their visibility before consumers. Opposed to this, cloth pads or menstrual cups aren't nearly as visible in the public domain.

A certain portion of our respondents did mention that disposing of a product post usage is easier that washing it. When asked, how do they reuse their normal clothing, their response was that with clothing it is not challenging but washing a reusable sanitary napkin is unclean and makes one to experience discomfort. While disposing off can be convenient to many, we also have to consider that in most slums, the garbage dump is not always very secure but that problems in disposal are somehow more acceptable than washing the cloth pad. The fact that menstrual blood is considered impure and dirty makes washing the cloth pad brings in more shame, taboo and stigma. The hesitance and feeling of disgust can be in many cases a result of a similar perception.

With menstrual cups, there has been quite an interest to know more but the process of inserting a foreign body inside the vagina have acted as a deterrent for many. We tried to probe this hesitance in multiple situations and the undertone has indicated the existence of an apprehension regarding the insertion and the chance of rupturing the hymen which in our culture is an indicator of 'virginity'- a social construct.

Knowledge on contraceptives and its usage:

A significant take-away from our conversation is that of how little autonomy the women there had over their bodies. Contraception in our culture is mostly looked at as a way to just prevent pregnancies and in many communities in our experience the reasons for using or not using a contraceptive method is varied.

Interestingly, it is during these focussed group conversations, we got to know from our respondents that a lot of them have undergone installation of IUDs during institutional delivery at government facilities.

Bodies with uteri have always been a site of asserting control, policing, imposing limitations in the name of 'population control', 'family planning' or 'women empowerment'. It is baffling to witness normalisation, acceptance or hushing up of such violations of autonomy and agency of these individuals. In the realm of this discourse, it is critical to understand how these violations take place towards bodies that are marginalised and vulnerable, and try to reflect on what sort of consequences such violations will have if the bodies affected were to belong to those of an upper caste, class or a cis-male gender. The official reference manual of IUD services clearly states that verbal consent is needed from the patients before the childbirth. They are to be counselled about the advantages, limitations, effectiveness and possible side effects or complications of the IUD prior to delivery. However, the reality is that in many instances neither proper consent is taken nor is after-care provided to these women, who are left to deal with the repercussions of such violations on their own. There are multiple reports of this violation in not just west bengal but also other states in the country.

The incomplete information and inaccessible to judgement free safe abortion services often push women and girls to access unsafe abortions which lead to health complications and violation of global health standards.

Knowledge and perception about abortions:

In our work and interactions with our respondents, there are two parts of looking at how or why abortions is percieved as illegal and/or immoral:

- Access to genuine knowledge about the legality of safe abortion as a basic human right from verified sources
- The MTP act is not user centric along with the existing shame and stigma limits a womans' ability to seek abortions.

- The fact that an unwanted pregnancy or the need for abortion is a result of sexual intercourse and it takes precedance over procreation invites shame and stima. Women with vulvas/uteri do not have autonomy to make choices about their bodies or sexuality and have been often shamed for choosing their own sexuality or managing their reproductive choices. This is ofcourse deeply connected with exisiting hetero-patriarchal society that looks at women who are meant to be nurturers and motherhood comes naturally to them. Women are not expected to seek pleasure and choose to value their lives over motherhood.

Recommendations:

Collaborative efforts must be undertaken under the leadership of government and healthcare experts along with civil body organizations to raise awareness at the community level. To counter this, a multi-pronged, inter-generational approach is required like:

1. Awareness creation through Menstrual health education programs at schools.
2. Including stakeholders in the programs and finding ways to create community ownership. The young person is impacted by a multitude of stakeholders and realities which demands that all interventions acknowledge it.
3. Campaigns on Menstrual and Reproductive Health organized collaboratively across districts which includes both young menstruators as well as their mothers/guardians.
4. An interactive, discussion- based approach to such programs which isn't merely about dissemination of information but dispelling and debunking myths.
5. Campaigns like those which were being run on television and radio to combat the AIDS epidemic in the early 2000s could go a long way in terms of destigmatizing the conversation around menstruation.

- **Creating public healthcare infrastructure which includes menstrual health as a primary health concern is necessary to tackle the problem at the level of finance.** There is a major financial constraint for people from lower income backgrounds to access menstrual healthcare or afford medical checkups even when they face problems.

Incentivize people in these communities to consider using alternatives to sanitary napkins by making them aware of the economic and long term benefits of using such products. Such integrated programs can go a long way in terms of creating a tangible impact.

Sensitize non-menstruators to the nuances of Menstrual Health care and management as awareness creation cannot solely be restricted to those who are cis-women or menstruators. This can create a ripple effect by gradually destigmatizing the conversation around the subject and also enabling more people to help and support people in their communities to tackle large scale issues pertaining to Menstrual Health.

Comprehensive dissemination of knowledge about bodies, sexual and reproductive health, rights and services at a young age can be made part of all educational and healthcare institutions so that the youth are able to make informed choices about their bodies and exercise their rights.

Mandate sensitisation of grassroot level service providers to ensure non-judgmental stigma-free delivery of information, products and healthcare services to young people.

- **Mandate sensitisation of grassroot level** service providers to ensure non-judgmental stigma-free delivery of information, products and healthcare services to young people. Campaigns, helplines and information sharing tools can be used in a more large-scale set up by service providing facilities (both government and non-governmental) where individuals can know more about contraceptives, safe abortion services, it's correct usage, process to access those and the benefits of them.

- **Large scale research and data collection** should be conducted in district and state levels by both government and non-government organizations in combined or different manner so that the correct figures can be recorded and appropriate policy level design and execution can be considered.

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