A Capability Approach to Examining the Experiences and Perceptions of Menstrual Hygiene Management (MHM) Among Homeless Women in Cape Town

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ABSTRACT

Homeless women face many challenges. They lack adequate housing and financial support and are confronted with the daunting challenge of securing sanitary products when menstruating (Parrillo and Feller, 2017). Menstruation is a crucial part of women's sexual and reproductive health (Reams, 2001). It is a significant biological experience that signifies a woman's transition from childhood to womanhood (Reams, 2001). For homeless women, purchasing menstrual products is an unreasonable financial burden (BRAWS, 2018). Homeless women end up using items such as rags, old socks, tissue paper, paper towels, torn pieces of clothing, or diapers to satisfy their menstrual needs (Mason et al., 2013). Often, homeless women go without menstrual protection altogether (Mason et al., 2013). This lack results in period poverty. Period poverty refers to a lack of sanitary products, menstrual hygiene education, toilets, hand-washing facilities, and/or waste management (Sanchez and Rodriguez, 2019). Period poverty manifests in the absence of Menstrual Hygiene Management (MHM). MHM is a term used to refer to menstruating females having absorbents to absorb or collect blood that can be changed in privacy as many times as required, having soap and water to wash the body, and having facilities to dispose the used menstrual management materials (Sommer and Sahin, 2013).

The purpose of the research study was to qualitatively explore the experiences and perceptions of period poverty among homeless women in Cape Town (South Africa) using the capability approach. As a result, the study was guided by a qualitative research design. Non-probability sampling was used in recruiting participants. In-depth interviews were conducted with 16 homeless women who experienced period poverty and received assistance from two organisations in Cape Town. The findings revealed that homeless women experience period poverty due to a lack of sanitary products and poor MHM. One of key challenges faced by the participants was that they do not have access to an adequate supply of water when having their period. Participants would then make use of dam, water under the bridge, public toilets or make use of a bucket in order keep clean during their period. This affected the confidence of the participants, making them feel inadequate. As a result, they developed unhealthy behaviours to survive the harsh realities of being homeless. This made them vulnerable to different forms of violence and affected their perception of the opportunities they believed they had access to. Based on the findings of this study, it is recommended that addressing period poverty amongst homeless

women requires multifaceted policies and responses. Furthermore, there needs to be intense support from all stakeholders so that the issue of period poverty amongst homeless women is addressed as a wider public-health initiative. The financial burden of sanitary products should be eliminated across the globe. Essentially, free menstrual products should be made available to all menstruating individuals, including homeless women.

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CHAPTER ONE:
INTRODUCTION

1.1. INTRODUCTION

This qualitative study explored the experiences and perceptions of period poverty among homeless women in Cape Town using the capability approach. This chapter provides the background to the problem, an outline of the purpose, rationale for and significance of the study. This is followed by the articulation of the main research questions, research objectives and main assumptions of the study. Lastly, key terms linked to this topic are clarified along with the main ethical considerations.

1.2. STATEMENT OF THE PROBLEM

Menstruation is a crucial part of a woman's sexual and reproductive health (Reams, 2001). It is a significant biological experience that signifies a woman's transition from childhood to womanhood (Reams, 2001). Menstruation or period is a process whereby a woman discharges blood and other material monthly. This usually commences from puberty until menopause, except when a woman is pregnant (Reams, 2001). For many decades, the menstrual needs of women and adolescent girls were neglected (Lutter, Sivakumar, Baurle, 2018). In those years, the menstrual needs of women were not prioritised, nor given attention. In many societies, menstruation is considered a taboo topic that needs to be a 'secret'. This form of 'secrecy' is one of the factors that has led to lack of access to appropriate infrastructure and menstrual management supplies that would enable females to manage their period effectively. Furthermore, by avoiding educating people on Menstrual Hygiene Management (MHM), men and women have been both ill- and uninformed about menstruation. Such realities have had an impact on the lives of menstruating females, affecting their health, well-being and education (Sumpter and Torondel, 2013). Sadly, such a situation also fuels gender inequalities and reinforces exclusion (Lutter, Sivakumar, Baurle, 2018). This is problematic. In recent years, there has been a greater focus placed on women and girls' menstrual needs by academics, policymakers and organisations such as the World Health Organisation, United Nations Women, United Nations International Children's Emergency Fund (UNICEF) and various NGOs. A focus of this nature helps bring about awareness regarding menstrual health and shapes the management of menstruation (Lutter, Sivakumar, Baurle, 2018). This, in turn, can have a positive impact on the health, well-being and aspirations of menstruating

females (Lutter, Sivakumar, Baurle, 2018). It is an empowering move that helps eliminate gender inequality and eliminates the exclusion of menstruating females (Lutter, Sivakumar, Baurle, 2018).

MHM was developed by the Joint Monitoring Program of the World Health Organization (WHO) and UNICEF in the year 2012. MHM is defined as 'Women and adolescent girls using a clean menstrual management material to absorb or collect blood that can be changed in privacy, as often as necessary, for the duration of the menstruation period, using soap and water for washing the body as required, and having access to facilities to dispose of used menstrual management materials (Hennegan et al., 2016: 2). Effective MHM requires clean absorbent, adequate frequency of absorbent change, washing the body with soap and water, adequate disposal, and privacy for managing menstruation (Hennegan et al, 2016). A definition of this nature focuses on the physical requirements that would allow for the hygienic and effective management of menstrual bleeding (Hennegan et al, 2016). One of the main purposes behind the development of this concept has been to eradicate unhealthy menstrual practices affecting a women's menstrual health, well-being and educational pursuits (Hennegan et al, 2016). It is important, however, to note that while the use of this definition has received great recognition, the operationalization of MHM has been inconsistent (Hennegan et al, 2016).

The absence of an operational definition makes it difficult to conduct a full assessment of MHM. This, in turn, makes it difficult to gather evidence and consensus regarding MHM (Sumpter and Torondel, 2013). If researchers do not have a uniform understanding of what constitutes adequacy in each aspect of the MHM definition, there is a problem. For example, the MHM definition does not provide clear guidance on optimal washing frequency or how to use soap and water properly when washing the body and genitals during your period (Winkler and Roaf, 2015). The MHM definition highlights the need for women to change sanitary products in private but menstruating females need privacy when engaging in all the other aspects of MHM, for example, when washing their bodies (Winkler and Roaf, 2015). Recently, there has been a push towards gathering quantitative evidence when it comes to MHM (Sommer et al, 2016). However, this will be difficult to achieve without a proper, consistent operational definition (Hennegan et al, 2016). A consistent operational definition could assist in the standard application of what can be regarded as 'good' and 'bad' MHM (Sumpter and Torondel, 2013). This could further assist in estimating how prevalent is MHM, create links between the predictors and consequences of poor MHM, and

evaluate interventions that seek to eliminate inadequate menstrual practices (Hennegan et al, 2016).

Indeed, the number of studies on menstrual health and the well-being of women and young girls is increasing, especially in low and middle-income countries (Sumpter and Torondel, 2013). This is good because menstrual health is required to achieve global health and gender equality. Studies on MHM have shed light on the many factors that hinder a woman's menstrual health, but a clear MHM theory has not been developed (Sumpter and Torondel, 2013). Research centered around menstrual health often relies on models and not problem theory that is detailed (Hennegan et al., 2016). An example of such a model would be Venn Diagrams with 3 circles: The first circle focuses on menstrual knowledge, the second circle focuses on menstrual products and the third diagram focuses on sanitation (Geerts et al., 2016; Sommer et al., 2018). The Venn models are able to provide an intuitive high-level picture that informs MHM programming, but Venn diagrams fail to develop a problem theory that is detailed and that shows relationships and pathways to hypothesized impacts on areas such as health. Hence the need for an MHM theory that will assist in directing intervention and evaluations (Hennegan et al., 2019).

One of the things that has complicated the development of problem theory when it comes to MHM, is the confusion or lack of clarity that exists when it comes to core concepts, or terminologies in menstrual research (Sommer and Sahin, 2013). For example, there is a term known as 'menstrual hygiene'. Menstrual hygiene refers to "women and adolescent girls using a clean menstrual management material to absorb or collect blood that can be changed in privacy as often as necessary for the duration of the menstruation period, using soap and water for washing the body as required, and having access to facilities to dispose of used menstrual management materials" (Sommer and Sahin, 2013: 35). This definition, however, does not take into consideration the menstrual needs revealed in qualitative research (Sommer et al, 2016). As a result, the definition has been expanded and includes the following: "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" (Sommer et al, 2016: 35). Expanding the definition of 'menstrual hygiene' facilitates a more comprehensive advocacy but does not addresses the absence of a problem theory that is unified and that acknowledges the various components of menstrual health (Hennegan et al., 2019).

Improved MHM is directly linked to fulfilling many of the Sustainable Development

Goals, (SDGs), such as Goal 3 (Ensuring healthy lives and promoting well-being), Goal 4 (Ensuring inclusive and equitable quality education and promoting lifelong learning opportunities), Goal 5 (Achieving gender equality and empowering all women and girls), and Goal 6 (Ensuring availability and sustainable management of water and sanitation) (UNDESA, 2015). The following sentences will explore the relationship between MHM and the SDGs. The lack of access to sanitary products causes menstruating females to use unhygienic materials such as rags and newspapers. Such unhygienic practices cause health complications like reproductive tract infections (Menstrual Hygiene Day, 2017). Improved MHM helps promote healthy menstrual health and well-being (UNDESA, 2015). The continuous lack of sanitary products discourages females from attending school and in participating in various social activities (UNDESA, 2015). For example, the United Nations Educational, Scientific and Cultural Organization estimates that one in 10 African menstruating females do not go to school when on their period (World Bank, 2016). In fact, they eventually drop out of school because of menstruation-related difficulties, such as not being able to access affordable sanitary protection, the social taboos related to menstruation and the culture of silence that surrounds it (World Bank, 2016). Improved MHM assists in bringing about education that is inclusive, equitable and that promotes lifelong learning opportunities for menstruating females (UNDESA, 2015). The taboos and myths around menstruation often create the impression that women and girls are inferior to men and boys, that menstruating females are less than men and boys (Menstrual Hygiene Day, 2017). Improved MHM is one of the tools used to bring about gender equality and eradicate discrimination and exclusion. In fact, this tool is used to empower menstruating females, enabling them to manage their menstruation safely, hygienically and with dignity (Menstrual Hygiene Day, 2017). Interestingly, 2.4 million people do not have access to adequate sanitation facilities. This form of lack affects the privacy and hygiene of menstruating females (Menstrual Hygiene Day, 2017). MHM highlights the need for adequate sanitation facilities to manage menstruation (Menstrual Hygiene Day, 2017). Put differently, MHM contributes in pushing Goal 6 of SDGs and helps ensure that menstruating females have access to water and sanitation facilities that are safe, acceptable and that allow for the safe disposal of sanitary products (UNDESA, 2015).

Poor or non-existent MHN results in period poverty. Period poverty refers to a lack of sanitary products, menstrual hygiene education, toilets, handwashing facilities, and/or waste management (Sanchez and Rodriguez, 2019). This is an issue that mostly affects women and

young girls based in low- and middle-income countries (Oppenheim, 2018). An example of such a country would be Kenya. Period poverty is a widespread problem in Kenya where UNICEF discovered that 7% of women and girls used old cloths, pieces of blankets, chicken feathers, mud and newspapers when having their period, 46% used disposable pads and 6% used reusable pads (Oppenheim, 2018). UNICEF also found that 65% of females in Kibera, Nairobi, exchanged sex for sanitary pads (Oppenheim, 2018). This was due to the high rate of period poverty and the shame and stigma associated with menstruation (Oppenheim, 2018). According to Bobel (2019:13), "Menstrual stigma is potent, ubiquitous, and impactful, even if its intensity varies from place to place." Furthermore, in this part of Nairobi, Oppenheim (2018) found that there was a great deal of public health misinformation regarding menstruation. According to Patkar et al. (2016), public health misinformation regarding menstruation can lead to negative beliefs, myths and social restrictions that negatively impact on a woman's ability to effectively manage her period.

Period poverty impacts women's experiences of water, sanitation and hygiene facilities as homeless women do not have access to safe water, sanitation facilities and hygiene. The Water Supply and Sanitation Collaborative Council (WSSCC) and the UN Women Joint Programme on Gender, Hygiene and Sanitation conducted interviews with women working in West and Central Africa; these women highlighted that they do not have access to adequate WASH (water, sanitation and hygiene) facilities and this lack affects their productivity, especially during menstruation (WSSCC, 2013). A woman's menstrual cycle can last many years of her life and yet adequate facilities are still lacking for the average woman's needs. This is problematic and infringes upon a women's menstrual rights, health and dignity. The WSSCC (2013) argues that ignoring a woman's menstrual hygiene needs violates her rights – for example, her right to human dignity, non-discrimination, equality, bodily integrity, health, privacy and the right to freedom from inhumane and degrading treatment from abuse and violence.

Regarding period poverty, it is important to note that much of the research has focused primarily on adolescent girls. For example, the work of Montgomery et al. (2012) and of Mason et al (2013) indicates that the provision of sanitary pads in schools can assist in improving school attendance and the life chances of young women. Grant, Lloyd and Mensch (2013) found that menstruation alone did not cause girls to be absent from school but other menstrual related issues (such as cramps and heavy bleeding) contributed to their absenteeism. One could go on listing the plethora of studies shedding light on MHM and period poverty amongst adolescent girls. However,

research conducted on other menstruating females, such as homeless women, is scarce. Homeless women also struggle to purchase menstrual products and resort to items such as rags, old socks, tissue paper, paper towels, torn pieces of clothing, or diapers during menstruation (Tull, 2019). Additionally, the lack of sanitary products causes homeless women to bleed through their undergarments and wear blood-soaked items for days or even weeks (Jones, 2016; BRAWS, 2018). WHO/UNICEF (2012) paint a picture of MHM in which women and adolescent girls have access to sanitary products, can change sanitary products in private as often as necessary, have access to safe water, are able to use water and soap for the washing of the body, and have access to sanitation facilities that allow for the adequate disposal of used menstrual materials. However, homeless women do not live out this ideal picture. Herewith this study which qualitatively explores the experiences and perceptions of homeless women, in Cape Town, regarding period poverty. This was done to better understand the lived experiences of homeless women and their physical and emotional requirements during menstruation. This is important because much of the focus has been placed on adolescent girls. Furthermore, South Africa has not tackled the issue of period poverty from the perspective of homeless women. There is a need for a new wave of literature that will focus on other groups and aspects of period poverty. Homeless women, for example, face many challenges such as not having a place to stay (Vora, 2017). This often means they do not have access to a safe and adequate place to change and dispose their sanitary products when on their period (Vora, 2017). Additionally, they do not have a place to shower and keep clean. They have limited access to clean underwear, laundry and menstrual supplies, which make women uncomfortable during their menstrual week (Vora, 2017). Furthermore, homeless women experience financial hardships that make it difficult for them to buy sanitary products (Vora, 2017). These harsh realities make it difficult for homeless women to effectively manage menstruation in a dignified manner.

As established, research investigating the experiences of homeless women and how they manage their menstrual health is scarce. This is problematic because consistent awareness and data is needed to develop problem theory of MHM and advocate effectively for the elimination of period poverty. Capturing women's lived experiences and perspectives on contextual factors affecting their lives, health and identity in a modernizing society is important for global health and gender equality. Capturing the lived experiences of homeless women, in particular, sheds light and adds depth to this highly ignored area. Furthermore, such research works to deepen the

understanding of period poverty and its effect on other critical areas such as health, dignity and identity. From an academic perspective, a study of this nature aims to enrich this unresearched area, especially in South Africa. This, in turn, could influence policy, programmes, activists in this space, and initiatives related to this issue. It is important for policymakers to have access to quality research that can be used to effect change, refine implementation processes and frameworks, create an awareness, and shape thinking when it comes to MHM. Research of this nature also allows development practitioners to gauge for themselves the true impact that an undertaking of this nature can have on the lives of homeless women. Additionally, there are other programmes and initiatives that have been set up to address the issue of period poverty. Results from this study could be of use to those developing and running these programmes and initiatives. In other words, this study may serve to assist both policymakers and development practitioners to identify programmes, initiatives (centred around period poverty) that work, and those that do not, so that effective programmes can be promoted, and ineffective ones can be discontinued.

1.3. RATIONALE AND SIGNIFICANCE OF THE STUDY

This study amplifies the voices of marginalised women – homeless women. As a result, the results from this study are beneficial to policymakers, the community, government, researchers, activists and other key relevant stakeholders, as they can serve as empirical data providing suggestions on the benefits and importance of a continuous supply of menstrual health resources (such as sanitary pads) to homeless women. This study also contributes to the field of social development, sexual and reproductive health of women and raises an awareness on the experiences and perceptions of homeless women when it comes to MHM. The results from this study draw awareness to menstrual health and menstrual justice – which are neglected concepts in academia and in practice. Consequently, the results from this study can be used as reference material by other researchers, particularly those in the field of women's health and social development. This study is critical in furthering the United Nations Sustainable Development Goals as it pertains to gender equality and Goal 6 of the Sustainable Development Goals, which seeks to ensure available and sustainable management of water and sanitation for all. Focusing on MHM is important in advancing the cause for women. MHM is not only a sanitation matter but a step towards protecting the dignity, bodily integrity and overall life opportunities of menstruating females (World Bank, 2018). The promotion of MHM is a move towards gender equality. However, fostering adequate MHM

conditions requires appropriate sanitation facilities and access to water. Work of this nature is crucial at both the micro and macro levels and is important locally, provincially, nationally, continentally, and globally.

1.4. RESEARCH TOPIC

A Capability Approach to Examining the Experiences and Perceptions of Period Poverty Among Homeless Women in Cape Town.

1.5. MAIN RESEARCH QUESTIONS

- What challenges did homeless women face when it came to Menstrual Hygiene Management before the provision of free sanitary products? In particular:
    - How did they access sanitary products?
    - What did they use?
    - Where did they change their sanitary products?
    - How did they dispose of used sanitary products?
    - How did they access soap and safe water?
- How did poor Menstrual Hygiene Management due to lack of access to sanitary products affect homeless women's perceptions of self?
- How did poor Menstrual Hygiene Management due to lack of access to free sanitary products affect homeless women's perceptions of life and physical health?
- How did poor Menstrual Hygiene Management due to lack of access to free sanitary products affect homeless women's sense of respect?
- How did poor Menstrual Hygiene Management due to lack of access to free sanitary products affect homeless women's sense of bodily integrity?
- How did poor Menstrual Hygiene Management due to lack of access to free sanitary products affect homeless women's perceptions of opportunities they believed they had access to?
- How does the provision of free sanitary products affect homeless women's experiences of Menstrual Hygiene Management?

1.6. RESEARCH OBJECTIVES

- To unpack the challenges homeless women, face when it comes to Menstrual Hygiene Management before the provision of free sanitary products.
- To determine how poor Menstrual Hygiene Management, due to lack of access to sanitary products, affect homeless women's perceptions of self.
- To investigate how poor Menstrual Hygiene Management, due to lack of access to free sanitary products, affect homeless women's perceptions of life and physical health.
- To unpack how poor Menstrual Hygiene Management, due to lack of access to free sanitary products, affect homeless women's sense of respect.
- To understand how poor Menstrual Hygiene Management, due to lack of access to free sanitary products, affect homeless women's sense of bodily integrity.
- To determine how poor Menstrual Hygiene Management, due to a lack of access to free sanitary products, affect homeless women's perceptions of opportunities they believe they have access to.
- To determine how the provision of free sanitary products affect homeless women's experiences of Menstrual Hygiene Management.

1.7. MAIN ASSUMPTION

The study explored the experiences and perceptions of Menstrual Hygiene Management among homeless women in Cape Town, using the capability approach. It was therefore assumed that the participant's experiences and perceptions of MHM were gauged.

1.8. CLARIFICATION OF TERMS

Menstruation/menstrual period/period **-** or the menstrual flow, is a social, psychological and cultural symbol that comes with being female (Reams, 2001). The word menstruation stems from a Latin word called 'mensis' and this word means 'month' (Reams, 2001). A woman's period can last up to 7 days (Reed, Bruce and Carr, 2018). During menstruation, the uterus experiences change in structure and function (Reed, Bruce and Carr, 2018). Furthermore, hormones such as estrogen

and progesterone are released to assist with developing and transforming the endometrium (Reed, Bruce and Carr, 2018). If conception does not take place, estrogen and progesterone levels drop (Reed, Bruce and Carr, 2018). When these hormone levels drop, the tiny arteries and veins in the uterus begin to close off (Reed, Bruce and Carr, 2018). Thereafter, the lining ceases to be nourished and begins to shed and a female experiences her period (Reed, Bruce and Carr, 2018). *Menarche* refers to the first time a woman menstruated, and *menses* is a term that refers to the time of menstruation when blood and other matter are released from the uterus (Reams, 2001). The menstrual phase refers to the days when a woman is actually bleeding (Reams, 2001). A female's period can last between two to eight days, with the average being four to six days (Reams, 2001). Thereafter, a new follicle begins to grow, hormones are secreted, and a new uterine lining develops – the cycle then begins all over again (Reams, 2001).

Menstrual Hygiene Management - A terms used to refer to "women and adolescent girls using a clean menstrual management material to absorb or collect blood that can be changed in privacy as often as necessary for the duration of the menstruation period, using soap and water for washing the body as required, and having access to facilities to dispose of used menstrual management materials" (Sommer and Sahin, 2013: 1557).

Period poverty - refers to a lack of sanitary products, menstrual hygiene education, toilets, hand-washing facilities, and/or waste management (Sanchez and Rodriguez, 2019; Tull, 2019).

Homelessness **-** refers to a situation whereby an individual does not have a permanent home and ends up living on the streets, in hostels, squats and/or other temporary accommodation (Rahman, 2016; Reeve, 2011). A homeless person lacks a conventional home and other economic and social features that a home provides (Rahman, 2016; Reeve, 2011).

1.9. CONCLUSION

This chapter gave an overview of and background to the study. The statement of the problem, the significance of the study along with the title of the research topic, main research questions and research objectives were addressed. Furthermore, the main assumptions were outlined, and concepts were clarified.

CHAPTER TWO:
LITERATURE REVIEW

2.1. INTRODUCTION

In this chapter, literature relevant to this study is reviewed. Thereafter, the Capability Approach by Amartya Sen (1995; 2000) and Robeyns' (2003) Capability Approach to Gender Inequality is outlined and used to examine period poverty and Menstrual Hygiene Management, from the perspective of homeless women. Furthermore, the Draft Sanitary Dignity Policy Framework and the National Development Plan 2030 and their relevance to the study, are presented.

2.2. REVIEW OF LITERATURE

2.2.1. Menstrual Hygiene Management and gender equality

Menstruation is an important process when it comes to a woman's sexual and reproductive health (Reams, 2001). About half of the world's population menstruate in their lifetime (VanLeeuwen and Torondel, 2018). Menstruation is a significant biological process that needs to be managed accordingly. In fact, healthy Menstrual Hygiene Management (MHM) requires that menstruating females have access to the following components: Firstly, the provision of access to appropriate menstrual material (such as sanitary products and soap), as well as additional supportive material that will assist when it comes to storage, washing and drying (Hennegan et al., 2016). Secondly, the provision of an adequate infrastructure for water, sanitation and changing areas (Hennegan et al., 2016. Thirdly, access to privacy when changing sanitary products and mechanisms that allow for adequate waste disposal, and lastly, menstrual health education and promotion (Hennegan et al., 2016). When MacRae (2019) applied the above definition of MHM to assess its applicability in the lives of women in rural Odisha, India, the findings revealed something interesting. The findings suggested that there was a need for an improved definition of MHM. This was because the women of rural Odisha expressed needs that went beyond the needs articulated in the above definition. As a result, MacRae et al (2019) provided an expanded definition of MHM. Firstly, the expanded definition stresses that the menstrual management materials need to be clean, comfortable, reliable and must allow for the absorption and collection of menstrual blood (MacRae et al., 2019). Second, the definition highlights that menstruating females should have access to private spaces that allow for bathing, urination and defecation during menstruation (MacRae et al.,

2019). Third, the expanded definition argues that the cleaning, drying, changing, storage, and disposal of menstrual materials must be done in a manner that is private and safe (MacRae et al., 2019). Fourth, the definition highlights that in addition to menstruating and having access to soap and water to wash their bodies, females also require access to clean materials such as clothing and bedding (MacRae et al., 2019). The definition highlights the importance of receiving sufficient social support and pain management resources during menstruation (MacRae et al., 2019). Furthermore, the definition emphasizes the importance of menstrual education that would enable menstruating females to better manage their menstrual cycle with dignity and without fear, worry or discomfort, and in an environment that is socially and culturally enabling (MaeRae et al., 2019).

The focus on MHM and its evolution is very important in advancing the cause of women as it relates to gender equality. Menstruating females experience many difficulties when having their period. For example, there are social and financial hinderances related to the acquisition of sanitary products (Van Eijk, 2016; Sommer, 2010; Sahoo, 2015). There is also an infrastructure issue as many menstruating females do not have access to water and sanitation facilities that would allow them to effectively manage their period (WSSCC, 2013). There are also taboos, social norms and beliefs regarding menstruation that are a challenge for adolescent girls and women (World Bank, 2018). In certain cultures, menstruating women are regarded as impure (World Bank, 2018). As a result, women are systematically excluded from participating in activities such as education, employment, and cultural and religious practices (World Bank, 2018). Furthermore, when it comes to menstruation, there is a culture of silence or ignorance that exists (World Bank, 2018). This, in turn, perpetuates taboos and stigmas that affect the empowerment of women as well as their health and dignity (World Bank, 2018). Das (2017) argues that a failure to acknowledge the menstrual hygiene needs of menstruating females will foster gender inequality even more. The promotion of MHM is not only a sanitation matter but a move towards protecting the dignity, bodily integrity and overall life opportunities of menstruating females (World Bank, 2018). It is a move towards gender equality.

2.2.2. Menstrual Health Management and Period Poverty

In the absence of MHM, period poverty manifests. Period poverty refers to a lack of access to sanitary products, menstrual hygiene education, toilets, handwashing facilities and waste

management (Sanchez and Rodriguez, 2019; Tull, 2019). Many women and young girls, 800 million females globally, menstruate daily and 23 million do not have access to basic sanitation facilities (Parray, 2019). Less than 30% of people in developing countries have access to hand-washing facilities at home (Parray, 2019). This makes it difficult to manage your period in a safe and dignified manner. Women who are poverty-stricken are more vulnerable to experiencing period poverty. The United Nations Educational, Scientific and Cultural Organization argues that poor menstrual hygiene is associated with health risks that are of a physical nature and reproductive morbidities (Parray, 2019). Moreover, it hinders a woman from being able to reach their full potential due to missed opportunities that are fundamental to their growth (Parray, 2019).

Period poverty, or the lack of access to adequate resources and information to effectively manage menstruation, results in women developing their own personal strategies to cope with menstruation. These vary greatly from one country to the next as well as within countries, depending on one's personal preferences, available resources, economic status, local traditions and cultural beliefs and knowledge or education (Kaur, Kaur and Kaur, 2018). Period poverty creates a situation whereby women manage menstruation in ways that are unhygienic or inconvenient, especially in settings that are poor (Kaur, Kaur and Kaur, 2018). Studies reveal that there is widespread use of unhygienic and inadequate menstrual absorbents in Africa, South East Asia and the Middle East (Baisley et al., 2009). Research indicates that about 18% of Tanzanian women use sanitary products and the rest rely on cloth or toilet paper (Baisley et al., 2009). In Nigeria, between 31% and 56% of the schoolgirls use toilet paper and cloth as 'menstrual pads' when menstruating (Adinma and Adinma, 2008; Aniebua, Aniebua and Nwankwo, 2009). In Gambia, only a third of the women were able to use sanitary pads consistently (Demba et al, 2005). A study done in India found that between 43% and 88% of girls had to wash and reuse cotton cloth, as opposed to pads, when on their period (Dasgupta and Sarkar, 2008). Often, the cleaning of cloths is done without making use of soap or clean water (Narayan, Srinivasa and Pelto, 2001). Furthermore, the drying of the cloths typically takes place indoors, not outside where there is sunlight or open air (Narayan, Srinivasa and Pelto, 2001). Put differently, the cloth or material is not adequately sanitized (Narayan, Srinivasa and Pelto, 2001). This is due to the social restrictions and taboos that exist in communities, cultures and families, and is particularly the case in rural areas, and in lower socioeconomic groups (Narayan, Srinivasa and Pelto, 2001).

Poor MHM can lead to Reproductive Tract Infections (RTI), particularly in poor

communities (Bhatti and Fikree, 2002). Furthermore, unhygienic practices of menstruation can result in Toxic Shock Syndrome (Khanna, Goyal and Bhawsar, 2005; Narayan, 2001; Rajaretnam and Hallad, 2010) and pelvic infections (Balsara et al., 2010). Kuhlmann, Henry and Wall (2017) argue that more research needs to be done to understand the relationship between MHM and health outcomes, such as genitourinary infections, social development and sound mental health.

In addition, women are not educated about how to adequately dispose of used menstrual items. Often menstrual products are disposed of as domestic waste and/or in public toilets (Kaur, Kaur and Kaur, 2018). When women flush menstrual products down toilets, it is often because of their being unaware of the consequences that come with such an act, the consequences of blocking the system (Kaur, Kaur and Kaur, 2018). This goes to show that there is a need to educate females about the environmental pollution and health hazards associated with the inadequate disposal of menstrual products (Kaur, Kaur and Kaur, 2018). For example, sanitation systems are designed to accommodate urine and faeces and not menstrual absorption materials (Arthur, Crow and Pedezert, 2008). As a result, menstrual absorption materials can clog sewer pipelines resulting in a system backflow (Arthur, Crow and Pedezert, 2008). The use of modern techniques like incineration can contribute to the disposal and reduction of menstrual waste (Kaur, Kaur and Kaur, 2018). There is also a need to increase awareness when it comes to the use of reusable or natural sanitary products made from banana and bamboo fibre, sea sponges, water hyacinth, and so on (Kaur, Kaur and Kaur, 2018). Van Leeumen and Torondel (2018) argue that MHM and period poverty are not researched enough despite their recent popularity.

2.2.3. Period Poverty: Social Stigma, Cultural beliefs and restrictions during Menstruation

Period poverty is associated with feelings of anxiety, shame, psycho-social stress, fear and lack of dignity. This perpetuates the stigma and shame linked to menstruation and increases the risk of females being exploited and violated (Hennegan and Montgomery, 2016; Sphere Project, 2011; Sommer et al, 2016 and Sommer et al, 2015). For many centuries, menstruation has been considered a dirty process, accompanied by secrecy and taboo (Vora, 2016). Across the globe, the stigma of menstruation continues to thrive as many women have trouble talking about it, even to their families (Vora, 2016). For them, periods are embarrassing (Vora, 2016). In some cultures, there is ‘menstrual seclusion’ - where menstruating women do not participate in certain activities such as preparing food, using communal vessels and entering spaces of worship. In some Western

societies, perceiving menstruation as unclean and toxic continues (Vora, 2016). As a result, women change their behaviour to avoid indicating that they are having their monthly cycle (Kissling, 2006). For example, women may actively avoid wearing clothing that is white and abstain from activities such as swimming (Kissling, 2006).

Misleading beliefs about menstruation arise from misconceptions and attitudes regarding menstruation within a particular culture, or religion (Umeora and Egwuatu, 2008). Menstrual hygiene practices are influenced by cultural norms, parental influence, personal preferences, economic status, and socioeconomic pressures (Umeora and Egwuatu, 2008). Menstrual beliefs, knowledge and practices are all linked to MHM (Umeora and Egwuatu, 2008). For example, in certain cultural settings, women are barred from cooking, working, bathing, eating certain foods and in engaging in sex when having their period (Mohamed et al., 2018). These restrictions come from the perception that menstruation is a dirty and polluting process (Jogdand and Yerpude, 2011). Furthermore, certain cultures believe that the washing, drying and burial of menstrual cloths should be done privately – where no one can see you (Dhingra, Kumar and Kaur, 2009). This is due to the belief that menstrual fluids may be misused for black magic (Sommer, Kjellen and Pensulo, 2013). As a result, in these cultures, women wash their used menstrual cloth only at night when others are sleeping (Sommer, Kjellen and Pensulo, 2013). Furthermore, women hide their menstrual cloths to because they fear that they might get cursed by witches – who might also curse the woman with infertility (Umeora and Egwuatu, 2008). Such beliefs indicate that there is a need for menstrual education to assist in effective implementation of MHM. Menstrual education must include both men and women so that false beliefs and taboos can be eliminated (Tjon A Ten, 2007). MacRae et al. (2019) argues that there is not enough research investigating how adult women manage menstruation as much of the focus is on adolescent girls in school settings. The research conducted by MacRae et al. (2019), established that women require tangible support to manage menstruation and those needs extend beyond the needs identified in the Joint Monitoring Programme definition. When it comes to menstrual health, even if menstrual management needs are met, women have concerns related to psychosocial support, agency, gendered environments, the role of men and boys, and the persistence of social norms (Hulland, 2015; Mahon, Tripathy and Singh, 2015). It may not be easy to capture the restrictions, fear and experiences of shame in a definition, but these are the vital features when it comes to a woman's experience of menstruation and their overall health and well-being (MacRae et al., 2019).

2.2.4. Homelessness

There is more than one definition of homelessness (Amore, Baker and Chapman, 2011). For some scholars, homelessness is a state in which one does not have a permanent place to stay. An example of such people would be those who live on the streets or in hostels, squats or temporary accommodation, basically, those without access to permanent rights of tenure (Reeve, 2011). Tipple and Speak (2009) argue that a homeless person is one that lacks not only a conventional home but the economic and social features that a home provides. In other words, a homeless woman has few to no resources, no immediate means and little prospect of supporting herself (Busch-Geertsema and Sahlin, 2007). The concept of 'home' includes aspects such as comfort, belonging, identity and security (Tipple, 2005).Khoza (2014) argues that homelessness can be regarded as a relative concept, just like poverty. In other words, people define their condition depending on how they perceive and compare themselves in relation to other members of society (Khoza, 2014). From a gender perspective, homelessness has different meanings for women and men (Tenai and Mbewu, 2020). For both men and women, homelessness makes reference to a lack of privacy and dispossession (Rahman, 2016). For women, this lack and dispossession refers to the disruption of everyday routines (Rahman, 2016). Such an argument creates the impression that homelessness is more serious for women than men.

Scholars argue that there are two trends that lead to homelessness (Rahman, 2016). The first trend relates to large scale structural changes such as industrialisation and systematic shocks connected to wars and depressions (Rahman, 2016). These roots of homelessness increase the gap between subsistence needs, which would be housing in this case, and availability of economic resources to fulfil the needs of the increasing population (Rahman, 2016). However, it is not structural factors alone that determine who becomes homeless. Biographic factors, the second trend, play a role in determining who becomes homeless (Rahman, 2016). These biographic factors include demographics (e.g., race/ethnicity); human capital (e.g. educational level); social capital (e.g. family attachments); disabilities (e.g. substance abuse and mental illness) (Rahman, 2016). Here we see that homelessness can be best understood by taking into consideration the overlap between structural and biographical factors (Rahman, 2016).

2.2.5. Menstrual Hygiene Management and Homeless Women

Homeless women not only lack adequate housing and support but are confronted with the daunting challenge of securing sanitary products when on their period (Parrillo and Feller, 2017). For homeless women, purchasing menstrual products is an unreasonable financial burden (BRAWS, 2018). According to Kane (2017), a woman experiences approximately 456 periods over 38 years, which comes close to 6.25 years of her life. In order to avoid infection, women are encouraged to change a tampon every four to eight hours (Bowerman, 2017). However, this is not always realistic considering how pricey menstrual products can be. As a result, many menstruating females end up using items such as rags, old socks, tissue paper, paper towels, torn pieces of clothing, or diapers to satisfy their menstrual needs (Mason et al., 2013). If women do not have these items, they simply go without menstrual protection (Mason et al., 2013). This causes them to bleed through their undergarments and various forms of clothing (Jones, 2016). In as much as this is unsanitary and unhealthy, it also results in homeless women wearing blood-soaked items for days or even weeks (BRAWS, 2018). Homeless women do not have access to safe water, sanitation and hygiene. This is extremely problematic even though the United Nations General Assembly adopted two resolutions, one in 2010 and the second in 2015, that emphasise one's human rights to water and sanitation (Aïdara, 2016).

There are consequences to making use of unclean rags and items during menstruation, for homeless women. These consequences come in the form of unwelcome bacteria and infections (Andersen, 2017). Period poverty, experienced by homeless women, can result in homeless women wearing blood-soaked clothing for days and at times, weeks (Andersen and Marks, 2017). Unhygienic methods can result in homeless women suffering from health-related issues such as toxic shock syndrome, yeast infections, bacterial vaginosis, and basic discomfort (Andersen and Marks, 2017; House, Mahon and Cavill, 2012). The use of unhygienic methods brings about an element of discomfort to the lives of homeless women who are overlooked by society (Andersen and Marks, 2017). This matter is further compounded by the stress that comes with lacking menstrual protection, privacy, cultural stigma and not having access to restrooms, extra clothes and places to take a bath (Andersen and Marks, 2017). In addition, homeless menstruators are not understood by society and do not receive the support that would help in meeting their menstrual needs (Andersen and Marks, 2017). The conditions homeless women find themselves in make it difficult for them to access adequate menstrual management. This, in turn, makes their lives on the

streets extremely difficult (Andersen and Marks, 2017). Period poverty experienced by homeless women is a healthcare injustice that needs to be urgently rectified.

All these issues could be eliminated if women had unequivocal access to menstrual equity. Even when sanitary products are made available, they must be provided in sufficient and large quantity so that homeless women can change them often, especially homeless women suffering from endometriosis (House, Mahon and Cavill, 2012). Endometriosis is a condition which affects more than 11% of women and girls aged between 15 and 44 (House, Mahon and Cavill, 2012). A condition of this nature causes longer and heavier periods and requires the use of more menstrual supplies (House, Mahon and Cavill, 2012). Access to adequate and sufficient quality and quantity of menstrual products and facilities should be prioritized for women, including homeless women, and policy reform is needed to ensure that this comes to fruition.

Women mainly manage their periods by purchasing and making use of disposable sanitary products. However, for those who are poor, it is difficult to purchase pads (Vora, 2016). Good menstrual hygiene not only protects women from obvious leaking or staining but contributes towards reproductive and gynaecological health (Vora, 2016). Period poverty can cause many women, for example, homeless women, to use unhygienic methods in order to meet their menstrual needs. Menstruation is a biological process that involves fluctuating emotions and pain and for homeless women, this can be an added burden as they struggle to find a place to sleep and food to eat (Vora, 2016). Based on this background, Vora (2016) argues that more research needs to be done to better understand the menstrual needs of homeless women. Furthermore, Vora (2016) emphasizes the need to raise awareness, break menstrual taboos linked to homeless women and provide a safe environment for them to express their menstrual needs.

2.2.6. Violence against homeless women

A survey conducted in Florida, involving 800 homeless women, revealed that violence was the main reason they ended up homeless – the violence being mostly of a physical and sexual nature (Jasinski et al, 2005). The violence experienced by these women led to negative outcomes such as alcohol and drug use, depression, and low self-esteem. Many of the reasons leaving people homeless can be traced back to events, experiences, victimizations and misfortunes that they experienced during their respective childhoods (Padgett et al., 2012). One of the reasons why violence is so common, when it comes to homeless women, is because their daily activities and

sleeping patterns expose them to potential offenders (Jasinski et al, 2005). Victimized homeless women rarely go to police authorities to report incidents of victimization (Jasinski et al, 2005). As for the times they have been known to report incidents, the responses from the authorities have been unsavoury, which totally discourages many homeless women from even trying (Jasinski et al, 2005).

2.2.7. Substance abuse by homeless women

A study done in Canada revealed that cocaine (58%) was the most common drug used by homeless women, followed by alcohol (53%), cannabis (41%) and heroin (30%) (Torchalla et al., 2011). 58.3% of the sample taken were of women using substances and experiencing mental health disorders (Torchalla et al., 2011). Women living on the streets are two times more likely to depend on drugs than women living in shelters (Torchalla et al., 2011). Multivariate analyses revealed that women who were younger, homeless, had attempted suicide and engaged in sex work, were more at risk of being dependent on drugs and alcohol (Torchalla et al., 2011). Accessible and innovative programs that will address the needs of homeless women are required, particularly when considering the severity of the problem as it relates to polysubstance dependence and high rates of psychiatric comorbidity (Torchalla et al., 2011).

2.2.8. Menstrual Hygiene Management as a Human Right

Access to menstrual products and sanitation are important when it comes to MHM, but there are other factors to consider in terms of policy. Such factors include pain management, the wider community or communities where the menstruating woman/girl exists, taboos and stigma linked to menstruation, the woman/girl's knowledge of menstruation and the reproductive cycle and an understanding of her own reproductive and sexual health (Johnson-Robledo and Chrisler, 2013). These are factors that are not covered in the Joint Monitoring Programme (JMP) definition of MHM. It is particularly striking that the JMP definition is silent about the taboos and stigma linked to menstruation; yet it could lead to a better understanding of menstruation in all contexts. It would be useful to explore the severe impact that stigma and taboos have on the rights of women and girls as well as their dignity and well-being (Johnson-Robledo and Chrisler, 2013).

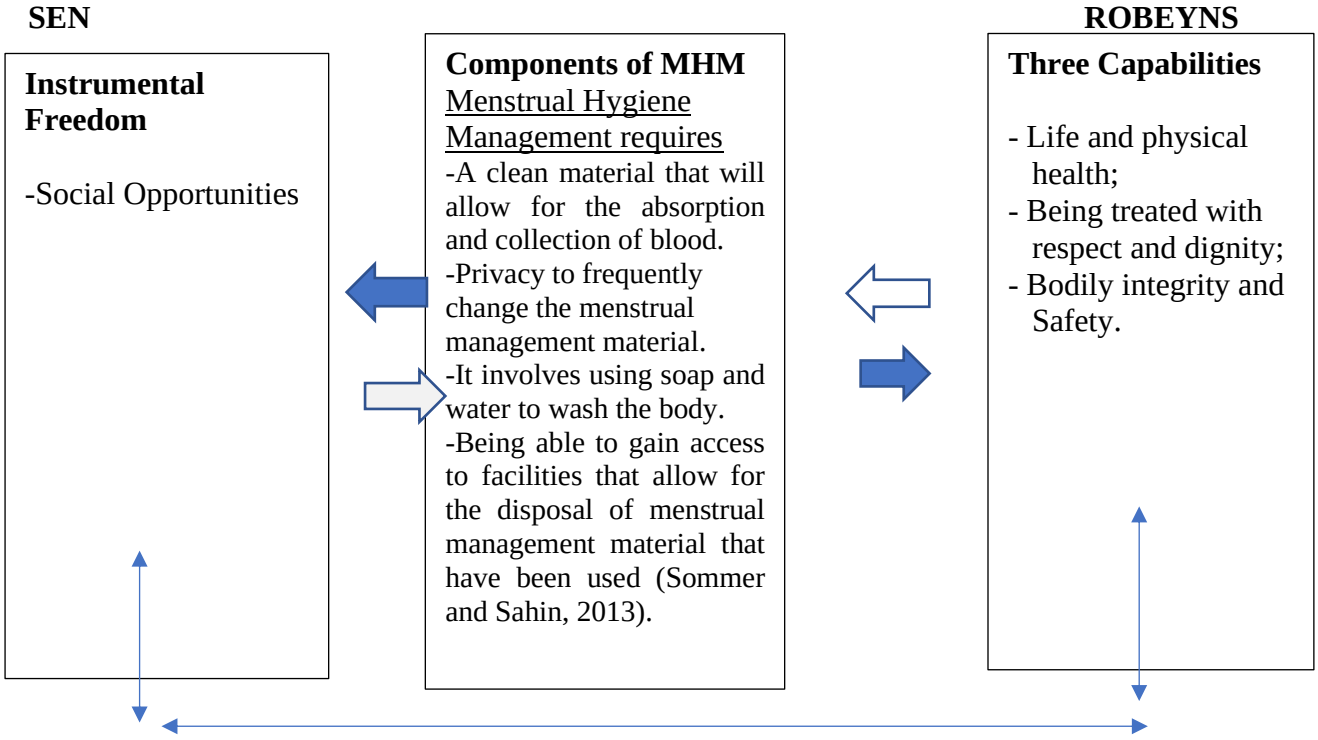
Thomas et al. (2019) argues that the move to a rights-based understanding of menstruation would help eliminate many of the concerns that exist; concerns related to, for example, security,

safety, stigma and taboos. By this, Thomas et al. (2019) infers that menstruation is a biological process that females experience in their lifetime and therefore, it needs to be viewed as a right, a right to safe, healthy and dignified menstruation. By framing it in this manner, it goes from being a negative problem that needs to be solved to an affirmative principle that acknowledges and validates the lives of women and girls (Thomas et al., 2019). Focusing on rights accentuates two things – the naturalness of menstruation and the menstruating girl or women as an individual with rights (Thomas et al., 2019). According to Thomas et al. (2019), a reframing of this nature can assist in the removal of the stigma that is linked to menstruation and act as a catalyst that will amplify the voices of those who advocate for better menstrual practices.

2.3. THEORETICAL FRAMEWORK

This section presents two theories that were used as a framework of analysis for the study, namely: The Capability Approach by Amartya Sen and Ingrid Robeyns's Capability Approach to the issue of Gender Inequality. Diagram 1 below presents a brief description of the interplay between these two models. Each model and their main characteristics are unpacked. Thereafter, a description of the interplay between the models is discussed.

Diagram 1: Theoretical Framework Interplay



2.3.1. Amartya Sen's Capability Approach

The Capability Approach by Sen is a popular theory used in various fields such as economics, political science, philosophy, theology, medicine, public healthcare, developmental studies, to name a few (Kuhumab, 2018). Sen (2000) argues that human development cannot be limited to factors such as the gross national product (GNP) or an increase in technology or industrialization. Human development is connected to the removal of major hindrances that affect the lives of people. An example of these hindrances are poverty, tyranny, poor economic opportunities and others (Sen, 2000). Human development manifests when people have access to greater capabilities (Kuhumab, 2018).

Capabilities can be defined as notions of freedom and reflect the real opportunities people have to live a life they value (Sen, 1995). For capabilities to be effective, the socio-cultural aspects that limit one's ability to flourish in society must be considered (Sen, 1995). Sen (1995) also refers to functionings, which is an umbrella term used to refer to physical or mental states (beings) and activities (doings) that assist people to actively participate in society. Examples of functionings include being well-nourished, experiencing good health, having clothes and shelter, avoiding premature mortality, being literate, being happy, participating in the community, having self-respect, being able to appear in the public without shame, participating in social and political life (Sen, 1995). The close relationship between capabilities and functionings together represent what makes life important (Sen, 2000). In as much as capabilities and functionings are closely related, they are slightly different (Sen, 2000). Capabilities refer to real notions of freedom and real opportunities people have to lead or achieve a certain type of life. Functionings, on the other hand, refer to living conditions available in living a certain type of life (Sen, 2000). To distinguish functionings from capabilities, Sen (2000) provides an example of a fasting person and a starving person. In as much as both individuals experience a similar level of functioning (i.e. nutritional deficiency), the fasting person possesses the capability of being nourished adequately, or put differently, they can make the decision to break their fast and eat; they have that possibility (Sen, 2000). The starving individual, on the other hand, does not have that capability. "A functioning is an achievement, whereas a capability is the ability to achieve" (Sen 1987: 36).

Sen (1999) identifies five 'instrumental freedoms' that, according to him, play a role in the general capability of a person to live more freely. The first freedom is known as 'political freedom' and refers to opportunities that allow an individual to decide on who should govern and using

which principles, holding authorities accountable, being able to exercise freedom of expression and free, uncensored press and enjoying multi-party elections, etc (Sen, 1999). 'Economic facilities' is the second freedom, which refers to the opportunities people just have to have in order to make use of economic resources or entitlements (Sen, 1999). However, economic entitlements of an individual are dependent upon resources owned or available for usage and on conditions of exchange (Sen, 1999). The third freedom is known as 'social opportunities'; it refers to facilities and arrangements available in society as it pertains to education and healthcare (Sen, 1999). For example, illiteracy can severely hinder participation in economic activities that require production based on specification or require firm quality control (Sen, 1999). Likewise, participating in political activities can be a major barrier if one is unable to read newspapers or communicate in writing with others who participate in political activities (Sen, 1999). Social opportunities are put in place to promote development in the lives of citizens (Sen, 1999). Another freedom is known as 'transparency guarantees', which highlights the requirement for openness, trust, and the provision of clear information (Sen, 1999). When trust is violated, this can have an adverse effect on the lives of many people (Sen, 1999). Transparency guarantees are important in preventing corruption and other sorts of financial irresponsibility (Sen, 1999). Lastly, 'protective security' is a needed freedom and social safety net that helps prevent and reduce deprivations, misery, starvation and even death (Sen, 1999). An example includes social protection for a vulnerable population, unemployment benefits, famine relief or emergency public employment to help those who are suffering (Sen, 1999). According to Sen, human development requires an expansion of instrumental freedoms and improving institutional frameworks such as markets, public services, the judiciary systems, political parties, mass media, and public discussions (Kuhamab, 2018). The Capability Approach has been an influential tool in analysing poverty using a gender lens.

2.3.2. Ingrid Robeyns's Capability Approach and Gender Inequality

Much of the work done by Sen focuses on poverty and inequality and Robeyns decided to use the Capability Approach to also explore inequality but from a gender perspective. Robeyns (2003) used the Capability Approach to conceptualize and assess gender inequality in western societies. Feminist scholars argue that when it comes to theories of justice - the lives of men become the standard. Equality is measured through the lens and on the terms of males (Robeyns, 2003). This is problematic because in the process, gender inequalities and injustices end up being hidden and

justified, (even if indirectly) (Robeyns, 2003). Sen does not have a definite list of capabilities (Robeyns, 2003). In tackling the issue of gender inequality in western societies, Robeyns (2003) developed 14 capabilities; 1) Life and physical health: Experiencing physical health enjoying life of normal length; 2) Mental well-being: Experiencing good mental health; 3) Bodily integrity and safety: Being protected from violence of all sorts; 4) Social relations: Actively participating in social networks and giving and receiving social support; 5) Political empowerment: Participating in political decision-making; 6) Education and knowledge: Being able to get educated and using and producing knowledge; 7) Domestic work and non-market care: The ability to raise children and look after others; 8) Paid work and other projects: The ability to work and participate in the labour market, undertake projects, including those of an artistic nature; 9) Shelter and environment: Being sheltered and living in an environment that is safe and pleasant;10) Mobility: Being able to be mobile; 11) Leisure activities: Involves engaging in leisure activities; 12) Time-autonomy: Exercising autonomy in how one allocates one's time; 13) Respect: Being treated with respect and dignity; 14) Religion: Having the opportunity to choose to live or not to live in accordance with religion (Robeyns, 2003). These capabilities were developed to assess gender inequalities in western societies (Robeyns, 2003).

In as much as Robeyns' Capability Approach was developed to assess gender inequalities in western societies, it could be useful in a country like South Africa where gender disparities are also prominent. Gender disparities in access to and control over resources, and the discrimination of women throughout history, stand in the way of national and international development agendas (Voluntary National Review, 2019). It is important to note that achieving gender equality in South African is linked to other goals of sustainable development, such as good governance, human rights, environmental sustainability, and poverty reduction (Voluntary National Review, 2019). Countries that have wide gender gaps tend to have negative indicators of growth and wellbeing, such as poor nutrition, high maternal mortality rate; high infant mortality rate; high poverty rate; low-life expectancy; low level of education; high HIV/AIDS and so on (Aina, 2008). Gender equality acknowledges the biological differences between men and women and appreciates the uniqueness that each gender group has, but it also highlights the different needs and priorities that these gender groups have in order to bring about gender equity, and social justice; both being important in bringing about sustainable development (Aina, 2008).

In Africa, poverty has the face of a woman and this reality can be traced back to gender

inequalities manifesting at both policy and practice levels (UNIFEM, 2000; World Bank, 2001); (i.e., through non-gender responsive methods of resource allocations, inequity in human resource development, low participation of women in decision making, and more importantly, in politics and governance; environmental insecurity; and non-gender responsive policy environment.) These barriers hinder a woman's participation and ability to get resources such as land (Aina, 2008). Focusing on gender equality in Africa is important in order to identify the causes and impacts of poverty and to also identify strategies that will be effective in eradicating poverty (Aina, 2008).

The elimination of gender inequality contributes to the protection of females from severe harm that could be caused by others. This could occur in two ways: firstly, through deliberate actions, or secondly, when there is a failure to protect human rights produced institutionally (Nickel, 2014). Human rights, in essence, protect individuals from severe social, political and legal abuse (Nickel, 2014). Examples of human rights include the right to life, food, freedom of assembly, freedom of religion, the right to a fair trial in instances where one has been charged with a crime, the right not to be tortured, and the right to privacy (Nickel, 2014).

2.3.3. Study's Theoretical Model Interplay Framework

When it comes to a women's menstrual health, the MHM definition provides clarity on what constitutes healthy management of a woman's period. Effectively, menstrual management requires the following features, namely: a) A clean material that will allow for the absorption and collection of blood, b) Privacy to change those menstrual management materials as often as liked, c) The use of soap and water to wash the body, and d) Having access to facilities that allow for the disposal of menstrual management material that have been used (Sommer and Sahin, 2013). The absence of these components unfortunately leads to period poverty. Period poverty refers to a lack of access to sanitary products, menstrual hygiene education, toilets, hand-washing facilities and waste management (Sanchez and Rodriguez, 2019). When period poverty exists, it affects various aspects of a woman's life. This will be illustrated below by looking at the social opportunities of homeless women as well as their right to life and physical health, being treated with respect and dignity and their bodily integrity and safety.

Sen (1999) identifies five 'instrumental freedoms' that, according to him, play a role in the general capability of a person to live more freely. Of the five instrumental freedoms, the third freedom,' social opportunities,' resonates deeply with this study. This freedom refers to facilities

and arrangements available to uplift society. Social opportunities are put in place to promote development in the lives of citizens. Examples of this would be access to quality education and healthcare. Access to quality healthcare impacts on MHM. Homeless women lack access to quality healthcare and therefore experience obstacles to achieve effective MHM. (Parrillo and Feller, 2017). The lack of sanitary products causes homeless women to resort to the unhygienic use of items such as rags, old socks, tissue paper, paper towels, torn pieces of clothing, or diapers, to satisfy their menstrual needs (Mason et al., 2013). Alternatively, they go about life without any menstrual protection and bleed through their undergarments and clothing (Jones, 2016; Mason et al., 2013). This results in them wearing blood-soaked items for days, or even weeks (BRAWS, 2018). In addition, homeless women do not have access to safe water and sanitation facilities that are required to effectively manage your period (Aïdara, 2016). Consequently, homeless women experience health issues such as toxic-shock syndrome, discomfort, yeast infections and bacterial vaginosis (House, Mahon and Cavill, 2012). Period poverty, due to a lack of adequate MHM, hinders menstrual equity (House, Mahon and Cavill, 2012) and makes living on the streets very difficult. This is a health care injustice and more needs to be done to cater to the needs of homeless women from a health perspective. Sen (2001) argues that discriminating against women in the health system, in a manner that decreases their life expectancy, would violate fairness in the process of redistributing health services. The unhygienic products used by homeless women can result in reproductive tract infections which affect a woman's right to life and quality health (Mirro et al, 2018). Inadequate menstrual hygiene is linked to infections and a poor health-related quality of life (Sveinsdottir, 2018). This compromises the development of homeless women and the opportunities they have access to. Social opportunities, such as healthcare and MHM, are vital when it comes to promoting healthy living and avoiding premature deaths among homeless women (Sen 1999). Furthermore, these interventions contribute to a more effective participation when it comes to economic and political activities. (Sen 1999). In addition, inadequate menstrual health and hygiene management is a major public health issue that affects a homeless woman's right and capability to life and physical health (Sen 1999).

Robeyns (2003) speaks of an important capability that is relevant to this study – dignity and respect. All women (including homeless women) require adequate MHM. As mentioned earlier, when WHO/UNICEF (2012) paints a picture of MHM, it is a picture where women and adolescent girls have access to sanitary products, change sanitary products in private as often as

necessary, have access to safe water, are able to use water and soap for the washing of the body, and have access to sanitation facilities that allow for the adequate disposal of used menstrual materials. However, homeless women do not live out this ideal picture. Furthermore, homeless women experience financial hardships that make it difficult for them to buy sanitary products (Vora, 2017). The harsh realities experienced by homeless women make it difficult for them to effectively manage menstruation in a dignified manner. When it comes to homeless women, there is a lack in every area from no place to live, an absence of a safe and suitable place to maintain hygiene management from keeping oneself clean, to being unable to do laundry, or even having access to clean water and menstrual supplies. This is a health injustice that infringes upon a homeless woman's dignity and results in period poverty.

Robeyns (2003) highlights a critical capability applicable to this study - bodily integrity and safety. This capability refers to being protected from all types of harm and violence. The capability of homeless women, in this regard, is affected when they encounter violence. Research indicates that homeless women experience violence of all sorts. Makiwane et al (2010) states that homeless women encounter severe conditions that make them vulnerable to harassment, mugging, direct violence and rape. Homeless women end up tolerating abusive behaviour from males who they rely on to be able to buy sanitary products. Transactional sex is often used by women to manage their menstrual health. For example, UNICEF found that 65% of females in Kibera, Nairobi, engaged in transactional sex in order to purchase sanitary pads. This was due to the high rate of period poverty and the shame, stigma and public health misinformation associated with menstruation (Oppenheim, 2018). MHM is necessary but when it is unavailable, period poverty arises. This, then affects homeless women's access to social opportunities and compromises their right to life and physical health, being treated with respect and dignity and their right to bodily integrity and safety.

2.4. POLICY AND LEGISLATION

2.4.1. Draft Sanitary Dignity Policy Framework

South Africa has not researched the issue of period poverty and MHM in relation to homeless women. This is problematic. South Africa does, however, have a Draft Sanitary Dignity Policy Framework. This policy seeks to promote sanitary dignity. Furthermore, the policy provides norms and standards pertaining to the provision of sanitary products to indigent persons (Department of

Women, 2017). The term ‘indigent persons’ refers to the girls and women who, due to poverty, are unable to afford necessities of life such as sanitary products (Department of Women, 2017). Homeless women are part of this category of women who are unable to access sanitary products. The policy argues that access to sanitary products is important in preserving a woman's dignity during menstruation and in curbing absenteeism at school or the workplace (Department of Women, 2017). According to the policy, the lack of sanitary products may affect an indigent person's health, well-being and compromise a female’s ability to participate in daily activities such as sport and cultural events (Department of Women, 2017). This, in turn, may also negatively affect the person's self-esteem and confidence (Department of Women, 2017). Therefore, the Department of Women (2017) has embarked on the process of developing an integrated policy on the provision of sanitary products to indigent persons (such as homeless women). This is an effort to ensure that such persons are afforded the opportunity to manage menstruation in a manner that is knowledgeable, safe, and dignified (Department of Women, 2017).

2.4.2. The National Development Plan (2030)

The National Development Plan (NDP) is an economic policy framework that seeks to alleviate poverty and reduce inequality by the year 2030 (National Planning Commission, 2012). Furthermore, the National Development Plan believes that these goals can come to fruition by creating an economy that is inclusive, by actively enhancing the capacity of the state, by building the capabilities of South Africans and by promoting leadership and partnership throughout society (National Planning Commission, 2012). These policies and legislations are important, especially since this research qualitatively explores homeless women’s perceptions and experiences of period poverty in Cape Town.

However, the NDP fails to address the issue of period poverty, especially from the perspective of vulnerable groups such as homeless women. Menstrual health and menstrual justice needs to be prioritised in the NDP. Perhaps another important omission in the NDP is the lack of integration among its chapters. The Plan follows the organisational trend of vertical and compartmentalised government services. For example, health and other chapters seem to be presented in ‘silos’ (Jager et al., 2012). Since the overarching goal of the NDP is to provide a broad cross-departmental, inter-sectoral approach, it must develop a well-integrated plan (Jager et al., 2012). This plan needs to guide each department on specific policy and provide the basis for future

‘joined-up’ or collaborative governance. Furthermore, the plan needs to prioritize addressing the needs of all women, including homeless women. This is essential in order to address the inequities that have remained since 1994, and from even before that (Jager et al., 2012). The NDP needs to involve Social Work and Social Development Practitioners in eradicating period poverty. This, in turn, will advance MHM.

2.5. CONCLUSION

Homeless women encounter many health inequities and challenges that must be addressed through targeted policy, frameworks and programmes. There needs to be a holistic approach to menstruation and MHM for women who are homeless. Furthermore, provision should be made for the type of sanitary products that homeless women are most comfortable using. This speaks to the concept of choice, catering to the needs of homeless women. These concluding remarks are supported by the literature presented in this paper along with the policy and legislation.

CHAPTER THREE:
METHODOLOGY

3.1. INTRODUCTION

This chapter outlines the methodological approach adopted in the study. The research design, population and sampling, data collection approach, data collection instrument, data recording, data analysis, data verification, limitations of the study and reflexivity will be unpacked in this chapter.

3.2. RESEARCH DESIGN

This study was concerned with gathering rich data that reveals the challenges homeless women face when it comes to MHM; it unpacks how poor MHM, due to a lack of access to sanitary products, affects homeless women's perceptions of self, their perceptions of life and physical health, their sense of bodily integrity and dignity. Data that will expose how the provision of free sanitary products affects homeless women's experiences of MHM, will be provided. In order to do justice to the research topic, the study was guided by a qualitative research design. Usually, the aim of a qualitative research design is to gather how people make sense of the world and the multiple aspects of life. Qualitative research is intentional about exploring meaning, purpose and reality (Babbie and Mouton, 2001). There were more advantages than disadvantages in using a qualitative research design in this study. For example, qualitative research enables the researcher to gather data that thoroughly describes the feelings, opinions, and experiences of participants (Babbie and Mouton, 2001). Furthermore, a qualitative research design enables the researcher to interpret the meanings of the participants' actions (Babbie and Mouton, 2001). By using a qualitative research design in this study, the researcher was able to gather extensive descriptions of participants' feelings, opinions, actions and experiences regarding the experiences of homeless women and period poverty (Babbie and Mouton, 2001). Furthermore, the researcher was able to interpret the meanings behind a participant's actions during the semi-structured interviews (Babbie and Mouton, 2001). This was possible because the qualitative research design provided a platform for the subtleties and complexities of the research subjects and topic explored (Babbie and Mouton, 2001). For a study of this sort, there needed to be a holistic understanding of how homeless women in a particular setting managed menstruation. A qualitative research design has tools that allow the researcher to understand the human experience (Denzin and Lincoln, 2002). In fact, qualitative

research design is an interdisciplinary tool that accommodates various epistemological viewpoints, research methods, and interpretive techniques, which assist in understanding human experiences (Denzin and Lincoln, 2002). It was also especially important for the researcher that each participant's experience was deeply acknowledged, given that research capturing homeless women's experiences and perceptions on the topic of period poverty and MHM was rare. A qualitative research design can better accommodate the different voices, meanings and events of participants (Richardson, 2012). Examples of common qualitative methods are participant-observation, unstructured interviews and direct observation (Cohen, Manion and Morrison, 2011). In this study, the researcher collected data by engaging directly with the participants who were homeless women, through semi-structured interviews. Such an approach meant that the data collection was subjective and detailed (Rahman, 2016). Lastly, a qualitative research design allowed for flexibility (Maxwell, 2012). Considering the complexity and sensitivity of the research topic, a qualitative design approach permitted participants to have the freedom to seek clarity and explore the research questions as best as they could.

3.3. POPULATION AND SAMPLING

3.3.1. Study Population

South Africa at present does not have a national census (conducted by Statistics South Africa) that would assist in getting a numerical sense of how many people are homeless (Cross et al., 2010). According to Cross et al (2010), there are about 100 000 to 200 000 people who are homeless. There are many reasons leading one to a path of homelessness. For example, discriminatory laws that were enforced during apartheid (such as forced removals and denial of documentations) contributed to homelessness (Obioha, 2016). During apartheid, land was taken away from black people (Obioha, 2016). As a result, black people were left landless and homeless (Obioha, 2016). This disadvantaged black people, creating a pattern of homelessness and landlessness (Obioha, 2016). In as much as homelessness impacts all the different races in South Africa, there are more black people who are homeless (De Beer, 2015; Roets et al., 2016). Unemployment and low wages also contribute to homelessness in South Africa (Obioha, 2016). Last year, the unemployment rate in South Africa was 27.1% (Obioha, 2016). Unemployment is specifically high amongst young people, the black community and women (Obioha, 2016). The loss of parents or the household breadwinner are some of the factors the lead to homelessness (Obioha, 2016). With each year, the

number of homeless people continues to increase (Kok, Cross and Roux, 2010). Black (2017) noted that comprehensive surveys taken in Limpopo, Gauteng and Mpumalanga demonstrated that there has been an increase from 0.02% to 0.22% in the population of the homeless. This was the case between 1996 and 2001 (Kok et al., 2010). In the year 2015, 0.2% of the population in the City of Cape Town were estimated to be homeless (Bernardo, 2015). These findings did not indicate how many of the homeless people in the City of Cape Town were female. Previously, most of the people living on the streets were men but more recently a larger number of women had been found living on the streets (Tenai and Mbewu, 2020). When it comes to the homeless community, women and children are the most vulnerable (Tenai and Mbewu, 2020). At times, homeless women trade sex for food and other essentials such as pads (Tembe, 2015). Homeless women experience many challenges daily. For example, they struggle to find a place to sleep and often end up using public toilets as a sleeping place. Also, they have trouble finding food or employment (Naidoo,2010; Thexton, 2014). Violence and crime, either from the perspective of a victim or perpetrator, are a daily occurrence for those who are homeless (Makiwane et al., 2010; Thexton, 2014). The streets are not safe for homeless women. As a result, homeless women end up keeping close relationships with males to be protected from rape and robbery and for economic purposes (Makiwane et al., 2010; Thexton, 2014). For homeless people, drugs are easily accessible and are used as both survival and escapism strategies (Tembe, 2015; Makiwane et al. 2010). Robbery and drug trafficking are some of the survival strategies used by homeless people, including homeless women (Khoza, 2014). The South African Constitution states that every citizen has the right to access basic health (Khoza, 2014). However, for homeless women, this right is distant, vague and unattainable. The fact is that some homeless women do not even have identity documents hence making it difficult for them to receive any assistance (Khoza, 2014). For this study, the study population included homeless women located in Cape Town who are above the age of 18.

3.3.2. Sampling technique

Sampling involves the selection of a portion of the finite population being studied (Battaglia, 2011). In this study, a non-probability sampling technique was used for the selection of knowledgeable and experienced participants who helped to address the research topic (Battaglia, 2011). The type of non-probability sampling technique used in this study was purposive sampling.

Purposive sampling is a technique that is intentional about selecting participants who will be able to explain a specific theme, concept or phenomenon (Battaglia, 2011). In this case, researchers rely on their own judgement when selecting participants who can assist in meeting the objectives of the study (Battaglia, 2011). As a result, 16 homeless women, based in Cape Town, and all over the age of 18, were selected to be part of the study. Two organisations, which for the purpose of this research were referred to as Organisation 1' and 'Organisation 2, assisted in gathering participants. The assistance of the organisations made it easier for the researcher to negotiate entry into the field and successfully carry out the research.

3.3.3. Sampling procedure

To recruit participants using non-probability sampling, the researcher worked with 2 organisations that are based in Cape Town. Organisation 1 was an NPO that distributed sanitary products to homeless women on a monthly basis and was thus able to refer the researcher to potential participants. Organisation 2 was an NPO that worked with destitute women from the ages of 25 to 63. The organisation engaged with homeless women and women who had been homeless and were thus able to assist the researcher in recruiting participants. Organisation 1 and Organisation 2 played a significant role in assisting the researcher to identify and speak to homeless women as well as gain permission and consent to conduct the research. The organisations were identified using Google.

3.4. DATA COLLECTION APPROACH

3.4.1. Data collection method

Given the extent and purpose of this research, in-depth individual interviews were used to collect the data. This was chosen as the data collection method as it allowed the researcher to see and understand the research topic from the perspective of the participants (Babbie and Mouton, 2001). The interviews engaged in a low degree of structure and open questions, enabling the researcher to better understand each interviewee's situation and actions (Babbie and Mouton, 2001). The responses to the interview questions enhanced the understanding of the nature and experiences of period poverty from the perspective of homeless women in Cape Town. The interviews were done mainly in English, but also some IsiZulu and isiXhosa. The interviews were approximately 45 minutes and had a flexible and open-ended tone whereby the researcher was not restricted to

questions on the interview schedule alone. This allowed for redirection, probing, thorough and appropriate analyses of the research topic to occur. All interviews were voice-recorded using a phone, notes were taken to capture the main points, and non-verbal gestures were used during interviews (Babbie and Mouton, 2001).

3.4.2. Data collection instrument

The choice of using a semi-structured interview schedule was made so that questions could be prepared ahead of time by the researcher. The semi-structured interviews helped provide reliable and comparable qualitative data (Babbie and Mouton, 2001). The use of a semi-structured interview schedule in this study enabled the researcher and participant to stay focused (Babbie and Mouton, 2001). Demographic information, experiences of menstruation on the streets, experiences and perception of menstruation before and after the provision of pads, menstrual practice and hygiene on the streets, aspirations, identity perceptions and health were the major topics covered by the semi-structured interview schedule (Babbie and Mouton, 2001). This provided participants with the freedom to fully express their views on their own terms unlike with a survey (Babbie and Mouton, 2001).

3.4.3. Data recording

Since semi-structured interviews often contain open-ended questions and allow for discussions to diverge from the interview guide, the interviewer believed that it was best to record interviews and to later transcribe these recordings for analysis (Creswell, 2014). When implementing this data-recording strategy, the researcher paid careful attention to the setting and the research participants' sensitivities, and only recorded participants who consented (Creswell, 2014).

3.5. DATA ANALYSIS

The data analysis aspect of this study relied on both the work of Creswell (2004) and Tesch (1990). Creswell (2004) authored numerous articles and books on mixed methods research, qualitative methodology and general research design. As a result, this study made use of the six steps provided by Creswell (2004). Furthermore, the study made use of the eight steps proposed by Tesch (1990) on coding data.

Creswell's Six Steps

Step 1

Step 1 involved transcribing the interviews, typing up any additional notes made during the interviews, and sorting and arranging information (Creswell, 2004).

Step 2

At this stage, the researcher engaged with the data. The researcher made notes in the margins of the transcripts and recorded general thoughts about the data (Creswell, 2004). Furthermore, the researcher asked herself numerous questions pertaining to the research, such as, what general ideas were suggested by the participants? The researcher also reviewed the overall depth, credibility and use of the gathered information (Creswell, 2004).

Step 3

The coding of data took place at this stage. Coding is the process of organising the data by breaking down the text data gathered during data collection into categories and labelling those categories with a term. Tesch (1990) proposed eight steps to consider in data analysis. It was these eight steps that were used in forming codes. Tesch's eight steps required of the researcher to

1. Read all the transcripts carefully and jot down some ideas that came to mind (Tesch, 1990).
2. Pick one document/transcript, perhaps the one that was most interesting to the researcher, the shortest one or the one on top of the pile etc (Tesch, 1990). The researcher went through the transcript and asked herself many questions such as "what is this about?" (Tesch, 1990). The aim was not to think about the content of the information but rather the underlying meaning and write one's thoughts in the margin (Tesch, 1990).
3. Make a list of all the topics and cluster together all the similar topics (Tesch, 1990). These topics were arranged into different columns labelled major, unique and leftover topics (Tesch, 1990).

4. Abbreviate the topics as codes which were then written next to the appropriate segments of the text (Tesch, 1990). This preliminary organising scheme was used to see if new categories and codes emerged (Tesch, 1990).
5. Turn the topics into categories. At this stage, ways of reducing the total list of categories by grouping topics that related to one another, were made (Tesch, 1990). One of the strategies used to achieve this, involved drawing lines between the categories to show any interrelationship(s) (Tesch, 1990).
6. Make a final decision on the abbreviation of each category and how the codes would be alphabetized (Tesch, 1990).
7. Assemble data material belonging to each category in one place to perform a preliminary analysis (Tesch, 1990).
8. Recode, if required, the existing data. (Tesch, 1990). The eight steps used by Tesch (1990) in code formation paved the way for the successful continuation of Creswell's approach to data analysis.

Step 4:

The coding process was used to generate a description of the setting or people, as well as categories or themes for analysis (Creswell, 2004). Description involved a detailed rendering of information about people, places or events in a setting. In this study, the codes were used to generate the themes (Creswell, 2004). These themes appeared as major findings in this study and were often used as headings in the findings section (Creswell, 2004).

Step 5:

The descriptions and themes were represented in a narrative passage to convey the findings of the analysis (Creswell, 2004). As a result, there was a detailed discussion of several themes (complete with sub-themes, specific illustrations, multiple perspectives from individuals and quotations) (Creswell, 2004).

Step 6:

The final step of data analysis in this study involved making an interpretation of the findings or results. It is here that the researcher asked herself the following question: "What were the lessons learnt?" (Creswell, 2004). These lessons could either have been the product of the researcher's

own interpretation, or derived from a comparison of the findings, with information being gleaned from literature or theories (Creswell, 2004).

3.6. DATA VERIFICATION

In terms of data verification, qualitative validity refers to procedures that the researcher employs to check the accuracy of the findings (Creswell, 2014). There are a number of approaches the researcher could choose to follow, to enhance his/her ability to accurately assess the findings and convince the readers of that accuracy (Creswell, 2014).

This study relied heavily on Creswell's (2014) approach to data verification. Creswell (2014) advocated for the use of rich and in-depth descriptions to convey findings. As a result, the researcher sought to offer many perspectives on a theme (Creswell, 2014). Such effort played a role in ensuring that the results were more thorough and hence realistic than they would otherwise have been (Creswell, 2014). A procedure of this sort therefore contributed to the validity of the findings (Creswell, 2014).

Reflexivity is a core aspect of qualitative research. Good qualitative research would include comments by the researcher on how his/her interpretation of the findings might have been influenced by personal characteristics such as background, gender, culture, personal history and socio-economic context (Creswell, 2014). In this study, the researcher believed in self-reflection (as demonstrated by journaling frequently) and acknowledged the biases that she brought to the study. According to Creswell (2014), such belief and acknowledgement possess the potential to increase the study's validity.

This study also made use of peer debriefing to enhance the accuracy of the research (Creswell, 2014). An individual was located and asked to review and ask questions pertaining to the study. This was done to ensure the study resonated not with just the researcher, but with other people too (Creswell, 2014).

The process of checking transcripts to verify that no obvious mistakes were made during the transcribing process was employed, and this ensured that reliability was safeguarded (Creswell, 2014).

3.7. LIMITATIONS OF THE STUDY

3.7.1. Language

Most of the respondents spoke isiXhosa or Afrikaans as a first language while the researcher's mother tongue was IsiZulu. The interview schedule, however, was in English. This multi-lingual approach was challenging as the researcher had to translate some words from the interview schedule into Xhosa or Afrikaans., However, the researcher managed to convert some of her isiZulu terms into words that could be easily understood by isiXhosa language speakers. There were times when the participants used slang to express themselves; slang that was not familiar to the researcher. When slang was used, the researcher had to seek clarity from the participants. The researcher would ask the participants to explain the slang word used.

3.7.2. Time Consuming

The data collection process took longer than the researcher had expected. The participants were not always available at the agreed times resulting in rescheduling, which ultimately prolonged the data-collection process. Furthermore, due to the qualitative nature of the study, there were moments when participants digressed from the main issue that was being discussed.

3.8. REFLEXIVITY

During the data collection process, the researcher had to make use of a reflective journal in which, among other things, she noted her own biases and attitudes. After every interview, the researcher spent substantial time penning observations and thoughts that had arisen during the data collection process. For example, there were moments when the situations described by the participants would be emotionally heavy, she would be left feeling helpless. The researcher did not cry during the interview but when the time came to write on about it, she certainly did. This process also made the researcher more empathic and the interview process more participant-centred (Patnaik, 2013). Perhaps what made the experience more emotional was the fact the researcher came face to face with her own menstrual management privilege. Some of the questions that the researcher asked were taken from Greenaway (2010) and (Hsiung, 2008). The following are examples of these questions:

- In what manner has my personal history influenced the choice of topic?
- What are my personal value systems? What influence can my personal value systems have on the research process?
- In what way does my gender, culture and professional background impact my positioning in the research topic and my relations with the participants?

- What are the alternate roles I might be called upon to play while interacting with the participant - part from my primary role as researcher?

- What possible advantages (in terms of personal history and professional competence) do I possess?
- What barriers would my personal history and professional competence potentially create during the data-collection process?

3.9. ETHICAL CONSIDERATIONS

3.9.1. Avoidance of harm: During research, participants can be harmed in a physical and/or emotional manner (Babbie and Mouton, 2001). As a result, potential risks that could have been harmful to each participant were considered thoroughly (Dane, 1990). For example, the problem of disclosing emotional and personal experiences that might have negatively impacted on the participants' emotional health was considered (Dane, 1990). The researcher, therefore, attempted to ensure that the setting for discussing each participant's emotional experiences was safe and supportive (Dane, 1990). Due to the sensitivity of the topic of the interviews, the researcher ensured that the participants were at ease with the degree of intensity and exploration during the interviews (Dane, 1990). Furthermore, participants were made aware beforehand about the potential impact that the investigation might have on them (Dane, 1990). Such information offered the participants the opportunity to withdraw from the investigation at any time (Dane, 1990).

3.9.2. Informed consent: The participation of individuals in this study depended on their freely given and informed consent. Consent was provided in writing by the participant, accompanied by their signature (Babbie and Mouton, 2001). Provision was made for participants who might have been unable to provide consent in writing, (for example, where a participant was illiterate). In such instances, consent would be recorded verbally in the presence of a literate witness who could verify in writing, duly signed, that indeed informed consent had been obtained (Babbie and Mouton, 2001). Additionally, the participants could refuse to participate or withdraw their informed consent given earlier, at any stage of the research without giving any reason and without experiencing any penalty (Babbie and Mouton, 2001).

3.9.3. Voluntary participation: In this research participants were given the opportunity to consent to participating in the research. Put differently, the participants were given the platform to exercise their rights as autonomous persons to voluntarily accept or refuse to participate in the study (Babbie and Mouton, 2001).

3.9.4. Privacy, anonymity and confidentiality: All personal information and records provided by the participants remains confidential. When interviews were conducted, it was made clear to the participants that confidentiality and anonymity would be safeguarded (Babbie and Mouton, 2001). Furthermore, a pseudonym was used to protect the identity of each participant (Babbie and Mouton, 2001).

3.9.5. No Deception of participants: The researcher did not withhold any information pertaining to the research or offer incorrect information to the participants to ensure participation of participants when they would otherwise possibly have refused (Neuman, 2000). This ensured that participants were not deceived (Neuman, 2000).

3.10. CONCLUSION

In this chapter, the methodology of this study was addressed. A particular focus was placed on the research design, population and sampling, data collection and analysis approach, data verification, limitations of the study, as well as reflexivity. Furthermore, the main ethical considerations were unpacked in this chapter.

CHAPTER FOUR:
FINDINGS

4.1. INTRODUCTION

This chapter presents findings from interviews conducted with 16 homeless women from Cape Town. These women provided insight regarding their experiences and perceptions of period poverty. The chapter begins with a profile of participants and is followed by an in-depth presentation and discussion of the major findings of the research. Out of the sixteen, all female participants, four were in their twenties, ten were in their thirties, two were forty and above. In terms of race, the participants were either black or coloured.

4.2. PROFILE OF PARTICIPANTS

The profile of participants provides an outline of reasons why each of them landed up on the streets. Most of the participants ended up on the streets due to family-related issues. Whilst some were willing to go into depth about why they were on the streets, others struggled, or were not eager to open up.

Participant #1: Jane

> Jane is a 32-year-old who began living on the streets in 2009. She was raised by her grandmother in the Eastern Cape. Jane finished her matric in the Eastern Cape and did an Office Administration course. When her grandmother passed away, she had nowhere to go so she went to live in Cape Town with her sister who was a policewoman. When she moved in with her sister, there was tension and her sister instructed Jane to live with her cousin instead. This is when Jane got involved with the wrong crowd. In fact, she said "I was hot back in the days and went to Johannesburg. I was that person who liked things, rich boys, going up and down. I liked nice things." However, things did not go well in Johannesburg and she had to come back to Cape Town. She did not go to her sister but decided to look for a job – when she could not find a job, she ended up becoming homeless.

Participant #2: Amy

> Amy is a 25-year-old who started living on the streets in the year 2017. She is from Cape Town, her family lives in Athlone. The main reason why she ended up living on the streets was because she wanted to be more independent.

Participant #3: Sally

Sally is 36 years and began living on the streets in 2015. She decided to stay on the streets due to family issues that she was experiencing. When she was asked to share more information on the family issues, she expressed that it was too much for her. As a result, she was unable to share further.

Participant #4: Amanda

Amanda is a 29-year-old from Maitland, Cape Town. She described Maitland as a rough area with many gangsters. As a result, she decided to live on the streets. For her, the streets are a place she can call home. She started living on the streets in 2015.

Participant #5: Faith

Faith is 26 years old; she has not been living on the streets for too long - she comes and goes. She does this because she has a child at home living with her grandmother; her mother passed away. Her boyfriend also lives on the streets.

Participant #6: Joy

Joy is 37 years old and comes from Bedford West. She came to Cape Town where she'd found a job, but this was when she began going to clubs and going out often. Eventually, she lost her job and started living on the streets. When asked how long she had been homeless – she responded by saying "yoh! many years."

Participant #7: Patience

This participant is 35 years of age and has been homeless for a year now. She is a widow as her husband passed away 3 years ago. She experienced abuse from her family; she was sexually abused by her uncle. As a result, she ended up taking drugs, heroin and tik, to be specific. Thereafter, she started sleeping on the stoop of a Congolese couple- she would have to be up at 7:30 am, as was the arrangement. According to her, she felt safer on a stranger's stoop than in her family's own backyard.

Participant #8: Sthandiwe

This participant is 32 years of age and has been homeless since 2011. In 2011, she decided to become a Rasta, but her mother did not support this decision. She also began smoking ganja [cannabis]. After a traumatic experience with her boyfriend, she began taking other drugs. Subsequently, she lost her job and began living on the streets.

Participant #9: Nicole

Nicole is a 25-year-old who has been living on the streets for a couple of years, she was unable to state the exact number of years. She stated that curiosity is what landed her on the streets. She is also a mother; her child currently stays with her (Nicole's) own mother.

Participant #10: Lerato

Lerato is 31 years of age. When asked what led her to live on the streets, she answered by saying "I did not run away to the streets for nothing, there were heavy issues at home that I could not handle. Therefore, I decided to live on the streets since 2010". She is originally from Cape Town and has 2 daughters. The last time she saw her daughters was in 2018. Her children live with their paternal grandmother. Lerato's parents passed away. She started living on the streets due to the heavy issues she was facing at home. She kept emphasizing that she did not run away to the streets for nothing.

Participant #11: Enzokuhle

Enzokuhle, 34 years of age, has been living on the streets for most of her life. When asked to elaborate further on how she ended up on the streets, she said, "life happened."

Participant #12: Sibongile

Sibongile is 35 years of age and has lost count on how many years she has been homeless. She said various circumstances led to her being on the streets but she was unwilling to unpack these circumstances any further.

Participant #13: Fatima

Fatima is from Cape Town and has been homeless for a very long time; she cannot recall the number of years she has been homeless. She also states that 'life events' led her to the streets. She was 37 years old in 2019.

Participant #14: Cindy

Cindy is a 32 year old female from Cape Town who has been homeless since the age of 16 due to family problems.

Participant #15: Sandy

Sandy is from Cape Town. She is 40 years old and has been homeless for 3 years. She says this is due to major issues she had with her family.

Participant #16: Hopeful

This participant, Hopeful, is 51 years of age and has been homeless for 28 years. She has two children whom she gave birth to whilst living on the streets. Her children live with their grandparents.

4.3. EXPERIENCES AND PERCEPTION OF MENSTRUATION

Participants were asked to share their experiences of their first period. This was important in order to get a sense of the feelings associated with their initial period, and to establish what played a significant role in their lives during this time. Menstruation happens to a female but there are various individuals, teachings, involvements and factors that shapes a female's understanding and experience of menstruation. A female's initial experience of menstruation is one of the factors that inform how she goes on to perceive it.

4.3.1. Experience of the first period

The participants indicated that their initial period took them by surprise. As a result, they felt confused, scared, anxious and restless when they had their first period. Most of the participants had their initial period between the ages of 12-15 years. It was interesting to note that many of the participants had a clear memory of the initial period, it was still fresh in their mind even though many years had passed. Perhaps, a female's initial period (which signifies a transition to adulthood) is unforgettable for many menstruating females.

> *I remember it like it was yesterday. I was on holiday in P.E. with my granny. I was playing and all my cousins were boys. We were playing by the beach. I saw blood and sat there the whole day. I wondered what I was going to say when I got home, what was my family going to think. I went home. When I was at home, my granny kept asking 'what is that smell?'. I sat there and said, 'I don't know'. Then my mother came asked what is wrong. She had seen the blood stains. She took me to the shower and asked, 'what is this?' I told her what happened, and she asked 'why did not you come to me? Why didn't you come to wash?' It was very scary. I was scared. I was very young, I was 12 (Enzokuhle, 34, Coloured).*

> *I was 15 years old; I was on the train with my sister's friend. Khona into ethi wulukuhlu [there is a heavy discharge I am feeling]. She told me to get up. I heard her say 'Yoh sis!' [She was shocked]. That is when I saw the blood. She took the towel she used to carry her child and said I must sit on it. Luckily, I was wearing black. When we got off the train, she used the same towel to wipe off the droplets of blood. My sister's friend was older than me. When I saw the blood, I was restless. Yoh!!!!!..I did not know what was going on because even when I was told to bath, the blood would not stop flowing [we both laugh]I did not understand why I was bleeding because I did not even get cut by a glass. My sister gave me the pad and I kept asking and wondering 'what is this?' They told me how to put a pad on, but I kept saying 'izophuma nje lento!' [this thing is going to fall out]. I wondered when this would be over! When the blood would come out, you would feel it, it would be warm.*

Yoh! As a child, you do not know what is going on. It was stressful, confusing and traumatic since I was a child (Lerato, 31, Black).

Many of the participants associated their first period with feelings of confusion, anxiety, stress and fear. These emotions were one of the factors that shaped the participants' understanding and experience of menstruation moving forward. Studies indicate that 66 % of girls are clueless about menstruation (Mooijman et al., 2010). As a result, when they had their first period – it was likely be a very negative and anxiety-arousing experience (Mooijman et al., 2010). A study conducted in Turkey revealed that 64.2% of the participants perceived their menarche as an unfavourable experience (Cevirme et al., 2010). Furthermore, 48.8% of the Turkish participants felt they had to keep the fact that they are menstruating a secret, and 2.2% perceived menstruation as a punishment from God (Cevirme et al., 2010).

4.3.2. Conversation about the first period

It was not only emotions that shaped these women's understanding and experience of menstruation but also what was said to them. The conversations had when participants had their first period, happened mostly with immediate family members (mother, granny, sister), individuals who were close to the family (sister's friend) and teachers. When educating their daughters on menstruation, most of the mothers of the participants instructed them to stay away from boys.

The first time I got mine was in school. I was very young, I was 13. The teacher asked me what is wrong? I told her there is blood coming out. Luckily, it was a female teacher. If it were a male teacher, I would have been so embarrassed. So, she told me that my body is changing, I am having my period now and she went into detail regarding what I should do and that it will happen every month. She took me to a room and showed me how to put the pad on. I asked her what I should tell my mommy, the teacher told me that my mom knows and will explain further. I did not come to school the next day because of the strong cramps. My teacher was very understanding (Fatima, 37, Coloured).

Ja, I was 14. I was in standard 6 when it happened. I was at school but my mother told me about periods, that this is going to happen and here is a pad but when I got home I was scared to tell her that it has started but eventually I told her it has happened. She then told me that I must not have boyfriends [laughs] (Sthandiwe, 32, Black).

I was 13. I was not feeling well. My mother was not there. At that time, the older people did not talk about this. It was not taught at school too. We only learnt in High School. When

my mom got home, I told her that there is blood. She explained to me and went on to say 'I must stay away from boys' (Sibongile, 34, Coloured).

Mothers perhaps gave such instructions out of fear of their children getting pregnant. The initial menstrual experience had an impact on how the participants viewed menstruation from adolescence throughout adulthood and how they educated others, including their daughters on menstruation. The participants acknowledged that the adolescent years were a good time to provide females with knowledge about the changes that happened in their bodies and what good menstrual hygiene practices were comprised of (United Nations Educational, Scientific and Cultural Organisation, 2014). Indeed, menstrual health education is an important factor in achieving menstrual equity and gender equality. Menstrual health education needs to be made available to parents, caregivers, teachers, principals, community leaders, who are both male and female (United Nations Educational, Scientific and Cultural Organisation, 2014). If these measures are effectively put in place, it would assist women (including homeless women) to better navigate and manage their menstruation, and society would be in a better position to support homeless women. Such information would help decrease the stigma and secrecy attached to menstruation.

4.4. DISCUSSION OF FINDING

Table 1: Framework of Analysis

THEMES	CATEGORIES	SUB-CATEGORIES
Challenges in Menstrual Hygiene Management (MHM) before provision of free sanitary products.	Lack of access to soap and water	Recycling water
		Bathing in water
		Washing in public toilets and under bridge
		Inconsistent supply of soap
	Lack of privacy	Having to change pads in front of men
		Having to wash in front of men
	Rely on unhygienic methods	Using cloths
		Using newspapers
		Using rags
		Using towels
		Using toilet paper
Lack of Access to Sanitary Products, Poor MHM and Perceptions of self.	Sense of inadequacy	Menstrual accidents
		Keeping 'menstruation' a secret
	Lack of confidence	Scared to ask for money to buy pads
		Odour during period
Lack of Access to Sanitary Products, Poor MHM and Perceptions of Life and Physical Health.	Alcohol and substance abuse	Use of heroin, tik, mandrax, crystal meth
		Keeping warm
		Coping mechanism
		Curiosity
	Develop strategies to feed addiction	Theft
		Staying in unhealthy relationships
		'Skareling'
		'Mince-ing'
Lack of Access to Sanitary Products, Poor MHM and Sense of Respect.	Being bullied	Going to police station to avoid harm
		Males take advantage
	Interaction with males	Depending on males for protection
		Men take chances
Lack of Access to Sanitary Products, Poor MHM and Sense of Bodily Integrity.	Vulnerable to different forms of violence	Emotional abuse
		Physical abuse
		Sexual abuse
	Uneven power dynamics	Escaping harm
		Rape
Lack of Access to Sanitary Products, Poor MHM and Perceptions of Opportunities.	Innovation	'Skareling'
		'Mince-ing'
	Inability to gain employment	Begging
	Turning over a new leaf	Resilience
		Defining moments

Experiences of MHM After Provision of Free Sanitary Products.		Pursuing change
	Suggestions for 'Organisation 1' and 'Organisation 2'	Cosmetics
		Clothes and blankets
		Medical
		Sanitary interventions
		Government and healthcare interventions

Table 1. above presents the Framework of Analysis that depicts the themes, categories and sub-categories that emerged from the interviews, and were guided by the research questions. The following section presents a detailed discussion of the findings linked to each theme.

4.4.1. Challenges in Menstrual Hygiene Management (MHM) before provision of free sanitary products

Participants were asked to share the challenges they faced when it came to MHM, before the provision of free sanitary products. The sentiments expressed by the participants indicated that homeless women did not have access to soap and water, lacked privacy and relied on unhygienic methods to manage their respective periods.

4.4.1.1. Lack of access to soap and water

One of key challenges faced by the participants was the lack of access to an adequate supply of water when on their respective periods. Participants would make use of the nearby dam, water under the bridge, public toilets, or make use of a bucket with water, to keep clean during their period. In addition to a lack of access to water, participants struggled to get soap.

> *We shower at the dam next to River Club. My boyfriend and I would wash together and change clothes daily. We would hustle for clothes by checking the dustbins. When we found clothes, we could change right there on the spot-next to the bin in which we found the clothes. We would put the dirty clothes in the bin. Some people wash their clothes, but it is those who live under the bridge. Other try to wash by using public toilets (Jane, 32, Black).*

> *I wash there where I am staying, under the bridge, sometimes under my blankets and it not nice especially in the winter… it is cold, and you are painful. At times, you do not have soap. Most of the time you skarel [hustle, you are on a mission] for things to survive. Sometimes I do not have pads and use towels. The towels make you get hurt. Especially when we do not have pads. Sometimes it is the panty I like that gets messed. Sometimes, you have to use a towel. You feel baie [very] terrible because you want to go somewhere*

and cannot walk properly because of the towel. Sometimes you must ask your friend if you have not messed yourself. We use buckets to wash our panties and if people steal the buckets, we use 5L cans and ja [yes] (Joy, 37, Coloured).

I wash by using a bucket and go somewhere where we (homeless people, men and women) can wash where there is water. To prevent the odour that I get when I am on my period, I wear tights underneath. I put the pad right through so that the pad does not move around. One pack of pads is normally not enough. I would like a pad that absorbs the blood longer so you can wear it for longer (Sandy, 40, Coloured).

The participants often had to rely on getting soap from organisations, such as Organisation 1 and Organisation 2. These unhygienic and inconvenient MHM practices are common amongst poor menstruating females, such as homeless women, making it difficult for them to meet their daily and menstrual needs (Das et al., 2015). According to Caruso et al (2016), the inability to access water, sanitation and hygiene resources to address bodily needs is a greater challenge for women than men. This is because menstruating females, homeless or not, have a greater need for a consistent supply of water, soap and sanitation facilities to take care of their personal hygiene (Stevenson et al, 2012; Wutich and Ragsdale, 2008; Fisher, 2008). One of the consequences of an inconsistent access to water and sanitation facilities is that it can impact a women's life and health and lead to increased psychosocial stress, urinary incontinence and constipation, maternal mortality, and preterm birth (Stevenson et al, 2012; Wutich and Ragsdale, 2008; Fisher, 2008). Such consequences can have an impact on a homeless woman's quality of life and physical health, thereby putting her at risk of getting infections such as those of the reproductive tract (Baker et al., 2017). Hygiene practices such as how often a woman bathes; douching; having access to a cloth to clean the vagina; quality of bathing water; absorbent material used during menstruation, have all been identified as risk factors for self-reported and diagnostically-confirmed vaginitis (McClelland et al., 2008; Bhilwar et al., 2015). An inadequate access to water, soap and sanitation facilities has an impact on menstruation, specific vaginal hygiene behaviours. This, in turn, can have a negative impact on the participants quality of life, physical health and potentially lead to chronically unhygienic vaginal conditions (Anand, Singh and Unisa, 2015; Hulland et al, 2015).

4.4.1.2. Lack of privacy

Participants expressed that they did not have access to privacy when menstruating. Such a situation put them in a position where they would change pads in front of men or wash in front of men.

> *There were times when my pads or menstrual items would get full and I had to rush to the station to wash. Take the panty off and wash. Or I would go to the market and ask for the lady to give me a key to the toilet. At times, I had to show her how I messed myself before she gave me the keys. At time she would think I am doing drugs when all I am doing is trying to wash and clean up after having an accident on my period (Patience, 35, Coloured).*
>
> *You need feminine items such as pads. A place to also bath in peace, privately. I would buy myself pads. I did not ask my boyfriend to buy it for me. However, when I did not have money, I would use newspaper when on my period. To prevent not getting an 'accident', I made sure I was sober always during that time of the month. If you are not sober you are most likely to mess yourself and not change your pad. I would be sober for 5 days (Jane, 32, Black).*

The lack of sanitary products and facilities made it difficult for the participants to effectively manage their respective periods. Changing sanitary products was something that the participants were not comfortable doing in front of men but felt like they had no other choice since they were homeless. The process of managing one's period as a homeless woman, can be an extremely humiliating process. For example, the participants often had to show how badly they were bleeding in order to get assistance. Such an experience is not only unfair but denies effective MHM from being carried out. One of the requirements of MHM is privacy and the participants did not have any privacy to attend to their menstrual needs. If public hygiene and sanitary facilities are introduced to cater to the needs of homeless people, these facilities must be created with homeless women in mind too. These facilities must allow women to have the privacy to wash and change their sanitary products in private, even in communal wash facilities (Sommer, Schmitt and Clatworthy, 2017). For example, discreet drainages should be installed in bathing or laundry spaces so that water with menstrual blood cannot be seen outside the unit (Sommer, Schmitt and Clatworthy, 2017). Furthermore, there should also be privacy when drying menstrual items such as reusable pads, underwear and cloths (SNV, 2015). Sunlight is required to fully dry menstrual items before use, but limited space and a lack of privacy make this a challenge for homeless women, in general (SNV, 2015).

4.4.1.3. Relying on unhygienic methods

To manage their menstruation, participants would make use of unhygienic methods. For example, participants used newspapers, cloths, rags, towels and toilet paper.

> *There was a lady who used to come around by Masikane, where we bought drugs, to give us pads but she gave everyone a goodie bag with pads, soap and a chocolate or packet of chips. If you did not get her, you had to go without. That is when I would use towels. My cousin used to work at a towel factory so she would give me pieces of rags to use. Sometimes I would use my panties until I could get R10 to buy a packet of pads (Patience, 35, Coloured).*

> *I used newspapers. We didn't have towels, so I used newspapers but sometimes the newspaper cuts. I would walk funny when I got the paper cut from the newspaper due to being on my period. If I make the newspaper too thick it was a problem, it I made the newspaper too thin it can leak. I rather made it thick even though it cut my thighs. My friends would know when I said 'paper cut'…they would be like, okay, she is coming from periods. Ja! I did not mind using pads. I love them (newspapers). At least I had something. For me it was better than toilet paper. Toilet paper is dangerous. It becomes like powder and goes inside of you and washing … I used to go to the beach. I was always a beach girl. I did the whole Atlantic. I lived close the beach (Sthandiwe, 32, Black).*

> *Before the organisation started giving us free pads, we would use the newspaper or toilet paper. Alternatively, you take a portion of your clothes…tear it up…and use it as a pad. You re-use that old rag when on your period (Lerato, 31, Black).*

Homeless women cannot afford sanitary products and as a result, they end up using potentially harmful materials such as toilet paper and newspaper as substitutes. They also do not have facilities to dispose of used materials. This matter is further compounded by the fact that homeless women end up using dirty water to clean soiled clothing items. Such circumstances can lead to reproductive tract infections, such as urinary tract infections, yeast infections, and vulvar contact dermatitis (Parrillo and Feller, 2017). From a Capability Approach perspective, the use of unhygienic materials such as rags, toilet paper, newspapers, cloths and towels affect each participant's social opportunities. The lack of access to quality healthcare resources to partake in hygienic menstrual practices, has an effect on the development of menstruating females and their ability to engage in various social activities (Hennegan et al., 2019).

4.4.2. Lack of Access to Sanitary Products, Poor MHM and Perceptions of self

When asked to share how poor MHM, due to the lack of access to sanitary products, affected the participants' perceptions of self, various responses arose. Most of the respondents mentioned that they often felt inadequate, unworthy and lacked confidence.

4.4.2.1. Sense of shame and inadequacy

One of the common sentiments expressed by the participants was a deep sense of inadequacy. The inadequacy was provoked by incidents that (had) happened while living on the streets. An example was experiencing a 'menstrual accident' and the resulting fear of homeless men finding out that a participant was on her period. Most of the participants felt that menstrual accidents or having to ask men for money to buy pads, was humiliating and made them feel inadequate.

> *Accidents (during period) have happened to me. I remember a time when I was sitting in the front entrance, as I usually do, asking for money. I was wearing a jean skirt. When I got up, I saw the blood. A man told me that I have blood stains. Yoh! I was so felt small. He was not loud about it though. He told me quietly. When I saw the blood, I wondered what other people might have thought of me. I went to get water and cleaned myself and acted as if nothing happened, but I was afraid to go back to my begging spot. I was so small in that moment. Yoh! Amahloni angakanani! [I was very ashamed]. Amahloni ami aqinile [I was extremely ashamed] (Lerato, 31, Black).*

> *It is hard to get right pad that suits you, for the night one, the one that will make sure you do not wet the bed. Well, it is not nice. Sometimes I have to go hustle to buy the pads and run to one of your laanies [good friend] to help me. You do not want to say in front of the man that it is that time of the month because this is a woman thing. If you ask for money (so that you can buy pads), the man will want to know what the money is for? It is difficult. It is humiliating. You feel small, incompetent, lacking, especially in front of the man (Cindy, 32, Coloured).*

In both scenarios, the participants highlighted that they felt small, incompetent, lacking. In other words, they felt inadequate. The narratives also revealed how homeless women aimed to keep menstruation a secret from homeless men. As a result, they put much effort into ensuring that homeless men did not see any trace of evidence they were on their period. The process of asking for money to buy pads or experiencing a menstrual accident made participants feel small. In many contexts, including those in which homeless women find themselves or come from, menstrual blood is seen as dirty and polluting and associated with feelings of social discomfort, inadequacy

and shame (Lahme, Stern and Cooper, 2016; McMahon et al. 2011). The participants of this study had to deal with the monthly shame they felt when on their respective periods. Reproductive shame is a term that refers to feelings of inadequacy, embarrassment, unworthiness and self-consciousness that women experience during reproductive events such as menstruation (Hawkey et al. 2017). In this study, the participants were afraid of experiencing menstrual stigma. Menstrual stigma occurs when the visibility of menstrual blood is seen as embarrassing or extremely shameful (Sanabria, 2011; Masuku, 2015). Although menses is in fact a normal physiologic process in menstruating females (Chang, Hayter and Wu, 2010), there is still a culture of concealment, shame and guilt associated with this healthy process. The culture of concealment or 'menstrual etiquette' creates the notion that menstruation should be kept private, even in female-only environments (Costos, Ackerman and Paradis, 2002; Ramathuba, 2015). Perceiving menstruation as shameful, dangerous and polluting leads to 'menstrual stigma' and negatively impairs how women experience their bodies, and how they perceive themselves (Johnston-Robledo and Chrisler, 2011). One of the key issues for MHM is the high level of fear and shame that girls and women face (UNFPA, 2017). Across settings and studies, menstruation is overwhelmingly associated with feelings of shame and distress, and should a woman's menstrual status be revealed, it results in menstrual stigma and intense fears of shame (Sommer, 2009; Crichton et al., 2013; Mason et al., 2013). Menstrual stigma affects a women's dignity.

4.4.2.2. Lack of confidence

The participants also indicated that poor MHM, due to the lack of access to sanitary products, affected their confidence and lowered their self-esteem.

> *My boyfriend does not want to talk to me when I am on my period and that affects my confidence. Also, there are very bad times when I do not have pads, so I wear the panty and after 5 minutes go and check and change and wash again. This also affects my confidence. I could not use toilet paper because of the rash it gives. I have used a towel, but you have to check every 5 minutes and you are scared it might fall off because it is not sitting well. It is not a nice feeling (Fatima, 37, Coloured*).

> *When I get my period, he (boyfriend) tells me to stay away because I stink. They (men) sometime say your mouth smells when you are on your period. And when I smell my breath when on my period, it does smell. This lowers your self-esteem (Sibongile, 35, Coloured).*

The lack of sanitary products and facilities experienced by homeless women had a negative impact

on their confidence, self-esteem and ability to be open about such a natural process (Scheff, 2003). This, in turn, affects a women's confidence, dignity and self-esteem (Fischer, 2018). In society, homeless women are already stigmatised, marginalised and alienated (Barrow and Laborde, 2008; Connolly, 2000; Gustafoson, 2011). Clearly, in the absence of MHM, it is not only the health of the women that is compromised, but their dignity. Such instances hinder the move towards gender equality. A failure to acknowledge the menstrual hygiene needs of menstruating females, such as homeless women, fosters gender inequality even more (Das, 2017).

4.4.3. Lack of Access to Sanitary Products, Poor MHM and Perceptions of Life and Physical Health

The harsh realities of experiencing poor MHM, lacking confidence and self- esteem, experiencing shame and menstrual stigma, created a situation where the participants relied on drugs and alcohol to try and escape what was happening to them. Some of the drugs used by the participants included tik, heroin, mandrax and crystal meth. Many of them developed strategies to feed their addiction. These strategies include 'skareling' (hustling by taking items to the scrapyard in exchange for money), recycling, theft and 'mince-ing' (finding items to sell).

4.4.3.1. Alcohol and substance abuse

The homeless do engage in drug and alcohol abuse to keep warm; to numb the pain that comes with being homeless; as a coping mechanism; out of curiosity and as a tool to escape their trauma and lack. This study was able to unpack the fact that the lack pf sanitary products and sanitation facilities are one of the tragedies homeless women try and escape from by using drugs and alcohol.

> *I stayed with my son's father. When we met, I was smoking crystal meth and he was only smoking mandrax [a sedative drug containing methaqualone and diphenhydramine hydrochloride]. As the relationship continued, he began to use mandrax and crystal meth and I began to use crystal meth and mandrax. That is how the relationship went for 6 years. It was also an abusive relationship up until I decided enough is enough…when I saw what it did to my mother, my son and me. I was curious to feel what is this drug that everyone is talking about. I want to feel it too. My ex-boyfriend worked every day, so he bought the drug and we smoked together. He never bought me pads. I was suffering and drugs were my escape. Every time my mum saw me … she would wonder "what happened to my daughter?!" Every time she saw me …she would cry and then the guilty feeling would come*

and then I was no! I did not want this. My son could have been taken away by the social workers BECAUSE of the environment we were in. (Nicole, 25, Coloured).

On the streets, you drink alcohol and take drugs to keep warm and forget your problems. We fight under the influence of drugs and alcohol. Using drugs is the way of life when on the street. As a woman, you also have your own problems you want to forget. (Jane, 32, Black).

For the homeless community, living on the streets is difficult. According to Martins (2008), the homeless community, including homeless women, resort to abusing drugs and alcohol in order to sleep, feel numb and escape the pain and experiences that come with being homeless. There are many challenges that must be dealt with such as getting food, keeping warm, finding a shelter for the night. Other difficulties include dealing with poverty, rejection and abandonment issues. As a result, drugs and alcohol are frequently used as a coping or escape mechanism. For homeless women there are additional challenges that they face which are different from the difficulties men face. For example, homeless women are at a higher risk of experiencing mental health problems and health issues such as injury and sexually transmitted diseases, including HIV (Frencher et al., 2010; Nyamathi et al., 2000). Furthermore, there are times homeless women experience greater difficulty gaining access to resources such as shelters and health care (Ponce, Lawless and Rowe, 2014). This form of lack played a role in the participants engaging in alcohol and drug abuse and using it as an escape or coping mechanism. Substance abuse, by homeless women, is a coping mechanism that can have a negative impact on their health. Substance abuse is higher among homeless women than housed women (Summer, 2016). Homeless women end up consuming all sorts of substances to cope with their trauma, lack of MHM resources and harsh realities (Yeater et al., 2010). These factors have a negative effect on their quality of life and physical health. Life and physical health are one of the 14 capabilities listed by Robeyns (2003); they are as important in the life of a woman as in achieving gender equality.

4.4.3.2. Developed strategies to feed addiction

As mentioned, the participants used drugs and alcohol as an escape mechanism. Poor MHM experiences seemed to be among the memories they wanted to forget. In order to have a continuous way to ‘escape’ or feed their addiction, the participants generated different ways to get alcohol and drugs. The major approaches used included skareling, mince-ing, theft and recycling.

My kids never knew I was on drugs until I took R20 from one of my daughters. It was her taxi money. She had invited me to visit her, that's when I stole from her. I took the R20 at 6 am, bought drugs and got the fix and returned it at 6:30 am. I gave it back. That's when my kids hated me. That hurt me. I just wanted to be free, it is tough as a woman. Then I got caught by the police, possession of drugs. I spent 4 months in jail and got 3 years outside sentence. I came out and was clean for 4 months in jail and 4 months outside. I used to take heroin and would take tik here and there. I started living on the streets because I experienced abuse from family and the loss of my husband. I was sexually abused by my uncle. The uncle did not want to stop his ways.
(Patience, 35, Coloured).

To feed our addiction, we *skarel [hustle]. This is a word used by those who live on the streets. It refers to hustling by going to look for things in the dustbins or taking copper, steel, white paper and taking it to the scrapyard. You then get money from taking these items to the scrapyard and then use the money to buy drugs. My boyfriend taught me all of this. Where he would go, I would go to! [laughs]. You smoke the drug, get high and then the high goes and you become paranoid but you forget your problems. Then you keep chasing it. Drug dealers also target homeless people. For them, money is money at the end of the day (Jane, 32, Black).*

To survive…I would go to the mince-ing. That what we called it. When the garbage bins would come out …we would go to Camps Bay, Clifton, Greenpoint and search for items to sell…like clothing, cellphones. Sometimes we would not find anything to sell. Then we would look for food but sometimes the food is all rotten but there would always be soup kitchens. So I fell over to recycling. I would make more or less R50 a day. If it was a nice day, I would make R80 but I would smoke it. Smoking made me escape. With the money, I would buy bread, go to soup kitchen and smoke the rest. I was based in Greenpoint, next to the traffic department on the road leading to Waterfront. I would push my trolley and collect stuff to take to the scrapyard (Sthandiwe, 32, Black).

It was interesting to note that some of the participants were taught by their boyfriends how to hustle and survive on the streets. However, when it came to wanting assistance regarding their period, the males were often not willing to assist. Menstruation was perceived as a 'woman' thing. For homeless women, the reality of being homeless is more devastating and severe when compared to homeless men, as the needs of homeless women and men are not the same. For example, homeless women need sanitary products, they need to be protected from men who would want to take advantage of them, (this applies to both men who are homeless and those who are not). The conditions for women to have her period are inadequate and many have to rely on other methods, such as newspapers, to manage their respective periods (Summer, 2016). Furthermore, in comparison to homeless men, homeless women encounter many health inequities such as not

having their menstrual needs met. Homeless women experience stress, smoking, sleep deprivation, exhaustion and poor nutrition at higher levels than women with housing (Summer, 2016). Homeless women also experience higher rates of mental health issues; about two-thirds have tried to kill themselves, compared to the general population (Summer, 2016). Others suffer from post-traumatic stress disorder after experiencing abuse, such as physical and sexual abuse (Summer, 2016). It is not surprising that the average death of homeless women is 43 years, an age that many of the participants are fast approaching (Summer, 2016). The reality of being a woman and homeless is horrific and requires targeted policy and programming. It is no wonder homeless women develop strategies to maintain their drug and alcohol dependence; they are trying to escape the daily struggles they face, which include MHM struggles.

4.4.4. Lack of Access to Sanitary Products, Poor MHM and Sense of Respect

The participants indicated that because they were female or happened to menstruate monthly, they were seen as weak and were vulnerable to being bullied. The researcher noticed that older homeless women, often at menopausal age, had more authority and were respected more than their younger counterparts. When organisations delivered sanitary products to homeless women, menopausal women would also take the pads. The researcher was informed that menopausal women sell the pads to other homeless menstruating females in need. They proceed to sell the pads at a lower price than at the shops and use the money to buy drugs and alcohol. At times, it is the menopausal women who threaten and bully the menstruating females into giving them the delivered pads. In the process, menstruating females feel disrespected.

4.4.4.1. Being bullied

The participants were bullied and mistreated by men (mostly homeless men). In order to protect themselves, most of them would flee to the police for refuge. Interestingly, homeless women needed to have something that would give them an advantage over men for them to escape being bullied.

> *Nizazithengisa. Niyazithengisa. Ungaba laleli abantu. Iza apha ndixukelele. Iza! Ungabalaleli abantu, they will sell eziPads [You sell pads. You sell pads. Do not listen to these people. Let me tell you something. Come! Do not listen to these people, they will sell*

the pads]. I drink a lot of alcohol. That is my problem. Also, I run away from disrespectful people who have no humanity. I learnt my sense of humanity in the Eastern Cape. I used to get beaten up by a cane by my teacher in school. I was taught respect (Hopeful, Black, 51].

You see that lady that got free pads, the old one, she is going to sell it because she drinks and as she is standing there…she is already drunk…and the other one that you were talking to…they will sell it. It's not right because there are younger girls who need it. It is not right …Me?!! Never! I would never sell pads. If I have, I give to someone else. If give my pads to my boyfriend to keep them safe so they are not sold (Amanda, Coloured, 29).

. There are occasions when menopausal women steal pads from menstruating females and sell them. Consequently, some of the participants have learnt they must keep their pads in a safe place or else the pads might be taken and sold. The money made from selling pads is frequently used for purchasing drugs and alcohol. Makiwane et al (2010) states that homeless women encounter severe conditions that make them vulnerable to different kinds of harassment, mugging and bullying. These acts are often never reported to the police (Daly, 1996). The work of Robeyns (2003) speaks of an important capability that is relevant to this study: respect and dignity. Being bullied, mistreated and becoming a victim of theft when one's sanitary products are stolen, infringes on the rights of menstruating homeless women, who should be treated with respect and be able to have their respective periods in a dignified manner.

4.4.4.2. Interactions with males

To survive living on the streets, the participants used various methods. Some of these methods included being in a relationship with a feared and respected homeless man. Being associated with someone like this gave a homeless woman an advantage. However, it took away their power too as they had to depend on the man. Alternatively, participants did business, which, at times, included transactional sex with men (homeless or not), in order to survive. The money from these interactions was used for various things such as buying food, drugs and to meet their menstrual needs (for example, buying sanitary products).

It is hard being a woman and living on the streets. What helped me was that I ended up dating someone who was a boss on the streets. He was older, matured. more powerful, knowledgeable about the streets and how to survive on the streets. He taught me the tricks. On the Streets you can be raped. When my boyfriend and I were fighting, and I was sleeping alone, men would come and want to take chances. The streets are unsafe. To survive and

> *feel safe, take care of myself, buy things for myself such as pads, I would have to go to him. I ended up depending on him. You become a slave. I did put my trust in him because he is a man and was protective. When I was with him it was hard (Jane, 32, Black).*
>
> On the streets, *you would end up being approached by men passing by with their cars; they would say that they want to do business with me. It was difficult. It is not safe because boys like to take their chances on you. (Lerato, 31, Black).*

These women engaged in different interactions with males to survive. The participants were not only trying to survive physical harm or gain respect, but they were also trying to gain financial assistance that would allow them to manage their menstrual needs. Being a homeless woman can be disempowering, especially when you must associate yourself romantically with someone in order to gain respect. However, for many of the participants, that was their only option. Frequently, these men (homeless women became involved with), were regarded as powerful by other males in the homeless community; they were usually older, more knowledgeable, and had been homeless for longer. Homeless women ended up depending on these men for protection, for income to buy basic needs (such as pads) and to be respected. In the process, these men treated the homeless women as slaves, making the women depend on them heavily. In such instances, there was often an infringement of the participant's right to respect as the homeless man felt like he owned the woman. Alternatively, there was the option of doing business, which at times included transactional sex, with men (homeless men) in order to survive. In this particular situation, the homeless woman's sense of respect was also breached, as the male customer felt entitled to do whatever he wanted with the woman since he was paying. In both cases, women depended on men to gain income that would enable them to gain access to sanitary products, food and drugs (for those who did drugs). In both cases, a woman's sense of respect and dignity could be, and was often violated. This, in turn, could impact on a woman's mental health and general health. Dladla and Vetten (2004) argue that homeless women who have been abused in their relationships, are most likely to continue being in abusive relationships because they depend on their male partners for income to meet their basic needs, which include their menstrual needs. There appears to be a complex interconnection that exists between homelessness, vulnerability, lack, abuse, mental health and general health (Summer, 2016). According to Summer (2016), a significant number of homeless women who were abused as children suffer from low-self-esteem and mental health problem and these issues contribute to their finding themselves in abusive relationships during adulthood. Consequently, one in five women who (have) suffered from pervasive abuse are

homeless, twenty times more likely than those who have not been extensively abused (Summer, 2016). This intersectionality of abuse, vulnerability and homelessness has large adverse implications for both mental and physical health and requires careful policy and programming that provides not only recovery, but also much-needed stability and security (Summer, 2016).

4.4.5. Lack of Access to Sanitary Products, Poor MHM and Sense of Bodily Integrity

Homeless women stated that the poor MHM conditions they were experiencing did not gain them empathy from homeless men. In fact, such conditions made them more vulnerable to different forms of violence, such as physical abuse, emotional abuse and sexual abuse. Secondly, it exposed them to uneven power dynamics which put them at risk of being constantly raped and harmed. Such could occur during their menstrual periods. Circumstances of this nature affect a woman's bodily integrity.

4.4.5.1. Vulnerable to different forms of violence

The participants experienced different forms of violence living on the streets: physical abuse, emotional abuse and sexual abuse.

> *I get nervous on the streets…You know why? Because I come from abuse. When I was 7 years old, my mother passed away. I had to stay with my uncle and aunt. My uncle used to call me into the bedroom and out on porn movies and say I must touch him. I used to say I am going to call my aunty. I never did, I said that to scare him off. I would lock myself in my room. I had daily chores and I would do everything fast before he came back from work. He was a big manager. He was evil. But the vicious cycle went on, the uncle did the same thing to my kids as well.* E*ventually his son-in-law did it to his children. So, the vicious cycle did not stop. What I am trying to say is that when I went to the SAPS they laughed at me. I am scared of this on the streets. Even on our period,* t*hey(males) want to have sex and sleep with us. There are sex perverts out there (Patience, 35, Coloured).*

> *I had to cut up clothes when on my period…Even though my boyfriend worked 7 days a week. He was very stingy with money. I had to every month cut clothes to use as a pad. Even though I had a boyfriend that works 7 days a week. He did not buy food. Even if he bought nappies, he would buy the smallest pack, but he got paid over R800 a week. Those small nappies would not even last a week. So, I would cut clothes, towels and use as a nappy. Until the day I went to go and get a social grant. I would use the money to buy nappies and my 2 packets of pads. I did not keep the social grant card, I would give it to my mum because I knew he would intimidate me, abuse me (physically and sexually), to use the social grant to buy drugs (Nicole, 25, Coloured).*

A majority of the participants experienced a great deal of abuse in their respective lifetimes. The abuse was mainly from men who violated homeless women while they were on their period. At times, these were the very same men who were unwilling to support the participants in acquiring resources that would enable them to effectively manage their menstrual health. This exposes the Gender-Based Violence that exists in South Africa. Further discussions need to be had about how a woman's menstrual health can be affected by various violations, such as physical and sexual abuse. Women generally feel unsafe in South Africa, and it is worse for homeless women who are more vulnerable to violence. One of the participants highlighted that, even when she is having her period, males want to have sex with her. It would seem that homeless women tolerate abusive and unfair behaviour in the hope that the males will give them money that will enable them to buy food and other items, such as sanitary products. As mentioned earlier, in instances where they are unable to get money to buy sanitary products, homeless women resort to using old rags, newspapers, towels etc. This form of lack affects a woman's right to bodily integrity and safety (Robeyns, 2003). The study of Dladla and Vetten (2004) revealed that the physical abuse that homeless women experienced included slapping, kicking, punching to stabbing and breaking bones. Even though a homeless woman may want to leave an abusive relationship, she struggles to leave because she's unemployed (Dladla and Vetten 2004). Without family support, self-esteem, resources (such as sanitary products), nor financial assets, it becomes impossible to escape the violence (Dladla and Vetten, 2004).

4.4.5.2. Uneven power dynamics and survival strategies

Participants highlighted the uneven power dynamics that existed in the homeless community. Homeless women often find themselves in situations where their lives are threatened, where their power is taken away, where their voices are not heard. In the process, they are stripped off their bodily integrity. The streets are an unsafe place for homeless women.

> *I saw a lot of things happen at night. There were times where I would see people breaking into cars. They would see my face and I would see their face. As a result, I would have to go find another stoop or place to sleep or else I would be harmed (Patience, 35, Coloured).*

> *I would literally get beaten up and woken up in the middle of the night when I was bleeding and on my period when I refused to have sex. I was beaten up and forced to have sex with*

my child's father. There were times where I would wake up and he is already doing it and I would be beaten up. I was raped a couple of times (Nicole, 25, Coloured).

Due to the uneven power dynamic, homeless women experience different forms of violence i.e. physical, sexual and emotional abuse. It is important to note that these violations can and have occurred during participants' menstrual periods. Sexual violence seems to be a major issue that homeless women face. The study of Wenzel et al., (2000) revealed that homeless women are at risk of being raped more than once in a year. They are more likely to have functional physical health limitations, report gynaecologic symptoms and conditions and other physical health conditions (Wenzel et al., 2000). These different forms of violence not only affect a homeless woman's bodily integrity and safety but also their quality of life and physical health. Research indicates that interpersonal violence and other traumas negatively affect the quality of life of homeless women (Sacks et al., 2008; Stein et al., 2002). A study conducted by Christensen et al., (2005) revealed that 100 % of homeless women reported having experienced a trauma such as physical or sexual abuse. Psychiatric and behavioural health concerns among homeless women have been known to the research community for decades (Schenck, 2017).

4.4.6. Lack of Access to Sanitary Products, Poor MHM and Perceptions of Opportunities

When asked how poor MHM, due to a lack of sanitary products, affected their perception of the opportunities they had, many of the participants said they were unable to work when on their period. The lack of sanitary products and poor MHM made them want to stay in one place in case they had a menstrual accident. As a result, they preferred begging when on their period. Other participants acknowledged as it was difficult to find employment, they engaged in skareling and mince-ing. All the participants acknowledged that the opportunities they had as homeless women were limited.

4.4.6.1. Innovation

To survive living on the streets and be able to buy sanitary products, the participants engaged in a process of skareling, mince-ing and recycling. The money received from performing these activities was used for various things such as buying drugs, food and sanitary products.

To survive…I would go to the mines-ing. That what we called it. When the garbage bins would come out …we would go to Camps Bay, Clifton, Greenpoint and search for items to sell…like clothing, cellphones. Sometimes we would not find anything to sell. Then we would look for food but sometimes the food is all rotten but there would always be soup kitchens. So I fell over to recycling. I would make more or less R50 a day. If it was a nice day, I would make R80 but I would smoke it. I would buy bread, sometimes pads, go to soup kitchen and smoke the rest. I was based in Greenpoint, next to the traffic department on the road leading to Waterfront. I would push my trolley and collect stuff to take to the scrapyard (Sthandiwe, 32, Black).

We skarel [hustle]. This is a word used by those who live on the streets. It refers to hustling by going to look for things in the dustbins or taking copper, steel, white paper and taking it to the scrapyard. You then get money from taking these items to the scrapyard (Jane, 32, Black).

Skareling and mince-ing are very popular in the homeless community. They are used to survive and buy various items such as food and sanitary products for women. The participants did not have easy access to shelter, clothing, healthy food, toilets, showers, washers, refrigerators, stoves or medical cabinets, which are considered essentials (Martins, 2008). To survive, many ended up engaging in piece jobs (Olufemi, 2010). Piece jobs, mince-ing and skareling, enable homeless women to get money to buy food and sanitary products. However, the money is not enough for them to buy healthy food that will strengthen their respective immune systems. Additionally, homeless women tend to lack a hygienic environment when on their periods. The reality is that poor MHM causes period poverty. All these factors affect the health of homeless women. Due to their typically weak immune systems caused by poor diet, homeless women often suffer from diseases such as hypertension or diabetes (Martins, 2008). Due to an inability to access healthy food and medication, their illnesses worsen (Martins, 2008). According to Hwang (2001), a lack of access to health care services is a major obstacle faced by the homeless community, and this obstacle is further compounded by the fact that many homeless people have lost their identity documents. The loss of their identification (identity books/cards) makes it difficult for them to find permanent employment.

4.4.6.2. Inability to gain employment

Many participants expressed that they were unable to find employment because they were homeless. As a result, they resorted to begging. The assistance gained from begging was used for

various things such as buying food and sanitary products. For these participants, poor MHM and the lack of sanitary products limited their opportunities.

> *I sit all day and beg. The only time I get up is when I have to go pee. So, I worry when I have been sitting for too long (Lerato, 31, Black).*

> *Getting money gets affected when on my period. It is difficult to beg even. When you beg we ask, and they give us or if little I buy bread for something to eat to survive. The lack of pads affects the opportunities you have access to (Joy, 37, Coloured).*

It was interesting to find that when it came to begging, the participants feared that they would have a menstrual accident. This appeared to be a consistent factor with the participants. In addition, participants indicated that the lack of sanitary products affected the opportunities they had.

For example, some participants would not go begging when menstruating. Participants highlighted that they preferred to not engage in most activities when on their period. This resonated with the work of Long et al (2013), who found that women and girls tended to alter their movements and participation socially when having their period. Furthermore, researchers have found that women and girls restricted doing activities such as running or other sports during menses (Garg, Sharma and Sahay, 2001; Parker et al., 2014).

4.4.7. Experiences of MHM After Provision of Free Sanitary Products

Participants were asked to share their experiences after receiving free sanitary products and assistance from Organisation 1 and Organisation 2. Participants also provided suggestions that might be helpful for Organisation 1 and Organisation 2.

4.4.7.1. Turning over a new leaf

The stories shared by the participants revealed their resilience. There were notable defining moments that made homeless women desire and pursue change.

> *I was homeless a few kilometres from where I work now*
> *[She went on to show me a video which captured how she looked whilst living on the street. In that video, she had no teeth. She showed me the spot she sat on for years as a homeless lady.]*

Initially, I did not want help. When you know who you are, and you are detoxing and want to be 'normal again' -I had to be serious and intentional about rehabbing myself. I did not want to involve people. What triggered the desire to change was…I woke up one morning and did not want this life anymore. This was in 2013. I was not happy. The people surrounding me had made the streets their life and weren't willing to turn back. For me, I knew this was not my life. I cannot live on the streets forever. Therefore, I began deleting the boyfriend, the drugs and alcohol, and dealt with myself. I rehabbed myself for 3 years. I began to volunteer at a certain organisation. I would watch their cars and clean. They then had a meeting and decided what they were going to do to help me. They began by putting a chair outside for me to sit comfortably. This one day, I came to volunteer and my chair was stolen [laughs].
During this time, I am planning on making my life better. This is when I began asking for help. I allowed them to take me to Loaves and Fishes for further rehabilitation.
The people at the organisation I volunteered at would give me pads or send me to buy food for myself. I would use the company cards and give them receipts. I feel happy and I am proud of myself and I want to help those who cannot help themselves (Jane, 32, Black).

I was living in Greenpoint, next to the traffic department on the road leading to Waterfront. I would push my trolley and collect stuff to take to the scrapyard. I remember passing by the Radisson hotel and an Indian man gave me a voucher. I did not know what it was, so I put it in my pocket. At night, I read it and it was a voucher (from an organization that helps the homeless) and I had seen a store they have in long street-it has food and items of clothing. I was like, tomorrow…I am going there. When I got there, I saw a girl and a boy, and I showed them the voucher. They told me I cannot buy with a voucher here, they accept cash…I would need to go to the rehab center in Claremont. There was a map behind the voucher. The girl and boy from the store told me I need to go there. get rehabilitated and get the food and item of clothing, they explained that they once used to be like me, they said they used to sell and smoke drugs. I looked at the clothes I wanted but could not buy [laughs]. But I walked out so inspired and imagined myself wearing black and white clothing like them and now I work there with them. I attended everything provided by the organization that helps the homeless and now I work there. I wanted to change because I always tired of smoking drugs, but I did not know how to get out and go home. When I heard of rehab places, they were places that paid thousands and thousands, and I was like no. I wanted to get out, but I did not know how. The voucher was my ticket to get out. BUT I did not go to Claremont Immediately. I went to Claremont maybe after 3 weeks and at that time my friend has stolen my voucher. But I went there without the voucher and explained everything. They said no problem and helped me, gave me food and clothes. That was the start of the rehabilitation. Yoh! I am so glad! I am so glad to be where I am! Even if sometimes the addictive mind wants to overcome the rational mind. On the streets if you did not feel like waking up and pushing your trolley, you could do that and sleep the whole day without food. You did not have rules and regulations. Sometimes that addictive mind comes but I fight it and say no! no! no! because where you are coming from was like hell. When I see the other people still there it hits me that I was also like them, I was also there on the streets. When you are the streets you see it as normal but now when I see the situation of those on the streets, I can see that they are suffering and making themselves suffer. I used to be like that too. I was there until I went to get help and I have never looked back.

If I tell myself I want to go back to the streets, then just know that this is me wanting to die. BECAUSE there is death, it is hell and I was on the verge of dying because I was smoking non-stop and not eating and I was so thin. My stomach would cramp up because of hunger but I would not buy food. Instead I would by drugs. When I had mommy, I would buy drugs. Maybe I would buy 2 slices. The people would come to borrow the pipe and I would smoke drugs. Going forward, me, I want to have my own store and have a move around festival and sell stuff that I make -shirts, t-shirts, upgraded takkies and stuff (Sthandiwe, 32, Black).

The defining moment for me, I think, it was last year March/April. I was smoking without eating. I feel ill for 2 weeks, laying in the shack. Nobody knew. My son was dirty. I could not lift myself up and take care of my son. I could not do anything. Every time my boyfriend came back, he would just yell at me without realizing the amount of pain I was in. I cannot clean or take care of myself. I would call for someone to take care of my son or have them call my mum and she would take care of my son. In the 2nd week my mum realized that something was wrong. That was basically my eye opener because when I laid in that bed I prayed to the Lord to deliver me from the drug addiction because this is not the life I know and not the life I want my son to know. Even if people remind my son that mummy was a drug addict but he must say 'but I do not know her like that' so that was my motivation …my mum and basically myself…I didn't want to live like that anymore. I feel good of the progress I have made. I am more confident because I used to have a low-self-esteem. I look better than what I was looking back in the days. When I go back to my mum now it is tears of joy. I really want to thank God whose grace is so sufficient in my life. I have come very far. I am on anti-depressants and sleeping tablets- I went to the doctor recently and he is also very impressed with my progress.
When I think about my future, I see myself in my own place hopefully, dream job as an IT Specialist and a good husband. And ja, I want another baby also. A girl. I have a boy already (Nicole, 25, Coloured)

The resilience demonstrated by the participants was moving to witness. To let go of unhealthy behaviours, the participants invested a lot into changing their lives around. Some of these involvements included letting go of toxic relationships, changing their lifestyles, being productive and receiving help from various individuals. The provision of pads was an empowering process that made the participants feel 'seen' and 'cared for'. As a result, the researcher argues that the provision of sanitary products should be the norm for all homeless women; they should always have access to adequate MHM facilities. There is a need to develop policy that is gender-sensitive and that responds to the needs of women. For this to happen, policy makers must consider the diverse and complex needs of all homeless women (Savage, 2016).

4.4.7.2. Suggestions for 'Organisation 1' and 'Organisation 2'

The suggestions made by the participants touched on various things ranging from cosmetics, clothes, blankets, medical, sanitary to government and healthcare interventions.

> *I do not have the energy to work. I am sick. You can see me. I have lost weight. Look at how I am. I do not know what to say. I am tired. I do not have the energy to work at all. They (the government) must help me with what they can (Lerato, 31, Black).*

> *I do not think they(government) is doing enough. They may be doing 50% but it is not 100% The sisters, for example, in the clinics do not give 100%. The sisters for example do not explain thoroughly about contraceptives. For example, I am on a 3-month injection. I was explaining to my fellow ladies that I was on the implant. When I was on the implant, I would get my period but then I removed it and am on the injection. I do not get my period now and I do not know why? Or what is causing that?! So where is the blood going? The sisters rush everything. They do not tell you what will happen, they are not thorough (Fatima, 37, Coloured).*

> *Perhaps 'Organization 1' can also go to prisons? I heard on the radio that female inmates on, get 4 pads. That is, it, only 4! In that sense, the government is not playing a role in helping women who are in jail and have menstrual needs (Sibongile, 35, Coloured).*

The feedback from these women needs to be noted and perhaps partnerships need to be formed to address and support the multiple needs of homeless women. For example, organisations that help homeless women with sanitary products could also form partnerships with those in the area of mental health, providing clothes, job creation, rehabilitation, etc (Homeless Ink, 2017). Considerations could be made in involving homeless women in the design, delivery and evaluation of services tailored to them (Homeless Ink, 2017).

4.5. CONCLUSION

This chapter presented findings from interviews conducted with 16 homeless women from Cape Town. The participants were able to share their experience and perceptions regarding Menstrual Hygiene Management. The chapter began with a profile of participants and was followed by an in-depth presentation and discussion of the major findings of the research.

CHAPTER FIVE:

CONCLUSIONS AND RECOMMENDATIONS

5.1. INTRODUCTION

This qualitative study explored the experiences and perceptions of period poverty among homeless women in Cape Town using the Capability Approach. The study focused on unpacking the challenges homeless women faced when it came to poor MHM, i.e. before the provision of free sanitary products. The study investigated how poor MHM, due to lack of access to sanitary products, affected homeless women's perceptions of self, perceptions of life and physical health, sense of respect, sense of bodily integrity, and the perception of opportunities they believed they had access to. Lastly, the study determined how the provision of free sanitary products affected homeless women's experiences of MHM. This chapter summarises the findings and provides recommendations that can be implemented to resolve some of the issues highlighted in the paper.

5.2. SUMMARY OF THE MAIN FINDINGS

5.2.1. To unpack the challenges homeless women face when it comes to Menstrual Hygiene Management before the provision of free sanitary products.

One of key challenges faced by the participants was that they did not have access to an adequate supply of water when on their respective periods. Participants would then make use of dams, water under bridges, public toilets, or use water in a bucket in order keep clean during their respective periods. Participants struggled to get soap and lacked the privacy required to manage their menstrual needs. To manage their period, participants would make use of unhygienic methods. For example, participants used newspapers, cloths, rags, towels and toilet paper to manage their menstrual needs. These unhygienic methods had an impact on each participant's quality of life and physical health.

5.2.2. To determine how poor Menstrual Hygiene Management, due to a lack of access sanitary products, affects homeless women's perceptions of self.

One of the common sentiments expressed by the participants was a deep sense of inadequacy. The inadequacy was provoked by incidents that happened when living on the streets, for example, experiencing a 'menstrual accident' and the fear of homeless men finding out that they were on their period. Most of the participants felt that menstrual accidents or having to ask men for money to buy pads were humiliating things which made them feel inadequate and unworthy. Since the participants did not have access to sanitary products, they relied on items such as toilet paper, towels and their panties. These items, however, were not as reliable as pads or tampons, for example. In addition, they did not receive support from their boyfriends. Such factors had a negative impact on their confidence, self-esteem and ability to be open about such a natural process. It affected how homeless women experienced their bodies and how they perceived themselves. As a result of both coping with poor MHM and the lack of sanitary products, participants were intent on keeping their period a secret.

5.2.3. To investigate how poor Menstrual Hygiene Management, due to lack of access to free sanitary products, affect homeless women's perceptions of life and physical health.

The participants revealed that they drank alcohol and took drugs such as tik, heroin, mandrax and crystal meth for many reasons. One of the reasons included the fact that they wanted to keep warm, to numb the pain that came with being homeless, another reason for booze and drugs was that they were used as coping mechanisms; yet another reason was out of curiosity and/or as a tool to escape their trauma. To survive on the streets and feed their addiction, the participants engaged in activities such as skareling (hustling by taking items to the scrapyard in exchange for money), recycling, theft and mince-ing (finding items to sell). It was interesting to note that some of the participants were taught by their boyfriends how to hustle and survive on the streets. However, when it came to wanting assistance regarding their periods, the males were often not willing to assist. Menstruation was perceived as a 'woman' thing. The reality of being homeless and female was more devastating and severe when compared to homeless men, as the needs of homeless women and men were not the same. For example, homeless women require sanitary products, and

they need to be protected from those men want to take advantage of them, (this applies to both men who are homeless and those who are not). The conditions for homeless women to manage their respective periods are inadequate and many have to rely on other methods, such as newspapers, to manage their periods. These are some of the health inequities that homeless women are faced with.

5.2.4. To unpack how poor Menstrual Hygiene Management, due to lack of access to free sanitary products, affect homeless women's sense of respect.

The participants were bullied and mistreated by men (mostly homeless men). In order to protect themselves, most of them fled to the police for refuge. Being a homeless woman can be disempowering, especially when you must associate yourself romantically with someone in order to gain respect. However, for many of the participants, that was their only option. Often the men homeless women associated themselves with were regarded as powerful by other males in the homeless community, were older, more knowledgeable, and had been homeless for longer. Homeless women ended up depending on these men for protection, income and respect. In the process, these men treated the homeless women as slaves, such that the women depended on them heavily. In such instances, there is often an infringement of the participant's right sense of respect as the homeless man feels like he owns the woman. Alternatively, there was the option of doing business, which at times included transactional sex, with men (homeless men) in order to survive. In this situation, the homeless woman's sense of respect was also breached as the male customer felt like he could do whatever he wanted with the woman since he was paying. In both cases, women depended on men to gain income that would enable them to gain access to sanitary products, food and drugs, (for those who do drugs). Also, in both cases, a woman's sense of respect and dignity could be violated. This, in turn, could negatively affect a woman's mental health and general health. There appears to be a complex connection that occurs when it comes to homelessness, vulnerability, lack, abuse, mental health and general health (Summer, 2016).

5.2.5. To understand how poor Menstrual Hygiene Management, due to lack of access to free sanitary products, affects homeless women's sense of bodily integrity.

The participants experienced different forms of violence living on the streets such as physical, emotional and sexual abuse. For many of the participants, they also experienced abuse when they were younger and/or before they began living on the streets. Participants also highlighted the uneven power dynamics that existed in the homeless community. The homeless women often found themselves in horrific situations where their lives were threatened, where their power was taken away, where their voices were not heard. At times, participants tolerated abusive behaviour in the hope that they would get some sort of protection and money to buy food and sanitary products. In the process they were stripped of their bodily integrity. The streets were an unsafe place for homeless women. These different forms of violence and uneven power dynamics not only affected a homeless woman's bodily integrity and safety, but also her quality of life and physical health.

5.2.6. To determine how poor Menstrual Hygiene Management, due to a lack of access to free sanitary products, affects homeless women's perception of opportunities they believe they have access to.

Many of the participants said they were unable to work when on their period. The lack of sanitary products and poor MHM made them want to stay in one place - in case they had a menstrual accident. As a result, they preferred begging when on their period. The participants also expressed that they were unable to find employment. To survive, the participants engaged in skareling, mince-ing and recycling. The money received from performing these activities was used for various things such as buying drugs, food and sanitary products. All the participants acknowledged that their opportunities, as homeless women, were limited. and that poor MHM and the lack of sanitary products limited their opportunities even further.

5.2.7. To determine how the provision of free sanitary products affect homeless women's experiences of Menstrual Hygiene Management

The stories shared by the participants were heartfelt and revealed the resilience that these women had. It was interesting to see that there were specific defining moments that made homeless women desire and pursue change. The participants also provided suggestions to help Organisation 1 and

Organisation 2 improve their performance. The suggestions touched on various things ranging from cosmetics, clothes, blankets, medical, sanitary to government and healthcare interventions.

5.3. RECOMMENDATIONS

Period poverty refers to a lack of access to sanitary products due to constraints that are of a financial nature. WHO and UNICEF (2012) define Menstrual Hygiene Management as having access to clean materials that allow for the absorption and collection of menstrual blood when on your period. MHM also requires that women and adolescent girls have the necessary privacy to change sanitary products as often as they desire; being able to wash their bodies with soap and water as often as they like and having facilities that are convenient for the disposal of used materials (Tull, 2019). Menstrual health education is also an important aspect of MHM. In other words, women and girls need to have access to information about their menstrual cycle and how best to handle their cycle with dignity and not fear or discomfort (Tull, 2019). Put differently, policy should ensure that all women, including homeless women, have access to free disposable menstrual products (Tull, 2019). Improved MHM helps achieve Sustainable Development Goal 4, (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all), Goal 5 (Achieve gender equality and empower all women and girls), and Goal 6 (Ensure availability and sustainable management of water and sanitation for all) (UNDESA, 2015). The provision of menstrual products and hygiene facilities that accommodate the needs of women can help increase women's participation and empower women (WSSCC, 2016).

<u>Recommendations to curb the MHM issue faced by homeless women.</u>

From this research, it has become clear that sanitary products are not the only item homeless women lack in order to experience menstruation in a dignified manner; homeless women also need warm, safe spaces, clean underwear, clean water, clothing, and medication to help ease any pain they might experience. The provision of these resources could help ease the discomfort felt by homeless women. In addition, gender-sensitive policy and practice should be implemented. Initiatives to educate and raise awareness about period poverty and how it affects homeless women must take place. Such efforts would assist in destroying the taboos associated with menstruation and ensure that women are not negatively impacted on when having their periods (Vora, 2017).

Having dialogues, conversations and holding awareness campaigns could help de-stigmatise menstruation and the use of sanitary products. Open, honest and educational conversations could help create a society where women are free to publicly acknowledge their periods (Rosa Fund, 2019). When this happens, the deprived will no longer have to suffer in silence (Rosa Fund, 2019). Also, the results from the study could help improve the South African Draft Sanitary Dignity Policy Framework

The issue of period poverty, amongst homeless women, requires polices and responses that are multifaceted (UNCHS, 2000). When it comes to the issue of homelessness, there is little research on best-practice models on sustainable, multifaceted policies and responses to homelessness, even though the UNCHS (2000) has provided guidelines. According to Cross et al. (2010), South Africa does not have any policies or consensus on how to effectively deal with the issues of homelessness in South Africa. A study conducted by Sanchez (2010) revealed that it was mostly faith-based organisations in Johannesburg and Pretoria that assisted the homeless, which included providing shelter, assistance in finding jobs, food, healthcare and counselling. Furthermore, Sanchez (2010) argued that in as much as these organisations had a good understanding of the complexity of being homeless, and rendered valuable services to the poor, these organisations did not offer sustainable structural solutions that provided opportunities to exit conditions of poverty and homelessness (Richter et al., 2012). As a result, to effectively address the issue of homelessness, multifaceted, multidisciplinary, long-term structural changes are needed to be prioritised and implemented (Richter et al., 2012; Sanchez, 2010). The UNCHS (2000) acknowledged the complex nature of addressing homelessness and proposed holistic, policy-driven processes.

Studies have revealed that most homeless women suffer from untreated physical and mental-health problems. According to Petersen (2016), the main reason why women end up being homeless can be classified into two categories; the first involves the use and effects of drugs, alcohol, prostitution and mental illness. The second category involves a loss of independence and self-sufficiency due to physical illness, job loss, house fire and/or eviction. There is a strong need to provide MHM resources, continuous training and support to organisations and structures that support homeless women (Chamberlain et al., 2007; Johnson et al., 2008; Rayburn et al., 2005; Tually et al., 2008; Wenzel et al., 2000). Social Work and Social Development Practitioners can

play a role in providing MHM support and resources. Educational assistance (focussing on sexual and reproductive health) must also be provided to homeless women (Hennegan, 2019). In addition, homeless women require access to free counselling, especially those involved in substance abuse and/or those who have experienced abuse, violence and trauma (Winkler, 2014). Support is required from all industry leaders (Winkler, 2014). For example, there needs to be intense support from physicians, a global public health initiative, focused on helping all women - particularly those who are poor and homeless (Winkler, 2014). There is a need to eliminate the financial burden experienced by women, all over the world, when it comes to the purchasing of pads (UNFPA, 2017). Menstruating females, including homeless women, should have easy access to free menstrual products (UNFPA, 2017). The free sanitary products should be adequate, safe, effective in controlling leaking, odour, offer comfort and provide dignity (UNFPA, 2017).

Homeless people, in general, lack regular healthcare services compared to the general population (Summer, 2016). This makes access to healthcare services a major challenge, including access to routine screening and treatment programmes (Summer, 2016). This lack of access to healthcare causes homeless women to live with medical issues (such as Reproductive Tract Infections) due to poor MHM, until they worsen. As a result, homeless women find themselves in the emergency department of hospitals more often than women who have homes (Summer, 2016). Furthermore, there is a lack of information on the plight of homeless women, including data that specifically explores the health of homeless women (Summer, 2016). There is a need to have more comprehensive and up-to-date research and data on the topic, in order to develop effective policy and programming that will deal with the issue of increased homelessness among women, and the issue of period poverty amongst homeless women (Summer, 2016). Furthermore, homeless women need to be educated and supported when pregnant (Little et al., 2005). This is due to the fact that homelessness during pregnancy brings about, and increases the risk of birth complications, low birth weight, and nutritional or substance abuse related physical and neurological effects on newborns (Little et al., 2005). Irrespective of the age of the mother, homeless mothers often report suffering from depression and stress as well as post-traumatic stress disorder and comorbid mental disorders (Meadows-Oliver, 2002; Tischler, Rademeyer and Vostanis, 2007). Homeless women also tend to consume high rates of alcohol during pregnancy which can have neurological effects on the child, and cause fetal alcohol spectral disorders, for example (Chapman et al., 2007; Stanwood and Levitt, 2004). Homeless women also engage in

substance use during pregnancy, which increases the risk of miscarriage (Chapman et al., 2007). A holistic approach towards homeless women, however, would assist in accelerating MHM interventions, improving the life and physical health of homeless women and in making strides towards gender equality.

Future research should explore the experiences and needs of various populations such as migrants, refugees, those with disabilities, and transgender, queer, and non-binary menstruators (Tull, 2019). This requires an intersectional approach to menstrual health by exploring how, for instance, income interacts with race, ethnicity, age, and needs across the life cycle (Tull, 2019).

The National Development Plan (NDP) is an economic policy framework that seeks to eliminate poverty and reduce inequality by 2030 (National Planning Commission, 2011). Put differently, the NDP aims to ensure that all South Africans attain a decent standard of living through the elimination of poverty and reduction of inequality (National Planning Commission, 2011). The core elements of a decent standard of living identified in the NDP are:

- Housing, water, electricity and sanitation;
- Safe and reliable public transport;
- Quality education and skills development;
- Safety and security;
- Social protection;
- Quality healthcare;
- Employment;
- Recreation and leisure;
- A clean environment;
- Adequate nutrition.

The positive aspect about the NDP is that it offers a long-term perspective and framework for development (National Planning Commission, 2011). However, not enough attention is paid to the homeless, and in this case, homeless women. There is a need for the NDP to acknowledge that period poverty exists and should be rectified in South Africa. However, for that to happen there must be a linkage established between what is done locally, provincially and nationally, as it relates to the goals of the NDP. Different stakeholders can play a role in ensuring that the goals of the

NDP come to fruition. (This should include the goal to eliminate period poverty amongst homeless women). For example, local, provincial and national stakeholders need to collectively engage in detail with aspects of the NDP that relate to core local, provincial and national priorities, and identify specific proposals that can be implemented immediately (National Development Plan, 2020). These stakeholders need to pay greater attention to the quality of management within departments and ensure that public servants are both challenged and supported so that they can contribute fully to the work of their departments, strengthen administrative relations between local and provincial departments and their national counterparts (National Development Plan, 2020).

Citizens need to commit to collectively formulating ways of combating the rife issues that South Africa faces, as a nation, which should include period poverty. Also, local, provincial and national governments should make use of solid monitoring and evaluation mechanisms (National Development Plan, 2020). In other words, there is a need to introduce comprehensive and effective monitoring and evaluation systems that feed back into refining the NDP (National Development Plan, 2020). It is such goals that will contribute to ensuring that the goals of the NDP become a reality. This, in turn, will assist in improving the lives of many South Africans, particularly those that are homeless, poor and come from poor households and communities (National Development Plan, 2020). Homeless women should not be neglected, and their needs should be prioritised too.

5.4. CONCLUSION

The chapter began by proving a summary of the main findings. The research objectives played a big role in how the main findings were summarised and organised. Thereafter, the chapter provided recommendations that could be implemented to resolve some of the issues highlighted in the paper. Some of the recommendations made in this chapter catered to the menstrual needs of homeless women, and included raising awareness on menstrual health, providing menstrual education to both men and women, providing free sanitary products and access to quality sanitary facilities, and the development of policies and frameworks.

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7. APPENDIX

7.1. CONSENT FORM

UNIVERSITY OF CAPE TOWN

DEPARTMENT OF SOCIAL DEVELOPMENT

RESEARCH TOPIC:

A Capability Approach to Examining the Experiences and Perceptions of Menstrual Hygiene Management (MHM) Among Homeless Women in Cape Town

NAME OF PRINCIPAL RESEARCHER(S):

……

PARTICIPANT'S INVOLVEMENT:

• I agree to participate in this project.

• I agree to these results being used for education and research on condition my privacy is respected.

• I understand that I am under no obligation to take part in this project and that a decision not to participate.

• I understand I have the right to withdraw from this project at any stage.

Name of Participant/Guardian:

……

Signature of Participant/ or Guardian (if under age 18):

……

Date:

……

7.2. RESEARCH INSTRUMENT

SEMI-STRUCTURED INTERVIEW GUIDE:

A Capability Approach to Examining the Experiences and Perceptions of Menstrual Hygiene Management (MHM) Among Homeless Women in Cape Town

INRODUCTION

My name is ……. and I am conducting research on…….
Discussion on ethical considerations, voluntary participation, audio recording of the interview, anonymity and confidentiality.
Clarification that there are no "right" or "wrong" responses.

DEMOGRAPHIC INFORAMATION

What is your name?
How old are you?
When did you start living on the streets?
What happened that led you to living on the streets?
How is it to be a woman that lives on the streets?
How do you survive as a woman living on the street?
What needs do you have as a woman that differ from needs of men on the street?

EXPERIENCES AND PERCEPTION AROUND MENSTRUATION

What is your understanding of menstruation?
Who first spoke to you about menstruation?
Where did this conversation take place?
How did you feel when this conversation was taking place? Did you have any thoughts during this conversation? If so, what were those thoughts?
Tell me about the day you got your first period?
How old were you?
How did you feel?
What did you use once you started bleeding?
Who was the first person you told? What did they say?
What are your thoughts regarding menstruation?
How does it make you feel to talk about menstruation right now?
Do you feel ashamed when you get your period?
Do you think being a woman on the street and lacking sanitary products affects you emotionally? mentally? Socially?
If so, what makes you say that?

EXPERIENCES AND PERCEPTIONS OF MENSTRUATION ON THE STREETS BEFORE PROVISION OF FREE SANITARY PADS

Please share your experience of being on your period when on the streets?
What did you use when on your period?

How did the lack of sanitary products affect your life on the streets?
How did the lack of sanitary products affect your perception of self and your dignity?
How did the lack of sanitary products affect the opportunities you want or believe you should have access to?
Do you get cramps and/or vomit when on your period? How do you deal with that when homeless?
Have you had a menstrual 'accident' when you were on your period? How did you deal with that? Did you get assistance? If so, from who?
Where and how do you dispose the item used when on your period?
How do you wash when on your period? How often?
How long do you wear the sanitary product when on your period?

EXPERIENCES AND PERCEPTIONS OF MENSTRUATION AFTER PROVISION OF FREE SANITARY PADS

What were your initial thoughts when you first heard about the work being done by 'Organization 1' and/or 'Organization 2' initiative regarding the provision of free sanitary pads?
What are your current thoughts regarding this initiative?
How has the provision of free sanitary pads affected your life?
How has the provision of free sanitary pads informed your perception of self?
How has the provision of free sanitary pads informed the opportunities you believe to have access to?
Is the provision of free sanitary helpful to your health?
-If so, in what way?
-If not, what makes you say that?
What do you like about this initiative?
What do you dislike about this initiative?
How would you improve this initiative?
How did other homeless women respond to this initiative?
How did homeless men respond to this initiative?

CLOSING

Thank you for spending time with me.
Is there anything that you want to know before we wrap up?
How has the interview been for you?