



Women and girls in remote Indigenous Australian communities: cultural, financial and knowledge barriers to menstrual hygiene management

Hall N (2018)

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Suggested citation

Hall N (2018) Women and girls in remote Indigenous Australian communities: cultural, financial and knowledge barriers to menstrual hygiene management. *HealthBulletin* 18(2).

Abstract

Objective: This article specifically reports on barriers to menstrual hygiene management issues and associated needs within remote Indigenous communities in Australia.

Method: Seventeen qualitative interviews were conducted with representatives from key organisations providing water, sanitation and/or hygiene to three or more discrete, remote communities in four states and territories of mainland Australia.

Results: Menstrual hygiene management (MHM) was raised as one of several health-related hygiene issues of concern. A combination of an apparent lack of knowledge, products and facilities is contributing to girls not attending school for several days each month during menstruation. This is caused by cultural issues of ‘shame’ around the topic of menstruation, limited provision of MHM in the school’s health education program and health clinic engagement, and high costs for feminine hygiene products. This situation is exacerbated by overcrowding in homes that affects the functionality of hardware for washing and privacy.

Conclusions: Within the context of the United Nations’ Sustainable Development Goals, these findings indicate that Australian Indigenous girls and women in remote locations are not able to attain aspects of the Sustainable Development Goals (SDGs) for health and wellbeing (SDG 3), gender quality (SDG 5), and water, sanitation and hygiene (SDG 6).

Implications: Removing the barriers to MHM can improve the dignity, school attendance and social engagement for girls and women in remote communities.

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Core funding
is provided by the
Australian Government
Department of Health



Australian Indigenous
HealthInfoNet



Introduction

The ability for girls and women to maintain their hygiene-related health is contextualised within the United Nation's Sustainable Development Agenda, which contains 17 Sustainable Development Goals (UN SDGs) for attainment by 2030 (1). 'Hygiene' refers to infrastructure and technologies, cleaning products, services and behaviour that contribute to health-related, hygienic outcomes (2). Of particular relevance to the hygiene of girls and women, are the Sustainable Development Goal (SDG) targets for health and wellbeing ('ensure universal access to sexual and reproductive health-care services'; SDG 3.7), gender equality ('ensure universal access to sexual and reproductive health'; SDG 5.6), and water, sanitation and hygiene ('access to adequate and equitable sanitation and hygiene for all ... paying special attention to the needs of women and girls'; SDG 6.2) (1).

A specific personal health-related hygiene issue for all women and girls is menstrual hygiene management (MHM), defined by the World Health Organisation and UNICEF 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 (3).

Globally, many girls and women in remote areas experience physical barriers to MHM including the absence of adequate water and sanitation amenities during menstruation, which are often compounded by psycho-social barriers such as cultural taboos, privacy issues, shame, insecurity and embarrassment (4, 5). Research from developing country contexts has documented how MHM may be a barrier to school attendance due to a lack of products to manage menstruation, privacy for hygiene, pain management, and puberty education (6-8). These barriers can limit the capacity of women and girls to effectively manage their periods and to participate in routine social activities like school and work (4).

Australia is one of the 196 signatory countries to the UN Agenda, and is committed to progress the SDGs within and beyond its own borders by 2030 - including the Goals relevant to MHM (1). While it is not a developing country and therefore not able to be compared to those documented above, the social and environmental determinants of health and wellbeing inequalities between Indigenous and non-Indigenous Australians are widely documented, and are acknowledged as being particularly challenging in more remote and isolated communities (9-12).

In late 2016, the seventh Overcoming Indigenous Disadvantage review identified that health outcomes for Indigenous communities – particularly those in remote and very remote locations – were compromised by a range of environmental health factors within homes and communities (13). This includes issues of hygiene-related health.

This article focuses on MHM in discrete, remote communities on mainland Australia that are permanently inhabited by a predominantly Aboriginal and Torres Strait Islander population – referred to here as Indigenous Australians. A discrete Indigenous community is defined as a geographic location with cadastral boundaries, with more than half the population identifying as Indigenous residents, and where housing and infrastructure is managed on a community basis (14). Census data from 2016 estimated the total resident population of Aboriginal and Torres Strait Islanders as 3% (approximately 649,000) of the Australian population (15). Of these, 21% live in remote and very remote areas (16). The majority of these populations are located in four states and territories: Northern Territory (NT), Western Australia (WA), Queensland (Qld) and New South Wales (NSW) (17).

In order to understand the health-related hygiene aspects being experienced in these remote communities, this research was undertaken as a broad scan of priorities – within the context of the SDGs. A significant impact on healthy living practices is overcrowding. For example, the household size in remote areas was three times that of non-remote areas for 38% of the Indigenous adult population in 2015 (16). Facilities for washing people, clothes and bedding, for safely removing waste, and/or for enabling the safe storage and cooking of food was not available or did not work for 28% of this remote population (16). Earlier research (from 2011-12) in Central Australian remote communities, found that very few households possessed soap on a regular basis, despite evidence showing links between hand-washing with soap and the prevention of childhood diarrhoeal disease (10, 12).

The above aspects all affect the ability to manage menstrual hygiene. This forms the focus of this article, as one aspect requiring potential action towards attaining the hygiene-related SDGs in Australia. The findings of this research are anticipated to inform and assist national, state and local government health agencies, schools and civil society organisations that provide menstrual hygiene-related services to improve the health and wellbeing outcomes for girls and women in these Australian communities.

Methods

This article reports on the specific hygiene-related issue of MHM from a wider study of water, sanitation and hygiene priorities in remote Indigenous communities. Qualitative interviews were conducted with representatives from key organisations providing water, sanitation and/or hygiene to three or more discrete, remote communities in four states and territories of mainland Australia. The resulting 17 interviews are detailed Table 1. The sample included representatives from state and territory government (6), Indigenous (4), research (3), utility (2) and non-government (2) organisations. All interviewees consented to the interview, and their responses were de-identified to enable open reflection on issues and needs that may otherwise have been restricted by identification.

The interviewing approach used open-ended questions in order to secure ‘deep’ and detailed accounts and perspectives, and to describe both observed issues and solutions (18). The focused case study approach on water, sanitation and hygiene, applied theory and strong focus on dialogue involved a small sample while delivering higher ‘information power’ or detail and depth (19). The final sample size was achieved once ‘saturation’ occurred and no further new information was revealed during subsequent interviews (20). Each interview lasted approximately 45 minutes, with 15 interviews conducted by telephone to limit project costs; one interview was conducted by email and one in-person at the request of those two participants.

The project aims and core questions were reviewed for cultural and other sensitivities by researchers with extensive experience in Australian Indigenous research. The project received ethical clearance from the University’s Human Research Ethics Committee. The questions explored perceptions of whether the drinking water, wastewater treatment and hygiene access and services met the needs of the remote community residents. The questions were intentionally broad to enable interviewees to share their perceptions from their organisation’s speciality, services and jurisdiction. Additional questions were asked based on the interviewees’ responses to the core questions explore them in further detail, which is a common qualitative approach to data-gathering (18).

Table 1: Summary and total number of interviews conducted

Organisation type	No.	Jurisdiction	No.	Organisation focus*	No.
Government	6	Northern Territory	8	Health and Hygiene	10
Indigenous	4	Queensland	3	Drinking Water	5
Research	3	South Australia	3	Sanitation/Wastewater	5
Water utility	2	New South Wales	2	Indigenous	5
Non-government (NGO)	2	Australia	1		
Total	17	Total	17		

*n.b. organisational focus can be multiple

The interviews were transcribed, uploaded into QSR NVivo qualitative software, and analysed using qualitative social science methods informed by grounded theory to elicit the emerging themes (20, 21). Quotes from the interviewees are provided in the Results and Discussion section to illustrate the key themes raised, although the same topic was often raised by multiple interviewees.

Results and Discussion

The specific hygiene topic of MHM was alluded to by a number of interviewees when discussing toilet blockages from non-flushable items – namely sanitary pads, material and underwear – that were used in place of formal products. MHM was also alluded to by interviewees describing overcrowding of homes affected the ability to maintain personal hygiene, described as:

[In some communities] you’re looking often at housing situations where you’ve got upwards of 20 plus people in a three-bedroom home. [One community] used to have 148 houses for about ... 3,000 people. So, you’re averaging about 18 people per house (Indigenous organisation #1).

Maintaining clean facilities as well as personal hygiene of all residents in the overcrowded house were noted as major difficulties by interviewees. This included the cost of washing supplies when used by a large number of the house’s residents. This was noted to pose a challenge in addition to the cultural expectations of sharing assets among family members:

When you’ve got 20 people in your house, do you have the ways and means to keep a supply of shampoo, soap even where the facilities are working? Once again, am I going to put my \$5 bottle of shampoo in the shower recess when there’s 20 other people and in the first day it’s gone? ... Indigenous culture of course is kinship and it’s sharing... So, you’ve got all those dynamics playing a part as well (Indigenous organisation #1).

High populations per household were described as impacting the ability of hardware to function where overused—and thus limit privacy in bathrooms without lockable doors and limit bathing facilities to enable adequate body washing, particularly during times of menstruation. This was described as:

A female Aboriginal elder on one of the communities said to me, ... “How can we wash hands when we don’t have hand basins that work and we don’t have showers that work and we don’t have the infrastructure?” (Indigenous organisation #1).

Four interviewees explicitly described MHM issues in detail. Notably, all of these interviewees were female; two represented research organisations in the NT and WA, and two represented Indigenous organisations in the NT. Given this small sub-sample and limited geographic reference (NT and WA), these findings can only be considered as anecdotal evidence that illustrate MHM in a limited context.

The range of words used by the four interviewees to describe causes and impacts of MHM were analysed, with the most frequent words displayed in Figure 1. The most frequently-mentioned words after ‘girls’ were school, toilet, access, women, talk, youth, shop and pads. These words provide an indication of how menstruation is considered to impact girls and women in remote communities.

Figure 1: Word cloud describing menstrual hygiene management Australian remote Indigenous communities (4 transcripts; 28 references; 50 most popular words- excluding un-descriptive words)



The interviewees described how the combination of an apparent lack of knowledge, products and facilities were leading to girls not attending school for several days each month due to menstruation:

Mothers and grandmothers have said that girls are missing school when they have their periods ... because they don’t want to change [pads] at school ... [at schools] often there’s no soap, ... there’s often no rubbish bins or there’s one rubbish bin outside the toilet which is really embarrassing to use. In terms of the infrastructure that I can put in place to help girls, it’s rubbish bins, it’s soap, it’s running water and toilets that flush, and privacy (Indigenous organisation #3).

The interviewees suggested that the non-attendance at school and other social activities was partly due to issues of ‘shame’ around the topic for some specific cultural groups that can limit the ability for discussion and knowledge, described as:

There’s a lot of shame around it ... [Also,] traditional forms of learning [aren’t] necessarily functioning within families for everything ... Traditionally, it’s a grandmother’s role, ...but a lot of grandmothers experienced mission times where there was very strong puritan Christian values around your body, which meant you don’t talk about it (Indigenous organisation #3).

There also appeared to be a limited provision of MHM in the school’s health education program and health clinic engagement, described as:

There’s such a demand on every single [health education] resource available and everything is under-resourced. If you’re dealing with someone’s diabetes and if you’re dealing with chronic illness, [then] menstruation is not [seen as] a sickness... [MHM education] is missing in the [remote] regions and it is a serious concern that has an impact on girls’ and women’s lives. ... [including] being able to go to school (Indigenous organisation #3).

Furthermore, buying feminine hygiene products in remote communities where there is often a single shop, was noted as raising an issue of both higher costs and embarrassment or exposure to community members:

Access to pads can be really expensive at local shops: \$10 a packet ... [depending on] how it’s located in the store ... there are cases of women stealing – who would never normally steal – but they’re just so embarrassed that they steal pads (Indigenous organisation #3).

People aren’t going to the shop and buy it, because they’re tiny places and people will know that you’ve bought it because you’re menstruating ... There’s sort of a bit of ... stigmatising or feeling ashamed (Researcher #2).

As a result of these barriers, alternatives are sometimes used in place of feminine hygiene products:

Underwear is another thing that can be used and flushed down ... the local plumbing services say there are a lot of problems with not just tampons being flushed, but various pieces of clothing (Indigenous organisation #3).

Previous and current efforts have sought to make MHM products available to girls and women more discretely through medical clinics and schools, or in more discrete locations within the local shop, described as:

Many years ago, the health centres used to give [pads and tampons] out. But it's a cost ... no one's got the money to ... give it away. So, people have to buy it now (Researcher #2).

For both the education of and the logistical provision of products, an interviewee described how non-Indigenous 'outsiders' to the community can provide a neutral presence that can alleviate the shame that may otherwise arise from interaction on this topic with familiar people:

[Having an external educator on MHM is helpful] not because [they] don't know this stuff, but because it helps having someone neutral and from outside so that [they're] not too shy ... [With] shop purchasing ... depending on who's working at the cash register, if it's a male then it's definitely a no – you just don't buy anything [for MHM] ... So, sometimes, in some instances, having a whitefella worker can be really helpful because it's just neutral (Indigenous organisation #3).

Conclusions

From a limited sample, the research results indicated a gap in MHM in some remote Australian Indigenous communities, where the ability of girls to attend school and participate in other activities appears to be prevented during menstruation. This is caused by one or several aspects regarding the cost and process to purchase feminine hygiene products, aspects of shame and embarrassment, and a lack of traditional, school-based or medical education regarding menstruation. The disposal of sanitary product alternatives may be linked to higher levels of toilet blockages that in turn can be delayed for repair due to the remote locations of communities. Aspects that could otherwise support MHM, such as access to facilities for private showering and waste disposal, can be impacted by crowded households in many communities.

Within the context of the UN SDGs, these findings indicate that Australian Indigenous girls and women in remote locations are less able to attain aspects of the SDGs for health and wellbeing (SDG 3), gender quality (SDG 5), and water, sanitation and hygiene (SDG 6).

These indicative findings from a very small sample warrant further research to validate the extent of these MHM needs across Australia's Indigenous population and in a range of geographic locations, including but additional to WA and NT. The resulting exposure of these needs and possible responses - directed by Indigenous community organisations to ensure cultural appropriateness- could contribute to the attainment of the UN sustainable development agenda, and ensure 'no one is left behind'.

Acknowledgements

The author wishes to thank the representatives of the organisations interviewed, and for their ongoing contribution to hygiene outcomes for remote Indigenous communities. Thanks also to [organisation name withheld] for their advice and in-kind support of this project.

Funding statement

The author received no financial support for the research, authorship or publication of this article.

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Australian Indigenous
HealthBulletin



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Core funding
is provided by the
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