RESEARCH PAPER

Stigmatization and Menstrual Hygiene of Women of Reproductive Age: A Comparative Study of Rural and Urban Areas of Kashmir

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ABSTRACT
The paper is the comparative study of rural and urban areas of Kashmir, exploring the variable of menstrual hygiene. The sample size of 300 respondents was taken 150 from each rural and urban areas, using multistage sampling. The findings show women still do not use sanitary napkins for their periods especially rural women, they rely on unhygienic means during their monthly cycle.

Keywords: Menstrual hygiene, Stigmatization, Rural women, Urban women, Kashmir
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INTRODUCTION

Stigmatization and Women Reproductive Health

Stigma is a part of human psychology, so is the stigmatization, it evolves with the evolution of human history leading to disturbances within an individual psychological and social cohesion. In the beginning stigma was an unusual human affair limited to some metaphysical, unseen or unknown life components, but with the evolution of human life, stigma is now patently an obvious human experience that has entered many aspects of human life. It is now an established social fact with advanced evolutionary character. Stigmatization is a social concept which not only had its impact on an individual life only but had its immense impact on a society too. Social Stigmatization begins with indifference, apathy and misconceptions. Stigma has its roots in 'differences'. The pain and emotional hurt experienced by the stigmatized person is linked to others' pity, fear, disgust and disapproval of this difference, whether that difference is one of personality, physical appearance, illness and disability, age, gender or sexuality. Stigma can be defined as an attribute that serves to discredit a person or persons in the eyes of others. A Social stigma in general creates a gap between an individual, groups or within a society, even every stigma comes with a perceived negative or abhorrent notion that puts a victim into a kind of socio-psychological crisis. Most stigmas probably hold an element of threat for people who are exposed to them. The experience of stigma has a profound effect both in its emotional impact for the individual concerned and in its social repercussions for the marginalized group as a whole. A stigma alienates a concerned individual from a family, group or society, depending upon the type of stigma. A particular type of stigma has a particular type of impact on concerned individual, group or community. Stigma has profound effects across a wide range of outcomes, including well-being and self-esteem, self-perception, group identification, motivation, task performance, and social interaction. As the research shows, members of stigmatized groups may be devalued, ignored, and excluded. Persons among any group, community, gender, ethnicity or any religion, who have been stigmatized throughout the history, have gone through discrimination, sufferings, persecution, alienation or suffering, in many cases-like disabilities, diseases or abnormal birth a stigmatized person is treated as a deviant or ill-fated. A stigma in many cases results into the disturbance of social cohesion. A stigma of blackness across USA many times created social upheaval, similarly a stigma of caste system in India has not only hampered the social cohesion but the socioeconomic development has also come under its effect as it hampers the coordinated effective economic progress. Throughout history individuals with mental disorders and disabilities have been stigmatized and labeled and as a consequence have faced many types' of discrimination and hardships, including physical abuse, sterilizations, murder, and infanticide. Almost every sort of stigma- enacted stigma, felt stigma, internalized stigma or anticipated stigma-takes toll of health of an individual that comes under the influence of stigma. Stigmatization comes with lot of ills and affects, it alienates an affected individual and makes him or her to feel inferior. Regardless of whether it is consciously or unconsciously motivated, expressed blatantly or subtly, or exerted through interpersonal interactions or institutional policies, enacted stigma may arouse physiological and psychological stress reactions

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among members of stigmatized groups and lead to unhealthy coping behavior, all of which adversely impact health but sometimes a health issue or routine biological change within an individual attract a stigmatic wrath. Menstruation is still considered as a social stigma across many parts of the globe. A study conducted by the International Women's Health Coalition in 2018, found that there are about 5,000 slang words used to refer to menstruation in 10 different languages. "The curse," "on the rag," "that time of the month," and "the red plague," are just a few examples of the many euphemisms describing the same thing, menstruation and such euphemistic expression used to describe, denote or denigrate a particular kind of biological change has led to many severe health issues among the women across developed, under developed and less developed nations as the women facing euphemism or social stigma *vis-a-vis* their reproductive health issues became silent, docile or alienated from the society which elevates their health crisis instead of minimizing the same. The impact of stigmatizing attitudes on the stigmatized individual can vary in form and intensity. Much of the behavior, however, towards the stigmatized serves to emphasize 'difference', and thus there are forms of discrimination and prejudice which can be identified in the interactions between the 'normal' and the 'discredited'. Stigmatization have compound impact on an affected individual, it has depressing bearing on individuals social as well psychological life, the graveness of the impact bumps up, when it (stigma) is linked to genuine reproductive health issues or any other health issue. Though the stigmatization is not confined to only human or social sector but the most stigmatic issues are linked with the women reproductive health. Stigma can prevent individuals from seeking help or health services and can lead to thoughts of suicide, depression or self-isolation from social settings. Stigma has often been described in the fields of epilepsy, Human immunodeficiency virus (HIV), mental health, sexual violence, hepatitis C, and obesity. So far as women reproductive health is concerned, Infertility, Abortion, contraception, family planning, sexuality and even the birth of female child is still more or less counted as stigma across many parts of the globe. The new developments in women reproductive health like medical techniques to overcome infertility, the gap in child birth even the sharing of sexual needs between partners pull one towards a stigma. If a women put up with any reproductive health issue like delayed or early orgasm, partner's sexual flaw, white discharge or some other RH issue, she is not only stigmatized but faces a different behavior not only from her close ones but the medicos who are meant to care such problems too act differently most of the times.

RESEARCH METHODOLOGY

Sampling Design

Multistage random sampling was applied to draw the sample size for the study. The theme and the universe of the *study that is rural and urban areas of Kashmir: a comparative study between district Srinagar and rural villages in the district Pulwama* demands the sequential clustering because a large number of units can be sampled for a given cost under multistage sampling (*C K Kothari, 2004),*so in order to draw the sample size, the multistage random sampling technique (stratified, systematic and purposive random sampling) was utilized and the sample size of about **300** respondents under the age group of **15-49** was taken, **150** from rural areas and **150** from urban areas giving representation to all class/caste of the society.

For district Pulwama out of **5** blocks (Pampore (31 villages), Tral (87 villages), Pulwama (97 villages), Kakapora (62 villages), Keller (42 villages)) ***3 Blocks*** have been chosen randomly: Pulwama, Kakapora, and Keller and out of these three blocks 10 villages have been taken proportionately at **5%** margin while applying systematic random sampling,**5** from **Pulwama:***Naina, Payer, Bonrah, Tahab, Shadipora, Sheikhhor*,**3** from **Kakapora:***Dahoo Gam, Pochal, Athora,* and **2** from **Keller:***Sangerwani, Arhbal*. The total number of respondents taken proportionately at **15%** margin from each village is **150**.

For district Srinagar out of four stratified zones, East, West, North and South (**35** administrative wards), **8** wards have been taken randomly, for zone east: *1. Dalgate and Lalchock 2. Hassaana Abad and Makhdoom Sahib* for zone west: *1. Nawa kadal and Allahi Bagh, 2. Shaheed Gunj and Karan Nagar,* for zone north*: 1. Lal Bazaar and Umer-Colony 2. Zakura,* for zone south *1. Khumani Chowk 2. Raj Bagh, Wazir Bagh and Sarai Bazaar*. These 8wards contain **100** Mohallas for example selected two wards of zone east contain (24 mohallas), selected two wards of zone west contain (25 mohallas),selected two wards of zone north contain (22 mohallas), selected two wards of zone south contain (29mohallas),***18 mohallas*** (Out of 100 Mohallas) have been chosen systematically, **4 mohallas** from zone east: *1. Barrow Ghat, 2.Ashraf Khan, Jabgari Mohalla, Tibitan Colony*, **5 mohallas** from Zone west*:1. Nawa Bazaar, Dabtal, Syed Hamid Pora, 2. Shutra Shahi, Bal-garden,***4 mohallas** from zone north: *Zaribal, Botashah mohalla, Baghat Shoore, 2. Sarfaraz Colony,***5 mohallas** from zone south: *Durbal, 2. Kursoo Rajbagh, Tulsi Bagh, Haft Chinar, Hanuman Mandir.*The total number of respondents taken purposively with the ratio of **37:38:37:38** is **150**. All the respondents both from rural Pulwama and urban Srinagar will be approached purposively.

RESEARCH DESIGN

The present study is a descriptive and exploratory study designed to analyze the reproductive health among women of rural and urban areas in Kashmir comparatively with special reference to Pulwama and Srinagar districts.

In-depth interviews were conducted with the married and pregnant women aged 18-45 years. The pregnant women fallen in the variable age group and married women with one or more than one child were preferred during the interview. The interviews were conducted on the door steps across the study area-Srinagar and Pulwama. During

the interview the problem was precisely put into the questions and passed on to each respondent in the simplified way. The tool of observation was also used in data collection along the administered interview schedule.

It includes questions regarding the menstrual and reproductive hygiene in which the question like use of napkins, availability of napkins, alternative of napkins and the spouse support in assessing napkin were included.

The process of assigning meaning to the collected information and determining the conclusions, significance and implications of the findings was carried out after data collection. The data has been classified and tabulated for making the further analysis and interpretation. The study is a descriptive and exploratory in nature. The collected data are arranged properly, analyzed systematically and interpreted precisely using certain statistical tools and techniques like percentages, arithmetic mean, frequency etc have been used to arrive on certain conclusions.

THEORETICAL RELEVANCE

Erving Goffman's theory of Stigma

Canadian born American Sociologist Erving Goffman (1922-1982) in his famous book *'Stigma: Notes on the Management of Spoiled Identity'* grossly mentioned three types of stigma, First there are abominations of the body-the various physical deformities. Next there are blemishes of individual character perceived as weak will, domineering or unnatural passions, treacherous and rigid beliefs, and dishonesty, these being inferred from a known record of, for example, mental disorder, imprisonment, addiction, alcoholism, homosexuality, unemployment, suicidal attempts, and radical political behavior. Finally there are the tribal stigma of race, nation, and religion, these being stigma that can be transmitted through lineages and equally contaminate all members of a family. The stigmatic appraisal of women reproductive health points to the fact that many reproductive issues, disorder or physiological processes associated with the women reproductive health, fall into the three categories described by Ervin Goffmann in theory of stigma. From infertility to childlessness many aspects of women reproductive health (WRH) like use of contraception, maintaining menstrual hygiene, using sanitary napkins even menstrual cycle is at times considered as stigma. "Menstrual blood is a stigmatizing mark" that fits Goffman's three categories of stigma: the "abominations of the body," the "blemishes of individual character," and the stigma related to specific marginalized social groups. While menstruation itself may be considered an abomination, its visible presence equally may be viewed as an individual character flaw. In addition, menstrual blood remains symbolic of the "tribal identity of femaleness". The menstrual cycle linked with all the three categories of Goffman's Stigma is at time considered as taboo or stereotype in many parts of the world even religious connotations of menstrual cycle are at times attracting the stigmatic public notions. Contracting a sexually transmitted infection, whether or not evidenced by blemished skin, disclosed a blemished character, and in more modern times homosexuality—whether or not resulting in HIV infection was a stigmatizing disposition, still characterized in the Roman Catholic Church as an "abomination" justifying disgust. Although without moral taint, infertility is sometimes considered shameful or discrediting, not least by married couples anxious to conceal resort to medically assisted reproduction. Women's contraceptive sterilization was once considered their dishonorable denial of the duty and virtue of motherhood, and a man's vasectomy without just cause, such as preventing transmission of hereditary disease, was considered "degrading to the man himself and injurious to his wife…to say nothing of the way it opens to licentiousness. Goffman explained that stigma spoils or tarnishes stigmatized individuals' social identities, with the effect of cutting them off from reputable society so that they stand discredited and face an un-accepting world which can led to social dormancy and affect an individual's wellbeing and capability, so incase of reproductive health stigmatization a women conceals her reproductive issues, hesitates to go for fertility check or sterilization to avoid what Goffmann calls *'spoils of social identity'*. He showed how a spoiled identity could rarely be redeemed because it denies stigmatized individuals an opportunity to present themselves to others and to society as they might justly be entitled to appear. Goffman puts this behavior in his own way by saying that an individual as a performer tends to conceal or underplay those activities, facts, and motives which are incompatible with an idealized version of himself and his products. So, to feel humiliated in expressing ones needs, requirements or interests, whatever, leads to stigma. There is evidence that people who perceive themselves demeaned by stigma often undergo a chronic physiological stress response, affecting for instance their cardiovascular health. Regarding resort to healthcare services, people who experience or fear stigmatization in this setting may avoid seeking care from which they would benefit. The advancement in the technology during the recent times have led to sophisticated system of testing like fetal Deoxyribonucleic Acid (DNA) test employed to found any such ailment that can attract stigma. Such advancements employed in pretext of stigma or any other blemishes abominations directly affect the reproductive health of a women especially fertility and reproductive choice. This development might expand the scope of stigma affecting reproductive choice to range from decisions to terminate pregnancies to decisions to continue them. It also projects stigma beyond birth to death into prenatal life and decisions regarding children yet unborn, and un-conceived. That is, stigma can attach to the full spectrum of reproductive choice, concerning whether to conceive; selection of reproductive partners or third-party gamete or embryo donors; acceptance or rejection of in vitro embryos for transfer; continuation of pregnancy; and neonatal care of seriously impaired newborn children. Like, other social, human and individual issues, the women reproductive issues too attract stigma and many of the women reproductive matters attract stigma falling in

the categories established by Erving Goffman. Most of the RH issues fall in the category of *concealable stigma*. The 'spoil of social identity' among the women facing stigmatizations vis-à-vis reproductive issues affect the capability and well being, thus hampering the proper development reproductive and reproductive opportunities.

Goffman's Management of Stigma

Goffman in his stigma theory while explaining the *'Spoils of Social Identity'* proposes the management of stigma employing the concepts of *personal* and *social identity* based on self identification. Goffman says that the concept of social identity allowed us to consider stigmatization. The concept of *personal identity* allowed us to consider the role of information control in stigma management. The idea of ego identity allows us to consider what the individual may feel about stigma and its management, and leads us to give special attention. By exploring the concepts of *Personal* and *Social Identities,* Goffman's theory implies that a stigmatized individual should explore the subjective sense of his own situation and his own continuity and character that an individual comes to obtain as a result of his various social experiences. Hence, in order to manage the stigma, a stigmatized person should uphold and bring the personal identity to fore in relation to social identity, which can only be achieved by self identification and self awareness besides knowing the veracity of factors of stigma. So, the continuing argument acknowledges the application of Goffman's Theory of Stigma, to explore the management stigmatized issues of women reproductive health, such issues can be addressed by applying the concepts of personal and social identities in relation to the awareness and self identification. Hence to explore the concealed or other types of stigma about women reproductive health Goffman's theory can only be useful when the concepts of stigma management are used to explore the veracity of causes that led to the stigmatization of reproductive health issues. It is intended that the theory will be employed to evaluate the causes of stigmatization prevalent in the study area *vis-à-vis* Women menstrual hygeiene.

1.1 FINDINGS

Menstrual hygiene refers to management of hygiene associated with the menstrual process. *'Women and adolescent girls are using a clean menstrual management material to absorb or collect menstrual blood, that can be changed in privacy as often as necessary for the duration of a menstrual period, using soap and water for washing the body as required, and having access to safe and convenient facilities to dispose of used menstrual management materials'* (WHO & UNICEF). Any deficiency in the menstrual hygiene can negatively shape a women's health. The lack of access to menstrual hygiene resources like absorbent sanitary products can induce women to use uncouth methods or improper resources to manage menstruation, which can be harmful for the reproductive health of women. Hence to keep up the menstrual hygiene women should have proper assess to absorbent sanitary products or other requisites needed to manage the reproductive health properly. So, in order to find awareness about the menstrual hygiene scholar sought answer about many questions related to menstrual hygiene and the data collected is shown in the Table 1.1

The table shows that 53.3 percent of the rural respondents were using sanitary napkins during periods while 46.7 didn't use any. Similarly 84 percent of respondents in urban area use sanitary napkins while 16 didn't use any napkin during periods. Among the 56 percent rural respondents 52.7 percent reach out local shops to get sanitary napkins only seven percent visit local health centres to get the same. The percentage of respondents in urban areas who had access to government Health centres to get the sanitary napkins is same as that or rural (7 percent) while the respondents who reach out local shops are 84 percent. The data shows that 46.7 respondents in rural areas and 17.3 percent among urban respondents are using cloth as an alternative.

Table 1.1

do you use sanitary napkins during periods, yes =1, no= 2						
Utilization of sanitary napkins		Code	Rural Frequency	Percent	Urban Frequency	Percentage
Yes		1	80	53.3	126	84.0
No		2	70	46.7	24	16.0
		Total	150	100.0	150	100.0
If yes where from u get sanitary napkins						
Don't use	0	70	46.7	25	16.7	
Shops	1	79	52.7	124	82.7	
Health centre	2	1	.7	1	.7	
	Total	150	100.0	150	100.0	
If no, what is the substitute						
Sanitary napkin	0	80	53.3	124	82.7	
Using cloth	1	70	46.7	26	17.3	

	Total	150	100.0	150	100.0
Does your spouse support you in using sanitary napkins					
Spouse support in using sanitary napkins	Code	Rural Frequency	Percent	Urban Frequency	Percentage
Un defined	0	31	20.7	8	5.3
Yes	1	76	50.7	119	79.3
No	2	43	28.7	23	15.3
	Total	150	100.0	150	100.0

Table further shows that 50.7 percent of rural respondents had spouse support in using sanitary napkins while 28.7 percent had unenthusiastic spouses. Similarly 79.3 percent of urban respondents have spouse support while 15.3 have unenthusiastic spouse support.

Comparatively the Table 5.4.1 revealed that:-

- Respondents in urban areas are more (84 percent) inclined to use of sanitary napkins in comparison to rural respondents (53 percent).
- 52 percent of respondents among rural sample and 84 percent get sanitary napkins from public market.
- 46.7 percent in rural sample and 17.3 in urban sample use cloth as an alternative of the sanitary napkin.

Menstrual Hygiene and the physical hygiene is an important component of women reproductive health. The findings shown in the Table 1.1 revealed that **53.3** percent of the rural respondents and **84** of urban are using sanitary napkins most of the respondents from rural areas cited reasoned economic constraint as a reason of not using sanitary napkins. Among the 53 percent rural respondents 52.7 percent reach out local shops to get sanitary napkins only .7 percent visit local health centers to get the same. Findings show that only .7 percent of urban respondents have visit government health centers to get napkins. Lacking proper sources of awareness, respondents were not aware about the government schemes launched about the menstrual hygiene, not a single initiative was taken in this direction. Findings (Tab 1.1) revealed that the data shows that **46.7** respondents in rural areas and **17.3** percent among urban respondents are using cloth as an alternative. Women (particularly rural) still use cloth as an alternative for sanitary napkins, citing various reasons. One of the respondents said,

"I have been using cloth since I am having periods and I don't feel it is causing me any harm, it is convenient and inexpensive"

(Waheeda, 38, Tahab-Pulwama)

"I feel lot of trouble in disposing off the sanitary pads after use; even it is embarrassing to purchase pads from shops. Hence, I prefer cloth"

(Nazia, 36, Payar-Pulwama)

It has also been observed that the use of cloth too is less than a problem especially when such cloth needs to be washed or dried outside, because the process demands complete secrecy leaving ample chances of infection because of improper handling. One of the respondents said,

"I have put the cloth out of sight, and one day out of darkness I took the cloth, used it and later in morning noticed that it had got some worms"

(Khalida, 32, Pochal-Pulwama)

It was found that **50.7** percent of rural respondents had spouse support in using sanitary napkins while **28.7** percent had unenthusiastic spouses and **79.3** percent of urban respondents have spouse support while **15.3** have unenthusiastic spouse support.

CONCLUSION

Following the data collection and analysis it was observed that the respondents are not aware about the menstrual hygiene (MH) properly. The government health centers established to deal with the MH were fund unable to attract people sufficiently, as a lesser amount of people are visiting centers to acquire sanitary napkins. Economic constraints are responsible beside the existing socio-cultural barriers. Women preferred conventional methods and compromise their hygiene and reproductive health.

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