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Waiting and Menstruation: A look at Homeless and At-Risk Women's Experiences

An honors thesis presented to the
Department of Anthropology,
University at Albany, State University of New York
in partial fulfillment of the requirements for graduation from The College of Arts and Sciences:
Anthropology Honors Program
and
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Abstract

Homeless and at-risk homeless women spend time in homeless centers where their time, behaviors, relationships and bodily functions are dictated by the institutions. This study looks at how women relate to their peers and staff in the homeless center as well as how they relate to menstruation. By both conducting participant observation and interviews at a homeless drop- in center, I aim to understand homeless women's experiences in the shelter.

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Introduction

“I can always get toilet paper somewhere, and if you have enough, you can change it before it shreds up, you know” said Liane¹, a white woman in her late thirties. She was carrying a plastic shopping bag, filled with her personal belongings. I was surprised at her statement and I responded, “So sometimes if you don’t have access to pads and tampons, you’ll use toilet paper instead.” Liane expanded her statement by adding “Toilet paper, paper towels.”

It was my first day doing field research, unsure of myself, but somehow I found someone who was interested in being interviewed. I had a set of questions, but I was not sure what the answers would be like. I wanted to know where homeless and at risk women obtained menstrual supplies, the different struggles they faced, and how they felt about it all. We headed up to the nurse’s office on the second floor of the homeless center. Liane signed the confidentiality papers, agreed to be recorded and then we started the interview. New to interviewing techniques, I was nervous, but Liane was very frank and open. Liane was saying that if she could not get menstrual sanitary products, that are marketed to and accepted by U.S. women as appropriate and necessary to use during menstruation that she would use other items instead. This was shocking to me as I had never encountered someone who found using paper towels and toilet paper as a typical way of “menses management”. I began to learn that many of these behaviors are not solely because of the lack of individual resources of homeless women but are interwoven with intuitional issues as well as other cultural factors.

When I began research, my main research question for this project was “How do homeless women relate to menstruation?” More specifically, I wanted to know how these women navigated systems and networks of homelessness to access feminine products and healthcare

¹ All names have been changed

services. From my ethnographic work, I found that part of my project shifted, from just looking at how women relate menstruation to a more holistic approach of what it is like as a woman to experience homelessness. I found that most homeless women do not perceive menstruation as a hindrance to their daily life. While researching, I also came to the ethnographic realization that the act of waiting is a large chunk of a homeless women's experience that impacts how they develop relationships, communities, and interactions with different systems. I focus my paper more on the waiting period, but also examine its effects on women's perceptions on menstruation.

Homeless women's experiences are extremely relevant to today's world. In 2015, in the U.S. more than half a million people were homeless (NIEH 2016), and, in the state of New York 9.5% of the population is homeless (NIEH 2016). At the center in which I conducted my research, Downtown Homeless Center² in upstate New York, approximately 76 people a day on average come through, with a total of 1541 people in 2016. While DHC does not provide data on how many of these are women, my observation suggests that it falls between one third to one half of the "guests" on a given day. "Guests" is the term used by the DHC in their program literature. Homelessness is not unique to this geographical area, nor is it unique to only New York but a national issue. Women's experiences need to be explored as there is an absence of this in the literature.

I have always had an interest in how women relate to their menstrual health, since before I was even menstruating myself. Growing up, I perceived that "having your period" was a negative experience, filled with pain and discomfort, although more recently, perhaps due to

²Referred to as DHC

social media, I have witnessed much more “period positive” rhetoric. I find it funny, as I reminisce about my personal history with this topic, that as a pre-teen, I walked around with a sanitary napkin or “pad” in my backpack, anticipating the day that I too would “become a woman.” The sanitary napkin was distributed during my single sex elementary school’s fifth grade year, as part of the much anticipated ‘Period Talk.’ Yet in all my time as a menstruating woman, I never realized what a tremendous privilege it is to be able to walk around with a sanitary napkin, just in case it is needed. I started thinking about this project late in my junior year as part of my honors thesis requirement. After many late-night brainstorming sessions, this idea seemed to take hold regarding homeless women and menstruation. I also felt it was a good mesh of concepts from my major in Anthropology and my minor in Public Health. What I found though, as my project shifted, is that I developed a keen interest in day to day of homeless women’s experiences.

Methodology

My research is situated within a homeless center in a city in the state of New York. The center is in a low-income neighborhood with a recent addition of a new affordable housing project. The center provides refuge and services to those experiencing homelessness as well as anyone in need. During the winter months, it also functions as an emergency shelter at night and on the weekends. I started exploratory research in the area around the beginning of September 2016, setting in place official documentation and coordination with the administration to conduct my project. From then on I would go down to the center every few weeks to start understanding the day-to-day activities and to develop relationships with staff and participants. I would attend in the morning, as that was when my schedule allowed. My primary research took place three weeks in January, throughout my winter break. During the research period, I attended in the

afternoon, for about three to four hours a day. I also went to the center when timing permitted in the spring semester.

I took notes while at the center, from a few words to jog my memory to longer detailed explanation of observations. My written notes included maps of the overall center and maps of the specific rooms where I spent most of my time. During my time in January, I also conducted five interviews, three of which were audio recorded and two that were not. In the two that were not audio recorded, I did my best to write down notes and quotes as the interview progressed. I would then write a more detailed account of my day on my computer and would also make a copy of the audio files from the device onto my computer. The five interview subjects were women ranging in age from early twenties to late fifties. Each had an experience with living at shelters, homelessness, and poverty. Either I would introduce myself to them or someone from the staff would introduce me to them. I conducted interviews on the premises, once in an office on the second floor and four times in an office downstairs. The office downstairs was adjacent to another office, and many times we had to pause the interview so someone could pass through.

My questions during the interviews were aimed at understanding women's experience with homelessness and menstruation. The questions asked about their experiences with homelessness and menstruation, access to feminine products, pain and pain management, as well as social or familial support. I want to acknowledge that while I was trying to understand these women's perspective, that I was only capturing cis-gendered females and therefore these women's experiences do not encapsulate all homeless women's experiences. During my interviews, I had a script for the questions I wanted to answer. I found reading straight from the script tended to create very stilted answers and I soon tried to allow conversations to unfold by paying attention to the women's responses and asking them to expand on certain areas. I found my interviews had

provided insight into the women's experiences with menstruation, but did not satisfy my quest fully. Perhaps this was due to the limited time I had to perform my research or this being my first time conducting interviews, but I found that my participant observation is where the crux of my knowledge came from.

Throughout my time in the center, I was always aware (as were others) that I was the odd one out. I would sit with a badge that read "Nurse Volunteer" – this is what the center handed to me, as I got permission to be there from the nurse. I feel this badge, and my demeanor as a college student, differentiated me from the participants. I was not a full-time staff, nor was I offering services such as healthcare or housing at the center and so I did not fit into any of the usual categories of frequenters. I was not there to help anyone, but I was nevertheless not on equal footing with a participant. I want to acknowledge these dynamics to be aware of the reflexive nature of how both I and the participants interacted and its effect on the research.

Menstruation

Homeless women not only experience the general collective experience of homelessness but also have the added experience of menstruation and its taboos. In "Blood Magic; The Anthropology of Menstruation", a collection of articles is edited and introduced by Thomas Buckley and Alma Gottlieb, the topic of menstruation is discussed mostly in an indigenous or "non-Western" contexts. Yet many of these articles resonate with my own research topic. Buckley and Gottlieb argue that there is not one menstrual taboo, but rather that taboo is varied across cultures (Buckley and Gottlieb 1988, 6-8). They organize taboos into two categories, one that restricts the behavior of menstruating women themselves, and one that restricts the actions of those around them (Buckley and Gottlieb 1988, 8). In most of my interviews with women, they

stated they did not believe there were things they could not do because of menses, yet most of the woman later described experiences that did encapsulate menses taboo.

One of my interview questions related to perceptions of menstrual taboos. I asked questions regarding their second classification- if menstrual taboo restricts women's behavior (Buckely and Gottlieb 1988, 8). While menstrual taboo is not explicitly stated by the women, looking at how they describe their actions during menstruation illustrates that they do change their behavior, although not necessarily restricting it, during menstruation. My question usually paraphrased into something along the lines of "Is there anything you do differently or not do during menstruation?" Denise, a Latina woman in her thirties, said she takes over the counter medication for menstrual cramp relief. She stated "I go to work in pain, not in pain, whatever I have to do." Denise notes that her behaviors during her period are not restricted due to any preconceived cultural norms, noting a lack of menstrual taboo at play in her life. When asked if her menstruation changes her daily routine, Liane answered, "I want to be discreet, or use discretion, not have diapers falling out of my bag, I have a little makeup case that way no one be like who's on the rag." Liane's response to this question illustrates menstrual taboo. She states her need to act privately as to not alert anyone of her menses. Her description of her behaviors shows that there is aversion to having menses and that it should not be known publicly. While one woman focused on period pain management and the other on discretion of supplies, they both focused on something that altered their daily life while trying to maintain normalcy.

Vieda Skultans, who studied women living in an isolated mining village in the early 1970s, provides another view about how women perceive their menstrual cycle. Skultans looks at how these women relate to both menstruation and menopause in "Menstrual Symbolism in South Wales." The dichotomy here is that this village is both part modern or "western" United

Kingdom but also has in place many traditional gender roles, such as women who do not work outside the home and are responsible for domestic work (Skultans 1988, 137-160). Skultans separates her interviewees into two categories, those who view menstruation as unwanted and a “pathological weakness,” and those who see it as natural and contributing it too “general health” and wellbeing (Skultans 1988, 142-143). In my interviews with homeless women, I found that many did not describe it as a mark of health and wellbeing. The homeless women described menstruation more pathologically or as a condition. If we analyze Liane and Denise’s statements once again, we see that the way they describe menstruation is as a condition that needs to be managed. This way of talking about it sounds pathological but does not illustrate the view of “weakness” that Skultans speaks about. If anything, Denise’s statement about going to work, regardless of pain she may experience, is saying that while there could be weakness due to this condition, she will not let it alter her productivity. Homeless women experience both menses and homelessness concurrently, and so while they can be separated into isolation, I explored them together.

Waiting and the Development of Social Support

Waiting

Robin, a middle-aged black woman, is knowledgeable on how services are set up at DHC. She explained to me that she waits all day at DHC to sign up for the winter emergency night shelter that is available after normal DHC hours. She waits all day, and signs up after dinner is served at 3 o’clock. Throughout my time at the center, I observed her talking to men and women, shuffling in between the rooms, dozing off, watching television and going to the restroom. After I had interviewed Robin, she and I would speak informally for the rest of my research period. I usually would find her welcoming and friendly, sitting in DHC’s community room, which was

essentially dirty couches, chairs and a television. Many times, she would say to me as well as aloud to others, is “I’m so bored.” At my time of interviewing Robin, she was waiting for a health insurance card to arrive in the mail at DHC for her. She wanted to be able to see an oncologist regarding tumors in her breast, as well as procure some of her prescriptions she received for her chronic conditions that were prescribed to her during her weeklong visit to the hospital. Robin’s life is spent waiting. She was waiting for a bed to sleep in, for her friends to show up at DHC, for the dinner meal to be served, for health insurance and health care.

The choices that homeless women like Robin make is suspended in the context of time and waiting. In “Patients of The State; The Politics of Waiting in Argentina,” Javier Auyero looks at the interaction between poor and state actors through ethnographic work in waiting rooms and lines. Auyero views this process and accepted experience by the poor as a way state actors hold “dominion” over the poor (Auyero 2012, 62). The poor wait on line in Argentina daily, and are subject to state employees to receive services. This control creates a dynamic in which the state has power over the daily life of poor people. I found this theory compelling, and while looking through my data, I found that it holds true to the experiences of those who I interviewed. Homeless women at the DHC are subjected to both governmental and private services that create dominating power structures that affect homeless women daily. Robin, as mentioned above, is waiting for an insurance card that is most likely state sponsored and interacts daily with DHC’s programs, services and protocols. DHC uses both public funds and private donations to operate. Some staff at DHC are AmeriCorps members, a program that is extended from the federal government. One day during my field work there was a social worker helping those who wanted to apply for federal and state assistance programs. There are also other contexts that homeless women may have interacted with state actors, police, courtrooms, and

other governmental program assistance in the area. Tina, one of my interviewees, does not have custody over her children currently and has had periods of waiting in her interactions with governmental family services and possibly government courtrooms. Tina is waiting for the day that her child will be old enough that she may have visitation rights. Waiting is not bound to the confines of one place. It is present in the interactions between homeless women and state and non-governmental actors.

While Auyero's work focuses on state agents' power over the poor, Amy Cooper's focus is on the temporality of homeless women's lives, either by themselves or through what Auyero might call 'agency dominion.' Cooper divides time into the two extremes of "empty time" and "overscheduled time" that was demonstrated when conducting research in Chicago (Cooper 2014, 167). Cooper argues that there is time of nothingness and waiting, while some times are overscheduled with multiple organizations or agencies demanding the time of the homeless, where homeless women have a working knowledge of institutional timetables (Cooper 2014, 168-169). These constructs Cooper describes regarding movements of homeless women can be applied regarding the constituency at DHC. Many people first enter DHC a half hour before the afternoon meal at 3 pm is served. Some people that I had seen earlier in the day at DHC who may have taken advantage of the coffee that is almost always available, or gone to the clothing pantry or grabbed a bite if there was food available during the day, will leave and come back for dinner. Homeless men and women are knowledgeable of the time schedule at DHC and even other services in the area. I overheard two people waiting in line for food say to one another that they might go over to the Catholic charity, even with having to listen to a sermon, if they were not satisfied with the food at DHC. State and non-governmental actors enforce waiting, schedules, empty and overscheduled time into homeless women's daily actions.

Staff and “Guest” Relationships

I am sitting in DHC’s dining room, called the “kitchen.” It is a crowded room with three horizontal tables and a small round table running the center of the room. It has a buffet counter and closet running the left wall and on the right wall two refrigerators and a sink. It is a major thoroughfare, as not only is it the only place you can eat in at DHC, but also because it adjoins the only bathroom (there is also a staff bathroom) and the nurses’ office. One of the male staffers, a black man in his young twenties, is in the kitchen. A man walks into the kitchen and asks the staffer for a slice of bread. The staff member answers shortly, “no.” Perhaps there was no bread available, but it was not clear why he answered that way. Some time passes, and the male staffer leaves the kitchen to sit at the reception desk in the hallway. A usual “guest” of the center walks into the kitchen, a short black man probably in his late twenties, and is playing music aloud from a mobile device and a speaker. The male staff enters the kitchen, and the man says jovially, “I know as soon as I would play it, you’d come in.”

While this example between staff and participants does not involve women, you can see here the dynamic and structure between staff members and participants. Throughout my participant observation at the homeless center I observed the relationship between staff and participants. The staff primarily regulates behaviors of participants and is the gatekeeper to resources and amenities. This creates a power division within the center in terms of those who can distribute resources and those who must request it. Within the client population, the division splits once again into new and old participants. Most of the people who come through the shelter are returning “guests”, and I soon became used to seeing familiar faces. Staff and participants know each other’s names and speak cordially to each other, while still maintaining the hierarchy of the structure. In the above example, the participant knew he was not following the rules, playing music aloud and knew how the staff would respond. While actively defying the expected behavioral conduct, he knew at the same time who had the power in the space. The staff’s role in regulating “guests” behaviors can be seen as extension of DHC’s dominion over “guests.”

Homeless women have unique experiences because of their homelessness. They also experience homelessness with the implications of culturally imposed gender constructs that are at

play in the way they are treated by the staff at DHC. In “Premenstrual syndrome: Discipline, and Anger in Late Industrial Societies,” Emily Martin explores gendered aspects of reproduction for women in industrial societies. Martin analyzes language used to describe the time before and during menses. Martin attributes many of the narratives and feelings women express before and during menses as culturally constructed, or caused by culturally constructed phenomena. She also attributes these to gender constructs and to the subordination of women to men in post industrialized nations (Martin 1988, 179-180). While my work did not examine PMS, it is apparent that gender constructs manifest within homelessness. Not only are some shelters separated into male and female, or have separate living quarters, but so are experiences that happen at DHC. For example, at DHC “Women and Children first” is said daily by the staff when distributing dinner. First, it implies implicitly that children are solely accompanied by women, and not men. Second, it also classifies women as needing assistance or protection and as more vulnerable than men. While everyone is portioned the same amount when in line for food at DHC, there is the unfortunate reality that there might not always be enough food, and so this process reflects the concept that it would be better for a man to go hungry than a woman. These gendered experiences are in line with the construct of gender in late industrial nations, described above. I further exploring staff and women’s relationships in the procurement of feminine products later on in this paper.

Positive “Guest” to “Guest” Relationships

Two women appearing to be in their early 20’s are in the community room. One of them is straightening the other’s hair with a flat iron. It is past 3 o’clock and “Women and Children” have already been called in to eat dinner in the kitchen. The women do not stop their pursuit of straight hair to go and eat. A male “guest” who was waiting in the community room to be called in to eat after the women and children’s turn, asked the two women why they were not attending dinner. The hairdresser of the duo responded, “I have to do her hair before her interview.”

Auyero's fieldwork also observed social ties and networking between the poor in the waiting periods (Auyero 2012, 97). People share food and converse whereby "informal interactions transmit information about existing soup kitchens, the availability and prices of housing in the city, required paperwork for a specific welfare plan (Auyero 2012, 97)." I noticed similar interactions at DHC. "Guests" share cigarettes, snacks, information and even provide services to one another. For instance, take the scenario mentioned above. It seemed premeditated and formal that the women planned to come to the center in order for one of them to prepare for an interview. It is also possible that it was a spur of the moment activity that occurred while waiting at the center for dinner. Either way we see that the public space in DHC is used to exchange a service (formal or informal) and also creates social connections amongst "guests." The man who conversed with the women felt that it was in his responsibility, while he was waiting for dinner, to make sure that they ate and that services were allocated towards them first. These interactions of waiting and informality occur throughout the day at DHC.

In the example above there is a sense of comradery and familiarity between participants, as is usually the case in DHC. Many of the participants frequent DHC on a regular basis for many hours at a time. They come for food, the clothing pantry, laundry or a shower, but mostly people come and sit in the kitchen or in the community room. Throughout that time resources and information are shared between participants. In *Seizing the Moment: Power, Contingency, and Temporality in Street Life*, Anne Lovell describes verbal interactions as an important resource, describing them as "sociability" (Lovell 1992b, 92). Sociability is defined as a "form of greetings, jokes, story-telling, gossip etc." and forms the relationships through which physical goods are exchanged (Lovell 1992b, 92). Interactions like the one above, where the man is asking the women about their dinner, is an aspect of sociability that may in the future lead to

trust and exchange of goods. It is evident that this occurs at DHC as participants at the center ask each other for cigarettes, pass each other newspapers, or share knowledge about resources about jobs and housing. It is common for participants to ask each other to “watch their stuff,” while they go talk to someone in another room or use the bathroom. I was asked to watch people’s belongings multiple times, but specifically was not allowed to in my contract with the center. Auyero calls these interactions “active and relational” as well as “informal” (Auyero 2012, 97-98). They create relationships between people during a waiting period and there is no set and formal time that these occur (Auyero 2012, 97). I would argue that being in the center is essentially an extensive waiting period, time spent waiting for a meal, for resources, for a phone call, or to wait until the next shelter or pantry opens for the day.

Negative “Guest” to “Guest” Relationships

A black woman is sitting on the front couch facing the TV, speaking on the phone and organizing her stuff. She is very visibly pregnant. She takes out a cigarette, and places it unlit in her mouth. A white man sitting on a chair a few feet behind the couch, yells at her “Take that shit out of here.” She yells back, still on the phone, “Shut the fuck up.” She finishes her conversation and eventually leaves to smoke in the backyard. The man who yelled at her says, “She just needs to pop that thing out of her, already.”

Though mostly positive, informal interactions can also be negative and not cordial. I witnessed both physical and verbal confrontations that took place during my time at the center. The need for someone to ask another person to “watch their stuff” also illustrates an element of distrust and discontent with other frequenters of DHC. It is common to hear bickering, specifically while participants are sitting in the community room. Many times, it is about politics or news events, because the TV is supposed to be only on the news channel (although many times it is not.) Other times, like in the confrontation mentioned previously, arguments intensify with yelling and cursing. This may be because there is sometimes heightened stress in the community room, usually when it is very crowded before dinner. Another factor may be drug and alcohol

consumption. While not always apparent if some are under the influence, there have been times I could identify it due to smell or behavior. Another factor could also be mental illness, in which sometimes one may be able to visually see in behaviors (such as muttering and loud outbursts). While I only witnessed one physical fight and one situation that was about to escalate into a fight but was then called off, it is apparent that while there is trust and comradery in DHC, there is also negativity and mistrust that occurs during this extended waiting period. The basis of this I could speculate is due to similar factors that create arguments: stress, drug and alcohol abuse, mental illness, as well as general poverty and lack of resources. This may cause people to not trust the other “guests” in DHC, even more so if they themselves are currently sober or on a upwards path towards ending their homelessness.

Romantic Relationships

In the community room, we are all sitting around watching TV, a man walks in, says hello to a woman sitting there and then continues with “You still with that guy?” They then briefly discussed her relationship status.

Throughout my time at the homeless center, I noticed that conversation often focused on partnership, boyfriends, girlfriends, and more permanent domestic partnerships. Interactions in the center, as well as in my interviews, underscored that having a partner is very highly desirable. Three out of five women spoke about relationships. One lengthy interview took a turn and we mostly spoke about one woman’s history with domestic abuse in the past. In the center, many times people spoke about different relationships, referring to the father or mother of their children, or their friends or family who may be involved in different levels of their life. A few times, men sat down and spoke to me about their trials and tribulations with their current or former partners. I was also asked twice if I had a boyfriend. Robin, whose interview I mentioned earlier, counted on her boyfriend to visit her in the hospital. He came, and also bought her the

television service and phone service for a few of the days she was there. She said that only he visited her in the hospital and no other friends or family. Reliance on a romantic partner seems important to Robin, as it provides emotional stability as well as, in this case, monetary support in times of need.

I believe these relationships are important to the women I interviewed as they go beyond the informal exchanges that happen between “guests” at DHC and provide what Lovell describes as generalized reciprocity (Lovell 1992a). Lovell describes generalized reciprocity as “the provision of tangible and intangible resources by kinfolk that does not carry an obligation of return” (Lovell 1992a, 280). While Lovell speaks about this in relation to mother figures in homelessness (Lovell 1992a, 280), I argue that this type of reciprocity is experienced in romantic relationships, such as in the case with Robin’s boyfriend who visited her in the hospital. During my time at DHC I also observed two couples in the community room. One was an interracial heterosexual couple, who were sharing a jar of pickles, and the other was a heterosexual Spanish-speaking couple, in which the female partner was sick and the male partner was taking care of her. These couples illustrate the importance of partner/ romantic relationships in homelessness as they provide care and support which does not need to be immediately reciprocated. Support (care during sickness and sharing of food) can be seen as a resource and important, as during this time homeless men and women may not have other resources such as employment, housing and health.

Procurement of Healthcare and Feminine Products

The committee on Health Care for Underserved Women at The American College of Obstetricians and Gynecologists have found that homeless women’s access to health care, specifically preventative care, is low (ACOG 2013). Instead of primary care, homeless women

use emergency services for issues that could have been resolved under primary care is more common (ACOG 2013). Research suggests that homeless women know where resources are to be found, but may not utilize services due to a myriad of factors pertaining to scheduling and lack of practical transport (Gelberg, Browner, Lejano, & Arangua 2004, 98). For many, the time and the multiple steps to get to health services by public transportation, or the difficulty in finding someone who could drive them during clinic hours, is a deterrent to the utilization of services. Other factors are that women perceive that the health situation is not immediately urgent, and therefore not important to take care of right away, considering time or monetary cost (Gelberg, et al. 2004, 98).

The question of perceived urgency is an important aspect to understand when looking at how homeless women in DHC relate to their health. For instance, there is a nurse at DHC but she is not a primary care physician. She may be able to guide them to a physician, but she cannot make sure that they maintain their appointment or transport them there. The nurse or social workers present at DHC may aid these women by filling out paperwork for Medicare or Medicaid, or advise them when health insurance agencies may come to the shelter, but cannot ensure that the women will go to healthcare providers or follow through with their instructions. While women spend considerable time in the shelter and may receive advisement from any of the resources there, they are still at risk for not fulfilling preventative health services, which is known to be an obstacle to health. Understanding how homeless women interact with both the medical system as well as other agencies and nonprofits is essential for understanding homeless women's experience as well as what type of access or behaviors they have to the procurement of feminine hygiene products.

A key research question at the beginning of this project asked how women managed to obtain sanitary products. In my preliminary stages of doing research at DHC, I noticed that in the clothing pantry of the center, a few women came in and asked for tampons and other toiletries. I had asked the staff member in charge of the pantry a few questions regarding what I observed. She stated that they get these items from donations, so they may or may not have items when women come in and ask for them, and noted that the women usually ask for tampons. She was responsible for not only the distribution of these goods, but also frequently having to inform women that there is none in stock or not able to give the amount women requested as to preserve for other women who will also request these products.

With this in mind, the women I interviewed were also very aware of the strategies needed to obtain sanitary products. As mentioned in the opening vignette, Liane stated that she would use toilet paper and paper towels if she could not get typical feminine products. I believe this is typical of the homeless population. Liane stated that to procure feminine products as well as other goods, she would go to pantries in the first or third week of the month. Denise, who works at an arena in town as an aide, stated she goes to Family Dollar to buy feminine products. The shelter that she lives in now does not supply feminine products to women who are working and “can support themselves,” and thus, she had to spend some of her very limited earnings to purchase sanitary products. While I did not ask her to elaborate on what else the shelter she lives in does or does not supply, it seems like it may be a burden for the women who live there to have to purchase these necessities to their health.

The choice in feminine hygiene products is not as simple as how the staff member explained to me, “most women want tampons”. In her book, Iris Lopez develops the Integral Model of Reproductive Freedom to understand the relationship between women, poverty and choice.

While she uses it to understand Puerto Rican women's constrained choice in sterilization, it can be used to look at how homeless women relate to their health. Lopez sees choice, not as a yes/no binary, but rather as an interplay between personal, cultural, historical and social forces (Lopez 2008, 144). Similarly, my interviewees' choice in what feminine products they use is largely dictated by what is available at DHC and other pantries in the area that are largely donations based. These donations are examples of larger sociocultural beliefs in which donors may believe one type of products is more useful to the women. Until 2016, feminine products in New York State were taxed as luxury or personal property and not as necessities thereby causing an increase in cost (Larimer 2016). These factors influence how women "choose" feminine products. Robin, previously introduced, says that her personal preference is a whole role of toilet paper she uses in a day, stating that she does not use tampons or sanitary napkins. From my interviews with Laine and Robin I learned that they view these supplies--toilet paper, paper towels, sanitary napkins and tampons--in the same spectrum of menstrual management. They use their knowledge of both institutional time frames and economic conditions to plan and procure these objects. Yet, their ability to do so is always constrained by powers beyond their control; donation-based supplies that may reflect sociocultural beliefs of donators as well as historical tax implications.

Conclusion

By observing homeless people, we can see how the process of waiting is apparent in homeless women's lives. Throughout this time connections and relationships between staff and homeless men and women are made, as well as peer-to-peer relationships. Women spend time waiting in DHC and therefore experience menstruation throughout this time. Women's experiences being

homeless cannot be fully understood without looking at how they experience or relate to their menses.

In search for both public health literature and anthropology literature pertaining to homeless women and menses, I could not find articles pertaining to both. What I found in the public health literature on homeless women was work that primarily focused on sexual health, STI, OBGYN visits, and childbirth--not the monthly occurrence that is in total alignment with these important issues. The anthropological literature I have presented here focused on menses in women in industrialized nations who may have low socioeconomic status, but not homeless women. I would urge both anthropologists and public health officials to look at the needs of homeless women with an interdisciplinary approach such as the Ecologic model.

The Ecologic Model accounts for multi levels that can influence the health of homeless women and accounts for how important social ties are. The Intrapersonal Level accounts for the individuals' characteristics, behaviors and attitudes. The Interpersonal Level accounts for social networks such as family, friends and informal social connections. The Institutional level accounts for a specific organization and the Community Level combines multiple organizations and other community factors such as the environment. The Public Policy level encompasses laws and regulation (American College Health Association 2016). Throughout my time at the DHC, I have listened to and observed women's attitudes, beliefs, and social ties. They frequent both the specific institution of DHC but also other centers and facilities within the community and experience the effects of public policy and enforcement. It is important to the understanding of anthropological perspectives of power, taboo, and choice, and how they intersect with all levels of the Ecologic health model. I urge both anthropologists and those studying public health to

stop looking at women's health in terms of just 'reproductive organs' and to embrace that menses effects how both homeless and non-homeless women relate temporally.

Finally, I would like to applaud New York City's City Council, council member Julissa Ferreras-Copeland whom proposed legislation and Mayor Bill De Blasio for passing legislation on providing free feminine/ menstrual products in shelters, public schools and jails in NYC (Ruiz- Grossman 2016). These products are not luxury items and should be treated as the necessary items they are, in areas where women are cared for publicly. I urge states, including NY, that still tax feminine hygiene products as luxury goods, to critically assess and reflect on what it means to tax these products.

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