EXECUTIVE SUMMARY

INTRODUCTION

Menstruation, which is a natural process, heralds the most significant reproductive changes that women undergo at both Menarche and Menopause, as well as in the aftermath of menopause. Around the world, including in India, what compounds the issue is the community based taboos and restrictive myths along with inter-sectoral inadequacies. Globally speaking, humanity has still to arrive at full implementation of efficacious solutions for Menstrual Hygiene Management (MHM) and there are still miles to go in several countries. The world over, approximately, 500 million women and girls suffer from period poverty (World Bank, 2018).

In the Indian context, National Family Health Survey (NFHS) collects menstruation data, and according to an estimate there are over 355 million menstruating women and girls in India (54% of the female population). According to Census 2011, 36% are in the age group 25-49 years. Though the percentage of women between the age of 15-24 years using hygienic methods of protection during menstruation has increased from 57.6% in 2015 to 77.3 % by 2019-21 (NFHS-5, 2019-21), yet it is not 100%. NFHS-4 estimated that out of 336 million menstruating women in India only about 121 million used sanitary napkins (Upadhyay, 2019). Nearly 23 million girls drop out of school when they reach puberty due to menstruation related barriers (Dutta & Bhaskar, 2018).

The impressive upsurge in use of hygienic methods of protection by women in the age group 15-24 years in India has been due to limited policy initiatives by various State Governments to reach out to adolescent girls through educational institutions. However, this leaves a stark gap at two levels, firstly beyond the age of 24 years and secondly, practices among girls outside educational institutions. Not all girls have the privilege of attending school or receiving regular MHM services or infrastructure.

There are many more aspects in MHM than just sanitary napkins which have been examined in our report. There is an absence of a wider policy on MHM covering all aspects, as well as lapses in WASH which have an adverse effect on health. Our research strives to deepen knowledge on grassroot experiences, and builds an argument for a strong bond between public policy, MHM, women's rights, Water and Sanitation Hygiene (WASH), education, health, open discourse and advocacy. The objective of this project is to bring out instances of silence over periods from our evidence based participatory research in the districts we examined, such that the silence could be broken and gaps between policy and practice could be filled.

We analyse how women in various remote, isolated and marginalised communities in fourteen districts in seven states of India fare in terms of menstrual wellbeing, needs and perceptions. Eleven were aspirational districts identified under Niti Aayog's Aspirational Districts Programme (ADP), and three more were added due to their specific vulnerabilities. The project period was from February 2022 to April 2023.

The report gives findings on community beliefs and taboos, corroborative evidence on MHM practices, inter-sectoral correlations, as well as data on engagement of women with health infrastructure and public policy. Based on observations from our qualitative and quantitative data, we present recommendations to the state and civil society ways in which women in India can move towards a sustainable healthy empowerment on MHM.

This study widens the scope of the menstruation discourse beyond adolescent girls to include menstruating women between the ages of 20 to 49 years. We identify barriers and enablers for this group for realisation of safe, secure, equity-based, dignified and hygienic menstrual practices across sectors such as WASH, education, health, unorganised work, and livelihood.

We have combined desk reviews, qualitative and quantitative research methods with a community-based participatory approach and analysis on MHM and WASH. Using a structured search strategy, we investigate women's and adolescent's preparedness & encumbrances from menarche till menopause, and analyse community-based knowledge and practices on menstruation, health and hygiene and their relation to WASH.

Our study indicates that the age cohort of 11 years to 19 years, though surrounded by profound MHM challenges, does not completely represent the full realities of menstruating women beyond 20 years of age. Our identification and analysis of barriers among menstruating women beyond 24 years' age through participant discourses on enablers suggest community specific ways forward.

PURPOSE OF THE PROJECT:

- Acquire understanding of inter-sectoral patterns on menstruation through Surveys (MPQs and MPNSs), KII, Focus Group Discussions (FGDs) as well as a critical review of available literature on MHM.
- Assess knowledge levels, beliefs and practices in MHM in the fourteen districts in the seven states of Assam, Bihar Chhattisgarh Haryana Maharashtra, Odisha and Tamil Nadu, thus covering diverse communities.
- Determine vulnerabilities, issues and risks pertaining to Menstruation and social as well as inter-sectoral stress factors.
- Understand multiple layers of silences and the building blocks by mapping the real-time MHM spaces and times as lived realities of women.
- Identify structural-institutional challenges hindering MHM and explore opportunities to overcome such challenges, including suggesting suitable product awareness campaigns and ground level advocacy techniques.
- Collect data on menstrual health to determine the effects and demographics of menstruation, including puberty trends with individual as well as comparative insights.
- Recommend customised suggestions for legislators, leaders, Civil Society members, Social Workers, Grassroots Leaders; Women Sarpanches, ASHAs and SHG teams.
- Conceptualise, publish, and disseminate the research report based on the above assessments and share with government and other stakeholders.
- The project's motive is to interpret and analyse both the community-based, ethnographic as well as policy-driven facts, knowledge and practices against the prevalence of MHM systems and WASH in India.
- With a view to bring out grounded, bottoms-up suggestions on issues faced by vulnerable communities living in remote and marginalised as well as disaster prone regions, we have engaged interalia with women and adolescent girls from Dalit, forest-dwelling, tribal, Particularly Vulnerable Tribal Groups (PVTGs), and minorities.

1.1 FRAMEWORK OF RESEARCH: DESIGN, METHODS, AND TECHNIQUES

Data collection, analysis and interpretation for this research was completed with an inter-sectoral, inter-disciplinary and participatory focus. Eleven districts from Assam, Bihar, Chhattisgarh, Haryana, Maharashtra, Odisha, and Tamil Nadu were chosen on the basis of their inclusion in the Aspiration District Programme (ADP) of the Government of India (GOI). The remaining three districts, namely, Kokrajhar from Assam, Jhajjar from Haryana and Beed from Maharashtra were included on the basis of various vulnerabilities including women facing a large number of MHM related health and WASH issues, ethnic tensions and community-based barriers.

Combining desk reviews with qualitative and quantitative research methods, the study employed community–based, ethnographic and statistical tools. Seeking community-based data as well as voices, literature reviews, comparative analysis, statistical correlations complemented the grounded findings to arrive at our final inferences.

1.2 STATEMENT OF PURPOSE (SOP)

Recognising the limitations of the present policies which usually give primacy to adolescent girls, this study is with the aim of expanding the focus beyond school years to **Elder and Ageing Menstruating Women (EAMW)** between the age of twenty to forty-nine years. We collected data and completed analysis on the barriers and enablers that the EAMW experience and accept or are keen to change.

Our coverage between EAMW, Women undergone hysterectomy and those attained menopause was as under:

(Data is in %)

Status of Menstruation	Assam	Bihar	Chhattisgarh	Haryana	Maharashtra	Odisha	Tamil Nadu	Total
Elder and Ageing Menstruating Women (EAMW)	83.7	83.3	87.5	81.6	81.1	83.3	91.5	84.3
Women undergone Hysterectomy	6.4	7.8	2.3	5.1	11.4	1.2	3.3	5.3
Women attained Menopause	9.9	8.9	10.2	13.2	7.5	15.4	5.3	10.4
Total (No:s)	**717**	**856**	**792**	**702**	**577**	**738**	**457**	**4839**

1.3 REGIONS AND AREAS

The primary focus is on women from an average of five villages in each district covering diversely vulnerable communities.

The geographic breakup of areas covered in our study is given below. Except for Kokrajhar, Jhajjar and Beed, the other 11 are aspirational districts under Niti Ayog's Aspirational Districts Programme (ADP):

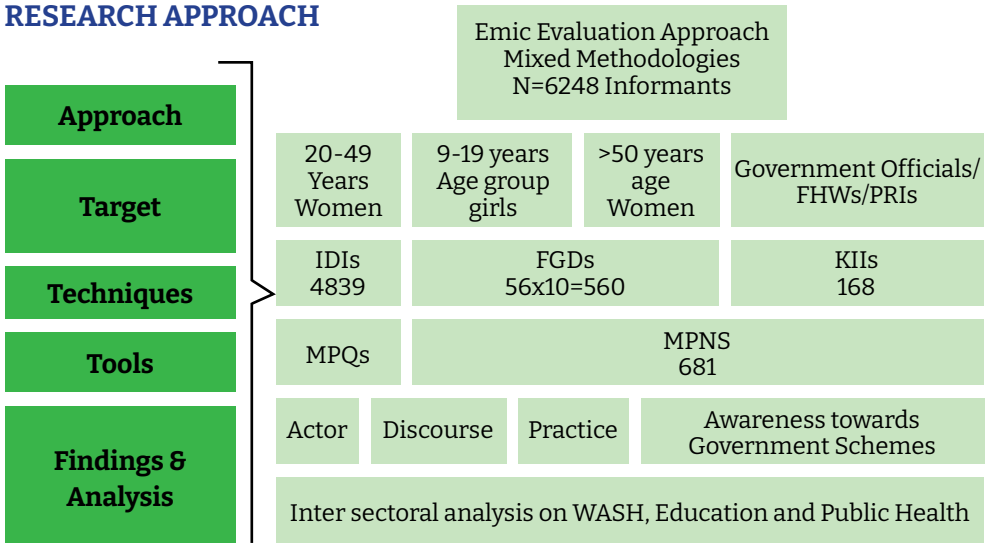
State	Districts	Total Block	Revenue Villages/ Hamlets	Municipal Corporations
1. Assam	Baksa	1	5	0
	Kokrajhar	2	5	0
2. Bihar	Katihar	2	4	1
	Khagaria	2	5	0
3. Chhattisgarh	Mahasamund	1	5	0
	Uttar Bastar Kanker	2	5	0

State	Districts	Total Block	Revenue Villages/ Hamlets	Municipal Corporations
4. Haryana	Jhajjar	2	5	0
	Mewat (Nuh)	1	5	0
5. Maharashtra	Osmanabad	2	5	0
	Beed	1	5	0
6. Odisha	Malkangiri	1	14	0
	Kalahandi	1	13	0
7. Tamil Nadu	Ramanathapuram	2	4	1
	Virudhunagar	2	4	1
Total	**14**	**22**	**84**	**3**

NITI Ayog's ADP programme:
Owing to inter and intra-regional disparities, disasters, risks and developmental lags especially in the human and social development sectors, the Aspirational Districts Programme(ADP) of the GOI announced in 2018, is an attempt to shift the focus back on health, nutrition, livelihood and education in the ADP selected districts. The health sector itself comprises of 13 indicators in the Aspirational Districts (ADs) (Kapoor and Green 2020). Overall, the ADP is based on three core principles of convergence, collaboration, and competition amongst various stakeholders involved, the unique programme aimed to track and measure the growth of the districts under it on 49 developmental indicators, ranging broadly across five themes namely, health and nutrition, agriculture, financial inclusion and skill development, basic infrastructure, and poverty (Deb 2021).

1.4 RESEARCH METHODOLOGY AND ANALYSIS

The Emic Evaluation Approach (EEA) was adopted, for its relevance in mapping vulnerable communities in sensitive situations. Using a combination of ethnographic tools and methods, the **EEA is based on three circular steps, namely, the actor analysis, discourse analysis and practice analysis.** These three steps also became our thematic categories adopted to collect, analyse, and draw inferences from our data with comparative, inter-sectoral and context-specific perspectives. Since our research covered many participants from whom we sought data of qualitative as well as quantitative significance, we chose a mixed-methods design. A mixed



(The project adopted a mixed methods design, incorporating primary data collection that was done through quantitative and qualitative tools and data collection strategies with the Emic Evaluation Approach (EEA) as the covering methodology. A review of the literature was done including policy documents, and media reports, academic databases through google scholar. Additionally, qualitative interviews of key stakeholders).

methods design helped devise data collection tools and utilise them to collect information on MHM from randomly selected interviewees from selected villages and hamlets in fourteen districts. While seeking precise information on actor profile, discourses as well as practices, in order to detect women's felt needs, preferences and experiences from a inter-sectoral perspective, open-ended In-depth Interviews (IDIs) were held.

Tools such as Menstrual Practice Questionnaires (MPQs) as well as the Menstrual Practice Needs Scale (MPNS) were adapted for suiting our research design for completing IDIs among women 20 to 49 years of age. Data collection was further supported by interactive Focus Group Discussions (FGDs) amongst adolescent girls and EAMW. Key Informant Interviews (KIIs) with local partners complemented our fieldwork and provided us with critical findings, ground insights and inferences. Such a combination of interviews, discussions, and interaction from individual menstruators, group as well as key informants enhanced our statistical participatory research process to provide us with corroborative information alongwith analytical insights.

1.5 DATA COLLECTION TOOLS: MPQS, MPNS, FGDS AND KIIS

Interaction was done with women belonging to different communities and groups such as Scheduled Castes (Dalits), Scheduled Tribes (STs), Particularly Vulnerable Tribal Groups (PVTGs) and various religious groups and minorities. Data collected was regarding perceptions, beliefs, experiences and practices on MHM employing four kinds of tools:

- MPQs: Menstrual Practice Questionnaires (MPQs) through in-depth interviews amongst women in the age group of 20 years to 49 years of age.
- MPNS: Menstrual Practice Needs Scale (MPNS).
- Focus Group Discussions (FGDs) with adolescent girls (10-19 age group) and elderly women (above 50 years). In-depth interviews of 168 respondents were conducted embedding quantitative components to further investigate qualitative themes. Periodical review was conducted for checking the quality of the process and content of the MPQ, and stakeholders' interview codebook was developed in depth.
- KIIs: Key Informant Interviews (KII) collected data from Anganwadi Workers (AWWs), Asha Workers, Auxiliary Nurse and Midwives (ANMs), School Teachers, Frontline Health Workers (FLHWs, School Counsellors, Medical Officers, Ward Members, Sarpanches and social activists.
- Data collection was facilitated on ground by local partner organisation who helped by conducting MPQs, MPNS, FGDs and KIIs.

PART 2 KEY FINDINGS

Women and girls constitute half of India's population. Yet, gender disparities remain a critical issue in India impacting women and girls' education, health, and workforce participation owing to many reasons, menstruation being an important one. MHM intervention could be a gateway towards addressing other inter-sectoral linkages of MHM.

There is an increasing inter-sectoral focus on policies in India related to toilets, water supply and good sanitation. MHM requires providing safe, secure, private, and functional WASH facilities for girls and women. Despite national efforts to improve sanitation, women and girls lack appropriate facilities and community support to manage their menstruation privately and safely. There are over 355 million menstruating women and girls in India, but millions of women across the country still face significant barriers to a comfortable and dignified menstrual hygiene management experience. Enhancing the national focus on attaining MHM milestones to meet WASH and Gender Equity parameters of SDGs can go a long way.

Although India has been progressing on the issue of MHM and WASH, the evidence linking the impact of poor menstrual health on critical health outcomes is limited. Current studies have small sample sizes and rely on qualitative, self-reported, or anecdotal data making it difficult to generalise findings across diverse adolescent and women population in diverse cultural and socio-economic regions.

There is need for more research on the impact of menstrual health interventions on life outcomes. This present report by Sulabh Sanitation Mission Foundation (SSMF) on 'Combating the Silence from Menarche to Menopause – A Comprehensive Report on Menstrual Hygiene Management in India' is a small but significant step to understand the layers of silence and potential ways to combat it .

Below, we present some salient Pan-India findings

2.1 INFRASTRUCTURAL AND PHYSICAL BARRIERS

Schools, Toilets, and the Silence: Our data indicates that girls are fearful of using school toilets during menstruation owing to lack of water, soap, sanitation, missing doors and taps, and even missing dustbins. This provokes absenteeism from schools during periods, which implies that for up to 60 days in a school year a menstruating girl is either unable to attend classes or goes half-heartedly, feeling ill-at-ease. It emerges from our findings that distance from home to school is not as big a deterrence for girls to miss school, as is lack of MHM facilities. Girls even cycle their way to school far away. However, if they do not get regular menstrual hygiene material such as pads, they find it safer to stay at home. It is a forced choice when young girls chose security, privacy and safety of their home to manage their periods over the dismal absence of sanitation and MHM facilities in schools.

- Menstruation is an embodied experience. The felt emotions and risks during menstruation to adolescent girls in schools without facilities, far outweighs and silences the benefits of schools. Women exercise their choice on bodily comfort, hygiene and safety and guide their adolescent daughters and granddaughters to opt for safer MHM scenarios.

2.2 BARRIERS ON CHOICE & ACCESS TO HEALTH SERVICES:

Diseases, Taboos and Silence: For EAMW, married, unmarried women beyond school going years, young mothers and middle-aged women living in remote, rural and impoverished areas, there are day- today taboos and restrictions on their menstrual health choices. Our findings indicate that many (7%) women prefer to skip consulting doctors for intimate health issues related to menstruation. Others opined that medical help was far away (1.7%), no one to accompany (0.7%) and lack of women doctors (91.7%), hesitation to consult male doctors (2.0%), all of which contributes to deepening the maize of barriers around the issue.

Most (55.8%) women who end up with RTIs, UTIs, uterine and cervical disorders, and diseases state not being able to pursue treatment as a major factor for their condition. What makes it worse is that despite family income through regular or seasonal work, many women in marginalised situations do not have access to family cash. Fifty percent of those who did pursue treatment for MHM related maladies, either optout mid-way owing to high expenditure or start relying on quacks, home remedies, ASHA etc. Therefore, our data indicates that community and family-based taboos, alongside patriarchal constraints such as lack of disposable income in the hands of the woman, all have a constrictive influence on a woman's MHM wellbeing.

- Taboos, myths and social norms on menstruation across many cultures in India are restrictive enough on their own, but when these intersect with lack of a woman's financial independence, then her dignity and voice over her menstrual health and wellbeing stands compromised.

2.3 ATTITUDE AS DETERRENCE TO MHM

Negligence, Denial and Silence: Poverty, family negligence, meagre availability and access to healthcare as well as infrastructure aside, nearly half of our respondents assumed that, issues such as white discharge, pain, swelling, burning and itching near vagina were not serious and life threatening and do not require medical intervention. Rather than negotiating their marginalisation to voice their needs when faced with social and infrastructural barriers, many (25.5%) women prefer to remain silent and in denial of the risks associated with poor menstrual hygiene.

- During our surveys, many (65.3%) women chose the option, 'Do not have any health problem' when asked about their menstrual well-being. Perhaps this denial is a calculated response helping women to remain silent on MHM issues in the face of all kinds of social pressures.

2.4 ONUS OF PUBLIC POLICY TO GIVE VOICE ON MHM, WASH AND SDGS

Power Relations impact Resource Availability, Wellbeing and Rights of women: Families and communities are not the only barriers that produce zones of silence on MHM. Knowledge, Attitude and Practice (KAP) on MHM are influenced by various factors that allude to not only communities and cultures but also to public policy and a politics of rights. Absence of Policy, implementation, and monitoring induces various kinds of silences as is evident from our findings that indicate the following:

- Adolescent girls in India face various constraints in terms of lack of opportunities for pursuing higher education owing to increasing family responsibilities (household chores, sibling care) and community-based restrictions that start from the school years onwards, but do not end there. Women, as homemakers or professionals as well as labour in the unorganised sector continue to face stark discrimination.
- Women who make their living by selling products in open markets such as fisher-women, those who work in fire- cracker making units, tea Gardens and on labour –intensive sugarcane farms and brick-kilns undergo a double whammy in terms of their freedom to manage their bodily hygiene during periods. Family & community barriers aside, their workplace lacks pad-changing and disposal mechanism, availability of adequate menstrual materials, and in general, functional toilets with water and sanitation facilities.

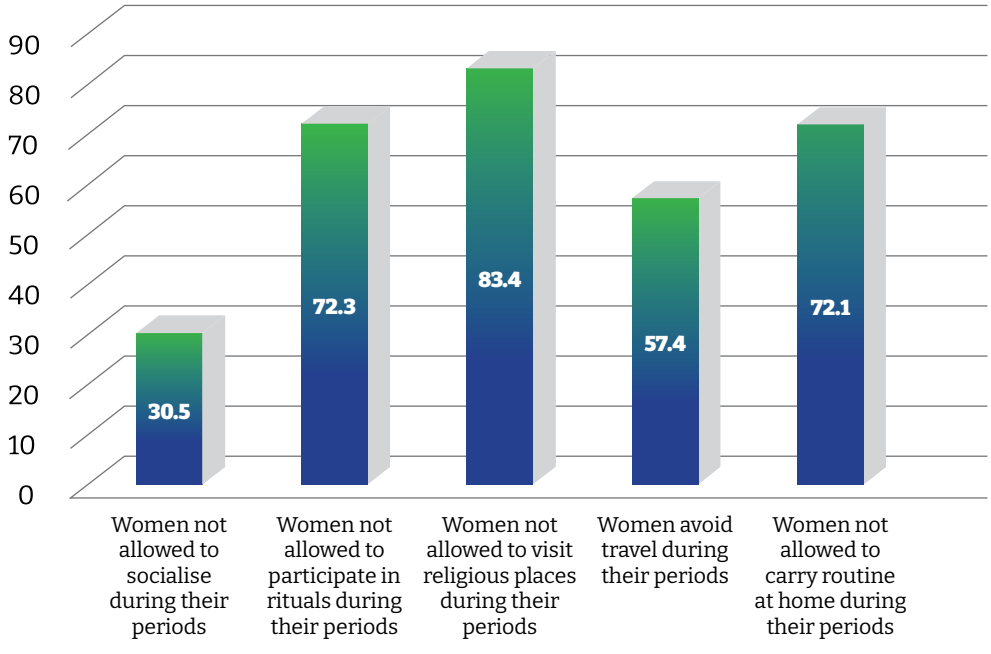
2.5 COMPLIANCE ISSUES AND SOLIDARITY TOWARDS SAFETY AND SECURITY OF WOMEN

Relations, power and resource distribution structures within families, terms of production and exchange and principles of equity all influence how women perceive their wellbeing and how they have access to opportunities to deal with intimate MHM and other health issues. Policy silences can be administered and monitored by governments and other stakeholders in tandem to ensure gender mainstreaming and compliance for women's safety and security in line with India's commitment to SDGs.

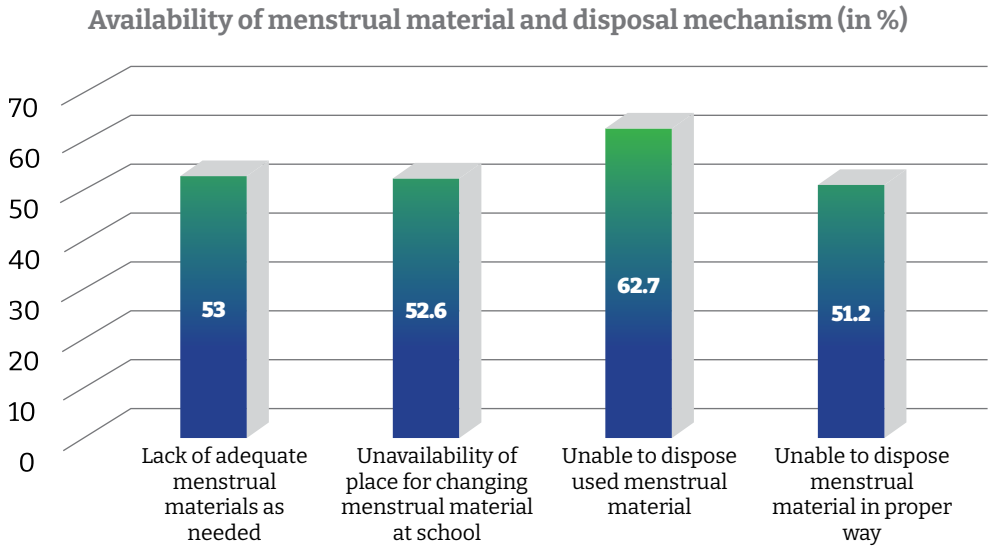
- Only when gender-based health, education and economic self-sufficiency and wellbeing is assured for school going and young girls; mothers and ageing women alongwith community-based awareness, can India move towards a SDG-conducive ecosystem. In fact, streamlining MHM and WASH will improve more than just SDG related targets.

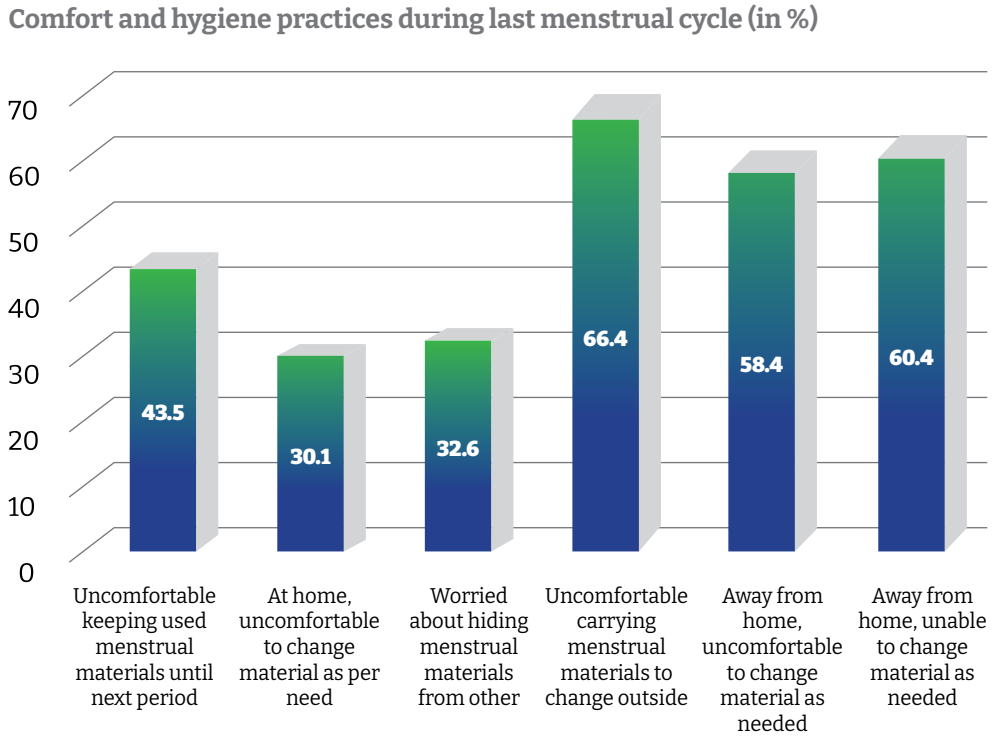
Some of the Social Customs, Beliefs, Taboos and Myths we encountered are listed below:

2.6 SOCIAL CUSTOMS, BELIEFS, TABOOS AND MYTHS N=4389 (IN %)



EAMW'S VOICES: AN ACCOUNT OF FELT NEEDS DURING LAST MENSTRUAL PERIOD AMONG 681 PARTICIPANTS





PART 3 KEY RECOMMENDATIONS

3.1 FORM STATE MHM COMMITTEES

Despite country-wide strides made in delivering services such as free sanitary and toilet facilities, yet the progress and monitoring still suffer for vulnerable communities in states, districts and villages. A State level Menstrual Health Committee can integrate women's menstrual health and hygiene wellbeing (specially for remote and isolated places) into the State's ADP and MHM plans.

3.2 MHM AT DISTRICT, BLOCK, GRAM PANCHAYAT LEVEL

Information, Education, and Communication (IEC) for menstrual hygiene education and awareness be operationalised at school level; also for EAMW, with community sensitive methodologies and knowledge on MHM products and safe disposal of menstrual materials' waste.

3.3 INTEGRATE NATIONAL SCHEMES LIKE JJM WITH MHM

Schemes such as Central Government's Jal Jeevan Mission (JJM) can be widened in scope to also focus on water supply in rural schools, villages, anganwadis, community, livelihood- spaces (such as markets) and places of work (such as farms and factories). Ensuring sustainable water sources along with augmenting and strengthening of water sources, and provision of Functional Household Tap Connections (FHTCs) to all households (under JJM) will go a long way in providing a WASH support to MHM. JJM initiatives in Aspirational Districts will achieve good health outcomes for menstruating girls and EAMW.

3.4 RESOLVE INFRASTRUCTURAL INADEQUACIES AND GIVE VOICE TO MHM IN WELFARE SCHEMES

According to our findings, villages need urgent infrastructural interventions to bring relief to EAMW. Community voices assert that owing to poverty, water shortages, lack of toilets and remote existence, women beyond school years lack opportunities to take proper care of MHM or invest in sanitary pads. EAMW demanded to be provided free sanitary pads or, priced at a token amount of one Rupee per pad, including for young menstruating girls during school vacations. The EAMW also proposed monthly or three-monthly compulsory health check-ups to be organised in their villages.

3.5 MAKE SCHOOLS AND TOILETS PERIOD SAFE

Provide community toilets as well as toilets in workplaces with washing areas, bathing cubicles, and running water under SBM(G) phase II wherever required. If all toilets are more MHM friendly & safe in terms of sanitary dignity and security to change and dispose menstrual hygiene products, then women and girls can achieve more robust participation in education and employment. Schools should be provided with separate toilets for girls with running water through tap connection and proper storage tanks under the JJM or other scheme. Toilets in homes, public places and workplace should be properly constructed, having regular water supply. There should be a separate room for women workers in factories & farms, and in community and coastal workplaces to enable them to change their menstrual pads and clean themselves.

3.6 PAD/ MENSTRUAL ABSORBENT DISPENSING AND DISPOSAL

Our data indicates that EAMW not only demand that pads/ absorbents be available within reach for marginalised communities, but they be given the infrastructure for proper disposal of menstrual waste. Women feel unsafe and sad if they out of compulsion at workplace have to use a thornbush facade for changing and throwing menstrual waste. Though many women are aware of the importance of cleanliness, hygiene, and their duty to the environmental, yet they are forced to dispose menstrual waste in the open, for want of better disposal facility. We suggest that disposal systems be urgently facilitated and monitored, and maintained for sustained use. Orientation to young girls and women to deal with menstrual waste in a dignified and secure way be given. Installation of Pad-Vending Machines at every Anganwadi and SHG premises will further help MHM.

3.7 EARLY MHM INTERVENTIONS

Young menstruating girls feel extremely uncomfortable to go to school for four to five days during menstruation owing to the fear of no toilets in school. Teachers, school counsellors and social workers and FLWs themselves need to be oriented to (a) propose infrastructural interventions at the school level through Gram Sabha/ Panchayats resolutions; (b) proactively ensure that school sanitation facilities are monitored regularly c) help raise awareness for adolescent girls for better MHM at home and in schools such that a menstruating girl's

education remains uninterrupted and periods do not become a hurdle owing to apprehension and fear of going to a school which is not MHM safe.

3.8 CAPACITY BUILDING AMONG YOUNG GIRLS

Improving a young girl's orientation towards MHM will ensure that they continue their schooling smoothly post-menarche. Educating children entering puberty is a prime need that EAMW point out in all villages under study. Growing girls need to have physical and reproductive knowledge of their body and well-being. If menstruation is not given a proper place in the discourses in an adolescent female's life, they go through feelings of isolation, stress, embarrassment, and confusion over this issue. Making schools period -safe, in terms of knowledge, sanitation and proper MHM care is important in order to ensure continuity in education by girls.

3.9 EAMW AS FIRST LINE OF DEFENCE

Since, EAMW are experienced, adult women with a grounded and intergenerational wisdom, they can enthuse positive changes and guidance on ground. We recommend that the EAMW be encouraged to participate in as well as hold MHM awareness drives.

3.10 EMPOWER WOMEN, PROVIDE DISPOSABLE INCOME

Lack of monetary resource and decision making powers for EAMW to travel and approach doctors and hospitals for vital and timely advice and treatment impedes MHM outcomes in communities. Building vocational skills and income capacity of EAMW from remote, poor, and marginalised backgrounds through micro financing and SHGs will provide them with disposable incomes. This will in turn empower women to manage MHM with long-term sustainability for themselves as well as younger girls in their families.

3.11 EXPLORE MICRO- CREDIT FACILITIES THROUGH SHGS AND ADP

Women Self Help Groups (SHGs) in villages are often provided with revolving funds. The scope of financial assistance can be widened under ADP and other schemes of GOI to provide credit facilities to EAMW to help augment their earning capacity enabling active decision making by them for their MHM and health.

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