COMBATING THE SILENCE FROM MENARCHE TO MENOPAUSE

A COMPREHENSIVE REPORT ON MENSTRUAL HYGIENE MANAGEMENT IN INDIA

A RESEARCH REPORT FROM:

- ASSAM
- BIHAR
- CHHATTISGARH
- HARYANA
- MAHARASHTRA
- ODISHA
- TAMIL NADU

Covering 14 Districts of India (11 Aspirational)

COMBATING THE SILENCE FROM MENARCHE TO MENOPAUSE

A COMPREHENSIVE REPORT ON MENSTRUAL HYGIENE MANAGEMENT IN INDIA

A RESEARCH REPORT FROM:
ASSAM, BIHAR, CHHATTISGARH, HARYANA, MAHARASHTRA, ODISHA, TAMIL NADU

Sulabh Sanitation Mission Foundation (SSMF)
New Delhi

The complete report can be read online on
our dedicated MHM knowledge hub.

www.sulabhmhm.com

ISBN : 978-93-5996-853-7

Designed & Printed by :

Xtreme Office Aids Pvt. Ltd.

Phone: +91-9311156526, 011-41254436
E-mail: xtremeofficeaids@gmail.com
info@xtremeonline.co.in
website: www.xtremeonline.co.in

1943-2023

This book is in the
memory of Late Dr. Bindeshwar Pathak
(Padma Bhushan awardee).

OUR TEAM

Nirja Bhatnagar was the Team Leader which made this Research Project and its Report possible. Sulabh Sanitation Mission Foundation (SSMF) expresses its sincere gratitude to her and to the following members of the Research Team:

Dr. Bobby Luthra Sinha,
Lead Researcher.
PhD and Post -doc.
28 years of experience as a researcher and academician.

Dr. Bobby Luthra Sinha fulfilled her role as Lead Researcher for this project. Dr. Bobby Luthra Sinha is a Social Anthropologist and Political Scientist who holds a PhD form the University of Basel, Switzerland and a Post-doc from the University of KwaZulu Natal, Durban , South Africa.

Deepali Yakkundi,
Quantitative Data Analyst,
Researcher in Health (Data analyst) working in health sector since last 17 years.

Ms.Deepali Yakkundi, possesses profound understanding of quantitative research, utilizing wide array of statistical tools. Her hands-on involvement in the quantitative report was crucial to the project.

Praveenkumar Pawar
Project Manager,
BBA, MS (NGO),
WASH & DRR Expert, 23 years of experience

Mr. Praveenkumar Pawar's invaluable contributions, unwavering dedication, and exceptional expertise played a pivotal role in ensuring the successful completion of the project.

Mohd. Uvais,
Research Assistant.
MA (Political Science).

Mr. Mohd. Uvais was a constant source of support for the research team and he fulfilled his role extremely diligently

Pratik Sunkar
Project Coordinator,
B.A.LL.B., MSW.

Mr. Pratik Sunkar's constant support to the research team during the entire duration of this research study, contributed to it's success.

OUR PARTNERS

SSMF is sincerely grateful to it's grassroots NGO partners mentioned below (in alphabetical order) as well as their volunteers/interviewers. They have worked tirelessly to engage with the respondents and meticulously collect data on such a sensitive topic with a compassionate lens.

Adivasi Samata Manch (Uttar Bastar Kanker, Chhattisgarh)

Centre for Action Research (Kalahandi and Malkangiri, Odisha)

Community Renovation and Organisation Advancement Trust (Ramanathapuram and Virudhunagar, Tamil Nadu)

Janvikas Samajik Sanstha (Beed, Maharashtra)

Nav Jagriti (Khagaria, Bihar)

Paryay (Osmanabad, Maharashtra)

Prayas Foundation for Social Change and Economic Reforms (Katihar, Bihar)

Shree Jan Kalyan Samaj Sevi Sanstha (Mahasamund, Chhattisgarh)

Souls in Quest for Social Action Foundation (Baksa and Kokrajhar, Assam)

SSMF extends it's sincere gratitude
To

Dr. M. Sivakami

Professor,
School of Health Systems Studies, Tata Institute of Social Sciences, Mumbai.

Scientific and technical advisor to the project and an external reviewer of the report.

MESSAGE

I am pleased to know that Sulabh Sanitation Mission Foundation has done an extensive research study titled 'Combating the Silence from Menarche to Menopause – A Comprehensive Report on Menstrual Hygiene Management in India' across fourteen districts (11 aspirational) across seven states namely Assam, Bihar, Chhattisgarh, Haryana, Maharashtra, Odisha, and Tamil Nadu. The research is extremely important at a time, when the Government of India, under the leadership of the Prime Minister Narendra Modi has made the subject of Menstrual Hygiene Management (MHM) an important policy issue. The Prime Minister specifically talked about Menstrual Hygiene Management during his Independence Day address to the nation in 2020 and underlined that safeguarding woman and girls' health has always been a priority for the government.

India is doing well in addressing the issues of MHM but as this study shows that much more needs to be done. MHM has a crucial part in achieving the U.N. Sustainable Development Goals. This study is based on ethnographic data of menstruating women between the age of 20-49 years old. More specifically it also collected data on menstrual challenges of Elder and Ageing Menstruating Women. It collected in-depth data on actors, practices, and discourses with an inter-sectoral and analytical perspective on Menstrual Hygiene Management (MHM).

The study addresses the needs of diverse communities cutting across ethnicities, caste, cultures, and religions and interrogates various underlying issues surrounding menstruation. It also looks at the needs of women who migrate for work or with families especially those working in relocation destinations such as sugarcane farms, brick kilns, mines, and factories. The narrative of the participants from every district shows new evidence-based knowledge that can be leveraged to strengthen existing policies or inform new MHM policies so that all women and girls derive the health benefits of our menstrual hygiene polices.

The study also underlines that women's health and wellbeing does not exist in silos. Whilst availability of affordable sanitary pads are extremely important, structural issues of water, sanitation, and hygiene (WASH), efficient delivery of public schemes, education, and community awareness to tackle prevailing stigma around menstruation are equally important. Importantly, the data suggests that more awareness on personal hygiene, MHM and WASH is required among menstruators between the ages of 20 to 49 years.

The research fulfills an important knowledge gap in the challenges and barriers that elder and ageing menstruating women as well as adolescent's girls face in some of our remote areas. I am optimistic that the study will inform policy makers, researchers and those working in MHM and guide them towards adopting programmes that address one of the vital needs for the well-being of all women and girls in the country. I hope the report will be useful to the government and policy makers to implement a holistic policy around MHM to safeguard our women and girls.

I take the opportunity to congratulate the research team for producing this outstanding study.

Kumar Dilip
President, Sulabh International Social Service Organisation

September 2023

FOREWARD

Pankaj Jain, IAS (Retd)
Former Secretary Government of India
Ministry of Drinking Water & Sanitation

Menstruation is a natural body process, nothing to be ashamed of. Yet all over the world there is discrimination, ostracization and lack of equal opportunity women face during periods. This study comprehensively documents the existing taboos and barriers around menstruation, specially in socially and economically disadvantaged areas of India with respect to Elder and Aging Menstruating Women, as also school girls. Silences on the subject makes the issue more unhelpful to menstruators. This study is in the right direction to break this Silence by documenting the voices of the menstruating age women in first person spelling out the deprivations they undergo. The individual interviews documented in this research book gives one the feel of the existing barriers. The study ends with a host of good suggestions for affirmative action to make life for women more comfortable with respect to menstruation.

The study brings out the fact that about 50% women in India still use cloth rags (including re-used) or other rudimentary practices, as many are not empowered enough to make their own economic decision to purchase pads or other menstrual materials. Schoolgirls lack water and sanitation facilities in schools, as a result of which they either miss school during periods, else drop out of school altogether. This scenario is more typical of rural areas in backward districts.

I do feel there is a huge need to overcome Period Poverty and create menstrual equity in society. There is lack of menstrual and related hygiene advocacy & education, lack of affordability of clean sanitary products like pads instead of re-using washed rags. Due to economic necessities, users often find buying food a better priority than pads.

There is a need to make availabile Clean Toilets with a Menstrual Corner in the Ladies' section, in close distance within schools, offices and workplace, specially for labour. Toilets that are Period/ MHM friendly having running water, washing facility and changing room, enabling change of soiled sanitary pad as per demand once or twice or thrice a day. This menstrual corner would prevent absenteeism and dropout in schools and possible hysterectomies in female labour which is prevalent now due to lack of menstrual facilities. Pad dispensing machine and facility for safe & scientific disposal of used Pads through green disposal methods should be a part of this menstrual corner, which will ensure that animals or flies do not prey on used pads and spread disease.

This study gives some suggestions for practitioners and stakeholders which will do away with Period Poverty and create Menstrual Equity. Taking a cue from this study, Government may like to implement a Policy Framework, and also allot sufficient budget to State Governments, and possibly implement Menstrual Equity in a Mission Mode through a Nari Sehat Mission as a successor to Swachh Bharat Mission, specially in rural areas. Health of women of India will translate to the Health of India.

We need to cover Menstrual Education and Advocacy in schools, villages, urban slum areas, and isolated workplaces through lectures, workshops, hoardings and pamphlets. Also distribution at affordable cost or free sanitary pads and other sanitary materials; filling any missing gaps in availability of toilets in Homes, Schools, Markets, Offices and Workplaces and adding a menstrual corner as an exclusive area in Ladies Toilets.

Upto now, there has been some limited success in MHM through a scheme for distribution of Pads at a cost of Rs 6 and now Rs 12 for a bundle of 6 pads. Even then it is estimated that still about 50% of girls and women in India still use rags and re-used/washed and dried cloth, specially in our villages. Partly Affordability is to blame, partly it is not considered as a necessary household expenditure due to lack of education of the ills of using rags, and also because in many cases women are not empowered to make their own financial decisions. Empowering women financially to use household funds for their own health would be helpful.

I would like to thank the research team for bringing out an excellent compendium, and hope that the suggestions put forward by the researchers are put in practice on the ground by various stakeholders.

Pankaj Jain, IAS (Retd)
Sr. Principal Advisor, Sulabh Sanitation Mission Foundation

September 2023

PREFACE

Nirja Bhatnagar
Team Leader

In a world that strives for progress, development, and equity, there remain profound challenges that require our unwavering commitment and concerted efforts. Among these, gender disparity and gender equality stand as pivotal issues that demand our collective attention. In the heart of India, where traditions coalesce with modernity, Sulabh International Social Service Organisation has been a torchbearer of change for five decades. Through its pioneering work in providing public toilets across the nation and around the world, this organization has illuminated a path towards a brighter, more inclusive future.

India, like many other countries, grapples with the complex issue of gender inequality. It's a challenge that intersects with numerous social and economic disparities, such as socioeconomic status, disability, age, geographic location, ethnicity, gender identity, and sexual orientation, among others. Gender-based discrimination, particularly against women and girls, not only perpetuates inequality but also jeopardizes their health and well-being. In the shadows of rigid and harmful gender norms, women and girls face discrimination that transcends into their health and access to essential services. It's a stark reality that begs to be addressed. This study explores these multifaceted issues, delving deep into the cultural and social aspects that have led to the stigmatization of menstruation—a natural and vital process in a woman's life.

The journey from menarche to menopause is a significant part of a woman's life, spanning approximately 1,400 days in a low-income country. Yet, the silence surrounding menstruation remains deafening, leading to countless health problems and complications due to the absence of accurate information and open discussions. While some organizations have embraced the natural phenomenon of menstruation and implemented progressive approaches, the broader social implications of ineffective menstrual hygiene management continue to persist. Passive schemes alone are insufficient. What's needed is a multidisciplinary effort to understand the wide-reaching issues that affect millions of women and girls across our nation. Poor menstrual hygiene has tragically emerged as one of the leading causes of mortality worldwide. It is high time that we, as a society, recognize our responsibilities towards women and their menstrual rights. We must ensure that women receive the resources necessary to maintain their menstrual hygiene without discrimination or shame.

Sulabh International has been at the forefront of community engagement on Water, Sanitation, and Hygiene (WASH) issues for more than half a century. In our quest for deeper insights into gender issues within WASH, we embarked on a journey across seven Indian states. What we discovered was a stark deficit in livelihood opportunities, education, sanitation, health services, and transportation, especially for women. This study is a testament to our commitment to addressing these critical issues. It emphasizes the need for regular evaluation and monitoring of schemes aimed at improving menstrual hygiene. Through health education, nutritional supplementation, personal hygiene enhancements, and sanitation improvements, we can pave the way to a healthier future for women and girls.

Menstruation is a natural, biological process—one that signifies good health. It should be normalized and celebrated, not shrouded in stigma. Inadequate menstrual hygiene creates barriers to women's safety, dignity, and health. A human rights and equity perspective are essential when addressing the menstrual hygiene of vulnerable women and girls. Socially rigid taboos and Social control can very well be combatted with education and health services which is affordable, accessible and acceptable to all, and they should be provided with quality, equity and dignity. We must break the culture of silence and end the cycle of neglect. This report is a call to action to break the cultural taboos and discrimination against women. It invites policymakers, social workers, educators, media and every individual to stand together in support of gender equality and menstrual hygiene. Together, we can break the chains of discrimination, celebrate the natural processes of a woman's body, and create a world where health of every woman and girl can thrive.

September 2023

Nirja Bhatnagar
Team Leader, Research Project
Combating the Silence from Menarche to Menopause-
A Comprehensive Report on Menstrual Hygiene Management in India

From the Research Team...

The objective of this study was to assess the various social & infrastructural barriers and enablers to a proper Menstrual Hygiene Management among women in India beyond school years, especially in the age group of 20 years to 49 years. Some issues relating to and concerning school going girls have also been brought out. This report also attempts to bring out the possible policy decisions & action interventions that maybe required at the level of Governments in each state on Menstrual Health Management so as to ensure better & safer health to all menstruating women. The coverage in the study has been restricted to some of the most backward 14 districts in 7 states of India, 11 of which fall under Government of India's Aspirational Districts Programme (ADP).

The research team consisted of professionals alert to the ethics and sensitivities necessary for a community-based, participatory research. Consent of all interviewees was taken, and their identities have been anonymized.

The states, districts, blocks, and villages in this report indicate the research areas selected and our qualitative and quantitative interactions have been conducted across sample populations within these areas. The statistics, percentages as well as inferences indicated in the report therefore pertain to our findings across the selected sample in the selected research areas, and may thus vary from the overall results in areas outside of research areas or in outside of the districts surveyed & from the situation in states other than the researched states. Yet, with minor, variations, the issues brought out have general applicability & relevance across the country.

Our attempt was to highlight the issues of concern in some of the most backward villages/districts of the country so that it could lead to an effective intervention policy at the National & State Levels in order to address these concerns.

All findings by our research team are grounded to a real-time understanding of practices on Menstrual Hygiene Management (MHM) in the selected areas of the study.

We hope our study will lead to policy initiatives at the appropriate levels so as to address the concerns brought out.

September, 2023

CONTENTS

ACRONYMS

AAY	APJ Abdul Kalam Amrut Aahar Yojana
ADP	Aspirational District Program
AD	Aspirational District
AEP	Adolescent Education Program
AIDS	Acquired Immunodeficiency Syndrome
AIADMK	All India Anna Dravida Munnetra Kazhagam
ANNA	Affordable Nutrition & Nourishment Assistance
ANC-PNC	Ante Natal Care-Post Natal Care
Anganwadi	Type of Rural Child Care Centre
ANM	Auxiliary Nurse Midwife
ARSH	Adolescents Reproductive Sexual Health
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
Badi	Indian Dry Snack
BC	Backward Classes
BCC	Behaviour Change Communication
BIHAN	Chhattisgarh State Rural Livelihood Mission
BJD	Biju Janata Dal
BJP	Bhartiya Janata Party
BPL	Below Poverty Level
BRGF	Backward Regions Grant Fund Programme
BTAD	Bodoland Territorial Area District
BTC	Bodoland Territorial Council
BTR	Bodoland Territorial Region
CBO	Community Based Organisation
CDPO	Child Development Project Officer
CHC	Community Health Centre
CRPF	Central Reserve Police Force
CSO	Civil Society Organisation
DMK	Dravida Munnetra Kazhagam
EAMW	Elder and Ageing Menstruating Women
EEA	Emic Evaluation Approach
EWS	Economically Weaker Sections
FGD	Focus Group Discussion
FHTCs	Functional Household Tap Connections
FHWs	Frontline Health Workers
Fitkari	Alum
FLW	Frontline Workers
Gadda	Deep Pit
GCR	Girl's Common Room
GMIs	Government Medical Institutions
GOI	Government of India
GSDP	Gross State Domestic Product
GSVA	Gross State Value Added
HIV	Human Immunodeficiency Syndrome

ICDS	Integrate Child Development Services
IDIs	In-depth Interviews
IEC	Information Education Communication
IFSC/IFA	Iron and Folic Acid
IHHL	Individual Household Latrines
INC	Indian national Congress
JDU	Janata dal United
JJM	Jal Jeevan Mission
Jodi/s	Husband-Wife Team / Women working together with a partner on farms
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
KBK	Kalahandi – Balangir-Koraput
KIIs	Key Informant Interviews
Kutcha	House Roof, wall and floor all made up with kutcha material
LIC	Life Insurance Corporation
LMIC	Low-and Middle-Income Countries
MAVIM	Mahila Arthik Vikas Mahamandal
MBC	Most Backward Classes
MFP	Minor Forest Produce
MHM	Menstrual Hygiene Management
Mitanin	ASHA/Female Health Worker
MPNS	Menstrual Practice Needs Scale
MPQ	Menstruation Practice Questions
NFHS	National Family Health Survey
NGO	Non-Government Organisation
NREGA	National Rural Employment Guarantee Act
NRHM	National Rural Health Mission
NT	Nomadic Tribe
OBC	Other Backward Class
OD	Open Defecation
ODF	Open Defecation Free
OLM	Odisha Livelihood Mission
OOSC	Out of School Children
Papad	Roasted/Fied Indian Wafer/Flat bread
Para	Small hamlets (part of the village situated away from village)
PDS	Public Distribution System
PHC	Primary Health Centre
PID	Pelvic Inflammatory Diseases
PIP	Project Implementation Plan
Pishvi	Uterus
PMBJP	Pradhan Mantri Bharatiya Janausadhi Pariyojna
PMMVY	Pradhan Mantri Matru Vandana Yojana
Pooja Prayer	
Pucca	House Roof, wall and floor all are made up of pucca material then pucca house
PVTG	Particularly Vulnerable Tribal Group
RCH	Reproductive Child Health
RH	Rural Hospital
RKSK	Rashtriya Kishori Suraksha Karyakaram
R&D	Research and Development
RTI	Reproductive Tract Infections
SATH	Sustainable Action for Transforming Human
SBA	Swachh Bharat Abhiyan
SBM (G)	Swachh Bharat Mission (Gramin)
SBM (U)	Swachh Bharat Mission (Urban)
SC	Schedule Caste

SDG	Sustainable Development Goal
Semi Pucca	House either 1 or 2 from roof, wall and floor is made up of kutcha/ makeshift materials
SHGs	Self Help Groups
SSMF	Sulabh Sanitation Misssion Foundation
ST	Schedule Tribe
STD	Sexual Transmitted Disease
TB	Tuberculosis
TDS	Total Dissolved Solids
TN	Tamil Nadu
TNSRLM	Tamil Nadu State Rural Livelihood Mission
UG	Undergraduate
UNICEF	United Nation Children Emergency Fund
UT	Union Territory
UTI	Urinary Tract Infection
VHC	Village Health Centre
VHN	Village Health Nurse
VHNC	Village Health and Nutrition Committee
VHND	Village Health Nutrition Day
VHNP	Village Health Nutrition Programme
VRP	Village Resource Person
VWSC	Village water and Sanitation Committee
WASH	Water Sanitation and Hygiene
WCD	Women and Child Development
WIFS	Weekly Iron Folic Acid Supplement Scheme
WSSCC	Water Supply and Sanitation Collaborative Council

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):

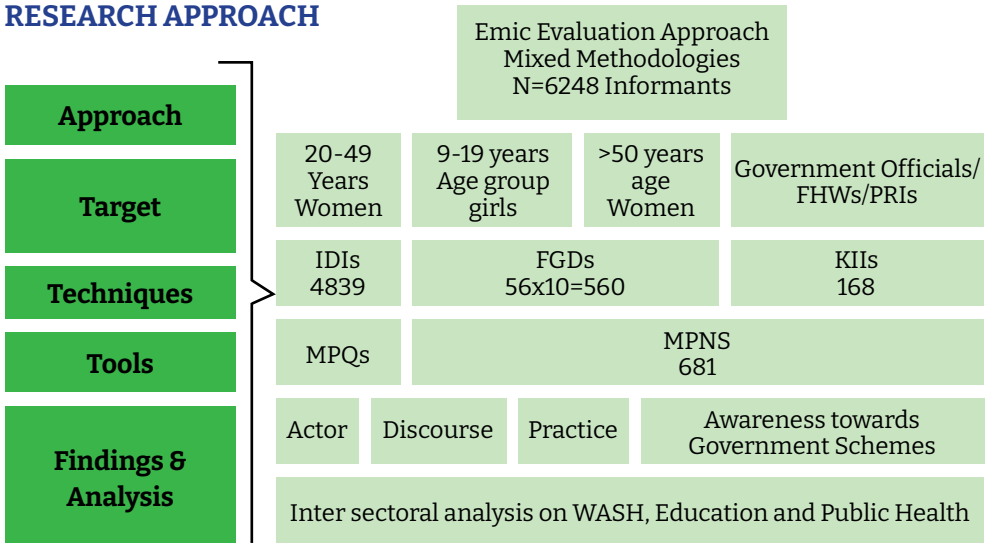
State	Districts	Total Block	Revenue Villages/ Hamlets	Municipal Corporations
1. Assam	Baksa	1	5	0
	Kokrajhar	2	5	0
2. Bihar	Katihar	2	4	1
	Khagaria	2	5	0
3. Chhattisgarh	Mahasamund	1	5	0
	Uttar Bastar Kanker	2	5	0

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.

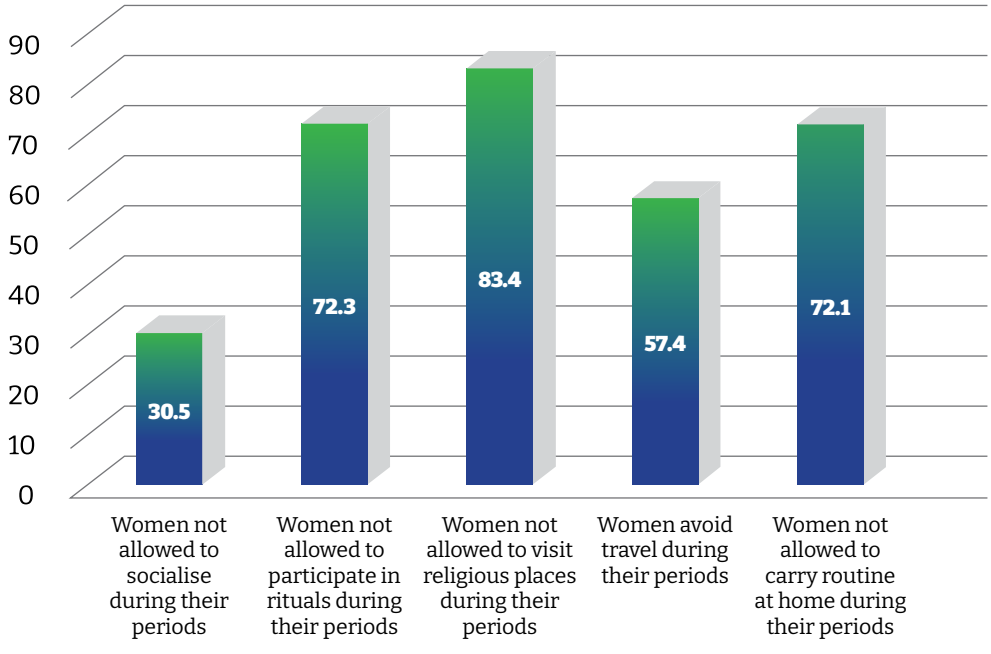
2.5 COMPLIANCE ISSUES AND SOLIDARITY TOWARDS SAFETY AND SECURITY OF WOMEN

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.

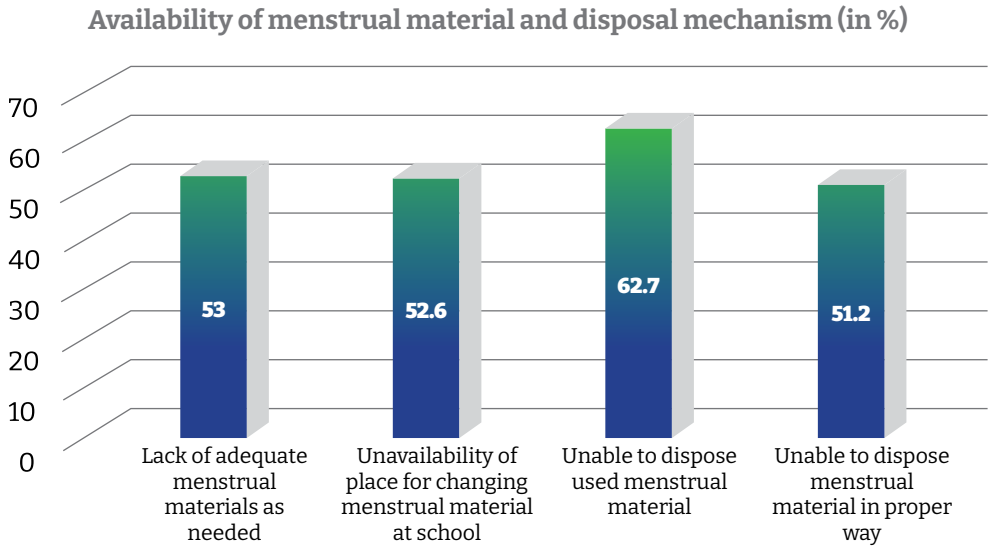
- Only when gender-based health, education and economic self-sufficiency and wellbeing is assured for school going and young girls; mothers and ageing women alongwith community-based awareness, can India move towards a SDG-conducive ecosystem. In fact, streamlining MHM and WASH will improve more than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

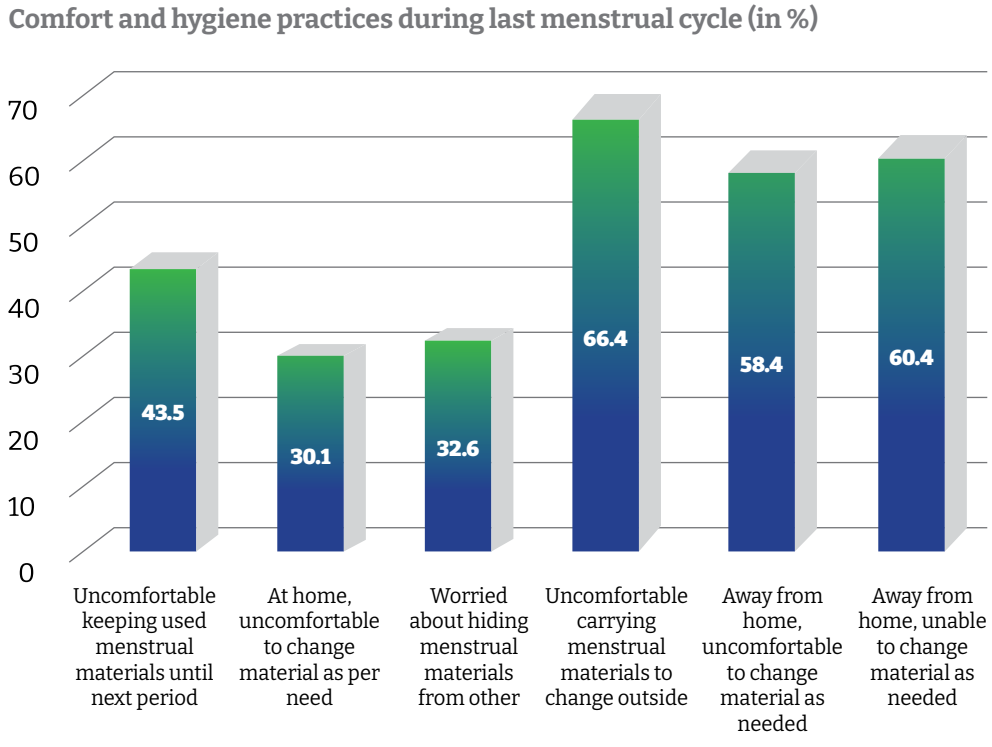
Some of the Social Customs, Beliefs, Taboos and Myths we encountered are listed below:

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.

REFERENCES

Dutta, S., & Bhaskar, S. (2018, May 28). 23 million Women Drop Out Of School Every Year When They Start Menstruating In India. Retrieved from https://swachhindia.ndtv.com/:https://swachhindia.ndtv.com/23-million-women-drop-out-of-school-every-year-when-they-start-menstruating-in-india-17838/

NFHS-5. (2019-21) IIPS International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS)-5, State and District Factsheets, Tamil Nadu. Mumbai: IIPS. 105 & 195. Available from https://data.opencity.in/dataset/national-family-health-survey-nfhs-5-2019-21/resource/nhfs-5-data---tamil-nadu-and-districts-combined [accessed 20 January 2023]

Pathak, P. K., Tripathi, N., & Subramanian, S. V. (2014, Nov 4). Secular Trends in Menarcheal Age in India-Evidence from the Indian Human Development Survey. Plos One, 9(11). doi:10.1371/journal.pone.0111027

Upadhyay, A. (2019, May 28). Menstrual Hygiene Day Facts: Only 36 Percent Of The Women In India Use Sanitary Pads During Periods. Retrieved from https://swachhindia.ndtv.com/: https://swachhindia.ndtv.com/menstrual-hygiene-day-facts-26-percent-use-sanitary-pads-periods-34309/

World Bank. (2018, May 25). Menstrual Hygiene Management Enables Women and Girls to Reach Their Full Potential. Retrieved from https://www.worldbank.org/en/news/feature/2018/05/25/menstrual-hygiene-management

INTRODUCTION AND METHODOLOGY

PART 1 BACKGROUND INFORMATION

1.1 PROJECT TITLE

Combating the Silence from Menarche to Menopause - A Comprehensive Report on Menstrual Hygiene Management in India.

1.2 PROJECT AIMS

The principal aim of the project is to analyse layers of silence on menstruation in India and search for enablers to combat these. We bring findings from people-centric and participatory research from fourteen districts in seven states of India such that an ethical, context-sensitive and ethnographic intervention to fill gaps between policy and practice can be enabled. Eleven of these were aspirational districts under Govt of India's Aspirational Districts Programme (ADP) and three more were included due to their various vulnerabilities.

1.3 PROJECT OBJECTIVES

a) To conduct survey; also to do a critical review of available literature on menstrual hygiene in India

b) To assess knowledge levels, beliefs and practices on menstrual hygiene across regions & communities in the chosen parts of 14 districts in the 7 states of Maharashtra, Haryana, Chhattisgarh, Odisha, Tamil Nadu, Bihar and Assam.

c) To determine vulnerabilities, issues and risks pertaining to Menstruation and social as well as inter-sectoral stress factors.

d) To understand multiple layers of building blocks by building an ethnographic profile in terms of MHM space and times as lived realities of women, particularly in the ages 24-49.

e) To identify structural challenges hindering proper MHM and explore opportunities to overcome these, including suggesting on ground suitable product awareness and policy related advocacy.

f) Collecting surveillance data on menstrual health to better understand the effects and demographics of menstruation, including puberty trends with individual as well as comparative insights

g) To tailor programme suggestions for Civil Society, Social Workers, Grassroots Leaders, Women Sarpanchs, Legislators and SHG Teams.

h) To publish the research report based on the above assessments and share with government, NGOs and other stakeholders.

1.4 RATIONALE

For our research, we have focused on data collection and analysis from communities living in some of India's Aspirational Districts[1].

The Aspirational Districts Programme (ADP) aims to quickly and effectively transform 112 most under-developed districts across the country. With States as the main drivers, this program focuses on the strength of each district, identifying low-hanging fruits for immediate improvement and measuring progress by ranking districts on a monthly basis based on incremental progress made across 49 Key Performance Indicators (KPIs) under 5 broad socio-economic themes - Health & Nutrition, Education, Agriculture & Water Resources, Financial Inclusion & Skill Development and Infrastructure. The delta-ranking of Aspirational Districts and the performance of all districts is available on the Champions of Change Dashboard.

1.5 PROJECT DURATION

The research was completed in the period from February 2022 to April 2023.

1.6 RESEARCH OWNERSHIP

This research has been organised and executed under Sulabh Sanitation Mission Foundation (SSMF) Delhi.

1.6.1 ABOUT SULABH REFORM MOVEMENT

SSMF is a part of the Sulabh Reform Movement, a pioneer in the field of WASH (Water, Sanitation and Hygiene). The founder of the Sulabh Reform Movement, Dr. Bindeshwar Pathak (Padmabhushan awardee) has taken the sanitation movement and his twin-pit technology to a level where he has been able to free the scavengers from the inhuman task of manual scavenging, and enabled alternative employment through vocational training. His work has received large scale national and international recognition. In the course of this journey, different organisations were established under the Sulabh Reform Movement from time to time. Sulabh Sanitation Mission Foundation (SSMF) was established in 2006 with the idea of integrating WASH interventions with strategies for education, women's economic empowerment, and health and nutrition programmes. Since 2014, SSMF has played a significant role in facilitating Government of India's Swachh Bharat Abhiyan, a programme for ending open defecation in India. Additionally, SSMF has been actively implementing projects that work towards the achievement of SDG 3, SDG 4, SDG 5 and SDG 6 targets, and has a special consultative status with the UN Economic and Social Council (UN ECOSOC).

Under Sulabh Reform Movement, so far about 16 lakhs household toilets, more than 10,000 public toilet complexes and 20,000 toilet blocks in schools have been constructed, benefitting thousands of schoolchildren especially girls, who had to otherwise struggle for proper school sanitation facilities. 'Sulabh School Sanitation Club' is a project, where school students, youth, parents and teachers come together and learn to work towards a more hygienic world through various fun activities. It is a girl-led movement which empowers children through hygiene education leading to a positive social transformation and has so far been implemented in over 200 schools in India and abroad. Training sessions in rural and urban communities are also held where women and girls are educated about myths, taboos and shame that promotes a culture of silence around menstruation which silence puts health at risk. This intervention has had a positive outcome on the overall health of girls and women, and now SSMF is working on a proper sanitary napkin disposal mechanism in schools and villages.

PART 2 INTRODUCTION: PROBLEMATISING MENSTRUATION

2.1 SILENCE, VOICE AND VISION ON MENSTRUAL HEALTH MANAGEMENT

The history of Menstrual Hygiene Management (MHM) in India has been painful, moving from a deep and a shameful silence just a decade back to the present time when now 28th May every year is observed as MHM Day. From being absent in public health agenda to having a dedicated program on MHM, menstrual hygiene has come a long way. Though there is a positive momentum in terms of options to manage periods in a safe

[1] The broad contours of the Aspirational Districts Programme are Convergence (of Central & State Schemes), Collaboration (of Central & State level Officers & District Collectors), and Competition among districts through monthly delta ranking; all driven by a mass movement.

and healthy manner, yet the social barriers continue to be a challenge. Efforts are on to provide School toilets for girls, free or subsidized sanitary pad distribution in schools and toilets at household level. Yet only a little over half (58%) women between 15-24 years use a hygienic method of menstrual protection as per the National Family Health Survey-4 (2015-16).[2]

We observed that though India has achieved some goals in menstrual hygiene through centrally sponsored and state schemes, still the journey to achieve equity and wellbeing for women of all ages and circumstances seems to be a long and arduous one. While adolescent and school going girls have begun to derive restricted benefits of various govt. programmes, yet creating positive perceptions in homes, institutions and society on menstruation, as well as proper MHM among Elder and Ageing Menstruating Women(EAMW) has not been adequately addressed. In India, there is (a) an intersectoral silence and lack of dialogic wellbeing on MHM among EAMW and; b) debilitating voices that equate periods with a negative, restrictive, prohibitive and segregational connotations. The silence on periods is not only layered and inter-sectoral, but in its insidious reach in homes, institutions and livelihoods, this lack of rationalisation of menstruation reflects a missing analytical engagement on barriers and enablers.

With a motive to understand the patterns of silence as well as the voices on menstruation in India, our research study juxtaposed barriers with enablers through analytical inferences from data and by presenting felt needs, perceptions and experiences emerging from our data.

Vision: Menstruation is an embodied experience for a woman, who from menarche to menopause encounters not only her changing biological situation but also the socio-political-economic-cultural challenges. Menstruators[3] in our study belonged to diverse communities and contexts which influenced their periods' experience in a variety of tangible intangible ways. While period poverty and lack of resources represent tangible challenges, the veritable silence and restricting beliefs over menstruation reflect the intangible encumbrances. To ensure menstruating women a basic dignity and well-being, it becomes pertinent to address her challenges from menarche to menopause. Our vision is to suggest community sensitive ways to combat the silence over the myths and taboos, and recommend policy interventions in accordance with findings from each state. In this way, we hope to create a dialogic space and the basic hygiene, sanitation and reproductive health facilities for women beyond their school years.

Our research strives to bridge literature gaps, deepen the knowledge on grassroots experiences and ideas on menstruation, to build a positive relationship between MHM, public policy, women's rights, WASH and targeted advocacy and to break the silence over periods.

Menstruation is generally associated with perception of impurity in Indian society. Isolation of the menstruating girls and restrictions on them have imparted a negative attitude towards this phenomenon. People fail to understand that menstruation is an integral and normal part of human life. This subject is too often a taboo and has met many cultural hindrances and negative attitudes due to embedded perceptions and cultural beliefs that menstruating women and girls are "contaminated", "dirty" or "impure". Girls undergo severe mental trauma and have no accurate or direct access to information on the subject. Adolescent girls in schools suffer most from period stigma, lack of sanitation services, facilities to cope with the physical and psychological changes and in addressing difficulties during menstrual periods. Inappropriate facilities at school poses challenges to girls attending schools during menstruation. While the government has established some programmes to address the education and awareness on this issue, its coverage for school going girls[4] and also for older menstruators maybe less than desired.

A study conducted by AC Nielsen reveals that inadequate menstrual management practices makes adolescent school girls (age group 12-18 years) miss 5 days of school in a month (50 days a year). Around 23% of girls drop

[2] MENSTRUAL HEALTH IN INDIA:AN UPDATE; Ministry of Health and Family Welfare, Government of India. https://pdf.usaid.gov/pdf_docs/PA00W863.pdf

[3] 'Menstruators' as a term of reference is used here as a gender neutral and inclusive term for all our period conversations.

[4] i) In India, 66% of schools lack functioning toilets, leading to menstruating girls missing, on an average, 5 days of school every month or dropping out completely once they start lagging in their studies. ii) Teachers are not trained or capable of providing the girls with credible answers and practical ways of managing their menstruation. In fact, many female teachers themselves miss school during their menstruation. iii) 23% of adolescent girls in the age-group 12-18 drop out of school after they begin menstruating

out of school after they start menstruating. Generally, women have been facing several cultural and physical barriers and violence since time immemorial, and cultural practices against women, largely stemming out of patriarchy and superstitions, have made women extremely vulnerable to violence, physical, cultural, emotional, and social.

Gender dynamics and relations change throughout the course of one's life, and caste, community, ethnicity, age, marital status, number of children, sex of the children born, disability, economic resources and educational level can all determine status of a woman in her household. Women including adolescent girls often have the lowest status where families see women as assets to be protected and got rid of post puberty. The cultural barriers further worsen her condition in the household as she belongs to none. In our work with some indigenous communities, we have noticed the abominable practice of a woman staying out of the house during menstruation in huts or cattle-shed, as she is considered, "impure" during her menstruation. Such attitudes may expose her to an infectious environment, besides causing her emotional alienation.

Such practices make a woman or girl extremely vulnerable to physical and sexual violence from outside and compromises her right to life with dignity and right to residence in her parental or marital home. The mental and emotional trauma that women and girls endure are unspeakable. Research has identified that adolescent girls are particularly vulnerable and susceptible to gender-based discrimination including sexual violence, forced and early marriage, dropping out of school and risk of death during childbirth due to poor hygiene and sanitation practices. Many organisations are now working on the issue of prevention of early marriage and early pregnancy as they have adverse effects on the girl's health and may inhibit their ability to take advantage of educational and job opportunities. The issue of menstrual hygiene needs to move out of the corridors of discussion into the practical world of making communities aware and active on securing protective lives for women.

Adolescent girls and Menstruation: Menstrual hygiene management (MHM) is an essential part of hygiene for women and adolescent girls between menarche and menopause. Despite being an important issue concerning women and girls in the menstruating age group, we found MHM in our study districts to be largely limited to a short solution such as provision of sanitary pad. However, the focus should be on determining the knowledge, perception and practices on menstrual hygiene across various sections of communities. As of now, there is no discussion on the process of menstruation, and the subject is a taboo and it is still common for people in India to feel uncomfortable about the subject.[5] A holistic approach is required as the subject cuts across multiple sectors and involves multiple stakeholders to overcome the gaps and challenges through a single window system and not merely providing part solutions like sanitary pads.

The sexual and reproductive rights of girls and women are compromised when they must alter their daily routines; face stigma in their communities, schools, and workplaces; and be at risk of poor sexual and reproductive health outcomes because they cannot manage menstruation with dignity. Society must also take the responsibility to sensitize boys and men on issues pertaining to Menstruation.

2.2 SCOPE OF THE STUDY

2.2.1 THEMATIC FOCUS

Our study focuses on women between the age group of 20-49 years. Although our study has mainly taken into consideration policy and healthcare gaps in MHM, WASH and wellbeing of women, however data on adolescent school-going girls has also been collected and analysed. This is connected to our argument that the community and policy should engage more on menstrual health issues and knowledge building of adolescents. In contrast, the EAMW are very much left to their own resources seeking help from whichever quarter possible or worst, suffering in silence in many isolated, deprived, impoverished and hostile circumstances.

[5] National Guidelines on Menstrual Hygiene Management, Ministry of Drinking Water and Sanitation, Government of India

2.2.2 HERMENEUTIC TOOL

Our study conceptualises the term, 'Elder and Ageing Menstruating Women'(EAMW) as this is the age group that we call special attention to, owing to a neglect both in policy and literature. Women between the ages of 20 to 49 years of age seldom enjoy exclusive focus on menstrual hygiene and WASH, unless they themselves have the capacity to exercise their voice. Factors such as educational and economic background; livelihood constraints, remote and isolated lifestyles away from medical and infrastructural hubs, all influence a woman's capacity and options to speak up and pursue intimate health issues. Social structure (taboos, myths, dos and don'ts of family and community) in traditional set-ups are such that shy newly married women and young mothers face hurdles on MHM. Similarly the EAMW feel hesitant and neglected, and face everyday adversities. We propose that EAMW need community focus and a special policy empowerment to overcome encumbrances and build dialogic spaces to uphold their rights and wellbeing.

2.2.3 REGIONS AND AREAS

We focused on approximately five villages each and diversely vulnerable communities in fourteen districts in seven states, eleven of which were Aspirational Districts under Government of India's, ADP programme[6]. We also included three non-ADP districts which either suffer grave natural disasters or have vulnerable communities.

2.2.4 LIMITATIONS OF THE STUDY

The research and conceptual design are closely linked to the fact that in India, although there is a growing policy focus and engagement on the well-being of young menstruating girls (10-19 years), yet adequate infrastructure, socio-medical support system, as well as resources for young, adult and ageing pre-menopausal women (between 20-49 years of age) are rare. Our primary focus in this report is on methodical accessing and processing of information, opinions and critical reviews on MHM and WASH from a bottom-up perspective for a better policy direction.

This project covers specific themes, and Menopause is not within its ambit. Although focussing on women's voices, yet at the same time, we believe that men and women can complement the process of menstrual relief in India, and the study brings on board some narratives of women who confide with the men in their lives. Together, women and men can partner to improve the prospects of MHM and WASH not only in policy making but also in implementation, at both the National and community and family level.

This study closely looks at the presence or lack of logistic, social, emotional, medical and economic support systems for menstruating women beyond adolescence and before menopause. Our study also includes some voices of menopaused aged women, as they form an essential part of menstruation as a lived experience.

The project is aware that the term 'menstruators' is more gender inclusive, and non-reductionist. However, this study barring some exceptions centres on primarily women menstruators, and how they undergo the socio-physiological, structural, inter-sectoral and reproductive health issues connected to menstruation. The intricate processes and challenges, and requisites of the 'Third Gender' menstruators are not part of this research. Additionally, specific target groups such as sex workers and trafficked, incarcerated, physically and mentally disabled and special needs women and girls are outside the purview of this study. Our experience indicates that more work needs to be done amongst these vast target groups, and could be part of a subsequent study. Till then we are happy to bring into public domain this inter-disciplinary knowledge on women menstruators from seven states and fourteen districts of India.

[6]Owing to inter and intra-regional disparities, disasters, risks and developmental lags especially in the human and social development sectors, the ADP of the GOI announced in 2018, is an attempt to shift the focus back on health, nutrition, livelihood and education. 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. 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).

2.3 ENGAGING WITH LITERATURE ON MHM: A REVIEW

Through this review, we aim to provide a comprehensive research on how women's menstrual health is closely related to social customs, taboos, beliefs and practices on the one hand, and the available policy and infrastructural resources towards MHM including WASH on the other. The social relationships and life-processes in groups and communities ascertain how menstruating women will fare through their periods, whereas the educational, participatory, economic and technical facilities available to her determine how well the support systems ensure her socio-medical wellbeing (Roberts 2020).

Literature on MHM indicates how active engagement with a woman's basic human right to public health during menstruation assures her status as a dignified member of society. In today's era of equity, justice, women's rights as human rights, social growth and sustainable development, societies have failed when almost 50% of the population suffer a silent yet stark neglect. (World Bank 2018). Our project juxtaposes key insights and inter-linkages from public policy, public health, political science, social anthropology, disaster risk-resilience and human capital literature with actual findings from the field. Our unique contribution has been the combined insights from desk-based, existing, inter-disciplinary research with reflective knowledge and perspectives from menstruating women-actors with the following potential benefits:

- Given the challenges in India's public health policy and dearth of literature on MHM and WASH issues, provisions for women in the age group of 20-49 years in India, the voice of menstruating women over the issue can impart a critical awareness to policy, women's rights and sustainable development.
- By comparing our findings with prevalent behaviour and social norms observed through factors such as women's marriage age, trends in schooling and education, nutritional and social taboos in the seven chosen states, we contribute a insight on removal of gender discrimination on MHM and barriers to WASH.
- Finally, a study such as ours has achieved two objectives: a) Informed us, to what extent the findings of age cohort 15-24 years represent the realities of menstruating women beyond 24 years and; b) Prepared us to analyse the particular factors that determine the health and wellbeing of older menstruating women across in India. In the subsequent sections of this report, we will draw on findings and facts to illustrate both these points.

2.4 A RESPONSIBLE ENGAGEMENT WITH EXISTING KNOWLEDGE

The study aims to propose critical interventions in conception and practice from interpretations of quantitative and qualitative data findings. Our findings address gaps in prevailing literature. At the same time, our data also tallies with existing literature on many accounts, at times by extending its focus. The instances where we have consensus with existing literature is how barriers to MHM and WASH are detrimental to women's trans-generational menstrual health from the following perspective:

1. At a national and global context, India may struggle long to make her women equal, if they lack MHM and WASH facilities as basic rights.
2. In states and regions and w.r.t community specific developmental indicators, menstruating Adolescent women and EAMW face actual MHM and WASH related traumas. Resilience alone may not always pull her through barriers and anomalies during deprivations and disasters as women then become even more vulnerable. EAMW seldom get the eco-system to bail them out. Pandemic related MHM products shortages are a recent case in point.
3. We argue that when menstrual inequities exist amidst lack of medical and social care, ignorance and neglect become encoded in layers of silence, and it requires individual courage and collective wisdom as well as coordinated national, regional and local efforts for redressal.

Meanwhile, our contention is that the more prolonged existing barriers, silences and lags become, the more overarching are likely to be the acts of exclusion of and compromises in women's rights. A weakened status of women impacts her menstrual, reproductive and sexual health directly by impinging upon her choice,

participation and decision making in socio-political life and sustainable development aspects. Hence it is the need of the day to combat the silence on menarche, menstruation, menopause and also see beyond menopause.

2.5 MENSTRUATION: THE PROCESS AND ITS IMPLICATIONS

Menstruation is a standard, regular biological process that half the world's population undergoes for a noteworthy part of their lives (Global Menstrual Health Collective: 2020). Menstruation is the process in which the uterus sheds blood and tissue through the vagina. The process begins in young girls around 10-12 years of age and occurs naturally and cyclically with an interval of approximately 28 days. Depending on the individual, uterine shedding can last anywhere between 2-5 days and is often accompanied by a range of physiological symptoms including cramping, headaches, nausea and fatigue (Li et al., 2020).

The average menstruator undergoes around 450 menstrual cycles in their lifetime (Chavez-MacGregor et al., 2007). Menarche, the period that heralds the beginning of menstruation, has been found to generally remain stable between 12 to 13 years in the case of populations that are well-nourished and belong to developed countries (American Academy of Paediatrics et al., 2016).

In India, the mean age of menarche was 13 ± 1.1 years with wide variations, i.e., 10–17 years. 73.1% had a cycle duration of 21–35 days (Omidar and Amiri et.al 2018). It is estimated that mostly 98% of females would have reached menarche by the time they are 15 years old (Chumlea et al., 2003). Although the duration, intensity, patterns and symptoms of most menstrual cycles typically ranges from and last up to 3 to 5 days, a range of 2 to 7 days seems to be a more accurate representation of the overall duration of menstruation each month. More or less in developing countries too, 13 years seems the average age for the onset of menstruation. With menarche, girls register immense changes in their being as well as social responses not only at a young age but later on in adult life and during childbirth, maternity, child rearing years and beyond. Yet from a practical societal perspective, Singh (2020) observes that menstruation is not just about women. It influences men too. For instance, boys seem to recognize, but are saddened by the resulting change in the nature of their friendships with girls once they reach menarche. In effect, they lose friendships, Chang and colleagues (2012) and Penakalapati (2009).

Allen and colleagues studying undergraduates in the US further describe this (2011) as a 'gender wedge'. This phenomenon may stem from the girls' own change in attitude on reaching puberty and withdrawing from boys generally, but particularly during menstruation. It is also likely to be perpetuated in societies where male/female relationships are restricted, as well as in cultures where girls reaching menarche are seen as ready for marriage. Other authors refer this as the 'sexualising of menstruation', akin to the sexualisation of women at menarche (Mason and Sivakami 2005).

Good menstrual hygiene is important for the health, confidence, and self-esteem. It is also linked to gender equality and basic human rights. In India, the number of women in the reproductive age group (15–49 years) is more than 31 crores (Census 2011).

Understanding the quantum of morbidity and poor quality of life that a woman would have to bear in the absence of proper MHM practices in the country, Government of India has incorporated MHM into national policies and programs as part of improving health, well-being, and nutritional status of adolescent girls and women. Initiatives have also been taken for reducing school absenteeism among adolescent girls. WHO and UNICEF is also providing technical guidance and support towards raising awareness, addressing behaviour change, capacity building of frontline community cadre, sensitization of key stakeholders, and creation of WASH facilities including safe disposal. Although there is no direct mention of any goal for menstrual health and hygiene in the UN Sustainable Development Goals (SDGs), it is well recognized that poor MHM practices will adversely affect the initiatives and performances of the countries toward achieving a number of important developmental goals (SDGs 3, 4, 5, 6, 8, and 12).

This study is a situational analysis of Menstrual Hygiene practices and needs in selected villages and has tried to augment existing research and ground knowledge.

2.6 MENSTRUAL HYGIENE MANAGEMENT (MHM) AND WASH

2.6.1 MHM:

Menstrual Hygiene Management (MHM) is defined as, "women and adolescent girls using a clean menstrual management material to absorb and collect blood, that can be changed in privacy as often as necessary for the duration of the period, using soap and water for washing the body as required and having access to facilities to dispose of used menstrual management materials." (UNICEF 2013 and 2014). Menstrual Hygiene Management (MHM) refers to the overall mechanisms that allow for the upkeep of hygiene during the course of menstruation. This includes but is not limited to having proper access to menstrual hygiene products to absorb or collect blood flow during menstruation (e.g., sanitary napkins, tampons, menstrual cups), and having safe, secure and private environment to change the materials and having adequate access to facilities that allow effective disposal of menstrual wastes.

MHM collectively also refers to several wider-scaled factors responsible for linking menstruation and menstruators with concerns of health, well-being, gender equality, empowerment, equity, education and fundamental rights (UNICEF, 2019). Studies indicate that MHM practices by adolescent females of low and middle-income countries (LMICs) are causes of severe concern (Chandra-Mouli & Patel, 2020), given that over 50 % of adolescent females have been found to follow unsatisfactory MHM practices. It must be noted, that this percentage of MHM anomaly is higher in rural areas compared to urban ones, (Hennegan & Montgomery, 2016; Khanna et al., 2005).

2.6.2 WASH:

Women use toilet facilities to manage their menstruation. Good MHM practices means that women and adolescent girls are using a clean menstrual management material to absorb or collect menstrual blood, and the MHM product 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.

(Sommer & Sahin, 2013).

India produces over twelve billion non-biodegradable pads annually. Many of them are heavily plastic-based and can take up to eight hundred years to decompose. But that's not all. In India, sanitary waste disposal faces an additional challenge: the manner and place in which it is disposed. Attempts to understand either process have not, at present, yielded pleasant results. A sizable proportion of India's menstruating population resorts to discarding used menstrual products in open fields and rivers; still more opt for throwing it away as part of the routine waste. Not only does this compromise the health of various water bodies, but also exposes sanitation workers, who take up the task of regularly segregating such sewage, to a variety of deadly diseases (Singh 2020). In order to look efficaciously into such challenges, an enabling environment for capacity building of states, society, CBOs and frontline workers is a need.

The frequency with which materials used for absorption of the menstrual flow are changed is also of critical importance. Not doing so can result in rashes and irritation to more serious issues like Urinary Tract Infections (UTIs), Reproductive Tract Infections (RTIs) and Toxic Shock Syndrome. There are several causes of this, ranging from a lack of awareness and poverty to widespread myths and taboos surrounding menstruation, (Majeed et al., 2022, Shanbhag et al., 2012 and Cherrier et al., 2018).

Poor menstrual hygiene management (MHM) can negatively impact the health and psycho-social well-being of women and girls. Menstrual hygiene management in the WASH sector is not formally defined in the Sustainable Development Goals (SDGs). However, clear linkages are there in: SDG3 (physical health and psycho-social well-being for women and girls), SDG4 (quality education for girls), SDG5 (gender empowerment and equality), SDG6 (water and sanitation), and SDG12 (responsible consumption and production for the environment). Proper management of MHM and WASH reduces not only health risks for men and women, but also eases the strain on sustainable development. Various kinds of menstrual materials, commercial and non-sustainable

products like sanitary napkins and tampons often contain harsh chemicals like dioxins (bleach), pesticide residues (from the cotton used as the base), artificial perfumes and other compounds. Dermal contact with this compromises the health of the external and internal vaginal region.

The long-prevailing taboos regarding menstruation and sanitary issues in Indian rural socio-economic populations results in the hesitation towards the usage of menstrual materials. Safe hygiene practices include not only washing and timely changing of menstrual hygiene products but also their proper disposal. Other factors might be influenced by the kind of menstrual materials used. Expectedly, this is highly problematic and has a number of adverse implications for India's ecological well-being (Singh 2020).

2.6.3 WASH, EDUCATION AND MHM IN INDIA

It is widely discussed in different studies, why there is a need for improving sanitary provisions for adolescents in schools in India, and the safe disposal of materials. For, instance, data analyses (Sivakami and van Eijk 2019; van Ejik and Sivakami et. al 2016) on MHM and WASH amongst school going girls in India states that while nearly all (93%) menstruating girls had received some information about menstruation, one in five girls using disposable pads had to take the used napkin home for disposal. A third complained of pain (36%); other worries included fear of staining, smell, or feeling unwell, and discomfort with movement and sitting. The type of menstrual hygiene problems differed for different items used. The discomforts and experiences of feeling unwell and restricted in movement etc. were more common among users of cloth (used by 28% of girls) compared to disposable pad users (used by 45%). Moreover, the status of sanitary facilities in schools is often reported to be inadequate, compromising girls' ability to manage their menstruation. Identifying discomforts associated with MHM, wellbeing and disposal during periods, the authors (Sivakami and van Eijk 2019; Also see, van Ejik and Sivakami et. al 2016) conclude that MHM and WASH lapses in various states of India impact quality as well as quantity of school time. Regularity of attendance of growing girl-children can be improved by national investment in menstrual hygiene management in schools,

Van Ejik and Sivakami et,al (2016), estimate that about half of Indian adolescent girls starting menarche are unaware of its cause, with only a quarter understanding the source of bleeding. The majority of girls faced numerous barriers and restrictions, and only one in eight girls faced no restriction at all. Commercial pads were more commonly used in urban areas and urban schools, while girls in rural areas mainly dependent on cloth.

About one in five girls disposed of their soiled absorbents in inappropriate locations. A quarter of girls reported that they did not attend school during menstruation. Absenteeism due to menstruation did not decrease over time; school absence was inversely associated with the prevalence of pad use in univariate analysis, but not when adjusted for region. Cloths are traditionally used to absorb menstrual flow; they are cheaper and environmentally less polluting, but are gradually being replaced by pads, particularly in urban areas. Cleaning and drying cloths is a problem if girls lack water, privacy and a drying place.

2.7 MENSTRUAL HEALTH, WOMEN'S EMPOWERMENT AND SUSTAINABLE DEVELOPMENT GOALS (SDGS)

MHM in schools makes a crucial contribution towards achieving the SDGs. Supporting adolescent girls during menstruation is also a step towards building their confidence in themselves and their bodies, enhancing their engagement at school and in their wider communities. Success in improving MHM in schools means success in improving quality education (SDG 4), gender equality (SDG5), and clean water and sanitation (SDG 6), enhancing the lives of girls across the world (UNICEF 2020). According to the Terminology Action Group of the Global Menstrual Collective Menstrual Health and Hygiene (MHH), good MHM practices are essential to the well-being and empowerment of women and adolescent girls. Access to affordable and sustainable menstrual products is key to improving menstrual health and hygiene, but millions of women around the world cannot afford these products. Menstruation has also been shown to be a reliable indicator of various parameters of an individual's health (e.g., Popat et. al., 2008).

Our view is that while facilities on MHM should in fact begin and continue throughout schooling to enhance a growing girl-child's intellectual and physical capacities and wellbeing, nonetheless these should not terminate therein. Beyond school years as well as in spaces outside of school, women and girls still require MHM and WASH support to be able to deal with emotional, reproductive, private health issues as well as sexual wellbeing.

Menstrual health management among adult women and the issues that they face up till menopause and beyond finds little focused attention . There is a need to adopt a holistic approach to include these EAMW in MHM, WASH and gender- wellbeing initiatives. Millions of women, girls and transgender people face menstrual related barriers across their life course due to discriminatory menstrual practices, inadequate menstrual health and hygiene services that prevent them from participating fully in life. Access to economically viable and sustainable menstrual products (e.g., menstrual cloths, reusable pads, disposable pads, menstrual cups and tampons) is key to improving menstrual health. Yet only a small segment of women and girls in developing countries use sanitary products during menstruation (World Bank: 2021).

2.8 DEALING WITH MENSTRUATION AS STIGMA, TABOO, SHAME

One of our prime concerns is that despite evolving policy framework and schemes in India as well as a growing national and international understanding on MHM and WASH, still there are huge gaps in implementation. Implementation at grassroot level requires a two-way approach. Governments need to be aware of what to deliver and to whom, and communities in turn, need the awareness on what to ask & expect. Additionally, if experts, policy makers, specialists, think tanks and community workers do not worry beyond adolescence, how will MHM and WASH be achieved for the women in the age group of twenty to forty-years?

Our research questions, reviews and ground-work on MHM is a bird's eye perspective for all stakeholders to empower communities and support national frameworks on women's health, community development, behavioural preparedness and social change. Our data is a resource of information on the current situation and presents a glimpse into the skills, resilience, and wisdom of the communities themselves. A circular two-way approach on the issue, we argue, can help coping up with menstruation as a social, economic, behavioural, health and hygiene issue specifically with regards to barriers and taboos, myths and obstacles to MHM and WASH

2.8.1 SOCIAL BELIEF, EXCLUSION & MENSTRUATION

Extensive stigma and taboos around menstruation- from menarche to menopause, however, converts itself into a source of fear, embarrassment, deprivation, ill-health and shame for many. Scholars in the western context have asserted that menstruation is more like a hidden than a visible stigma, but that is because women go to a great deal of effort to conceal it (Oxley 1998). Menstrual hygiene products (for example, tampons, pads) are designed to absorb fluid and odours, not to be visible through one's clothes, to be small enough to carry unobtrusively in one's purse, and to be discreetly discarded in a bathroom container (Kissling 2006). It is usually not possible to know for certain that a woman is menstruating unless she says so or unless menstrual blood leaks through her clothes and exposes her condition.

In the Indian context, however, we have different practices on menstruation depending upon region, social strata and the ethnicity. There are communities who segregate the girls and women when periods occur and ask them to live with bare minimum during periods. This exposes the menstrual status of the girls and women and not in the best of ways. There are those who celebrate the onset of puberty and menarche through traditional rituals. The restrictions during periods such as not going to holy places (in case of Hindus), cooking or praying etc, actually make women' period public, even though ironically the phenomenon itself is hidden in layers of silence in public domain. Restrictions continue to apply, though not without generating national debates on the issue now and then.

Published literature indicates that in addition to investment in safe and functional toilets with clean water for girls in both schools and communities, countries such as India must consider how to improve the knowledge and understanding and how to better respond to the needs of early adolescent menstruators. Our observation is

that alongwith this, due attention must also be given to elder and ageing menstruators (EAMW). Strengthening of MHM programmes in India is urgently needed, and Community and women's need for awareness, access to hygienic absorbents and their disposal need to be addressed. Local initiatives can also lead the way. For instance, In 2021, Raigarh district in Chhattisgarh initiated *Pavna*, a community-led menstrual hygiene programme, including training and supporting SHG members to produce and distribute pads through village markets. Through its "whole-of-society" approach, it facilitated breaking of social taboos in remote areas, while simultaneously increasing the usage of sanitary pads from 40 per cent to 75 per cent within a year (Rana 2022). Convergence with other schemes and departments, such as the Rurban mission and Department of Education was helpful.

Exclusion and shame lead to misconceptions and unhygienic practices during menstruation. Rather than seek medical consultation, girls tend to miss school, self-medicate, and refrain from social interaction. Relatives and teachers are often not prepared to respond to the needs of girls. In general, it has been found that in less developed contexts, the lack of preparation, knowledge, and poor practices surrounding menstruation are key impediments not only to girls' education, but also to self-confidence and personal development. The long-prevailing taboos in rural India result in lack of proper understanding on the usage and disposal of menstrual materials, as also personal hygiene practices necessary during menstruation and the frequency with which to change menstrual materials during the day.

2.9 WOMEN-CENTRIC, INTER-SECTORAL AND HEALTHIER WAYS TO LOOK AT MENSTRUATION

An important way to reduce stigma is social activism as well as pro-active & participatory community-based work. Bobel (2006, 2008, 2010) has written extensively about the history of menstrual activism as well as the myriad ways contemporary menstrual activists are drawing attention to the health and environmental hazards of menstrual hygiene products through organisations, political action, zines, and other publications. Finally, health care providers are beginning to recognize and promote menstruation as an important indicator, even a vital sign, of girls' and women's overall health (Diaz, Laufer, and Breech 2006; Stubbs 2008). The mission of the Project Vital Sign (www.projectvitalsign.org) campaign is to raise awareness about the role of menstruation in women's psychological and physical health with the ultimate goal of encouraging an open dialogue on menstruation between health care providers and female patients. Efforts to normalise menstruation would go a long way toward reducing its stigmatised status.

Individuals use specific menstrual hygiene products based on their awareness, availability, affordability/ income, and region, based on comfort level of use stemming from the cultural context. On any given day, more than 300 million women worldwide are menstruating. In total, an estimated 500 million lack access to menstrual products and adequate facilities for MHM (World Bank 2022). To manage their menstruation effectively, girls and women require access to WASH facilities, affordable appropriate menstrual hygiene materials, information on good practices, and a supportive environment where they can manage menstruation without embarrassment or stigma.

PART 3 MENSTRUATION, PUBLIC POLICY AND DISCOURSE IN INDIA

3.1 THE INDIAN DISCOURSE ON HEALTH, HYGIENE, WASH AND GENDER EQUITY

Rarely talked about and articulated in the open, Menstruation in India was linked to WASH sector only in the recent couple of years just as public health, sexual and reproductive health, and education sectors have begun a recent focus on this issue. Even the National MHM Guidelines (2015) observes that menstruation is not spoken about openly and causes unnecessary embarrassment and shame. As a result, the practical challenges of menstrual hygiene are made even more difficult by socio-cultural factors and millions of women and girls continue to be denied their rights to WASH, health, education, dignity and gender equity. Layers of socio-political silence on the subject have prevented the theme of menstrual wellbeing and justice from being articulated as a mainstream issue. MHM and WASH policies need a community-sensitive dialogic space to

reach their full potential in India. Newer policies on comprehensive and inter-sectoral understanding of MHM have been indicative steps in the right direction. Through these various initiatives, menstrual hygiene has improved, yet gaps remain.

Existing anomalies in MHM in India, especially in impoverished and marginalised contexts have led the government to acknowledge, "If girls and women are to live healthy and productive lives, with dignity, menstrual hygiene is a priority", (Ministry of Health: Adolescent Menstrual Hygiene Guidelines). GOI data on the issue confirmed some worrisome findings at that time: India's 113 million adolescent girls are particularly vulnerable at the onset of menarche; At this time, they need a safe environment that offers protection and guidance to ensure their basic health, well-being and educational opportunity. In a 2015 survey the GOI found that in 14,724 government schools only 53% had a separate and usable girl's toilet. At home, the situation also needs to improve as 132 million households do not have a toilet (MHM Guidelines 2015), leaving adolescent girls and women to face the indignity of open defecation. However, safe and effective MHM along with WASH is a trigger for better and stronger development for adolescent girls.

The project argues that combining MHM and WASH for EAMW will go a long way in making the approach to health and wellbeing truly gendered and inclusive. It is up to every state to show willingness, initiate open participatory dialogues and ensure that policies and schemes are implemented better. That would be a credible route to combat the silence as well as tackle the anomalies on MHM.

India counts on maternal and infant health schemes and policies at the centre, state and union territory levels. However, despite consistent focus on mother and child health, enough attention is not forthcoming for specific women's health issues such as menstruation, sexual and reproductive health, voice and rights. There are 253 million adolescents in the age group 10-19 years in India. This age group comprises individuals in a transient phase of life requiring nutrition, education, counselling and guidance to ensure their development into healthy adults. They are susceptible to several preventable and treatable health problems, like early & unintended pregnancy, unsafe sex leading to STI/HIV/AIDS, nutritional disorders like malnutrition, anaemia & overweight, alcohol, tobacco and drug abuse, mental health concerns, injuries &violence (National Health Mission, GOI)[7][1].

Females comprise almost 47 per cent and males 53 per cent of the total adolescent population. More than half of the currently married illiterate females are married below the legal age of marriage. Nearly 20 percent of the 1.5 million girls married under the age of 15 are already mothers. According to the Ministry of Health and Family Welfare's, 'Adolescents Reproductive Sexual Health (ARSH) Strategy' implementation Guide for states; adolescents (10-19 years) in India constitute 22% of the country's population. "Adolescents are not a homogenous group. Their situation varies by age, sex, marital status, class, region and cultural context. A large number of them are out of school, get married early, work in vulnerable situations, are sexually active, and are exposed to peer pressure. These factors have serious social, economic and public health implications" (Ministry of Health Statement, GOI 2006). This calls for health interventions that are flexible and responsive to their disparate needs. Adolescent health is hence, one of the key technical programmes under the National Rural Health Mission and RCH-II. It is important to raise awareness regarding the health-seeking behaviour of adolescents, as their situation will be central in determining India's health, mortality and morbidity; and the population growth scenario[8]. The Ministry of Health and Family Welfare introduced a scheme for promotion of menstrual hygiene among adolescent girls of 10-19 years in rural areas. The major objectives of the scheme are i) to increase awareness among adolescent girls on Menstrual Hygiene ii) to increase access to and use of high-quality sanitary napkins by adolescent girls and iii) to ensure safe disposal of Sanitary Napkins in an environmentally friendly manner.

Asian countries show greater use of cloth during menstruation in comparison to other parts of the world, (Elledge and Muralidharan et. al 2018). Not all women in India use sanitary pads or other market-based products to manage periods owing to lack of availability in remote areas such as where forest dwellers and tribals live

[7] https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=818&lid=221

[8] http://www.nrhmhp.gov.in/content/adolescent-reproductive-sexual-health-programme. Accessed 6th October, 2022.

owing to socio-economic factors as well as cultural beliefs, myths and taboos (Elledge and Muralidharan et. al 2018). Moreover, there are diverse MHM trends in rural and urban Indian contexts and among different communities. In an urban resettlement area of New Delhi for instance, the use of sanitary pads was more likely to be associated with young women (20–29 years old) rather than older women (≥30 years old) and with those whose mothers were better educated, as they provide more information to the girls. Anand et al. studied census data (2007–2008) of India and pointed to the use of cloth as the main menstrual hygiene product used by females aged 15–49 years.

However, urban India saw greater use of sanitary pads, a trend likely to increase in the future. Such findings show to policy makers how in majority of rural areas, there was a worrisome neglect of menstrual hygiene due to low awareness levels and lack of access to sanitary products. Anecdotal evidence and cross-sectional studies suggest that the lack of access to MHM products and infrastructure, including sanitary napkins, school toilets, water availability, privacy and safe disposal, could constrain school attendance and also contribute to infections. Additionally, taboos and myths surrounding menstruation limit girls' access to schooling and socialising, adding to the existing gender discrimination. Hence, a major policy focus is on adolescent MHM and WASH. Creating awareness and increasing access to the requisite sanitary MHM infrastructure is a must.

3.2 SCHEMES FOR THE PROMOTION OF MENSTRUAL HYGIENE AMONG ADOLESCENT GIRLS IN THE AGE GROUP OF 10-19 YEARS SINCE 2011

The Ministry of Health and Family Welfare has implemented the scheme for Promotion of Menstrual Hygiene among adolescent girls in the age group of 10-19 years since 2011. The scheme is supported by the National Health Mission through the State Programme Implementation Plan (PIP) route based on the proposals received from the States / UTs. The major objectives of the scheme are (i) to increase awareness among adolescent girls on menstrual hygiene; (ii) to increase access to and use of high-quality sanitary napkins by adolescent girls, and (iii) to ensure safe disposal of sanitary napkins in an environment friendly manner. Under the scheme, a pack of sanitary napkins are provided to adolescent girls by the Accredited Social Health Activist (ASHA) at a subsidised rate of Rs. 6 per pack[9].

3.2.1 JANAUSADHI SUVIDHA SANITARY NAPKIN

Further, to ensure access to sanitary napkins and good quality medicines at affordable price, Department of Pharmaceuticals under Ministry of Chemicals and Fertilisers implements the Pradhan Mantri Bharatiya Janausadhi Pariyojna (PMBJP). Under the scheme, an important step in ensuring the health security for women was taken up by announcing Oxo-biodegradable sanitary napkins named Suvidha at Re. 1/- per pad only. Over 8700 Janaushidhi Kendras have been set up across the country[10].

3.2.2 MENSTRUAL HYGIENE MANAGEMENT NATIONAL GUIDELINES 2015

The Menstrual Hygiene Management National Guidelines were issued by the Ministry of Jal Shakti (Department of Drinking Water and Sanitation) in 2015 to support all adolescent girls and women throughout India. It outlines what needs to be done by state governments, district administrations, engineers, technical experts of line departments, and school head teachers and teachers.

The guidelines suggest adequate space for girls to change their sanitary materials and to wash themselves. Toilet cubicles with a shelf, hooks or niche to keep clothing and menstrual adsorbents; dry disposal system for menstrual waste, a well-positioned mirror so that girls can check for stains on their clothes, and a private bathing or changing unit that includes a place for drying their reusable menstrual absorbent. Access to adequate and sustained water supply and soap is also a prerequisite to improved menstrual experience for girls in schools.

[9] The Union Minister of Women and Child Development, Smt. Smriti Zubin Irani gave this information, in a written reply in Lok Sabha on July 2022. (Release ID: 1846147) Visitor Counter: 1369: https://pib.gov.in/PressReleasePage.aspx?PRID=1846147

[10] http://janaushadhi.gov.in/pmjy.aspx. Accessed 10th October 2022; Also, refer to- Press Release July 29, 2022 https://pib.gov.in/PressReleasePage.aspx?PRID=1846147. Accessed 6th October 2022.

The detailed guidelines focus on rural India and have dedicated sections on menstrual health in schools. They stress the importance of sensitively involving male students as a means to increase positive effect on how girls perceive issues around menstruation. The guidelines also suggest the establishment of support groups as the soft input, such as the Girls Hygiene Clubs, linked to the existing child cubicles as an essential part of ensuring peer-to-peer learning and sharing of information. These guidelines also lay down a suggested template for training sessions for school girls.

3.2.3 NATIONAL GUIDELINES ON MHM

The Ministry of Drinking Water and Sanitation under Swachh Bharat Abhiyan seeks to create awareness in rural areas as part of its overall interventions related to behaviour change on sanitation hygiene. Guidelines for Swachh Bharat Mission (Gramin) 2017 released by the Ministry of Jal Shakti, included guidelines for support to MHM for girls and women. (Guidelines, were produced with the help of UNICEF). Under the guidelines, funds available under the IEC component may be used to raise awareness and skills on Menstrual Hygiene Management (MHM), specifically amongst adolescent girls in schools. IEC plans should include an MHM component for raising awareness among all stakeholders. Funds under the SLWM component can also be used for setting up incinerators in schools, PHCs and public toilets. The guidelines outline what needs to be done by state government, district administration, engineers and technical experts in line departments; and school teachers, CSOs and SHGs. The National Guidelines on MHM (2015) are presented by the Ministry in three parts, the Main Guideline; a series 'Action Guides' that describe what each key stakeholder must do, why and how; and Technical Guides. The main guideline (this document) is organised as follows: Part 1: About the guideline; Part 2: Swachh Bharat is India's nationwide sanitation initiative launched by the GOI for the first time in 2014.

Who needs to know what, why and how; Part 3: Providing adolescent girls with menstrual hygiene management choices; Part 4: MHM infrastructure in schools and the safe disposal of menstrual waste (MHM National Guidelines 2015)

3.2.4 SWACHH BHARAT MISSION (GRAMIN) AND GENDER ISSUES IN SANITATION

In 2014, the Indian government rolled out the Swachh Bharat Mission (Gramin) with the ambitious goal to make India open-defecation free. This mission was primarily focused on rural areas where rates of open defecation were higher compared to urban areas. Embedded within this ambitious mission was the component focused on improving menstrual health for girls. The SBM (G) guidelines mandate that funds available for information, education, and communication (IEC) materials may be used to raise awareness & disseminate information. Under the solid waste management component, the guidelines mentioned that provisions should be arranged for menstrual waste disposal. The Swachh Bharat Mission (Urban) guidelines have no specific mention of menstrual needs of women in urban areas. Nonetheless, guidelines demonstrate a progressive shift in the government's approach to sanitation by acknowledging the role of gender in WASH initiatives. These guidelines call for special attention to menstrual hygiene needs of women while constructing toilets in schools. They also suggest holding counselling sessions on menstrual health and hygiene for girls in schools.

3.2.5 MENSTRUAL HYGIENE SCHEME: 2017

The Ministry of Health and Family Welfare in India introduced a scheme for promotion of menstrual hygiene among adolescent girls in the age group of 10-19 years in rural areas (Menstrual Hygiene Scheme: 2017). The objectives were to increase awareness among adolescent girls on Menstrual Hygiene; increase access to and use of high-quality sanitary napkins to adolescent girls in rural areas and ensure safe disposal of Sanitary Napkins in an environmentally friendly manner. The scheme was initially implemented in 2011 in 107 selected districts in 17 States wherein a pack of six sanitary napkins called "Freedays" was provided to rural adolescent girls for Rs. 6. From 2014 onwards, funds are now being provided to States/UTs under National Health Mission for decentralised procurement of sanitary napkins packs for provision to rural adolescent girls at a subsidised rate of Rs 6 for a pack of 6 napkins.

The ASHA will continue to be responsible for distribution, receiving an incentive @ Rs 1 per pack sold and a free pack of napkins every month for her own personal use. She will convene monthly meetings at the Aanganwadi

Centres or other such platforms for adolescent girls to focus on the issue of menstrual hygiene and also serve as a platform to discuss other relevant SRH issues. According to India's last National Family Health Survey (NFHS)-V (2019-21), 73 per cent of rural women aged 15 to 24 years use hygienic methods of menstrual protection, up from 48 per cent in NFHS-IV (2015-16) (Rana 2022).

3.2.6 ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH (ARSH) AND THE ADOLESCENT EDUCATION PROGRAMME (AEP) 2019[11]

Existing national health programmes such as the Adolescent Reproductive and Sexual Health (ARSH) and the Adolescent Education Programme (AEP) include a range of interventions for adolescent girls and boys who are in school and out of school. While pilot interventions to promote menstrual hygiene exist, the scheme for menstrual hygiene provides an opportunity for states to implement these in multiple districts.

3.3 LIMITATIONS OF OUR RESEARCH

Our research and conceptual design are linked to the fact that in India, although there is a growing policy focus and engagement with well-being of menstruating girl-children (10-19 years), yet infrastructure and socio-medical support system as well as resourses for young, adult and ageing pre-menopausal women (between 20-49 years of age) are rare. Our primary focus has remained on a methodical accessing and processing of information, opinions and critical reviews on MHM and WASH from a bottoms-up perspective for better policy uptake. The project has covered only specific themes and actors with special focus on women voices. Menopause is not within the ambit of this study.

We also believe that men and women can complement the process of menstrual relief and uplift in India. From a comprehensive gendered approach, the study brings on board narratives of women who confide with the men in their lives, especially their spouses. Together, therefore both can surge ahead in partnership to improve the prospects of MHM and WASH both in policy making as well as in implementation.

The current study casts a close glance on the state of real life presence or the lack of available means and options in relation to logistical, social, emotional, medical and economic support systems of menstruating women beyond adolescence and before menopausal stages of life. Our study also includes voices of menopausal, elderly as well as aged women too, as they form an essential background of menstruation as lived experience. The project is aware that the term 'menstruators' is more gender inclusive, and non-reductionist. However, this study barring some exceptions, centres on primarily women menstruators, and how they negotiate as well as undergo the socio-physiological, structural, inter-sectoral and reproductive health related phenomenon of menstruation in their life. Hence, we opted to use the terms women or girl-children rather than the word menstruators. The intricate processes of affirmation, challenges, discriminations and medical as well as socio-psychological requisites against menstruating individuals who identify as 'Third Gender' in India are beyond the scope of this research.

Additionally, specific target groups such as sex workers and trafficked, incarcerated, physically and mentally disabled and special needs women and girl-children are outside the purview of this current study and findings. Our experience indicates that much work needs to be done amongst these other vast groups that could not be included in this participatory research.

PART 4 METHODOLOGY

COVERING APPROACH, METHODS AND ETHICS OF RESEARCH

The study employed both qualitative as well as quantitative methods and approaches to make tools, collect and process data and used a mixed methodology perspective for final inferences and conclusions. The Emic Evaluation Approach was used for collecting and processing qualitative data, while reaching out to the large

[11] https://adityacbse.com/adolescent-education-programme-aep/. Accessed 10th October 2019

numbers of participants and arriving at the sampling processes required using quantitative techniques. However, the qualitative and quantitative team worked together at each stage and the questionnaires were developed keeping in mind both kinds of data.

4.1 EMIC EVALUATION APPROACH AS THE COVERING APPROACH AND METHODOLOGY

As a covering methodology for Qualitative Data Collection and Interpretation, the principles of Emic[12] Evaluation Approach (or the EEA) be followed. As a theoretically informed approach, the EEA strives to overcome the one-dimensional conception of 'the' emic (insider, exclusive) perspective by incorporating the full range of how actors relate to each other in social life. Hence, it brings forward the exclusive actor-based view and experiences while juxtaposing these inter-subjective social, relational as well as political realities with each other. Involving three broad steps of research: a) Actor Analysis; b) Discourse Analysis and; c) Practice Analysis, the EEA is highly suitable where sensitive groups and populations are to be covered in conflictual/contested realities or sensitive zones. Using the normal range of ethnographic/actor-oriented tools such as interviews and interactions with the actors themselves, group discussions, observations, interviews, recording of and immersion in the field, the EEA entails authorised, consent-based as well as ethical use of note-making, observations, participation, target-group discussions, focus group discussions and workshops as methods of research and advocacy. Next, following the same principled approach under the EEA video/audio cameras; Dictaphones and formal as well as informal interviews can be used to generate and collect data. Though the exact modalities of the research problems will be better known once an-in-depth literature review is accomplished and fields mapped, in the interim and as of now, complementing the EEA with the ethics of participatory research methods, tools and techniques of data collection and analysis are adequate starting points.

4.2 ETHNOGRAPHY, EEA AND MIXED METHODOLOGY

4.2.1 QUALITATIVE ASPECTS OF RESEARCH

Our research analyses grounded data that has been systematically collected, organised and interpreted to uncover social relationships, discourses and practices; attitudes, belief systems and behaviours; communicative as well as participative processes of individuals and communities on themes related to menstruation. The Emic Evaluation Approach (EEA), which was adopted as our covering approach, is inspired from a wide variety of literature and methods across disciplines. The EEA relies on ethnography (which can be used across disciplines) and related approaches to define its toolkits and processes. Employing field and community- based inductive methods of observation and documentation, the EEA also places immersion and interviewing to investigate social practices and the meanings behind social action. Ethnographic research was found suitable as our investigation design required us to build a qualitative information base from participants. Ethnographic approaches have proven to be relevant in collecting and interpreting qualitative data in medical research (Atkinson and Pugsley 2005; Reeves and Peller et.al 2013) over a plethora of issues including for medical education. Under the EEA, ethnography is used in a way that corroborates evidence by following three steps of analysis: a)Actor Analysis; b) Discourse Analysis and; c) Practice Analysis. EEA is beneficial for grounded research as it helps overcome the limitations of relying solely on interviews and participant generated data. Hence, the EEA offered us the opportunity to complement our qualitative methods with the potential to yield detailed and comprehensive accounts of different social phenomena, (actions, behaviour, interactions, beliefs) in the field.

4.3 ETHICS, MIXED METHODS AND THE QUANTITATIVE ASPECTS OF RESEARCH

To complement the qualitative research with non-narrative, inter-sectoral data on MHM and WASH, a mixed-methods approach using quantitative survey and tools was used. However, notwithstanding approaches, backgrounds, age groups and regions, MHM still remains an extremely sensitive topic in India like in other

[12] Emic signifies curate ethnographic descriptions and analysis from an internal or 'emic' perspective, which brings the native point of view. In other words the insiders' views/testimonies- taken from involved actors, key informants and other stakeholders who live and witness the situation directly even if they do not embody or experience it.

developing countries and traditional societies. Hence, the project adhered to consensual and voluntary participation; sensitive, confidential, ethical data collection and; monitoring methods as well as WHO mandated protocols. The basic ethical principles maintained include doing good, Do No Harm principles and protecting the autonomy, wellbeing, safety and dignity of all research participants. All research protocols have been adequately followed to safeguard the privacy of information provided by respondents. Dissemination and reporting of research findings will follow the basic principles of beneficence and non-maleficence (Association of Social Anthropologists of the UK and the Commonwealth 1999).

4.4 TOOLS AND TECHNIQUES USED

The project's mixed methods design, incorporating primary data collection, was done through quantitative and qualitative components. Data was collected from the Menstrual Practice Questionnaire through in-depth interviews (20 – 49 age group) regarding their perceptions and experiences with menstrual hygiene practices. This was accompanied by focused group discussions with adolescent girls (10-19 age group) and elderly women (above 50 years). A review of the literature was done including policy documents, and media reports, academic databases through google scholar. Additionally, qualitative interviews of key stakeholders (In-depth interviews of 168 respondents) were conducted and Menstrual Practice Needs Scale (MPNS) was filled during the data collection process. Embedding quantitative components to further investigate qualitative themes, the periodical review was conducted for checking the quality of the process, and content of the MPQ, and the stakeholders' interview codebook was developed in depth.

4.5 JUSTIFICATION FOR MIXED METHODS: AN OVERVIEW OF METHODOLOGICAL

4.5.1 APPROACHES

We chose a mixed-methods design to allow detection, via open-ended interview questions, of unanticipated factors influencing the factors affecting menstrual hygiene while assessing inter-sectoral focus via analysis of survey responses, to determine whether these influences were shared by a broader population of states than those we interviewed and to investigate factors that individual interviewees may have had limited ability to report from their own personal experiences.

4.5.2 INCLUSION AND EXCLUSION CRITERIA

Quantitative data was obtained using a cross-sectional survey with women of 20-49 years' age from selected villages of 14 districts from 7 states namely Maharashtra, Haryana, Bihar, Chhattisgarh, Assam, Odisha, and Tamil Nadu across India where the strong base of organisations was present and was working at the grass root level on various issues like health, education, livelihood, WASH, etc. in rural, peri-urban and municipal areas of the states. From the mentioned states aspirational districts or the districts with prominent problems were selected.

4.5.3 SAMPLING FRAMEWORK AND SAMPLE SIZE

For the cross-sectional survey, Cochran's formula was used to create the sampling framework. The number of samples required for the survey was assessed by Cochran's formula, I.e., $n = pqz2 / d2$

n = required sample size

p = proportion of the women's hygienic methods of protection during their menstrual period

q = 1-p

z = Z value of confidence level

d = degree of precision

The proportions of the women's hygienic methods of protection during their menstrual period (p) were taken for different districts of each study state using NFHS-5 data.

Further, we kept the confidence level at 95% (Z value of 95% confidence level is 1.96) and the degree of precision at 5%. So, by considering all these parameters plus accounting for a sampling error of 10%, the final sample size for each district of all the study states is provided below:

State	District	Prevalence (NFHS-5)	Final Sample Size
Maharashtra	Beed	70.70%	351
	Osmanabad	86.50%	198
Haryana	Jhajjar*	97.40%	269
	Mewat	58.10%	413
Bihar	Katihar**	49.50%	424
	Khagaria**	50.50%	424
Chhattisgarh	Mahasamund	61.40%	402
	Uttar Bastar Kanker**	53.10%	422
Assam	Baksa	63.40%	393
	Kokrajhar	72.30%	339
Odisha	Malkangiri	64.70%	387
	Kalahandi	70.50%	352
Tamil Nadu	Ramnad*	98.30%	178
	Virudhunagar*	97.30%	279

From the above table, it is clear that in states where the prevalence rate is higher the sample size of the population is lower. The three districts, namely, Jhajjar* (Haryana); Ramnad* and Virudhunagar* (Tamil Nadu) have the highest prevalence rates whereas Katihar** and Khagariya** (Bihar) and Uttar Bastar Kanker** (Chhattisgarh) have the lowest prevalence rates. Therefore, the sample numbers are inversely proportional to the prevalence rates that have been taken from the Government of India (GOI) NFHS-5 databases.

4.5.4 SELECTION OF THE VILLAGES

The villages/ hamlets for conducting the survey from each district have been selected purposively based on the following criteria: In each district, at least five locations are selected by focusing on mixed communities and proximity to health facilities and other developments, as well as remote / cut off/ last mile locations and homogenous communities like tribal, Dalits, minority groups, migrant workers, etc. were selected by multi-stage sampling. From the final list of villages in each district where the study will be conducted, a list of eligible populations for the study was collected from ANMs/ASHAs/Anganwadi Centres/ Panchayat of the selected villages, voters list, ward-wise block office, Nagar panchayats in peri-urban/ urban areas. From the lists received of the eligible women, final subjects were identified randomly using computer-generated random numbers from the listing of women between the 20-49 age group from the selected villages of each district.

4.5.5 DATA COLLECTION TOOLS

A total of four types of survey tools were designed. All tools were drafted in five languages: English, Hindi, Odiya, Assamese, and Tamil.

4.5.5.1 MPQ (20-49 AGE GROUP)

The standard Menstrual Practices Questionnaire (MPQ)[13] is available for download from the Menstrual Practice Measures website (www.menstrualpracticemeasures.org). The tool is available under a Creative Commons Attribution-Non Commercial International License and is free to download and use.

High-quality evidence is needed to inform policies and programmes aiming to improve menstrual health. Quantitative studies must address the many evidence gaps in this field, and practitioners have increased monitoring and evaluation efforts to track their progress. A significant barrier to improving the rigor of this work is the lack of comprehensive and comparable measures to capture core concepts. The Menstrual Practices Questionnaire (MPQ) is a new tool to support comprehensive and standardised assessment of the activities undertaken in order to collect, contain, and remove menstrual blood from the body in self-report surveys.

The questionnaire is freely available online and can be adapted for use across contexts and age groups. MPQ is considered as one of the best-practice tool to align the description of menstrual practices and provide a foundation for further question refinement. Increased acknowledgement that unmet menstrual health needs result in consequences for physical, mental, and social well-being has motivated policy and programme responses around the world.

However, there is a dearth of evidence to support these efforts. Research is needed to understand menstrual experiences and inform the development of interventions, and to test and monitor their impacts. Quantitative methodologies are required to address many research questions, but have been limited by a lack of tools to measure core concepts To address this need the Menstrual Practices Questionnaire (MPQ), offers a comprehensive set of self-report questions to capture menstrual practices: all of the activities undertaken in order to collect, contain, and remove menstrual blood from the body. The MPQ draws on past research to provide a best-practice tool which can be refined through future work.

THE MPQ HELPS IN THE FOLLOWING

(1) rationale for the consistent assessment of menstrual practices; (2) the development of the MPQ including the coverage of questions and question formats (including recall period, location specificity, and use of single-, multiple-response or frequency questions); (3) directions for future research to improve the measurement and reporting of practice-related questions.

SINGLE-RESPONSE, MULTIPLE-RESPONSE, AND FREQUENCY QUESTIONS

Many menstruators use multiple methods for each menstrual practice. For example, they use a variety of menstrual materials over their period. In collecting data to most accurately reflect menstrual practices, surveys may use multiple-response questions which record multiple behaviours, single response questions which force selection of only one response, or frequency-based questions which capture how often or in what proportion of instances respondents enacted a practice.

QUESTION PILOT AND ACCEPTABILITY

MPQ should be piloted as part of a cross-sectional survey of target communities (Girls, married women, pregnant women, older women etc). Such a pilot-study framework can allow us a rich insight into the world of MHM and WASH as co-related to each other and how these two unfold together to impact the menstrual, physical and reproductive health and well-being of a meaningfully selected and diversely relevant sample representative, in the best possible way of the phenomenon and issue under study. These questions related to menstrual hygiene practice, perceptions and needs can indicate for the world of knowledge and policy, how feasible and desirable it would be to enact larger studies on the issue too.

[13] For detailed information about the development of the Menstrual Practices Questionnaire (MPQ), including guidance for use and the selection of questions, please see the full publication at (https://www.menstrualpracticemeasures.org/mpq/): Hennegan, J., Nansubuga, A., Akullo, A., Smith, C., & Schwab, K.J., (2020). The Menstrual Practices Questionnaire (MPQ): Development, elaboration, and implications for future research. Global Health Action, 13(1), 1829402. https://doi.org/10.1080/16549716.2020.1829402

SURVEY CONTENT

Menstrual materials used; Changing materials; Washing hands and genitals; Disposal; Storage; Washing materials; Drying materials; Sterilising menstrual materials; Toilet/latrine use during menstruation etc.; conversation possibilities on Menstruation; Menstruation Related Illnesses etc. The MPQ was adapted to carry out a process of in-depth interviews (IDIs): Field workers visited the villages with the total women-participants' list containing names and addresses of randomly selected women. Prior information, consent and interview time was sought by every field worker conducting 3 to 4 interviews per day. Each interview took 30 to 40 minutes. Fieldworker conducted the interviews by taking the consent of the respondent.

4.5.5.2 ABOUT THE MENSTRUAL PRACTICE NEEDS SCALE (MPNS-36)

The Menstrual Practice Needs Scale (MPNS-36) is a set of self-report questions that work together to measure women's and girls' menstrual experiences. The scale focuses on a respondents' experience of her last menstrual period and captures experiences of the practices undertaken, and environments used to manage menses.

Items ask about perceptions of comfort, satisfaction, adequacy, reliability as well as worries and concerns during the last menstrual period.

The Menstrual Practice Needs Scale (MPNS-36) measures the extent to which respondents' menstrual management practices and environments were perceived to meet their needs during their last period.

The scale provides a quantitative (number) estimate of the extent to which women's and girls' needs are being met. It can be used for needs assessment in baseline or cross-sectional investigations, or for programme evaluation, to monitor differences in experience over time or between groups[14]

4.5.5.3 FGDS (ADOLESCENT AND ELDERLY WOMEN)

For Adolescents, the place of the interview was school premises or Anganwadi or any comfortable place to gather, same as for the elderly women age group. These discussions were executed by prior planning. The group gathered together, consent was taken, permission for recording was taken, then these discussions were conducted by 2 interviewers for around 30 to 50 minutes depending on the capacity of the respondents to answer and the capacity of the interviewers to generate discussion. All respondents were expected to fill out MPNS forms at the end of FGDs.

4.5.5.4 KIIS (KEY INFORMANT INTERVIEWS FROM KEY STAKEHOLDERS)

Field coordinators were identifying key stakeholders from their respective areas. Key informant interviews were getting conducted by their prior appointments simultaneously with the FGDs and MPQs. Getting information and permission for recording interviews from health workers, local authorities, and officials was a skillful task. Interview time was around 20 to 30 minutes depending on the capacity of the respondents to answer and the capacity of the interviewers to generate discussion. All respondents were expected to fill MPNS forms.

4.6 NGO PARTNERS, PARTICIPANTS AND KEY INFORMANTS

The data was collected with the help of NGO partners in each state. By use of *in-situ* presence and observations, the local data collection team and partners had the skill to 'immerse' themselves in the social setting, thereby generating precise and in-depth data on social action. Participant observation that we oriented and capacitated the partners with, gave them the opportunity to gather empirical insights from the realm of social practices and imagination, which are normally 'hidden' from the public, 'gaze' (see Reeves and Peller et.al 2013). Additionally, using holistic social accounts that are the mainstay of ethnographic research, our study identified, explored and linked social phenomena across sectors with the help of EAMW. As such, ethnographic research differs from other forms of qualitative research such as phenomenology (the analysis of interviews to understand individual's lived experiences) or discourse analysis (the analysis of talk and/or documents to understand the

[14] (https://www.menstrualpracticemeasures.org/mpns-36/) For more detailed information on MPNS-36 development and validation, please see the full publication at: Hennegan, J., Nansubuga, A., Smith, C., Redshaw, M., Akullo, A., & Schwab, K.J. (2020). Measuring menstrual hygiene experience: Development and validation of the Menstrual Practice Needs Scale (MPNS-36) in Soroti, Uganda. BMJ Open, 10, e034461. http://dx.doi.org/10.1136/bmjopen-2019-034461

influence of embedded discourses) and overcomes many of their limitations. Keeping this in mind, the project core research team and field -work teams did not rely exclusively on interview data alone to seek and interpret findings. Using the EEA, a circular mapping and analysis of actors, discourses and practices was conducted in light of one another. Once the data gave us a glimpse of the lifeworld, across regions, we coded, categorised and analysed data using both qualitative and quantitative methods as well as processes. This enabled extremely relevant and pertinent grounded inferences to emerge with the help of combined interpretations.

4.6.1 OUR LOCAL PARTNERS

State	District	Name of the Partner Organisation
Maharashtra	Beed	Jana Vikas Sanstha, Beed
	Osmanabad	Paryay, Osmanabad
Haryana	Mewat	Sulabh Sanitation Mission Foundation (SSMF)
	Jajjhar	Sulabh Sanitation Mission Foundation (SSMF)
Bihar (Bobby)	Khagariya	Nav Jagriti and : Website- www.navjagriti.org.in
	Katihaar	Prayas Foundation For Social Change And Economic Reforms
Chhattisgarh	Mahasamund	Shri Jan Kalyan Samaj Sevi Sanstha
	Uttar Bastar Kanker	Adivasi Samta Manch
Assam	Baksa	SiQSA
	Kokrajhar	SiQSA
Odisha	Malkangiri	Centre for Action Research
	Kalahandi	Centre for Action Research
Tamil Nadu	Ramnad	CORORAT
	Virudhunagar	CORORAT

The project brings forward first-hand information made possible through a collaborative research design and methodology in which the partners facilitated local information collection and opened the doors for effective field -based research. The local partner organisations in fourteen districts were oriented and given support during all stages of data collection and research on the issue of MHM and WASH through virtual, physical meetings and exchange of information sessions. The partner organisations' rich experience and expertise has helped us access approximately five thousand women participants from diverse backgrounds Viz., Migrant workers; farmers; plantation and factory workers; tribal and PVTGs; Dalits and other castes; religious and social minorities; girl-children; community leaders; frontline health workers such as doctors and AWWs, ASHAs; administrative officers; Village Presidents (Sarpanchs) and homemakers all form vital respondents and core participants of our ground research.

4.7 DATA CLEANING AND ANALYSES

Data collection and the data cleaning process were conducted simultaneously. Every interview was allotted a Unique Identity Number as per the interview category. Quantitative data was analysed in Excel as well as in SPSS using a well-defined template of the study instrument. Overall analysis, situational analysis, and multistate analysis were done thoroughly. The Likert scale was tested to assess the normality of the data. Non-parametric

tests were performed on selected ordinal and nominal variables. Measures of central tendencies were applied to the data. Statistical tests like significance analyses were performed on selected variables in SPSS20. We considered P values $p<0.05$ to be statistically significant. Qualitative and quantitative data were synthesised together to develop a comprehensive understanding of menstrual health and hygiene management. Audio-recorded interviews like KII and FGDs with an average length of 30 to 40 minutes were transcribed verbatim into English or Hindi. The transcripts were de-identified to ensure anonymity and coded with the assistance of qualitative software. Codes and themes were developed after carefully reading the transcripts. Similar codes were categorised and broad themes were developed to carry out thematic analysis.

4.8 LIMITATIONS OF THE DATA COLLECTION PROCESSES

- This study mainly focused on understanding the needs for menstrual health and hygiene practices amongst women in the age group of 20 to 49 years (whom we refer as EAMW) who live in remote, isolated and marginalized circumstances. Typically, they also belong to communities and social strata that hardly derive MHM benefits from the public system. Apart from ANC/PNC-related services, schemes and benefits, these women are usually less integrated with the public health system owing to their locations, lack of resources and awareness as well as taboos.
- This entire study was conducted to understand the situation regarding community practices, taboos, available resources, and perceptions to deal with menstrual health and hygiene. The findings of this survey might potentially serve as a tool for breaking the silence in the community regarding menstruation and sums up the concrete MHM needs of women in the outside periphery of adolescent age.
- Both the qualitative and quantitative methods in this study had limitations. In the qualitative interviews, responses could have been subject to social desirability bias, in which interviewees may have given answers that they felt would be more "socially acceptable" than their true beliefs. The quantitative survey was intended, in part, to address this limitation, since the vast majority of items (especially those concerning sensitive topics, such as income, and spending capacity) did not ask individual survey respondents to describe how specific factors affected their professional satisfaction. Instead, quantitative associations were inferred by combining responses from multiple survey respondents.
- In addition, our analysis of survey responses, which controlled for measures of individual response tendency, was designed to mitigate bias due to respondent-to-respondent variability in susceptibility to social desirability.

ANNEXURE I

MHM RESOURCE MATERIAL IN INDIA: A 360 DEGREE APPROACH TO ADOLESCENT HEALTH

A range of IEC material has been developed around MHM, using a 360-degree approach to create awareness among adolescent girls about safe & hygienic menstrual health practices which includes audio, video and reading materials for adolescent girls and job-aids for ASHAs and other field level functionaries for communicating with adolescent girls. Below is a thematic introduction of some of interventions that have contributed to the growth of the menstrual health sector in India. With collaborative platforms such as the Menstrual Health Alliance India gaining traction, there are more opportunities for various actors to share learnings and explore collaborations. Most of these interventions have a rural focus but can be adapted and applied to urban settings too.

Menstrual Health Education Knowledge and awareness of ideal menstrual health practices is a critical first step to improving menstrual health, reducing stigma, and ensuring that girls are able to achieve their highest potential. Some curricula cover menstrual health in combination with puberty education in a format where lessons are delivered separately to boys and girls. This format allows for young girls to ask questions without feeling embarrassed and for an in-depth discussion around the hygiene practices associated with menstruation.

Champa Kit

Thoughtshop Foundation the Champa Kit is based on a story, where the central character is a twelve-year old girl named, Champa. The story is presented through flip charts and contains five modules. Each module is self-sufficient and can be used either independently or in sequence with other modules. The sequence of issues covered include self-esteem, puberty, menstruation, conception and sex determination, and birth spacing.

Menstrupedia Comic and Illustrated Website

A friendly comic-style guide, Menstrupedia is designed to help girls and women stay healthy and active during their periods. Speaking to other women about their own experiences, Gupta and Paul the authors, says Sahariah (2016) realised there was a general need for greater awareness among young Indian women about menstruation and menstrual hygiene. In 2012, they launched Menstrupedia, an illustrated website that teaches visitors about the physical and emotional changes girls go through when they reach puberty, as well as answering questions such as, "How important is it for a girl or woman to be aware of her body?" Menstrupedia aims at delivering informative and entertaining content on menstruation through the character of ' 'Priya Di," who is a doctor and a reliable source of menstrual health information for girls. The Menstrupedia Comic is being used by more than 7,500 schools, 270 NGOs and 1.2 million girls across India.

Ritukalin Bandhobi Dolon Di (Dolon - our friend in need during periods)

Nirman Foundation in Kolkata published the Bengali comic book on menstrual health called, Ritukalin Bandhobi Dolon Di. This is an in-house publication which has been rolled out by Nirman Foundation in various menstrual health projects in West Bengal along with other IEC materials developed by the foundation in-house.

As We Grow Up – WSSCC and Government of India

As We Grow Up was jointly produced by the Water Supply and Sanitation Collaborative Council (WSSCC) and the Government of India (GOI). The images in the flipbook allow participants to visualise the changes in the body that take place from childhood to adulthood. Taking a 'show don't tell' approach eases the participants into the topic of menstruation. WSSCC has also launched a version of this module for girls with disabilities.

Paheli ki Saheli – UNICEF and Johnson & Johnson's

The Paheli ki Saheli (roughly translated as "the answer to our riddles") package is a comprehensive tool for educating adolescent girls as well as their mothers and teachers on menstruation. Apart from a story based illustrated flipbook, it also contains five short five-minute films, riddles, and activity-based games. It's an initiative by UNICEF India and Johnson & Johnson's to break the silence around menstruation and trigger a transformation in menstrual health and hygiene for girls.

Chhaa Jaa - Girl Effect in India

Girl Effect has launched Chhaa Jaa (Go Forth and Shine), a brand aimed at empowering adolescent girls in India through digital media content. In the segment Khullam- Khulla (Talk Openly! Without Hesitations!), an everyday girl Rani talks about various aspects of sexual and reproductive health with a special focus on menstruation.

The She Pad - Menstrual health product – Access and Use 2017

The 'She Pad' project was launched in 2017 by Kerala government as a product-based intervention in schools. The widely talked about project supplied schools in the state with sanitary napkins, almirah, and incinerators. The project covered 400 schools in the state and was implemented by the Kerala State Women Development Corporation .

REFERENCES

1. American Academy of Pediatrics, Committee on Adolescent Health Care, American College of Obstetricians and Gynecologists & Committee on Adolescence.

2. Association of Social Anthropologists of the UK and the Commonwealth Ethical Guidelines for Good Research Practice Anthropologists of the UK and Commonwealth. 1999. Available online: https://www.theasa.org/downloads/ethics/Ethical_guidelines.pdf. Accessed 9th October 2022

3. Atkinson P, Pugsley L. Making sense of ethnography and medical education. Med Educ 2005; 39(2)228–234

4. Menstruation in girls and adolescents: Using the menstrual cycle as a vital sign. Paediatrics 137, (2016).

5. Chandra-Mouli V, Patel SV. Mapping the Knowledge and Understanding of Menarche, Menstrual Hygiene and Menstrual Health Among Adolescent Girls in Low- and Middle-Income Countries. 2020 Jul 25. In: Bobel C, Winkler IT, Fahs B, Hasson KA, Kissling EA, Roberts TA, editors.

6. Das P., Baker K.K., Dutta A., Swain T., Sahoo S., Das B.S., Panda B., Nayak A., Bara M., Bilung B., et al. Menstrual Hygiene Practices, WASH Access and the Risk of Urogenital Infection in Women from Odisha, India. PLoS ONE. 2015; 10:e0130777. doi: 10.1371/journal.pone.0130777.

7. Deb, Rouhin (2021). A Ray of Hope for Rural India: Aspirational District Programme (ADP). Observer Research Foundation (ORF) June 23, 2021. Online: https://www.orfonline.org/expert-speak/a-ray-of-hope-for-rural-india-aspirational-district-programme-adp/. Accessed 11th October 2022

8. Chang YT, Hayter M, Lin ML. Pubescent male students' attitudes towards menstruation in Taiwan: implications for reproductive health education and school nursing practice. J Clin Nurs. 2012;21: 513–21.

9. Chavez-MacGregor, M. et al. Lifetime cumulative number of menstrual cycles and serum sex hormone levels in postmenopausal women. Breast Cancer Research and Treatment 108, 101–112 (2007).

10. Cherrier, H., Goswami, P. & Ray, S. Social Entrepreneurship: Creating Value in the context of institutional complexity. Journal of Business Research 86, 245–258 (2018).

11. Chumlea, W. C. et al. Age at menarche and racial comparisons in US girls. Pediatrics 111, 110–113 (2003).

12. Elledge MF, Muralidharan A, Parker A, Ravndal KT, Siddiqui M, Toolaram AP, Woodward KP. Menstrual Hygiene Management and Waste Disposal in Low and Middle Income Countries-A Review of the Literature. Int J Environ Res Public Health. 2018 Nov 15;15(11):2562. doi: 10.3390/ijerph15112562. PMID: 30445767; PMCID: PMC6266558

13. Global Menstrual Health Collective (2020). Global Menstrual Health Collective Statement. Online at: https://www.globalmenstrualcollective.org/uploads/2020/07/gmc-foundational-statement.pdf. Accessed 6th October 2022.

14. Hennegan, J. & Montgomery, P. Do menstrual hygiene management interventions improve education and psychosocial outcomes for women and girls in low and middle income countries? A systematic review. PLOS ONE 11, (2016).

15. Hennegan, J., Nansubuga, A., Akullo, A., Smith, C. & Schwab, K. J. MPQ: View & Download, menstrual practice measures. Menstrual Practice Measures (2020). Available at: https://www.menstrualpracticemeasures.org/mpq/mpq-view-download/. (Accessed: 4th October 2022)

16. House S. Menstrual Hygiene Matters: A Resource for Improving Menstrual Hygiene around the World. 2012. p. 347. WaterAid Report. Available online: http://www.wateraid.org/what-we-do/our-approach/research-and-publications/view-publication?id=02309d73-8e41-4d04-b2ef-6641f6616a4f

17. Kapoor, Amit and Michael Green. 2020. Aspirational Districts Programme shifts the focus back on Development. Economic Times. The September 16, 2020

18. Khanna, A., Goyal, R. S. & Bhawsar, R. Menstrual practices and reproductive problems. Journal of Health Management 7, 91–107 (2005).

19. Li, K. et al. Characterizing physiological and symptomatic variation in menstrual cycles using self-tracked mobile-Health Data. npj Digital Medicine 3, (2020).

20. Mason, Linda and Muthusamy Sivakami 'We do not know': a qualitative studyexploring boys perceptions of menstruation in India. Mason et al. Reproductive Health (2017) 14:174. Available from: https://www.researchgate.net/publication/321673230_'We_do_not_know'_a_qualitative_study_exploring_boys_perceptions_of_menstruation_in_India. Accessed 9th October 2022.

21. Majeed, J., Sharma, P., Ajmera, P. & Dalal, K. Menstrual hygiene practices and associated factors among indian adolescent girls: A meta-analysis. Reproductive Health 19, (2022).

22. MedlinePlus Menstruation. Available online: https://medlineplus.gov/menstruation.html. Accessed 7th October 2022.

23. National Rural Health Mission (NRHM) Operational Guidelines Promotion of Menstrual Hygiene among Adolescent Girls (10-19 Years) in Rural Areas P. 9 Online at: https://nhm.gov.in/images/pdf/programmes/arsh/guidelines/MHS-operational-guidelines.pdf. Accessed October 3, 2022.

24. National MHM Guidelines. 2015. National Menstrual Hygiene Management Guidelines 2015. Ministry of Drinking Water and Sanitation. Government of India

25. Omidvar S, Amiri FN, Bakhtiari A, Begum K. A study on menstruation of Indian adolescent girls in an urban area of South India. J Family Med Prim Care. 2018 Jul-Aug;7(4):698-702. doi: 10.4103/jfmpc.jfmpc_258_17. PMID: 30234040; PMCID: PMC6132001. Accessed 7th October 2022.

26. Oxley, T. (1998). Menstrual management: An exploratory study. Feminism & Psychology, 8, 185–191

27. The Palgrave Handbook of Critical Menstruation Studies [Internet]. Singapore: Palgrave Macmillan; 2020. See, Introduction: Menstruation as Embodied The Palgrave Handbook of Critical Menstruation Studies, 2020. Online: https://link.springer.com/chapter/10.1007/978-981-15-0614-7_16. Accessed 7th October, 2022

28. Penakalapati G (2009) Boys don't have knowledge about menstruation: they think it is a bad thing' knowledge and beliefs about menstruation among adolescent boys in Gicumbi district Rwanda Hubert Department of Global Health.

29. Popat, V. B., Prodanov, T., Calis, K. A. & Nelson, L. M. The menstrual cycle. Annals of the New York Academy of Sciences 1135, 43–51 (2008).

30. Rana, Tanya. 2022. Menstrual Health Services in India: A Comprehensive Overview of the Public System. Accountability Initiative. September 2, 2022. Online: https://accountabilityindia.in/blog/menstrual-health-services-in-india-an-overview/. Accessed 10th October 2022.

31. Raj A, McDougal L, Rusch ML. Changes in prevalence of girl child marriage in South Asia. JAMA. 2012 May 16;307(19):2027-9. doi: 10.1001/jama.2012.3497. PMID: 22665097; PMCID: PMC4386922.

32. Raj A. When the mother is a child: the impact of child marriage on the health and human rights of girls. Arch Dis Child. 2010;95(11):931–935.

33. Reeves, Scott, Jennifer Peller, Joanne Goldman & Simon Kitto (2013) Ethnography in qualitative educational research: AMEE Guide No. 80, Medical Teacher, 35:8, e1365e1379, DOI: 10.3109/0142159X.2013.804977.

34. Shanbhag, D. N. et al. Perceptions regarding menstruation and Practices during menstrual cycles among high school going adolescent girls in resource limited settings around Bangalore 8 city, Karnataka, India. International Journal of Collaborative Research on Internal Medicine and Public Health 4, (2012).

35. Singh, Tanmay. 2020. We need to abandon the notion that periods are just a menstruator's business. Environment and Menstruation. Youth Ki Awaaz December 10, 2020. https://www.youthkiawaaz.com/2020/12/bleeding-for-the-environment/. Accessed 9th October 2020.

36. Sommer, M. & Sahin, M. Overcoming the taboo: Advancing the global agenda for Menstrual Hygiene Management for schoolgirls. American Journal of Public Health 103, 1556–1559 (2013).

37. Sumpter C., Torondel B. A systematic review of the health and social effects of menstrual hygiene management. PLoS ONE. 2013;. doi: 10.1371/journal.pone.0062004.

38. Sutirtha Sahariah. 2016. The comic that is taking on the Taboos of Periods, in, The New Humanitarian. December 19 2016. https://deeply.thenewhumanitarian.org/womenandgirls/articles/2016/12/19/indian-comic-book-thats-taking-taboo-periods.

39. Swedish International Development Cooperation (SSIDC) Menstrual Hygiene Management. Agency SSIDC; Stockholm, Sweden: 2016.

40. Thapa, Purnima and Muthusamy Sivakami. 2017. Lost in transition: menstrual experiences of intellectually disabled school-going adolescents in Delhi, India. October 2017. Waterlines 36(4):317-338. DOI: 10.3362/1756-3488.17-00012. Accessed 9th October 2022.

41. https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1021&lid= 391#:~:text=The%20Ministry%20of%20Health%20and,adolescent%20girls%20on%20Menstrual%20Hygiene. Accessed 6th October 2022

42. http://www.nrhmorissa.gov.in/writereaddata/Upload/Documents/5-%20Operational%20guideline%20of%20Menstrual%20Hygiene%20Scheme%20-%20Odisha.pdf. Accessed 6th October 2022

43. UNICEF (2013, and 2014) Proceedings of the MHM Virtual conference, https://www.unicef.org/wash/schools/files/MHM_vConf_2014.pdf. Accessed: 4th October 2022

44. UNICEF 2019. Guidance on menstrual health and hygiene. UNICEF (2019). Available at: https://www.unicef.org/documents/guidance-menstrual-health-and-hygiene. Accessed: 4th October 2022

45. UNICEF 2020. Innovation in MHM: Putting Girls at the Centre. Proceedings of the 8th Virtual Conference Menstrual Hygiene Management in Schools. May 21, 2020. Programme Division/WASH 3 United Nations Plaza New York, NY 10017 USA www.unicef.org/wash. Accessed: 7th October 2022.

46. Van Eijk A.M., Sivakami M., Thakkar M.B., Bauman A., Laserson K.F., Coates S., Phillips-Howard P.A. Menstrual hygiene management among adolescent girls in India: A systematic review and meta-analysis. BMJ Open. 2016;6:e010290. doi: 10.1136/bmjopen-2015-010290.

47. World Bank 2018. Menstrual Hygiene Management Enables Women and Girls to Reach Their Full Potential. The World Bank: IBRD- IDA. May 5, 2022. Available at: https://www.worldbank.org/en/news/feature/2018/05/25/menstrual-hygiene-management. Accessed October 7, 2022.

48. World Bank. 2021. A Holistic Approach to Better Menstrual Health and Hygiene: Entrepreneurs in Action May 21, 2022. Online at: https://www.worldbank.org/en/news/feature/2021/05/24/a-holistic-approach-to-better-menstrual-health-and-hygiene-entrepreneurs-in-action. Accessed October 7, 2022.

INFERENCES AND WAY FORWARD

1.1 MHM AND WOMEN'S HEALTH: INTEGRATING WOMEN TO WELLBEING POLICIES OF THE COUNTRY:

It is important to integrate menstrual health management into public health policy in India to achieve the well-being of the Elder and Aging Menstrual Women(EAMW). The EAMW, being in the prime of their life (beyond school years and before menopause: 20-49 years), form a veritable social-economic national resource, and thus reaching out to them needs to become an urgent concern in the country's policy making. If menstrual health concerns are not resolved or are pushed to the periphery, or remain shrouded in silence, then not only menstruating women but their families, society and the country would have much to lose socially and economically. For combating MHM related silences**,** engaging in active care for the EAMW is a prime need in the country.

1.2 MIGRATION AND MHM AND HEALTH

In the unorganised sector, there is often seasonal migration. Such work is often based on completely unfair labour contracts and harsh working conditions without relief or empathy for menstruating women in the prime of their lives. Consequently, both women and their partners (working as a team) are subjected to undue monetary wage deductions for leaves on account of adverse menstrual health symptoms. Complications in intimate health during and after menstruation are not uncommon given the shabby MHM conditions on farms and factories or other places of work in the unorganised sector. The women seldom have any recourse to get proper treatment for their menstrual health

1.3 HYSTERECTOMIES AND MHM: GENDER MAINSTREAMING THE UNORGANISED WORK SECTOR

Our findings on hysterectomies suggest that the informal labour sector that employs marginalised farming, Dalit and tribal communities and migrants discriminates against women and creates pressures on husband-wife teams (*Jodis*). Moreover, misconceptions about uterine relevance post-motherhood abound. Exploitative labour situations are bereft of adequate MHM and WASH facilities, and marginalised women face complex labour-rights related challenges regarding their reproductive health, oftentimes leading to hastily executed hysterectomies. MHM should become a vital part of labour laws, public health and community-based awareness drives on menstruation.

1.4 AWARENESS AND MHM: PERSONAL HYGIENE AND WASH PRACTICES DURING LAST MENSTRUAL CYCLE INDICATE LACK OF AWARENESS

Our data indicates that more awareness on MHM and WASH, alongwith better access to WASH infrastructure and sanitation is the basic need for EAMW, specially in rural belts in the country where otherwise women agricultural labourers normally suffer MHM related deprivations.

1.5 EDUCATION, SOCIAL NORMS AND MHM

We recommend that governments prioritise strengthening existing policies, programmes and capacities to deliver awareness, improve the reach and quality of low-cost pads and other menstrual hygiene products, and improve targeting influencers such as leaders, FLHWs etc. The ability of girls to manage their menstruation is hindered by broader gender inequities and discriminatory social norms across India. MHM can be leveraged as a less sensitive entry point to address other issues and concerns like sexual and reproductive health, reproductive rights, maternal infant wellbeing, teenage pregnancy prevention, prevention of STDs etc; and thereby improve a girl's empowerment. In this area, research and programming are still nascent. Menstruation should not disrupt women's health, education, or growth. However our data indicates that even educated women still opted for uterus removal. While those who have never gone to a school or received education go in for hysterectomies in public hospitals, the educated women prefer private hospitals.

1.6 WOMEN'S DISPOSABLE INCOMES AND MHM OUTCOMES

Women can augment family income from traditional knowledge and customary skills, and thus vocational courses coupled with micro-financing to enhance disposable incomes can be organised for women struggling with socio-economic vulnerabilities. Disposable incomes give women a better opportunity towards empowered decision-making for MHM, personal and medical care. Our surveys indicate a good level of education among the EAMW. Therefore, these women can be willing participants in endeavours that try to hone their skills and talents through formal training and internships to expand their employment. The EAMW, especially with good levels of education can be targeted through existing SHGs.

1.7 MHM AND WASH

During menstruation a woman's WASH needs are relatively higher as compared to the rest of the days, as she needs more water to clean herself for personal and intimate hygiene, including after defecation. In addition, ensuring that a woman has the facility of a private and secure place to change her menstrual absorbents after cleaning herself are a profound part of her sense of dignity and safety. Therefore, the access to a toilet and bathroom becomes a critical need during periods. It emerges from our data that despite a good amount of IHHLs with coverage under SBM and JJM, inadequacies still abound and open defecation is still practised presenting a daunting privacy and health challenge for menstruating women. Additionally floods and droughts constitute water scarcities and influence MHM outcomes negatively.

1.8 PUBLIC POLICY AWARENESS AND MHM: AWARENESS OF PUBLIC POLICY AND COUNSELLING ON MHM CAN HELP WOMEN

Our survey revealed that women are quite familiar with the local state services under the public health system. However the proportion of women covered under women and child welfare and adolescents' health schemes differs across states and districts, and many times this remains low. However, once women become familiar with the schemes meant for them, they tend to become dependent on their benefits owing to their own marginalised existence. Spreading awareness towards government schemes and wellbeing on MHM among women beyond school years is still a long way from being actively considered as a public policy in India. Owing to the vast reach of and acceptance of Public Health system in India, the MHM of EAMW can get a much-required boost if it receives adequate public policy attention. We feel that women's participation in the Aspirational Districts Programme (ADP) can increase if MHM is piloted as an inter-sectoral intervention.

1.9 SALIENT FINDINGS FROM DATA: LAYERED SILENCE AS WELL AS THE WAY OUT

- Evidence from our qualitative and quantitative evaluation pertaining to the seven states under study suggests that there is a layered silence on women's menstrual health owing to inter-sectoral hindrances and policy barriers.

- Attitudes, myths, beliefs, and discriminatory practices make this silence doubly potent in bringing profound challenges to MHM among EAMW. Community-voices across the sample population portray a negative discriminatory attitude towards periods. These discriminatory voices and attitudes are practised by both men and women across social strata. Many EAMW as well as key informants endorsed negative attitudes towards menstruation, either owing to the circumstantial difficulties they themselves experienced growing up or for want of better knowledge and support systems on the issue. Inadvertently, such voices contribute to perpetuation of a debilitating discourse on menstruation.
- Our research shows that menstrual health related policies on nutrition, free pad distribution, educational awareness through Schools, interactions with ASHA and community-based events for adolescent girls are followed in varying degrees all over India. According to our data from KIIs, the most regularly implemented scheme is the free distribution of IFA tablets, followed by free health check-ups. Free pad distribution scheme is in some areas, whereas discontinued in others. Our key informants indicate that policies that are implemented regularly become a part of social endorsement as well as expectations, such that people anticipate as well as welcome these, and become reliant on such public good gestures. This is true for health check-ups and nutritional tablets. However, where regularly awaited and needed schemes are not implemented well or discontinued without explanation, people become disheartened, anguished, and unhappy with the state. This is true in the case of free pad distribution schemes. Existing governmental policies require to be in sync with menstrual health schemes and awareness for adolescents as well as women.
- The key to combating the inter-sectoral and community-based silences and barriers on MHM among women beyond school years lies in augmenting positive practices and discourses on menstruation.
- One of the best ways to achieve this is by involving multiple key stakeholders such as EAMW, leaders, influencers, families, policy makers and implementers. Mainstreaming MHM into programmes such as ADP can ensure gender perspective and gender equity in all actions, projects and programmes.
- Policy makers and implementing agencies need to realise that where taboos or myths present cultural barriers to MHM, only schooling will not serve as the panacea for all ills. In addition, provisions for MHM and WASH, as well as gender mainstreaming laws and approaches need to be incorporated into social upliftment programmes in community spaces, villages, anganwadis, schools, as well as in organised and unorganised sector workplaces.

A RESEARCH REPORT FROM

ASSAM

PART 1 INTRODUCTION

In Assam, our research report on the 'Combating the Silence from Menarche to Menopause – A Comprehensive Report on Menstrual Hygiene Management in India', was conducted in the districts of Baksa and Kokrajhar. Baksa and Kokrajhar both have a specific set of inter-sectoral challenges connected to women's health and wellbeing in both the districts. Baksa falls under Niti Ayog's Aspirational District Programme (ADP)[1]. Kokrajhar, which is a non -aspirational district was included in this research due to its identity- conscious politics and the need to understand women's health issues employing community-sensitive as well as policy-based perspectives. Baksa and Kokrajhar each have the commonality of water scarcity and increasing inaccessibility to potable water in the villages selected for research. Drinking water crisis, energy deficiency and accessibility challenges to basic health and education facilities, transport system, poor monetary gains, high rate of unemployment issues faced by villagers in both the districts.

For completing our research sample in Baksa and Kokrajhar, ten villages were selected for field research and surveys. Research, including data collection and analysis for this case- study on Assam were done through the period of April 2022 to February 2023. Following a participatory and mixed-methods approach, information was sought and processed on the local situation on Menstrual Hygiene Management (MHM), Water Sanitation and Hygiene (WASH), education, health, livelihood, income, and availability of support systems to women in the selected districts. Though both districts are doing well on many parameters under the ADP, our study indicates that Baksa and Kokrajhar have much to achieve in terms of combating the silences on MHM with inter-sectoral perspectives on wellbeing of, what we refer to as, '**Elder and Ageing Menstruating Women'** or EAMW. Nevertheless, because our interaction included women as mothers, teachers, counselors, and caregivers of young girls within schools and families, we include a lateral analysis on the menstrual wellbeing requirements of school-going girls as well.

Our research has been designed to collect thick ethnographic data on actors, practices and discourses with an inter-sectoral and analytical perspective on Menstrual Hygiene Management (MHM) in selected research areas. Water, Sanitation and Hygiene (WASH), availability of community support systems, schemes and education as well as felt needs of menstruating women form a vital part of this research. We bring data through fieldwork, interviews, Focus Group Discussions (FGDs) and observations on MHM through women's participatory voices and opinions. A total of 717 interviews were conducted by employing the Menstrual Practice Questionnaires (MPQs) wherein data was collected from 377 women from Baksa and 340 women from Kokrajhar. Our research covered populations ranging from Other Backward Classes (OBCs), Scheduled Tribes (STs) , tea garden workers, skilled and unskilled workers. Interviews and interactions took place in local languages, dialects and Hindi in which women were comfortable to communicate.

Focusing primarily on the category of, what we refer to as, **'Elder and Ageing Menstruating Women'** (henceforth EAMW) between the ages of 20 years to 49 years, we also share our findings on MHM related enablers and barriers for young school going girls. In an attempt to understand the well-being of menstruating women beyond their school years, this study on Assam documents the various kinds of barriers and silences in the effective MHM of EAMW. Nonetheless, we also explore our primary data to critically discern potential enablers towards an effective MHM of women between the ages of 20 years to 49 years. Our exclusive focus is on EAMW. However, as mothers, teachers and relatives of growing girls, these EAMW deal with young girls, hence we impart a 'lateral' focus on girls.

[1] ADP aims to improve the socio-economic status of the citizens expeditiously. The three core principles of the program are - Convergence (of Central & State Schemes), Collaboration (among citizens and functionaries of Central & State Governments including district teams), and Competition among districts (Niti Aayog 2018).

In the final sections, our findings are examined against the voices of key informants to crystallize the salient findings from our primary data as well as delineate context- specific and community-sensitive areas of improvement. Therefore, this case-study on Assam ends with suggestions on short term as well as mid-term enablers and recommendations for combating the inter-sectoral hindrances prevalent in areas observed.

BAKSA AND KOKRAJHAR DISTRICT OF ASSAM

Assam is situated in the North-East of India and is the largest northeastern state in terms of population while second in terms of area. Assam covers an area of 78,438 km^2 (30,285 sq miles). A significant geographical aspect of Assam is that it contains three of six physiographic divisions of India – the Northern Himalayas (Eastern Hills), the Northern Plains (Brahmaputra plain), and Deccan Plateau (Karbi Anglong) (Government of Assam, 2023).

Assam is the meeting ground of diverse cultures. The people of the enchanting state of Assam are an intermixture of various racial stocks such as Mongoloid, Indo-Burmese, Indo-Iranian and Aryan. The Assamese culture is a rich and exotic tapestry of all these races evolved through a long assimilative process. The natives of the state of Assam are known as "Asomiya" (Assamese), which is also the state language of Assam. The state has a large number of tribes, each unique in its tradition, culture, dress and exotic way of life (Government of Assam, 2023).

Assam is rich in water resources and has vast tracts of fertile land. It is also the third-largest producer of petroleum and natural gas in the country and has ample reserves of limestone. With its five national parks and 18 wildlife sanctuaries, the state is a biodiversity hotspot. Other potential areas of investment include power and energy, mineral-based industries, tourism, and crude oil refining (IBEF, 2023).

Assam has a history of disasters ranging from large earthquakes to severe floods (ASDMA, n.d., State Profile section). Annually many people and communities in Assam are affected by heavy monsoon that causes devastating floods across the state displacing tens of millions of people every year. Women and girls suffer disproportionately due to these floods. Additionally, water levels in the Brahmaputra and Barak River of Assam tend to rise and overflow during heavy rainfall inundating many territories, marooning villages causing displacement, homelessness as well as ecological, agricultural, crop and infrastructural damage and discontinuities (Deen & Debbarma 2020, pp. 105-109). .

This study brings into discourse the MHM and sanitation conditions and needs of communities existing in lesser-known contexts such as tea garden workers in Baksa and Kokrajhar districts of Assam. Tea garden-labourers have contributed substantially to the economy of Assam yet they are one of the most impoverished communities in the state. Low wages, discrimination, poor housing, and lack of education have perpetually kept them in a state of subjugation since the 19th century (Hazarika & Boruah, 2020).

BAKSA DISTRICT

As a result of the historic Bodoland Territorial Council (BTC) accord signed on February 10th, 2003, Bodoland Territorial Area District (BTAD) was formed with four districts namely Baksa, Chirang, Kokrajhar and Udalguri. Baksa district was carved out of Nalbari, Barpeta, Kamrup and a small portion of Darrang district (Baksa District Official Website, n.d., District Profile Section). In 2011, Baksa had a population of 950,075 of which male and female were 481,330 and 468,745 respectively. Average literacy rate of Baksa in 2011 was 69.25%. Male and female literacy rates were 77.03% and 61.27% respectively. With regards to sex ratio in Baksa, it stood at 974 per 1000 male compared to the 2011 census figure of 957 (Census,2011).

Baksa is one of the seven Aspirational districts from Assam, and has had a visible improvement in the health and nutrition sector after the inception of Baksa in Niti Aayog's ADP (Borah, Raj & Sharma, 2020). The improvement is also reflected in the district's change in ranking from 107 out of the 112 districts since the ADP's introduction in 2018 to now being ranked as 26 out of 112 aspirational districts for health and nutrition as of July 2020. This significant change in ranking could be a result of all the major health and nutrition programmes that the district is currently undertaking.

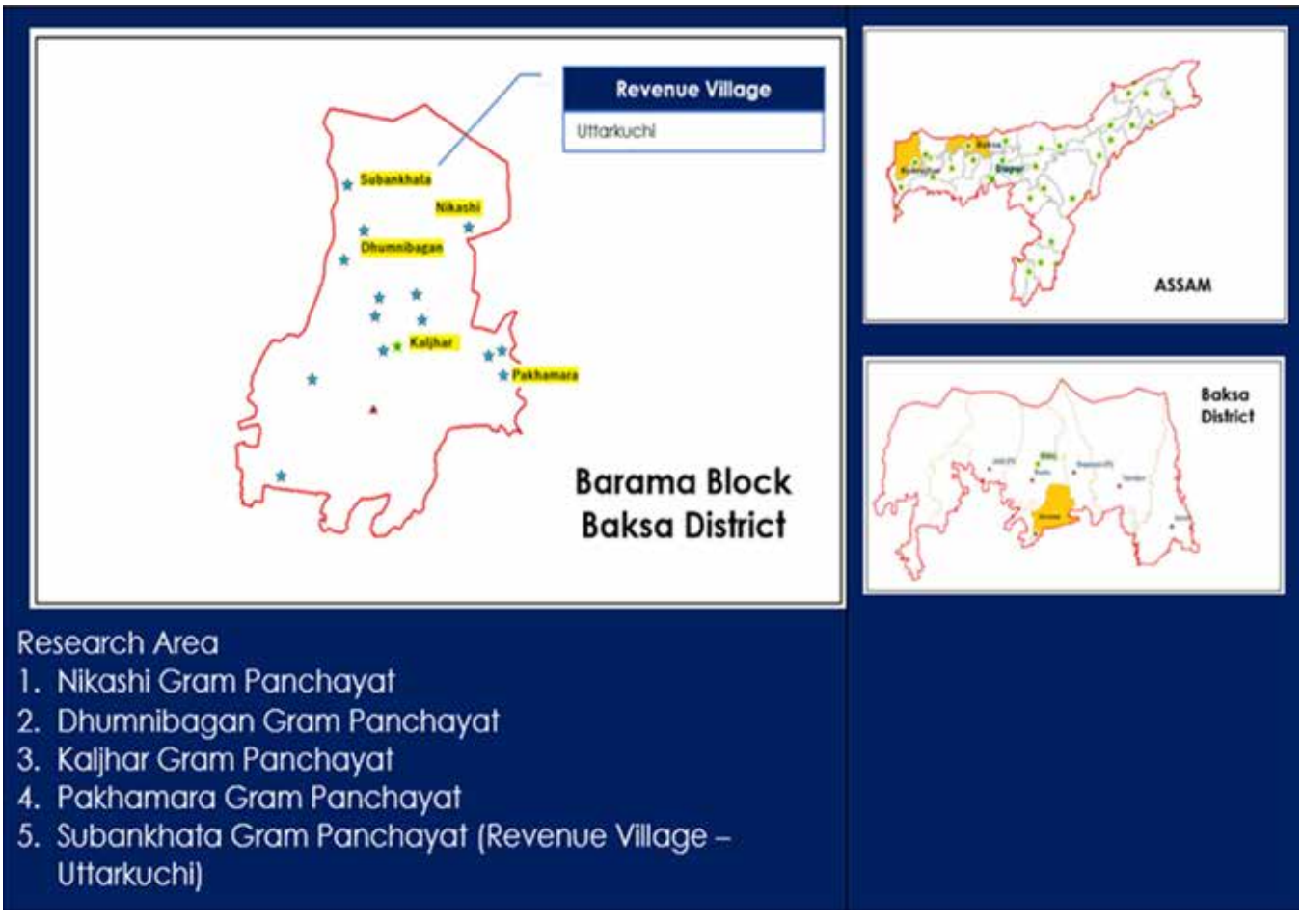
KOKRAJHAR DISTRICT

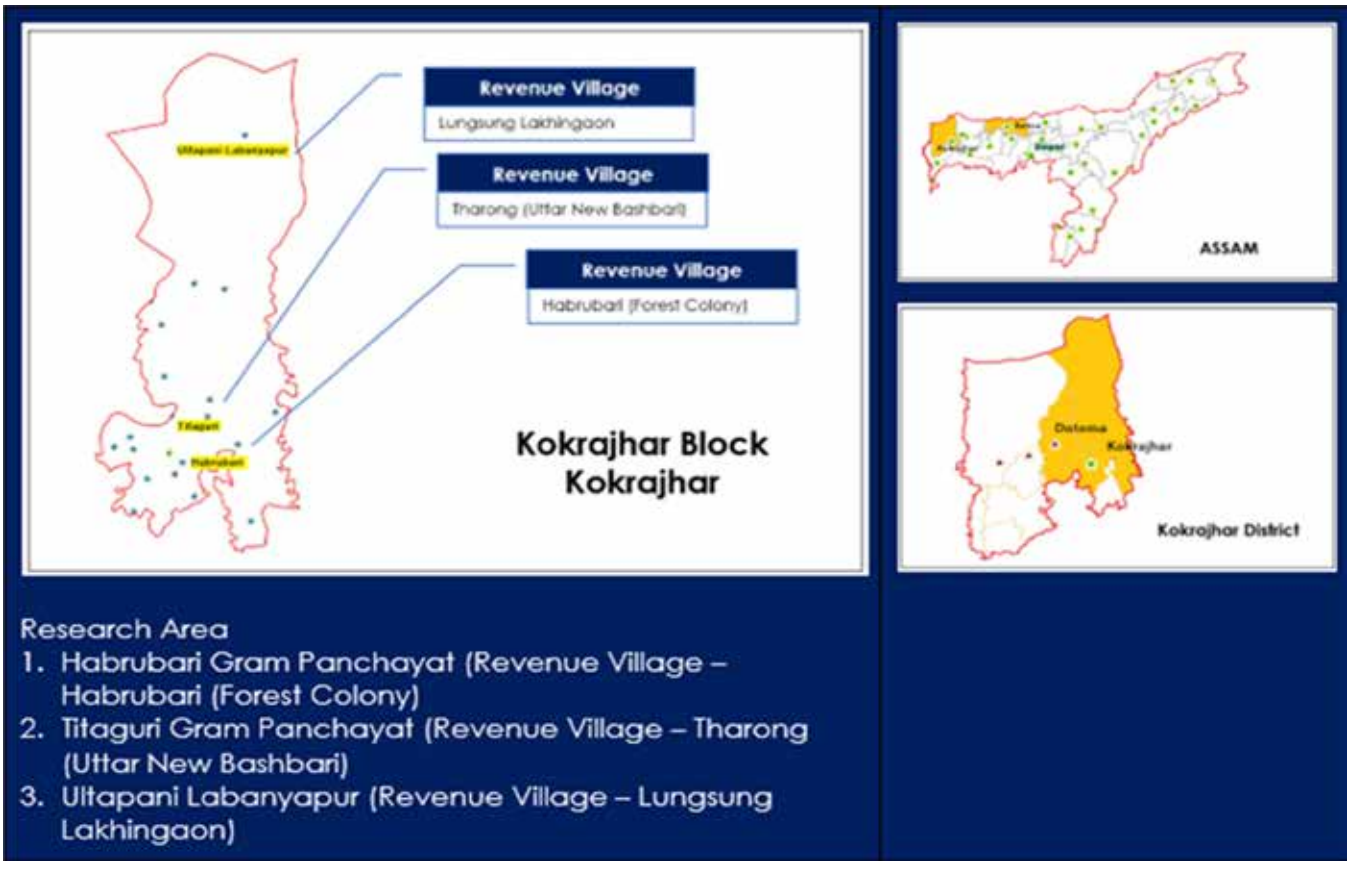
Kokrajhar district is an administrative district in BTR of Assam. It is predominantly inhabited by the Boro tribe. In 2011, Kokrajhar had a population of 887,142 of which male and female were 452,905 and 434,237 respectively. Average literacy rate of Kokrajhar in 2011 were 65.22%, male and female literacy were 71.89% and 58.27% respectively (Census, 2011). With regards to sex ratio in Kokrajhar, it stood at 959 per 1000 male compared to 2001 census figure of 946. The average national sex ratio in India is 940 as per latest reports of Census 2011 Directorate. In the 2011 census, the child sex ratio is 954 girls per 1000 boys compared to the figure of 955 girls per 1000 boys of 2001 census data (Census, 2011).

In the past, Kokrajhar district has been the epicenter of ethnic conflicts in lower Assam but now enjoys relative peace but the issues of infrastructural underdevelopment, education, health, nutrition and most importantly, deforestation in the district is important to be addressed. Deforestation is one of the burning environmental issues in Kokrajhar district of Assam. It impacts adverse changes in forest cover which disrupts the environmental eco- system, threatens the biodiversity and sustainability of livelihood, especially of the tribal population and other forest-dependent communities of the region (Goyari & Mushahary, 2020).

Though both districts are doing well on many parameters where improvement is needed such as education, literacy and infrastructure, our study indicates that Baksa as an ADP and Kokrajhar as non-ADP have much to achieve in terms of combating the silences on MHM. An inter-sectoral perspective on wellbeing of the EAMW in particular, as well as a policy-appropriate focus on school-going menstruating girls can bring a desired positive change towards MHM in these districts.

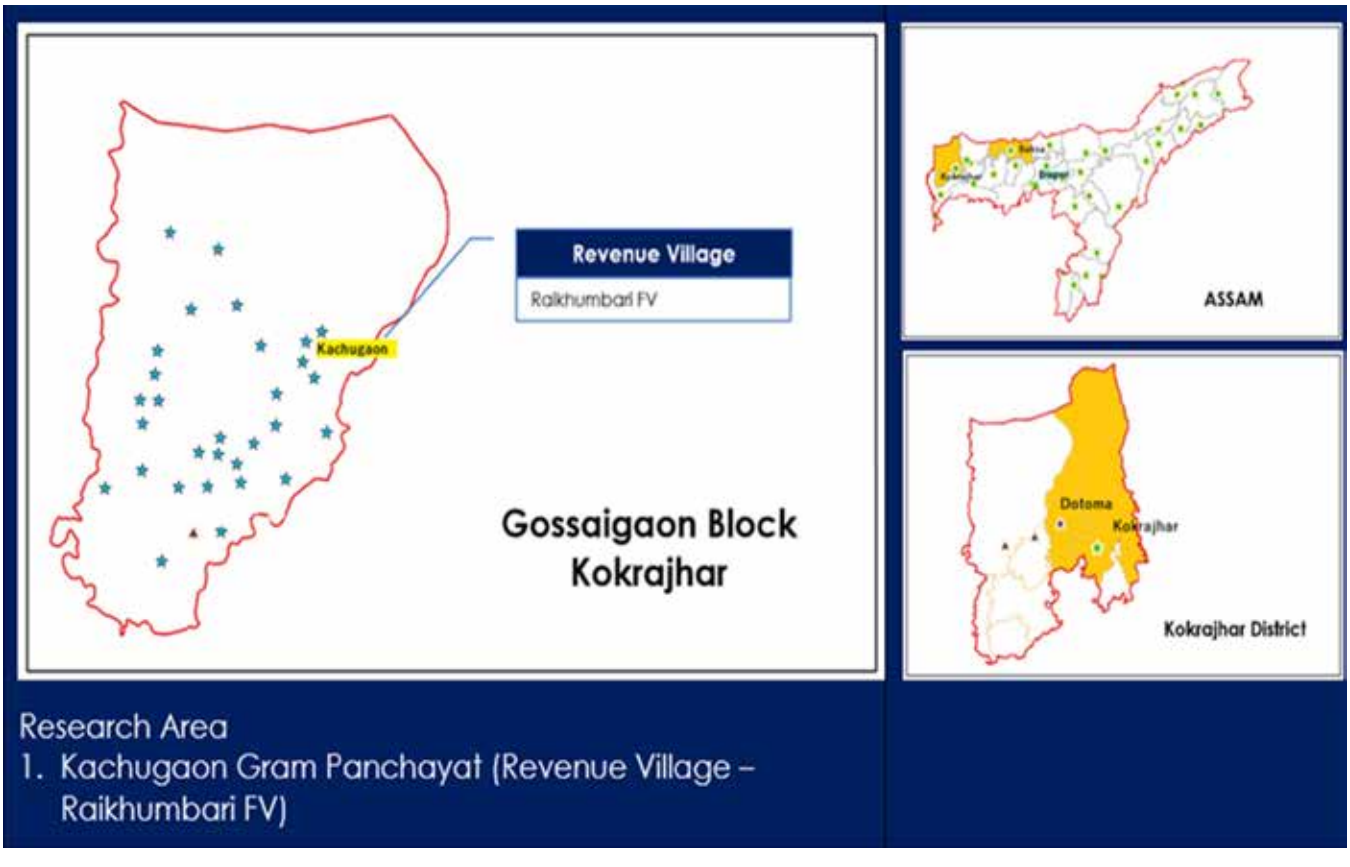
1.1 VILLAGES SELECTED FOR THE STUDY FROM BAKSA AND KOKRAJHAR





Research Area

1. Habrubari Gram Panchayat (Revenue Village – Habrubari (Forest Colony)
2. Titaguri Gram Panchayat (Revenue Village – Tharong (Uttar New Bashbari)
3. Ultapani Labanyapur (Revenue Village – Lungsung Lakhingaon)



Research Area

1. Kachugaon Gram Panchayat (Revenue Village – Raikhumbari FV)

PART 2 DATA TOOLS AND STRUCTURE OF THE CHAPTER

2.1 RESEARCH TOOLS, METHODS AND THEMATIC FOCUS FOR DATA COLLECTION, CORRELATIONS AND COMMUNITY-BASED ANALYSES:

Types of Interviews- Tools and Focus	Data Collection and Analysis- Methods and Themes	Assam	
		Baksa	Kokrajhar
Tool 1 Menstrual Practice Questionnaires (MPQs)	Method 1 The MPQs were In-depth Interviews (IDIs) for- actor, discourse and practice- analyses	377	340
Tool 2 Menstrual Practice Needs Scale (MPNS)	Method 2 Measurement of perceptions and needs based on the last menstruation cycle	52	62
Tool 3 Key Informant Interviews (KIIs)	Method 3 Voices, Excerpts, Salient Findings and Observations	12	12
Themes: WASH, Education, and Health, Livelihood	Focus: Inter-Sectoral findings and conclusion and comparisons		

PART 3 ACTOR ANALYSIS FROM MPQs

3.1 ACTOR ANALYSIS

In this section, socio-economic profile as well as the current menstruation status of the actors is detailed.

3.1.1 DEMOGRAPHIC PROFILE OF THE RESPONDENTS

Demographic Profile	Baksa (in %)	Kokrajhar (in %)
Total Respondents	**377**	**340**
Peri-Urban	0.0	10.9
Rural / Tribal	100.0	89.1
Religion		
Adidharma	0.5	0.0
Christian	7.7	17.9
Hindu	90.2	82.1
Muslim	1.6	0.0
Caste/ Tribe Type		
General	18.6	2.9

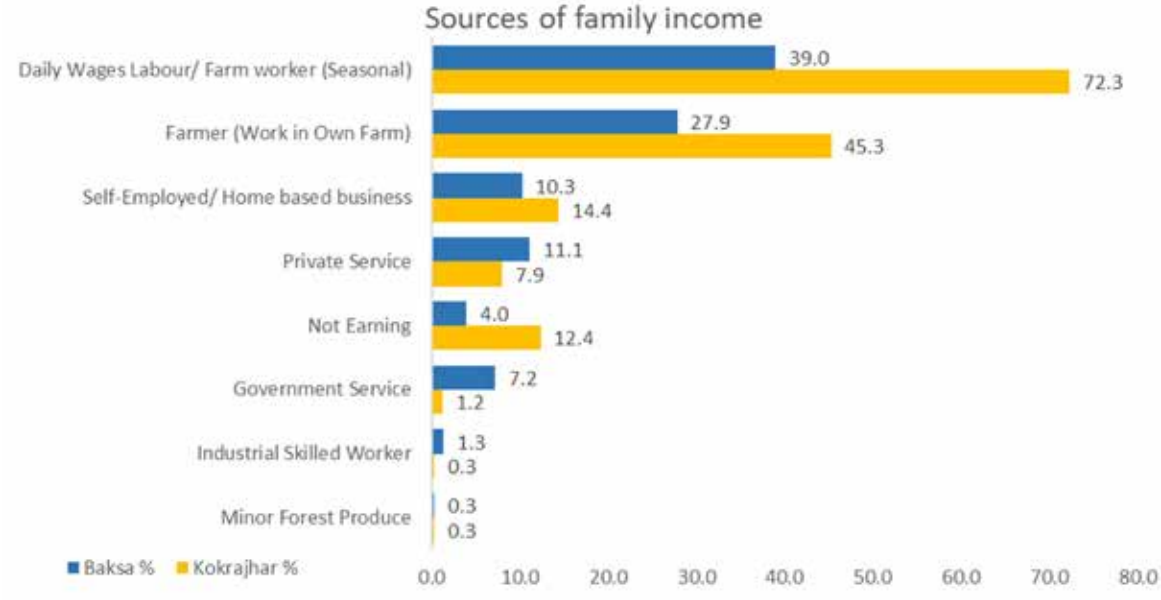
Demographic Profile	Baksa (in %)	Kokrajhar (in %)
OBC- Other Backward Castes	42.2	28.5
SC- Scheduled Caste	3.7	0.9
ST- Scheduled Tribe	35.5	67.6
Marital Status		
Never Married	14.1	18.2
Married	79.0	73.5
Widowed	6.6	7.4
Separated	0.0	0.9
Divorced	0.3	0.0

- **Religion:** More than 86.7% of our respondents stated Hinduism as their religion while the rest of the sample pertained to Christianity and others.
- **Community:** 50.8% of our respondents from both the districts belonged to the ST communities (Assamese, Bodo, Rabha) 35.7% were OBCs (Bengali, Chouhan, Gorkha, Kalita, Karia, Munda, Santhal, Urao), 11.2% from the General Categories (Brahmin, Gorkha, Nepali) and 2.4% from SC communities (Haldar, Mondal) formed the rest of the population interviewed.
- **Marital Status:** 76.4% of the women interviewed were married, highlighting the fact that in Baksa 14.1% interviewed women were never married and average age at marriage was 19 years whereas in Kokrajhar 18.2% of the women interviewed were never married with the average age of marriage being 22 years. In terms of age at marriage both Baksa and Kokrajhar were more progressive than other states in our survey.
- **Children and Family Size:** Average number of children was two and average family size was four.

3.1.2 AVERAGE INCOME

- **Family income:** The average yearly income of families in Baksa was 112898 INR as compared to 131955 INR for Kokrajhar. Average income of the families from both the districts were also found comparatively better than the rest of the ST focused districts from our survey.
- **Earning women:** Only 110 women, out of a sample of 717 respondents, from Assam earn. In total, 89 women from Baksa and 21 women from Kokrajhar were earning women. The median earning of women from both districts was 30000 INR to 40000 INR.
- More women belong to the working class in Baksa than in Kokrajhar, but the women in the former earn less than their counterparts in the latter district. However, along with a high average income reported by those women who work for a livelihood, our data informs us that income disparity in Kokrajhar is also higher than in Baksa.

3.1.3 SOURCES OF FAMILY INCOME

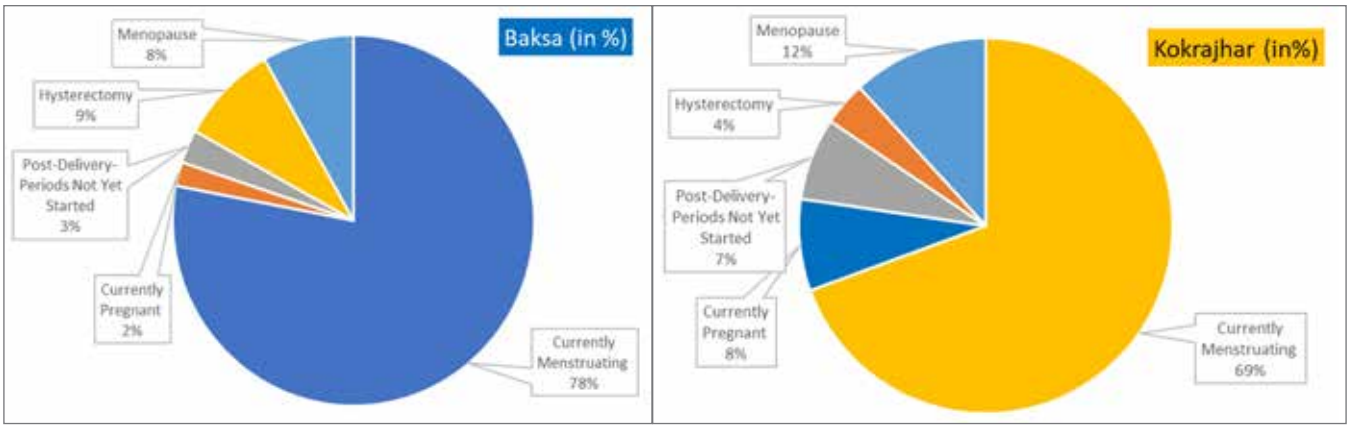


- **Farming** 259 families out of 717 i.e., 36.1% from Assam stated farming was their regular source of income. 39% respondents from Baksa and almost two third of the respondents i.e., 72.3% families earn from daily wages labour work, farm work or seasonal work was one of their sources of income.
- **Source of Income in Baksa:** 95.2% women in Baksa reported that their families had a single primary source and out of these 57% had a regular source of income. 42.2% of our respondents reported their primary earning source as irregular jobs such as daily wage labour, farm labour, Minor Forest Produce (MFP) collection and seasonal work.
- **Source of Income in Kokrajhar:** Only 31.5% women reported that their families earn through a single source of income. 40% women in Kokrajhar stated that their families earn primarily from farming along with other regular sources of income such as industrial/ skilled jobs and small businesses. All the remaining women from Kokrajhar informed that their families had multiple though irregular sources of income such as daily wages labour, farm labour and seasonal work etc.
- **Traditional Knowledge and Skills**:123 women out of 377 from Baksa possess traditional skills. Out of these, 55.3% earn from their skills. In contrast, 181 women out of 340 from Kokrajhar possess a traditional skill but only 1.1% earn from that.
- **Women lack Disposable Income:** Although they worked on their own farms and their families also counted on multiple sources of income. 607 (84.7%) of the women from our total sample in Assam reported that they 'did not earn'. Our data indicates that women remain hamstrung in terms of disposable income for personal expenses as well as any decision making on medical care in relation to MHM.

Since traditional skills and knowledge can empower women in various ways and augment family income, we suggest that women may be encouraged to earn through these activities. Besides, as the case of Kokrajhar illustrates, women drop out of schools owing to financial constraints and formal enhancement and training in traditional skills can generate income for and make young girls and women independent.

3.1.4 MENSTRUATION STATUS

- **Total EAMW**: 530 out of 717 women surveyed through the MPQs were in their active menstrual years.
- **Age at Menarche:** Average age of attaining menarche was 12, whereas the average age of menopause was 44 years.
- **Number of Hysterectomies**: Total 46 hysterectomies (i.e. 6.4% of total population) were reported from both the districts. In Baksa, where 33 women had undergone the procedure, the average age at hysterectomy was 31 years, whereas in Kokrajhar the average age of hysterectomy was 43 and a total of 13 women had undergone hysterectomies.



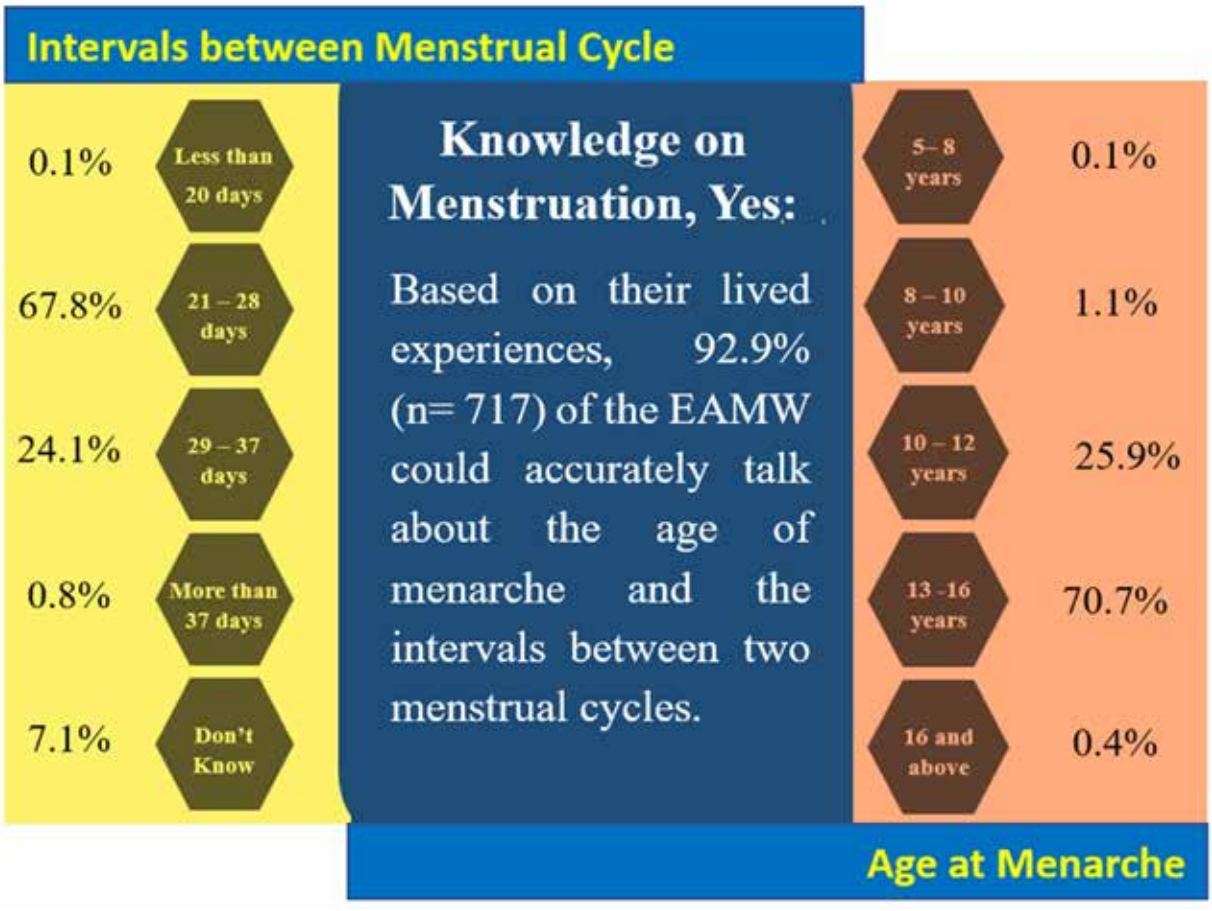
3.2 DISCOURSE ANALYSIS

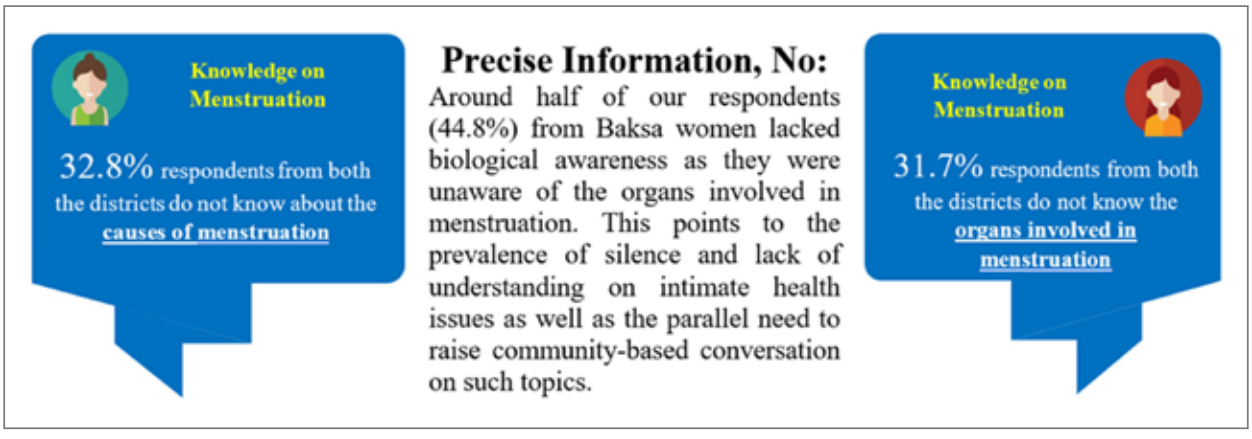
In this section, our findings relate to levels of knowledge that our respondents profess on the causes of menstruation, organs involved in it and an analysis of their discourses on the subject. In other words, we analyze the information given during the IDIs to understand how much general as well as precise comprehension women seem to have on menstruation as a monthly and bodily process. Further, we present our findings on the extent of communication as well as silence around the theme, for instance with whom and how much they chose to discuss or not discuss on issues experienced and their general observations related to MHM. We also present data on educational backgrounds of women, how the women position themselves on medical care options and facilities available/ not available and their awareness on use and disposal of menstrual absorbents, health risks as well as common disorders and symptoms they experience during menstruation and, in cases of hysterectomy, where applicable.

3.2.1 KNOWLEDGE ABOUT MENSTRUATION:

Knowledge About Menstruation	Baksa (in %)	Kokrajhar (in %)
Total Respondents	**377**	**340**
Causes of Menstruation		
Hormonal change	53.6	80.3
Disease	1.9	0.0
Don't know	44.6	19.7

Knowledge About Menstruation	Baksa (in %)	Kokrajhar (in %)
Organs Involved in Menstruation		
Uterus/ Birth canal	54.4	82.9
Abdomen/ Bladder	0.8	0.0
Don't know/ not answered	44.8	17.1





➲ **Basic Understanding, Yes:** Based on their lived experiences, 92.9% (n= 717) of the EAMW could accurately talk about the age of menarche and the intervals between two menstrual cycles.

- **Precise Information:** When questions were asked about biological awareness, 475 women (N=717) could answer about causes of menstruation and 487 women could tell us about organs involved in menstruation. Almost one- third of our respondents were found short of information.

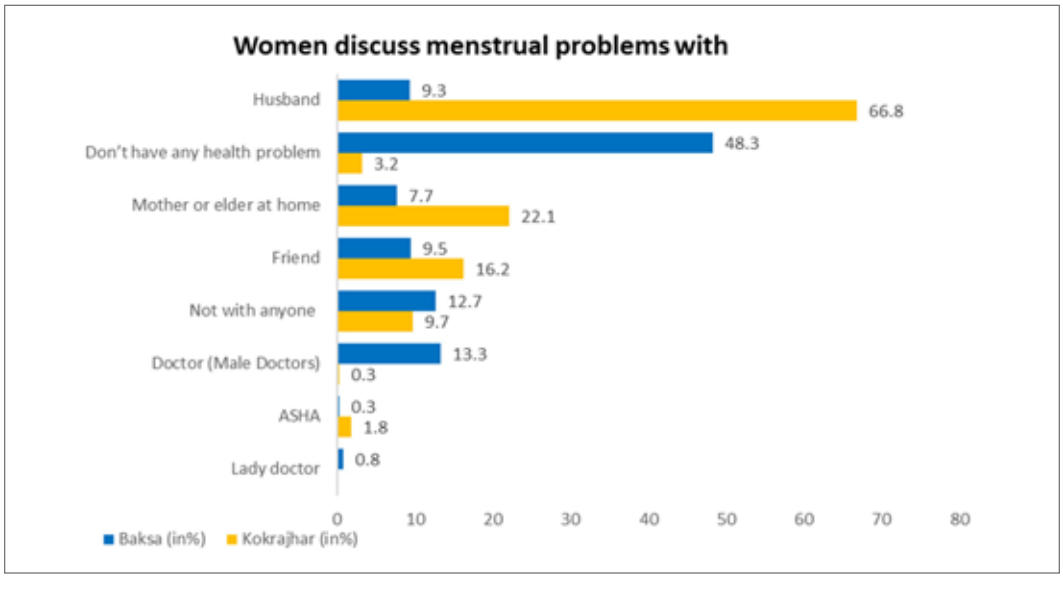
3.2.2 SOURCES OF INFORMATION ON MENSTRUATION

For young girls the top sources of information on menstruation emerged as follows:

- At the time of Menarche, girls were mostly informed about it by parents (mostly mothers), grandmother, sister, or sister-in-law reported from both of the districts.

Women like to discuss their menstrual problems with the following:

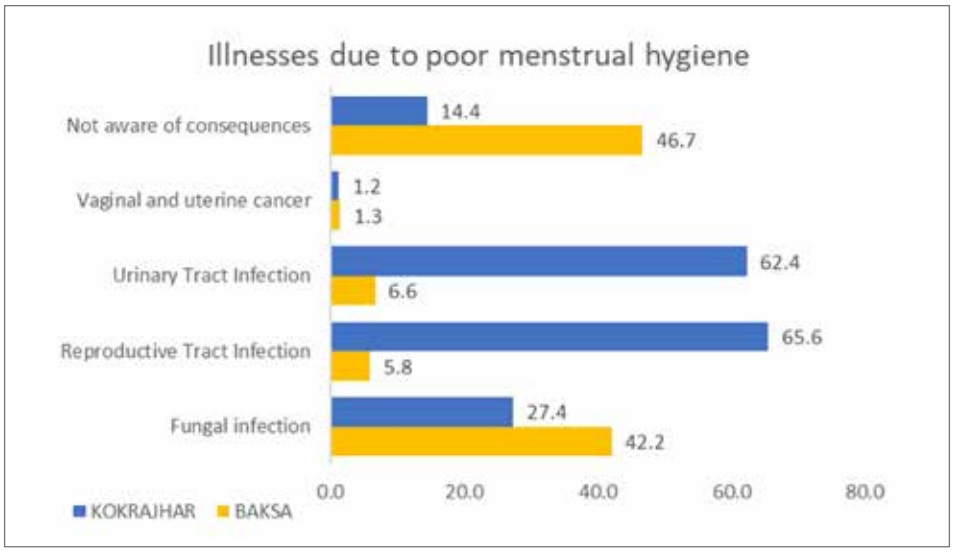
- **Close Relatives:** Mothers and elders were the most important source of information on menstruation related issues.
- **Frontline Health Workers (FHWs):** Out of the total of 738 EAMW surveyed, 186 (25.9%) discuss MHM issues with Accredited Social Health Activist (ASHA), Auxiliary Nurse and Midwife (ANM) and Anganwadi workers (AWW) which is a good indication of external support mechanisms functioning for women aside from family.
- **Spouses:** Above two third women i.e., 227 women out of 340 From Kokrajhar felt comfortable talking about menstrual problems with husbands whereas only 35 women out of 377 from Baksa were comfortable talking about their menstrual problems with husbands. Our data gives evidence of a perfect positive correlation between age at marriage and discussing MHM related problems with husbands. If men can be oriented, stay alert and helpful on their wive's MHM issues, that would bring a positive health outcome for EAMW, besides combating the silence on it.
- **Nobody:** However, 12.7% of our respondents from Baksa and 9.7% from Kokrajhar prefer to talk with no one and remain silent about their menstrual problems. Moreover, nearly half i.e., 182 women from Baksa denied having any problems w.r.t MHM.



*Multiple Choice Question

3.2.3 MENSTRUAL HEALTH, EDUCATION, AND AWARENESS ON INFECTIONS

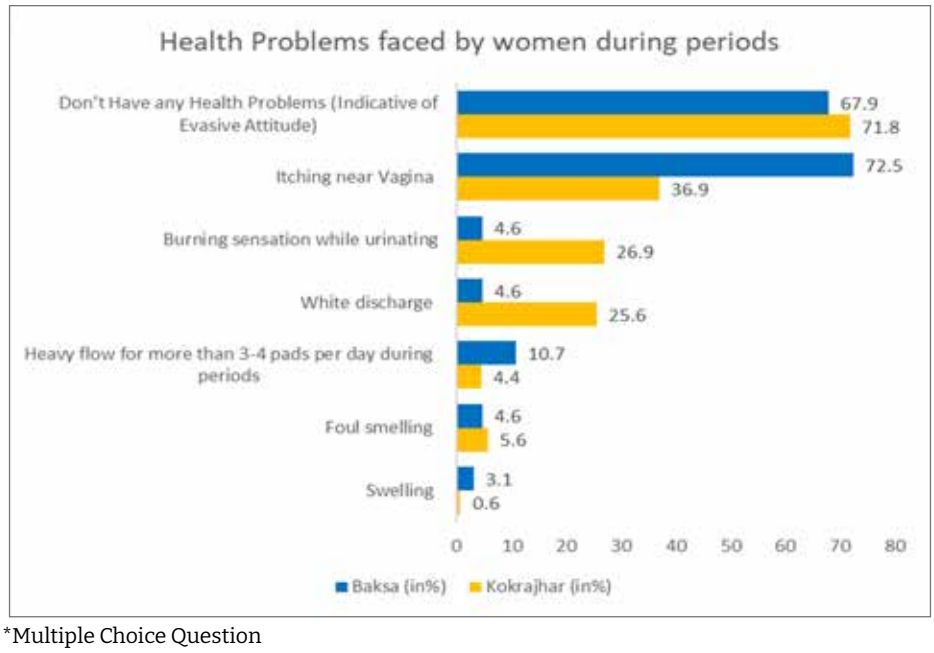
Apart from the use of different menstrual products, the study brought to light the health problems which our respondents experienced during menstruation. It was further verified whether they visit the doctor in case of any health issues or prefer to keep quiet and bear it. Adverse health conditions while working in or outside the home may lead to rashes, urinary tract infections (UTIs), and reproductive tract infections (RTIs) for many women, as indicated by our survey findings.



*Multiple Choice Question

- **Knowledge about poor menstrual hygiene**: When asked about the side effects of poor menstrual hygiene, 291 EAMW out of 340 from Kokrajhar (85.6%) could speak about the impacts of poor menstrual hygiene. In Baksa only half the EAMW i.e., 201 out of 377 women could answer.
- **Fungal Infections and UTIs:** Around half of the women from Baksa ie 42.2% and 27.4% women from Kokrajhar knew about lack of MHM and stated that poor menstrual hygiene leads to fungal infections while above two third of women from Kokrajhar were aware and said it causes RTIs or UTIs.
- **No Schooling, Taboos and Communication Barriers:** However, given that speaking about periods itself is a taboo or is a challenge due to shyness/ hesitancies, generalizations on awareness on MHM may be misleading. Community and area specific conclusions are a better way ahead. One of the most noteworthy findings from both the districts of Assam has been that around 23.9% women from Baksa and 2.6% women from Kokrajhar did not attend schools. 37.8% of our participants (from a total of 717) were women who attended school only up to secondary grades. In other words, all these women did not receive formal education. EAMW who participated in our study either remain shy to speak or know about menstruation or effectively become silent on the theme.

3.2.4 HEALTH SYMPTOMS DURING MENSTRUATION

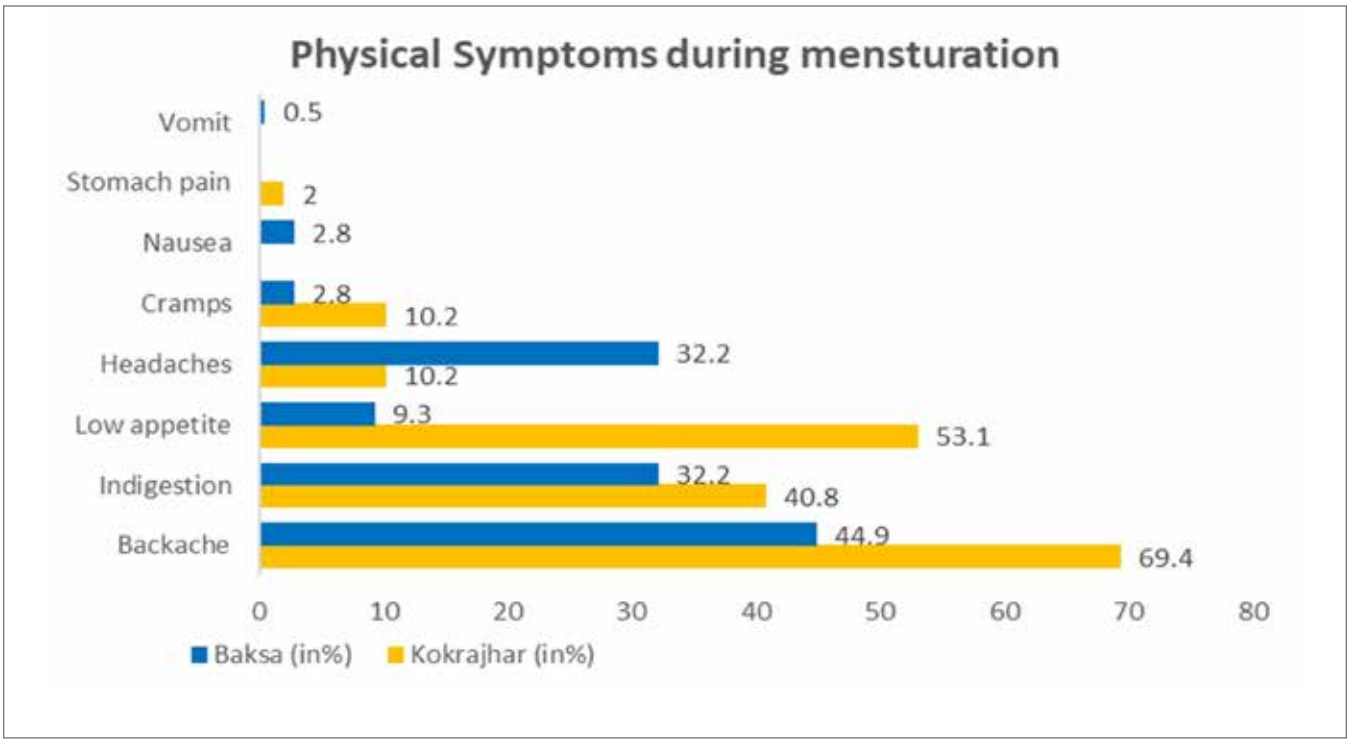


*Multiple Choice Question

- **MHM, health and accessibility to health care**: Apart from the modes as well as patterns of and awareness on MHM, the survey imparts light on the health problems undergone by participants during menstruation. For arriving at inter-sectoral findings on health management, women were asked if they visit a medical professional to resolve menstrual health issues and reasons if they do not.
- **Vaginal symptoms and attitude:** Around 500 EAMW out of 717 from both districts reported that they did not have any health problems during menstruation. In the later part of the survey, however, itching near vagina and burning sensation while urinating and white discharge we are the top three issues women faced due to poor vaginal hygiene.

The prevalent level of knowledge indicates that women in Baksa and Kokrajhar know about medical and topical health problems owing to low menstrual hygiene. Not being able to understand and/or give answers on the relationship between MHM and rashes, infections and other risks would have indicated widespread ignorance. However, given that speaking about periods itself is taboo or stems from shyness/ hesitancies, generalizations, knowledge on health risks itself do not suffice and ways to combat the layered silences on menstruation are an urgent need: EAMW in both the districts are knowledgeable on MHM risks in absence of personal cleanliness and hygiene, yet the prevalence of intimate health related disorders and conditions across our sample population indicates that women may still exist in silence rather than opting to seek medical advice or discuss MHM and sanitation issues openly. Hence, community-sensitive, and area-specific steps to combat the gaps and silences are a better way ahead.

Mechanisms to handle menstrual discomforts: In Kokrajhar, women take rest during their periods as a way to handle menstrual discomfort. However, from our research, it emerges that a few women, specifically the daily wagers (farmers or otherwise); tea garden workers are also afraid to take leave from work for menstruation related discomforts and do not take rest. Others rather take painkillers, take rest for some time, and go to work because a leave means wage-cuts. Such discriminatory work conditions and severe repercussions that it may imply for a women's income, physical and mental wellbeing can be seen in other contexts across India, such as the case of Maharashtra (in this study) also shows.



*Multiple Choice Question

Indeed, if health anomalies during menstruation are not resolved, pushed to the peripheries or remain shrouded in silence, women have much to lose in social, economic and personal spheres. For combating health and hygiene related silences on menstrual hygiene and care for women beyond school years to benefit the EAMW, the governmental healthcare must tune itself to hear their voices. In the last section of this chapter, titled 'Excerpts and Voices', we bring community-based views and suggestions from women over this issue.

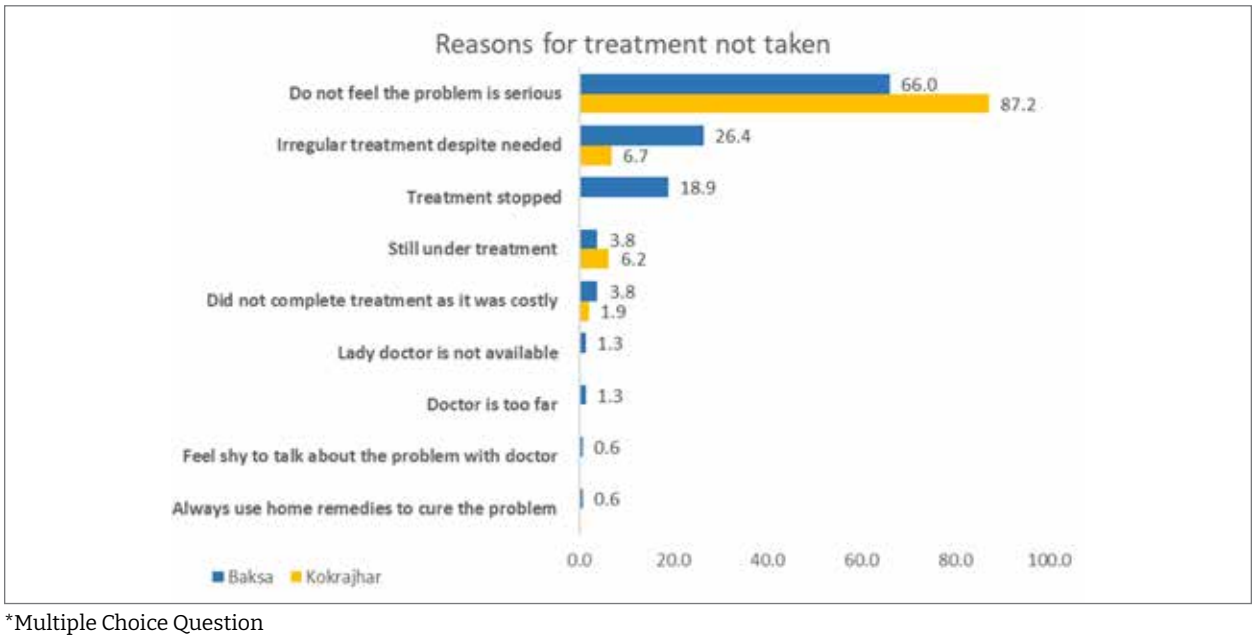
Speaking about MHM: When asked with whom they talk to or discuss menstruation problems, 60% of women from Baksa reported they do not think the problem is serious and do not talk with anybody, whereas 66.8% of women from Kokrajhar said they discuss their problems with their husbands. Our survey findings from Kokrajhar district in Assam bring to notice a good practice as women feel encouraged to speak with their husbands on their MHM needs and experiences.

- **Treatment:** However, when asked if they visit a doctor or gynecologist regarding any of the above-mentioned menstrual symptoms and discomforts, 50% from Baksa and 36.8% from Kokrajhar reported that as they do not think the problem was serious, they have yet to approach the health system and prefer to wait silently for it to get over.

Neglect, hesitation, and Silence: There seems to be a negligent attitude towards medical follow up as well as a hesitation and economic encumbrances to approach doctors. Only 28.4% of women from Baksa and merely 5.3% of women from Kokrajhar visited a doctor, out of which 20% of women from Baksa stopped taking treatment as it was not affordable. 1.9% of women out of 5.3% stopped treatment as it was not affordable.

Medical Care, Access, and Unaffordability: 21.5% of women from Baksa and 55.9% from Kokrajhar did not take treatment at any health institution/ center. 86% of women did not feel the problem was serious. 10% of women did not have money to visit the doctor, and others preferred to bear it silently as they felt shy to disclose the problems to a doctor. Few of them reported the unavailability of a lady doctor or inaccessibility to reach the doctor.

3.2.5 REASONS FOR NON-TREATMENT (BAKSA N=377, KOKRAJHAR N=340)



*Multiple Choice Question

- **Ignorance:** The main reason for 66% women from Baksa and 87.2% women from Kokrajhar, for not going to the doctor or gynaecologist was they did not feel that the problem they face is serious. No money was the second major reason. This contributes to not talking or discussing the problem with anyone unless it becomes unbearable.

- **No Lady doctor/ Gynaecologist:** Apart from these reasons access to doctors also came up as one of the reasons and if the lady doctor is not available nearby.
- **Attitude (Shyness and Silence):** Women feel shy to discuss the problems related to menstruation with doctors. A total of 26.4% from Baksa reported about availing irregular treatment.

Besides, women's attitudes and beliefs on talking about menstruation or not, lack of affordability, accessibility, and ad-hoc self-care modes (consulting traditional medical practitioners, seeking advice from others etc.) were the major causes found for non-treatment as well as silence on MHM, as shown in the table. We suggest that women should be given employment and equal opportunities to earn as well as spend money on their physical, sexual, and reproductive health.

We suggest that awareness drives on medical care for solving the anomalies and hindrances related to MHM in sensitive ways can help the women combat negligence of menstrual well-being and silence around the issue. Also, women need counseling and support services/ programs to empower them towards prioritizing MHM in Baksa and Kokrajhar.

3.2.6 HYSTERECTOMIES

Out of 717 respondents, 46 had undergone hysterectomy. As per district wise breakup, 33 (8.8%) women from Baksa and 13 (3.8%) from Kokrajhar reported having undergone the removal of uterus.

- **Biological Causes:** Out of 33 women from Baksa, 25 women said that hysterectomy was done under medical advice. One woman underwent hysterectomy to avoid the risk of cancer due to uterine fibroids and another reported that after two children, she did not find the uterus as an important part of the body and hence opted for an elective hysterectomy. The remaining six women from Baksa and all 13 women from Kokrajhar chose not to specify the cause.
- **Socio-economic Causes:** All 46 women specified various combinations of physical symptoms and conditions before hysterectomy, such as tiredness while working during menstruation (69.7%), stomach pain during menstruation (28.3%), abnormally heavy bleeding during menstruation (21.7%), fibroid or other problems related to the uterus (15.2%), backache and weakness (15.2%). Few also experienced white discharge, itching, and swelling.
- **Government:** Overall two -third women out of 46 (30 respondents) underwent hysterectomy in a government hospital. Half of the respondents went to Government hospitals due to the convenience to reach and considered it a reliable place for treatment. Average expenses for hysterectomy in government hospitals were 1470 INR, whereas average expenses for hysterectomies in private hospitals were found to be 28000 INR.
- **Post operative consequences:** Out of 46 women, 41 women who underwent hysterectomies reported that their life became complicated after the surgery. All 41 women were facing weakness post-hysterectomy, followed by 22 who confided that they are not able to work like before.

Our findings on hysterectomies in Baksa and Kokrajhar suggest that the informal labour sector in tribal areas of Assam discriminates against women and creates pressures on them almost in the same way as it happens elsewhere such as in the sugarcane farming and other work sectors in various states. Moreover, misconceptions about uterine relevance post- motherhood abound. Further, MHM related encumbrances experienced in exploitative labour situations also subject a woman to inadequate WASH facilities. Not surprisingly, marginalised women face complex challenges and crossroads regarding their reproductive health as well as wellbeing options, oftentimes leading to hastily executed hysterectomies. MHM of EAMW should become a vital part of labour laws, public health, and community -based awareness drives.

3.3 PRACTICE ANALYSIS

Good menstruation practices start with the usage of clean menstrual absorbents followed by maintenance of reproductive hygiene from menarche till menopause. This section brings to light the prevalence of practices regarding personal hygiene such as washing hands and genitals during menstruation as well as usage and disposal patterns of menstrual hygiene products. We also bring data on how personal and community-based beliefs, customs and taboos influence MHM outcomes and self-care regimes of our respondents. In the tribal belts of Baksa and Kokrajhar, given their circumstances women adhere to traditional methods of MHM over pads etc. Out of a total of 600 menstruating women interviewed (EAMW) from Baksa and Kokrajhar, 247 i.e. 41.2% women use cloth. Though 313 i.e. 69% women in Baksa and 287 i.e. 48.1% women in Kokrajhar use sanitary pads, they use sanitary pads in combination of cloth.

3.3.1 SANITARY PADS OR OTHER ABSORBENTS

Type of Menstrual Products Women Use	Baksa (in %)	Kokrajhar (in %)
Total Respondents	**313**	**287**
Sanitary pad	69.0	48.1
Cloth	31.9	51.2
None	1.3	0.0
Other	0.6	1.4

- **Cloth:**100 women from Baksa i.e. 31.9% and 147 women from Kokrajhar i.e. 51.2% use cloth during menstruation because of its ready availability, affordability, durability and also, lack of awareness about other menstrual products.
- **Sanitary Pads in combination with Cloth:** Out of those using pads, most combined its use with cloth because women found cloth as a readily available and affordable option. The reasons behind it were mainly that cloth was more easily available during menstruation than pads. The ready availability and durability of home-based/ reusable menstrual hygiene products were a couple of other reasons for using cloth.

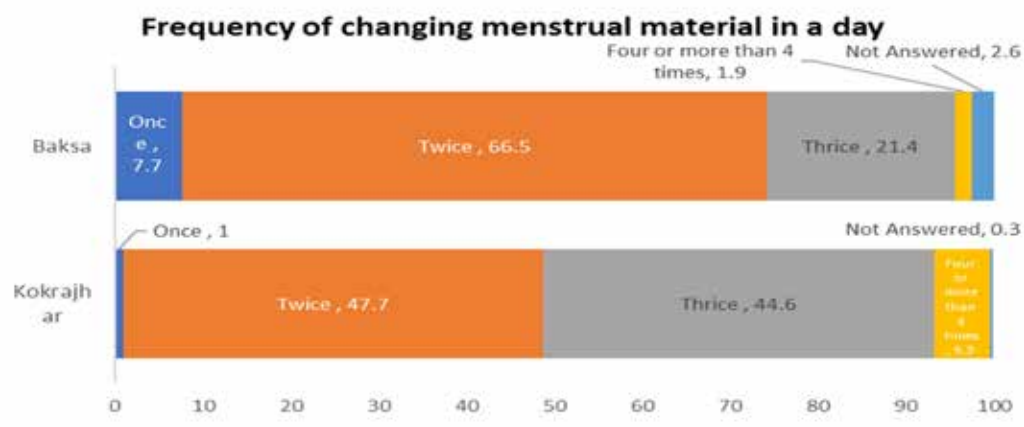
Surprisingly, in Baksa, where menstrual awareness is lower than in Kokrajhar, women reported higher use of pads. This could be reflective of work-related exigencies that tea garden workers live through and their search for convenient MHM products. Perhaps that explains why many (see the section on KIIs below) demand free sanitary pads because they may think of these as more convenient in their remote plantations or flood-prone and water-contaminated zones, but lack financial capacity to buy these. Most of the women reported using a combination of sanitary pads with cloth.

3.3.2 SPENDING CAPACITY ON MENSTRUAL HYGIENE PRODUCTS

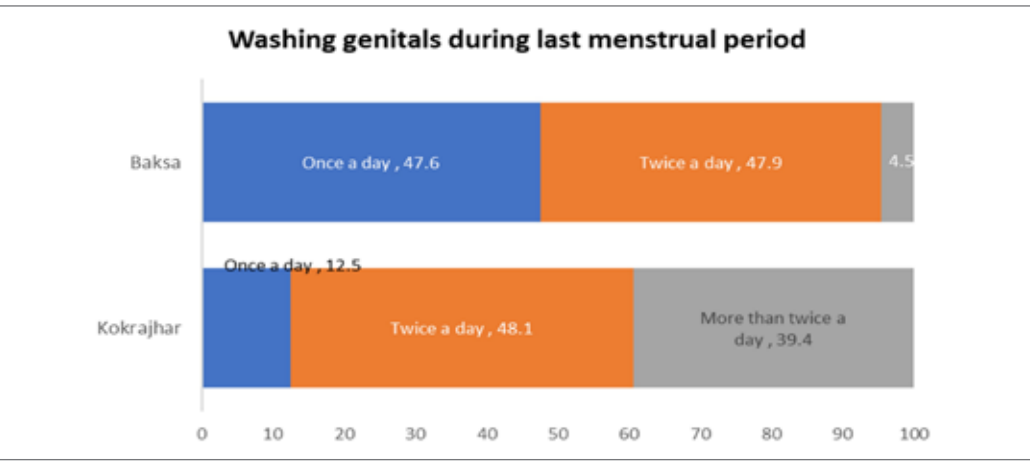
- 70% EAMW from Baksa and 48.4% EAMW from Kokrajhar spend on sanitary pads. The average spending of sanitary pad users was found to be merely 87.8 INR per month.
- 82.2% of (n= 219) women from Baksa reported spending up to 100 INR on menstrual products, whereas 99.3% women (n=139) from Kokrajhar reported spending 51-100 INR on menstrual products. In this sense, it is clear that women's earning capacities and opportunities to earn have to be taken up as policy goals and implemented in rural and semi-urban scenarios.

3.3.3 PERSONAL HYGIENE PRACTICES AND WASH DURING LAST MENSTRUAL CYCLE

Safe hygiene practices consist of washing and timely changing menstrual absorbents as well as their proper disposal. This may vary with the absorbent type. Personal hygiene also depends on changing the absorbent during the day, keeping genitals clean, washing hands before and after changing the menstrual absorbent. The survey assessed all practices used to follow hygiene and management of material during menstruation.


Frequency of changing menstrual material in a day
Four or more than 4 times, 1.9
Not Answered, 2.6
Baksa
Onc e , 7.7
Twice , 66.5
Thrice , 21.4
Once , 1
Not Answered, 0.3
Kokrajh ar
Twice , 47.7
Thrice , 44.6
0 10 20 30 40 50 60 70 80 90 100


Wash hands before and after changing your menstrual materials
Never , 2.2
Baksa
Every time , 91.1
Kokrajhar
Every time , 63.8
Sometimes , 36.2
0 10 20 30 40 50 60 70 80 90 100


Washing genitals during last menstrual period
Baksa
Once a day , 47.6
Twice a day , 47.9
Once a day , 12.5
Kokrajhar
Twice a day , 48.1
More than twice a day , 39.4
0 10 20 30 40 50 60 70 80 90 100


Use of soap while washing genitals
Baksa
Every time, 66.5
Sometimes , 24.6
Kokrajhar
Every time, 15.7
Sometimes , 53.3
Never, 31
0 10 20 30 40 50 60 70 80 90 100

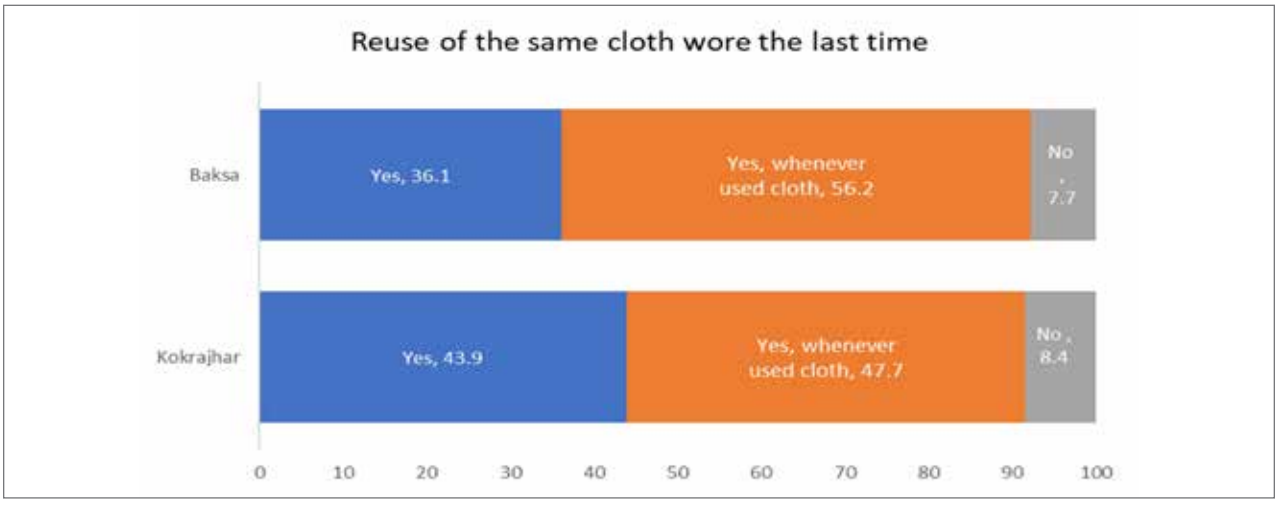
- **Frequency**: From both the districts, around 87.9% EAMW from Baksa and 92.3% EAMW from Kokrajhar change menstrual material twice or thrice a day.
- **Washing Hands:** 91% EAMW from Baksa and 63.8% EAMW from Kokrajhar wash their hands every time they use or change menstrual material.
- **Washing genitals during the last Menstrual Period** :52.4%, EAMW from Baksa and 87.5% EAMW from Kokrajhar washed their genitals more than twice a day during their last menstrual periods. Use of soap while washing the genitals was found more frequently in Baksa than in Kokrajhar.

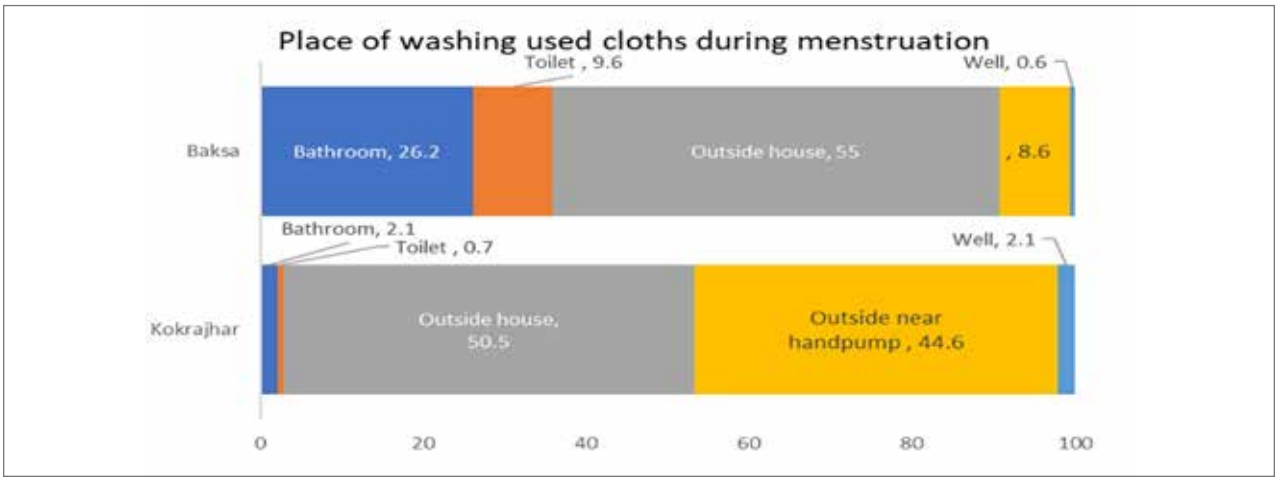
Our data indicates adequate awareness towards MHM and WASH alongside provision of and access to proper WASH infrastructure and sanitation services in both districts of Assam where women agricultural labourers suffer adverse working conditions owing to menstruations.

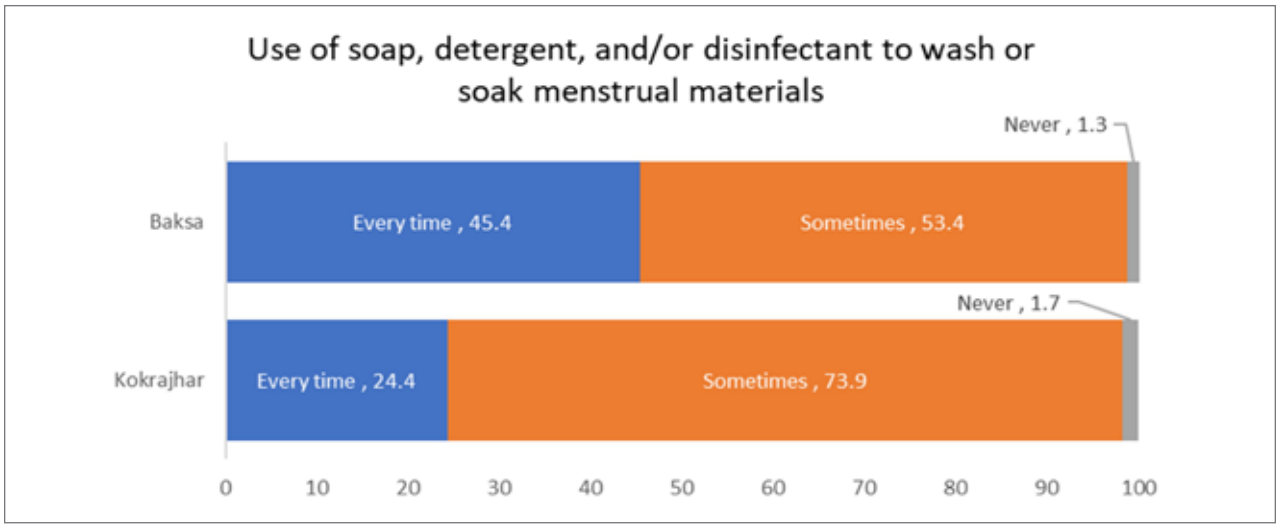
More awareness on personal hygiene, MHM and WASH is required among menstruators between the ages of 20 to 49 years as our data suggests. Behavior changes and hygiene practices in this case go hand-in-hand not only with an enabling infrastructure, clean water but also community-sensitive drives towards an enabling attitude.

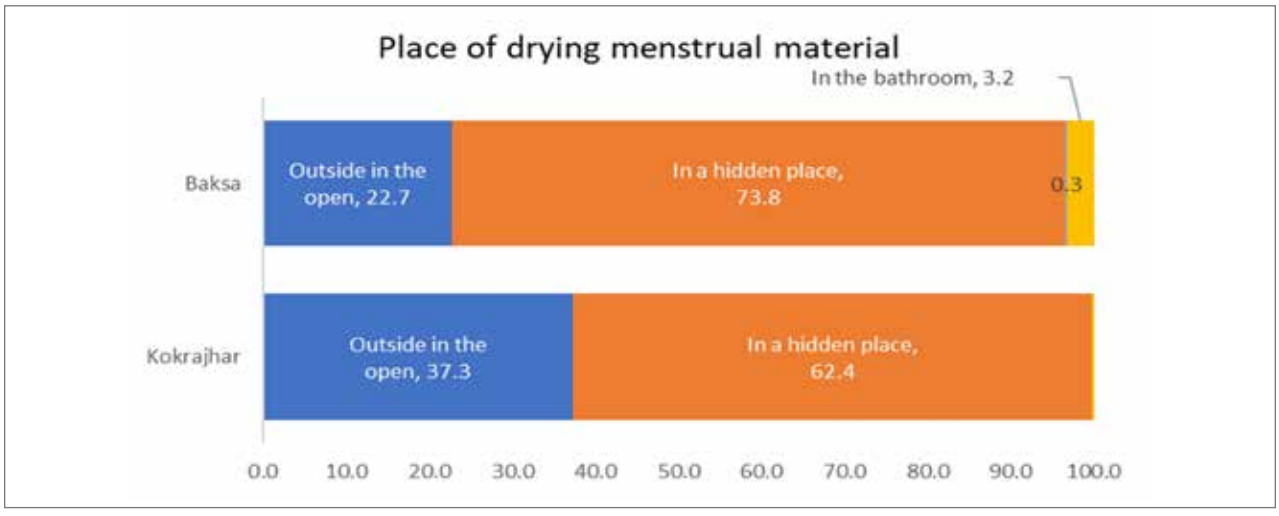
3.3.4 MENSTRUAL HYGIENE PRACTICES

Safe hygiene practices consist of washing and timely changing menstrual absorbents as well as their proper disposal. This may vary with the absorbent type. Personal hygiene also depends on changing the absorbent during the day, keeping genitals clean, washing hands before and after changing the menstrual absorbent. The survey assessed all practices used to follow hygiene and management of material during menstruation.









- **Reusing MHM Products:** 52.2% EAMW reported that they reuse the same cloth during menstruation.
- **Washing MHM Products:** 63.6% EAMW from Baksa and 95.1% EAMW from Kokrajhar washed their menstrual clothes outside their homes or near hand pumps most of the time. 35.8% of EAMW from Baksa wash their menstrual clothes in the bathroom or the toilet.
- **Use soap every time:** 45.4% EAMW from Baksa and 24.4% EAMW from Kokrajhar use soap or detergents regularly.
- **Use soap sometimes:** 54.7% of women from Baksa and 75.6% from Kokrajhar use soap or detergent very sparingly.
- **Drying MHM products**: While reusing cloth during menstruation, apart from washing, one also needs to follow the practice of drying the cloth properly in sunlight. 22.7% EAMW from Baksa and 37.3% EAMW from Kokrajhar dry their menstrual clothes in the open, while the rest practice drying their menstrual clothes in hidden places.
- **Use of dry menstrual material:** Only 37.1% EAMW from Baksa and 35.9% from Kokrajhar ensure that their clothes are completely dry before using them.

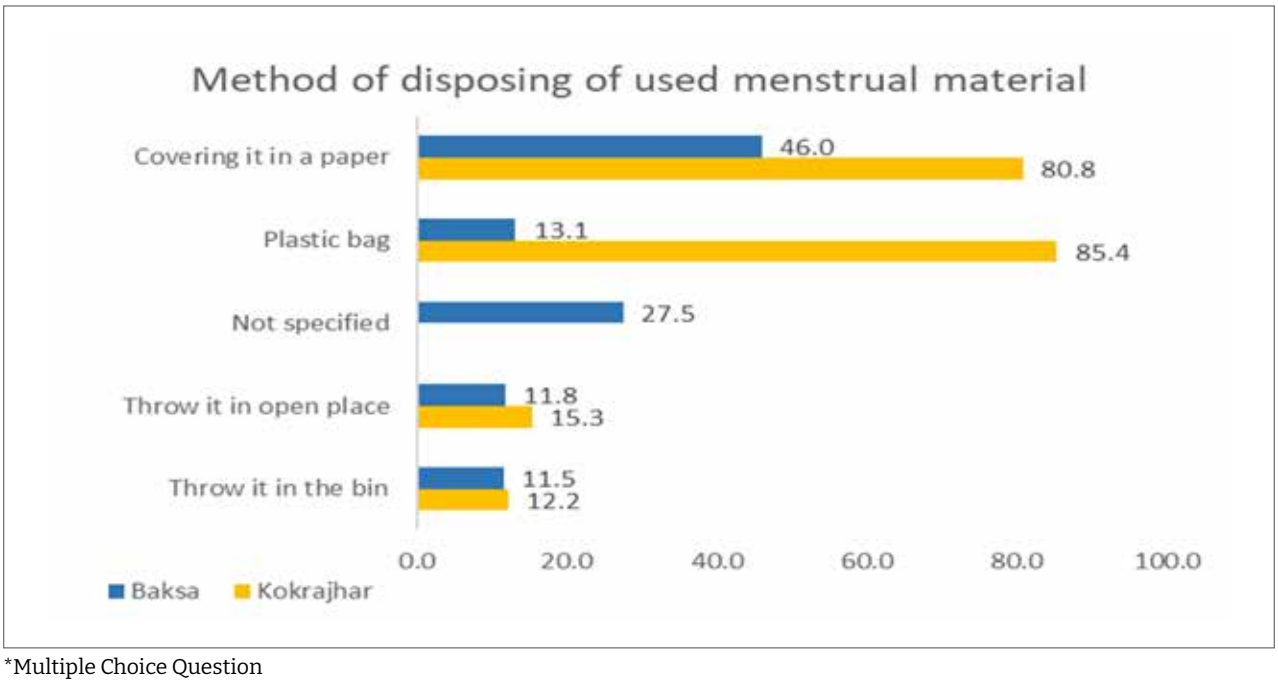
3.3.5 AREA-SPECIFIC DISPOSAL MECHANISMS

- **No specific Disposal Mechanism in place:** When asked about the system of disposal of menstrual material in their area, it was found that women have to manage problems at their own levels. The district does not have any disposal mechanism for menstrual materials nor monitoring mechanisms to follow-up and optimize implementation of hygienic practices.

METHODS OF DISPOSAL

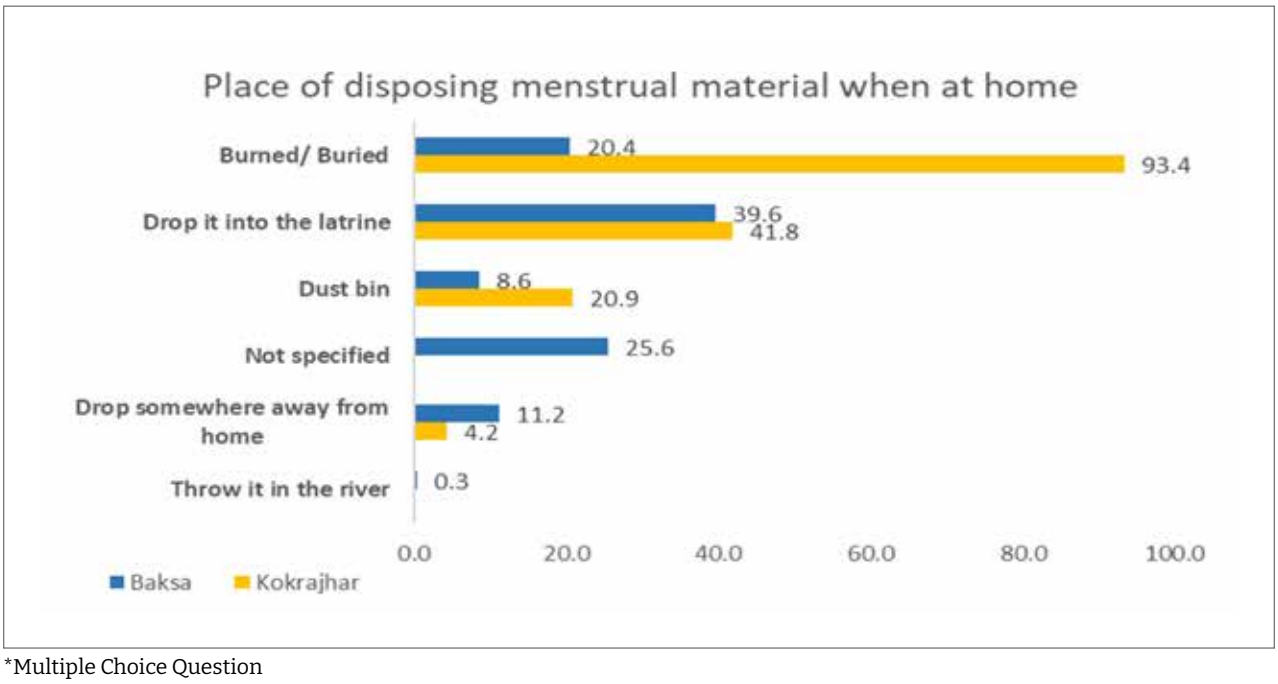
Respondents were enquired through a set of multiple choice questions regarding the methods of disposal used by them to discard menstrual material. Our respondents had various preference and even a mix of preferences depending upon they daily routines, such as when they were outside or inside the house and so forth.

Common Practices for disposing of menstrual material were found to be different in Kokrajhar than in Baksa. In Kokrajhar, one third women don't prefer to change menstrual material during periods when they are away from home.



*Multiple Choice Question

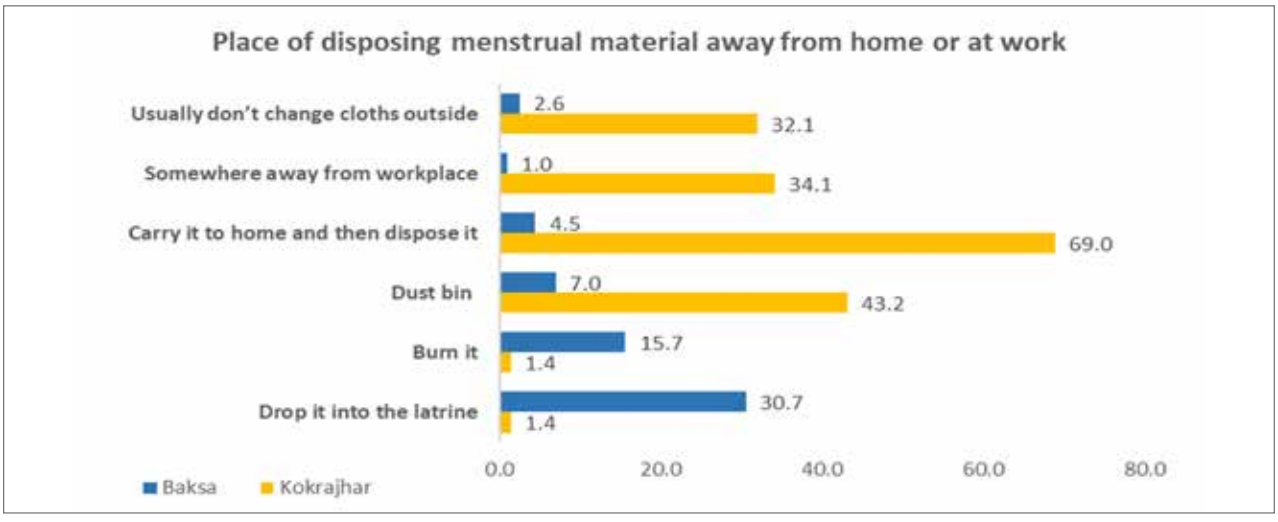
Methods of disposal in both districts - When at home



*Multiple Choice Question

- **Top Practices at Home:** When at home, women in Kokrajhar either bury or burn the used menstrual material whereas more women in Baksa drop it in the latrine or burn it.

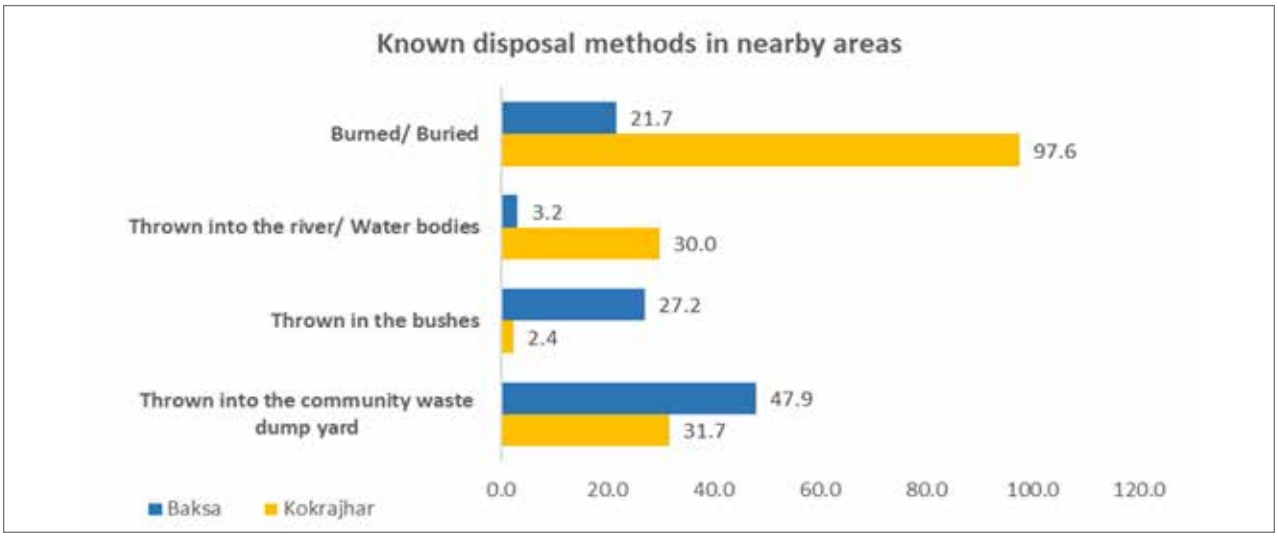
Methods of disposal in Both Districts: When away from Home



*Multiple Choice Question

- **Top Practices away from Home:** When women are away from home, as per responses, nearly one third women from Kokrajhar usually do not prefer to change menstrual material. If at all they change material outside, more than two third women carry it to home and then dispose of it. Rest of the women in Kokrajhar throw used menstrual material either in the dustbin or throw somewhere away from the workplace in open space. It was seen that 30.7% women from Baksa follow poor practices like dropping used menstrual material into the latrine.

3.3.6 KNOWN METHODS OF DISPOSAL IN THE COMMUNITY AS WELL AS NEARBY AREAS



- **Baksa:** According to our respondents, different practices were followed in both the districts of Assam. From Baksa responses almost half 47.9% women throw used menstrual material into community waste dump yards followed by second common practice as throwing it into bushes or burning it.
- **Kokrajhar:** In Kokrajhar, 97.6% women responded that used menstrual material is mostly burned or buried at the community level in the village and nearby areas. While selecting multiple responses 30.7% women said they throw used menstrual material into the river or water bodies.

3.3.7 SOCIAL CUSTOMS, BELIEFS, MYTHS, AND TABOOS

The world of social customs, replete with its mandatory do's and don'ts in various communities represents their beliefs and mandates. Social customs, beliefs, myths and taboos contain overt and covert forms of barriers and enablers which influence MHM related practices as well as everyday experiences of menstruating

women. In this respect we have quite similar findings from Assam's Baksa and Kokrajhar districts, the same being presented as follows:

Customs followed by women in reference to menstruation: Baksa District (in %)

Baksa (377 Respondents)	Strongly Agree	Agree	Disagree	Strongly Disagree
I am allowed to mix with others socially during my periods.	12.7	55.7	30.2	1.3
I am not allowed to attend any social rituals during my periods.	7.2	63.1	29.4	0.3
I do not go to religious places during periods.	22.8	72.9	4.0	0.3
I avoid traveling during periods.	4.5	62.9	32.1	0.5
I am told to stay in the corner of the house during my periods.	1.9	30.0	66.0	2.1
	Yes	**No**		
I am allowed to carry out routine work at home during my periods.	75.1	24.9		
I am allowed to cook in the kitchen during my periods.	50.9	49.1		
Others in my family take care of me during periods.	89.1	10.9		
I can visit a doctor in case of any health issues.	91.2	8.8		
I am allowed only special foods during periods.	25.2	74.8		
I sit for lunch and dinner with all my family members.	81.7	18.3		

Customs followed by women in reference to menstruation: Kokrajhar District (in %)

Kokrajhar (340 Respondents)	Strongly Agree	Agree	Disagree	Strongly Disagree
I am allowed to mix with others socially during my periods.	4.7	90	4.1	0.3
I am not allowed to attend any social rituals during my periods.	0.6	20.6	78.2	0.6
I do not go to religious places during periods.	22.8	79.7	7.1	10.9
I avoid traveling during periods.	0.6	5.9	93.5	0.0
I am told to stay in the corner of the house during my periods.	0.0	0.0	99.4	0.6

	Yes	No
I am allowed to carry out routine work at home during my periods.	41.2	58.8
I am allowed to cook in the kitchen during my periods.	96.5	3.5
Others in my family take care of me during periods.	26.2	73.8
I can visit a doctor in case of any health issues.	100.0	0.0
I am allowed only special foods during periods.	0.3	99.7
I sit for lunch and dinner with all my family members.	97.7	2.3

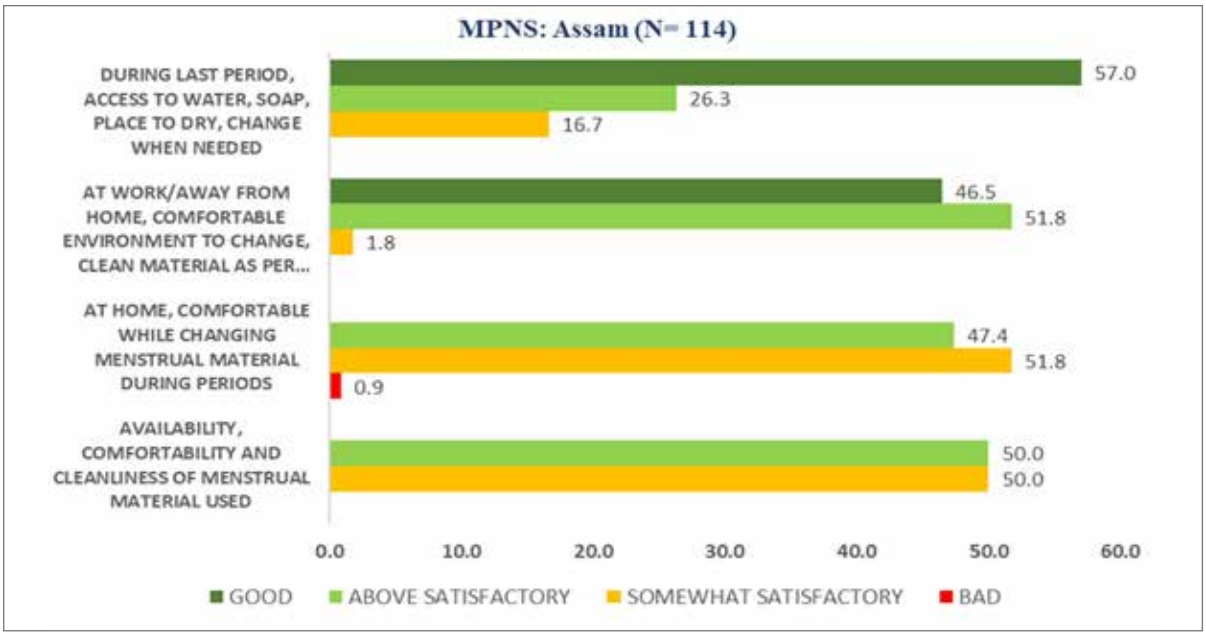
- **Social customs in Baksa:** More than half of the women in Baksa(63.1%) were not allowed to socialize during their menstrual cycle. Almost three- fourth of the women are not allowed to visit religious places. Nearly two- thirds of them cannot attend any social rituals and avoid traveling during periods. Almost one in every three women (31.9%) in Baksa is still segregated and told to sit in a corner of their home during their periods. Only 5 in 10 women said that they can carry routine work and cook in the kitchen during their periods. Also, 91.2% have the freedom to visit a doctor in case of any health issue.
- **Social customs in Kokrajhar:** More than three- fourth of the women in Kokrajhar (78.8%) were not allowed to attend social rituals and religious ceremonies. Almost all said that visiting religious places was out of bounds for them. But 9 out of 10 women freely traveled during periods and not a single woman reported that they were segregated or isolated and confined to a corner of their home during the periods. In these last two aspects, women from Kokrajhar seemed to enjoy more freedom during their menstruation than those in Baksa. Though more than half of the women were not allowed to carry out routine work at home during periods, almost all (96.5%) women were allowed to cook in the kitchen during periods. Likewise, all women reported freedom to visit the doctor for health issues as well.

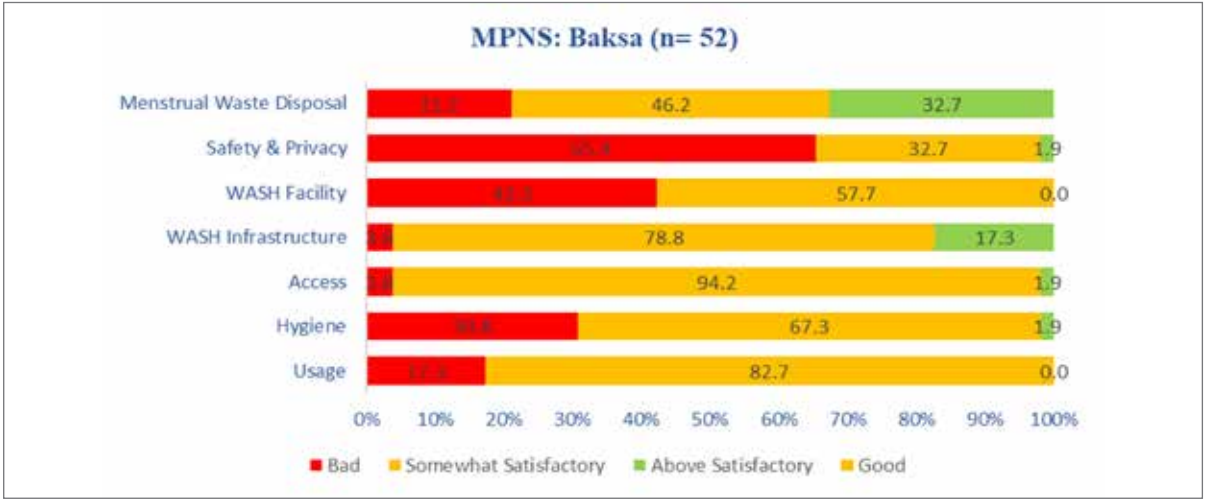
3.3.8 MENSTRUAL PRACTICE NEEDS SCALE (MPNS)

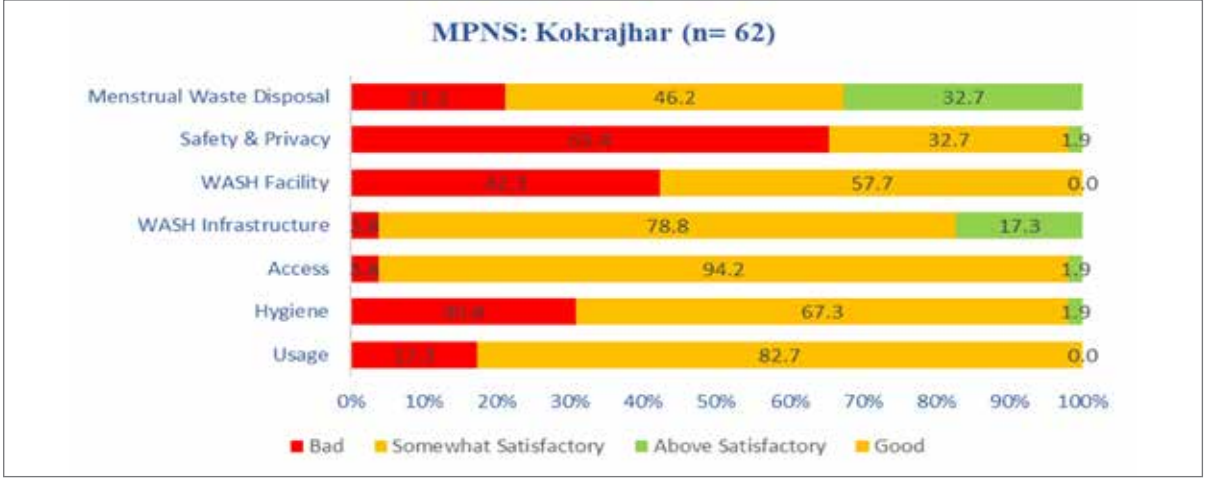
The Menstrual Practice Needs Scale (MPNS) was used to measure and assess the felt needs and experiences of women during their last menstrual period. 114 respondents from both the districts in Assam shared their perceptions/experiences on availability of water, sanitation, hygiene, safety, and privacy as well as access to menstrual absorbents. Through the use of MPNS, we were able to access the actual trends, practices and experiences w.r.t MHM, WASH, safety and privacy which form the 'menstrual everyday' of surveyed women in Baksa and Kokrajhar districts in Assam.

52 women from Baksa, when measured on the MPNS, based on their last menstrual experience, assessed their privacy and wash facilities as bad to below satisfactory level. Even WASH infrastructure, hygiene practices, access and usage of menstrual material was rated at below satisfactory levels during their last menstrual cycle.

62 women from Kokrajhar, when measured on the MPNS, based on their last menstrual experience about privacy, access to menstrual products and hygiene rated it as below satisfactory levels. 37.1% women rated wash facilities as bad and remaining rated it at somewhat satisfactory level. More than three- fourth women assessed the WASH infrastructure and availability of clean menstrual products as being at a good level during their last menstrual experience.







Our findings suggest that perhaps, women and families in Kokrajhar try their best to make MHM as smooth an experience as they can. This also indicates that in Kokrajhar women may be taking some firm steps into social transitions and be in a better position to search for enabling conditions. However, in terms of customary do's and don'ts or taboos, women in Kokrajhar have only a relative liberty as compared to women in Baksa because there are religious restrictions placed on them during their periods.

3.4 MHM FROM AN INTER-SECTORAL PERSPECTIVE

Reading the everyday realities of a menstruating woman requires an inter-sectoral position because her life unfolds not just at home, but in community spaces, schools, farms and workplaces during her periods. Moreover, a menstruating woman also negotiates various socio-economic and inter-sectoral circumstances such as WASH, public health facilities, migration and public policy. Hence, this part of our study examines vulnerabilities, issues, and risks pertaining to menstruation with respect to an inter-sectoral focus:

- As villages selected from Baksa and Kokrajhar districts are tribal communities dominant, they depend on natural farming and Minor Forest Produce (MFP) collection. Water scarcity and increasing inaccessibility of potable water are crucial issues in these villages. Drinking water crisis, energy deficiency and challenges on accessibility to basic health and education facilities, transport system, poor monetary gains, high rate of unemployment issues faced by villagers in both the districts.
- Though Assam gets ample rain and has fertile land, proper mechanisms of rainwater harvesting and sources are not generated for the villages. People mainly depend on bore water.
- Against this background, we present a brief inter-sectoral data analysis on migration and MHM, WASH and MHM, Education and MHM and lastly, MHM from the perspective of awareness towards public policies.

The overall narrative of different practices on MHM in these villages related to community-based vulnerabilities, socio-economic conditions and beliefs including monetary freedom or disposable income of women besides health and education related inter-sectoral factors. Against this background, we present a brief inter-sectoral data analysis on migration and MHM, WASH and MHM, Education and MHM, Livelihood and MHM and lastly, MHM from the perspective of awareness towards public policies. The villages surveyed in both the districts were SC (Scheduled Caste) and BC (Backward Classes) dominant. Above 30% of people from both the districts still use open defecation suggesting that either they may not have WASH facilities at their disposal, or they may not have adapted to WASH facilities available. Around three-fourths of the population had a low education level and in some villages, there were no schools. For livelihood, people were mainly dependent on rainfed land for cultivation. More than half the population was dependent on daily wage labour -work.

3.4.1 MIGRATION AND HEALTH

- Out of a total of 110 respondents migrating from Baksa 79.1% women reported migrating for seasonal work located near the village.
- Out of a total of 78 respondents (n= 340) from Kokrajhar, all women migrate for seasonal work near the village.
- Out of 188 migrants combined from both the districts,178 migrate to Tea Leaf Plantations as daily wage labourers.
- Our findings indicate that 165 out of the 188 migrant women strongly feel that their seasonal work conditions and resource scarcity influences their menstrual health negatively.

A closer observation and analysis of migration and MHM in districts of Assam should be done for achieving better health prospects for menstruating women between 20 to 49 years of age. Most of our findings relate to migrants who work in tea gardens and hence we suggest that more studies and policies on this theme would be able to cater to urgent MHM needs.

3.4.2 TRADITIONAL SKILLS AND EARNING CAPACITY

In Baksa and Kokrajhar 62.5% practiced farming, fishing, cattle rearing, dairy products, preserving, hunting followed by 31.3% women who practiced traditional art and craft as well as skill-based work.

- In Baksa, out of the 123 women (n=377) who possessed traditional skills, 68 practiced farming, fishing, cattle rearing, dairy products, preserving, hunting; 37 practiced arts, music, dance; another 37 women practiced craft, bamboo craft embroidery, knitting, weaving; and 24 women were into tailoring.

- In Kokrajhar, out of the 181 women (n=340) who possessed traditional skills and art, 122 women practiced arts such as bamboo craft, embroidery, knitting and weaving followed by 58 women who practiced art, dance, music. .
- While 68 women reported earnings from traditional knowledge and skills in Baksa, only 2 women from Kokrajhar managed to earn using their traditional skills and know-how .

Given that there is a possibility of augmenting family income from traditional knowledge and customary skills, vocational courses can be organised for women struggling with socio-economic vulnerabilities to enhance their means of livelihood and disposable income. A disposable income can give women better opportunities towards an empowered decision -making w.r.t MHM as well as personal and medical care.

3.4.3 WASH AND MHM

NFHS-5 data shows that 68.9% households in Baksa and 72.2% from Kokrajhar use an improved sanitation facility (International Institute for Population Sciences (IIPS) and ICF 2021, p. 93, 99).

WASH & MHM	Baksa (in %)	Kokrajhar (in %)
Total Respondents	**377**	**340**
Water Facility at Home		
Bore well/ Tube well/ Well covered	35.0	45.0
Hand pump/ Standpipe	6.1	57.4
Piped water/ Piped to yard/ Plot/ Public tap	58.1	3.2
Protected Spring	0.0	7.9
Tanker/Truck / Cart with small tank	7.2	1.2
Toilet Facility at Home		
Individual household latrine	92.8	95.3
Community toilets	5.8	1.8
Open defecation	1.3	2.9
Type of House		
Kutcha	30.5	47.9
Pucca	21.0	3.5
Semi pucca	48.5	48.5

- **Kind of House:** Housing conditions were found to be better in Baksa than in Kokrajhar. 69.5% of women from Baksa reported that they stay in semi-pucca or pucca houses. Whereas nearly half (47.9%) of the families in Kokrajhar stay in kutcha houses. *Pucca* houses are made of roof, wall and floor with a concrete or pucca material as compared to kutcha houses that have roofs, walls and floors all made up with non-concrete or kutcha/ makeshift material.

- **Compromised Toilet Facilities:** According to our findings, Individual Household Latrines (IHHL) are used by 92.8% families in Baksa and 95.3% in Kokrajhar respectively. Open defecation is practiced but in negligible numbers in both the districts. Pucca houses can have toilets built within as opposed to Kutcha houses where such a provision is not possible. Irrespective of the housing patterns, people preferred to use toilets for defecation owing to various positive anomalies such as good practices and community-wide preferences for usage of toilets and environmental cleanliness.
- **Drinking Water Challenges:** One of the main everyday challenges in the area emerged to be compromised access to drinking water facilities. Our findings indicate that only 230 families out of the 717 surveyed across both the districts use piped water for drinking purposes. The remaining families rely either on bore wells, tube wells, or hand pumps near their dwellings. Almost all EAMW from both the districts reported water scarcity and problems related to presence of iron in the water and constraints on availability of sufficient water for MHM in households, schools and institutions. Moreover, drinking water supply and sanitation challenges exacerbate during floods and post- flood situations.

It is clear that during menstruation a woman's WASH needs are relatively higher as compared to the rest of the days of the month. When a woman experiences her periods, she needs more water to clean herself for personal and intimate hygiene, including after defecation. Besides, a regular supply of clean water, ensuring that a woman has the facility of a private and secure place to change her menstrual absorbents and clean herself are a profound part of her sense of dignity and safety. In places such as Baksa and Kokrajhar, during floods and immediate post- flood situations, contaminated water and practices such as open defecations increase the risk of communicable diseases and vector borne diseases. For menstruating girls and women, such a scenario poses extremely serious threats to their intimate and personal hygiene making them susceptible to various kinds of genital, uterine and urinary infections. Therefore, access to clean and functional toilets and bathroom/ bathing cubicles become a critical need during periods, in normal routine or situations of natural calamities and disasters.

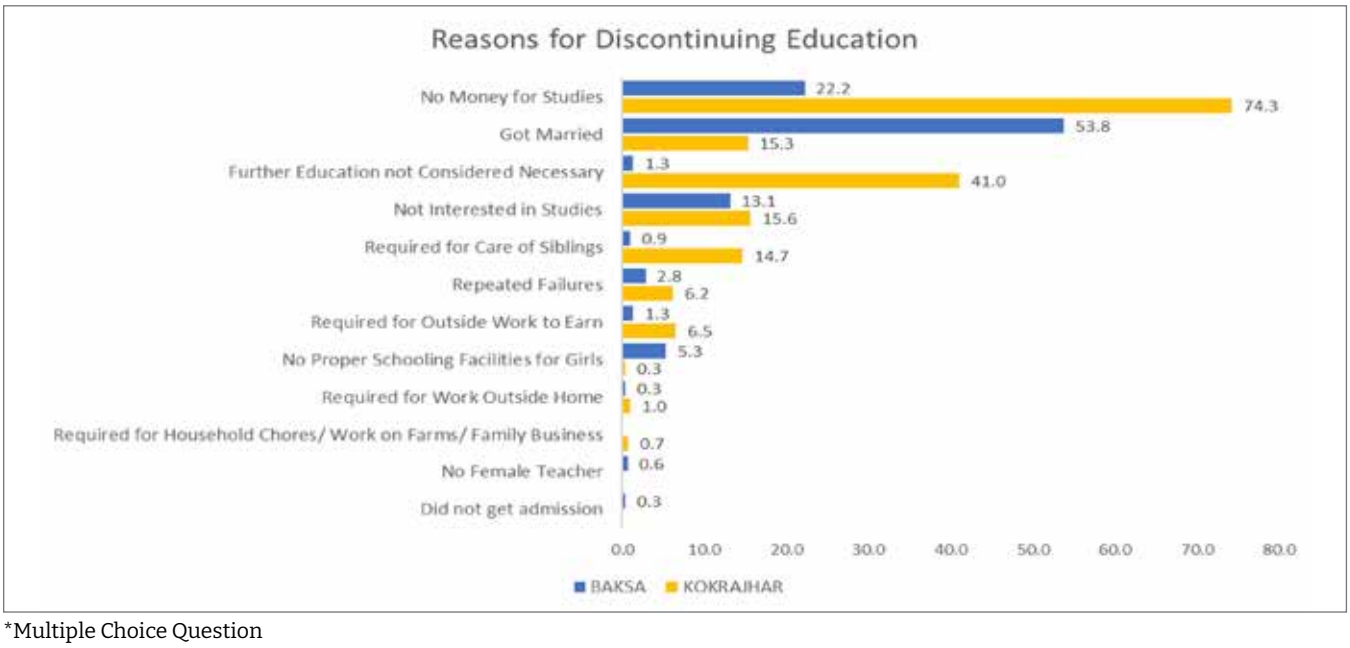
3.4.4 EDUCATION AND MHM

Out of our total respondents (N=717), 99 women were illiterate across Baksa and Kokrajhar. Whereas 618 EAMW preserved education primary to other education levels.

- 90 women (n=377) from Baksa were illiterate whereas 148 had received education till the 7th standard; 66 were educated till higher secondary, and the rest, 73 were educated beyond the 10th standard, including having completed graduation and post-graduation.
- In Kokrajhar, 42 women (n=340) were educated till the 4th standard, 176 were educated till higher secondary, and another 103 were matriculates and above.

Education and MHM	Baksa (in %)	Kokrajhar (in %)
Total Respondents	**377**	**340**
Education		
No education	23.9	2.6
Primary (1st -4th)	10.3	14.7
Secondary (5th-7th)	28.9	21.5
Higher secondary (8th-10th)	17.5	30.3

Education and MHM	Baksa (in %)	Kokrajhar (in %)
12th/ Undergraduate	8.8	27.6
Graduate and above	10.6	3.2
3.4.4 Reasons for Discontinuing Education		
Lack of Facilities	0.9	0.0
Monetary Barriers	23.8	82.4
Family Barriers	55.9	71.0
Educational Barriers	15.9	21.8



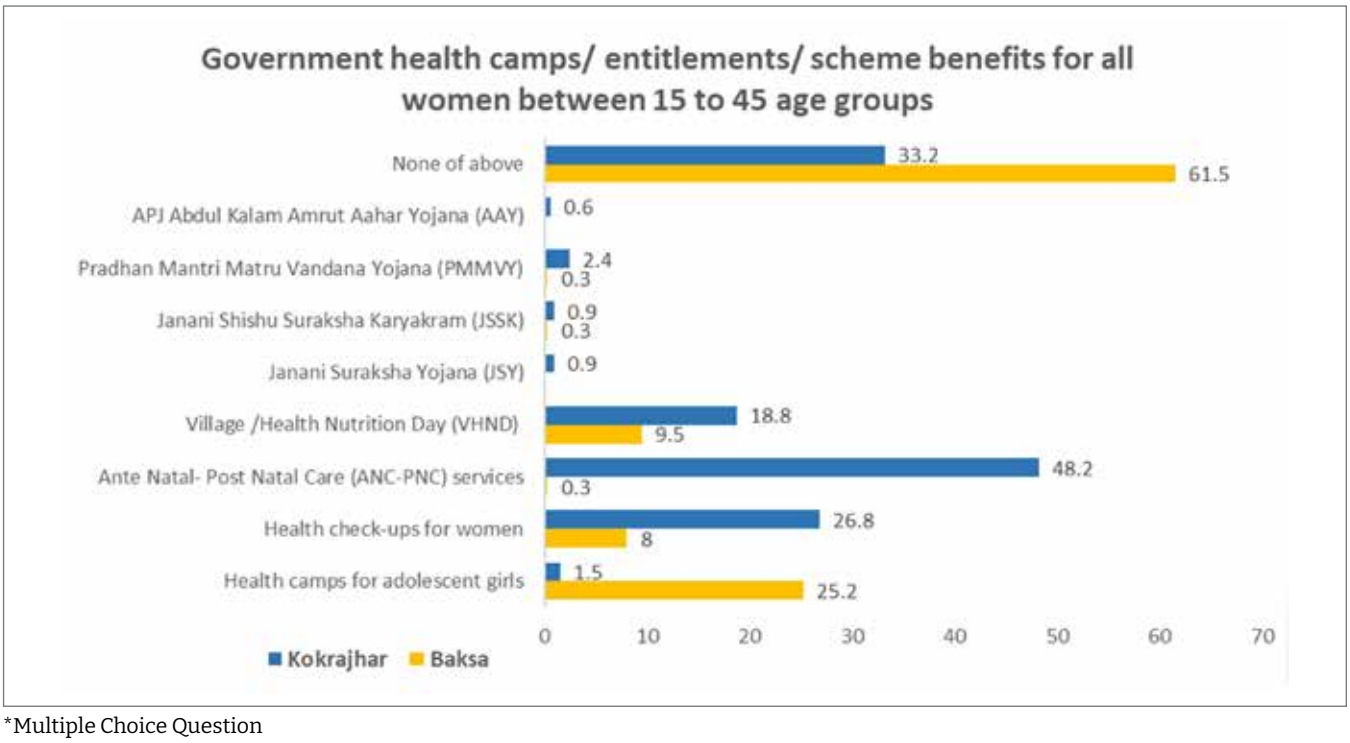
*Multiple Choice Question

- **Bottlenecks such as Poverty**: In places such as Baksa and Kokrajhar, during floods and immediate post- flood situations, contaminated water and practices such as open defecations increase the risk of communicable diseases and vector borne diseases. For menstruating girls and women, such a scenario poses extremely serious threats to their intimate and personal hygiene making them susceptible to various kinds of genital, uterine and urinary infections. Therefore, access to clean and functional toilets and bathroom/ bathing cubicles become a critical need during periods, in normal routine or situations of natural calamities and disasters
- **Failing/ Lack of Interest**: 281 of the total women respondents who discontinued education reported reasons such as education was not considered as a necessity, repeated failures, and further education not considered necessary.
- **Improper Facilities in Schools:** Other discernible hindrances to complete education related to the absence of proper schooling facilities and infrastructures for girls (40) and no female teacher (2).
- **Menarche and Marriage:** In Assam, across our sample population 255 women dropped out of school and got married post-menarche and attainment of puberty. Menstruation emerges as a major criterion for some parents and families laying restrictions on the movement of a girl outside of home, including a preference that adolescents drop from school. Girls being absent from school due to MHM related issues

including physical symptoms such as pain etc. also lead to interruptions in education post -menarche in some cases. While community beliefs such as a girl being 'ready for adulthood' in early post-menarche years leads to pressure on the family to marry her off .

3.4.5 AWARENESS TOWARDS PUBLIC POLICY AND COUNSELING ON MHM

Public Policy: National Health Mission runs various programs for the age group of 15 to 45 years, i.e., for adolescent girls as well as women. From the survey, 61.5% of Baksa women and 33.2% of Kokrajhar women were not aware of Government health entitlements and scheme benefits.



*Multiple Choice Question

- **Significance of Public Health Facilities:** Public Health facilities usually play an important role in providing free and affordable treatment. Health support systems in India are designed such that for every 1000 population there is ASHA appointed, for around 5 to 6 villages, there is a Sub- Centre where treatment for small illnesses as well as 24/7 facility of delivery is available. After that, for every 30000 people, there is a Primary Health Centre (PHC). And as we move further, Rural or Sub-District hospitals, district hospitals in urban areas, municipal corporation health clinics, and hospitals.
- **Accessibility and Choice:** When asked whether they get accessible/affordable treatment from government health facilities, 57.6% of women (n=164) from Baksa and 54.4% from Kokrajhar (n=340) responded positively. Very few respondents from both the districts reported that they do not avail treatment from public health facilities. EAMW covered in this survey were then asked through IDIs about the nearest accessible public health facilities for getting treatment or pursuing their health issues. The nearest and most accessible public health facilities reported by the EAMW in Baksa and Kokrajhar emerged as Sub-Centers and PHCs. Out of a total of 504 women interacted with, 231 reported that Subcenter were their nearest health recourse, while 68 EAMW consulted Primary Health Centers and finally the District Hospital emerged as the go-to institution for 53 women who opted for it as their first choice. Around 30% of our respondents, however, in Kokrajhar were unaware about the nearest public health facility around their villages.
- **Local health Services:** In Kokrajhar, out of the EAMW (n=340) who affirmed that ongoing public health services had benefited them, half reported having benefited from ANC-PNC services, whereas in Baksa, out of the EAMW (n=164) who availed benefits from ongoing government schemes, only 0.3% respondents received ANC - PNC services .

- **Engagement with Public Health services**: Our findings indicate that though women are familiar with the services they get from the public health system, very few EAMW from both the districts could talk about the schemes for them other than ANC-PNC or health check-ups. Therefore, the community was unaware of Janani Suraksha Yojana (JSY), Pradhan Mantri Matru Vandana Yojana (PMMVY) etcetera.
- **Importance of Health Camps**: Women across various contexts are differently integrated with the national public health infrastructure and policies. Health camps, which are periodically organised in villages, are specifically important and needed in areas which are remote and cut-off or where Sub-centers are not available. Our survey findings indicate that in Baksa one in every four adolescents (of 15 years and above of age) in the village attended health camps as compared to 1.5% girls from villages in Kokrajhar. However, three times more respondents (91) from Kokrajhar participated in health camps for women as compared to only 13 respondents from Baksa. If health camps start covering the wellbeing of EAMW in remote and isolated areas, women will stand to benefit from many health based objectives and parameters of the Indian government.

Our findings indicate that other than ANC-PNC services, women between the 15 years to 45 years age group are not familiar with Government health camps, entitlements, scheme benefits for them. Our data is indicative of the absence of women's voice and reach over health schemes and benefits for their welfare. Such a lack of information also leaves unaddressed their hesitation to speak and articulate on MHM concerns in day-to-day life. In this way the EAMW face a double silence as even the policy makers have so far been unable to adequately combat the silence on this obviously important health issue.

COUNSELING

There are various maternal and child health programs, services and schemes designed by the government of India benefit the women on menstrual health as well if counseling sessions are a part of these. However not much is known about the pattern of organisation of these sessions, or if these were conducted in villages. EAMW who participated in this survey, expressed enthusiasm, and underlined counseling on MHM as an urgent need where not given. If counseling on MHM is given regularly to EAMW, they would benefit in terms of being better informed and more attentive towards self-care, thereby managing to bring community insights and voices to dispel the silence and myths around the issue through active participation.

Received counseling on Menstrual Hygiene from health workers	Baksa (in %)	Kokrajhar (in %)
Total Respondents	**377**	**340**
No	45.1	91.2
Yes	54.9	8.8

Respondents were asked if they ever received any counseling on menstrual health and two- third answered in the negative. However, the prevalence of counseling on menstruation in Baksa was far better than in Kokrajhar.

- **Yes:** Upon being asked if they ever received any counseling on menstrual health, only 33.1% of our EAMW responded in the affirmative. Counseling on MHM was received from health workers such as ASHA, ANM and AWW.
- **No:**170 women in Baksa (n=377) answered no, while 310 women from Kokrajhar (n=340) did not receive any counseling at all.

Menstrual health of women beyond school years is still a long way from being actively considered as a public policy measure in India. Owing to the vast reach and significance of, as well as a substantial reliance on Public Health system in India, the MHM of EAMW can get a much required boost if the issue receives adequate attention through public policy. Even the ADP can stand to gain women's participation if MHM is piloted as an inter-sectoral intervention cutting across education, social security, health, WASH and livelihood and other relevant sectors.

PART 4 VOICES, EXCERPTS AND OBSERVATIONS

As part of our research, we conducted Key Informant Interviews (KIIs) in both the districts. People interviewed during this exercise were important stakeholders in communities and villages such as Anganwadi workers, ANM, Doctors, Teachers, ASHA workers etc. the voices of these stakeholders are critical for the development of the community as they give a unique point of view on the village population and in a small but significant manner, have helped us analyze how to combat the silence on menstrual health issues in area- specific and community -sensitive ways. The highlights of these interviews are as follows:

Baksa (Data derived from 5 villages of the district): In Baksa, our study shows that respondents from 4 villages were not aware about any government scheme related to menstrual hygiene. Two villages had scarcity of water. In one village, free sanitary napkins were no longer distributed. No awareness generation initiative for women, MHM and WASH existed in any of the villages.

Kokrajhar (Data derived from 5 villages of the district): In Kokrajhar, free sanitary pads were not distributed in 4 of the 5 villages under study. 3 informants stated that their villages do not have any awareness generation programme or initiative related to menstrual hygiene. Two of the selected villages experience scarcity of water.

4.1 VOICES, EXCERPTS AND OBSERVATIONS OF RESPONDENTS: BAKSA

Our respondents from the field have shared their experiences, conceptions and observations on MHM. Below are some voices and excerpts from our interactions with them.

Pramila (Interview conducted during July-August 2022)[2], an **Anganwadi Worker (AWW)** in Baksa stated, the village does not have any scheme related to menstrual hygiene. On menstrual needs of women between 20 to 49 years of age, she explained, most of the girls in her village got married at the age of 20 which leads to early pregnancies. This affects their health, and the village urgently needs nutritional health programs for women. On WASH conditions in the village and schools, she informed us that water pipeline installation was completed but supply remained pending. On sanitation, only meetings were held in the village so far, although schools have been provided with water testing kits to check the purity of the water. The ANM recommended the need of creating more awareness among villagers on menstrual hygiene and importance of maintaining cleanliness. She explained how despite some positive changes, villagers continued to follow rigid customary beliefs and rituals such as strict segregation of menstruating women to the point of total isolation. Women are not allowed to step out of the home for 4 days and that includes girls not being allowed to go to school and lastly, prohibition of participation in religious ceremonies.

An **ASHA Supervisor** (Interview conducted during July-August 2022)[3], working under the National Rural Health Mission (NRHM) in Bagaribari village of Baksa district spoke of the lack of any specific scheme on menstrual health for older women, though iron tablets do get distributed to women of different ages. From her account, it was evident that Bagaribari conducted regular awareness programmes to teach women about hygiene and nutrition. On WASH needs in the community and schools, she stated there was an adequate water supply in the village and the school including the availability of potable water. On taboos related to menstruation in the village she asserted that, "there were no superstition or debilitating myths in the village. People were aware on MHM at a personal level and follow some good habits such as providing healthy food to women and prevention of hard labour during menstruation."

Kabita (Interview conducted during July-August 2022)[4], a **supervisor of ASHA workers** in a village in Baksa shared that regular awareness programmes were conducted in the village on using pads and maintaining cleanliness during menstruation". On WASH conditions in community and schools she added, "Some schemes are being implemented in our village in the name of water supply but I have not heard anything linking them to menstrual hygiene management." Potable water was available in the village school. On customary practices and taboos, she informed that women were treated as untouchables during menstruation, they were not allowed to enter the kitchen and other places of worship, they were also not allowed to participate in religious rituals.

Basanti (Interview conducted during July-August 2022)[5], an **ASHA worker** in a village in Baksa responded that regular awareness programmes were held to teach women about using pad and maintaining hygiene during menstruation. Moreover, a special awareness programme under Village Health Nutrition Day (VHND) was conducted for women dealing with malnutrition and breast-feeding issues. Responding to WASH queries in her village, she informed us that, "water pipelines had been installed in the village but water supply has not started yet". The ASHA worker said that there were no harmful superstitions around menstruation in their village but some good practices abound such as serving healthy food to women and preventing them from lifting weights or doing physically heavy work during menstruation.

Dipasmita (Interview conducting during July-August 2022)[6], an **AWW** in a village in Baska claimed, "she has heard about Kishori Suraksha Karyakaram but no one has benefitted in the village from this scheme." The village convened a regular awareness programme to teach women about hygiene and cleanliness during menstruation.

Sunita (Interview conducted during July-August 2022)7, a **SHG member** in a village in Baksa discussed how earlier under a 'free sanitary pads' distribution scheme sanitary pads were subsidised but now the scheme has been stopped. Her village suffered a shortage of sanitary pads so women used cloth and it is therefore observable that families should be provided sanitary pads at a 'very nominal price'. On taboos and myths related to menstruation in the village, she explained women were not allowed to touch any religious objects, to cook or enter the kitchen and temples. Also, menstruating women were not allowed to eat sour fruit and eggs. In some houses, women did not have the permission to sleep on the bed during menstruation.

Upasana (Interview conducted during July-August 2022)[8], a **Doctor** in a village dispensary in Baksa responded that under *Rashtriya Kishori Suraksha Karyakaram (*RKSK*)* a theme-based program on menstrual health and hygiene is active in 27 districts of Assam. She added women do use cloth as well during menstruation. Diseases such as inflammatory disease and urinary infections, malnutritions were commonly seen in EAWM women in her villages. Entering the kitchen and going to temples during menstruation is taboo in their social set-up.

4.2 VOICES, EXCERPTS AND OBSERVATIONS OF RESPONDENTS: KOKRAJHAR

Our respondents from the field have shared their experiences, conceptions and observations on MHM. Below are some voices and excerpts from our interactions with them.

Hema (Interview: 23.08.2022)[9], a **Teacher** in an upper primary school in Kokrajhar district of Assam responded, she had no idea about the scheme related to menstrual hygiene for girls in the village. She added if any emergency happened in school the teacher bought the sanitary pads for students. On WASH conditions in the village and schools she responded, village and schools had water filters in place as well as separate toilets for boys and girls in the school. She further added the village school does not have any vending machine for sanitary pads. Hema opined that in her village, "speaking about menstruation was itself a taboo in the society as people still hesitate from discussing it openly". She insisted upon creating more awareness among peoples about menstrual hygiene.

[4] AS KII3 BAK: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[5] AS KII4 BAK: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[6] AS KII5 BAK: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[7] AS KII6 BAK: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[8] AS KII7 BAK: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[9] AS KII1 KOK: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

Hiraboti (Interview: 24.07.2022)[10], an **Anganwadi worker** in a village in Kokrajhar stated that it was urgent that schemes such as free sanitary pad distribution to adolescent girls be continued and monitored well lest discrepancies mar their vigour. Regular awareness programmes should be held in collaboration with the health department to help the village women learn state-of-the-art knowledge on MHM . She further added that her village had a piped water facility but it was not accessible to every household. Every household had a toilet installed under *Swach Bharat Abhiyan* (SBA), though there were water scarcities. On taboos in the village, she explained menstruation itself is considered taboo in the society as no one even wants to discuss it openly.

Respondent Ms Indira (Interview: 25.07.2022)[11], an **ANM** in a village in Kokrajhar responded with the program of free distribution of sanitary pads to adolescent girls in the village and regular awareness programme to sensitize women about maintaining cleanliness during menstruation. Her village, she informed, does not have any drinking water facility from any governmental schemes. Further, lack of financial resources was a major reason in achieving proper menstrual health as she said, "people who are economically better off can afford to purchase sanitary pads from the market whereas people who are economically weak and not in the position to buy sanitary pads make use cloth while menstruating." She further added people were not open to discussing menstruation except the Bodo community in the village. There is a need to raise awareness about menstruation in the village.

Sitralekha (Interview: 24.08.2022)[12], a **School teacher** in a high school in a village in Kokrajhar stated that she is unaware of any scheme about menstruation in the village and school. She added "a few years ago there was a free sanitary pads distribution program for girls in the school but now the government has stopped that." On WASH in the village school, she replied the school had separate toilets for boys and girls with running water in the school which are clean and usable. School also had installed dustbins in the premises of the school so that all the dry waste can be disposed of at the dustbins rather than littering. She emphasised that creating awareness among women about menstruation would remedy the hesitation among people to talk about it with the opposite gender. Sitralekha spoke of 'Tolani Biya' which is a celebration hosted enthusiastically just as a wedding when the girl gets her first period. Throughout these rituals, girls are not allowed to come out from the room or work for three days and only certain special foods are served to her. On day four, the girl steps out of her room/ segregational space and bathes, after which she is allowed to mingle with other people as usual. This rule is exclusively for those attaining menarche. During the monthly periods menstruating girls carry on their daily routine but there is a restraint on going to religious places.

Sumitra (Interview: 22.08.2022)[13] an **ASHA worker** in a village in Kokrajhar responded that, "There are no particular schemes for adolescent girls and women now, however a few years ago the government used to distribute free sanitary pads for the girls and women especially the age group of 18-40 years. Though the scheme was for the age group of 18-40 years only, we as ASHAs used to make a list of all menstruating girls and women and distribute accordingly." Moreover, the village had sessions on peer group information for adolescent girls to spread awareness about menstruation under the RKSK scheme. She added there is an installation of water taps in the village. Toilets have been built in every household under *Swachh Bharat Abhiyan*. She suggested the village needed a free sanitary pads distribution programme for every menstruating woman.

4.3 SALIENT FINDINGS FROM DATA

Processing through our data from Baksa and Kokrajhar, we have gained some valuable insights on women's health, education, livelihood and overall community outlook on menstrual health management needs and transformations on ground.

On sanitation, only meetings were held in the village so far, although schools have been provided with water testing kits pointing out our key informants and respondents from Baksa. Nutrition for pregnant and lactating

[10] AS KII2 KOK: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[11] AS KII3 KOK: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[12] AS KII4 KOK: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[13] AS KII5 KOK: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

women, as well as proper MHM possibilities and provisions are the main concern of the health related to the EAMW in Baksa. In Kokrajhar, our findings indicate that the tribal communities have diverse belief systems over menstruation. Bodos are the most forthcoming to talk freely on MHM. A high school teacher informed us that the Tolani Biya ritual takes place at the onset of periods or Menarche. For three days after her first period, the girl is secluded. At the end of this period, she takes a bath and is allowed to socialize with others. Menstruating women and girls are allowed all tasks other than those related to religious places including prayers and worshiping rituals.

Sanitary Pads are freely distributed to adolescent girls in most villages. Indira, an ANM opines that this helps in sensitizing both the girls and women towards the maintenance of cleanliness and hygiene during periods. In Kokrajhar, in most villages there is free sanitary pad distribution. In one of the villages our respondent Sitralekha informed that free sanitary pad distribution has been but stopped recently.

However, owing to resource scarcity, only the women who are economically better off can afford to buy sanitary pads and the others use cloth during menstruation. Villages in our sample have a paucity of clean drinking water though under the Swach Bharat Abhiyaan water taps have been installed in the villages. On a more positive note, Sumitra, a young woman from a village in Kokrajhar informed us that toilets have been built in every household and schools count on a good water supply with separate toilets for boys and girls. Our respondents feel the need to have a pad-vending machine to make it a more secure experience for young girls and encourage attendance in schools and WASH.

Our respondents spoke at length how education affects a growing woman's practices and choices. However, education per se, may not be the only factor over women's menstrual well-being or betterment, but we found how the community learns to see educated girls returning to the village from their hostels in a newer light. Young school –going girls who live in hostels are faced with the challenge of learning to manage their menstrual needs alone and away from the comfort zone of home. They are able to look after themselves by adopting and becoming aware of newer knowledge, practices and options such as pads provided by schools.

Conversely, elderly women and communities on their part do not expect the girls who have been away from village life to follow area-specific customs/taboos or even beliefs related to MHM when they come home or return to the village. Segregation during menstruation, for instance, wanes as a practice as both, the attitude of the girls as well as community outlook towards them, registers transformations. Slowly and with rising awareness the communities learn to reflect upon their practices. Our data indicates the potential capacities that change and transformation have when they arise from within and communities do adapt to their own advantage changing needs. Hence, we recommend launching inter-sectoral awareness drives and a participatory search for enablers towards better MHM in Baksa and Kokrajhar would help in combating the silences that women still encounter or a part thereof on ground.

From our interactions and databases pertaining to Assam, it clearly emerges that apart from a silence on women's menstrual health in terms of inter-sectoral hindrances and policy related negligence in India, there are community-voices that portray a negative and discriminatory attitude towards periods. These discriminatory voices and attitudes in Assam, just as our research from some other parts of India shows, pertain to both men and women across social strata. Many EAMW as well as key informants endorse negative attitudes (as told to our surveyors and field-researchers) towards menstruation, either owing to the circumstantial difficulties that they grow up experiencing or for want of better knowledge and support system around the phenomenon. Inadvertently or otherwise, such voices contribute to the perpetuation of a debilitating discourse on the phenomenon. The key to combating the inter-sectoral and community -based silences and barriers on MHM among women beyond school years lies in augmenting positive practices and discourses on menstruation. One of the best ways to achieve this is by involving multiple actors, key and critical stakeholders such as EAMW, leaders, influencers, families, policy makers and implementers. Hence, gender mainstreaming MHM can ensure gender perspectives and attention to the goal of gender equality in all activities, projects, and programmes.

4.4 RECOMMENDATIONS/ AREAS OF IMPROVEMENT

URGENT

1. **State- of- the art Knowledge Drives**: To improve the MHM related outcomes in Baksa and Kokrajhar, existing schemes be regularised and monitored while awareness drives are incorporated within these with programme-based targets.
2. **Enable existing Village Health and Nutrition Committees (VHNCs) on MHM:** For overall capacity building on menstruating women's health and nutrition at the village level, empower the existing VHNCs to address the issue locally in Baksa and Kokrajhar.
3. **Enable existing Village Water Sanitation Committees (VWSC) on MHM:** MHM drives should be conducted alongside the promotion of information on WASH. Get the enablers in terms of WASH in tandem with community voices. The VWSC in each village to understand the MHM barriers and is to be operationalised under the national Jal Jeevan Mission (JJM) and is composed of a five women-team. Local Community Based Organisations (CBOs) can help mobilize community support to this end.
4. **Lady doctors in PHCs:** The presence of women medics in PHCs or visiting sub-centers regularly/ once a month to monitor health needs of menstruating girls and women and not just pregnant and lactating mothers will help cover those who are in need of medical help .
5. **Free and fair distribution of menstrual hygiene products to combat health risks:** Regularizing Free pads/ menstrual absorbents distribution schemes for school going girls and extended to elder women in the village. Respondents in surveyed villages raise the demand that women also need clean cloth to be made available for use during menstruation, for those who prefer traditional methods of protection and hygiene.
6. **Capacity Building on Household Water Treatment Systems (HWTS)**: Village folk are eager to rid water of iron contamination, therefore imparting learning and holding workshops on HWTS is recommended. These initiatives can be activated through the existing (Free Test Kit) FTK women groups (under Jeevika Scheme) formed under the JJM scheme.
7. **Disaster-prone zones:** For disaster prone areas, such as flood zones in Assam, MHM cubicles or at least separate makeshift toilet facilities be set up for menstruating women for the sake of privacy as well as community hygiene during emergencies

SHORT TERM

8. **MHM Kit for Relief Distribution:** Provision and Distribution of life saving hygiene items such as soaps, detergents, disinfectants, sufficient quantity of menstrual hygiene products (pads/ cloths as preferred but essentially dry when put to use), etcetera to be included in the list of relief materials with an MHM perspective in post- flood situation.
9. **Ensure that there are schools and make Schools MHM Friendly:** Where there are no schools, ensure that in such remote and impoverished areas, schools are established within vicinity and reach as per the population demographics and requirements of adolescents. This will ensure a relevant focus on the girl child as well. Nevertheless, capacitation of young girls towards MHM and educational continuity can happen only if schools in both the districts are equipped with proper facilities. Educating children entering puberty is a prime need that EAMW firmly points out in all villages. Growing girls need to have a sense of composite physical and reproductive know-how of their body and well-being, as women in Assam observe. If menstruation is not given a proper introduction and discursive/interactive space in an adolescents' world view and life, they go through feelings of isolation, stress, embarrassment, and confusion over the issue. Making schools period -safe, in terms of knowledge and skill proliferation, sanitation and care in order to ensure continuity in education as well as proper MHM is the foremost demand from Assam.
10. **WASH in Schools and Community**: Girls should be provided with separate toilets equipped with running water tap connections.

11. **Micro- Credit facilities through SHGs**: Provide credit facilities to EAMW through Assam State Rural Livelihood Mission (ASRLM) and other government supported credit schemes that could enhance the earning capacities whereby menstruating women can become active decision makers in self-care.

LONG TERM

Assam MHM Committee: A State level Menstrual Health and Wellbeing Committee be initiated to integrate remote places, mountainous regions etc. into the state and national ADP and MHM plans.

12. **MHM at District, Block, Gram Panchayat Level**: Information, education, and communication (IEC) for menstrual hygiene education and awareness that includes information around safe menstrual hygiene products; and menstrual waste management with safe disposal facilities.
13. **Alternative livelihood options for EAMW**: Build capacities and skills of women from poor, marginalised households through functionally effective SHGs for gainful self-employment under Assam State Rural Livelihood Mission (ASRLM).
14. **MHM at Family level:** Ensure sustainable water source along with source strengthening measures and provision of Functional Household Tap Connections (FHTCs) to all households under National Jal Jeevan Mission scheme. Consider disaster resilient WASH infrastructure for all weather access.
15. **Jal Jeevan Mission (JJM) for Institutions and MHM:** Institutional water supply under JJM scheme should have adequate running water in girl's toilets in schools. Iron removal water treatment systems to be constructed/ installed in the village water supply scheme.
16. **Make 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 where needed.
17. **Menstrual Waste Disposal:** More Research and Development (R&D) is essential to evolve an environment appropriate disposal mechanism of menstrual waste.

REFERENCES

Assam Disaster Management Authority (ASDMA), State Profile. Available From http://sdmassam.nic.in/state_profile.html [accessed 11 December 2022]

Brahma, Anu Rani. (2022) Women and Armed Conflict in Assam. *International Journal of Humanities and Social Science Invention (IJHSSI)*, (11)3 28-31. Available from https://www.ijhssi.org/papers/vol11(3)/Ser-2/D1103022830.pdf. [accessed 11 December 2022]

Baksa District Official Website (n.d.) District Profile. Retrieve. Last updated 14 February 2023. Available from https://baksa.assam.gov.in/frontimpotentdata/district-profile [accessed 15 February 2023]

Borah, P.K., Raj, S., Sharma, G.K. (2020). Role of Knowledge Management in Transformation of Aspirational Districts Programme – A Case Study of Health & Nutrition Sector in Baksa District of Assam. *Journal of Interdisciplinary Cycle Research*. (12)7. [accessed 5 January 2023]

Census 2011 Office of The Registrar General and Census Commissioner, Ministry of Home Affairs, Government of India. Available from https://www.census2011.co.in/census/district/141-baksa.html [accessed 1 January 2023]

Census 2011 Office of The Registrar General and Census Commissioner, Ministry of Home Affairs, Government of India. Available from https://www.census2011.co.in/census/district/159-kokrajhar.html [accessed 2 January 2023]

Deen, Sahab., Debbarma, Atul. (2020) Flood Disaster Management in Assam. 10. 105-109. . Available from https://www.researchgate.net/publication/347999448_Flood_Disaster_Management_in_Assam. [accessed 11 December 2022]

George et al Enarson, Elaine Enarson and Betty Hearn 1998. Morrow. Westport, CT: Praeger.George, Sudhir Jacob. (1994) The Bodo Movement in Assam: Unrest to Accord. *Asian Survey*, (34)10 878-892 [accessed 11 December 2022]

Goyari, Sanchuma., Mushahary, Bijuta. (2020) An Analysis of Deforestation in Kokrajhar District of Assam using Remote Sensing Technique. *International Journal of Research, Culture, Society*, (4)1 157-161. Available from https://ijrcs.org/wp-content/uploads/IJRCS202001031.pdf [accessed 20 January 2023]

Government of Assam (2023) *Assam State Portal.* Available from https://assam.gov.in/about-us/391#:~:text=About%20Assam,-Assam%20is%20situated&text=Assam%20covers%20an%20area%20of,West%20Bengal%20to%20the%20west. [accessed 20 January 2023]

Hussain, Monirul.(1987) Tribal Movement for Autonomous State in Assam, *Economic & Political Weekly*, (22)32. [accessed 11 December 2022]

Hazarika, Bonti. Boruah, Deepika. (2020) Rights of Marginalised and Role of State: A Study on Tea Garden Labourer in Assam: *Journal of Critical Reviews,* 7(4) 2151-2152. [accessed 10 January 2023]

International Institute for Population Sciences (IIPS) and ICF. 2020. National Family Health Survey (NFHS)-5, State and District Factsheets, Assam. Mumbai: IIPS. 9 & 135. Available from http://rchiips.org/nfhs/NFHS-5_FCTS/COMPENDIUM/Assam.pdf [accessed 12 January 2023]

Indian Brand Equity Foundation (IBEF), Ministry of Commerce and Industry, Government of India (2023) *About Assam: Tourism, Industries in Assam, Agriculture and Economy*. New Delhi. Available from https://www.ibef.org/states/assam [accessed 20 January 2023]

Niti Aayog, Government of India (2018) *DEEP DIVE Insights from Champions of Change The Aspirational District Dashboard.* Available from https://smartnet.niua.org/sites/default/files/resources/firstdeltaranking-of-aspirational-districts.pdf [accessed 08 January 2023]

Sarmah, Satyendra Kumar. (2014) Script Movement Among the Bodos of Assam, *Proceedings of the Indian History Congress, 2014*, Vol.75 1335-1340. [accessed 11 December 2022]

ANNEXURE I

Criteria/ Reason for Selection of villages

Sr. No	Block/TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/hamlet/ ward	Total Population (refer JJM/ SBM data)	Total Households	Prevailing social issues/ issues of inclusion/ etc.
Baksa District					
1	Dhamdhama	Uttarkuchi	1589	308	Drinking water crisis
2	Dhamdhama	Pakhamara	1319	252	High rate of out of school Children (OoSC) and lack of access to education for girls especially. High concentration of Fe in ground water
3	Baska	Nikasi	2510	485	Drinking water crisis. Poor communication
4	Barama	Kaljhar	2867	593	High rate of unemployment. Inactive Self-Help Groups (SHGs)

Sr. No	Block/TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/hamlet/ ward	Total Population (refer JJM/ SBM data)	Total Households	Prevailing social issues/ issues of inclusion/ etc.
5	Baska	Doomni	6855	1413	Low transition rate, lack of awareness on need of education. Alcoholism
Kokrajhar District					
1	Kachugaon	New Raikungbar	204	57	Health, livelihood, nutrition, education, WASH etc.
2	Kokrajhar	New Bashbari	342	83	Accessibility of health and education facilities, transportation, livelihood, nutrition, hygiene
3	Dotma	No.3 Sonapur	292	77	Accessibility to health and educational facilities, transportation, WASH, gender, child marriage etc.
4	Kokrajhar	Lungsung Lakhigaon	162	40	Access to education, health facility, hotspot of TB, Transportation, livelihood, WASH, trafficking, child marriage etc.
5	Kokrajhar	Forest Colony	171	43	Child marriage, livelihood, poverty, health, nutrition, WASH etc.

ANNEXURE II

Important Women-Centric Schemes in Assam

- *Assam Affordable Nutrition & Nourishment Assistance Yojana (ANNA Scheme)*: This scheme was started in March 2019 by the Chief Minister Shri Sarbanad Sonowal (BJP) with a budget of 489 crore annually under the Ministry of Food, Civil Supplies, and Consumer Affair, Government of Assam. The aim is to provide rice at just Rs. 1 per Kg. ANNA yojana in Assam would serve the basic purpose that all poor citizens particularly children and women have nutritious meals every day. Around 53 lakh households in Assam will benefit from this scheme.
- *Gyan Deepika Scheme:* This scheme was started in February 2019 by the Chief Minister Shri Sarbanad Sonowal (BJP). Under this scheme students are going to get more benefits like 50,000 INR subsidy on educational loans, free uniforms for Class 9th, 10th students, free Textbooks, E -battery bikes for Girls.
- *Indira Miri Sarbajanin Bidha Pension Achoni:* This scheme was started in 2019 by the Chief Minister Shri Sarbanand Sonowal (BJP) under the Ministry of Panchayat and Rural Development, Government of Assam. Under this scheme, one-time financial assistance will be offered to the grieving families, where the eligible widows will be provided with a lump sum amount of 25,000 INR as immediate family assistance.
- *Wage Compensation Scheme for Pregnant Women in Tea Gardens* Scheme: This scheme was started in October 2018 by the Chief Minister Shri Sarbanand Sonowal (BJP) under the Ministry of Health, and Family Welfare, Government of Assam. The aim of this scheme is that each pregnant woman in tea

gardens will get a sum of 12,000 INR so that she can take better care of herself and her unborn baby without compromising the livelihood of her family.

- *Assam Arogya Nidhi:* This scheme was started in 2013 by Chief Minister Shri Tarun Gogoi (INC) under the Ministry of Health, and Family Welfare, Government of Assam. The scheme is to provide financial assistance up to 1,50,000 INR to BPL families and families having a monthly income of less than 10,000 INR (Rupees Ten Thousand) for general and specialised treatment of (i) life threatening diseases; (ii) of injuries caused by natural and manmade disasters, such as industrial/farm/road/rail accidents, bomb blasts etc. Life threatening diseases include heart diseases and Heart Surgery, Cancer, Kidney, and Urinary diseases, Orthopaedic, Thalassemia, Bone marrow Transplant, AIDS, and chronic Mental Illness with Surgical Treatment.
- *Comprehensive Abortion Care:* This scheme was started in 2010 by Chief Minister Shri Tarun Gogoi (INC) under the Ministry of Health, and Family Welfare, Government of Assam. The scheme is to understand each woman's particular social circumstances and individual needs and tailor her care accordingly. The scheme aims at addressing the needs of young women and also, reduces the number of unintended pregnancies and abortions, and identify and serve women with their sexual or reproductive health needs.
- *Weekly Iron Folic Acid Supplementation scheme (WIFS):* This is a central government scheme adopted by the Government of Assam under the Ministry of Health, and Family Welfare, Government of Assam, to institute a school and Anganwadi based weekly IFA supplementation (WIFS) programme for control of anemia in adolescent boys and girls, age between 10 to 19 years.

A RESEARCH REPORT FROM

BIHAR







PART 1 INTRODUCTION AND METHODOLOGY

Our study was conducted in the districts of Katihar and Khagaria. These districts falling under Niti Ayog's Aspirational Districts Programme (ADP)[1] have a scarcity of school and higher education facilities.

Both the districts share the commonality of socio-economic vulnerabilities such as poverty, relatively high school drop-out rates, illiteracy and with a large number of marginalized communities living in regions that experience floods and inundation each year. In both the districts the areas under research were remote and interior tribal and Dalit villages/ hamlets.

For completing our research data collection and analysis during April 2022- Feb 2023, ten villages of Katihar and Khagaria districts were selected for field research and surveys. Following a participatory and mixed-methods approach, information was sought and processed on the local situation on Menstrual Hygiene Management (MHM), Water Sanitation and Hygiene (WASH), education, health, livelihood, income and availability of support systems to women in the selected districts. Though both districts are doing well on many parameters under the ADP such as education, literacy & infrastructure, our study indicates that the districts have much to achieve in terms of combating the silences on MHM and on the inter-sectoral perspectives and wellbeing of **'Elder and Ageing Menstruating Women' (EAMW)**[2] and of school going menstruating girls. As our interaction also included women as mothers, teachers, counsellors and caregivers of young girls within schools and families, we have also included an analysis on the barriers, enablers & menstrual wellbeing of young school-going girls, though our primary focus remained on barriers, enablers & silences on the wellbeing of **EAMW.**

We collected ethnographic data on actors, practices and discourses with an inter-sectoral and analytical perspective on MHM in the areas selected. Water, Sanitation and Hygiene (WASH), availability of community support systems, availability of schemes and education; as well as what are the felt needs of menstruating women form a vital part of this research. Data was collected through field-work, interviews, Focus Group Discussions (FGDs) and observations on MHM through women's participatory voices and opinions. 856 interviews were conducted (433 women in Katihar and 423 women in Khagaria) using the Menstrual Practice Questionnaires (MPQs) to collect data, covering populations ranging from Muslims and Desi-Palias to Mushars and Maha Dalits. Interviews and interactions took place in local language, dialects and Hindi, in whichever the women felt comfortable.

Finally our findings from primary data are examined and crystalized against the voices of key informants, and delineate the context- specific and community-specific areas of improvement ending with recommendations on the short term and mid-term enablers for combating the inter-sectoral hindrances in proper MHM.

BIHAR

Bihar located in eastern India, is surrounded by Nepal in the north, West Bengal in the east, Uttar Pradesh in the west, and Jharkhand in the south. It has a unique location advantage being close to the vast Eastern and North Indian markets, access to Kolkata and Haldia ports, and to raw materials and minerals from neighbouring states. It has witnessed strong per capita net state domestic product growth. At current prices, its per capita NSDP grew at a CAGR of 10.73% (in INR) between 2015-16 and 2020-21 (IBEF, 2023). It is one of the strongest agricultural states in the country, and the percentage population employed in agriculture is around 80%, much higher than national average. It is the fourth largest producer of vegetables and the eighth largest producer of fruits in India. Food processing, dairy, sugar,

[1] ADP aims to improve the socio-economic status of the citizens with the core principles of Convergence of Central & State Schemes, Collaboration among citizens and functionaries of Central & State Governments and district teams, and Competition among districts (Niti Aayog 2018).

[2] EAMW are the Elderly and Menstruating women beyond their school years and adolescence falling in the ages between 20-49.

manufacturing, and healthcare are some of the fast-growing industries in the state. The state has planned for the development of education and tourism, and also provides incentives for information technology and renewable energy projects (IBEF, 2023).

1.1 KATIHAR

Katihar became a separate district in 1973, and is a part of Mithila region. In 2011, Katihar had a population of 3,071,029 (males 1,600,430 and females 1,470,599, sex ratio 919 per 1000 male), with average literacy rate 52.24%, (male 59.36% and female 44.39%). The average national sex ratio in India is 940 (Census, 2011).

The district has severe water contamination with the source mainly hand pumps. The water of this district may be categorized as "hard water", and has lead concentration in the range of 0.112 mg/L to 4.91mg/l, fluoride and Fe3+ in the range of 0.004 - 0.012 and 0.40 - 1.27 mg/l respectively (Krishna, Singh & Mandal, 2009). The lead is responsible for kidney damage, neuro- problems, and mental retardation in children in the district and the low fluoride is responsible for a large number of dental caries. The very high value of iron is responsible for staining of teeth due to iron deposition on enamel, and of clothes and utensils. (Krishna, Singh & Mandal, 2009).

Ministry of Panchayati Raj in 2006 named Katihar as one of the country's 250 most backward districts, and is one of the 38 districts in Bihar receiving funds from the Backward Regions Grant Fund Programme (BRGF). It has also been included in the ADP of Government of India since 2018, to improve its socio-economic indicators. The District Administration of Katihar set up *Jeevika Yuva Paramarsh Sah Sansadhan Kendra* (JYPSSK) under ADP to support migrant workers. JYPSSK is a centre for employment and income-generating activities, focused on counseling the youth, and providing resources to support them (Niti Aayog, 2020). In various blocks, livelihood clusters and producer groups for cattle-rearing, bamboo crafts, jute crafts, protective masks, honey and mushroom production have been set up. Migrant workers' families have been provided loans to start activities like fishery, piggery, household dairy and agriculture-related works, and running shops (Niti Aayog, 2020).

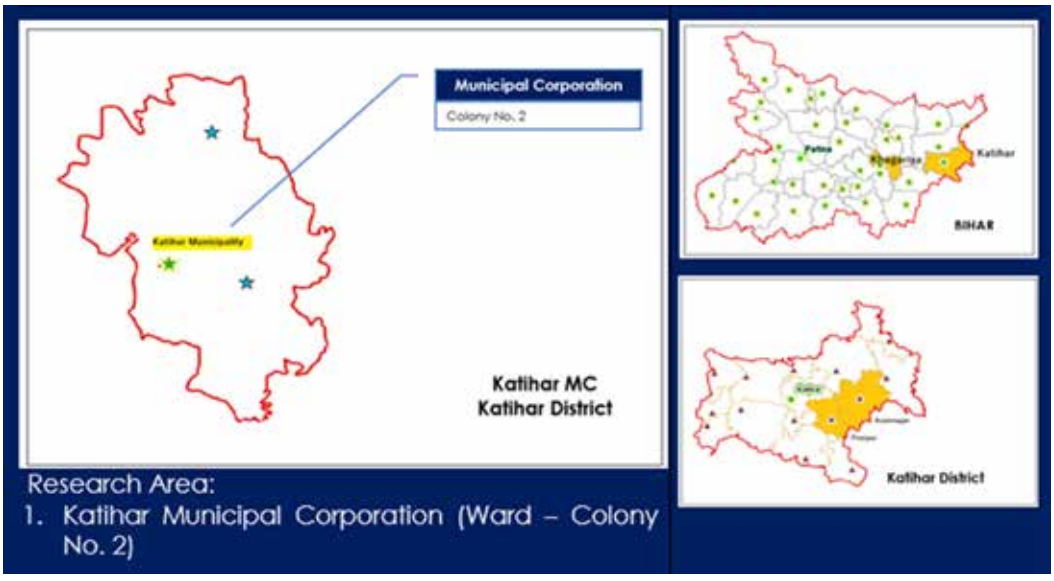
1.2 KHAGARIA

Khagaria district was a subdivision of Munger district, upgraded to a district on 10th May, 1981. In 2011, Khagaria had a population of 1,666,886 (males 883,786 and females 783,100, sex ratio 886 to 1000 males), with an average literacy rate of 57.92% (males 65.25% and females 49.56%). The average national sex ratio in India is 940 (Census, 2011).

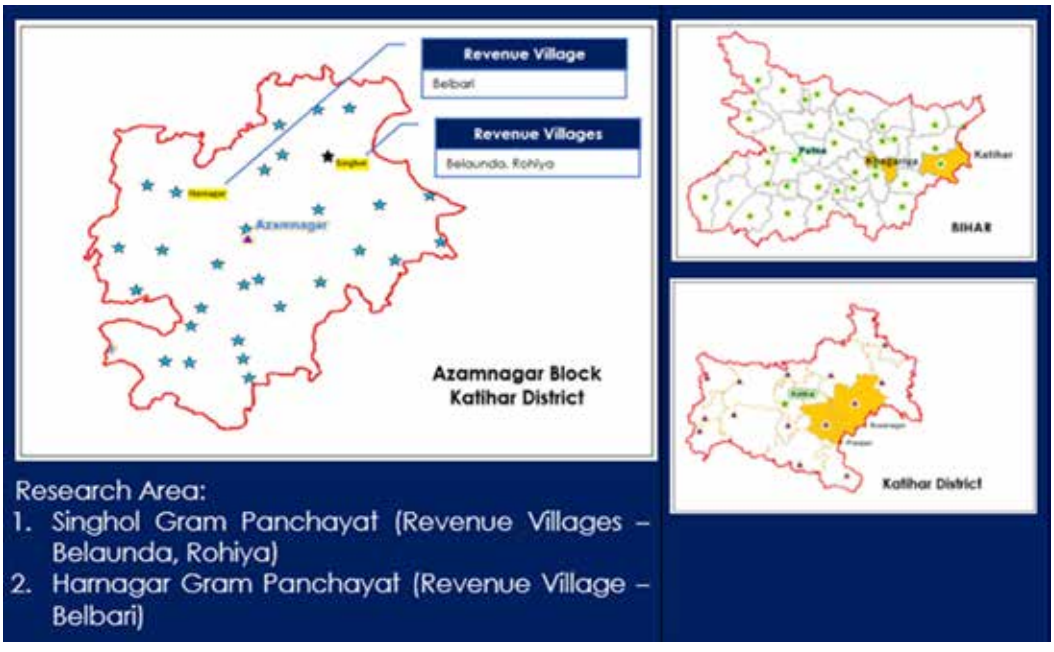
Recurrence of floods is an annual affair with five major rivers – Ganga, Gandak, Bagmati, Kamala and Koshi passing through the district. Recurrence of floods and water logging makes communication extremely difficult in rainy season and affects accessibility to health infrastructure. Under the Government of India (GOI)'s ADP, Khagaria is working on special elevated health centers for flood affected areas (Kumar, 2022). On the development front, the district secured second rank in the country in the Niti Aayog's Delta ranking on various parameters. The district performs well in the field of health, nutrition, education, agriculture, irrigation, skill development and infrastructure (The Times of India, 2022).

1.3 LIST OF VILLAGES SELECTED

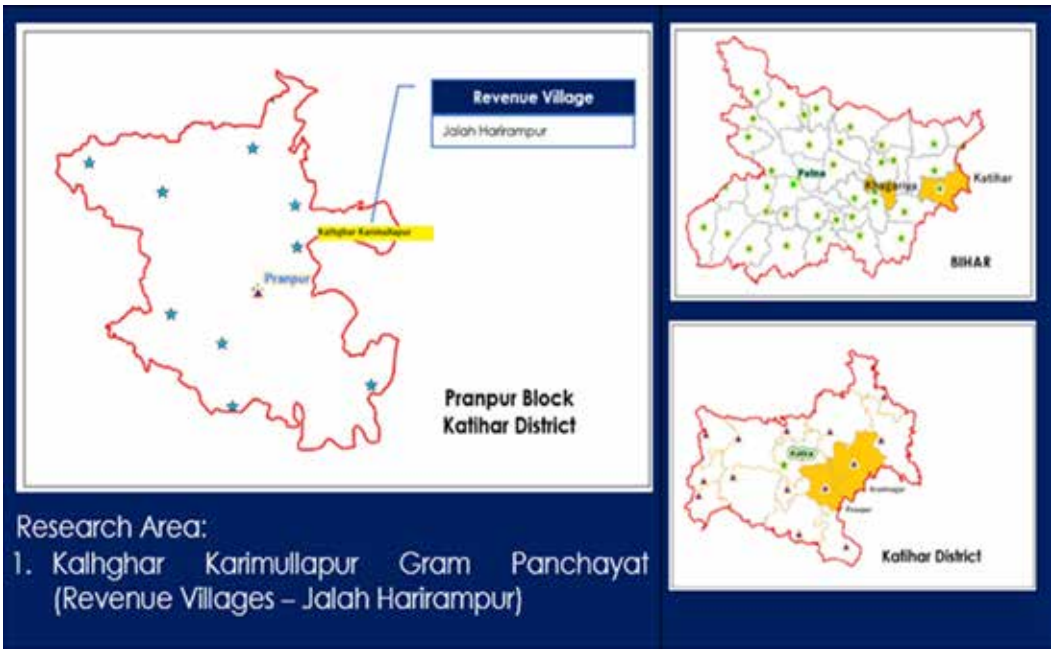
Five villages from each district were selected based on access to minority-focused villages, scarcity of safe drinking water, migration due to rainfed land, unskilled labourers, etc. In Katihar, three villages were selected from Azamnagar Block, one village from Pranpur Block and one ward in Katihar Municipal Corporation Colony No. 2. In Khagaria, four villages were selected from Mansi Block and One Village from Khagaria Block.



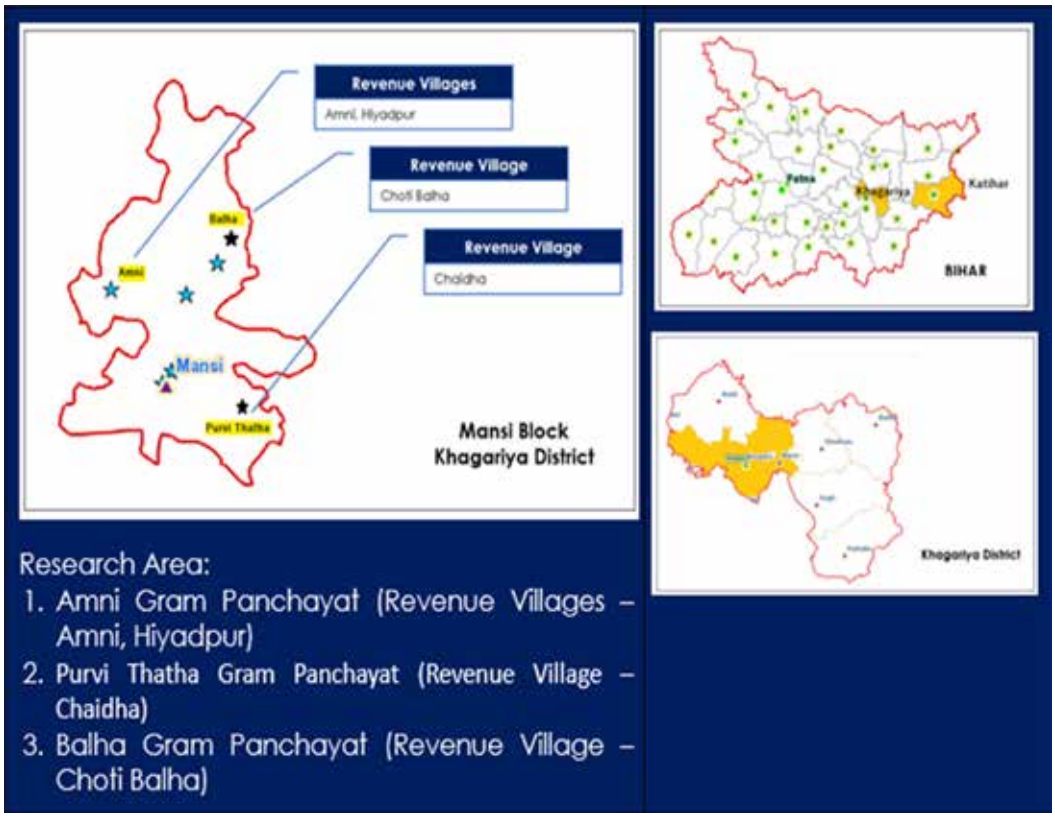
Research Area:
1. Katihar Municipal Corporation (Ward – Colony No. 2)

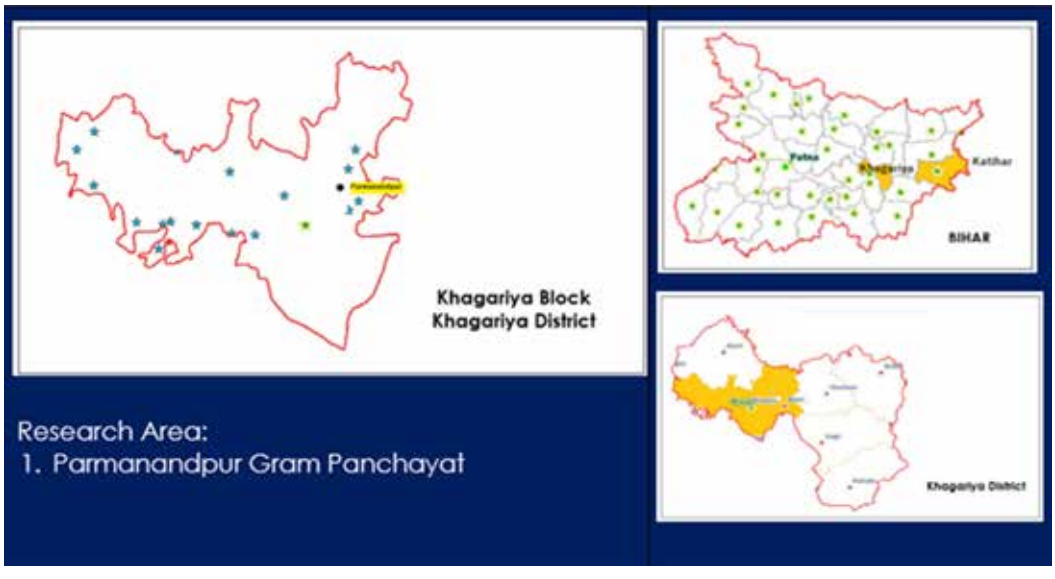


Research Area:
1. Singhol Gram Panchayat (Revenue Villages – Belaunda, Rohiya)
2. Harnagar Gram Panchayat (Revenue Village – Belbari)



Research Area:
1. Kalhghar Karimullapur Gram Panchayat (Revenue Villages – Jalah Harirampur)





PART 2 DATA TOOLS

2.1 RESEARCH TOOLS, METHODS AND THEMATIC FOCUS FOR DATA COLLECTION, CORRELATIONS AND COMMUNITY-BASED ANALYSES

Types of Interviews- Tools and Focus	Data Collection and Analysis- Methods and Themes	Bihar	
		Khagaria	Katihar
Tool 1 Menstrual Practice Questionnaires (MPQs)	Method 1 The MPQs were In-depth Interviews (IDIs) for- actor, discourse and practice- analyses	423	433

Tool 2 Menstrual Practice Needs Scale (MPNS)	Method 2 Measurement of perceptions and needs based on the last menstruation cycle	73	48
Tool 3 Key Informant Interviews (KIIs)	Method 3 Voices, Excerpts, Salient Findings and Observations	12	12
Themes: WASH, Education, and Health, Livelihood	Focus: Inter-Sectoral findings and conclusion and comparisons		

PART 3 FINDINGS FROM MPQs AND MPNs

3.1 ACTOR ANALYSIS

In this section, socio-economic profile as well as the current menstruation status of the actors is detailed.

3.1.1 DEMOGRAPHIC PROFILE OF THE RESPONDENTS

Demographic Profile	Katihar (in %)	Khagaria (in %)
Total Respondents	**433**	**423**
Peri-urban	10.4	2.8
Rural / Tribal	71.1	71.2
Urban	18.5	26.0
Mother Tongue		
Angika	0.0	99.5
Bengali	0.5	0.0
Hindi	46.4	0.0
Rajvanshi	6.2	0.0
Surjapuri	45.3	0.5
Urdu	1.6	0.0
Religion		
Hindu	81.5	99.8
Muslim	18.5	0.2
Caste/ Tribe type		
General	29.3	0.2
OBC- Other Backward Caste	64.2	4.3
SC- Scheduled Caste	4.2	33.8
ST- Scheduled Tribe	1.8	0.2
Demographic Profile	**Katihar (in %)**	**Khagaria (in %)**
MBC	0.0	11.3
BC	0.5	49.6
PVTG- Particularly Vulnerable Tribal Group	0.0	0.5

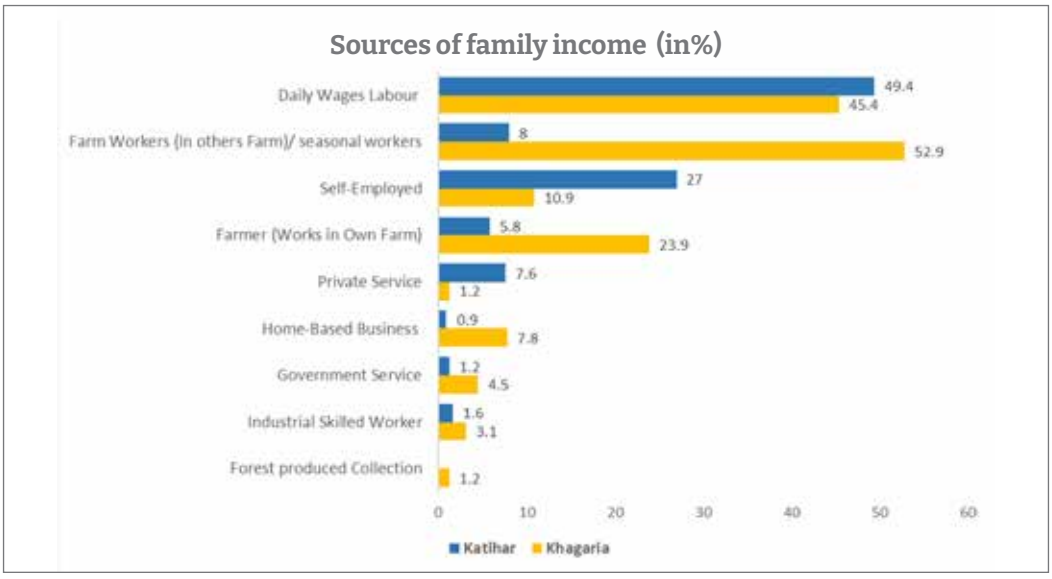
Marital Status		
Never married	3.5	0.7
Married	93.3	95.3
Widowed	3.0	3.8
Separated	0.2	0.0
Divorced	0.0	0.2

- **Community:** In Katihar almost two third respondents i.e. 64.2% were OBCs followed by General caste 29.3% and 6.5% were SCs, STs and BCs. In Khagaria, 49.6% were BC followed by SCs (33.8%) and OBC/ MBCs (15.6%) and few interviewees from General, ST and PVTGs. Specific Caste categories in both districts were as follows: General (Baniya), OBCs (Dhobi, Kahar, Koiri, Kumhar, Nhai, Thakur, Vaishya, Yadav, Kurmi), BCs (Dhanuk, Halwai, Julaha, Kalvar, Kanu, Kosare, Kushbah, Pasi, Tiyar), SCs (Badhai, Dusadh, Gurar, Musahar, Rajvanshi), and ST/ PVTGs (Gouri, Kahar, Santhal).
- **Marital status:** 94.3% of our respondents were married. The average age at marriage in Katihar was 19 years whereas in Katihar it was 17 years.
- **Children and Family Size:** Average number of children was three and the average family size was five persons.

3.1.2 AVERAGE INCOME

- **Family income:** In Bihar, median income in Katihar was in the range of 100000 INR- 150000 INR whereas in Khagaria it was found to be in the range of 75000 INR- 100000 INR. Half of the families earn from regular income sources. 53.1% of families from Katihar and 26.7% families from Khagaria derived their main income as daily wagers and unskilled workers
- **Earning women:** One-fourth of our women respondents i.e., 26.5% from Khagaria and only eight women (1.8%) from Katihar work outside and earn money, out of those six were earning in the range of 50000 INR-100000 INR per year. From Khagaria, out of 112 earning women, almost two third of women (64.3%) were earning only up to 10000 INR yearly. Whereas merely 10.7% of respondents were earning above 50000 INR per year.

3.1.3 SOURCES OF FAMILY INCOME

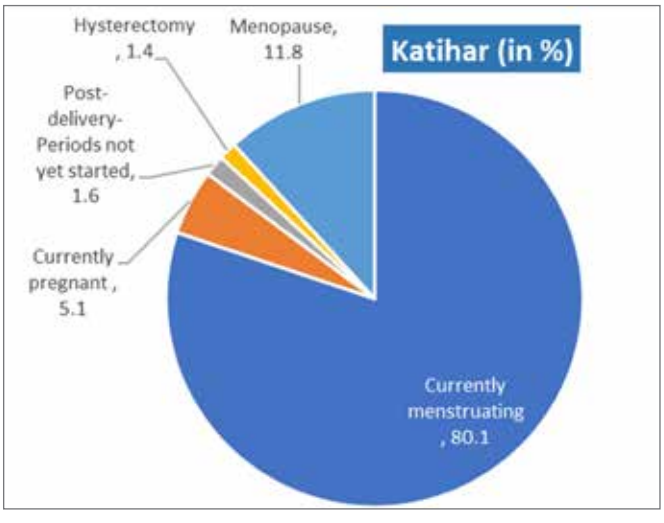


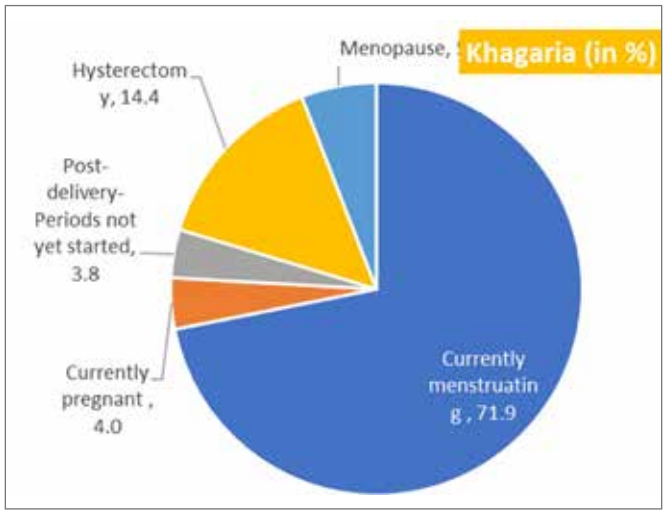
INCOME TRENDS:

- **Income Disparity in Districts:** Due to the flood-prone and/or rehabilitated areas in both districts, coupled with overall small size of farms, around half of the total families surveyed were dependent on wage-labour work.
- **Sources of Income in Katihar:** In Katihar families of 406 women (n= 433) surveyed, relied mostly on daily wage labour work. Seasonal work was confirmed by 138 families as the next major source of income followed by farming as stated by 25 of our respondents. However, 200 women also confirmed that these income sources were complemented by self-employment as a secondary source of income for their families.
- **Sources of Income in Khagaria:** Main source of income for families of 101 women (n= 423) surveyed in Khagaria was farming on their own land. In order to complement their main source of income, some families also relied on incidental labour-work (that could be agricultural or daily wages related) just as for some this kind of work constitute their main and only source of income as confirmed by 289 respondents. Seasonal work was stated by another 127 as a main or supportive source of income. Apart from this, 79 respondents informed that they also earn through home -based business.
- **Traditional Knowledge and Skills**: Out of total 856 respondents in Bihar, 198 respondents possessed traditional skills. Out of these 198 only, 38 respondents earn from their traditional skill-sets and knowledge. In Katihar, of the total 433 women surveyed, only 15 possessed traditional skills but none of them earned from the same. 183 women out of 423 from Khagaria reported that they possess traditional skills. Out of these, merely 38 earn from their skills.

3.1.4 MENSTRUATION STATUS

- **Total EAMW**: 86.8% (376 women) from Katihar and 79.7% (337 women) from Khagaria were in their active menstruating years.
- **Age at Menarche:** Average age of menarche was 13, whereas the average age of attaining menopause was 45 years.
- **Number of Hysterectomies**: More hysterectomies were found to have been done in Khagaria than in Katihar, with the average age at hysterectomy being around 33 years.





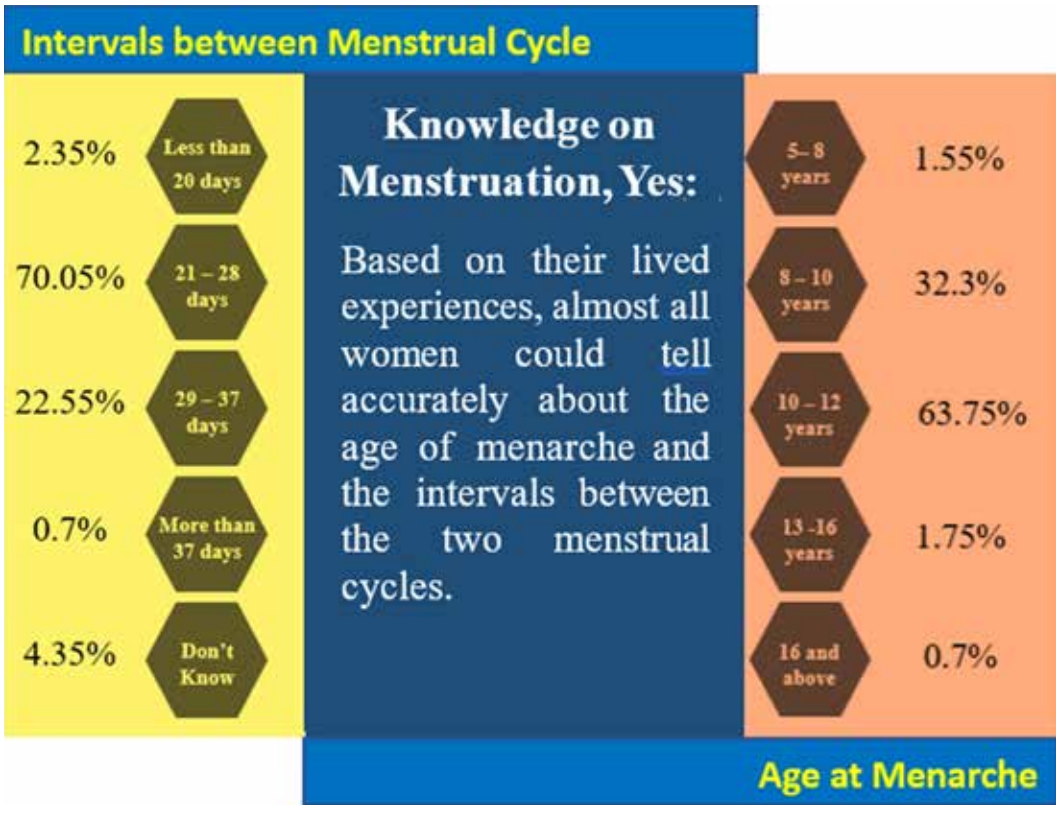
3.2 DISCOURSE ANALYSIS

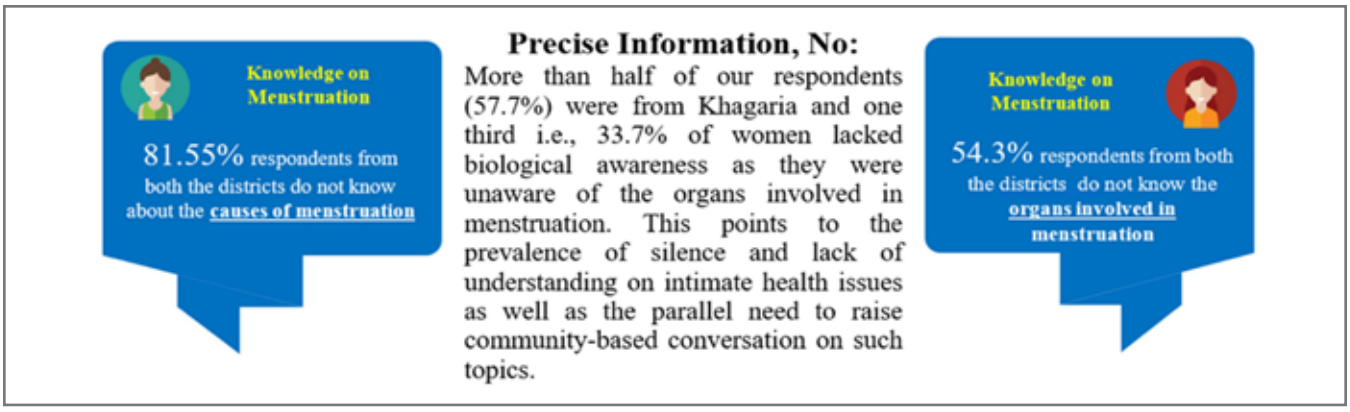
Our findings relate to levels of knowledge that respondents profess on the cause of menstruation, organs involved, and analysis of their discourses. Information from the In-depth interviews (IDI) were used to understand how much general and precise comprehension women have on menstruation as a monthly body

process. Further, we present our findings on the extent of communication or silence around the theme, with whom and how much they discussed, the issues experienced and their general observations on MHM. We also present data on educational backgrounds of women, how the women position themselves on medical care options and facilities available/ not available and their awareness on use and disposal of menstrual absorbents, health risks as well as common disorders and symptoms they experience during menstruation and hysterectomy.

3.2.1 KNOWLEDGE ON MENSTRUATION

Knowledge About Menstruation	Katihar (in %)	Khagaria (in %)
Total Respondents	**433**	**423**
Causes of Menstruation		
Hormonal change	12.0	24.8
Disease	0.0	2.8
Do not know	88.0	71.6
Natural process (naisargik/ prakrutik/ bhagwan ki den)	0.0	0.7
Organs Involved in Menstruation		
Uterus/ Birth canal	33.7	57.7
Abdomen/ Bladder	44.6	5.2
Do not know/ not answered	21.7	37.1





- **Basic Understanding: Four out of every five women (i.e. 684 out of 856 women) could not talk about the causes of menstruation. However, 92.6% of women could talk about menarche and the intervals between two menstrual cycles based on their lived experiences.**
- **Biological information: 33.7% of women from Katihar (n=433) and more than half of our respondents (57.7%) from Khagaria (n=423) lacked biological awareness as they were** unaware of the organs involved in menstruation. This points to the prevalence of silence and lack of understanding on intimate health issues as well as the parallel need to raise community-based conversations on such topics.

Knowledge gaps need to be bridged through government initiatives alongwith information exchange programmes and community dialogues with active menstruators in the age group of 19/ 20 years to 49 years. Frontline health workers at local level can play an active role.

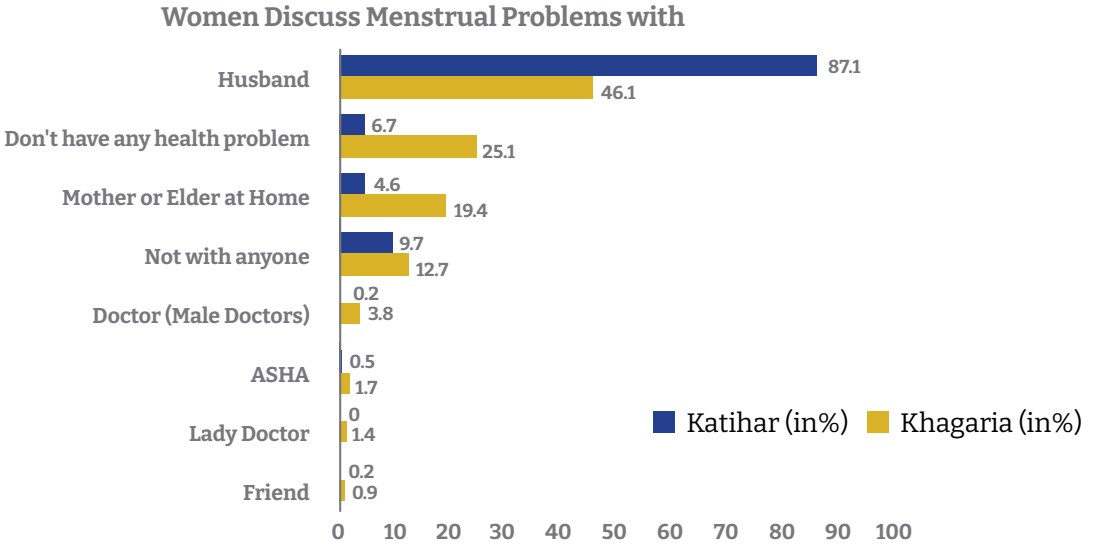
3.2.2 SOURCE OF INFORMATION ON MENSTRUATION

For young girls the top sources of information on menstruation emerged as follows:

- Top sources of information for young girls about menstruation at the time of menarche reported from both districts were parents, grandmother, sister, or sister-in-law.

Women like to discuss their menstrual problems with the following:

- **Friends:** Neighbours or friends were top sources with whom MHM related information and issues were discussed, as quoted by 89 women in Khagaria.
- **Frontline Health Workers (FHWs):** Only 29 women (6.9%) from Khagaria and very few, i.e. 3 women from Katihar, approached health support systems in the village regarding their problems on vaginal and menstrual health.

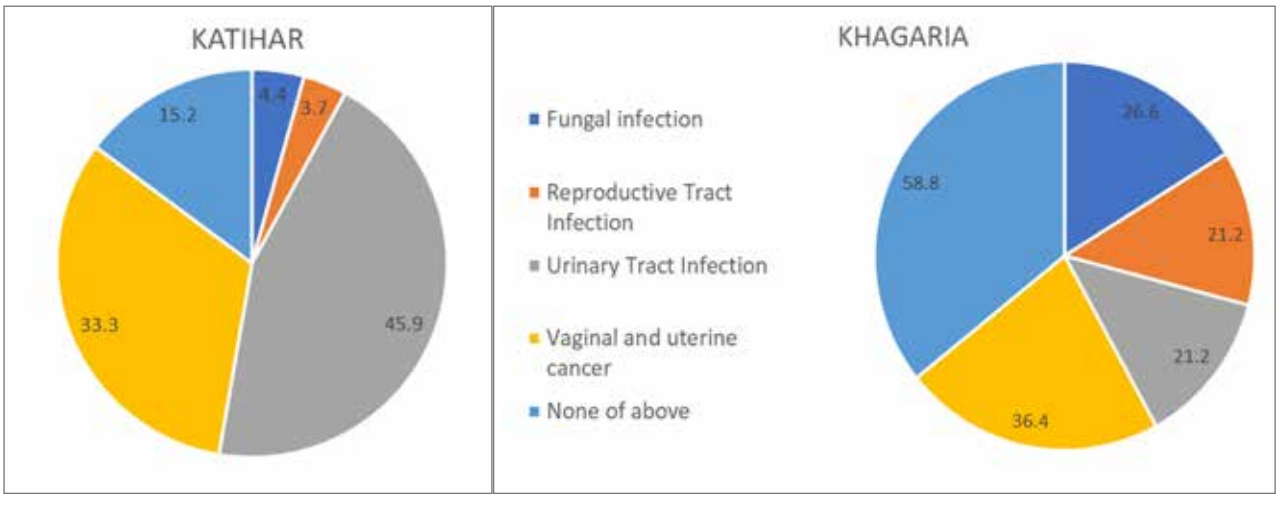


- **Spouses:** A critical finding that presents encouraging information on interpersonal relations was that 195 women from Khagaria and 377 from Katihar feel comfortable talking about menstrual problems with their husbands. If men can be oriented and stay alert and helpful on their wives' MHM issues, that would bring a positive health outcome for EAMW, besides combating the silence on it.
- **Nobody:** However, 5 of our respondents from Katihar and 46 from Khagaria either do not prefer to talk with any one and remain silent about their menstrual problems. 29 women from Katihar and 106 from Khagaria denied having any problems w.r.t MHM.

3.2.3 MENSTRUAL HEALTH, EDUCATION AND AWARENESS ON INFECTIONS

Apart from the use of different menstrual products, the study presents data on health problems which were experienced during menstruation. It was further verified whether they visit the doctor in case of any health issues or prefer to keep quiet. Adverse working conditions in or outside the home may lead to rashes, urinary tract infections (UTIs), and reproductive tract infections (RTIs) for many women, as indicated by our survey findings.

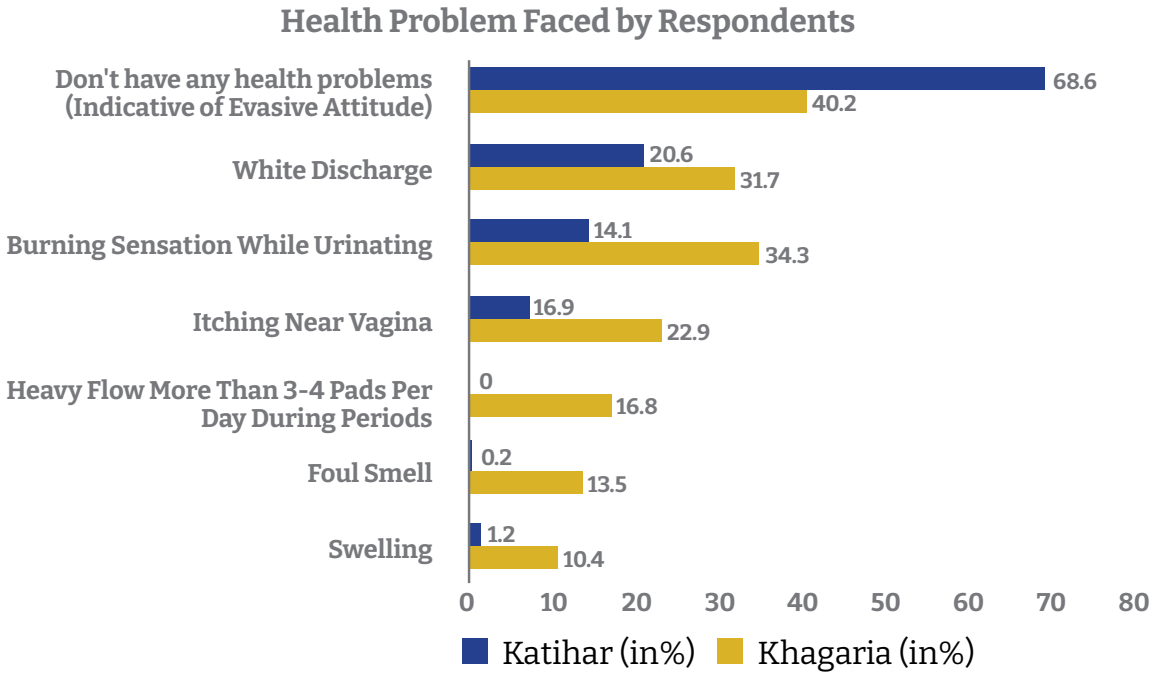
- **Widespread Ignorance**: When asked about the negative effects of poor menstrual hygiene, 15% of the women from Katihar (n=433) and almost half of the women (49.2%) from Khagaria (n=423) did not know.
- **Fungal Infections and UTIs:** However, when asked specific questions on topical infections, 14.4% (N=856) of the total women interviewed in both the districts, were aware that poor MHM could lead to fungal infections and some had also experienced these or recognised these as medical problems. Yet, in comparison to Khagaria where more than half of the women i.e., 58.8% (n=423) could not answer any query regarding compromised MHM and prevalence of infections, better responses were given by women from Katihar where 213 women (n=433) stated that poor menstrual hygiene leads to UTIs/ RTIs and another 150 stated that it leads to vaginal and uterine cancers.



- **Low knowledge on exact health risks:** Adverse health conditions while working in or outside home often lead to rashes, Urinary Tract Infections (UTIs) and Reproductive Tract Infections (RTIs). However, our findings indicate a lack of awareness on these risk factors. Not being able to understand or give answers on the relationship between MHM and rashes, infections and other risks, indicated ignorance per se.
- **No Schooling, Taboos and Communication Barriers:** However, given that speaking about periods itself is a taboo subject due to shyness/ hesitancies, therefore any generalization on awareness on MHM may be misleading. Community and area specific conclusions are a better way ahead. Around 26.2% women of both districts did not attend schools. 46% attended only up to secondary grade/ seventh standard. In other words, all these women lost the opportunity to be counseled or educated on MHM as part of school curriculum. EAMW participants in our study either were shy to speak or lacked the desire to know more about menstruation and thus effectively remained silent.

3.2.4 HEALTH SYMPTOMS DURING MENSTRUATION

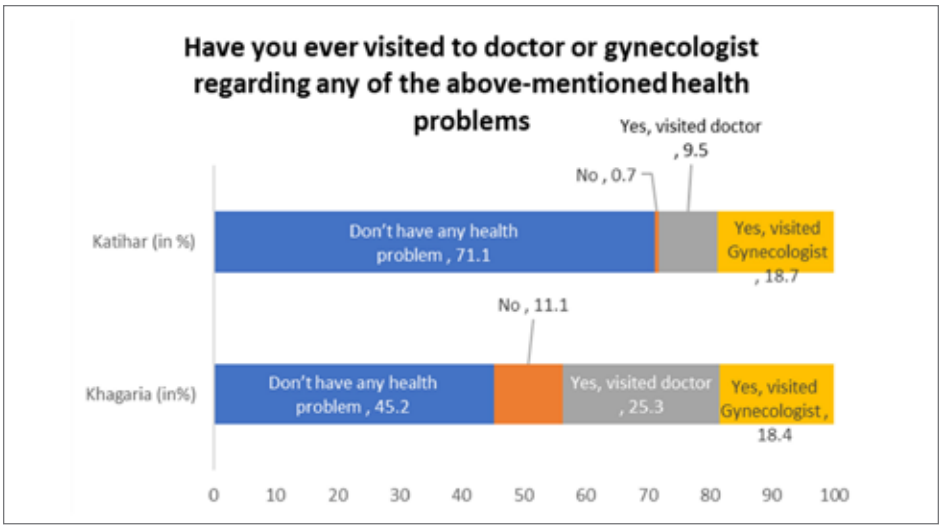
The actors reported the following symptoms and discomforts they suffered during menstruation:



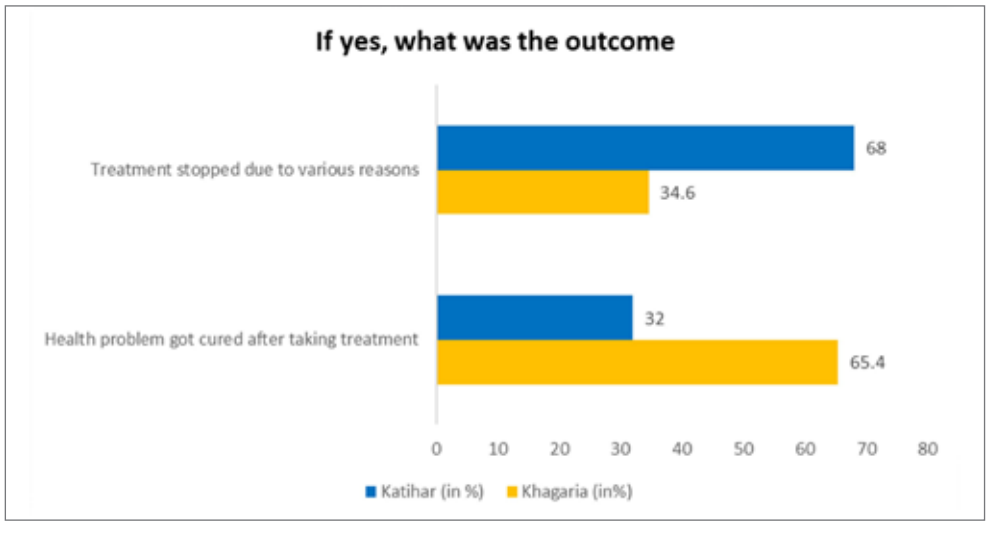
- **MHM, health and accessibility to health care**: Apart from the modes as well as patterns of awareness on MHM, the survey imparts light on the health problems undergone by participants during menstruation. For arriving at inter-sectoral findings on health management, women were asked if they visit a medical professional to resolve menstrual health issues and reasons if they do not.
- **Vaginal symptoms and attitude:** More than two thirds (68.6%) of the EAMW (n=376) from Katihar and 40.2% of respondents from Khagaria (n=337) reported that they did not have any health problems during menstruation. However, in the later part of the survey, white discharge, burning sensation while urinating, and itching near vagina emerged as the top three issues women faced due to poor vaginal hygiene. One third women reported seeking medical advice over menstrual health problems and half of them visited a doctor and got treated and cured.

Indeed, if health issues during menstruation are not resolved, and pushed to the peripheries or remain shrouded in silence, women have much to lose in social, economic and personal spheres. For combating health and hygiene related silences on periods among the EAMW, the government healthcare system must tune itself to hear their voices. In 'Excerpts and Voices', we bring community-based views and suggestions from women over this issue.

- **Consultations on MHM:** Out of a total of 856 women, 499 women (58.3%) from both districts reported that they did not have any health problems during menstruation. Out of the remaining women, 122 from Katihar (n=433) and 185 from Khagaria (n=423) reported that they went to a doctor in case they faced any kind of menstrual health problem.
- **Treatment:** Only 160 women out of the total 307 who took medical consultations in both the districts, got treated and cured. 121 women from Khagaria as compared to 31 in Katihar recovered after medical treatment. 42 women from both the districts reported that they were still under treatment for menstrual health related problems while 105 women in both Katihar and Khagaria had stopped their treatment owing to monetary barriers.

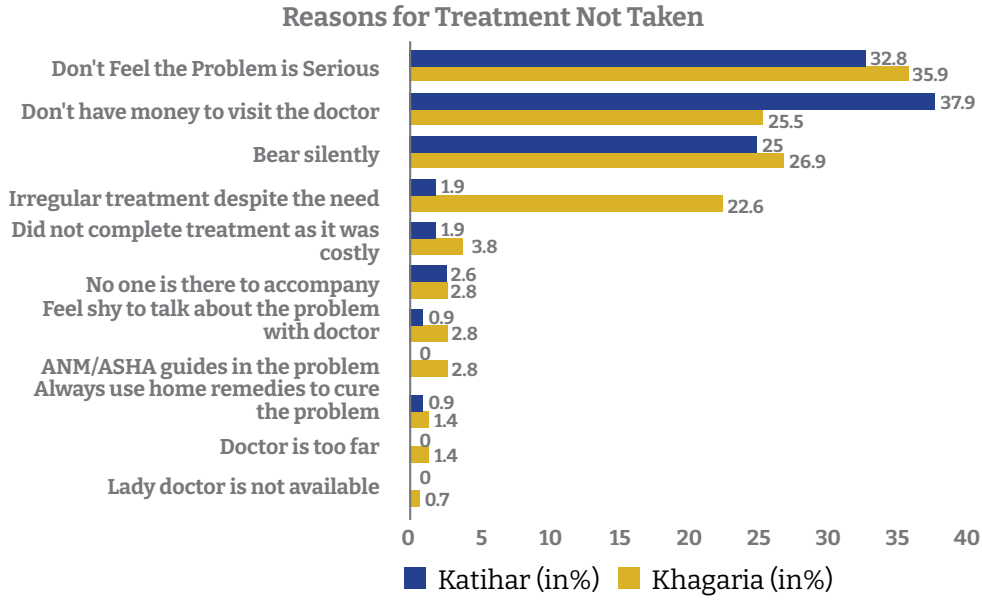


- **Neglect, hesitation and Silence:** EAMW in Katihar, despite having a better knowledge on menstruation tend to neglect health issues related to it more than the women in Khagaria, who are less informed on the issue. Nonetheless the barrier on knowledge and information exists in both the districts. This barrier is further exacerbated by the hesitation to speak on menstrual health and inability to seek medical advice on a regular basis, due to a number of reasons including poverty.
- **Medical Care, Access and Unaffordability:** Out of a total of 307 who started treatment on menstrual health related issues, 81 women (45 from Katihar and 36 from Khagaria) left their treatments incomplete due to various reasons, specially due to unaffordability. Another 24 women stopped the treatment completely because of accessibility. Rest of the 103 women, despite needing regular treatment, pursued it sporadically owing to its high cost.



Not even half of the women from these 2 districts (n=307) who needed treatment could reach a doctor for treatment and only half who reached could afford to complete the treatment. While some do not have access to healthcare, others stop the treatment due to monetary problems. Women who did not approach the doctor despite need, gave reasons such as 'do not feel the problem is serious', bear silently, feel shy to talk to male doctors where a lady doctor is not available nearby. When medical facilities are located faraway women refrain from accessing these as there is no one to accompany them, others use home remedies or rely on support from local health workers. 37.9 % women in Katihar and 25.5% from Khagaria indicated that the lack of money-in-hand was a huge deterrent to visit a doctor or pursue MHM.

3.2.5 REASONS FOR NON-TREATMENT



- **Ignorance: The main reason from 32.8% from Katihar and 35.9% from Khagaria, for not going to the doctor or gynecologist was they did not feel that the problem they face is serious.**
- **No money was the second major reason. This contributes to not talking or discussing the problem with anyone unless it becomes unbearable.**
- **No Lady doctor/ Gynaecologist: Lack of access to doctors is also a reason, specially if a lady doctor is not available nearby.**
- **Attitude (Shyness and Silence): Women feel shy to discuss the problems related to menstruation with a doctor. A total of 26% from both districts reported to bear silently and not avail treatment**.

3.2.6 HYSTERECTOMIES

In comparison to the other six states in our study, namely, Assam, Chhattisgarh, Haryana, Maharashtra, Odisha and Tamil Nadu, cases of hysterectomy at 7.8% of total respondents in both districts from Bihar, were on the higher side. Out of 856 women surveyed in the two districts, 67 had opted for hysterectomy, with 60 receiving pre and post operative counselling. 18 out of these were at the average age of 33 years, which is a very young age for such a procedure.

- **Biological Causes:**Anomalies related to menstrual cycle such as weakness due to heavy bleeding (23), irregular periods (17) and frequent periods (13) were reported in combination with other severe causes as the main cause for removing the uterus. Abdominal pains during menstruation and cramps were reported by 39 women followed by white discharge (8), Severe Pelvic Inflammatory Diseases (PID) (3), and prolapse of the uterus (5).
- **Socio-economic Causes:** Out of 61 who had undergone hysterectomies from Khagaria, two women stated that they did not find the uterus as an important part of the body after having children, another two considered periods as a hurdle while working outside and five could not afford losing daily wages as loss of stamina during menstruation made them take frequent unpaid leaves.
- **Preference to Private Hospitals:** Only 6 women out of 433 from Katihar reported having undergone uterus removal surgeries, and out of these, only 1 was operated in a government hospital, the rest all in private hospitals. Likewise, only 14 out of 61 hysterectomies from Khagaria were done in government hospitals. Women preferred to choose private hospitals because of pre-operative counseling (28), and wanting to get rid of the problem immediately (22). 23 women reported that private hospitals were convenient to reach, good for treatment (22), and were recommended by experience of family members (16), and therefore better. They indicated that access to the nearest health care facility is preferred. Average expenditure for hysterectomies in Katihar was 53000 INR and in Khagaria was 40019 INR.

- **Health Post-Hysterectomy:** Out of 67 women who underwent hysterectomies, 64 faced weakness post hysterectomy, and 47 said they are not able to work like before. 35 women stated that they were unable to lift heavy objects post-operation. Anemia (26) and backache (4) were also reported. In general the women opined that their life had became complicated after the operation,

Our findings on hysterectomies in Khagaria and Katihar indicate many women suffer serious uterine health risks due to poor personal hygiene and menstrual health issues. Others face pressures due to their husband-wife teams *(Jodis)* working together, that push women towards uterus removal. This is akin to what happens in the case of the sugarcane farming in Maharashtra. Moreover, misconceptions about uterine relevance post-motherhood abound. Further, proper MHM requirements cannot be met in exploitative labour situations due to encumbrances placed by inadequate WASH facilities. Marginalized women face complex challenges regarding their reproductive wellbeing, often leading to hasty hysterectomies. **Good MHM of EAMW should become a vital part of labour laws, and community health awareness drives.**

3.3 PRACTICE ANALYSIS

Good menstruation practices start with the usage of clean menstrual absorbents alongwith maintenance of reproductive hygiene. We studied the practices in personal hygiene such as washing genitals and hands during menstruation as well as use and disposal of menstrual hygiene products. We also bring data on how personal and community-based beliefs, customs and taboos influence MHM and self-care. Our data from Katihar and Khagaria revealed that traditional methods of MHM are preferred over pads etc, by the majority of EAMW from vulnerable sections.

- **Cloth:** Out of the total of 713 EAMW interviewed from both districts, 56.7% use only cloth during menstruation, due to easy availability, affordability and durability (161 EAMW in Katihar and 240 EAMW in Khagaria). There was also lack of awareness about modern menstrual products. Lack of financial capacity to buy MHM materials make free availability of menstrual hygiene products a better option.
- **Other Material**: Reusable sanitary pads were used by 8 and re-useable cotton/ other menstrual absorbents by 4 respondents out of a total of 713 EAMW surveyed (this totals to only 1.7% EAMW using reusable sanitary pads or cotton).

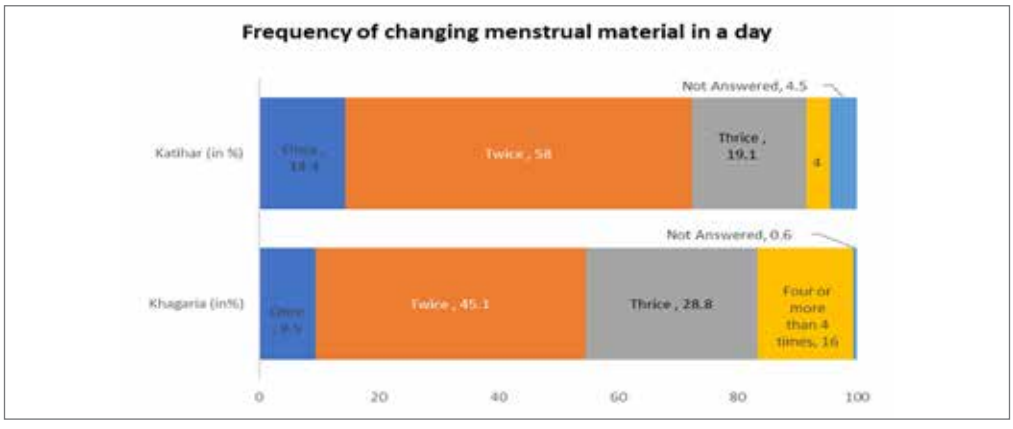
- **Combination of Pad and Cloth:** 401 (i.e. a majority) use cloth in combination with sanitary pad. The reasons behind it were mainly that cloth was more durable and easily available than pads, and was home-based and re-useable. Affordability was also the main reason for preferring cloth over pads in Katihar (reported by 63.8% of women). In both the districts, women have also stated that they need a supply of clean, traditional absorbents such as cloth during floods as even these home-based materials become difficult to get when regions become submerged.

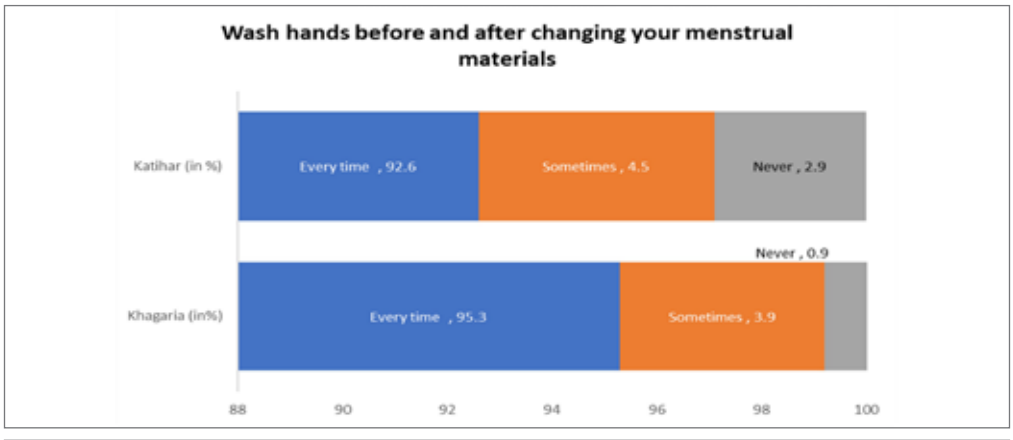
Choice of menstrual absorbents depends not only on attitudes and preferences, but also on the level of information and orientation that societies have on handling MHM. Culture, poverty, disasters as well as decision making all play a role in deciding how a woman opts to deal with MHM. Sanitary pads, for instance, were used by 232 EAMW from Khagaria and 130 from Katihar, but pads were used in combination with cloth as 75.6% from the total EAMW felt that cloth is easy to use, readily available, affordable and durable, making it a favorable choice.

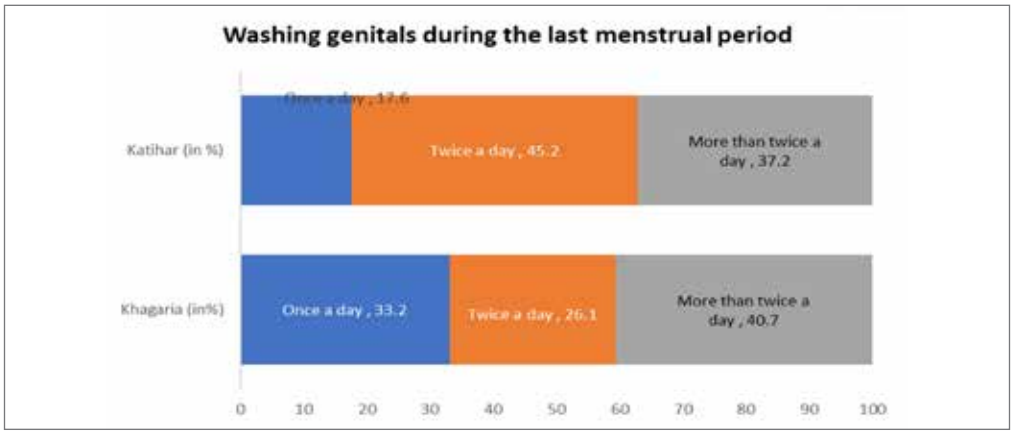
3.3.1 SPENDING CAPACITY ON MENSTRUAL HYGIENE PRODUCTS

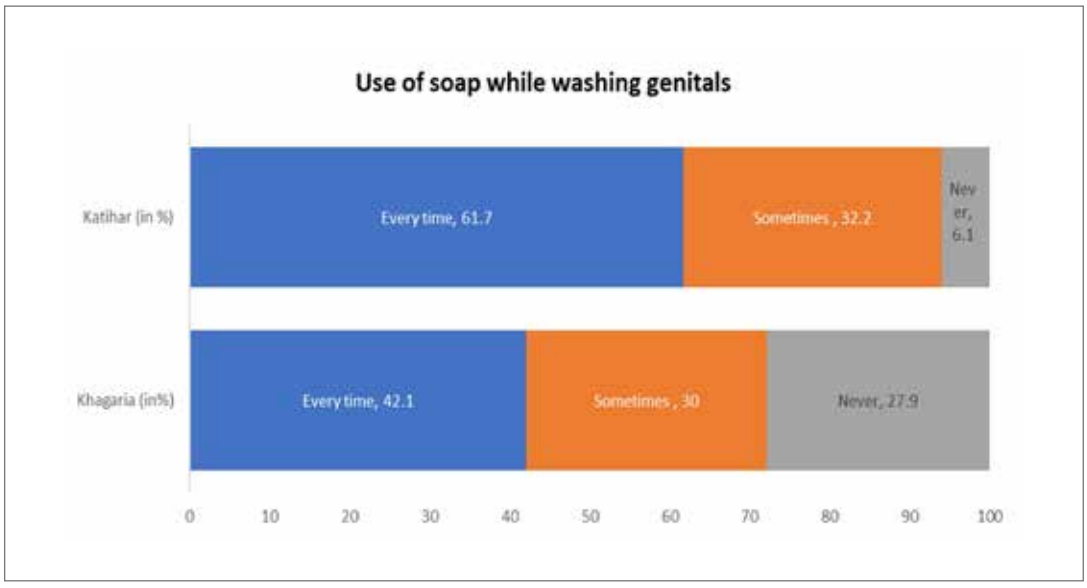
- 232 of women from Khagaria reported spending up to 100 Rupees on menstrual products whereas 130 of women from Katihar reported spending between 51-100 Rupees. Women in Katihar spend less on menstrual hygiene material and they use cloth in large numbers or a combination of pads and cloth to save money and make do with available resources.

3.3.2 PERSONAL HYGIENE PRACTICES AND WASH DURING LAST MENSTRUAL CYCLE





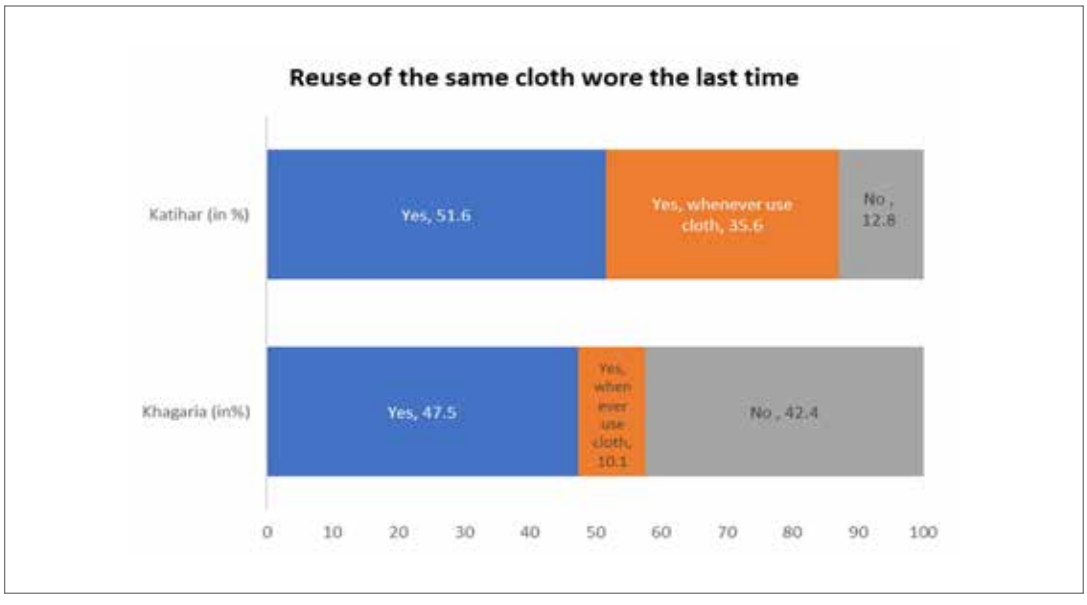


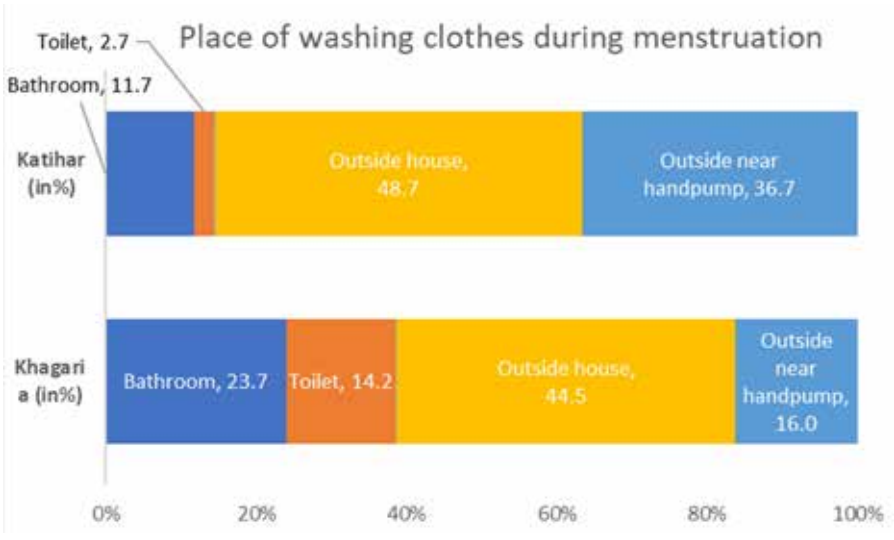


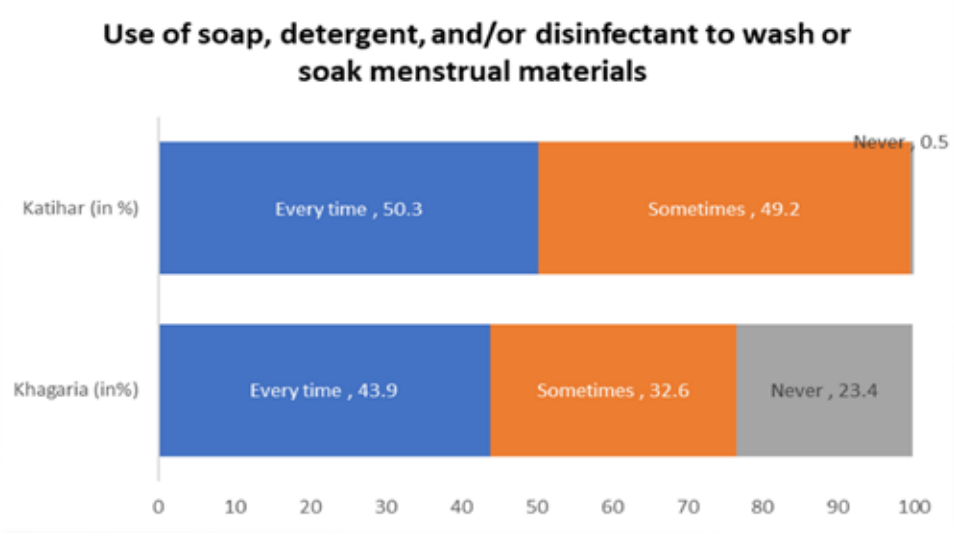
- **Frequency:** From both districts, around 85.7% out of 713 EAMW change menstrual material twice or thrice a day.
- **Washing Hands:** 93.8% EAMW from both districts wash their hands every time they use or change menstrual material. Hygiene practices were found to be equally prevalent in both districts.
- **Washing genitals during the last Menstrual Period:** 75% EAMW surveyed in both the districts washed their genitals twice a day during menstruation and all of them used soap while washing genitals every time.

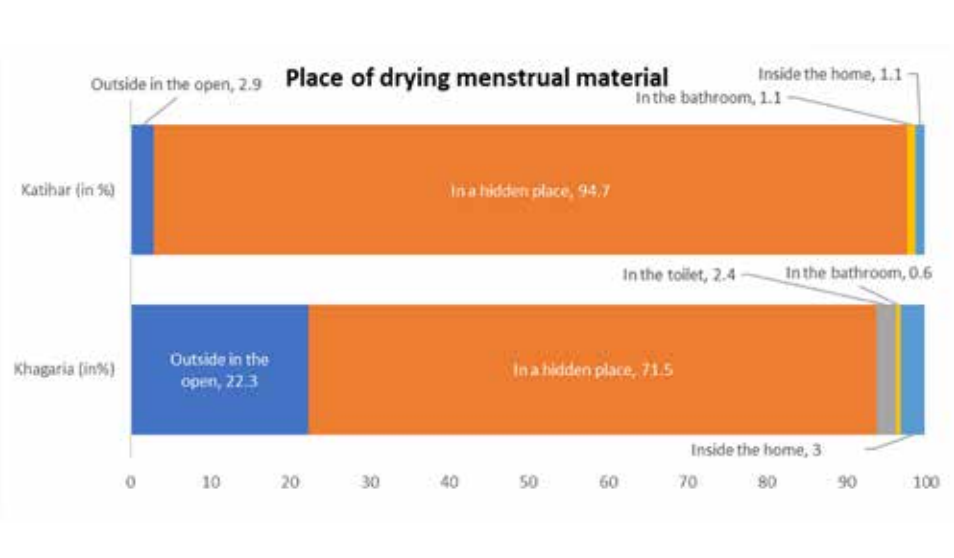
Our data indicates adequate awareness towards MHM with WASH.

3.3.3 MENSTRUAL HYGIENE PRACTICES




Place of washing clothes during menstruation
Toilet, 2.7
Bathroom, 11.7
Katihar (in%)
Outside house, 48.7
Outside near handpump, 36.7
Khagaria (in%)
Bathroom, 23.7
Toilet, 14.2
Outside house, 44.5
Outside near handpump, 16.0
0%
20%
40%
60%
80%
100%


Use of soap, detergent, and/or disinfectant to wash or soak menstrual materials
Katihar (in %)
Every time , 50.3
Sometimes , 49.2
Never , 0.5
Khagaria (in%)
Every time , 43.9
Sometimes , 32.6
Never , 23.4
0
10
20
30
40
50
60
70
80
90
100


Place of drying menstrual material
Outside in the open, 2.9
Inside the home, 1.1
In the bathroom, 1.1
Katihar (in %)
In a hidden place, 94.7
In the toilet, 2.4
In the bathroom, 0.6
Khagaria (in%)
Outside in the open, 22.3
In a hidden place, 71.5
Inside the home, 3
0
10
20
30
40
50
60
70
80
90
100

Safe hygiene practices consist of washing and timely changing menstrual absorbents during the day, as well as their proper disposal. Personal hygiene also depends on keeping genitals clean, and washing hands before and after changing the menstrual absorbent. Our survey assessed the practices followed covering hygiene during menstruation.

A SUMMARY OF PERSONAL AND MENSTRUAL HYGIENE PRACTICES:

Frequency of Changing MHM Product: From both districts, around 75.6% out of 713 EAMW responded that they change menstrual material 2-3 times daily.

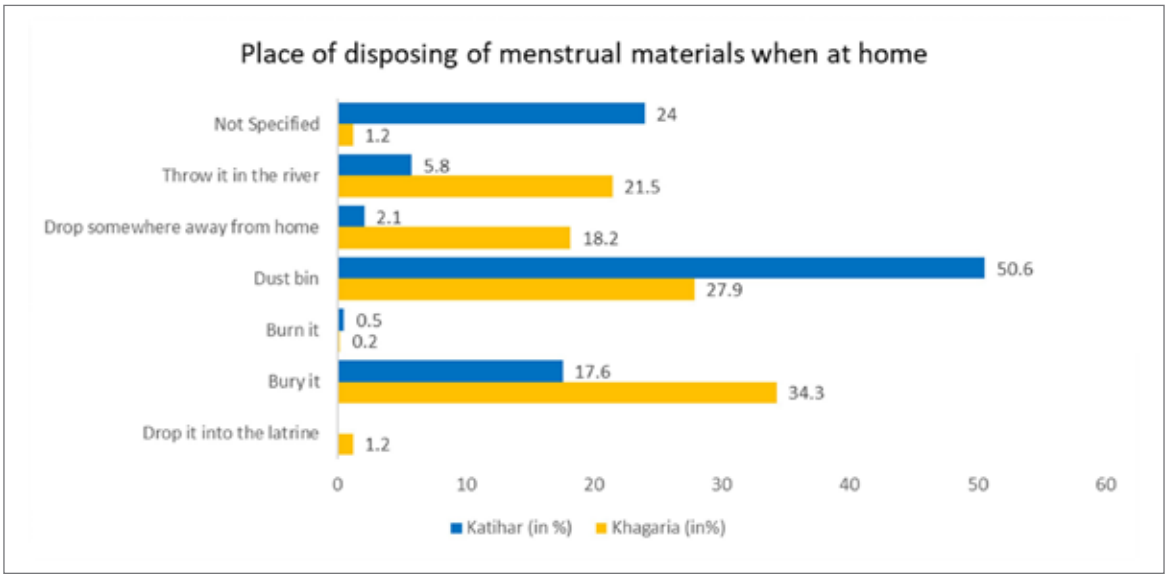
- **Washing hands at time of changing MHM Product:** In all, 669 of women stated that they wash their hands every time before and after changing menstrual material during periods. This was found equally present in both districts.
- **Use soap every time:** From both districts, three-fourths of women i.e. 535 women wash their genitals at least twice a day during menstruation, but only half 374 use soap.
- **Clean Cloth:** From both districts, 496 of women claimed to have used clean cloth during menstruation.
- **Washing practices:** 55 women out of 376 from Katihar and 129 out of 337 EAMWs in Khagaria wash their menstrual clothes in toilets or bathrooms, whereas the common practice in both districts is to wash menstrual clothes outside the house near the hand pump or well, which was followed by 525 women. 295 women from both districts use soap sometimes while washing menstrual clothes. 81 women neither use soap nor detergent in both the districts.

All the above practices highlight that around half of the women have basic facilities like water, toilet, and an affordable environment to use soap and clean clothes in both the districts, and try to adhere to hygienic practices. However, owing to lack of availability of infrastructure, resources and clean water etc. many others face gross hurdles in the way of personal hygiene and sanitary self-care.

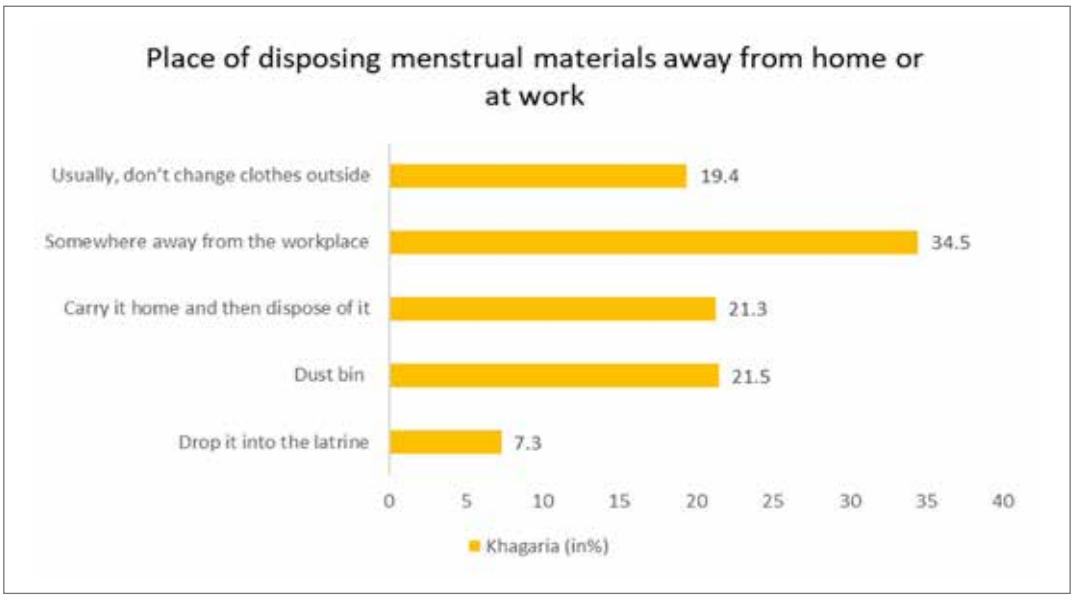
3.3.4 AREA-SPECIFIC DISPOSAL MECHANISMS

- **No specific Disposal Mechanism in place:** When asked about the system of disposal of menstrual material in their area, it was found that the women have to manage problems at their own level, as both districts do not have any organized disposal or monitoring mechanism. Responses received showed that women throw used menstrual material in open spaces, in the river or water bodies or in latrines. An organized disposal mechanism needs now to be facilitated for them alongwith raising community awareness on MHM waste management.

METHODS OF DISPOSAL IN BOTH DISTRICTS

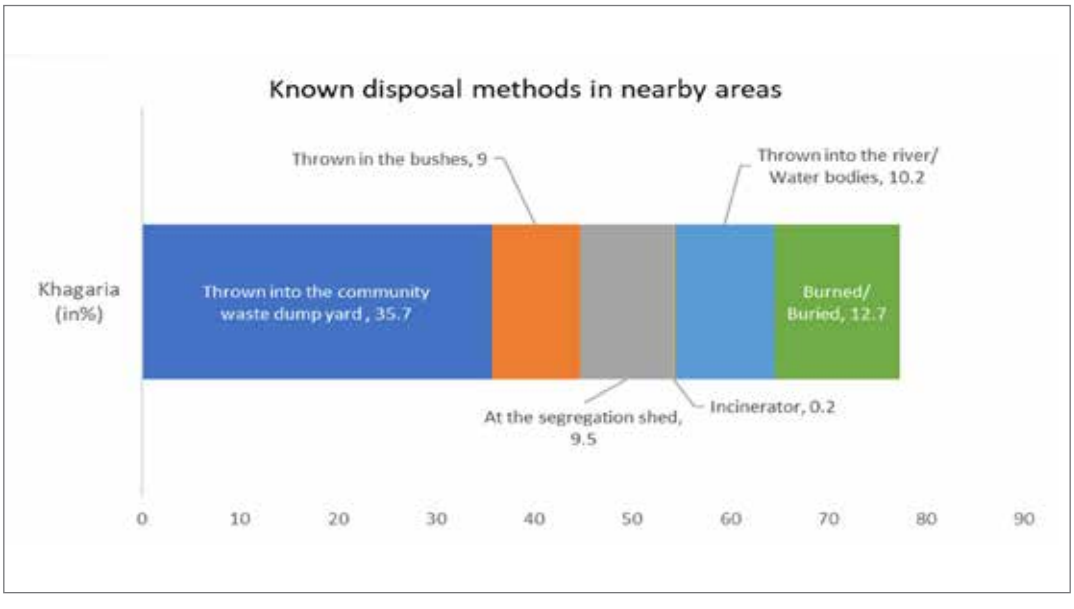


- **Top Practices of disposal at Home:** When at home, 737 EAMW from both districts throw used menstrual material in the dustbin. 221 women bury or burn the used menstrual material. Our study found that the environmentally risky practice of throwing used menstrual absorbents in the river was stated by 91 EAMW from Khagaria and 25 EAMW from Katihar. Additionally, 77 EAMW from Khagaria and 9 from Katihar throw used material in the open spaces near their homes.



- **Top menstrual product disposal practices when away from home:** When away from home, out of 423 respondents from Khagaria, 91 throw used menstrual material in dustbins, whereas 90 women do not change menstrual cloths outside home. If at all they change menstrual absorbents, they carry their used absorbents back to dispose it at home. 146 women responded that they throw used material somewhere away from home while 31 women throw it in the latrine.

KNOWN DISPOSAL METHODS IN THE COMMUNITY AS WELL AS NEARBY AREAS



151 women respondents from Khagaria opined that used menstrual material is mostly thrown in the village community waste dump and nearby areas. 38 women responded that menstrual material is thrown in the bushes and 43 said that it is thrown in the river or water bodies.

3.3.5 SOCIAL CUSTOMS, BELIEFS, MYTHS, AND TABOOS

The world of social customs, replete with its mandatory do's and don'ts in various communities represents their beliefs and mandates. Social customs, beliefs, myths and taboos form the overt and covert barriers and enablers which influence MHM practices as well as everyday experiences of menstruating women. In this respect we had quite positive findings from Katihar district rather than from Khagaria, as seen below:

Customs followed by women in reference to menstruation: Katihar District

Katihar (433 respondents)	Strongly Agree	Agree	Disagree	Strongly Disagree
I am allowed to mix with others socially during my periods.	1.2	97.9	**0.9**	0
I am not allowed to attend any social rituals during my periods.	**0.2**	**91.7**	8.1	0
I do not go to religious places during periods.	**0.5**	**94.7**	4.6	0.2
I avoid traveling during periods.	**0.2**	**34.4**	65.4	0.0
I am told to stay in the corner of the house during my periods.	0.5	2.3	97.2	0
	Yes	**No**		
I am allowed to carry out routine work at home during my periods.	**99.8**	0.2		
I am allowed to cook in the kitchen during my periods.	**99.3**	0.7		
Others in my family take care of me during periods.	**99.8**	0.2		
I have freedom to visit a doctor in case of any health issue.	**99.3**	0.7		
I am allowed only special foods during periods.	1.6	98.4		
I sit for lunch and dinner with all my family members.	97.0	3.0		

Out of 433 respondents from Katihar, almost all women reported that they were allowed to socialise during periods, carry out routine work at home, cook in the kitchen and even have freedom to visit a doctor in case of health issues. It was also seen that one third of women avoid travel during periods.

Customs followed by women in reference to menstruation: Khagaria District

KHAGARIA (423 respondents)	Strongly Agree	Agree	Disagree	Strongly Disagree
I am allowed to mix with others socially during my periods.	12.1	60.5	**24.1**	**3.3**
I am not allowed to attend any social rituals during my periods.	**9.2**	**48.2**	36.6	5.9
I do not go to religious places during periods.	**7.3**	**42.3**	35.9	14.4
I avoid traveling during periods.	**3.5**	**43.0**	44.7	8.7
I am told to stay in the corner of the house during my periods.	**5.7**	**9.5**	68.3	16.5

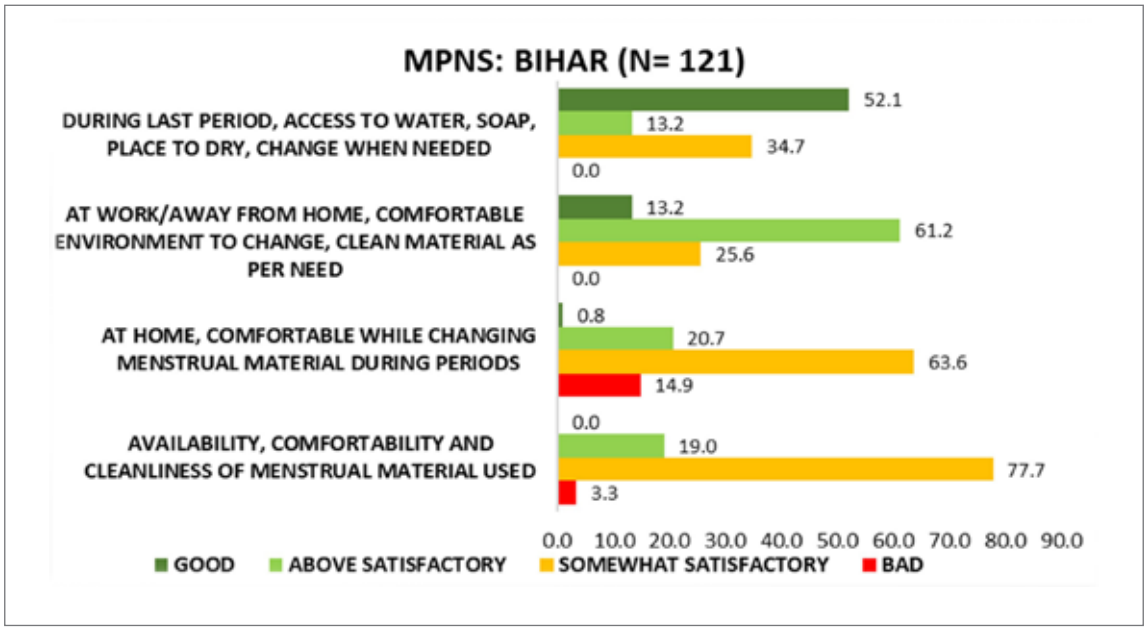
	Yes	No
I am allowed to carry out routine work at home during my periods.	**93.6**	6.4
I am allowed to cook in the kitchen during my periods.	**96.5**	3.5
Others in my family take care of me during periods.	**86.8**	13.2
I have freedom to visit a doctor in case of any health issue.	**78.7**	21.3
I am allowed only special foods during periods.	29.3	70.7
I sit for lunch and dinner with all my family members.	**83.7**	16.3

Out of 423 respondents from Khagaria, 102 (24.1%) were not allowed to socialize during their menstrual cycle. Nearly half of the women (210) do not visit religious places, 243 do not attend any social rituals and 197 avoid travel during periods. Three- fourths of the women, however, have the freedom to visit a doctor in case of any health issue.

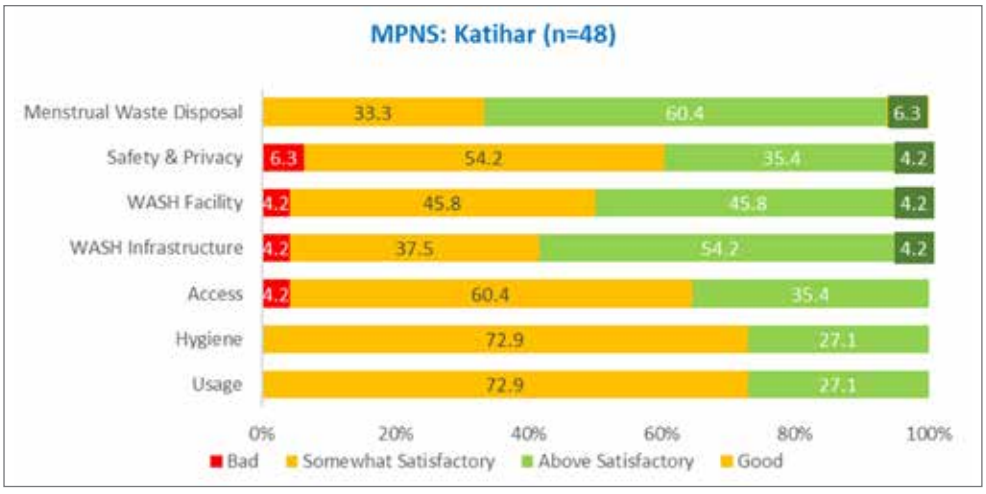
3.3.6 MENSTRUAL PRACTICE NEEDS SCALE (MPNS)

The Menstrual Practice Needs Scale (MPNS) was used to measure and assess the felt needs and experiences of women during their last menstrual period. 121 respondents from both the districts shared their perceptions/ experiences on availability of water, sanitation, hygiene, safety and privacy as well as access to menstrual absorbents. Through the use of MPNS, we were able to access the actual trends, practices and experiences w.r.t MHM, WASH, and safety in Katihar and Khagaria districts.

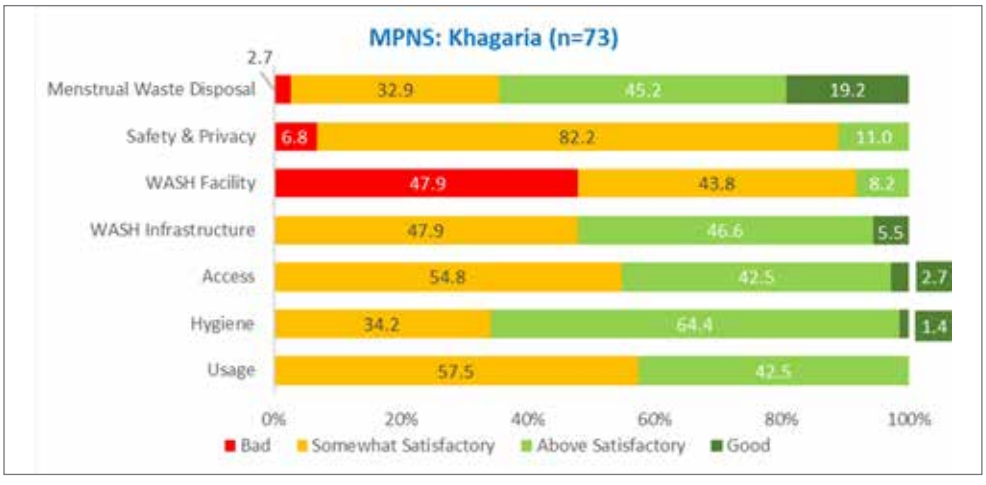
Safe hygiene practices consist of washing and timely changing menstrual absorbents during the day, as well as their proper disposal. Personal hygiene also depends on keeping genitals clean, and washing hands before and after changing the menstrual absorbent. Our survey assessed the practices followed covering hygiene during menstruation.



After being assessed on the MPNS it was observed that 77.7% of respondents rated the Availability, Comfort, and Cleanliness of Menstrual Material used at below satisfactory levels. Two thirds of the women had access to water, soap and a place to dry as well as change menstrual material at above satisfactory to good level.



➲ 48 women from Katihar when assessed on the MPNS reported that access to menstrual material, usage of desired absorbents, privacy, WASH infrastructure and facilities were found below satisfactory levels.



➲ 73 women from Khagaria, when measured on the MPNS reported that usage of desired absorbents, access to menstrual material, WASH facilities and privacy were found below satisfactory levels.

3.4 INTER-SECTORAL FOCUS

This part of our study examines vulnerabilities, issues, and risks pertaining to menstruation with respect to social as well as inter-sectoral stress factors, and we present brief inter-sectoral data analysis.

➲ As villages selected from Katihar and Khagaria districts are flood prone, water contamination and increased inaccessibility of potable water are crucial issues in these villages.

➲ Drinking water crisis, lack of electricity and lack of transport system, lack of education, and poor monetary gains, are issues faced by villagers in both the districts.

➲ Against this background, we present a brief inter-sectoral data analysis on **Migration and MHM, WASH and MHM, Education and MHM, Livelihood and MHM, and lastly, MHM and public policy.**

The villages surveyed in both the districts were SC (Scheduled Caste) and BC (Backward Classes) dominant. Above 30% of people from both districts still use open defecation suggesting that either they may not have WASH facilities, or they may not have adapted to available WASH facilities. Around three-fourths of the population had a low education level and, in some villages, there were no schools. For livelihood, people were mainly dependent on rainfed land for cultivation. More than half the population was dependent on daily labour wage. The overall narrative of different MHM practices in these villages related to- community-based vulnerabilities, socio-economic conditions and beliefs, monetary freedom and disposable income of women, besides health and education inter-sectoral factors.

3.4.1 MIGRATION AND HEALTH

- Out of a total of 433 respondents from Katihar, five families migrated for agricultural work. One for private service, and two for work in manufacturing industry. 167 families from both the districts also migrated to nearby villages as daily wage labourers.
- Nearly half of the families (n= 423) from Khagaria depend on farming along with labour work in other farms. It was found that only 20 families out of 423 from Khagaria migrated for work for a long duration. Out of the 20 migrating families, nine migrated locally for farming work; three migrated for construction and domestic work for 3-5 months. Seven families migrated for work in manufacturing industries and one to tea plantation.
- Our findings indicate that 179 out of the 186 migrant women strongly feel that their seasonal work conditions and resource scarcity influences their menstrual health negatively.

3.4.2 TRADITIONAL SKILLS AND EARNING CAPACITY

In Katihar and Khagaria 23% women practiced traditional art and craft as well as skill based work.

- In Katihar out of the 15 women who possessed traditional skills, the majority were into tailoring.
- In Khagaria out of the total number of women who possessed traditional skills and art, 119 women (n=183) practiced arts such as bamboo craft, embroidery, knitting and weaving.
- While no one reported earning from traditional knowledge and skills in Katihar, 38 women from Khagaria managed to earn using traditional skills.

Given the possibility of augmenting family income from traditional knowledge and skills, vocational courses can be organized for women struggling with economic vulnerabilities to enhance their disposable income. Affordability will empower women for better decision making on MHM and personal medical care.

3.4.3 WASH AND MHM

NFHS-5 data shows that 44.6% households in Katihar and 65% from Khagaria use an improved sanitation facility (International Institute for Population Sciences (IIPS) and ICF 2021, p. 93, 99).

WASH & MHM	Katihar (in %)	Khagaria (in %)
Total Respondents	**433**	**423**
Water Facility at Home		
Bore well/ Tube well/ Well covered	72.3	1.7
Hand pump/ Standpipe	0.5	73.3
Piped water/ Piped to yard/ Plot/ Public tap	23.1	24.6
Tanker/Truck / Cart with small tank	4.2	0.5
Toilet Facility at Home		
Individual household latrine	56.6	79.4
Community toilets	0.7	2.4
Open defecation	42.7	18.2

Type of House		
Kutcha	48.5	30.0
Pucca	21.9	50.6
Semi pucca	29.6	19.4

- **Kind of House:** Housing conditions were found to be better in Khagaria than in Katihar. 70% of women from Khagaria reported that they stay in semi-pucca or pucca houses. Whereas nearly half (48.5%) of the families in Katihar stay in kutcha houses.

  (*Pucca* houses are made of roof, wall and floor with a concrete or pucca material as compared to kutcha houses that have roofs, walls and floors all made up with non-concrete or kutcha/ makeshift material).

- **Compromised Toilet Facilities:** According to our findings, Individual Household Latrines (IHHL) are used by 56.6% families in Katihar and 79.4% in Khagaria. Pucca houses can have toilets built within as opposed to Kutcha houses where it is not possible. Though toilets were constructed under Swachh Bharat Abhiyan, 30.6% families still opt for open defecation in both districts owing to reasons like living in kutcha houses or poorly constructed toilets or due to community preference for open spaces.
- **Sanitation and Access to Water Challenge:** NFHS-5 data shows that drinking water sources have a coverage of 99.2% and 98.8% in Katihar and Khagaria. (International Institute for Population Sciences (IIPS) and ICF 2021, p. 93, 99). However, our findings indicate that only 23.8% of families (203 out of 856 surveyed) from both districts have the facility of piped water in their homes. The remaining either rely on bore wells, tube wells or hand pumps near their houses. This becomes a main everyday challenge to better hygiene including to MHM. Almost all women from both districts reported problem of presence of iron in the water and also scarcity of sufficient water for MHM in households, schools and institutions. Moreover, drinking water supply and sanitation challenges exacerbate during floods and post flood situations.

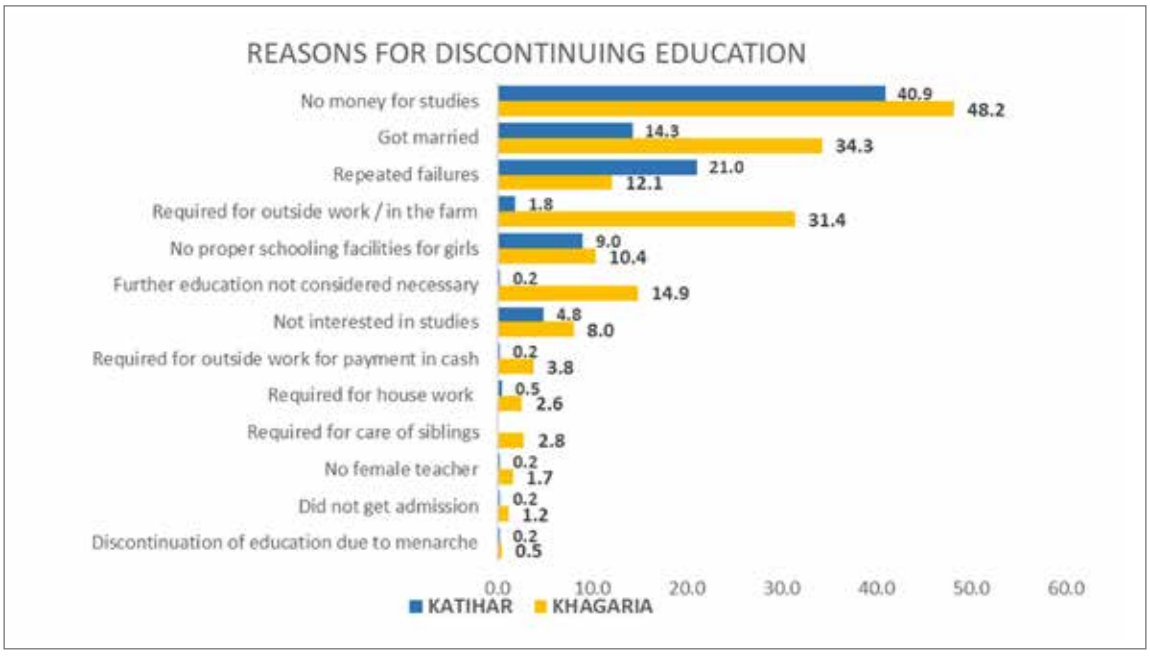
During menstruation a woman's WASH needs are relatively higher as compared to the rest of the days of the month. When a woman experiences her periods, she needs more water to clean herself for personal intimate hygiene, including after defecation. Besides, a regular supply of clean water, ensuring that a woman has the facility of a private secure place to change her menstrual absorbents and clean herself will re-confirm her sense of dignity and safety. In places such as Katihar and Khagaria, during floods and immediate post- flood situations, contaminated water and open defecation increase the risk of communicable and vector borne diseases. For menstruating girls and women, this poses a serious threat to their personal hygiene, making them susceptible to genital, uterine and urinary infections. Access to clean and functional toilets and bathroom/ bathing cubicles become a critical need during periods, both in normal times and in situations of natural calamities.

3.4.4 EDUCATION AND MHM

Out of our total respondents (N=856), 234 women had informal education whereas 224 women were illiterate across Katihar and Khagaria.

- 219 women (n=423) from Khagaria were illiterate whereas 64 had received education till the 7th standard; 90 were educated till higher secondary, and the rest 50 were educated beyond the 10th standard, including having completed graduation and post-graduation.
- In Katihar, two-third of the women (433) were educated till the 4th standard, 117 were educated till higher secondary, and another 38 were matriculates and above.

Education And MHM	Katihar (In %)	Khagaria (In %)
Total Respondents	433	423
Education		
No Education	1.2	51.8
1 Primary (1st - 4th)	65.4	6.6
2 Secondary (5th - 7th)	10.9	8.5
3. Higher Secondary (8th - 10th)	13.9	21.3
4. 12th / Undergraduate	4.2	7.6
5 Graduate and Above	4.6	4.3
Reasons For Discontinuing Education		
Lack Of Facilities	41.3	49.9
Educational Barriers	23.1	45.2
Monetary Barriers	5.1	25.8
Family Barriers	23.8	47.3



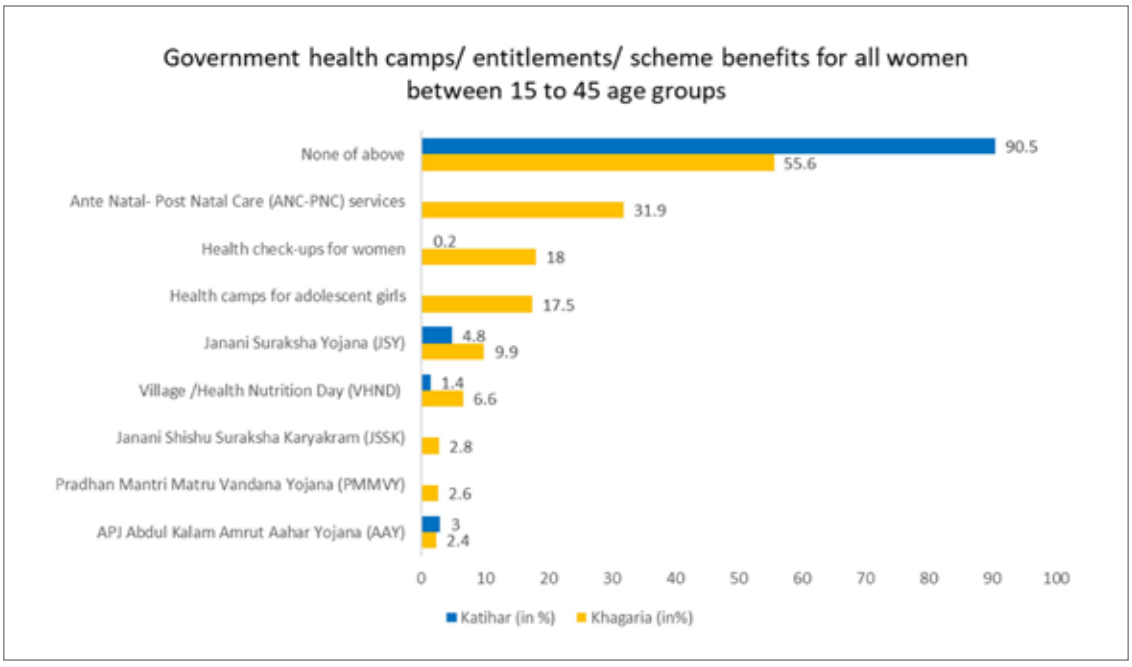
- **Bottlenecks such as Poverty**: In both districts, monetary barriers and family attitudes were the primary cause for educational discontinuity. When questioned about discontinuing education, lack of money (381) came as the top barrier in both the districts (N=856) followed by marriage (207) and family related barriers such as compulsion to work outside home (303) and education not being considered as a necessity (65). To enhance family income, women were required to do labour work on their farms or outside. As a hindsight on their educational status, women reflected that lack of proper schooling facilities in general and the non-availability of female teachers, less importance on education for girls, i.e. family-imposed responsibilities were other top reasons for them not being able to attend or complete school.
- **Failing/ Lack of Interest**: 238 of the total women respondents who discontinued education reported as not being interested in studies while 32 women left their education due to repeated failures.

- **Improper Facilities in Schools:** Other discernible hindrances to complete education related to the absence of proper schooling facilities and infrastructures for girls (83) and no female teacher (8).
- **Menarche and Marriage:** In Bihar, across our sample population 24.2% women dropped out of school and got married post-menarche and attainment of puberty. Community beliefs such as a girl being 'ready for adulthood' in early post-menarche years leads to pressure on the family to marry her off. Menarche & Menstruation emerge as a major criterion for some parents and families laying restrictions on the movement of a girl outside of home, including a preference to drop out from school. Girls being absent from school due to MHM related issues like pain etc. also leads to interruptions in education post -menarche.

3.4.5 AWARENESS TOWARDS PUBLIC POLICY AND COUNSELING ON MHM

PUBLIC POLICY

National Health Mission provides various programs for the age group of 15 to 45 years, i.e., from adolescent girls to women. There are various maternal and child health programs designed by the government of India through which menstruating women get benefits from various services and schemes. Along with other counseling sessions, if counseling on menstrual health hygiene is given to women, they would benefit in terms of being better informed and alert on MHM.



- **Significance of Public Health Facilities:** Public Health facilities usually play an important role in providing free and affordable treatment. Health support systems in India are designed such that for every 1000 population there is ASHA appointed, for around 5 to 6 villages, there is a Sub- Centre where treatment for small illnesses as well as 24/7 facility of delivery is available. After that, for every 30000 people, there is a Primary Health Centre (PHC). And as we move further, there are Rural or Sub-District hospitals, district hospitals in urban areas, municipal corporation health clinics, and hospitals
- **Accessibility and choice:** EAMW covered in this survey were asked through IDIs about the nearest accessible public health facility for getting treatment or pursuing their health issues. The nearest and most accessible public health facilities reported by the EAMW in Khagaria were District Hospital (72.6%), Community Health Centres (14.2%), and Primary Health Centre (12.5%). Around 60.7% of Katihar reported their nearest option was Sub District Hospital, followed by District Hospital (20.6%), and Primary Health Centre (10.2%). Affordability and Access to healthcare: When asked whether they get accessible/ affordable

treatment from government health facilities, 34.3% of women from Katihar did not receive treatment but 55.3% from Khagaria women responded positively. More than one-fourth i.e., 27% of respondents from Khagaria mentioned that they never visited Public Health Facilities to avail treatment.

- **Local health Services:** In Khagaria, only one-third of the women reported receiving ANC-PNC-related benefits such as maternal and child health. Only 76 women out of 423 were getting health checkups and even fewer (28) were attending Village Health Nutrition Day (VHND). Our findings indicate that though women are familiar with the services they get from the public health system, very few women knew about the schemes designed for them such as Janani Suraksha Yojana (JSY), Pradhan Mantri Matru Vandana Yojana (PMMVY) and so forth.
- **Engagement with Public Health services**: This finding indicates that if the women in these districts are ready to consult public health facilities, then distance does not play a role as much as better services and infrastructure does. Thus, they may opt for going to the District/ Sub-district Hospitals over visiting the Primary Health Centres (PHCs) and Community Health Centres (CHCs) / Rural Hospitals (RHs) etc. National Health Mission provides various programs for the age group of 15 to 45 years, i.e., from adolescent girls to women (see also, Annex I).
- **Importance of Health Camps**: Health camps, which are periodically organized in villages, are specifically important and needed in areas which are remote and cut-off or where Sub-centres are not available. Our survey findings indicate that 397 women (n=433) in Katihar and 260 in Khagaria (n=423) did not receive any scheme-based benefits and remained out of coverage of public health entitlements. According to our findings, EAMW in Katihar are less integrated with the public health system than those in Khagaria. If health camps start covering the wellbeing of EAMW in remote and isolated areas, women will stand to benefit from many health based objectives and schemes of the Indian government.

Our findings indicate that other than ANC-PNC services, women between 15 to 45 years age group are not familiar with Government health camps, entitlements, and scheme benefits for them. This is not only indicative of absence of women's voice and reach over health schemes and benefits for their welfare, but also explains their hesitation to speak and articulate on MHM concerns in day-to-day life. In this way the EAMW face a double silence as even the policy makers have so far been unable to adequately combat the silence on MHM issues.

COUNSELING

Received counseling on Menstrual Hygiene from health workers	Katihar (in %)	Khagaria (in %)
Total Respondents	**433**	**423**
No	98.2	65.7
Yes	1.8	34.3

- **Yes:** Upon being asked if they ever received any counseling on menstrual health, only 153 of our EAMW responded in the affirmative, out of which only eight women were from Katihar. Counseling on MHM was received from health workers such as ASHA, ANM and AWW.
- **No:** 278 women in Khagaria (n=423) answered no, while 425 women from Katihar (n=433) did not receive any counseling at all.

Menstrual health of women beyond school years is still a long way from being actively considered as a public policy measure in India. Owing to the vast outreach of Public Health system in India, the MHM of EAMW can get a much required boost if the issue receives adequate public policy attention. ADP districts can stand to gain by way of better health for 50% of its population if women's MHM issues are piloted as an inter-sectoral intervention cutting across education, social security, WASH and livelihood.

PART 4 VOICES, EXCERPTS AND OBSERVATIONS

As part of our research, we conducted Key Informant Interviews (KIIs) in both the selected districts. People interviewed during this exercise were important stakeholders in communities and villages such as Anganwadi workers, ANM, Doctors, Teachers, ASHA workers etc. The voices of these stakeholders are critical for the development of the community as they give a unique point of view of the village population and in a small but significant manner, have helped us analyse how to combat the silence on menstrual health issues in area-specific and community -sensitive ways. The highlights of these interviews are as follows:

Katihar (Data derived from 5 villages of the district): In Katihar, 11 respondents across 5 villages stated that their villages suffer acute water scarcity. Out of these, 7 of our key informants added that water in their villages has Iron content making it unsafe for consumption. 9 informed us that free sanitary pads were not distributed in their villages while 6 said that they were not aware of any government scheme related to menstrual hygiene. 3 confirmed the absence of any awareness generation initiative or the distribution of Iron and folic acid tablets to girls and women.

Khagaria (Data derived from 5 villages of the district): In Khagaria, 10 respondents across 5 villages stated free sanitary napkins were not distributed in their villages. 8 respondents spoke of acute water scarcities in their villages. 2 others added that the water was severely contaminated by iron. 4 confirmed the absence of awareness generation initiatives and stated they were not aware of any scheme related to menstrual hygiene. 3 of our respondents stated that their villages lack toilets. In one of the five villages in Khagaria neither the village nor the village school had toilets.

4.1 VOICES AND EXCERPTS: KATIHAR

Nirola, (Interview: 16.08.2022)[3], an **Anganwadi Worker** (AWW) in a village of Katihar district of Bihar responded that the village does not have any scheme on menstruation for school and community. Though the village had a common tube well for fulfilling water related needs, the school gets neither a water supply nor is there any toilet in its premises. It was not clear how women's WASH needs were fulfilled throughout the year. On EAMW's MHM needs in the village, she stressed upon creating awareness and suggested free sanitary pads, iron tablets, hand wash and clean water. However, she believed that, 'women should not perform pooja and should not enter the kitchen during menstruation'.

Tullo, (Interview: 31.07.2022)[4], an **ASHA worker** in a village of Katihar stated that the village had a program of providing free calcium and iron tablets but there was no such scheme for sanitary pads. On WASH, she informed that the villages had water but for general health and MHM the challenge was that it was contaminated with iron. She further added that the village needed free sanitary pads and medicine- distribution schemes for menstruating women. On taboos, she held that women 'should not' enter religious places during their periods.

Prabhawati (Interview: 21.08.2022)[5], a **Ward Member** of a village of Katihar district in Bihar stated that she was unaware of any scheme for menstruating women in the village. She further added that ASHA workers provided iron tablets to women from time to time. She added "Government does not provide resources to work, it just

[3] BR KII1 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[4] BR KII2 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[5] BR KII3 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

gives advice." On women's WASH needs, she explained that the village has *Jal Jeevan Mission* but no solution so far in sight for ridding the village of iron-contaminated water. Village School has water as well as a toilet. On taboos prevalent in her village and areas nearby, she informed us that women were considered untouchable during menstruation, not allowed to perform pooja, enter temples or go to the kitchen to cook food.

Asha (Interview: 02.09.2022)[6], an **ASHA worker** in a village in Katihar added that the village does not have any facility related to menstruation. Iron tablets are distributed for pregnant women. The village had a water tank under *Jal Jeevan Mission* but it does not have a tap. Moreover, the village does not have any school. From her account it was evident how during floods, villages became bereft of menstrual sanitation facilities and accessibility to products such as sanitary pads. Strong taboos forbid women to cook food, enter temples or consume eggs and onions during menstruation. However, the ASHA seemed to take it as a social given without much questioning.

Aparajita (Interview: 14.07.2022)[7], an **Anganwadi worker** (AWW) from a village in Katihar responded that her village does not have any facility for menstruators. AWWs distribute iron tablets but there is no scheme of sanitary pads. From her account, it was evident that the village had iron-contaminated water to the extent that villagers had to buy water for drinking and cooking. She insisted that creating awareness drives amongst EAMW and providing them with clean water, free sanitary pads, and medicinal facilities would be a good way ahead to ensure village -level MHM. On taboos and beliefs in the community, she informed that for the first three days of menstruation women, 'should not' perform pooja.

Madhu and Sulekha (Interview: 07.07.2022)[8] are ASHA **Workers** and **ANM, respectively**. ASHA workers responded that the village does not have any facility related to menstruation, ANM further added, "A free pad distribution scheme in the village used to be implemented until it changed to 250 INR annually and now it has completely stopped." On WASH they informed that the village had a tube well facility but the water was contaminated with iron. They emphasized upon creating awareness and suggested clean water, free sanitary pads, and a Primary Health Center (PHC) for menstruating women. On taboos both answered that women 'should not perform pooja, enter the kitchen, eat pickles, and should not put vermillion during menstruation.'

Pooja Devi (Interview: 05.08.2022)[9], an **AWW** of a village denied about the menstruation hygiene schemes in her village. She added there is only an iron tablet circulation scheme for pregnant women. On WASH related schemes, she claimed the village had *Jal Jeevan Mission* but it was not fully implemented. Further she added that her village needed a scheme for free distribution of sanitary pads, medicines, and Dettol. Taboos regarding menstruation included women forbidden to perform pooja, eat eggs or onion.

Kajal (Interview: 10.07.2022)[10], an **ASHA worker** in Katihar responded that the village had a programme of providing free iron tablets to women but there was no programme for free distribution of sanitary pads. She further added that under *RKSK,* the village had conducted counseling sessions for girls. On the requirement of 20-49 aged women, she suggested free distribution of sanitary pads, iron tablets, Dettol, and condoms. Further she added the village had a problem of iron in water, there is a *Jal Jeevan Mission* but not fully implemented. On taboos in the village, she informed us about the belief that women should not enter the kitchen for the first three days of menstruation.

Khushbu (Interview: 30.06.2022)[11], an **ASHA worker** in a village in Bihar added that the village had a free iron tablet distribution facility under the RKSK scheme. There is no such scheme for sanitary pad distribution. On WASH needs in community and school she answered water is contaminated, *Jal Jeevan Mission* is not completely implemented, school also had a problem of iron in water. On women's requirements she suggested educating the women about menstruation, free distribution of sanitary pads and Dettol.

[6] BR KII4 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[7] BR KII5 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[8] BR KII6 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[9] BR KII7 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[10] BR KII8 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[11] BR KII9 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

Sarita (Interview: 29.06.2022)[12], an **ASHA worker** in the village of Katihar added that the village had a programme of counseling on cleanliness especially on the theme of MHM. Free distribution of Iron tablets under the RKSK scheme. She further added that the village had a tube well for water facility but there was severe iron contamination of water, and the school also had the same tube well for school-going children. It was unclear how women's wash needs were fulfilled throughout the year. On women's requirements she suggested free distribution of sanitary pads, medicines, and Dettol.

Nitu (Interview: 21.07.2022)[13] an **ASHA worker** in a village in Bihar responded that under RKSK the village had a programme to advise women on using sanitary pads and maintaining personal hygiene. On WASH needs of the community and school she explained the *Jal Jeevan Mission* was implemented in the village and the school but it was not fully operationalised. On women's requirements she suggested free distribution of sanitary pads, medicines, and Dettol. Moreover, she added that women, 'should not cook food for the first three days of menstruation'.

Sulekha (Interview: 14.07.2022)[14] an **ASHA worker** in Katihar district of Bihar stated that two schemes, namely, Masik Dharm Swachhta Yojana and Rashtriya Gramin Swasthya Yojana were operational in village, there is also free distribution of Iron tablets and counseling for women under the RKSK scheme. On WASH needs she explained the Jal *Jeevan Mission* was not completely implemented and hence the water related needs remain unresolved. On EAMW's requirements, she suggested free distribution of sanitary pads as well as a medicine kit.

4.2 VOICES AND EXCERPTS: KHAGARIA

Manju (Interview: 10.07.2022)[15], a **teacher** in a village of Khagaria district in Bihar added that the village had a programme for free distribution of iron and calcium tablets, special leaves for menstruation women, and anti-tetanus vaccine for mothers- to-be/pregnant women. Further she added, the village does not have any specific schemes for menstrual health. On WASH needs in school and community she explained there were adequate water and toilet facilities in her village. She insisted on creating awareness among women on cleanliness and hygiene and suggested free distribution of sanitary pads and medicines for MHM. However, she was fine with women not entering the kitchen and religious places during menstruation.

Jyoti (Interview: 22.07.2022)[16], a **teacher** in a village of Khagaria district in Bihar responded that the village had free distribution of sanitary pads and medicine scheme for menstruating women. On WASH in school and community she explained that the village had *Jal Jeevan Mission*, there is a water connection in school also under this scheme, both school and community had a clean toilet facility. She added creating awareness about menstruation is very important and suggested distribution of free sanitary pads and medicine. On taboos she explained once women were not allowed to have baths and perform pooja but now the situation has changed positively.

Annupriya (Interview: 15.07.2022)[17], an **AWW i**n a village in Khagaria stated that the government lacked any scheme for menstruating women between 20 to 49 years in the village. She stated that free distribution of sanitary pads and rest during menstruation are urgent needs. Moreover, she suggested a pad making machine and potable water were urgently required in the village. On taboos she added that till a few years ago, women were not allowed to perform pooja, apply vermillion or cook. Women were even prohibited from seeing their husbands, but now the situation has changed women were freer from binding restrictions during menstruation.

Reena (Interview: 18.06.2022)[18], a **VRP (Village Resource Person) Jivika** in a village of Khagaria district in Bihar added, the government does not have any scheme for menstruation in the village. She added women were

[12] BR KII10 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[13] BR KII11 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[14] BR KII12 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[15] BR KII1 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[16] BR KII2 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[17] BR KII3 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[18] BR KII4 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

taught about sanitary pads use and to take iron tablets. On WASH needs in school and village community she explained that the village had a *Jal Jeevan Mission* but it was not completely implemented. The school had water and toilet facilities and provided 150 rupees annually to girls for sanitary pads. On women's MHM requirement, she suggested distribution of free sanitary pads, pad making machine and a special room in school for menstruating girl child for rest. On prevalent taboos, her answer was that women were not allowed to perform pooja and touch objects freely during menstruation.

Pooja (Interview: 06.06.2022)[19], an **AWW** in a village of Khagaria district of Bihar stated that the village has a cleanliness program, free distribution of iron tablets from Anganwadis, and regular health check-ups for menstruating women were also organized in her village. She further stated an awareness program was conducted in her village on using sanitary pads and maintaining cleanliness during menstruation under the RKSK scheme. From her account, it was evident that there was a problem of accessibility to markets that led to the unavailability of pads and medicines because the village lies across a river. On WASH she explained, that government schemes such as *Jal Jeevan Mission* and Open defecation-free villages are a good step. Schools also had clean toilets and water facilities with handwash. She further added that lack of education was a big hurdle in achieving proper menstrual health in the village. An awareness program about menstrual hygiene should be regularly organized for EAMW. Moreover, the village needed sanitary pads, medicines, clean water, and a program on hygiene. On taboos in the village, there was a common belief that women should not touch the holy *Tulsi* (Basil) plants during menstruation.

Sangeeta (Interview: 13.08.2022)[20], a **Bachat Gat (HGS) leader** in a village in Khagaria district of Bihar responded with the scheme of free iron tablet distribution in the village but there is also an awareness program under *Rashtriya Kishori Suraksha Karyakaram* to teach women about cleanliness and health. On WASH she explained that the government has implemented *Jal Jeevan Mission* and construction of toilets in the village, but the school does not have clean toilets and there is a problem of high levels of Iron and Lead in water. Further she added that the village needed sanitary pads, a clean toilet with contamination-free water and soap. On taboos, the villagers were of the firm belief that women should not be allowed to touch the Tulsi plant during menstruation.

Neelam (Interview: 26.08.2022)[21], a **Bachat Gat leader** in a village of Khagaria informed us that the village has conducted health camps for adolescent girls, moreover, they are also advised to use sanitary pads and maintain cleanliness during menstruation under RKSK scheme. On WASH in villages and schools she added *Jal Jeevan Mission is* implemented but is insufficient. About women's requirements in the village, she added that women needed sanitary pads, medicines, clean water, and toilet during menstruation. She further suggested a menstrual health training program and a small industry of sanitary pad making. Women not allowed to touch a Tulsi plant during menstruation emerged as a taboo and firm conviction in Neelam's village too.

Sulekha (Interview: 03.07.2022)[22], a **Teacher** in a village in Katihar stated that the school had a program of free distribution of sanitary pads and iron tablets as well as free health check-ups in the Anganwadi for girls. On the requirement of women between 20-49 years of age, she opined that the EAMW needed sanitary pads/ cotton cloth, iron tablet, clean toilets and clean water. She insisted upon a menstrual health training program to teach women sanitary pad-making courses. She informed us that an organization called *Meena Manch* has conducted some educational programs in the village that leads to changing people's behavior toward menstruation. With respect to beliefs around menstruation, she preferred to share her own experience of how her husband considers menstruation as sacred and pious.

Ramdulari (Interview: 03.07.2022)[23], a **Bachat Gat leader** in a village in Katihar district stated that the village had a program of free distribution of iron tablets through the Anganwadi. On WASH needs of village and school, no scheme implementation from government but *Nav Jagriti Mission* has made a *Jaltara* for village water needs.

[19] BR KII5 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[20] BR KII6 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[21] BR KII7 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[22] BR KII8 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[23] BR KII9 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

It was unclear how women fulfilled their WASH needs throughout the year from such a source of water. From her account it was evident that the village had a problem of accessibility to menstrual hygiene materials, as the nearest place to buy sanitary pads was 20 kms away. On taboos, she answered that the village had a tradition to bathe only with 2.5 *lotas* (mugs) of water during menstruation.

Babita (Interview: 03.07.2022)[24], an **AWW** in a village in Khagaria stated that she was unaware of any scheme on menstrual hygiene in the village or in the local school. She added the village needs clean water, sanitary pads and provision of hand-wash for menstruating women. On the WASH needs in villages and schools *Jal Jeevan Mission* is implemented but there is no specific scheme for menstrual hygiene, she added.

Reena (Interview: 03.07.2022)[25] an **ASHA worker** in Khagaria stated that regular health check-ups of adolescent girls were organized in the Anganwadi. On WASH she answered that the *Jal Jeevan Mission* was facilitated in the village but not yet completely implemented. She added the village school had mineral water provision but the students had to drink tap water. Educating the girl child in villages about MHM and raising early awareness was demanded by her as a way out to address hesitations, fears, silences and myths around periods and personal hygiene.

Savita (Interview: 03.07.2022)[26] a **Bachat Gat leader** in a village in Khagaria stated that her village had a program for free distribution of Iron tablets for adolescent girls. On WASH she explained that Nav Jagriti Manch, a local *NGO* had built *Jaltara* (Recharge pits/ pipes) for water needs of the village. *Jivika* organization had conducted educational programs on menstruation in the village. Creating awareness on menstrual hygiene, free distribution of sanitary pads and medicines among women would be a desirable intervention. Savita wondered on the ironic question of how villagers considered menstruation sacred but still prohibited women from performing 'Pooja'.

4.3 SALIENT FINDINGS FROM DATA

Processing through our data from Katihar and Khagaria, we have gained some valuable insights on women's health, education, livelihood and overall community outlook on menstrual health management needs on ground.

Our findings from these districts indicate that most of the interviewees were unaware about the schemes related to menstruation in the villages. However, informants were aware of common ongoing services such as free distribution of iron tablets in the villages of Katihar and iron and calcium tablets in Khagaria. Knowledge about schemes and services as well as entitlement, other than under RKSK and Anganwadi benefits, was almost negligible. While a concern emerged for creating awareness amongst women on cleanliness and personal hygiene with respect to menstrual health, the majority of the Key Informants from these districts were in favour of following community beliefs and taboos during menstruation.

Key informants from both districts indicated that till recently there was a scheme under which pads were distributed freely but now no longer. However, when the free pad distribution facility was discontinued, a contribution of 250 rupees started being deposited annually in every girl's bank account. But this too has stopped in Katihar. Reena, a VRP (Village Resource Person) Jivika in a village in Khagaria informed us that in her village, girls were provided 150 rupees annually for sanitary pads.

It was evident from all interviews that in general, villages suffer lack of water and functional toilets. During floods, the situation gets worse as villages face severe unavailability of sanitary pads. Pooja, an Anganwadi worker, informed us that her village had a problem with accessibility when the river overflows and they become cut off from the rest of the world and have zero access to pads and medicines. In general, the villages experience a scarcity of clean drinking water, sanitary pads, and hand wash/soap for menstruating women.

On taboos most of the interviewees from these districts reported restrictions on- performing pooja, entering

[24] BR KII10 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[25] BR KII11 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[26] BR KII12 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

kitchens and cooking. As well as eating eggs and onions in Katihar whereas in Khagaria women were not allowed to put vermillion on their foreheads or in the hair-parting, or touch the holy *Tulsi* (Basil) plant as well as ordained to stay away from their husbands. In some villages, women were taught the value of cleanliness and hygiene, but ironically, allowed only 2.5 *lota* (mug) of water during menstruation. In Khagaria the EAMW informed us that they get special leave during menstruation which can be considered as an empathetic practice for working women and other wage earners across Bihar.

From our interactions and database pertaining to these two districts, it clearly emerges that apart from silence on MHM in terms of inter-sectoral hindrances and policy-related negligence, there are community voices that portray a negative and discriminatory attitude towards periods. These discriminatory voices, similar to our observation in other states, pertain to both men and women across social strata. Many EAMW as well as other key informants endorsed negative attitudes towards menstruation, either owing to the circumstantial difficulties in which they themselves grew up experiencing a lack of a better support system. Such voices contribute to the perpetuation of a debilitating discourse on the phenomenon. The key to combating the inter-sectoral community -based silences and barriers on MHM among women beyond school years lies in augmenting positive practices and discourses on menstruation. One of the best ways to achieve this is by involving multiple actors, key and critical stakeholders such as EAMW themselves, leaders, influencers, families, policy makers and implementers. Gender mainstreaming MHM can ensure gender equality in all activities, projects, and programmes.

4.4 RECOMMENDATIONS/ AREAS OF IMPROVEMENT

IMMEDIATE

1. **Improve Enablers:** Our data from the two districts points to the widespread prevalence as well as endorsement of menstruation related taboos amongst the actor-participants themselves. Generating physical, mental and emotional awareness on menstruation focussing on positive as well as an enabling attitude among women should form a regional target on MHM.
2. **Enable existing Village Health and Nutrition Committees (VHNCs) on MHM:** For overall capacity building on menstruating women's health and nutrition at the village level, empower the existing VHNCs to address the issue locally in Katihar and Khagaria. This would ensure a positive outcome for the nutritional well-being of tribal women living in remote and marginalized areas.
3. **Enable existing Village Water Sanitation Committees (VWSC) on MHM**: MHM drives should be conducted alongside the promotion of information on WASH. Get the enablers of WASH in tandem with community voices. The VWSC in each village is to understand the MHM barriers which need to be addressed under the national Jal Jeevan Mission (JJM) guided by a women-team. Local Community-Based Organizations (CBOs) can help mobilize community support to this end.
4. **Lady doctors in PHCs:** The presence of women medics in PHCs or visiting sub-centers regularly/ once a month to monitor the health needs of menstruating girls and women and not just pregnant and lactating mothers will help cover those who are in need of medical advice.
5. **Enable capacity building in Household Water Treatment Systems (HWTS)**: Village folk are eager to rid water of iron contamination. Holding workshops on HWTS is recommended. This initiative can be facilitated through the existing FTK (Free Test Kit) women groups under Jeevika Scheme formed under the JJM scheme etc.
6. **Free pads distribution scheme and disposal mechanisms:** Free pads distribution should be continued for school going girls and extended to elder women in the village. In fact, our key informants raised a demand that many women also need clean cloth to be made available for use during menstruation, as they prefer more traditional methods of protection and hygiene. Both systems could run parallelly for some time till sanitary pads become more acceptable. Besides, disposal mechanisms need to be operationalized at the village level.

7. **Girls Common Room (GCR):** GCR should be facilitated in each school so that menstruating girls can take rest if they need to, during school hours.
8. **Vocational Training to enhance Disposable Income:** In rural and semi-urban settings of Bihar, traditional skills can make women self-dependent. Our survey findings indicate that scarcity of cash-in-hand prevent women from being able to make decisions on medical consultations or in buying hygienic material related to their menstrual health and general well-being. This causes various kinds of diseases and discomforts, at times even leading to early hysterectomies and risks of malignancies. We, therefore, suggest that to make positive changes in women's MHM, livelihood programmes and vocational training on traditional skills and knowledge can be initiated in Bihar.
9. **More awareness drives on Menstruation**, Monthly or three-monthly compulsory and inclusive health check-ups be organized with a focus on EAMW.

SHORT TERM

11. **Include MHM Kit in Relief Distribution:** Provision and Distribution of life-saving hygiene items such as soaps, detergents, disinfectants, a sufficient quantity of menstrual hygiene products (New pads/ cloths as preferred), etcetera to be included in the list of relief materials in post-flood situations.
12. **Ensure that there are schools in villages and to make these Schools MHM Friendly:** Where there are no schools, villages must be provided with the same, and also make them MHM friendly. Capacity building of young girls towards MHM and educational continuity can happen only if schools in both the districts are equipped with proper facilities. Educating children entering puberty is a prime need in all villages. Growing girls need to have a sense of composite physical and reproductive know-how of their body and well-being. If menstruation is not given a proper introduction and interactive space in an adolescents' view and life, they go through feelings of isolation, stress, embarrassment and confusion. Making schools period-safe, in terms of knowledge and skill proliferation, sanitation and care in order to ensure continuity in education as well as proper MHM is the foremost need.
13. **WASH in Schools and Community**: Girls should be provided with separate toilets equipped with running water through tap connections and storage tanks under the JJM Scheme. Villages in both the districts have a toilet deficit and still practice open defecation. Toilets should be constructed, operationalized and have regular water supply in homes, public spaces and workplace.
14. **Micro- Credit facilities through SHGs**: Provide credit facilities to EAMW through Bihar Rural Livelihood Promotion Society (BRLPS) and other government supported credit schemes that would enhance the earning capacities of menstruating women who can thereby become active decision makers in self-care.

LONG TERM

15. **Bihar MHM Committee**: A State level Menstrual Health and Wellbeing Committee in Bihar be formed to overlook, steer and monitor MHM plans with emphasis on remote areas of Bihar and integrate them into the State and National level MHM and ADP plans.
16. **MHM at District, Block, Gram Panchayat Level**: Information, education, and communication (IEC) for menstrual hygiene education and awareness that includes information around safe menstrual hygiene products; and menstrual waste management with safe disposal facilities needs to be strengthened.
17. **JEEVIKA - A source for alternative livelihoods for EAMW**: Build capacities and skills of women from poor, marginalized households through functionally effective SHGs for gainful self-employment under Bihar Rural Livelihood Promotion Society (BRLPS).
18. **MHM at Family level:** Ensure sustainable water source along with source strengthening measures and provision of Functional Household Tap Connections (FHTCs) to all households under National Jal Jeevan Mission scheme. Consider disaster resilient WASH infrastructure for all weather access.
19. **Jal Jeevan Mission (JJM) for Institutions and MHM:** Institutional water supply under the JJM scheme should have adequate running water in girls' toilets in schools. Iron removal water treatment systems to be constructed/ installed in the village water supply scheme.

20. **Make 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 where needed.
21. **Service Continuity:** For the overall well-being of adolescent girls and all menstruating women, ensure all time (normal and disaster situations) service continuity of clean menstrual hygiene products that are 'viable' and 'preferred' by all menstruators through Government Schemes.
22. **Menstrual Waste Disposal:** More Research and Development (R&D) is essential to evolve an environment appropriate disposal mechanism for menstrual waste.

REFERENCES

Census 2011 Office of The Registrar General and Census Commissioner, Ministry of Home Affairs, Government of India. Available from https://www.census2011.co.in/census/district/64-katihar.html [accessed 20 January 2023]

Census 2011 Office of The Registrar General and Census Commissioner, Ministry of Home Affairs, Government of India. Available from https://khagaria.nic.in/about-district/ [accessed 18 January 2023]

India Brand Equity Foundation (IBEF), Ministry of Commerce and Industry, Government of India (2023)

Industrial Development and Economic Growth of Bihar. New Delhi. Available from https://www.ibef.org/states/bihar [accessed 20 January 2023]

International Institute for Population Sciences (IIPS) and ICF. 2020. National Family Health Survey (NFHS)-5, State and District Factsheets, Bihar. Mumbai: IIPS. 93 & 99. Available from http://rchiips.org/nfhs/NFHS-5_FCTS/COMPENDIUM/Bihar.pdf [accessed 20 January 2023]

Krishna, Uday., Singh, Sanjeev. kumar., Mandal, T.N. (2009) Lead, Fluoride and Iron Contaminants in Drinking Water of North Bihar (Katihar) and Their Impact on Human Health. *Nature Environment and Pollution Technology An International Quarterly Scientific Journal*, (8)4 805-806. Available from http://neptjournal.com/upload-images/NL-1-32-(32)-B-1396.pdf [accessed 18 January 2023]

Khagaria District Website (n.d.) *About District Section*. Government of Bihar. Available from https://khagaria.nic.in/about-district/ [accessed 18 January 2023]

Kumar, Arun. (2022) Niti Aayog delta ranking: Backward Khagaria gets tops in Bihar, to get more funds. *Hindustan Times,* 20 January. Available from https://www.hindustantimes.com/cities/patna-news/niti-ayog-delta-ranking-backward-khagaria-gets-tops-in-bihar-to-get-more-funds-101642693471662.html [accessed 19 January 2023]

Ministry of Panchayati Raj, Government of India (2009) *A Note on the Backward Regions Grant Fund Programme*. Available from https://web.archive.org/web/20120405033402/http://www.nird.org.in/brgf/doc/brgf_BackgroundNote.pdf [accessed 17 January 2023]

Niti Aayog, Government of India (2018) *DEEP DIVE Insights from Champions of Change The Aspirational District Dashboard*. Available from https://smartnet.niua.org/sites/default/files/resources/firstdeltaranking-of-aspirational-districts.pdf [accessed 08 january 2023]

Niti Aayog (2020) Empowering Migrant Workers through Skill Development and Livelihood Generation Best Practices from States and Districts. *Skill Development & Employment Vertical* 31-34. Available from https://niti.gov.in/sites/default/files/2020-11/MigrantsWorker_Inside_10.pdf [accessed 18 January 2023].

The Times of India (2022, September 3) Khagaria 2nd in NITI Aayog Delta ranking. *The Times of India*. Available fromhttps://timesofindia.indiatimes.com/city/patna/khagaria-2nd-in-niti-aayog-delta-ranking/articleshow/93961152.cms [accessed 20 January 2023]

ANNEXURE I

Criteria/ Reasons for Selection of Villages from Khagaria

Sr. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (data accessed from JJM dashboard on 02/04/23)	Total Households (data accessed from JJM dashboard on 02/04/23	Prevailing social issues/ issues of inclusion/ etc.
1	Mansi	Amni	7810	1,946	Flood prone, disaster prone and heavy migration
2	Mansi	Purvi Thatha	12,050	2348	Flood prone, disaster prone and heavy migration
3	Mansi	Balha	7,350	1575	Flood prone, disaster prone and heavy migration
4	Mansi	Amni	669 (as provided by partner)	148 (as provided by partner)	Flood prone, disaster prone and heavy migration
5	Sadar TP	Parmanpur	1962	325	Flood prone, disaster prone and heavy migration

Criteria/ Reasons for Selection of Villages from Katihar

Sr. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (data accessed from JJM dashboard on 02/04/23)	Total Households (data accessed from JJM dashboard on 02/04/23)	Prevailing social issues/ issues of inclusion/ etc.
1	Azamnagar	Singhol	769	169	Flood prone, Muslim dominated, Desi Palia dominated and Mahadalit dominated.
2	Azamnagar	Harnagar	816	182	Flood prone, Muslim dominated, Desi Palia dominated and Mahadalit dominated.
3	Pranpur	Kathghar Karimullapur	2253	481	Flood prone, Muslim dominated, Desi Palia dominated and Mahadalit dominated.

Sr. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (data accessed from JJM dashboard on 02/04/23)	Total Households (data accessed from JJM dashboard on 02/04/23)	Prevailing social issues/ issues of inclusion/ etc.
4	Colony No. 2	Katihar MC	7000 (as provided by partner)	1750 (as provided by partner)	Urban-semi urban population, backward ward, lack of pure drinking water and sanitation problems, problem of garbage, mixed population from OBC, EBC, Dalits and women.
5	Azamnagar	Singhol	3045 (as provided by partner)	674 (as provided by partner)	Flood prone, Muslim dominated, Desi Palia dominated and Mahadalit dominated.

ANNEXURE II

Important Women-Centric Schemes in Bihar

- *Mukhyamantri Balak/ Balika Bicycle Scheme*: It was started in 2006 by the chief minister Shri Nitish Kumar (JDU) through the Ministry of Human Resource and Development, Government of Bihar. The aim of the scheme is to provide cycles as an efficient means to reach school. It is hoped that this will increase the attendance and retention rate.
- *Jeevika Project*: The Jeevika Project began in 2006 under the chief Ministership of Shri Nitish Kumar (JDU) through the Ministry of Rural Development, Government of Bihar with support of World Bank, the program was to provide income opportunities to BPL families residing in rural areas. Credit linkages were established with banks from the year 2007 onwards through Jeevika. This project aims at enhancing small savings.
- *Mukhyamantri Nari Shakti Yojana*: This scheme was started in 2007 by chief minister Shri Nitish Kumar (JDU) through the Social Welfare Department, Government of Bihar. The program envisages holistic empowerment of women in the economic, social, and cultural spheres, state-wide campaign against child marriage, work for eradication of dowry and to implement Bihar State Women Empowerment Policy 2015.
- *Nai Peedhi Swasthya Karyakram*: This scheme was launched by the Chief Minister Shri Nitish Kumar (JDU) in 2011 through the State Health Society Bihar, Department of Health, Government of Bihar. This programme entails carrying out State-wide health check-ups. This data needs to be entered in software developed especially for recording and maintaining complete health records of individuals with full-fledged data analytics feature.detailed health check-up of school children across the state, up to 18 years of age. Medical teams travel the length and breadth of the state.

- *Mukhyamantri Jhuggi Jhopdi Mahila Saksharta Yojana*: This scheme was started by the chief minister Shri Nitish Kumar (JDU) in 2013 through the Social Welfare Department, Government of Bihar. The objective of the scheme is instilling literacy among women in slum areas to empower and expand their opportunities.
- *Aarakshit Rozgaar Mahilaon ka Adhikar*: Started in 2015 by the chief minister Shri Nitish Kumar (JDU) under Women empowerment policy 2015, it implements 35% horizontal reservation to women in recruitment to all cadres and services of the state under "Aarakshit Rozgar Mahilaon Ka Adhikar"
- *Bihar State Women Empowerment Policy 2015*: This policy was started on March 22, 2015 under the chief Ministership of Shri Nitish Kumar (JDU) through the Ministry of Women and Child Development, Government of Bihar. The policy strives to eliminate gender-based discrimination, caste and structural hindrances restricting women's access to social, economic, political, educational and health related resources. It will also ensure women's judicious access to resources and creation of a conducive environment for their wellbeing. The policy envisaged the establishment of Gender Resource Centre for capacity building on laws and acts related to violence and to conduct advocacy on issues related to women. A Working Women Hostel was started in Patna to provide safe accommodation to working women. Pre-examination training was imparted to the girls through the pre-examination training centers. Students' Guidance Centres established in 2011 at Chandragupta Maurya Management Institute for scheduled caste girls. Training on the computer, accounting, tally, DTH installation, spoken English, and beautician to 30% Mahadalit women out of total trainees through Bihar Mahadalit Vikas Mission under Dashrath Manjhi Kaushal Vikas Yojana and to schedule caste women under Scheduled Caste sub-plan of Special Central Assistance Scheme.
- *Bihar State Women Information and Resource Center / Gender Resource Center*: This center is operated for the collection, publication and transmission of information related to women, research, and development related work.

A RESEARCH REPORT FROM

CHHATTISGARH

PART 1 INTRODUCTION

In Chhattisgarh, our research report on the 'Combating the Silence from Menarche to Menopause – A Comprehensive Report on Menstrual Hygiene Management in India', was conducted in the districts of Mahasamund and Uttar Bastar, which is also known as Kanker. Both these districts fall under Niti Ayog's Aspirational District Programme (ADP)[1]. In the aspirational districts of Mahasamund and Uttar Bastar, the areas under research were remote and interior villages with a dominant tribal population. Some of these villages constituted displaced tribal and other marginalized communities, including SCs (Schedule Caste) and BCs (Backward Class) and STs (Scheduled Tribe), PVTGs, and NTs (Nomadic Tribe) and migrant and displaced communities and populations. Populations therein depended mainly on farming and daily wage labour.

For completing the research sample, a total of ten villages i.e. five each were taken from both the districts for field work and surveys. Research, data collection and analysis were done from April 2022 to February 2023. Following a participatory and mixed-methods approach, information was sought and processed on the local situation on Menstrual Hygiene Management (MHM), Water, Sanitation, and Hygiene (WASH), education, health, livelihood, income, and availability of support systems to women in the selected districts. Though both districts are doing well on many parameters under the ADP, such as education, literacy and infrastructure, our study indicates that Mahasamund and Uttar Bastar have much to achieve in terms of combating the silences on MHM with inter-sectoral perspective on wellbeing of, what we refer to as, 'Elder and Ageing Menstruating Women' (EAMW). Nevertheless, because our interaction included women as mothers, teachers, counselors, and caregivers of young girls within schools and families, we include a lateral analysis on the menstrual wellbeing requirements of school-going girls as well.

Our research has been designed to collect thick ethnographic data on actors, practices, and discourses with an inter-sectoral and analytical perspectives on MHM in selected research areas. WASH, availability of community support systems, schemes and education as well as felt needs of menstruating women form a vital part of this research. We bring data through fieldwork, interviews, Focus Group Discussions (FGDs) and observations on MHM through women's participatory voices and opinions. A total of 792 interviews were conducted by employing the Menstrual Practice Questionnaires (MPQs) wherein data was collected from 381 women from Mahasamund and 411 women from Uttar Bastar. Interviews and interactions took place in local Udiya, Kui, Desia and other tribal languages in which women were comfortable to communicate in as Hindi and English were understood by none of the respondents.

Focusing primarily on the category of, 'Elder and Ageing Menstruating Women' **(henceforth EAMW)** between the ages of 20 years to 49 years, we also share our findings on MHM related enablers and barriers for young school going girls. To understand the well-being of menstruating women beyond their school years, this study on Chhattisgarh documents the various kinds of barriers and silences in the effective MHM of EAMW. Nonetheless, we also explore our primary data to critically discern potential enablers towards an effective MHM of women between the ages of 20 years to 49 years, In the final sections, our findings are examined against the voices of key informants to crystallize the salient findings from our primary data as well as delineate context-specific and community-sensitive areas of improvement. Therefore, this case-study on Chhattisgarh ends with suggestions on short term as well as mid-term enablers and recommendations for combating the inter-sectoral hindrances prevalent in areas observed.

[1] ADP aims to improve the socio-economic status of the citizens expeditiously. The three core principles of the program are - Convergence (of Central & State Schemes), Collaboration (among citizens and functionaries of Central & State Governments including district teams), and Competition among districts (Niti Ayog 2018).

Chhattisgarh[2] is one of the poorest states in India. About one-third of the population of Chhattisgarh lives below the poverty line (Bhatt 2022). It is home to several tribal castes such as Gonds of Bastar. Chhattisgarh has about 7.5 percent of India's tribal population comprising remote and Naxalite-affected areas. The districts of Mahasamund and Uttar Bastar selected in Chhattisgarh were included in the ADP, specially selected due to tribal-focused communities and remote districts.

MAHASAMUND AND UTTAR BASTAR/ KANKER DISTRICT OF CHHATTISGARH

Mahasamund is a district located in the central Indian state of Chhattisgarh. The city of Mahasamund is the district headquarters of Mahasamund which has the Mahanadi River flowing through it. In 2011, Mahasamund had a population of 1,032,754 of which male and female were 511,967 and 520,787 respectively (Census, 2011). Average literacy rate of Mahasamund in 2011 was 71.02%, male and female literacy were 82.05% and 60.25% respectively. With regards to Sex Ratio in Mahasamund, it stood at 1017 per 1000 male compared to 2001 census figure of 1018, which is higher than the average national sex ratio in India is 940 (Census, 2011).

Mahasamund is included in the Aspirational district programme of the Niti Aayog owing to various issues such as maternal and child health. The district faces severe challenges in the health and nutrition sector, with 36.8% and 25.8% children under 5 years are stunted and underweight respectively. 75.8. Children aged 6-59 who are anaemic in the district (International Institute for Population Sciences (IIPS) and ICF 2021, p. 111-113). The condition of women's health is also not very good in the district, 63% of women aged 15-49 years are anaemic in the district (International Institute for Population Sciences (IIPS) and ICF 2021, p. 111-113).

1.1 UTTAR BASTAR KANKER

Uttar Bastar Kanker district is in the Southern region of Chhattisgarh. Earlier Kanker was a part of the old Bastar district. But in 1998, Kanker was recognized as a separate district. The total area of the district is approximately 5285.01 square kilometers. The small mountainous area is seen in the whole mountainous area. Mainly flows through the district in five rivers- Milk River, Mahanadi, Hukkul River, Sindur River and Turu River (Uttar Bastar Kanker District, n.d., About district section). In 2011, Kanker had a population of 748,941 of which male and female were 373,338 and 375,603 respectively. Average literacy rate of Kanker in 2011 were 70.29, male and female literacy were 80.03 and 60.64 respectively. With regards to Sex Ratio in Kanker, it stood at 1006 per 1000 male compared to 2001 census figure of 1005. The average national sex ratio in India is 940 (Census, 2011). Being one of the underdeveloped districts in Chhattisgarh, Uttar Bastar Kanker, or Kanker is dealing with malnourishment and maternal health issues. In Chhattisgarh, around 40% of the rural women are anaemic. Kanker district has one of the highest prevalence rates of anaemia with 65.2% of the rural girls and women being anemic, according to the National Family Health Survey – 5 (NFHS-5) 2020-21.

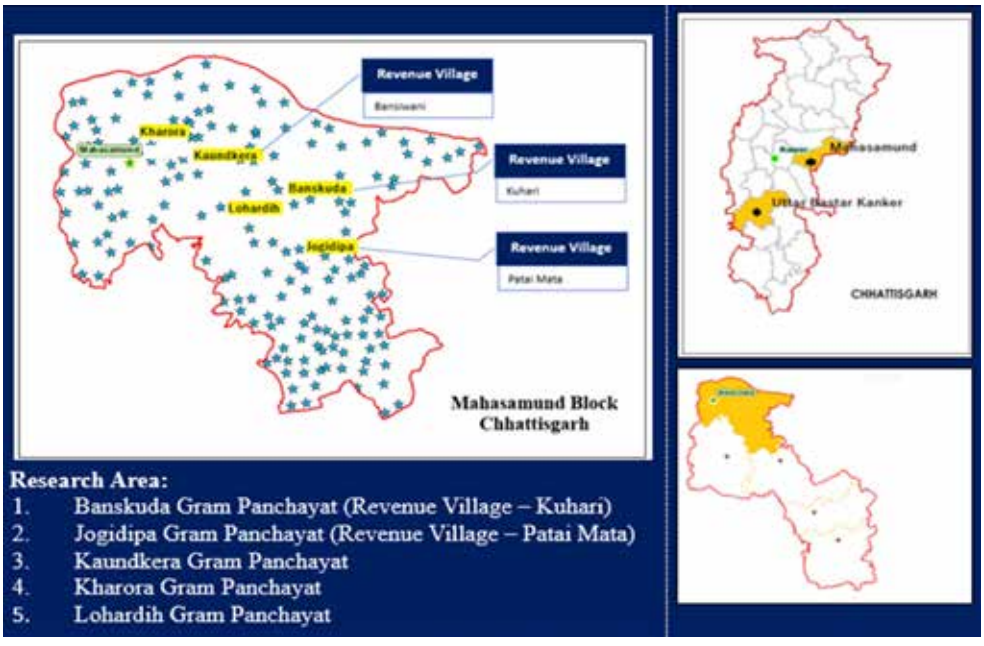
Aspirational district programme under Government of India came with great hope for Mahasamund and Uttar Bastar Kanker districts of Chhattisgarh. Since being selected as an aspirational district, Mahasamund has made significant progress in various areas. For instance, the district has developed a 'Model Colony' called Patsendri. The model colony is an innovation of various government schemes such as PM Awas Yojana, MNREGA, Jal Jeevan Mission and Mukhya Mantri Majra-Tola Vidyutikaran Yojana. Convergence of these schemes created a self-sustainable model for capacity building, employment generation, development, and positive use of social capital, with a focus on the Patsendri Community (Niti Aayog 2020). Uttar Bastar Kanker also progressed in various key areas after becoming Aspirational district in 2018. Most notable is the district's fight against anemia. The scheme 'Lalima – Loha Le Anemia Se' was launched in May 2019 in Narharpur and Bhanupratappur blocks

[2] Chhattisgarh is in the central part of India. The state shares its border with Madhya Pradesh and Maharashtra in the west, Uttar Pradesh in the north, Odisha and Jharkhand in the east, and Andhra Pradesh in the south. At current prices, Gross State Domestic Product (GSDP) of Chhattisgarh stood at 4.38 trillion (US$ 57.34 billion) in 2022-23. GSDP (in INR) of the state at current prices increased at a CAGR of 9.98% between 2015-16 and 2022-23 (IBEF, 2023, Chhattisgarh section).

of Uttar Bastar Kanker district in the first phase to tackle down severe Malnourishment and Anaemia in the district (Saha, 2020).

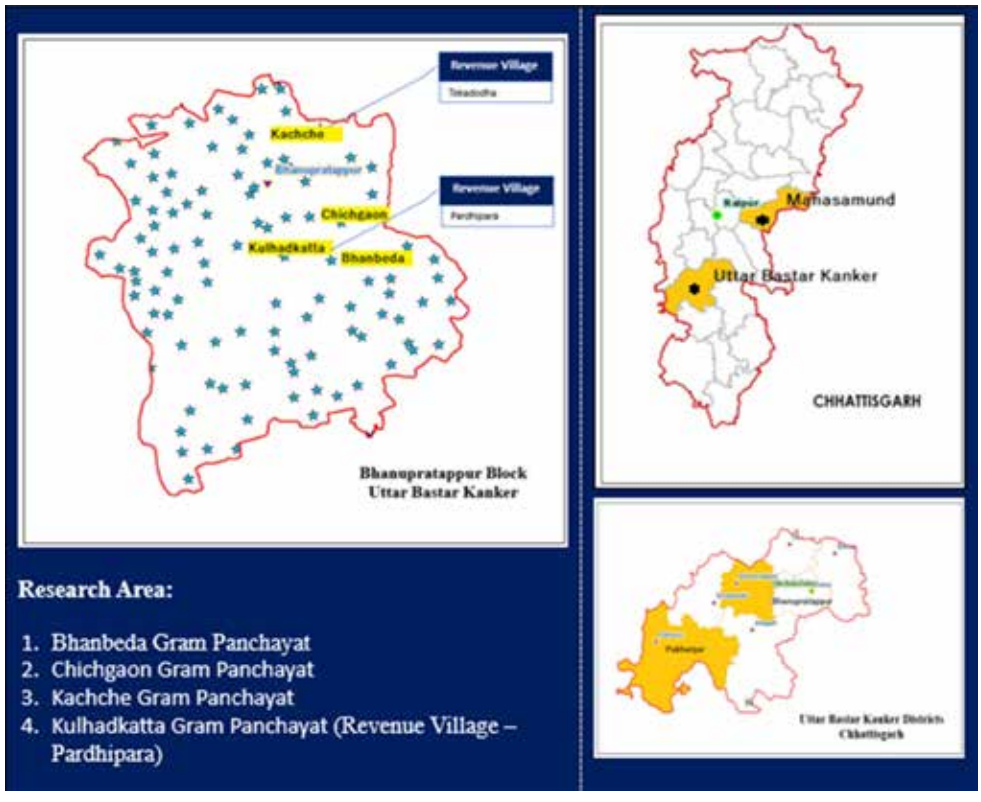
1.2 LIST OF VILLAGES SELECTED FOR THE STUDY FROM MAHASAMUND AND UTTAR BASTAR

On an average, five villages were selected from each of the fourteen districts across the seven Indian states selected for this study. In Chhattisgarh, the population sample in both the districts was taken from five Gram Panchayats of Mahasamund Block from Mahasamund and Bhanupratappur and Pakanjur Block in Uttar Bastar Kanker (See Annex 1). Factors such as access to health facilities, education, tribal villages, remote and isolated areas with scarcity of safe drinking water, electricity were taken into consideration while choosing the villages.



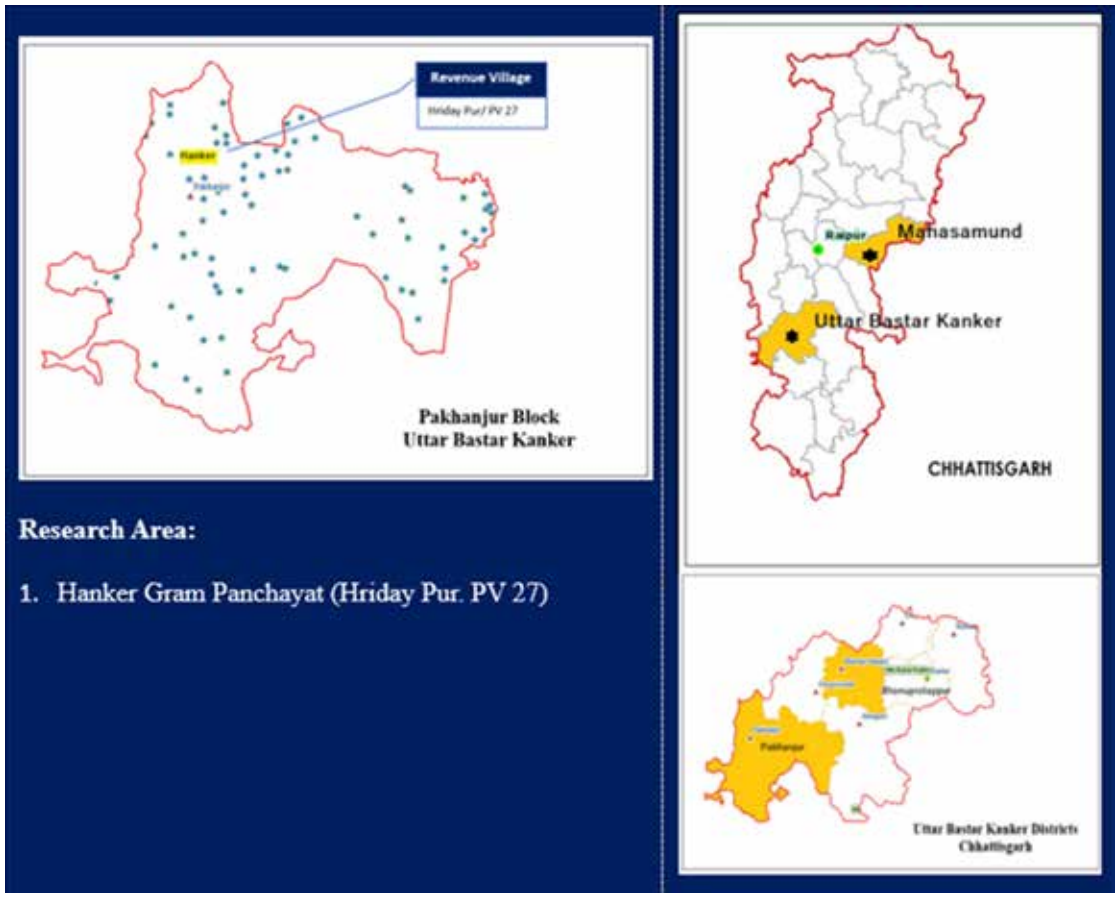
Research Area:

1. Banskuda Gram Panchayat (Revenue Village – Kuhari)
2. Jogidipa Gram Panchayat (Revenue Village – Patai Mata)
3. Kaundkera Gram Panchayat
4. Kharora Gram Panchayat
5. Lohardih Gram Panchayat



Research Area:

1. Bhanbeda Gram Panchayat
2. Chichgaon Gram Panchayat
3. Kachche Gram Panchayat
4. Kulhadkatta Gram Panchayat (Revenue Village – Pardhipara)



PART 2 DATA TOOLS AND STRUCTURE OF THE CHAPTER

2.1 RESEARCH TOOLS, METHODS AND THEMATIC FOCUS FOR DATA COLLECTION, CORRELATIONS AND COMMUNITY-BASED ANALYSES

Types of Interviews- Tools and Focus	Data Collection and Analysis- Methods and Themes	Samples	
		Mahasamund	Uttar Bastar
Tool 1 Menstrual Practice Questionnaires (MPQs)	Method 1 The MPQs were In-depth Interviews (IDIs) for- actor, discourse, and practice-analyses	381	411
Tool 2 Menstrual Practice Needs Scale (MPNS)	Method 2 Measurement of perceptions and needs based on the last menstruation cycle	30	100
Tool 3 Key Informant Interviews (KIIs)	Method 3 Voices, Excerpts, Salient Findings and Observations	12	12
Themes: WASH, Education, Health, and Livelihood	Focus: Inter-Sectoral findings, Conclusion and Comparisons		

PART 3 ACTOR ANALYSIS FROM MPQs

3.1 ACTOR ANALYSIS

In this section, socio-economic profile as well as the current menstruation status of the actors is detailed.

3.1.1 DEMOGRAPHIC PROFILE OF THE RESPONDENTS

Demographic Profile	Mahasamund in (%)	Uttar Bastar in (%)
Total Respondents	**381**	**411**
Rural / Tribal	381	411
Mother Tongue		
Bengali	0	22.1
Chhattisgadhi	96.3	71.8
other	3.7	6.1
Religion		
Adidharma	0	2.2
Hindu	100	97.6
Muslim	0	0.2
Caste/ Tribe type		
General	0.5	23.1
OBC- Other Backward Caste	47.5	11.2
SC- Scheduled caste/ BC	21.3	8
ST- Scheduled Tribe/PVTG/NT	30.7	57.7
Marital Status		
Never married	3.9	21.4
Married	90.0	71.3
Widowed	5.8	6.6
Separated	0.3	0.2
Divorced	0.0	0.5

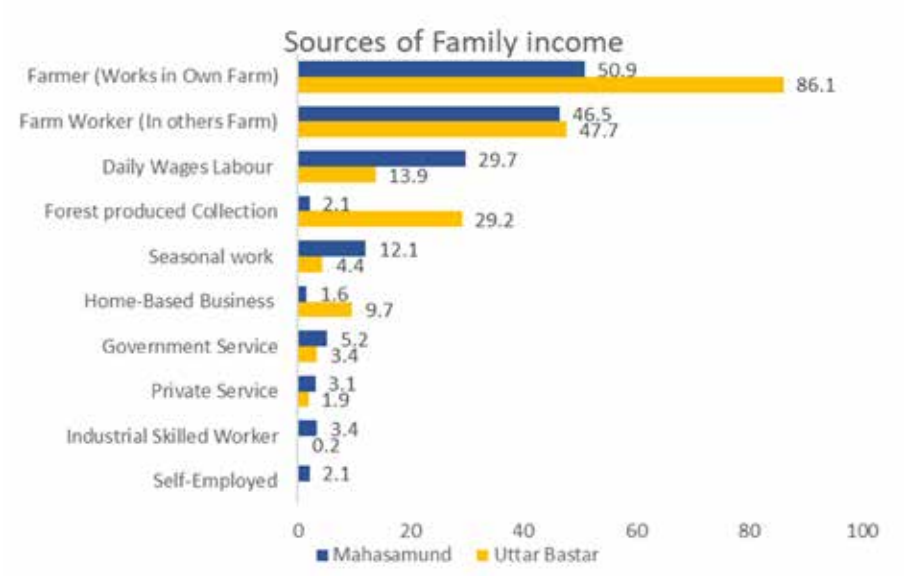
➲ **Religion:** Out of 792 of our respondents, 98.7% stated Hinduism as their religion while the rest of the sample pertained to Adidharm and Islam.

- **Community:** 345 of our respondents from both the districts belonged to the ST communities (Binzvar, Gond, Halba, Jogi, Kanvar, Khairwar, Madavi) while 8 were PVTGs (Kamar), 1 was NTs (Dhangar), 227 were OBCs (Chandrakar, Dhivar, Dhobi, Gadriya, Kalar, Kenvat, Lohar, Marar, Nhai, Nishad, Patel, Rajak, Raut, Sahu, Teli, Vishwakarma), 82 SCs (Chamar, Chauhan, Gada, Pahadiya, Sahis, Satnami) and 92% General formed the rest of the population interviewed.
- **Marital Status:** 636 out of 792 women interviewed were married, the average age of marriage in Mahasamund was 18 years and in Uttar Bastar it was 20 years.
- **Children and Family Size:** Average number of children was two and average family size was four.

3.1.2 AVERAGE INCOME

Family income on the lower side: The average yearly income of families in Kanker was 59402 INR as compared to 75598 INR for Mahasamund. 250 (65.6%) from Mahasamund and 324 (78.8%) from Uttar Bastar women were earners. The median earning of women from both districts was 10000 to 20000.

3.1.3 SOURCES OF FAMILY INCOME



*Multiple Choice Question

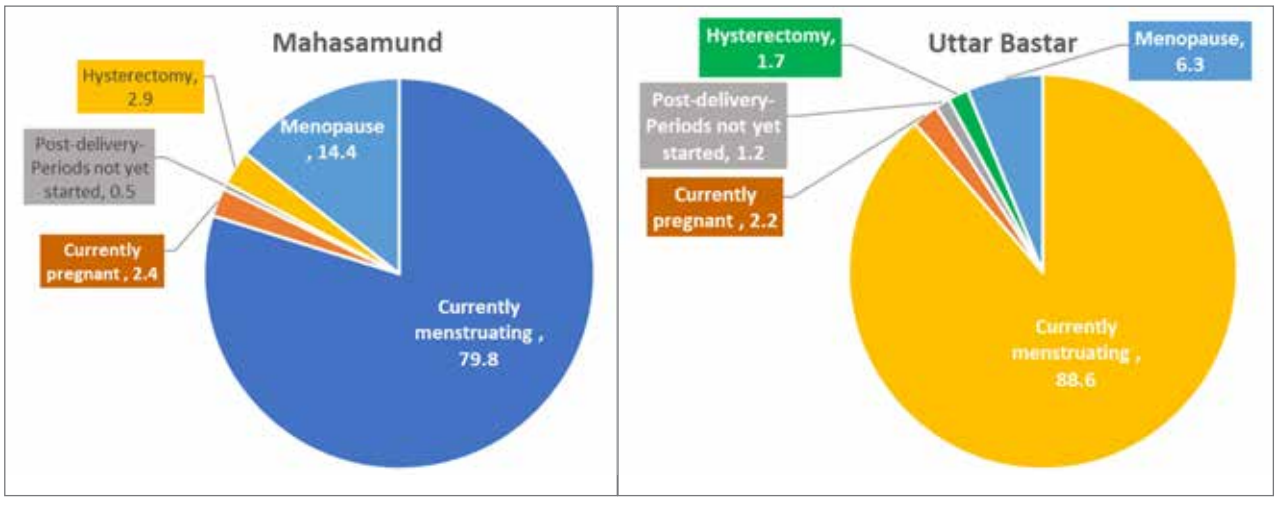
INCOME TRENDS: (MAHASAMUND N= 381, UTTAR BASTAR N=411)

- **Farming** was the main and single source of regular income for 86.1% for families of total women interviewed from Mahasamund and Uttar Bastar followed by Minor Forest Produce (MFP) collection that formed the main (single) or supportive (multiple) source of income for 25% of our interviewees. Contract labour as either daily wage work or seasonal farm work emerged as the second highest source of augmenting family income for nearly half of the families. In all, 75.4% respondents from Mahasamund and 61.6% from Uttar Bastar, reported working on other farms or daily wages laborer or seasonal workers was one of their sources of income.
- **Traditional Knowledge and Skills**: 17.3% of respondents from Mahasamund and 92.5% of respondents from Uttar Bastar possess traditional knowledge and skills such as art, craft, knitting, farming, dairy products, etc. Out of these, 446 total women possessed traditional skills from both the districts but only 16 (24.4%) women from Mahasamund and 13 (3.4%) from Uttar Bastar could earn using these.

- **Women lack Disposable Income:** Although they worked on their own farms and their families also counted on multiple sources of income, 27.5% of the women from our total sample in Mahasamund and Uttar Bastar reported that they 'did not earn'. Our data indicates that women remain hamstrung in terms of disposable income for personal expenses as well as any decision making on medical care in relation to MHM.
- 574 out of a total of 792 interviewed in both the districts were earning. Average income of 250 women (n=381) from Mahasamund was 36974 INR whereas 324 (n=411) women from Uttar Bastar earned only 24422 INR.

3.1.4 MENSTRUATION PROFILE (MAHASAMUND N= 381, UTTAR BASTAR N=411)

- **Total EAMW**: 84.3% of the total women surveyed through the MPQs were in their active menstrual years.
- **Age at Menarche:** Average age at menarche was 13, whereas the average age at attaining menopause was 43 years.
- **Number of Hysterectomies**: A total of 18 hysterectomies (i.e., among 2.3% of total population surveyed) were reported from both the districts with the average age at hysterectomy being around 34 years.



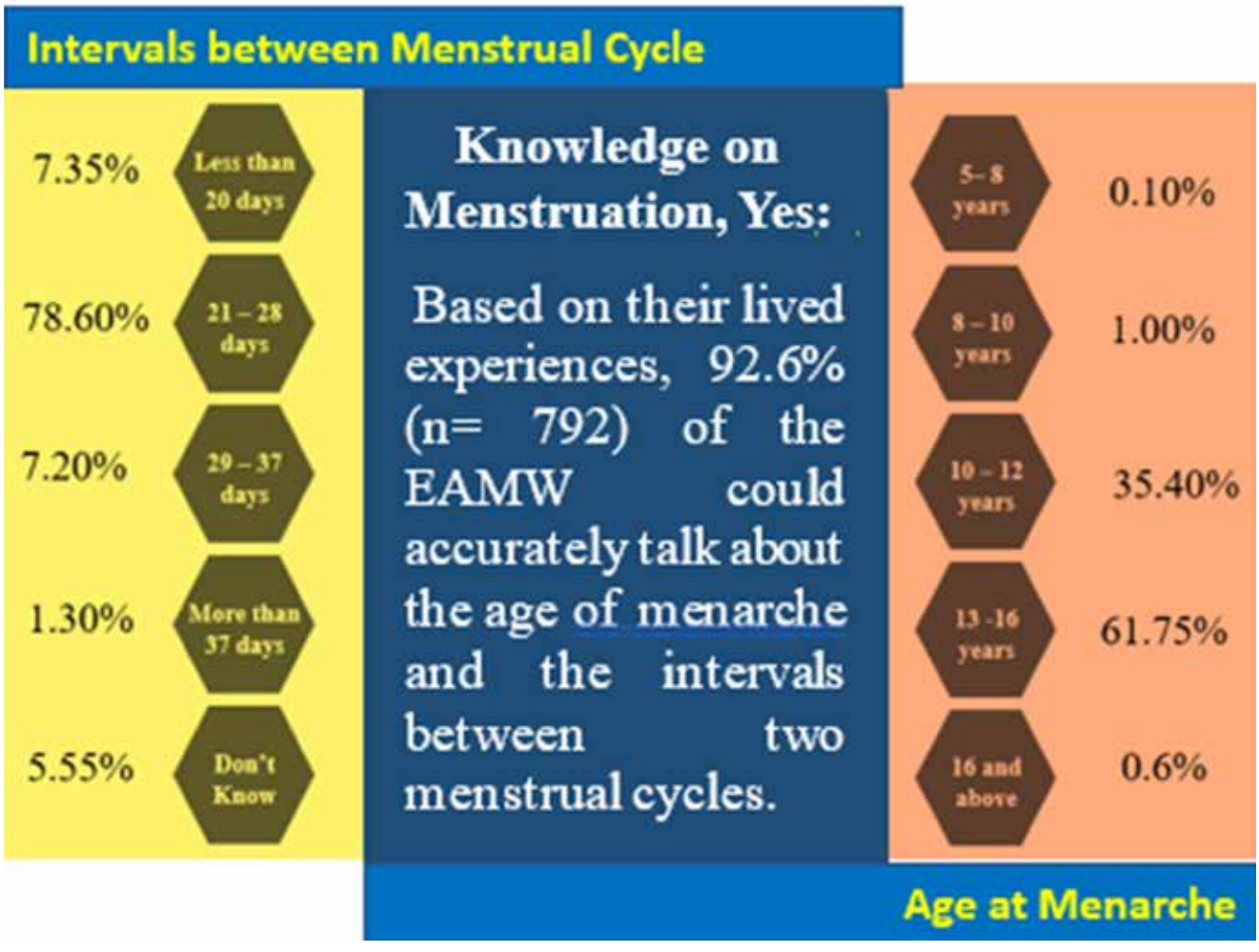
3.2 DISCOURSE ANALYSIS

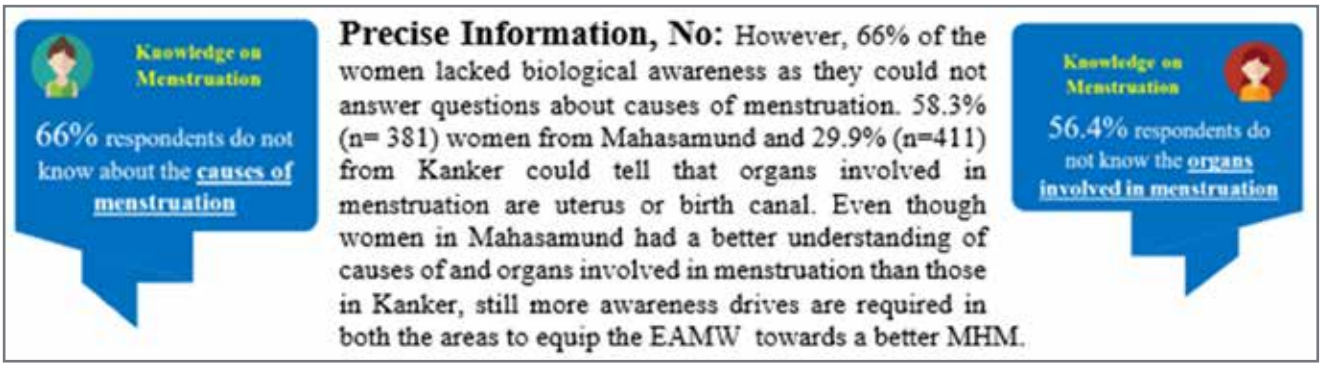
4. In this section, we analyze the information given during the IDIs to understand how much the women participant understand menstruation cycles and how it impacts their bodies Further, the findings also shed light on the level of awareness and the silence around the topic, for instance with whom and how much they chose to discuss or not discuss on issues related to MHM. Data is presented on educational backgrounds of women, how the women position themselves on medical care options and facilities available/ not available and their awareness on use and disposal of menstrual absorbents, health risks such as common disorders and symptoms they experience during menstruation including in cases of hysterectomy, where applicable.

4.1.1 KNOWLEDGE ON MENSTRUATION

Knowledge about menstruation	Mahasamund (in %)	Uttar Bastar (in %)
Total Respondents	**381**	**411**
Causes of Menstruation		
Hormonal change	32.8	33.3

Disease	1.0	0.2
Do not know	66.1	65.9
Natural process (naisargik/ prakrutik/ bhagwan ki den)	0.0	0.5
Organs Involved in Menstruation		
Uterus/ Birth canal	58.3	29.9
Abdomen/ Bladder	3.4	1.5
Do not know/ not answered	38.3	68.6



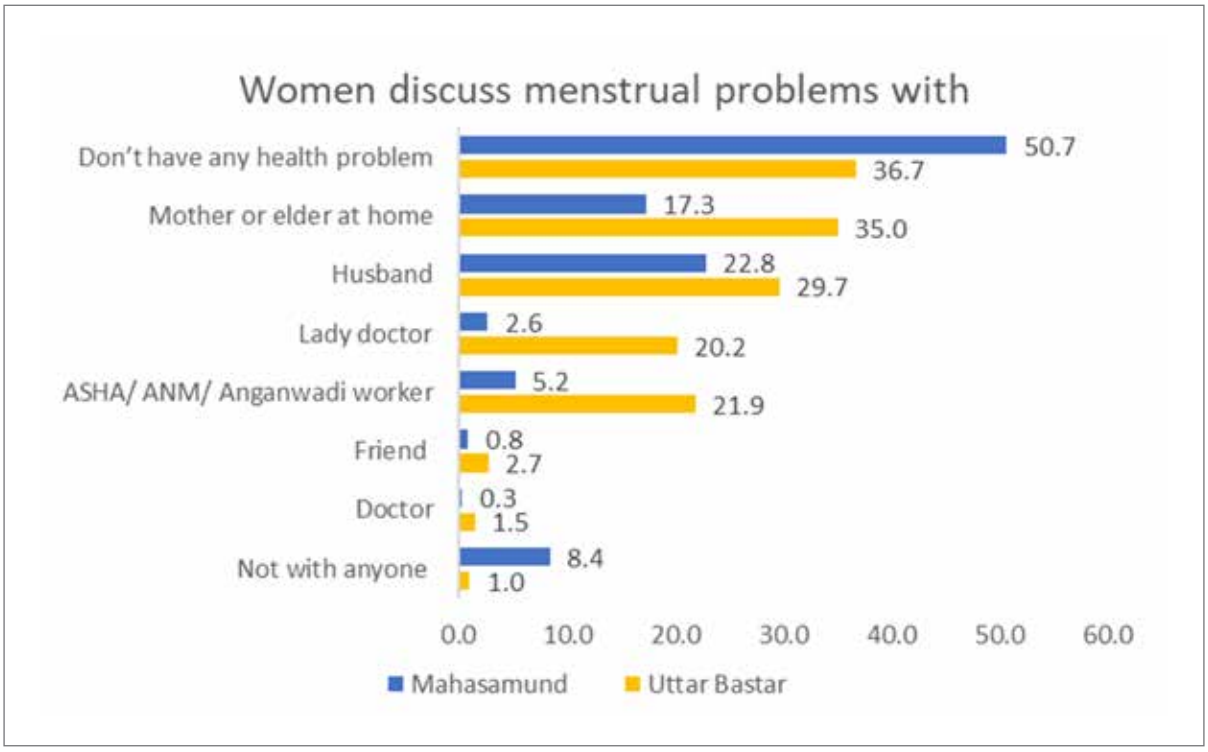


- **Basic Understanding, Yes:** Based on their lived experiences, 92.6% (n= 792) of the EAMW could talk accurately about the age of menarche and the intervals between two menstrual cycles.
- **Precise Information, No:** However, 66% of the women lacked biological awareness as they could not answer basic questions about causes of menstruation. 41.7 % (n= 381) women from Mahasamund and 70.1 % (n=411) from Kanker were unaware of the organs involved in menstruation.

4.1.2 SOURCE OF INFORMATION ON MENSTRUATION

For young girls the top sources of information on menstruation emerged as follows:

- Top sources of information for young girls about menstruation at the time of Menarche were parents, grandmother, sister, or sister-in-law reported from both districts.



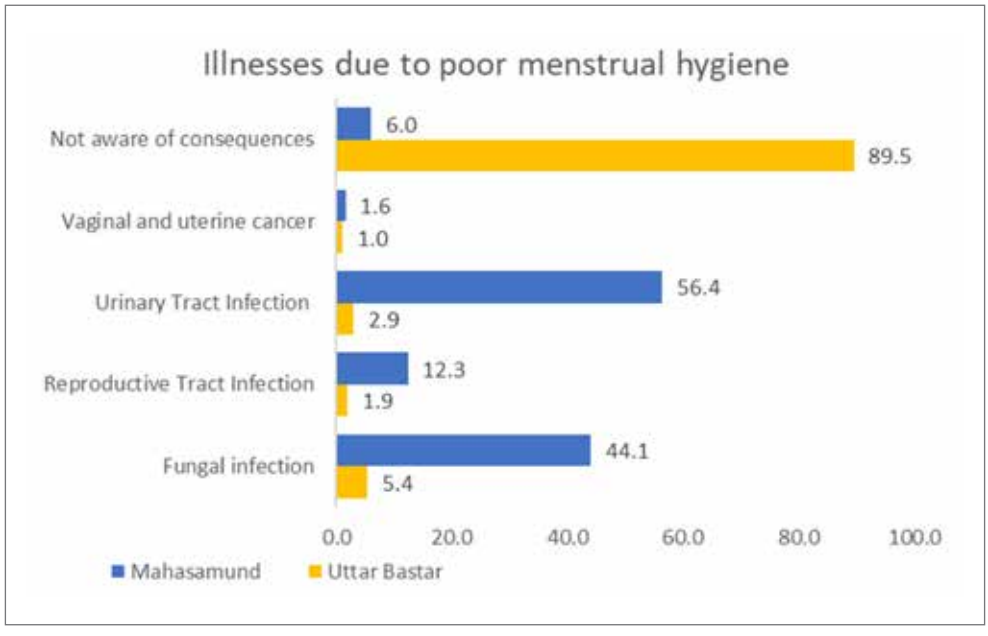
*Multiple Choice Question

WOMEN LIKE TO DISCUSS THEIR MENSTRUAL PROBLEMS WITH THE FOLLOWING:

- **Close Relatives:** Mothers and elders were the most important source of information on menstruation for our respondents when they experienced menarche as young girls.
- **Frontline Health Workers (FHWs):** Out of the total of 693 EAMW surveyed, only 2.4% from Mahasamund and 6.6% from Uttar Bastar received information about menstruation in the village such as Accredited Social Health Activist (ASHA), Auxiliary Nurse and Midwife (ANM) and Anganwadi workers (AWW).
- **Spouses:** 209 (26.4%) of Women from both districts felt comfortable talking about menstrual problems with husbands, which is a positive indication of trust between spouses on matters related to MHM and intimate health. If men can be oriented, stay alert and helpful on their wive's MHM issues, that would bring a positive health outcome for EAMW, besides combating the silence on it.
- **Nobody:** However, 8.4% of our respondents from Mahasamund and 1% from Uttar Bastar prefer to talk with no one and remain silent about their menstrual problems. 193 (50.7%) from Mahasamund and 151 (36.7%) from Uttar Bastar denied having any problems w.r.t MHM.

4.1.3 MENSTRUAL HEALTH, EDUCATION, AND AWARENESS ON INFECTIONS

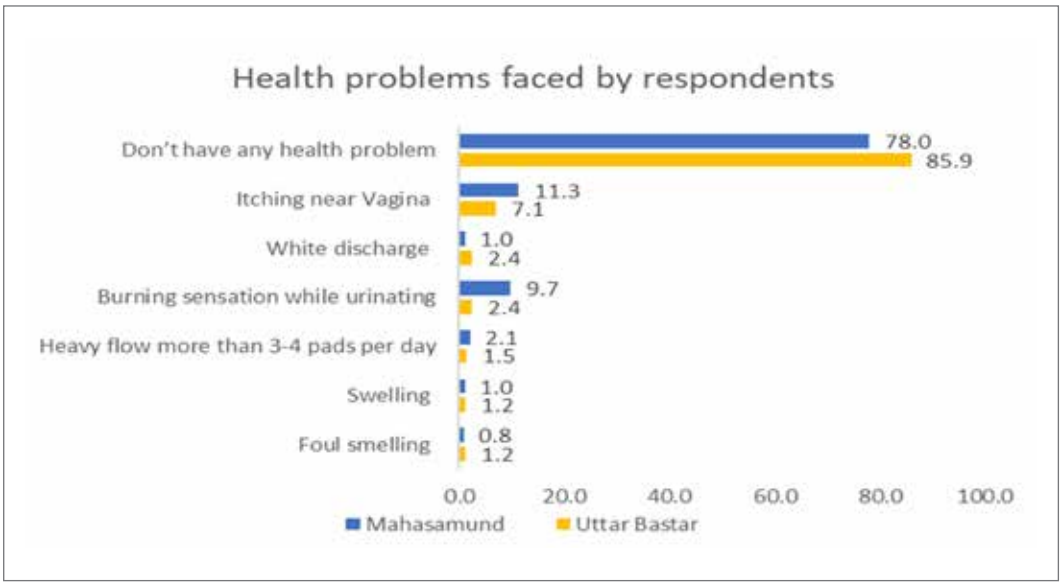
Apart from the use of different menstrual products, the study presents data on health problems which were experienced by our respondents during menstruation. It was further verified whether they visit the doctor in case of any health issues or prefer to keep quiet and bear it. Adverse health conditions while working in or outside the home may lead to rashes, urinary tract infections (UTIs), and reproductive tract infections (RTIs) for many women, as indicated by our survey findings.



*Multiple Choice Question

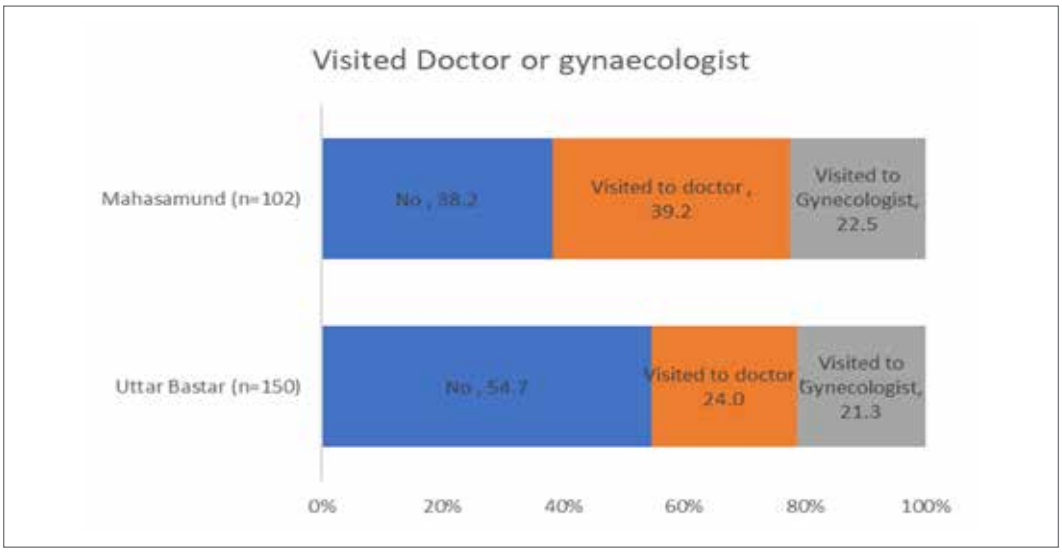
- **Widespread Ignorance**: When asked about the side effects of poor menstrual hygiene, only 46 EAMW from Uttar Bastar (n= 414) could speak about the impacts of poor menstrual hygiene. 368 women could not answer. Situation in Mahasamund about awareness was the exact opposite. 93.9% women out of 381 from Mahasamund could respond about the impacts of poor menstrual hygiene. Only 6% could not answer.
- **Fungal Infections and UTIs:** 94% women from Mahasamund knew about lack of MHM and risks of infection, 44.1% stated that poor menstrual hygiene leads to fungal infections while 56.4% said it causes UTIs.
- **Low knowledge on exact health risks:** Adverse health conditions while working in or outside home often lead to rashes, Urinary Tract Infections (UTIs) and Reproductive Tract Infections (RTIs). However, our findings indicate a lack of awareness on these risk factors. Not being able to understand and/or give answers on the relationship between MHM and rashes, infections and other risks indicates ignorance per se.
- **No Schooling, Taboos and Communication Barriers:** However, given that speaking about periods itself is a taboo or is a challenge due to shyness/ hesitancies, generalizations on awareness on MHM may be misleading. Community and area specific conclusions are a better way ahead. One of the most noteworthy findings from both the districts of Chhattisgarh has been that around 16% women did not attend schools. 44.3% of our participants (from a total of 792) were women who attended school only up to secondary grade. In other words, all these women did not receive formal education. EAMW who participated in our study either remain shy to speak or know about menstruation or effectively become silent on the theme.

4.1.4 HEALTH SYMPTOMS DURING MENSTRUATION

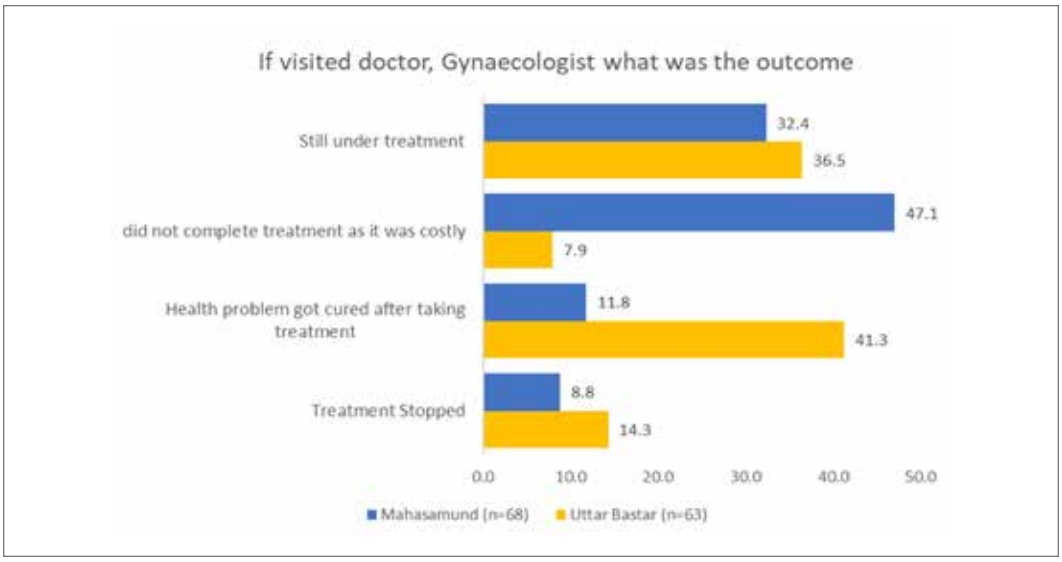


*Multiple Choice Question

- **MHM, health and accessibility to health care**: Apart from the modes as well as patterns of and awareness on MHM, the survey imparts light on the health problems undergone by participants during menstruation. For arriving at inter-sectoral findings on health management, women were asked if they visit a medical professional to resolve menstrual health issues and reasons if they do not.
- **Vaginal symptoms and attitude:** More than four-fifth (82.1%) of the EAMW (n= 693) from both districts reported that they did not have any health problems during menstruation. In the later part of the survey, however, they confirmed heavy flow, itching near vagina and burning sensation while urinating as the top three issues women faced due to poor vaginal hygiene. Half the women reported seeking medical advice over menstrual health problems and only four out of ten actually visited a doctor and got cured after completing treatment.



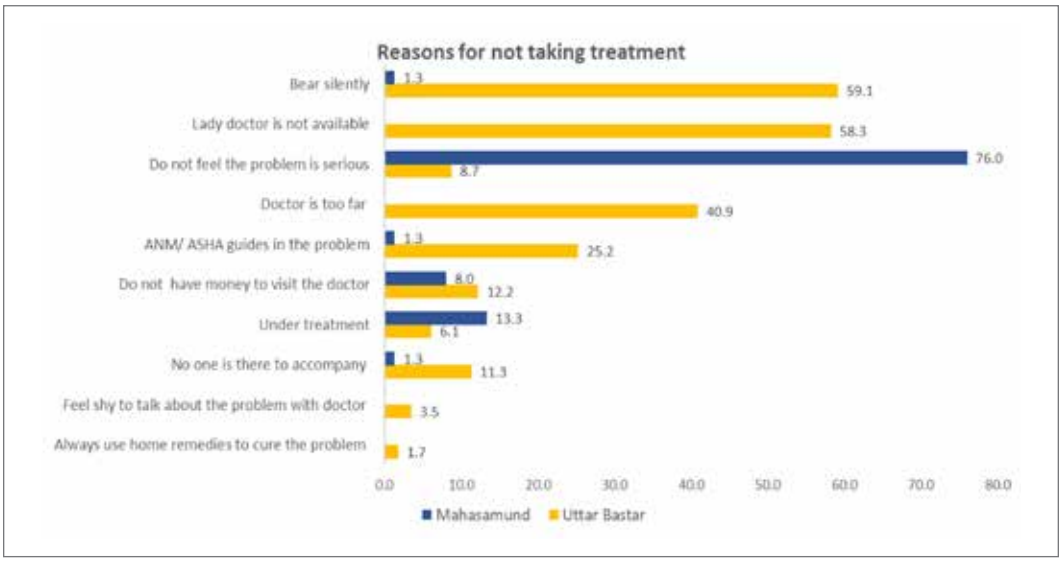
- **Treatment:** Out of 252 women from both districts who reported health problems during menstruation, 121 women i.e., 48% reported that they never went to a doctor for menstrual health problems they face. Only 34 (13.5%) women who informed us that they had visited a doctor, got cured after completing treatment. 45 (17.9%) women reported that they were still under treatment. Rest all women stopped their treatment due to monetary barriers.



Indeed, if health anomalies during menstruation are not resolved, pushed to the peripheries, or remain shrouded in silence, women have much to lose in social, economic, and personal spheres. For **combating** health and hygiene related **silences** on menstrual hygiene and care for women beyond school years to benefit the EAMW, the governmental healthcare must tune itself to hear their voices. In the last section of this chapter, titled 'Excerpts and Voices' we bring community-based views and suggestions from women over this issue.

- **Neglect, hesitation, and Silence:** Women tend to neglect health issues related to menstruation in Uttar Bastar district. This barrier is further exacerbated by the hesitation to speak on menstrual health and inability to seek medical advice on a regular basis owing to several reasons including economic encumbrances.
- **Medical Care, Access, and Unaffordability:** 52% of our respondents visited a doctor to seek treatment out of which only 26% got cured. 39.7% of our total respondents stopped treatment due various reasons, unaffordability and accessibility of medical care being the most prominent ones.

4.1.5 REASONS FOR NON-TREATMENT (N=792)



*Multiple Choice Question

- **Ignorance:** More than one-third of the total women, i.e., 35.3% did not feel that the problem was serious.
- **No Lady doctor/ Gynaecologist triggers a silence on MHM:** 58.3% of our informants from Uttar Bastar (n=411) refrain from seeking medical advice on MHM owing to non-availability of a lady doctor.
- **Attitude (Shyness and Silence) in Uttar Bastar:** 3.5% of the women singled out shyness as one of the main causes that impedes them to discuss their menstrual health openly. Effectively this means that 59.1% of our interviewees preferred to remain silent over their menstrual health issues.
- **Attitude in Mahasamund:** More than three fourth of the women from Mahasamund do not feel the problem is serious enough to seek treatment.

4.1.6 HYSTERECTOMIES

Out of 792 EAMW surveyed in both the districts, eighteen women had undergone hysterectomies at an average age of 34 years, which certainly is a very young age for opting for such a procedure. In total 18 women in both the districts had opted for hysterectomy out of which 12 had received both pre- and post-operative counseling. Nevertheless, in comparison to the six other states included in our study, namely, Assam, Bihar, Odisha, Haryana, Maharashtra and Tamil Nadu, cases of hysterectomy at 2.3% of total respondents in both districts from Chhattisgarh, were on the lesser side.

- **Biological Causes:** Hysterectomy causes ranged from stomach pain during menstruation, tiredness while working, fibroids and other gynecological issues. Heavy bleeding, irregular or frequent periods, and increased menstrual hygiene disorders were also reported.
- **Socio-economic Causes:** In Uttar Bastar Kanker, 28.6% (n= 411) of the EAMW surveyed reported the fear of loss of wages due to periods and hinted at unfair work conditions driving them towards MHM challenges and, increasing the likelihood of hysterectomies. In Mahasamund, 54.5% (n=381) of women reported they wanted to get rid of menstrual-related problems such as stomach pain, cramps etc. Weakness due to heavy bleeding or frequent periods, white discharge, to become safe from cancer due to uterine Fibroids convinced some women for hysterectomies.
- **Government/ Private Treatment:** In Uttar Bastar, 60% women preferred to go to government hospitals or missionary hospitals whereas 72.7% of women from Mahasamund went to private hospitals for hysterectomy. Four bores between 5000 INR to 30000 INR for hysterectomy procedures in private hospitals. Seven respondents reported expenditure was above 40000 INR, while one spent the sum of 100000 INR and another shelled out 150000 in a private hospital. Out of seven hysterectomy cases of Uttar Bastar, three who opted for Government hospitals, bore no expenditure.
- **Aftermaths of Hysterectomy:** 16 women suffered from weakness post-hysterectomies. Three women reported inability to lift heavy things, four had anaemia post-hysterectomy and eight reported that they were not able to work like earlier. Around 90% of total women operated for uterus removal, reported problems like weakness followed by not being able to work like earlier, the inability of lifting heavy things. Almost all women from Mahasamund received pre- and post-operative counselling, in comparison to Uttar Bastar where only half of the women received it.

Our findings on hysterectomies in Mahasamund and Uttar Bastar Kanker suggest that the informal labour sector in tribal areas of Chhattisgarh discriminates against women and creates pressures on husband-wife teams *(Jodi/s)* working together, almost in the same way as it happens elsewhere such as in the case of sugarcane farming sector in Maharashtra. Moreover, misconceptions about uterine relevance post motherhood are abound. Further, MHM related encumbrances and silences faced by women exacerbated by inadequate WASH facilities, endanger a women's menstrual/reproductive health and well-being. Not

surprisingly, marginalized women face complex challenges and crossroads regarding their MHM related wellbeing options, oftentimes leading to hastily executed hysterectomies. MHM of EAMW should become a vital part of labour laws, public health, and community -based awareness drives.

4.2 PRACTICE ANALYSIS

Good menstruation practices start with the usage of clean menstrual absorbents followed by maintenance of reproductive hygiene from menarche till menopause. This section brings to light the prevalence of practices regarding personal hygiene such as washing hands and genitals during menstruation as well as usage and disposal patterns of menstrual hygiene products. We also bring data on how personal and community-based beliefs, customs and taboos influence MHM outcomes and self-care regimes of our respondents. In the tribal belts of Mahasamund and Uttar Bastar, given their circumstances women adhere to traditional methods of MHM over pads etc. Out of a total of 693 menstruating women interviewed from Mahasamund and Uttar Bastar less than one-third women i.e., 31.5% women use sanitary pads, and 4.5% women use reusable sanitary pads, rest all women use cloth.

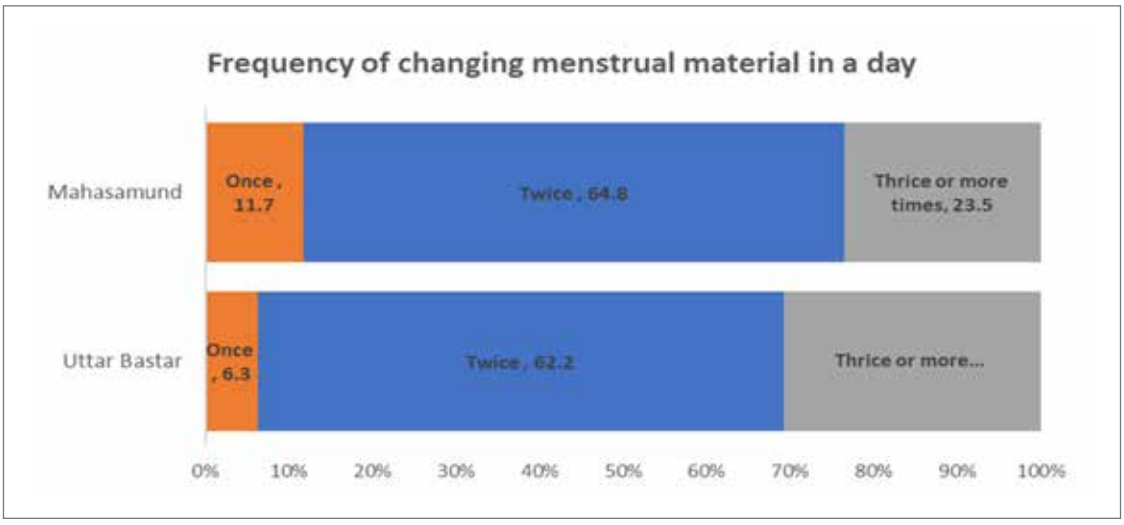
4.2.1 SANITARY PADS OR OTHER ABSORBENTS

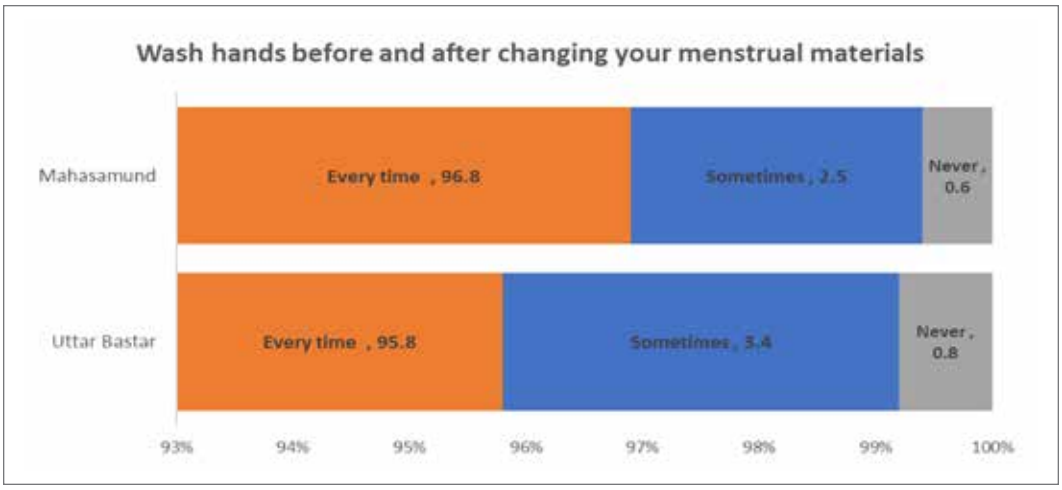
- **Cloth:** Out of the total of 693 EAMW interviewed from both districts, 69.7% women surveyed use only cloth during menstruation. Precisely, 83.5% EAMW in Mahasamund and 58.2% EAMW in Uttar Bastar use cloth because of its ready availability, affordability, durability and also, lack of awareness about other menstrual products.
- **Other Material**: Reusable sanitary pads were used by 31 EAMW; 4 women (out of 315) from Mahasamund and; 2 (out of 378) from Uttar Bastar use cotton. Nonetheless, choice of material during menstruation speaks of preferences as much as it does of scarcities as well as capacities to spend on MHM.
- **Pads in Combination with Cloth:** Sanitary pads, on the other hand, were used by 23.2% women from Mahasamund and 38.4% EAMW from Uttar Bastar. However, our data also indicates that pads are used in combination with a cloth as 56% from the total EAMW felt that the latter is easy to use and also easily available as pointed out by another 25.1% EAMW besides the view of 7.6% others who factor in its durability which makes it a favorable choice alongside its affordability (2.2%).

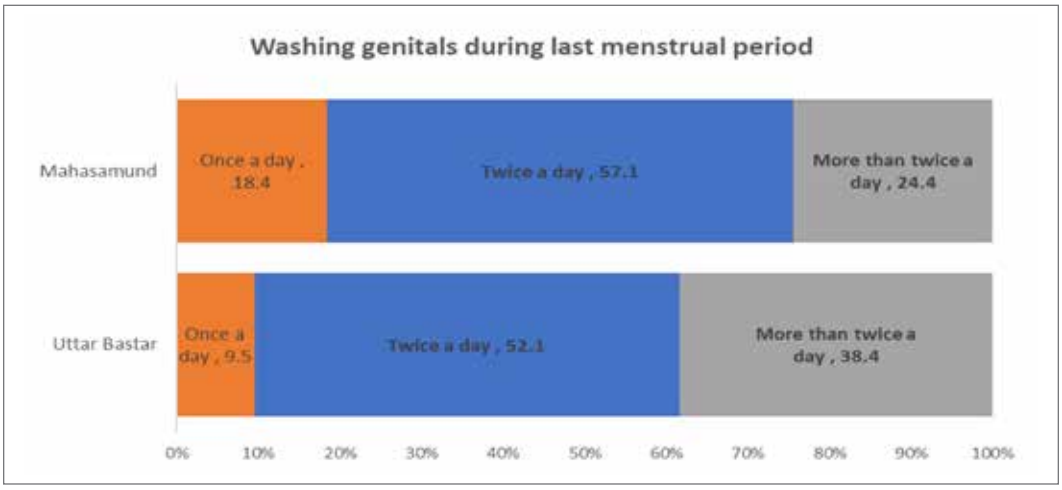
4.2.2 SPENDING CAPACITY ON MENSTRUAL HYGIENE PRODUCTS

- Only 27.3% EAMW from Mahasamund and 41.1% EAMW from Uttar Bastar spend on sanitary pads. The average spending of sanitary pads users was found to be merely 18 INR per month.

4.2.3 PERSONAL HYGIENE PRACTICES AND WASH DURING LAST MENSTRUAL CYCLE (N=693)



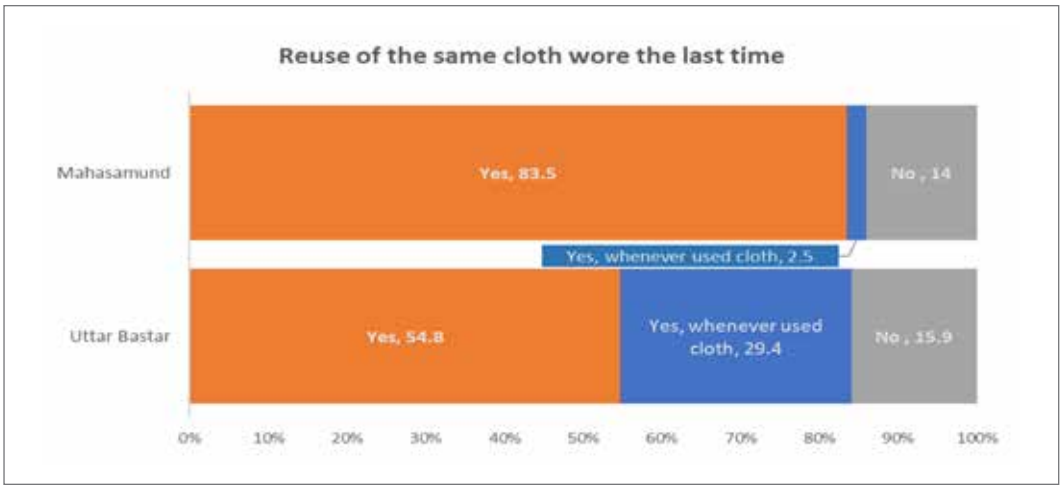


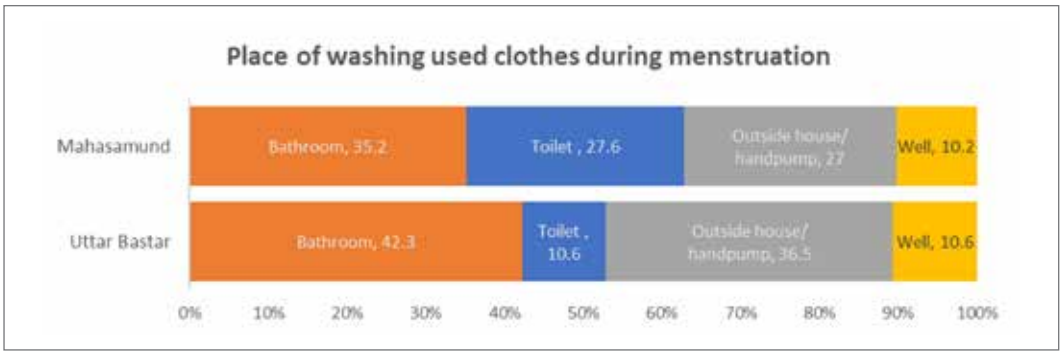


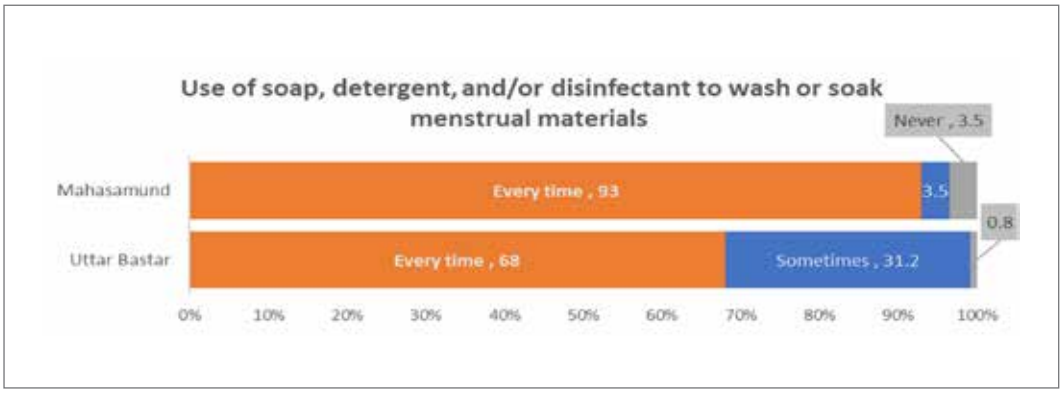
Our data indicates adequate awareness towards MHM and WASH alongside provision of and access to proper WASH infrastructure and sanitation services in both districts of Chhattisgarh

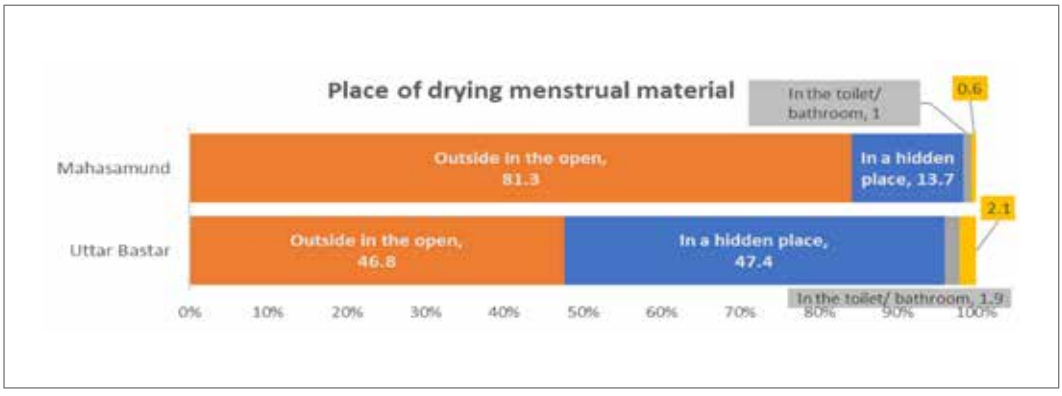
4.2.4 MENSTRUAL HYGIENE PRACTICES

Safe hygiene practices consist of washing and timely changing menstrual absorbents as well as their proper disposal. This may vary with the absorbent type. Personal hygiene also depends on changing the absorbent during the day, keeping genitals clean, washing hands before and after changing the menstrual absorbent. The survey assessed all practices used to follow hygiene and management of material during menstruation.









MENSTRUAL HYGIENE PRACTICES: MENSTRUATING WOMEN (N= 693)

- **Reusing MHM Products:** 83.5% from Mahasamund and 54.8% of EAMW from Uttar Bastar **reuse the cloth**.

- **Washing MHM Products:** 63.2% EAMW from Mahasamund and 52.9%EAMW from Uttar Bastar often wash their menstrual material in the bathroom and toilets. The rest of the women keep washing outside the house near the hand pump, well, and stand post.
- **Use soap every time:** 93% EAMW in Mahasamund and 68% EAMW in Uttar Bastar use soap while washing menstrual clothes every time.
- **Use soap sometimes:** However, in prevalence of WASH related hardships, 31.2% women from Uttar Bastar **use soap only sometimes** to wash menstrual clothes.
- **Drying MHM products**: While reusing cloth during menstruation, apart from washing, one also needs to follow the practice of drying the cloth properly in sunlight. In comparison to Uttar Bastar, practices related to drying reused menstrual clothes were found to be better in Mahasamund. 8 out of 10 EAMW from Mahasamund dry their menstrual clothes outside in the open. Whereas merely less than 5 women out of 10 follow this practice in Uttar Bastar. It was observed that only 15.2% EAMW from Mahasamund and nearly half, i.e., 51.3% EAMW from Uttar Bastar, dry their menstrual clothes in a hidden place.
- **Use of dry menstrual material:** 86.7% and 63.8% from Mahasamund and Uttar Bastar, respectively, ensure that their clothes are completely dry before using them.

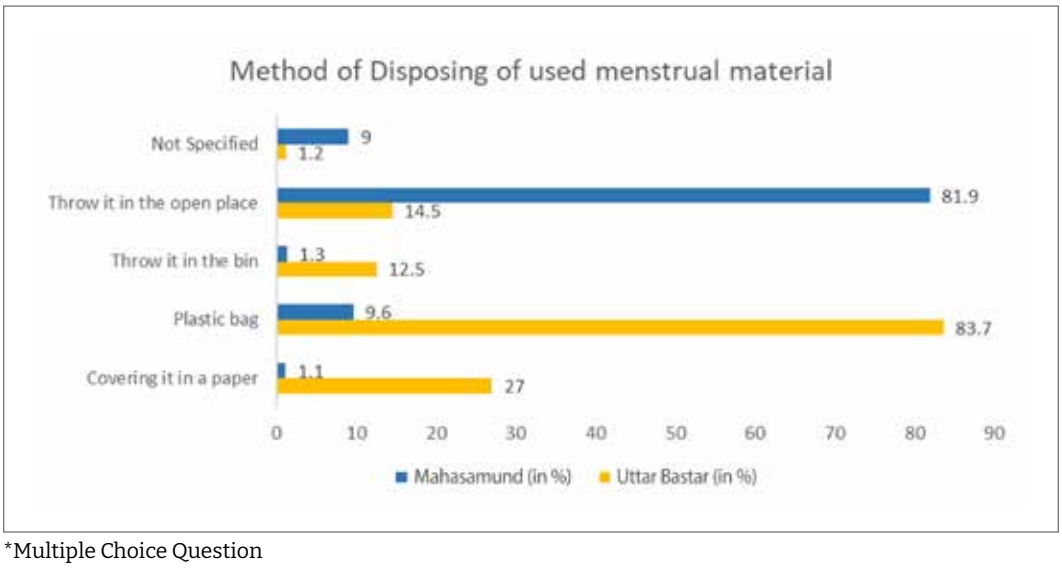
All the above findings depict that almost all women have basic facilities like water, toilets, and an affordable environment to use soap and clean clothes in both districts in Chhattisgarh. In case they lack these facilities, it is apparent that the EAMW in Chhattisgarh try to arrive at some makeshift arrangements to cater to the MHM requirements to the best of their possibilities.

4.2.5 AREA-SPECIFIC DISPOSAL MECHANISMS

- **No specific Disposal Mechanism in place**: When asked about the system of disposal of menstrual material in their area, it was found that women have to manage problems at their own levels. The district does not have any disposal mechanism for menstrual materials nor monitoring mechanisms to follow -up and optimize implementation of hygienic practices.

METHODS OF DISPOSAL

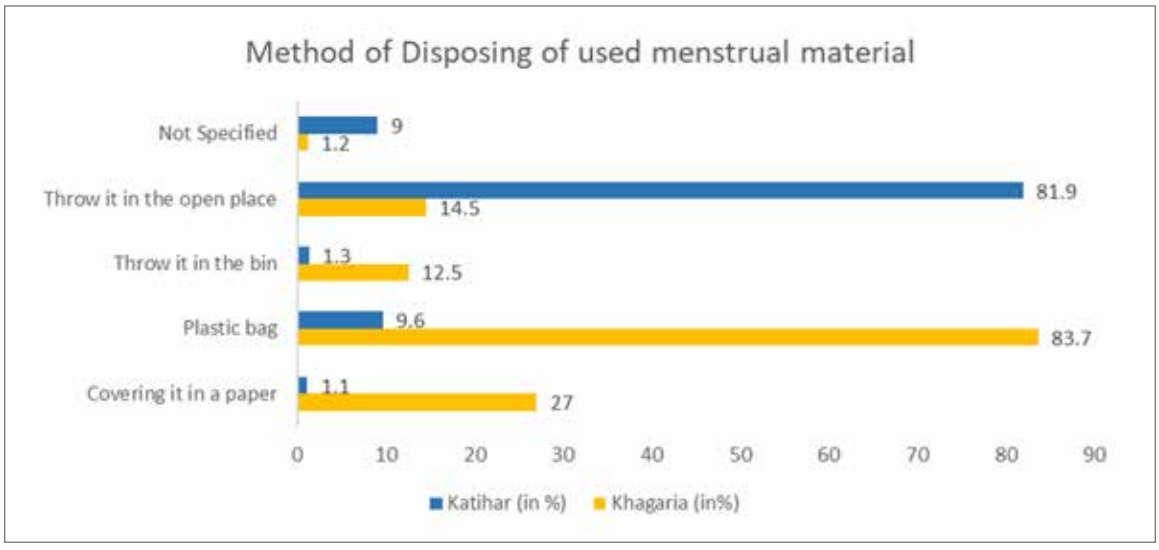
Common Practices for disposing of menstrual material were found to be different in Mahasamund than in Uttar Bastar. In Mahasamund, when women are away from home, they usually prefer not to change the menstrual material during periods until they return.



*Multiple Choice Question

Methods of disposal in both districts - When at home (Mahasamund n= 381, Uttar Bastar n=411)

- **Top Practices:** When at home, women in Uttar Bastar either bury or burn the used menstrual material whereas more women in Mahasamund throw it in the dustbin than burn it.

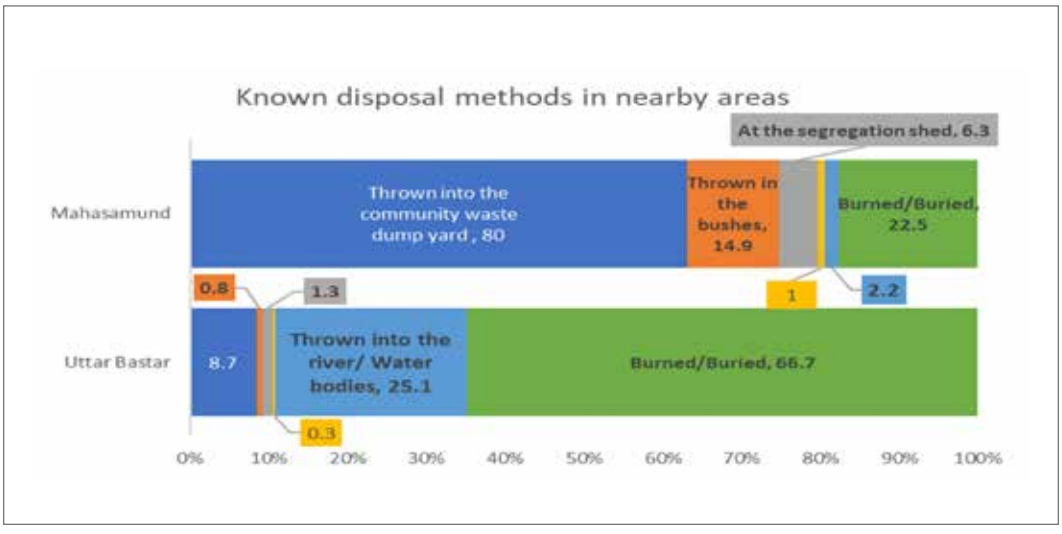


*Multiple Choice Question

Methods of disposal in Both Districts: When away from Home (Mahasamund n= 381, Uttar Bastar n=411)

- **Top Practices:** When women are away from home, they usually do not prefer to change menstrual hygiene materials outside. Rest of the women in Mahasamund burn or throw used menstrual material either in the dustbin or throw somewhere away from the workplace in open space. It was seen that 10.1% women from Uttar Bastar carry used menstrual material to home to dispose it there.

4.2.6 KNOWN METHODS OF DISPOSAL IN THE COMMUNITY AS WELL AS NEARBY AREAS (N=792)



- **Community dump yards/ Burn:** According to our respondents, different practices were Social customs, beliefs, myths, and taboos.

The world of social customs, replete with its mandatory do's and don'ts in various communities represents their beliefs and mandates. Social customs, beliefs, myths and taboos contain overt and covert forms of barriers and enablers which influence MHM related practices as well as everyday experiences of menstruating women. In this respect we have quite similar findings from Chhattisgarh's Mahasamund and Uttar Bastar districts, the same being presented as follows:

Customs followed by women in reference to menstruation: Mahasamund District

Mahasamund (381 respondents)	Strongly agree	Agree	Disagree	strongly disagree
I am allowed to mix with others socially during my periods.	**4.7**	**85.3**	**7.6**	**2.4**
I am not allowed to attend any social rituals during my periods.	**3.9**	**83.7**	**7.3**	**5.0**
I do not go to religious places during periods.	**1.8**	**73.5**	**16.3**	**8.4**
I avoid travelling during periods.	**2.1**	**29.9**	**63.8**	**4.2**
I am told to stay in the corner of the house during my periods.	**2.6**	**14.7**	**68.0**	**14.7**
	Yes		**No**	
I am allowed to carry out routine work at home during my periods.	98.4		1.6	
I am allowed to cook in the kitchen during my periods.	97.4		2.6	
Others in my family take care of me during periods.	99.7		0.3	
I have freedom to visit a doctor in case of any health issue.	99.2		0.8	
I am allowed only special foods during periods.	4.2		95.8	
I sit for lunch and dinner with all my family members.	98.2		1.8	

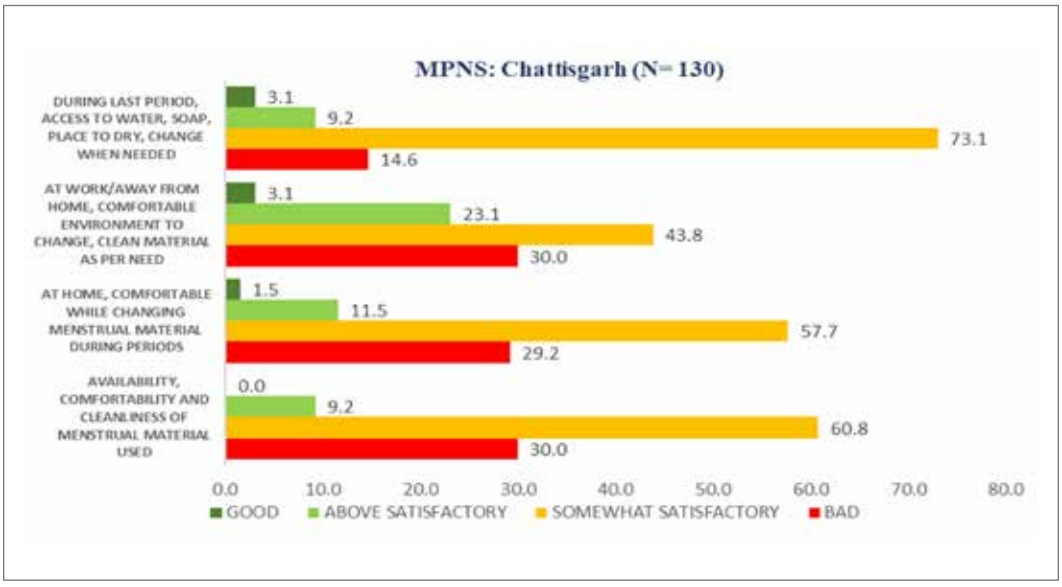
Customs followed by women in reference to menstruation: Uttar Bastar District

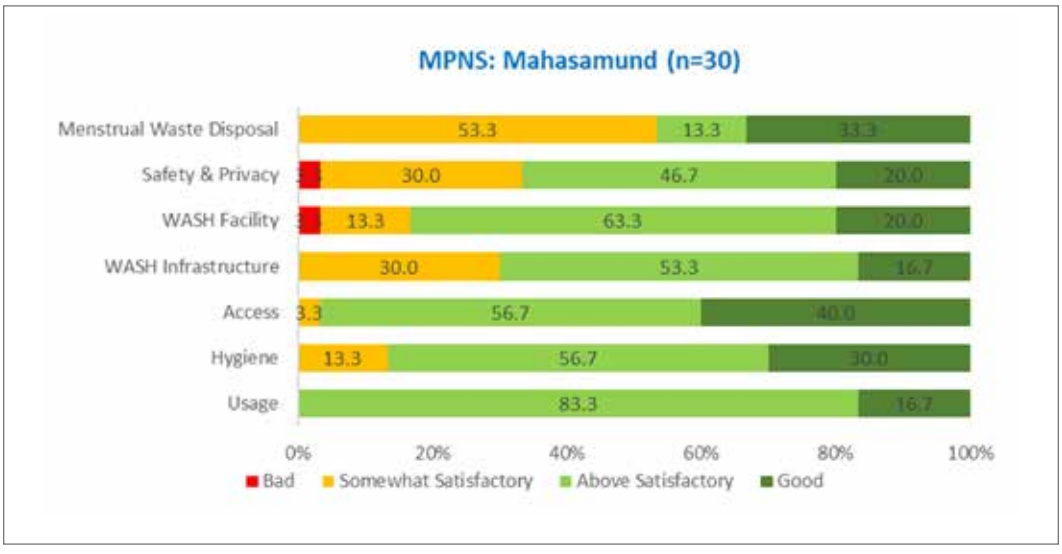
Uttar Bastar (411 respondents)	Strongly agree	Agree	Disagree	strongly disagree
I am allowed to mix with others socially during my periods.	65.2	34.8	0.0	0.0
I am not allowed to attend any social rituals during my periods.	55.7	42.1	1.9	0.2
I do not go to religious places during periods.	54.7	44.8	0.2	0.2
I avoid traveling during periods.	40.9	58.2	0.7	0.2
I am told to stay in the corner of the house during my periods.	3.4	50.1	34.3	12.2
	Yes		**No**	
I am allowed to carry out routine work at home during my periods.	90.8		9.2	
I am allowed to cook in the kitchen during my periods.	98.8		1.2	
Others in my family take care of me during periods.	74.0		26.0	
I have freedom to visit doctor in case of any health issue.	99.8		0.2	
I am allowed only special foods during periods.	2.4		97.6	
I sit for lunch and dinner with all my family members.	83.0		17.0	

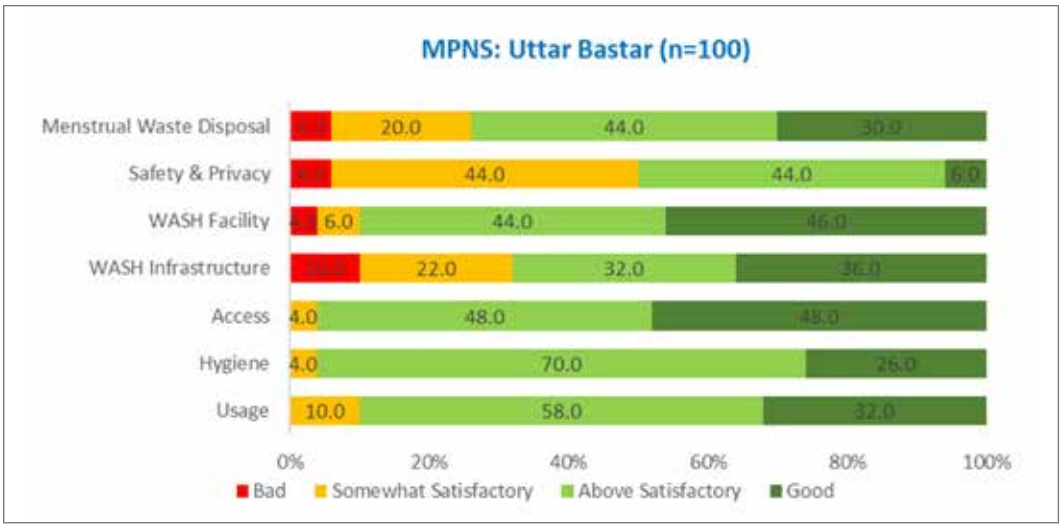
4.2.7 MENSTRUAL PRACTICE NEEDS SCALE (MPNS)

The Menstrual Practice Needs Scale (MPNS) was used to measure and assess the felt needs and experiences of women during their last menstrual period. 130 respondents from both the districts in Chhattisgarh shared their perceptions/experiences on availability of water, sanitation, hygiene, safety, and privacy as well as access to menstrual absorbents. Through the use of MPNS, we were able to access the actual trends, practices and experiences w.r.t MHM, WASH, safety and privacy which form the 'menstrual everyday' of surveyed women in Mahasamund and Uttar Bastar districts in Chhattisgarh.

- **Mahasamund:** When 30 EAMW in Mahasamund, were measured on the MPNS scale, more than half the women rated that menstrual disposal mechanism was below satisfactory levels. One- third women have poor privacy while changing menstrual materials, and around 30% women found the WASH facilities only somewhat satisfactory. Nonetheless, access to menstrual material hygiene was rated at above satisfactory to good level, probably because of the practice of using cloth during periods.
- **Uttar Bastar**: When 100 EAMW from Uttar Bastar were assessed on the MPNS scale, they reported that access to menstrual material, usage of desired absorbents was at above satisfactory to good level. Safety and privacy were rated poor to below satisfactory by 46% of the women. WASH infrastructure and menstrual waste disposal mechanism was rated poor to somewhat satisfactory by more than one-fourth women. All other aspects related to MHM such as WASH facilities hygiene and usage of menstrual material at above satisfactory to good level.







4.3 MHM FROM AN INTER-SECTORAL PERSPECTIVE

Reading the everyday realities of a menstruating woman requires an inter-sectoral position because her life unfolds not just at home, but in community spaces, schools, farms and workplaces during her periods. Moreover, a menstruating woman also negotiates various socio-economic and inter-sectoral circumstances such as WASH, public health facilities, migration and public policy. Hence, this part of our study examines vulnerabilities, issues, and risks pertaining to menstruation with respect to an inter-sectoral focus.

As villages selected from Mahasamund and Uttar Bastar Kanker are tribal communities as well as other forest dwelling communities dominant, they depend on natural farming methods and Minor Forest Produce (MFP) collection.

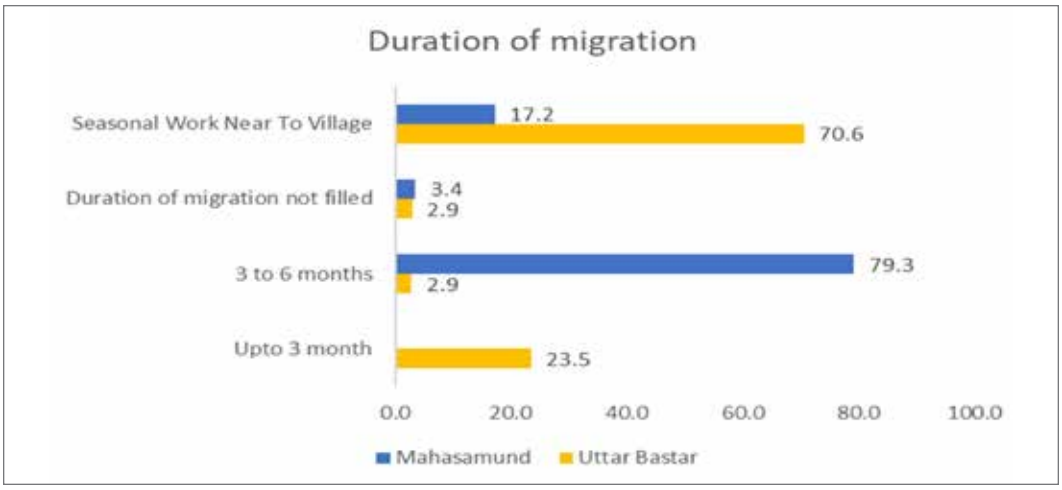
- Water scarcity and increasing inaccessibility of potable water are crucial issues in these villages.
- Drinking water crisis, lack of electricity and lack of transport system, lack of education, and poor monetary gains, high rate of unemployment are issues faced by villagers in both the districts.
- Tribal areas face accessibility and last mile connectivity challenges with schemes, policies, disbursements of benefits and claiming of entitlements. Within the already marginalized tribal communities, women and young girls form one of the most vulnerable sections of society.

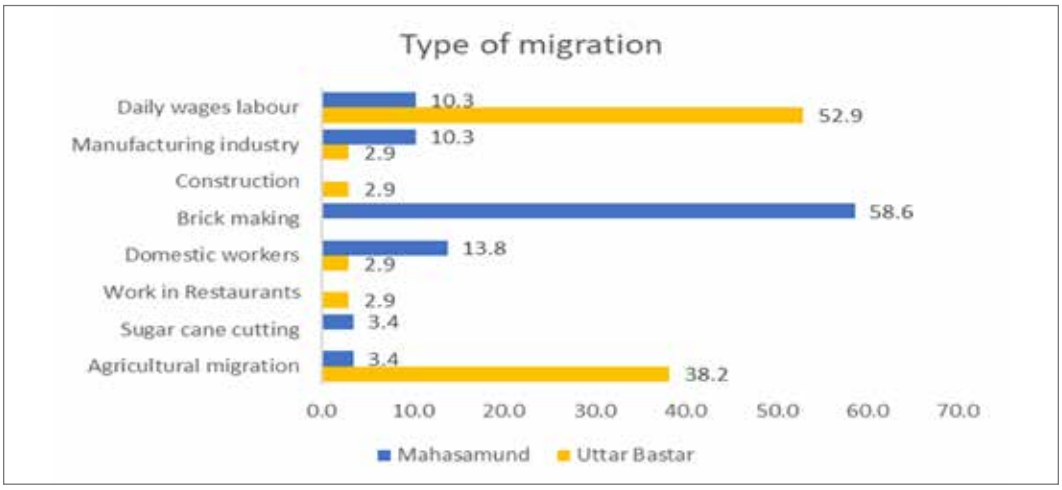
Against this background, we present a brief inter-sectoral data analysis on migration and MHM, WASH and MHM, Education and MHM and lastly, MHM from the perspective of awareness towards public policies. The analyses focus on vulnerabilities, issues, and risks pertaining to menstruation and social as well as inter-sectoral stress factors. The overall narrative of different practices on MHM in these villages related to community-based vulnerabilities, socio-economic conditions and beliefs including monetary freedom or disposable income of women besides health and education related inter-sectoral factors.

4.3.1 MIGRATION AND HEALTH (MAHASAMUND N= 381, UTTAR BASTAR N=411)

Not many women migrate for work with their families in Mahasamund and Uttar Bastar.

- 29 women (7.6%) who migrate for work from Mahasamund are mainly engaged in brick kilns followed by domestic labour, manufacturing industry and agriculture, in that order.
- In Uttar Bastar, 34 women (8.3%) migrate for working in manufacturing industry, domestic labour work and construction work.
- Out of total migrating women, 6 women from Mahasamund (out of 29) and 25 women from Uttar Bastar (out of 34) migrate near to their villages as agriculture labourers or daily wages workers.
- Our findings indicate that 28 out of the 63 migrant women strongly feel that their seasonal work conditions and resource scarcity influences their menstrual health negatively.





4.3.2 TRADITIONAL SKILLS AND EARNING CAPACITY

Out of the two districts, 66 women (17.3%) from Mahasamund and 380 from Uttar Bastar (92.5%) possess skills like art, craft, farming, fishing, hunting, tailoring, etc. Out of them, only 16 women from Mahasamund and 13 from Uttar Bastar earn from the traditional skills possessed by them.

Given that there is a possibility of augmenting family income from traditional knowledge and customary skills, as the case of Mahasamund shows, vocational courses can be organised for women struggling with socio-economic vulnerabilities to enhance their means of livelihood and disposable income. A disposable income can give women better opportunities towards an empowered decision -making w.r.t to MHM as well as personal and medical care.

4.3.3 WASH AND MHM

WASH & MHM	Mahasamund (in %)	Uttar Bastar (in %)
Total Respondents	**381**	**411**
Water Facility at Home		
Bore well/ Tube well/ Well covered	2.9	22.9
Hand pump/ Standpost	5.5	11.2

Piped water/ Piped to yard/ Plot/ Public tap	91.6	65.9
Toilet Facility at Home		
Individual household latrine	76.4	88.1
Community toilets	1.0	0.2
Open defecation	22.6	11.7
Type of House		
Kutcha	42.0	83.2
Pucca	41.7	9.7
Semi pucca	16.3	7.1

According to the NFHS-5 Report, 84.2% of our respondents from Mahasamund and 80.5% from Uttar Bastar use improved sanitation facilities (International Institute for Population Sciences (IIPS) and ICF 2021, p. 111, 165). Which is matching with our data.

- **Kind of House:** Housing conditions were found to be better in Mahasamund where more people lived in *Pucca* houses (if roof, wall and floor all are made up of pucca or concrete material then it is a pucca house) as compared to Uttar Bastar where most people dwell in *Kutcha* houses (roof, wall and floor all made up with kutcha/makeshift material).
- **Compromised Toilet Facilities:** Open defecation is practiced more in Mahasamund than in Uttar Bastar where more people use Individual Household Latrines (IHHLs).
- **Access to drinking water:** Barring 91.6% families from Mahasamund (n=381) and 65.9% from Uttar Bastar (n=411) that fetch water from piped water supply scheme, all others use water from either tube well, borewell or hand pumps. However, our key informants in Mahasamund and Uttar Bastar stated that in many tribal dominated zones, extractive industries as well as mining activities have drained the groundwater of its availability and purity.

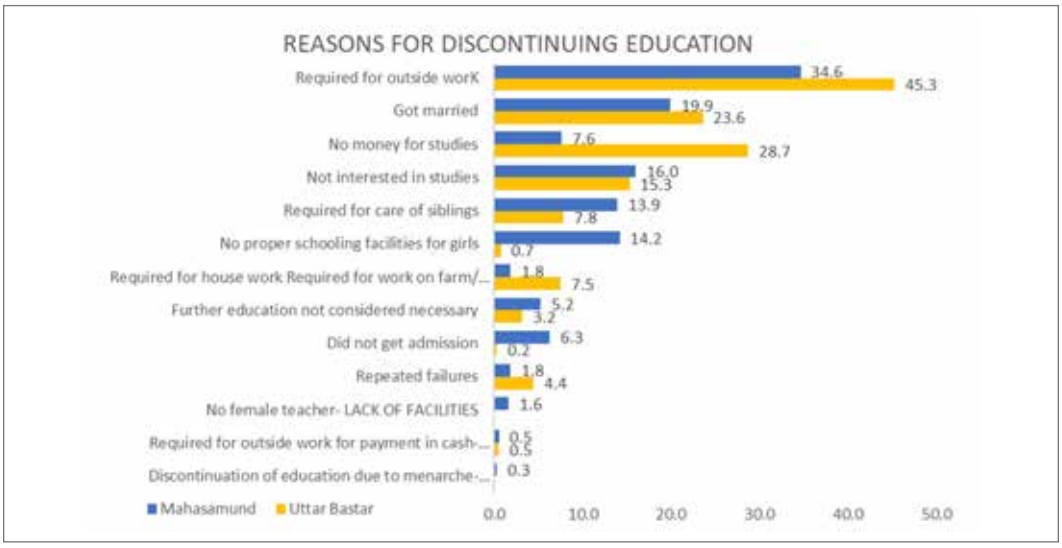
It is clear that during menstruation a woman's WASH needs are relatively higher as compared to the rest of the days of the month. When a woman experiences her periods, she needs more water to clean herself for personal and intimate hygiene, including after defecation. Besides, a regular supply of clean water, ensuring that a woman has the facility of a private and secure place to change her menstrual absorbents and clean herself are a profound part of her sense of dignity and safety.

4.3.4 EDUCATION AND MHM

Out of the total of 792 women surveyed, 127 had not received any formal education, the rate of illiteracy being much higher in Mahasamund than in Bastar. 351 women had completed education between 1st to 4th grade and/ or 5th to 7th grade. 136 women were matriculates while another 106 were undergraduates. It is commendable that almost 10% of the total respondents were graduates, some of whom were also pursuing their Masters.

Education and MHM	**Mahasamund (in %)**	**Uttar Bastar (in %)**
Total Respondents	**381**	**411**
Education		

No education	27.6	5.4
Primary (1st -4th)	28.9	15.8
Secondary (5th-7th)	14.4	29.4
Higher Secondary (8th-10th)	13.6	20.4
Undergraduate	6.0	20.2
Graduate and above	9.4	8.8
Reasons for Discontinuing Education		
Lack of facilities	22.0	1.0
Educational barriers	18.1	19.7
Family barriers	44.6	82.0
Monetary barriers	39.1	34.5



*Multiple Choice Question

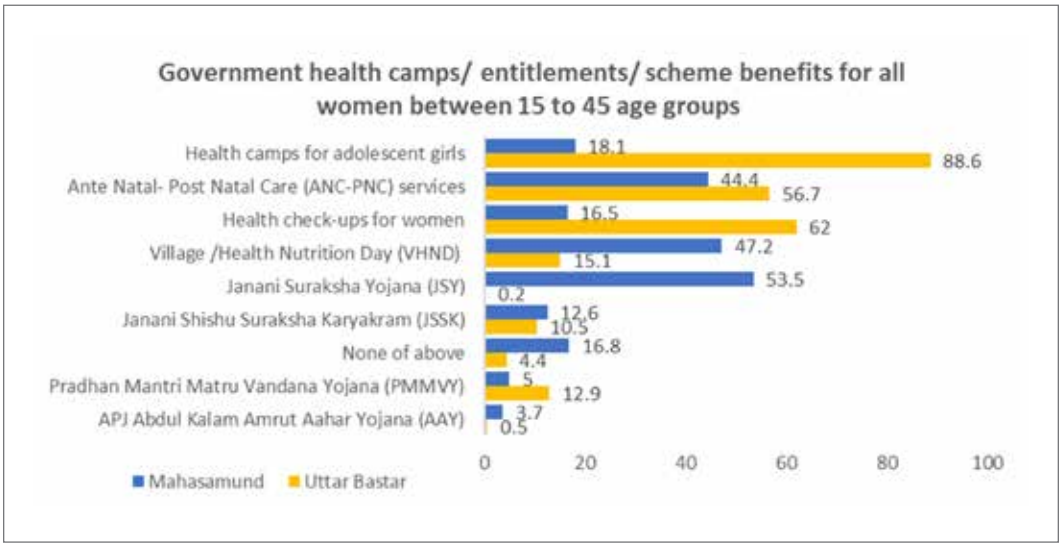
- **Bottlenecks**: Both in Mahasamund and Kanker women discontinued their education mainly due to monetary and family related barriers such as lack of financial resources, girls being required to work for daily wages to supplement family income or look after siblings and so on. As a hindsight on their educational status, women reflected that lack of proper schooling facilities in general and the non-availability of female teachers, less importance on education for girls, i.e. family-imposed responsibilities were other top reasons for them not being able to attend/ complete school.
- **Menarche and Marriage:** Menstruation is a major criterion for some parents and families to lay restrictions on the movement of a girl outside of home, including a preference that adolescents drop out from school altogether. Among those girls who do continue their schooling, being absent from school due to MHM related issues including physical symptoms such as pain etc. leads to interruption in education during post -menarche years. Community beliefs such as a girl being 'ready for adulthood' in early post-menarche years leads to pressure on the family to marry her off.
- **Failing/ Lack of Interest**: Not being inclined towards studies as well as repeated failures emerged as some other personal reasons for not being able to further their education.

Our data suggests that there is a rising trend among the tribal, PVTGs and other vulnerable sections (such as the SCs) of society towards seeking primary, secondary as well as higher education and enrolling in universities, despite socio-economic challenges. In Kanker, women seem more likely to experience such barriers as compared to their counterparts in Mahasamund. Under such circumstances, it would be relevant to suggest that schools and educational institutions become MHM friendly so that adolescents and young girls experience no menstruation related barriers in the way of their education. At the same time, other reasons for discontinuation of education in Mahasamund and Uttar Bastar Kanker should also be scrutinized and remedied through various social sector interventions in schools.

4.3.5 AWARENESS TOWARDS PUBLIC POLICY AND COUNSELING ON MHM (N=792)

Public Policy: National Health Mission provides various programs for the age group of 15 years to 45 years, i.e., from adolescent girls to women. Most women in both the districts were aware of public policy benefits as well as challenges.

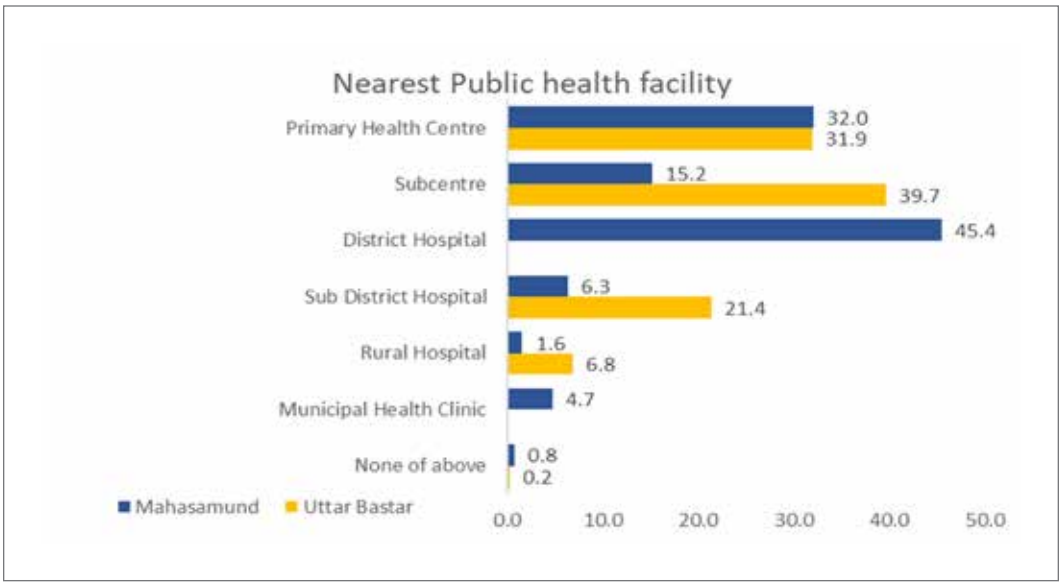
- **Local Health Services:** 50.8% of the total respondents availed the Ante- Natal and Postnatal services in both the districts whereas 16.5 % of women from Mahasamund and 62% of women from Kanker receive health check-ups at the village or at the Sub- Center level.
- **Engagement with Public Health Services**: Almost half the women in Mahasamund and around 15.1% in Kanker attend Village Health Nutrition Day (VHND) on a regular basis. Janani Surakhsa Yojna (JSY) is once again availed by half the respondents in Mahasamund as compared to almost negligible engagement with the JSY in Kanker.



*Multiple Choice Question

- **Significance of Public Health Facilities:** Public Health facilities usually play an important role in providing free and affordable treatment. Health support systems in India are designed such that for every 1000 population there is ASHA appointed, for around 5 to 6 villages, there is a Sub- Centre where treatment for small illnesses as well as 24/7 facility of delivery is available. After that, for every 30000 people, there is a PHC. And as we move further, Rural or Sub-District hospitals, district hospitals in urban areas, municipal corporation health clinics, and hospitals are available.
- **Importance of Health Camps**: Women across various contexts are differently integrated with the national public health infrastructure and policies. Health camps, which are periodically organized in villages, are specifically important and needed in areas which are remote and cut-off or where Sub-centers are not available. Our survey findings indicate that a major chunk of the population surveyed in Kanker benefits from health camps for adolescent girls as compared to only 18.1% families from Mahasamund. If health

camps start covering the wellbeing of EAMW in remote and isolated areas, women will stand to benefit from many health-based objectives and parameters of the Indian government.



*Multiple Choice Question

➲ **Accessibility-Challenges and Choice:** Women covered in this survey were asked through IDIs about the nearest accessible public health facilities for getting treatment or pursuing their health issues. The nearest public health facility is a Sub Centre. According to responses we received, only 15.2% of women from Mahasamund and 39.7% of women from Kanker feel confident about treatment and counseling in Sub Centers. Only one in three women from the research villages seeks treatment in PHCs. Apart from this, 45.4% of women in Mahasamund depend on the District Hospital whereas, not a single woman from Kanker finds District Hospital accessible. One in four women accesses Rural Hospital or Sub District Hospital facilities.

Our findings indicate that women in Mahasamund and Kanker are familiar with and dependent on the services guaranteed from the public health system in varying numbers depending upon accessibility and incentives such as Pradhan Mantri Matru Vandana Yojana (PMMVY) and transportation facilities under Janani Shishu Suraksha Karyakram (JSSK) along with ANC and PNC services. Women in Mahasamund were more familiar and aware of JSY probably as it is one of the oldest schemes launched by the government and related to direct monetary benefit after delivery. However, our survey findings indicate women were not familiar with schemes like PMMVY and transportation facilities under JSSK. In more vulnerable areas, where health infrastructure is scarce or inaccessible such as in Kanker, women seem more remote and less integrated to Sub-Centers or Primary Health Centers (PHCs) but keenly attend and rely on health camps. Therefore, in both the districts women can benefit with more awareness drives towards as well as responsiveness of public policy.

COUNSELING

There are various maternal and child health programs, services and schemes designed by the government of India to benefit the women on menstrual health. However not much is known about the pattern of organisation of these sessions, or if these were conducted in villages. EAMW who participated in this survey, expressed enthusiasm, and underlined counseling on MHM as an urgent need where not given. If counseling on MHM is given regularly to EAMW, they would benefit in terms of being better informed and more attentive towards self-care, thereby managing to bring community insights and voices to dispel the silence and myths around the issue through active participation.

Received counseling on Menstrual Hygiene from health workers	Mahasamund (in %)	Uttar Bastar (in %)
Total Respondents	**381**	**411**
No	34.9	26.3
Yes	65.1	73.7

Yes: Upon being asked if they ever received any counseling on menstrual health, 69.6% the EAMW responded in the affirmative. Counseling on MHM was received from health workers such as ASHA, ANM and AWW. Out of the total respondents, 65.1% EAMW from Mahasamund (n=381) and 73.7% from Kanker (n=411) reported that they seek counseling, guidance, and treatment on health issues from the public healthcare facilities.

No: In Chhattisgarh, 241 women, out of a total of 792 had never received counseling on menstruation or MHM in their villages.

Menstrual health of women beyond school years is still a long way from being actively considered as a public policy measure in India. Owing to the vast reach and significance of, as well as a substantial reliance on Public Health system in India, the MHM of EAMW can get a much required boost if the issue receives adequate attention through public policy. Even the ADP can stand to gain women's participation if MHM is piloted as an inter-sectoral intervention cutting across education, social security, WASH and livelihood.

PART 4 VOICES, EXCERPTS AND OBSERVATIONS

As part of our research, we conducted approximately twelve open -ended interviews with key informants. These KIIs were taken across each district, not necessarily restricting ourselves to voices of people from the villages included in our field research. People interviewed during this exercise were important stakeholders in communities/villages such as AWWs, ANM, Doctors, Teachers, ASHAs, Counselors and social workers etc. The voices of these stakeholders are critical for the development of the community as they give a unique point of view on the local village population as well as district-wide situations. In a small but significant way, these grassroots voices help us arrive at community-sensitive and area-specific recommendations and ways forward. Highlights from these interviews are as follows:

Mahasamund (Data derived from 5 villages of the district): In Mahasamund, seven respondents across five villages stated that menstruation related taboos are much prevalent and followed in the villages. Two respondents explained that their villages had no toilets and villagers were not aware of any scheme related to menstrual hygiene. Another two key informants stated that free sanitary napkins were not distributed in their village and open defecation was still practiced.

Uttar Bastar Kanker (Data derived from 5 villages of the district): In Kanker, eight respondents across five villages stated that free sanitary napkins were not distributed in the villages for women beyond school years, i.e. EAMW and two respondents added that nobody had ever addressed them on MHM themes. Six respondents informed us that their villages had no toilets and open defecation was still practiced by a few people. Four respondents spoke of extreme water scarcity in the villages. One respondent also apprised us in detail of the many taboos followed on menstruation in her village.

4.1 VOICES, EXCERPTS AND OBSERVATIONS OF RESPONDENTS: MAHASAMUND

Our respondents from the field have shared their experiences, conceptions and observations on MHM. Below are some voices and excerpts from our interactions with them.

Anjali (Interview: 21.08.2022)[3], an **ANM** in a village in Mahasamund district of Chhattisgarh informed us that her village had a sanitary pads distribution program for adolescent girls. Sometimes meetings were held with AWWs to educate women about cleanliness and nutrition. Moreover, the village also had an iron tablet distribution program under the Rashtriya Kishori Suraksha Karyakram (RKSK) scheme. Menstruation related problems experienced by women in the age group of 20-49 years commonly include white discharge and uterine infections. She further added that the village did not have any WASH related scheme, there are toilets in the community and school but without proper sanitation. Hence the toilets are not in a usable condition and only some schools have water facilities. She added that the village needs a pad disposal machine and a changing room near the village pond. On taboos in the village, she explained women were not allowed to touch pickles and not allowed to enter temples during menstruation.

Hameen (Interview: 21.08.2022)[4], a **Mitanin (ASHA)** in a village in Mahasamund responded that the village had a health and nutrition related program which covered school-going girls under free sanitary pad distribution program through the RKSK scheme. On WASH needs in schools and villages she stated, "we do not have WASH related schemes in communities and schools though there is water facility in every household under JJM Scheme". She explained, proper water and toilet facilities were some specific needs of the area. On taboos related to menstruation in the village she informed us that women were not allowed to touch food items such as pickles, *papad*, and *bari* until five days of menstruation.

Poonam (Interview: 22.08.2022)[5] an **AWW** in a village in Mahasamund stated that women were provided with medical advice, essential medicines, and ready to eat nutritional food under health mission. Moreover, girls are also provided with sanitary pads under the RKSK scheme. On the needs of women aged 20-49 years in her village, she added many of them were anemic and they were provided with warm cooked food from *Anganwadis* (Type of rural child care center). She further added, the village does not have any specific WASH related scheme, there is water facility in every household under Jal Jeevan Mission. On taboos related to menstruation in the village, she explained that in tribal homes women were not allowed to touch food items such as pickle, *papad, and badi* and not allowed to perform pooja and other sacred works.

Ms Sunita (Interview: 22.08.2022)[6]**,** the **Sarpanch** of a village in Mahasamund responded that women were provided with nutritional dry ready to eat food 6 days in a week under *Poshan Abhiyan*. There is an awareness program in the village to inform women about menstruation. On women's WASH needs in the village she stated there is water facility in every household under JJM Scheme. From her account it was not clear how women's WASH needs were fulfilled throughout the year. She further explained women need medicines with health advice in the village.

Koshalya (Interview: 22.08.2022)[7], a **Mitanin** in a village in Mahasamund stated that the village had health smartcards and Ayushman cards for women and regular awareness meetings with girls to teach them about menstrual hygiene. She further explained the village needed more community toilets with adequate water facility. On taboos in the village, she added women were not allowed to enter temples and perform *pooja*, they were also not allowed to touch pickle, *papad, and badi* during menstruation.

Bhojbai (Interview: 23.08.2022)[8] , a **Mitanin** in a village of Mahasamund responded that the panchayat does not have many schemes on menstruation, there are regular home meetings with women to inform them about menstrual hygiene. Moreover, girls were provided with sanitary pads and dry Ration under the RKSK scheme, but it is not regular. She added under MHM there is construction of *pad shala* and water and toilet facility in the school, but it was not enough for school needs. On WASH in the community, she added every household in the village has toilets under *Pradhanmantri Shochalya Yojana* but people still avoid using them. It was not

[3] CH KII1 MAH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[4] CH KII2 MAH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[5] CH KII3 MAH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[6] CH KII4 MAH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[7] CH KII7 MAH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[8] CH KII6 MAH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

clear from her account why the toilet was not being used in the village. On taboos in the village, she explained women were not allowed to touch pickle, *papad, badi* or allowed to enter the kitchen and temples.

Hirabai (Interview: 24.08.2022)[9], a **Mitanin** in a village in Mahasamund informed us that her village had a sanitary pad and nutritional food distribution program under the RKSK scheme. Moreover, awareness programs and meetings with girls to teach them about menstrual hygiene were also held. However, there were no schemes in place for menstruating women, in the age group of 20-49 yrs in the village. On WASH in the community, she added that the village had a water pipeline under Jal Jeevan Mission (JJM). In addition to that there are many schemes in the village but all are on paper. She insisted upon creating awareness among women with respect to menstruation. On taboos in the village, she narrated how women were not allowed to perform *pooja* (prayers) and touch pickle, *papad* and *badi*.

Kiran (Interview: 16.09.2022)[10], a **social worker** in a village in Mahasamund stated that the village had a regular awareness program to educate women about menstrual health and nutrition. On WASH needs in community and schools she explained the village had water facility under Jal Jeevan Mission and Toilet facility in every household under *Swacch Bharat Abhiyan*. On taboos she added women were not allowed to enter the kitchen, perform pooja or touch the head of the family.

4.2 VOICES, EXCERPTS AND OBSERVATIONS OF RESPONDENTS: UTTAR BASTAR KANKER

Our respondents from the field have shared their experiences, conceptions and observations on MHM. Below are some voices and excerpts from our interactions with them.

Aarti (Interview: 06.09.2022)[11], a **Doctor** in the Sub- center of a village in Kanker district of Chhattisgarh stated that the village had *Kishori Bachat Khata Yojana* and an awareness program to educate women about cleanliness and nutrition during menstruation. On the needs of menstruating women between 20 years to 49 years of age she added that the village needed distribution of sanitary pads and condoms. She added the village had water and *Sulabh Yojana* for toilets in community and school but from her account it was not clear how women's WASH needs were fulfilled throughout the year. On specific requirements of the area, she zeroed in on the need for an adequate water supply, toilets in every household and a pad disposal machine in the village. On taboos regarding menstruation in the village she informed us that in her village menstruation was considered sacred.

Pramila (Interview: 08.08.2022)[12], an **AWW** in Kanker stated that the village had regular health check-ups for diabetes, stunting, and blood pressure for women. An awareness and training program to maintain cleanliness and nutrition during menstruation. She further added that the village needs adequate water facility, free sanitary pads, vending machine for sanitary pads, pad disposal machine, health camp every month, and a female doctor in the village. On WASH needs in the community and school she added the school had adequate water facility but toilets were not in usable condition, school needed adequate water facility, pad disposal machine, and liquid soap facility.

Siyora (Interview: 06.09.2022)[13], an **AWW** in Kanker district of Chhattisgarh responded that the village had a free tablet distribution facility and regular health check-up of diabetes, stunting and blood pressure. On WASH needs in the community and the village school, she explained the village had a water facility but toilets were not in a usable condition. Regularisation of water supplies, sanitary pad vending machines and liquid soap in the toilets were an immediate need. Further she added there should be a toilet for women at work place and no payment cut during menstruation. On taboos in the village, she added, villagers considered menstruation sacred and treated women as *Kaali/Durga*.

[9] CH KII8 MAH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[10] CH KII5 MAH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[11] CH KII1 UB: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[12] CH KII2 UB: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[13] CH KII3 UB: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

Sushmita (Interview: 24.08.2022)[14], a **Doctor** in a village's PHC in Kanker district of Chhattisgarh responded that the village had *Rashtriya Kishori Swacchta Karyakaram* for adolescent girls. On WASH, she explained that the school and hospital had water and toilet facilities, but it was not clear how women's WASH needs in the larger community were fulfilled throughout the year. She further explained the village needed pure/ non-contaminated water, sanitary pads, and condoms.

Ms Reena (Interview: 10.08.2022)[15] an **ASHA** in a village in Kanker added that the village had distribution of Iron tablets, every month meeting with girls to inform them about menstruation, and ASHA workers advise them to change cloth thrice a day. On WASH she added the village had *Nal Jal Yojana* toilets, and vending machines for sanitary pads. On area specific needs on menstruation, she explained the village needed pure and adequate water facility, sanitary pads from *Anganwadi* or community center, and toilets in every household.

Priyanka (Interview: 08.08.2022)[16] an **ANM** in a village in Uttar Bastar responded with a scheme for menstruation such as free distribution of sanitary pads and iron tablets for adolescent girls. She added women also need sanitary pads and condoms. On WASH needs in village and school she explained, villages had toilets in every household under Sulabh Yojana, adequate water facility in school and village. On area specific needs she suggested vending machines in the village's PHC and a pad disposal machine in the village.

Pramilabai (Interview: 08.08.2022)[17] , the **Sarpanch** of a village in Uttar Bastar Kanker district of Chhattisgarh responded, the village had *Kishori Suraksha Yojana, Sukanya Yojana,* and rupees 1 lakh scheme for 2 daughters under RKSK program. Moreover, weight check of adolescent girls on every first Tuesday of month and meeting with 15 to 45 age groups of women in the village. On WASH she added that villages need free sanitary pads thru *Anganwadi* and maintenance of toilets in the village and school. She insisted upon creating awareness among people regarding menstruation as villagers considered menstruation as untouchability. She further explained some villagers considered menstruation sacred and treated women as *goddess Kaali/Durga*.

Ms Dulari (Interview: 08.08.2022)[18], **an ASHA** worker in a village in Uttar Bastar Kanker district of Chhattisgarh responded with schemes on menstruation in the village such as *Rashtriya Swacchta Yojana*, distribution of Iron tablets, nutritional food schemes for women, every month blood pressure and weight check-up. On WASH she added villages had *Ghar Ghar Jal Yojana* but it was not clear how women's WASH need fulfilled throughout the year. She further added there is need of sanitary pads, toilet, liquid soap, and dustbin on every street of the village. She explained, no positive behavior from family during menstruation, not eating healthy, and isolation from family were some disabling factors in achieving proper menstrual health. She stated that achieving proper MH, nutritional food to women and equality in society and at the workplace is necessary.

Pramila (Interview: 11.08.2022)[19], an **ANM** in a village in Uttar Bastar Kanker district of Chhattisgarh responded that women were given Iron tablets in case of hemoglobin deficiency and women were advised to use sanitary pads during menstruation. She insisted upon creating awareness among people about menstruation as villagers considered menstruation as untouchability. She explained the village needed sanitary pads and toilets.

Meena (Interview: 16.08.2022)[20], an **AWW** in a village of Uttar Bastar Kanker district of Chhattisgarh responded that the village had *Noni Suraksha Yojana (Save Girl Child, Beti Bachao Beti Padhao)* under RKSK scheme. 15-45 aged women were provided with regular menstruation check-ups, and on every first Tuesday of month, the village organised vaccination and weight measuring programs for adolescent girls. She explained the village needed sanitary pads, water, and toilet facilities.

[14] CH KII4 UB: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[15] CH KII5 UB: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[16] CH KII6 UB: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[17] CH KII7 UB: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[18] CH KII8 UB: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[19] CH KII10 UB: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[20] CH KII12 UB: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

4.3 SALIENT FINDINGS FROM DATA

Processing through our data from Mahasamund and Kanker, we have gained some valuable insights on women's health, education, livelihood and overall community outlook on menstrual health management needs and transformations on ground.

Overall our evidence from our research villages indicates that the majority of the menstruating women in tribal communities prefer to use cloth as a menstrual absorbent, washing and keeping these to be reused in the next menstrual cycle. Soaps and other detergents are used to wash the used cloth by the majority of respondents. Menstrual waste is preferred to be burned. Our key informants also stated that IHHL and school toilets have been built but not in use.

In Kanker, regular health checks to find/measure/monitor diabetes, BP and weight are conducted in tribal areas. Iron tablets are distributed to girls and pregnant women in all villages. In one of the five villages, sanitary pads have been available since the past ten years (since 2011) however nowhere else were these available, sold or subsidized. In most villages the tribal women are unaware of any scheme related to menstruation but a doctor in a PHC informed us that RKSK is operational for adolescent girls in his village. In another village a respondent informed about a 'Rashtriya Kishori Suraksha Karyakaram' being held.

Women demand that the lack of inadequate water facilities be solved. Only respondents from two villages informed us that a functional toilet had been built under SBM scheme. Rest of the women stated that toilets may exist as a bare structure, but these are far from being usable or operational. Under, JJM Scheme, sufficient water still does not reach the villagers. Women need more water for hygiene/ WASH purposes as their basic needs remain unfulfilled.

One of our most sensitive findings relates to women's responses on water availability: When tribal women were asked about water, many would claim, 'it is there in the village'. However, when these same respondents were asked about what they need for the achievement of MHM and WASH in their village, they would state, "we need a good supply of water."

In the tribal and PVTG areas of villages we selected from Chhattisgarh menstruation is ridden with ironic beliefs and myths. On the one hand it is considered as 'pavitra' (sacred) and women are treated as Kali/ Durga (Goddesses of Power) and, on the other hand, some families condemn them as 'untouchables' and segregate the menstruating women from everyday social contact and routines.

In Mahasamund, iron tablets are distributed in all villages. Sanitary pads availability was confirmed only by two interviewees. A Mitanin explained that the pad -supply is erratic. but whenever available these are duly distributed. Another Mitanin informed us that a 'Pad-Shala'. is being made in her village. According to Sarpanch, dry ready to eat nutritional food is served for six days a week under Poshan Abhiyan scheme in her village.

Ongoing schemes w.r.t WASH such as JJM Scheme ensure adequate water supply. Toilets have been built in all houses under SBA, however in many villages open defecation is still practiced and some have opined that people are still not using them. Under WASH a pad shala is being made in a school according to Mitananin Bhoj Bhai. On menstrual taboos we were informed that in the tribal areas women cannot touch food such as pickle, *papad, badi* or perform *Pooja* during their periods. A menstruating woman is prohibited from touching the head of the family.

From our interactions and databases pertaining to Chhattisgarh, it clearly emerges that apart from a silence on women's menstrual health in terms of inter-sectoral hindrances and policy related negligence in India, there are community-voices that portray a negative and discriminatory attitude towards periods. These discriminatory voices and attitudes in Chhattisgarh, just as our research from some other parts of India shows, pertain to both men and women across social strata. Many EAMW as well as key informants endorse negative attitudes (as told to our surveyors and field-researchers) towards menstruation, either owing to the circumstantial difficulties that they grow up experiencing or for want of better knowledge

and support system around the phenomenon. Inadvertently or otherwise, such voices contribute to the perpetuation of a debilitating discourse on the phenomenon. The key to combating the inter-sectoral and community -based silences and barriers on MHM among women beyond school years lies in augmenting positive practices and discourses on menstruation. One of the best ways to achieve this is by involving multiple actors, key and critical stakeholders such as EAMW, leaders, influencers, families, policy makers and implementers. Hence, gender mainstreaming MHM can ensure gender perspectives and attention to the goal of gender equality in all actions, projects and programmes.

4.4 RECOMMENDATIONS/ AREAS OF IMPROVEMENT

IMMEDIATE/ URGENT COURSE OF ACTION

1. **Equip schools for personal hygiene**: Ensure provision of liquid hand-wash or soap in schools and students be monitored as well as guided on proper usage of soap for hand washing.
2. **Make schools MHM Friendly:** Availability of Menstrual absorbent and disposal mechanisms for menstrual waste are needed by the community to encourage regular attendance and security of menstruating adolescents in schools. Provision of rest rooms in case of adverse and painful menstrual symptoms along with basic first-aid to deal with these. Keep parents informed of such facilities.
3. **Monthly Meet, Monitoring Mechanisms and Micro planning on Periods:** A special place/ space for conversations on MHM should be ordained in each village so that women and girls can come together and talk about periods every month under guidance from ASHA, AWWs and other FLWs. Such interactions will not only raise awareness but also function as participatory thresholds for micro-planning on periods.
4. **Disbursement and Disposal of Menstrual Absorbents:** Free distribution of pads/absorbent menstrual hygiene material should be continued for menstruating girls and expanded to provide for EAMW. Disposal mechanisms for menstrual waste need to be regularized and monitored as an interim measure till better systems are worked out.
5. **Enable existing Village Health and Nutrition Committees (VHNCs) on MHM:** For overall capacity building on menstruating women's health and nutrition at the village level, empower the existing VHNCs to address the issue locally in Mahasamund and Kanker. This would ensure a positive outcome for nutritional wellbeing of tribal women living in remote and marginalized areas.
6. **Enable existing Village Water Sanitation Committees (VWSC) on MHM**: MHM drives should be conducted alongside the promotion of information on WASH. Get the enablers in terms of WASH in tandem with community voices. The VWSC in each village to understand the MHM barriers and is to be operationalized under the national Jal Jeevan Mission (JJM) and is composed of a five women-team. Local Community Based Organisations (CBOs) can help mobilize community support to this end.
7. **Lady doctors in PHCs:** The presence of women medics in PHCs or visiting sub-centers regularly/ once a month to monitor health needs of menstruating girls and women and not just pregnant and lactating mothers will help cover those who are in need of medical help .

SHORT TERM

1. **State -of - the art Disposal Management**: Undertake a study on disposal mechanisms in villages under the Swachh Bharat Mission (Gramin) SBM(G) phase II through external Organisations working on WASH and community-sensitive approaches, to assess the current practices and evolve context specific environment appropriate options for disposal mechanisms of menstrual waste that includes segregation, collection, transportation and treatment.
2. **Disaster Resilience:** Ensure continuation of services for free pad distribution, medical support, and awareness to menstruating women and girls in regular times as well as through inclement weather conditions or during natural disasters.

3. **Health Service Delivery:** In remote, isolated, and vulnerable areas, where health infrastructure is scarce or inaccessible such as in Kanker, women seem less integrated to Sub-Centers or PHCs. However, they keenly attend and rely on health camps which may not have optimal services and expertise. Therefore a robust health service delivery system including infrastructures and human resources to connect the last mile should be an actionable priority.

INTERMEDIATE (SIX MONTHS AND ABOVE)

1. **State MHM Committee**: A State level Menstrual Health and Wellbeing Committee be initiated to integrate remote places, mountainous regions etc. into the state and national ADP and MHM plans.
2. **MHM at District, Block, Gram Panchayat Level**: Information, education, and communication (IEC) for menstrual hygiene education and awareness that includes information around safe menstrual hygiene products; and menstrual waste management with safe disposal facilities.
3. **Skill Development for EAMW**: Build capacities and skills of women from poor, marginalized households and with special attention in PVTG villages through functionally effective SHGs for gainful self-employment under Chhattisgarh State Rural Livelihood Mission (BIHAN).
4. **MHM at Family level:** Ensure sustainable water source along with source strengthening measures and provision of Functional Household Tap Connections (FHTCs) to all households under National Jal Jeevan Mission scheme.
5. **JJM for Institutions and MHM:** Institutional water supply under JJM scheme to ensure supply of adequate running water in girl's toilets in schools.
6. **Make Toilets MHM safe:** Ensure provisioning of community toilets as well as toilets in work areas with washing areas, bathing cubicles, and running water under SBM(G) phase II where.

REFERENCES

Bhatt, Wahed. 2022. 10 Poorest States in India 2022, in, Ground Report. Online at: https://groundreport.in/these-are-the-10-poorest-states-in-india/#:~:text= Chhattisgarh%20is%20one%20of%20the%20poorest%20states%20in,The%20poverty%20level%20of%20this%20state%20is%2039.93%25. Accessed April 4, 2023.

Census 2011: Mahasamund Office of The Registrar General and Census Commissioner, Ministry of Home Affairs, Government of India. Available from https://www.census2011.co.in/census/district/496-mahasamund.html [accessed 22 January 2023]

Census 2011: Uttar Bastar Kanker Office of The Registrar General and Census Commissioner, Ministry of Home Affairs, Government of India. Available from https://www.census2011.co.in/census/district/498-kanker.html [accessed 22 January 2023]

Indian Brand Equity Foundation (IBEF), Ministry of Commerce and Industry, Government of India (2023) State Profile Chhattisgarh. New Delhi. Available from https://www.ibef.org/states/chhattisgarh [accessed 22 january 2023]

International Institute for Population Sciences (IIPS) and ICF. 2020. National Family Health Survey (NFHS)-5, State and District Factsheets, Chhattisgarh. Mumbai: IIPS. p 111 & 165. Available fromhttps://cghealth.nic.in/cghealth17/Information/content/Statistics/NationalFamilyHealthholdSurvey5_District_Wise.pdf [accessed 10 January 2023

MSME Development Institute, Ministry of MSME, Government of India. *Chhattisgarh at a Glance.* Available from https://msmediraipur.gov.in/chhattisgarh.htm [accessed 10 january 2023]

Niti Aayog, Government of India (2018). *DEEP DIVE Insights from Champions of Change The Aspirational District Dashboard.* Available from https://smartnet.niua.org/sites/default/files/resources/firstdeltaranking-of-aspirational-districts.pdf [accessed 08 january 2023]

Niti Aayog (2020) Best Practices: Aspirational District Volume 1 Available from https://www.niti.gov.in/sites/default/files/2022-09/Best-Practices-from-Aspirational-Districts-Volume-1.pdf [accessed 10 February 2023]

Official Website, District Uttar Bastar Kanker, Government of Chhattisgarh. About District. Last updated 17 February 2023. Available from https://kanker.gov.in/about-district/ [accessed 23 February 2023]

Saha, Mohini. (2020) Treatment and awareness help women overcome Anemia, *Village Square: Stories and Insights from Rural India,* 5 October. Available from https://www.villagesquare.in/treatment-and-awareness-help-women-overcome-anemia/ [accessed 25 January 2023]

ANNEXURE I

List of Villages selected for the Study

#	District	Block/ Ward	Gram Panchayat/ Ward	Village
1	Mahasamund	Mahasamund	Koundkera	Bansiwani
2	Mahasamund	Mahasamund	Kharora	Kharora
3	Mahasamund	Mahasamund	Banskuda	Kuhari
4	Mahasamund	Mahasamund	Lohardih	Lohardih
5	Mahasamund	Mahasamund	Jogidipa	Patai Mata
6	Uttar Bastar	Bhanupratappur	Bhanbeda	Bhanbeda
7	Uttar Bastar	Bhanupratappur	Chichagaon	Chichgaon
8	Uttar Bastar	Koilebeda	Ghanker	Hriday Pur/ Pv 27
9	Uttar Bastar	Bhanupratappur	Kulhadkatta	Kulhadkatta- Pardhipara
10	Uttar Bastar	Bhanupratappur	Kachache	Tekadodha

Reasons for selecting Villages from Mahasamund

SR. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (refer JJM/ SBM data)	Total Households	Prevailing social issues/ issues of inclusion/ etc.
1	Mahasamund	Koundkera	1066	272	Forest villages, High rate of migration, Lack of awareness about healthcare and lack of primary healthcare facilities
2	Mahasamund	Kharora	2200	553	Forest villages, High rate of migration, Lack of awareness about healthcare and lack of primary healthcare facilities
3	Mahasamund	Banskuda	390	101	Forest villages, High rate of migration, Lack of awareness about healthcare and lack of primary healthcare facilities

SR. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (refer JJM/ SBM data)	Total Households	Prevailing social issues/ issues of inclusion/ etc.
4	Mahasamund	Lohardih	2806	703	Forest villages, High rate of migration, Lack of awareness about healthcare and lack of primary healthcare facilities
5	Mahasamund	Jogidipa	173	45	Forest villages, High rate of migration, Lack of awareness about healthcare and lack of primary healthcare facilities

Reasons for selecting Villages from Uttar Bastar Kanker

SR. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (refer JJM/ SBM data)	Total Households	Prevailing social issues/ issues of inclusion/ etc.
1	Bhanupratappur	Bhanbeda	1899	397	Tribal dominated, lack of primary healthcare facilities and belief on traditional remedies
2	Bhanupratappur	Chichagaon	1,761	410	95% Tribes Gonds; rest STs; Heavily Forested Area
3	Koilebeda	Hanker	1675	338	Only 3 families ST, rest are Bangladeshi. refugees
4	Bhanupratappur	Kulhadkatta	1,199	254	Primitive Tribal Group; marginalised
5	Bhanupratappur	Kachache	878	159	Mixed- Up+Bihar Migrants; Upper castes; Gada SCs and Lohar community+ Gonds and Kalhar Jaati- Daru making / OBC jaati etc; Mining Village; congested village plus exposure to industrial life

ANNEXURE II

Important Women-Centric Schemes in Chhattisgarh

- *Kaushalya Matritva Yojana:*This scheme was started in March 2022 by the chief minister Shri Bhupesh Bhagel, Indian National Congress (INC). Under this scheme, there is a provision to give a lump-sum assistance of 5000 INR to women beneficiaries on the birth of a second daughter. The scheme was conceived with the idea of upbringing and education of the girl child.
- *Minimata Mahtari Jatan Yojana:* Launched in 2017 by the chief minister Dr Raman Singh, it was enacted by the Bharatiya Janata Party (BJP) under the Ministry of Labour, Government of Chhattisgarh. The focus of this state government initiative is to reduce malnutrition among pregnant women. Nutritious meals, subsidized food, and health supplements are provided to women from poor families. The service is available six days a week, through select Anganwadis across the state.

- *Suchita Yojana:* It was started in 2017 by the chief minister Dr Raman Singh (BJP) under the Ministry of Child, and Women Development, Government of Chhattisgarh. Due to preference for traditional menstrual absorbents, conservative attitudes and economic reasons, women in rural areas do not have access to female hygiene products like sanitary napkins. The Chhattisgarh government has taken this challenge head-on with the Shuchita Yojana. Napkin vending machines have been installed in 2000 schools across the state. The government has improved the lives of 3 lakh girl students by helping them achieve menstrual hygiene.
- *Kishori Shakti Yojana:* This scheme was started in 2012 by the chief minister Dr Raman Singh (BJP) under the Ministry of Women & Child Development, Government of India. This program provides nutrition and health supplements to girls aged 11-18. Health check-ups, special counseling, and guidance on sexual health are also delivered through Anganwadis.
- *Mahila Samakhya Society Chhattisgarh:* It was started in the state by the chief minister Dr Raman Singh (BJP) under the Ministry of Human Resource Development, Government of India. It aims to educate and empower women in rural areas, particularly women from socially and economically marginalized groups.
- *Ayushmati Yojana:* The scheme was first launched in January 2002 by the chief minister Shri Ajit Jogi (INC) under the Ministry of Women and Child Development, Government of Chhattisgarh. It aims to provide health care access to women from low-income families and rural areas in the state. Under the scheme, women admitted to a PHC, district hospital or medical college for treatment are provided with cash up to ₹1000 for basic needs. Free medicines, food, and support facilities for bystanders are also provided.

A RESEARCH REPORT FROM

HARYANA







PART 1 INTRODUCTION

In Haryana, our research report on the, 'Combating the Silence from Menarche to Menopause – A Comprehensive Report on Menstrual Hygiene Management in India', was conducted in the districts of Nuh (Mewat) and Jhajjar. Nuh is included in Niti Ayog's Aspirational District Programme (ADP)[1]. Jhajjar, which is a prosperous district of Haryana, is not an aspirational district. It was selected for this study because aside from being a core intervention area of the Sulabh Sanitation Mission Foundation (SSMF), women in Jhajjar despite belonging to prosperous sugarcane farming families remain vulnerable on issues of Menstrual Hygiene Management (MHM) owing to various socio-economic and policy related anomalies and barriers. The population composition of areas selected for research in this sturdy was dominated by the general category followed by the presence of Backward Class (BC) and Most Backward Castes (MBC) as well as Other Backward Castes (OBCs) and Scheduled Castes (SCs).

For completing our research sample in Jhajjar and Nuh, ten villages were selected for field research and surveys. Research, including data collection and analysis, for this case- study on Haryana were done through the period of April 2022 to February 2023. Following a participatory and mixed-methods approach, information was sought and processed on the local situation on MHM (Menstrual Hygiene Management), WASH (Water, Sanitation, and Hygiene), education, health, livelihood, income, and availability of support systems to women in the selected districts. Though Nuh is beginning to work positively towards many parameters under the ADP, such as education, literacy, and infrastructure as an aspirational district, Jhajjar too needs to solve its socio-economic challenges. Our study indicates that Jhajjar and Nuh (Mewat) have much to achieve in terms of combatting the silences on MHM with inter-sectoral perspectives on wellbeing of, what we refer to as, **'Elder and Ageing Menstruating Women'** or EAMW. Nevertheless, because our interaction included women as mothers, teachers, counselors, and caregivers of young girls within schools and families, we include a lateral analysis on the menstrual wellbeing requirements of school-going girls as well.

Our research study has been designed to collect data and undertake inter-sectoral analyses on the Menstrual Hygiene Management (MHM) to emphasize on the objective of achieving menstrual health related wellbeing of women beyond their school years. We focus on the **'Elder and Ageing Menstruating Women' or EAMW** between the ages of 20 years to 49 years, though we also share our findings on MHM related enablers and barriers for young school going girls. Documenting the various kinds of silences in the effective MHM of EAMW, we suggest ways of combating the inter-sectoral hindrances towards the objective. Nonetheless, we also explore our primary data for critically appraising not only the barriers to MHM of women between the ages of 20 years to 49 years, but we also engage with the potential enablers. In the final section, our findings are examined against the voices of key informants to crystallize the salient findings from our primary data as well as delineate context- specific and community-sensitive recommendations and areas of improvement.

Focusing primarily on the category of, what we refer to as, 'Elder and Ageing Menstruating Women' (henceforth EAMW) between the ages of 20 years to 49 years, we also share our findings on MHM related enablers and barriers for young school going girls. In an attempt to understand the well-being of menstruating women beyond their school years, this study on Haryana documents the various kinds of barriers and silences in the effective MHM of EAMW. Nonetheless, we also explore our primary data to critically discern potential enablers towards an effective MHM of women between the ages of 20 years to 49 years, our exclusive focus is on EAMW. However, as mothers, teachers, and relatives of growing girls, these EAMW deal with young girls, hence we impart a 'lateral' focus on girls.

[1] ADP aims to improve the socio-economic status of the citizens expeditiously. The three core principles of the program are - Convergence (of Central & State Schemes), Collaboration (among citizens and functionaries of Central & State Governments including district teams), and Competition among districts (Niti Aayog, 2018).

In the final sections, our findings are examined against the voices of key informants to crystallize the salient findings from our primary data as well as delineate context- specific and community-sensitive areas of improvement. Therefore, this case-study on Haryana ends with suggestions on short term as well as mid-term enablers and recommendations for combating the inter-sectoral hindrances prevalent in areas observed.

NUH AND JHAJJAR DISTRICTS FROM HARYANA

Haryana, a state in northern India, is bounded by the union territory of Chandigarh and the state of Punjab on the north and northwest, the states of Himachal Pradesh and Uttarakhand on the north and northeast, the state of Uttar Pradesh and the union territory of Delhi on the east, and the state of Rajasthan on the south and southwest. Haryana has displayed strong economic growth with its GSDP at current prices estimated at US$ 121.77 billion for FY22, an increase of seven percent year-on-year. At current prices, Haryana's GDP growth is projected at 15.8 percent for FY22 (IBEF, 2023, Haryana section). In terms of industrial production, Haryana is one of the leading states in India. The main industrial products include passenger cars, motorcycles, mobile cranes and tractors. In addition to being a leading auto hub in India, Haryana has emerged as a base for the knowledge industry, including IT and biotechnology. Haryana is home to many large Indian and multinational companies due to its high-quality infrastructure and proximity to Delhi (IBEF, 2023, Haryana section). Haryana is also the second-largest contributor of food grains to India's central pool, earning itself the name of being one of the two bread baskets of India (the other is Punjab). It also accounts for more than 60 percent of the export of Basmati rice in the country (IBEF Presentation, 2020).

NUH (MEWAT)

Nuh district (Earlier officially known as Mewat district) is one of the 22 districts in the Indian state of Haryana. Mewat was a district in Haryana mainly known for agricultural yield on rain-fed land and agro-based activities. Now known as Nuh, the district was selected in the survey due to a concern for deepening knowledge on MHM and conceptions of the minority-dominated population of the area. In 2011, Mewat had a population of 1,089,263 of which male and female were 571,162 and 518,101 respectively. According to the 2011 Census, average literacy rate of Mewat in 2011 was 54.08%, male and female literacy were 69.94% and 36.60% respectively. For Muslim women in Mewat, the literacy rate ranges 1.76 % to 2.13 %, which is the lowest in the country (Census, 2011).

With regards to Sex Ratio in Nuh, it stood at 907 per 1000 male compared to the 2001 census figure of 899. The average national sex ratio in India is 940 as per the reports of Census 2011 Directorate (Census, 2011). The main occupation of the people of Mewat district is agriculture and allied and agro-based activities. The Meos (Muslims) who are the predominant population group, are fully agriculturists. Nuh has remained a region of slow transformations even after independence. The area lags the rest of Haryana on almost every indicator of development, even though the farthest point of Mewat is no farther than 145 Kms. from the country's national capital.

After becoming the only Aspirational district from Haryana, Mewat has achieved some developmental indicators but family planning, child immunisation, nutritional status of women and children, and maternal and child health have been some major challenges in the area. According to the National Family Health Survey-4, conducted by the Ministry of Health and Family Planning Welfare in 2015-16, only 15.5% people in Nuh practice family planning with just 2.6% using condoms (Kumar, 2019). Moreover, water crisis is another major issue in the district, with depletion of groundwater tube wells turning out to be contaminated and unfit for consumption. Supply of clean drinking water is a clear parameter on the development index while irrigation for fields is important to sustain agriculture, the mainstay of the economy (The Tribune, 2021).

JHAJJAR

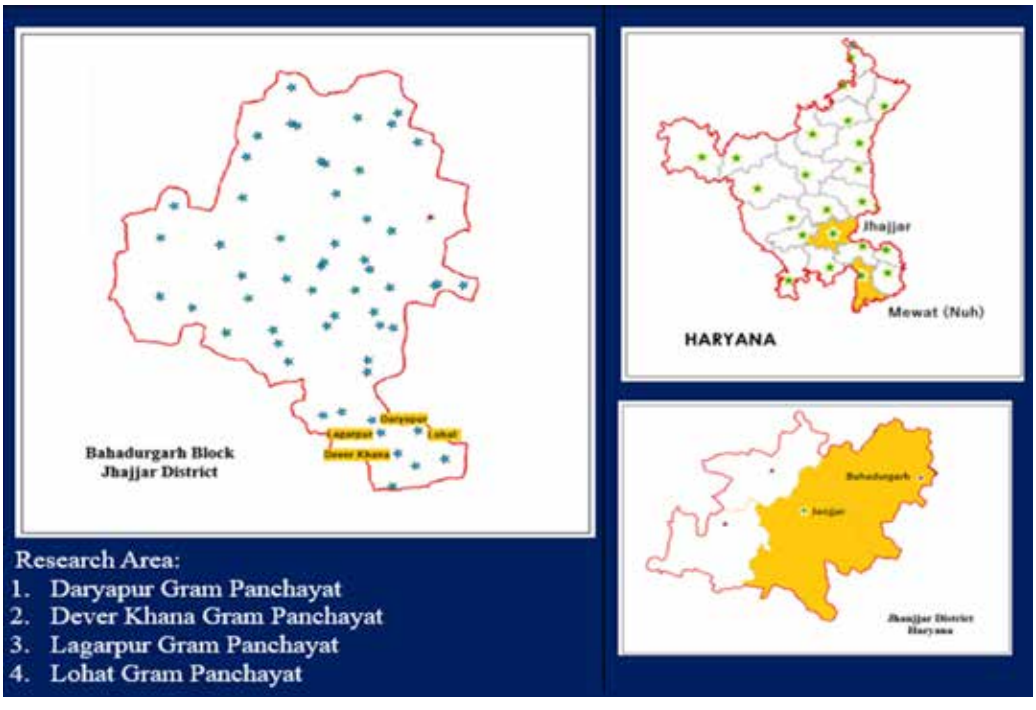
Jhajjar, a district in the state of Haryana, is known for its developing economy and infrastructural growth. Today it counts amongst the fast-developing regions of Haryana with focus on public welfare. Previously a part of Rohtak district, it was carved out of it and became an independent one on 15th July 1997 (Jhajjar district, n.d., About district section). Jhajjar is dominated by 74.2% rural communities engaged in agriculture (Malhan, 2020). Owing to its discriminatory set-up, women and girls in Haryana's Jhajjar feel vulnerable at public places such as parks, educational institutions, outside paan shops and even while traveling on public transport. Jhajjar is also infamous for its skewed gender ratio (The Tribune, 2018). In 2011, Jhajjar had a population of 958,405 of which male and female were 514,667 and 443,738 respectively (Census, 2011) Average literacy rate of Jhajjar in 2011 was 80.65, male and female literacy were 89.31% and 70.73% respectively. The average national sex ratio in India is 940 as per latest reports of Census 2011 Directorate (Census, 2011).

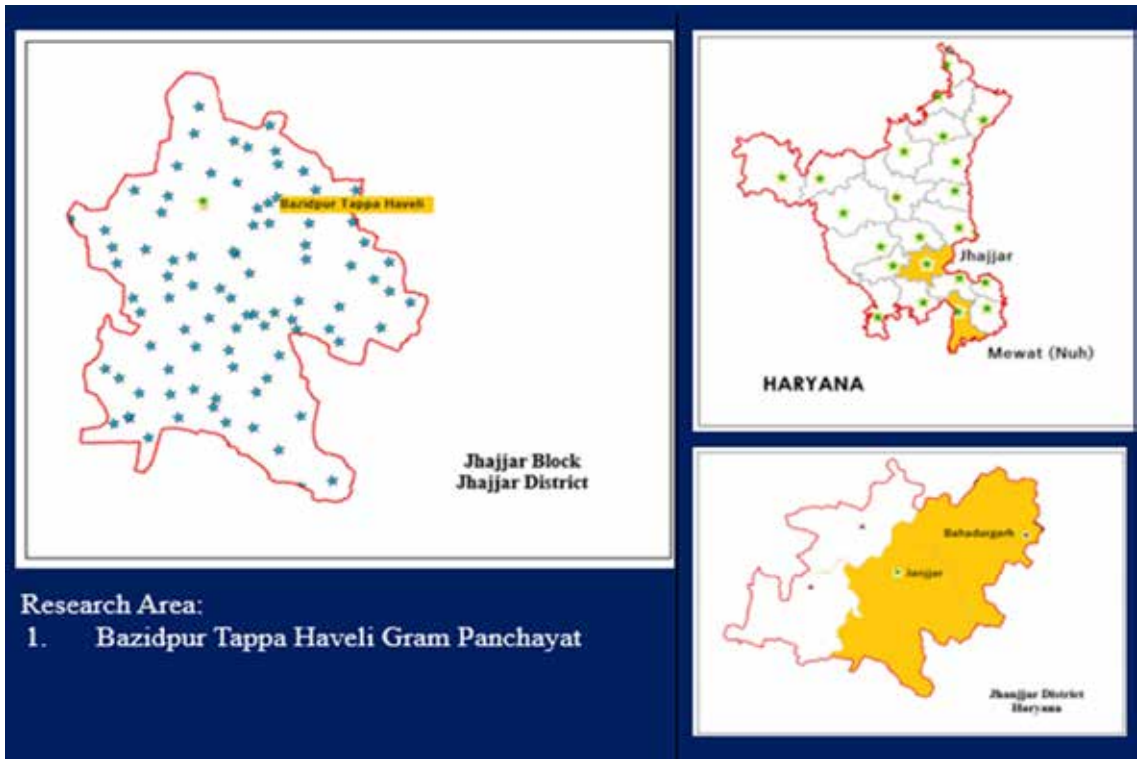
The groundwater, which is not potable, is saline along with prevalence of fluoride, chloride, and high TDS in the district (Komal, 2019). The hard and contaminated groundwater is also not being used for irrigation and water from other far areas is being brought by pipelines and canal water. Waterlogging is the major problem in areas where rice cultivation is increasing. Due to saline water, the pores of land are blocked and waterlogging starts in these types of areas. Using excess fertilizers and increase in chemical -farming also leads to increasing water logging (Komal, 2019).

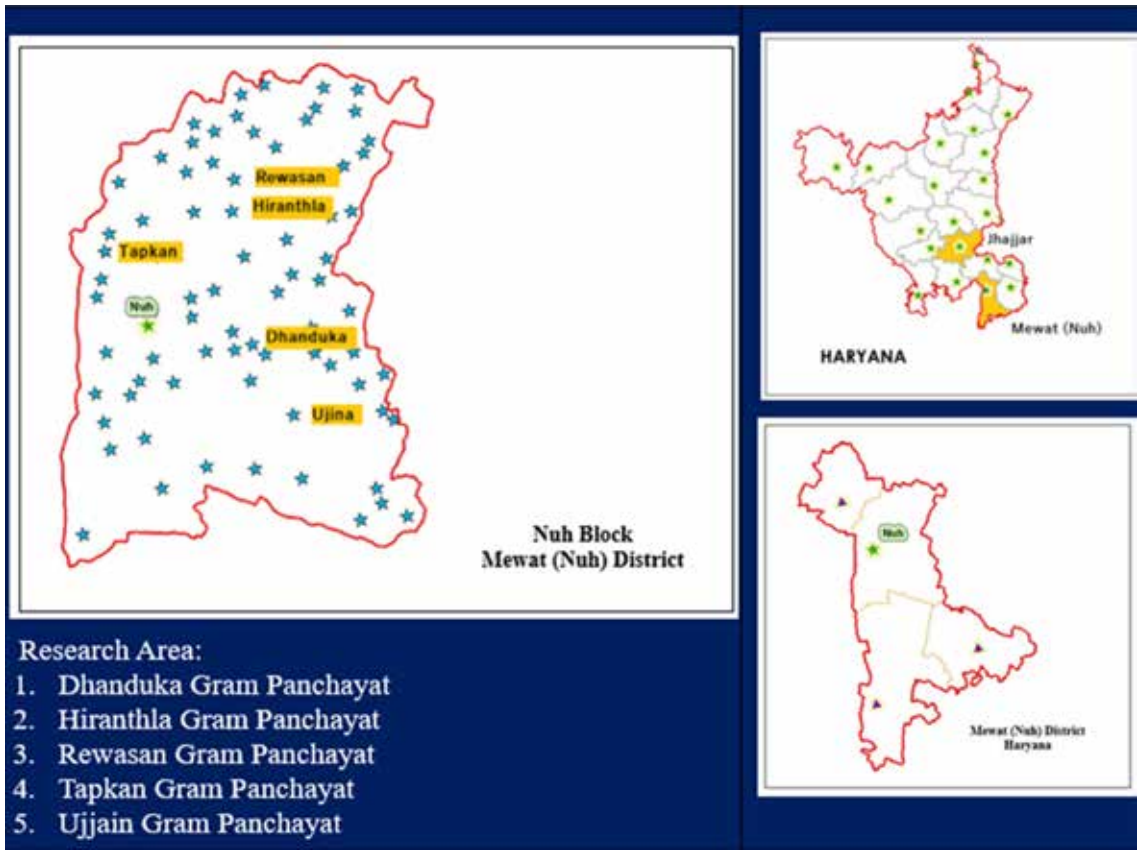
Though both districts are doing well on many parameters where improvement is needed such as education, literacy and infrastructure, our study indicates that Nuh as ADP and Jajhar as non-ADP have much to achieve in terms of combating the silences on MHM. An inter-sectoral perspective on well being of the EAMW in particular, as well as a policy-appropriate focus on school-going menstruating girls can bring a desired positive change towards MHM in these districts.

1.1 LIST OF VILLAGES SELECTED FOR THE STUDY FROM MEWAT AND JHAJJAR

On an average, five villages from each district were selected based on factors such as access to minority-focused villages, scarcity of safe drinking water, migration due to rainfed land, unskilled laborers, etc. Our sample covers daily wage labourers, workers from the informal sector and agricultural labour, industrial skilled







workers as well as workers from unskilled backgrounds and self-employed families. In terms of communities and groups, the villages we selected have a diverse population ranging from Muslims, General Category and OBCs to Dalits. Isolated and/ or marginalized communities and a difficult or hesitant access to health services are some of the common grounds based on which villages and populations in Nuh and Jhajjar were selected. Even though their backgrounds and characteristics differ, Nuh and Jhajjar share some common challenges towards women's wellbeing.

2 DATA TOOLS AND STRUCTURE OF THE CHAPTER

2.1 RESEARCH TOOLS, METHODS AND THEMATIC FOCUS FOR DATA COLLECTION, CORRELATIONS, AND COMMUNITY-BASED ANALYSES

Types of Interviews- Tools and Focus	Data Collection and Analysis- Methods and Themes	Haryana	
		Mewat	Jhajjar
Tool 1 Menstrual Practice Questionnaires (MPQs)	Method 1 The MPQs were In-depth Interviews (IDIs) for- actor, discourse and practice- analyses	428	274
Tool 2 Menstrual Practice Needs Scale (MPNS)	Method 2 Measurement of perceptions and needs based on the last menstruation cycle	59	58
Tool 3 Key Informant Interviews (KIIs)	Method 3 Voices, Excerpts, Salient Findings and Observations	12	12
Themes: WASH, Education, and Health, Livelihood	Focus: Inter-Sectoral findings and conclusion and comparisons		

3 ACTOR ANALYSIS FROM MPQS

3.1 ACTOR ANALYSIS

In this section, socio-economic profile as well as the current menstruation status of the actors is detailed.

3.1.1 DEMOGRAPHIC PROFILE OF THE RESPONDENTS

Demographic Profile	Mewat (in %)	Jhajjar (in %)
Total Respondents	**428**	**274**
Rural/ Peri-urban/ Urban		
Rural / Tribal	428	274
Mother Tongue	**Mewat (in %)**	**Jhajjar (in %)**
Haryanvi	1.4	100
Hindi	25.7	0
Mewati	72.9	0
Other languages you know		
Hindi	97.9	100
Mewati	1.9	0
Tamil	0.2	0
Religion		
Hindu	47.9	98.9
Muslim	52.1	1.1
Caste/ Tribe type		

General	29.9	68.2
OBC- Other Backward caste	22.9	24.1
SC- Scheduled caste	10.3	5.5
ST/ PVTG	2.3	1.1
BC/MBC	34.6	1.1
Marital status		
Never married	1.4	3.3
Married	90.2	96
Widowed	7	0.7
Divorced	1.4	0

- **Religion:** More than half of the interviewed from Mewat i.e., 52.1 percent of the women were Muslim, and others were Hindu. 98.9 percent of interviewed women from Jhajjar were Hindu.
- **Community:** Along with the Muslim -dominant interviewees, one-third population of Mewat was from BC or MBC constituting almost 34.6 percent. The scheduled Caste population was 10.3% (Koli, Meetha), and more than half, i.e., 52.9%, were from the General or OBC (Kasab, Koli, Kurmi, Lohar, Mali, Mewati, Nhai, Saaka). More than two third of women from Jhajjar were from the General caste (Thakur, Sheikh), i.e., 68.2 percent and 24.1 percent belonged to OBC.
- **Marital status:** 92.5% of respondents from the survey were married. In Mewat, the average age at marriage was found to be below 18 years. In Jhajjar, it was 19.9 years.
- **Children and Family Size:** Average number of children in Mewat was 4 and that of Jhajjar 3 i.e., lesser than Mewat. Thus, the average family size from Mewat was 6 persons, whereas, from Jhajjar, it was 5.

3.1.2 AVERAGE INCOME

- **Hesitation to Reveal income:** 31.1% of women (i.e.,133 out of a total of 428) from Mewat and 70.8% women (i.e.,194 out of a total of 274) from Jhajjar did not want to disclose their incomes.
- **%of Regular Income Families:** However, from the rest, we could find that the 59.1% (n=253) families from Mewat had regular income, as compared to 18.2% (n=50) of the families in Jhajjar with the same
- **Income Disparity in Districts:** At 174319 INR, the average yearly family income in Jhajjar was found to be more than in Mewat where the families earned 94732 INR on an average.

3.1.3 SOURCES OF INCOME

In Mewat, nearly half i.e., 47.4% of families were earning mainly from regular sources of income such as farming, industrial skilled work, Government service, Private service, or their own business as a single source of income. All remaining families were earning from irregular sources of income, working as daily wage laborers, farm workers, unskilled workers, and seasonal work.

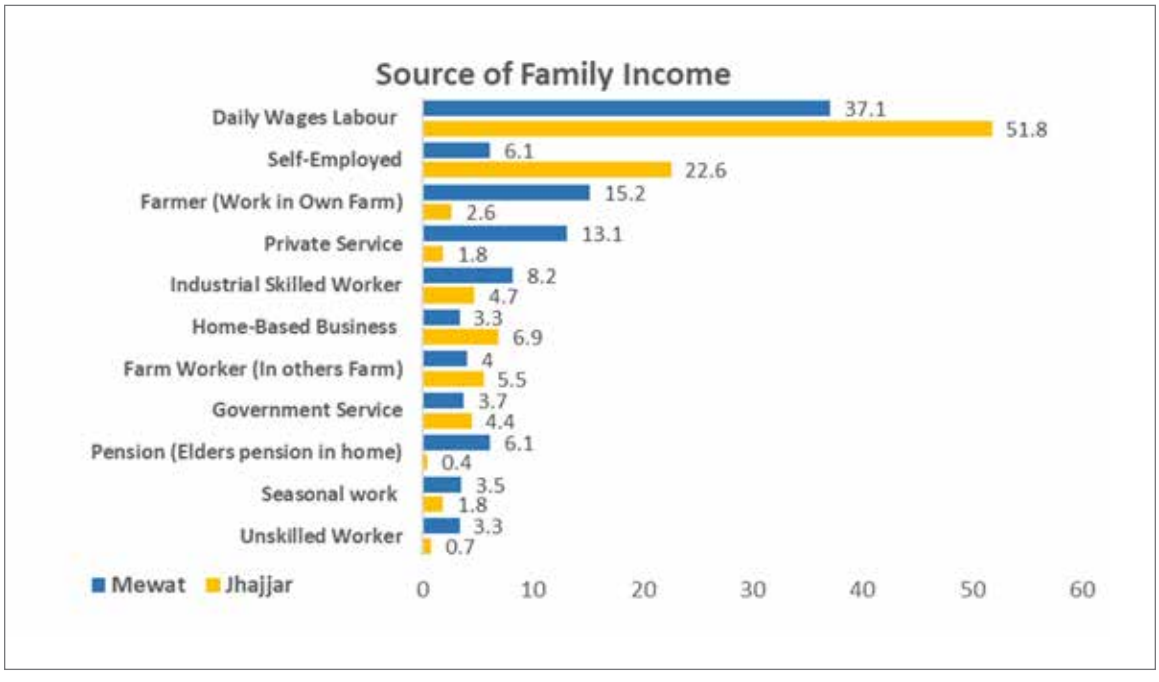
INCOME TRENDS

- **Sources of Income in Mewat**: In Mewat, 47.4% of the families who disclosed their income (n=253) were earning mainly from regular sources of income such as farming, industrial skilled work,

Government service, Private service, or from their own business as a single source of income. While the rest of the families in Mewat were earning from irregular sources of income, by working as daily wage laborers, farm workers, unskilled and seasonal workers.

- **Sources of Income in Jhajjar:** In Jhajjar, 29.2% (n=274) of the families who disclosed their income earned from regular sources. Rest of the families earned mostly from irregular work
- **Multiple Sources of Income:** Very few families from both the districts i.e., around 5 % of the total interviewees earn from multiple sources of income.
- **Women lack Disposable Income:** While families in both the districts earned from regular, irregular, or multiple income sources, 651 of our respondents (N =702) in our survey expressed that they do not earn despite working on their own farms. Neither do they have disposable income nor decision making powers to invest in personal medical care related to MHM.

3.1.4 SOURCES OF FAMILY INCOME



*Multiple Choice Question

TRADITIONAL KNOWLEDGE & SKILLS

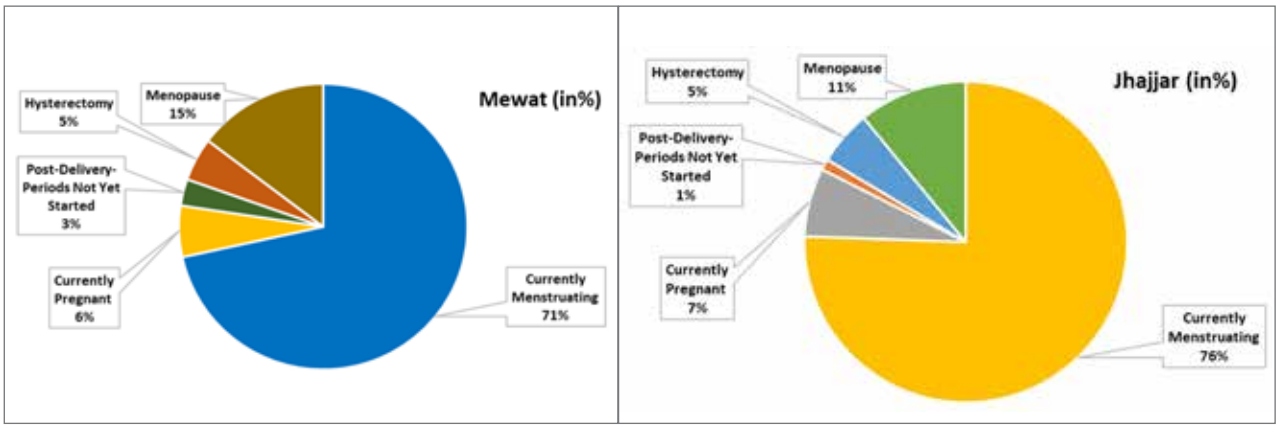
Women in Nuh and Jhajjar possess traditional knowledge and skills such as tailoring, pad-making, embroidery, knitting and weaving.

- **Traditional Skills:** 138 women from our sample in Nuh and Jhajjar reported possessing traditional skills. Only 28.3% women earn from these skills.
- **Income/ Earning in Mewat:** In Mewat, 23 (41.8%) out of the 55 women who reported possessing traditional knowledge and skills, earned from their skills. In Jhajjar, 16 (19.3%) out of 83 women who reported possessing traditional knowledge and skills utilise these to earn an income.
- **Income/ Earning in Jhajjar:** The proportion of women earning from their traditional skills in Jhajjar was nearly one in five whereas in Mewat 42% EAMW reported that they earn from the traditional skills they possess.

Since traditional skills and knowledge can empower women in various ways and augment family income too, we suggest that women may be encouraged to earn through native arts and talents, where they form one of the best options. In Mewat, many women seem to be enthusiastically earning through traditional skills such as tailoring, embroidery etc. Vocational training schemes and centers around such arts and crafts can help Mewati women to come up and improve their prospects while the women in Jhajjar who lag behind in traditional skills can become monetarily empowered and confident to protect themselves from discrimination and domination that they face in the local social context.

3.1.5 MENSTRUATION STATUS

- **Total EAMW**: Out of 702 women surveyed through MPQs from both the districts of Haryana, 573 women (i.e., 81.6 %) were in their active menstrual years.
- **Age at Menarche:** Average age at menarche was 13, whereas the average age at attaining menopause was 42.6 years.
- **Number of Hysterectomies**: A total of 36 (4.8%) hysterectomies were done among the women in our sample from Haryana, with the average age at hysterectomy around 38.7 years.



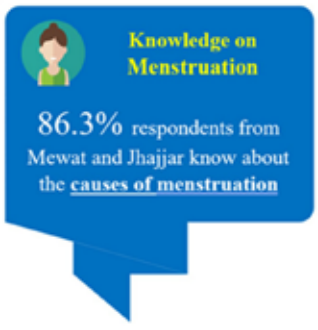
3.2 DISCOURSE ANALYSIS:

In this section, our findings relate to levels of knowledge that our respondents profess on the causes of menstruation, organs involved in it and an analysis of their discourses on the subject. In other words, we analyze the information given during the IDIs to understand how much general as well as precise comprehension women seem to have on menstruation as a monthly and bodily process. Further, we present our findings on the extent of communication as well as silence around the theme, for instance with whom and how much they chose to discuss or not discuss on issues experienced and their general observations related to MHM. We also present data on educational backgrounds of women, how the women position themselves on medical care options and facilities available/ not available and their awareness on use and disposal of menstrual absorbents, health risks as well as common disorders and symptoms they experience during menstruation and, in cases of hysterectomy, where applicable.

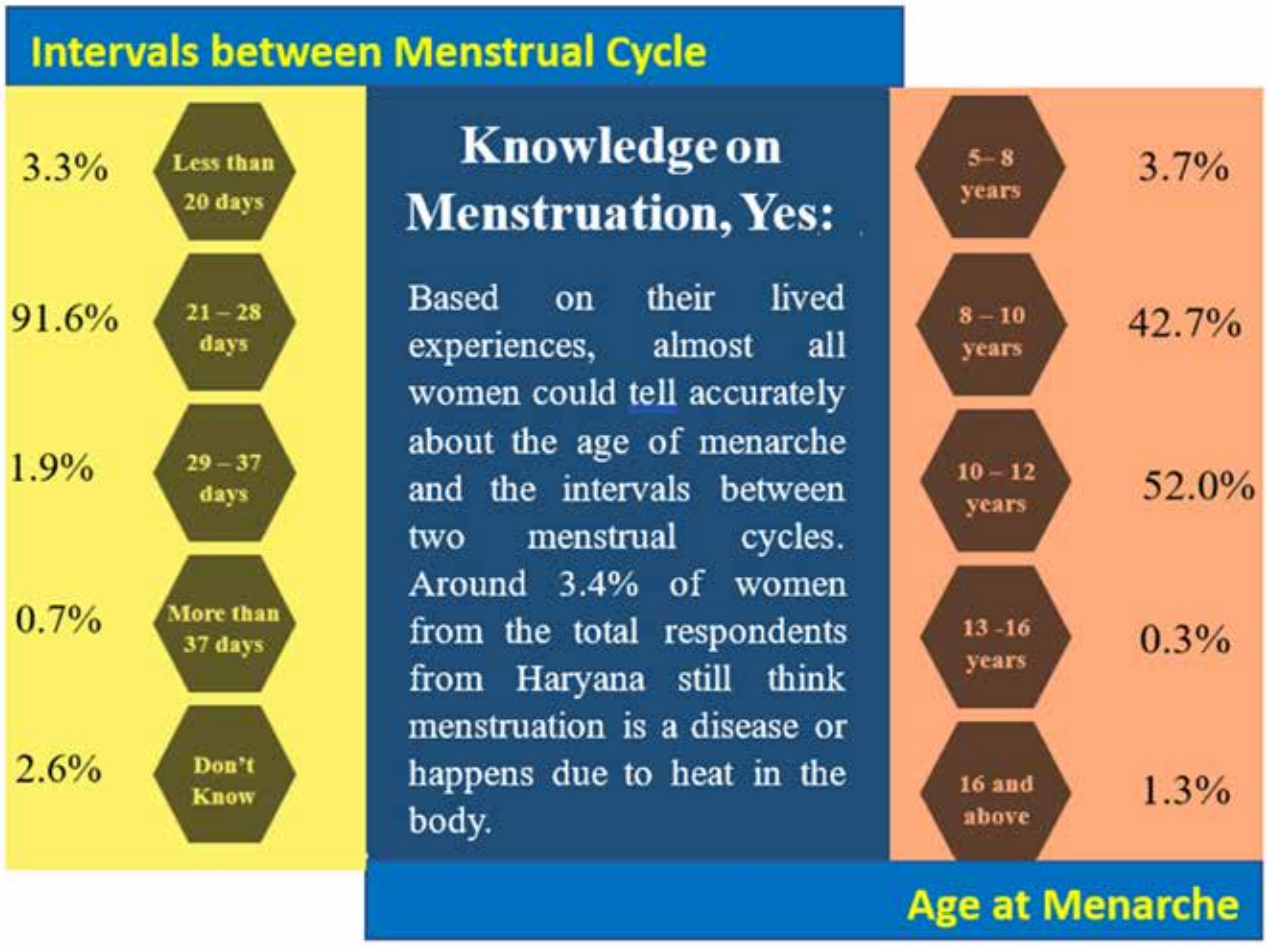
3.2.1 KNOWLEDGE ABOUT MENSTRUATION:

Knowledge About Menstruation	Mewat (in %)	Jhajjar (in %)
Total Respondents	**428**	**274**
Causes of Menstruation		
Hormonal change	83.2	91.2

Knowledge About Menstruation	Mewat (in %)	Jhajjar (in %)
Disease	3.3	3.6
Don't know	12.1	5.1
Due to heat in the body	1.4	0.0
Organs Involved in Menstruation		
Uterus/ Birth canal	93.5	96.0
Abdomen/ Bladder	2.3	0.7
Don't know/ not answered	4.2	3.3



Precise Information: Though, 95% of the women are biologically aware as they could answer questions on organs involved in menstruation, however 13.7% could not answer about causes of menstruation.



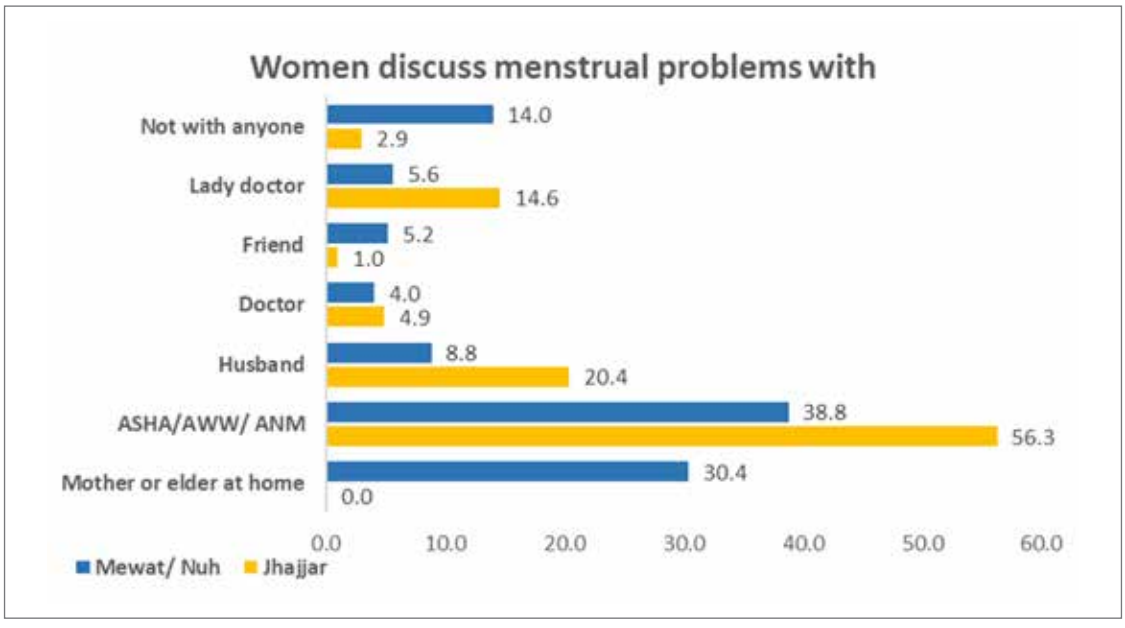
- **Basic Understanding, Yes:** Based on their lived experiences, almost all women could tell accurately about the age of menarche and the intervals between two menstrual cycles. Around 3.4% of women from the total respondents from Haryana still think menstruation is a disease or happens due to heat in the body.
- **Precise Information:** Though, 95% of the women are biologically aware as they could answer questions on organs involved in menstruation, however 13.7% could not answer about causes of menstruation.

3.2.2 SOURCE OF INFORMATION ABOUT MENSTRUATION

For young girls the top sources of information on menstruation emerged as follows:

- Top sources of information for young girls about menstruation at the time of Menarche were parents, grandmother, sister, or sister-in-law reported from both of the districts

Women like to discuss their menstrual problems with the following:

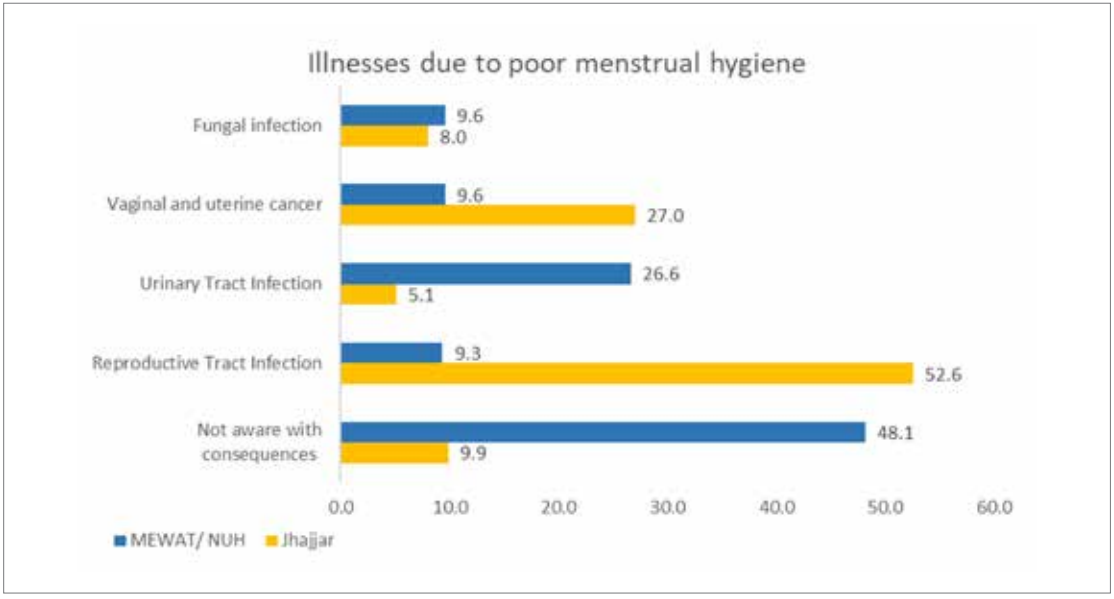


*Multiple Choice Question

- **Close Relatives:** Mothers and elders were the most important source of information on menstruation for our respondents when they experienced menarche as young girls. 73.4% of the respondents from Mewat and 58.1% respondents from Jhajjar claimed that the primary source of information on menstruation were parents, guardians and relatives like a grandmother, sisters, or sister-in-law.
- **Frontline Health Workers (FHWs):** Out of the total surveyed from Jhajjar, 56.3% were more comfortable to talk about their MHM problems with the FHWs in the village such as Accredited Social Health Activist (ASHA), Auxiliary Nurse and Midwife (ANM) and Anganwadi workers (AWW) rather than close relatives. Unlike in Jhajjar, only 6.8% women in Mewat reported their sources of information as government workers. It emerges that families transfer more information on menstruation in Mewat than they do in Jhajjar
- **Spouses:** 8.8% women from Mewat and 20.4% of Women from Jhajjar felt comfortable talking about menstrual problems with husbands. If men can be oriented, stay alert and helpful on their wive's MHM issues, that would bring a positive health outcome for EAMW, besides combatting the silence on it.
- **Nobody:** However, 14.0% of our respondents from Mewat and 2.9% from Jhajjar prefer to talk with no one and remain silent about their menstrual problems. While family awareness programmes could benefit the latter, familiarity, and knowledge of functions of FLHWs to spread awareness on women's health can empower the minority -community women in Mewat and this way close an information- communication gap in both the districts.

3.2.3 MENSTRUAL HEALTH, EDUCATION, AND AWARENESS ON INFECTIONS

Apart from the use of different menstrual products, the study presents data on health problems which were experienced by our respondents during menstruation. It was further verified whether they visit the doctor in case of any health issues or prefer to keep quiet and bear it. Adverse health conditions while working in or outside the home may lead to rashes, urinary tract infections (UTIs), and reproductive tract infections (RTIs) for many women, as indicated by our survey findings.

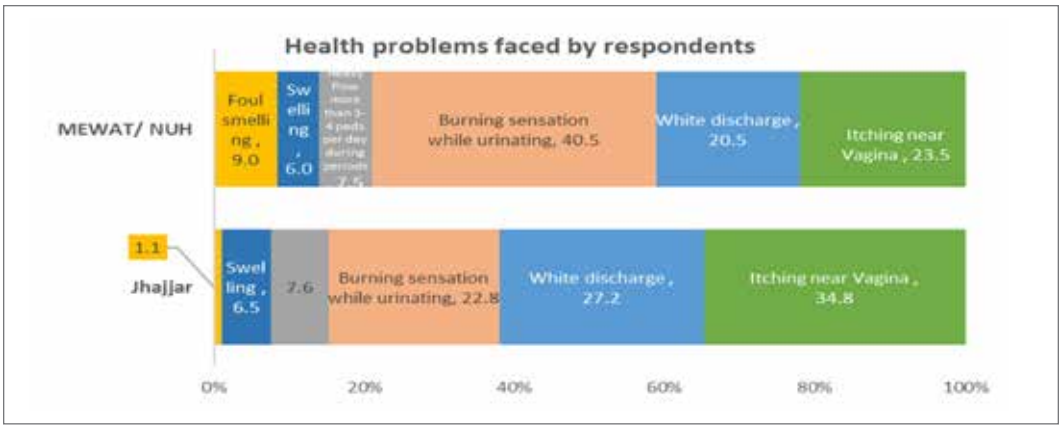


*Multiple Choice Question

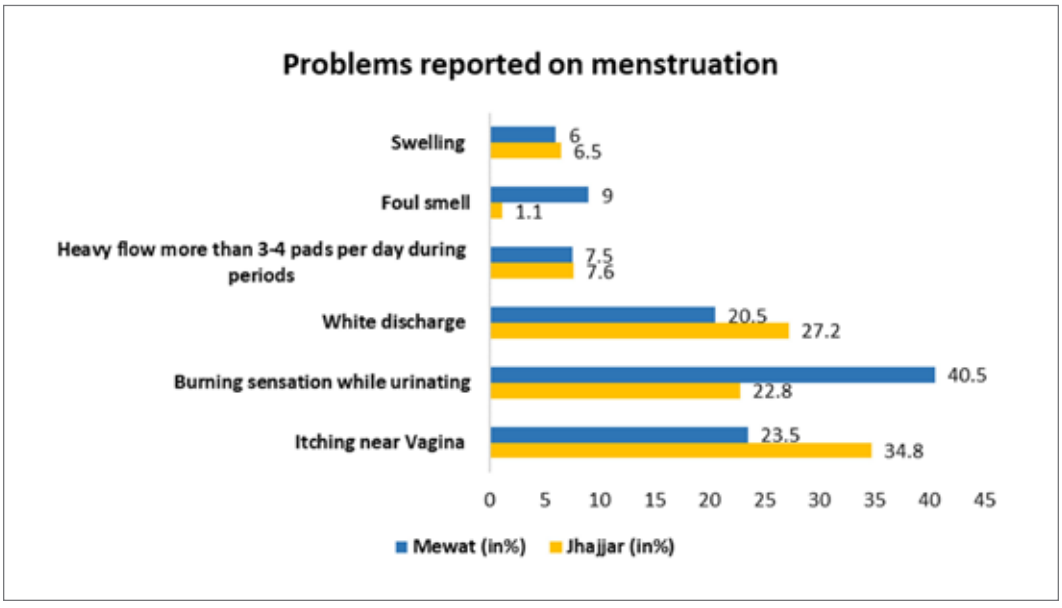
- **Widespread ignorance and low knowledge on exact health risks:** When asked about the side effects of poor menstrual hygiene, 48.1 % of women from Mewat couldn't answer,
- **Fungal Infections and UTIs:** In Mewat 26.9% of women could talk about the occurrence of urinary tract infection. In Jhajjar, almost nine out of ten women could talk about side effects. Reproductive Tract Infection (RTI) was reported by 52.6%, followed by 27% of women who told about vaginal and uterine cancer.
- **Low knowledge on exact health risks:** Adverse health conditions while working in or outside home often lead to rashes, Urinary Tract Infections (UTIs) and Reproductive Tract Infections (RTIs). However, our findings indicate a lack of awareness on these risk factors. Not being able to understand and/or give answers on the relationship between MHM and rashes, infections and other risks indicates ignorance per se.
- **No Schooling, Taboos and Communication Barriers:** However, given that speaking about periods itself is a taboo or is a challenge due to shyness/ hesitancies, generalizations on awareness on MHM may be misleading. Community and area specific conclusions are a better way ahead. One of the most noteworthy findings from both the districts of Haryana has been that around 26.5% women did not attend schools. 34.9% of our participants (from a total of 702) were women who attended school only up to secondary grade. In other words, all these women did not receive formal education and lost out on the opportunity to discuss it amongst peers, with teachers and counselors and break barriers of communication around the issue. EAMW who participated in our study, were women who could complete their school education and either remain shy to speak or know about menstruation or effectively become silent on the theme.

3.2.4 HEALTH SYMPTOMS AND PROBLEMS DURING MENSTRUATION (MEWAT N=344, JHAJJAR N=229)

Apart from health problems related to infections and diseases during menstruation, all menstruating women were further asked about any other symptoms or discomforts that they face:



- **MHM, health and accessibility to health care**: Apart from the modes as well as patterns of and awareness on MHM, the survey imparts light on the health problems undergone by participants during menstruation. For arriving at inter-sectoral findings on health management, women were asked if they visit a medical professional to resolve menstrual health issues and reasons if they do not.
- **Vaginal symptoms and attitude:** More than one-fifth (82.1%) of the EAMW from both districts reported that they did not have any health problems during menstruation. In the later part of the survey, however, they confirmed itching near vagina, burning sensation while urinating and white discharge were the top three issues that women faced due to poor vaginal hygiene. Symptoms like swelling and foul smell and heavy flow of more than 3-4 pads per day during periods were also reported by 6% - 9% of women from both the districts.
- Half the women reported seeking medical advice over menstrual health problems and only four out of ten visited a doctor and got cured after completing treatment.
- **Symptoms and Solutions:** Abdominal pain and backache followed by cramps and headache were the top three health symptoms reported by our respondents during menstruation. When faced with one or more physical symptoms, 63.1% of the women from Mewat take rest while 17.7% prefer painkillers. 1.5% of our women interviewees do not take rest/ leave from work due to discriminatory wage cuts. 54.3% of the women in Jhajjar take rest while 23.1% take painkillers in both districts. It was found that women take care of themselves during periods by consuming specific foods. However, more than one- third of the women from both the districts reported that they do not face any health symptoms during menstruation.

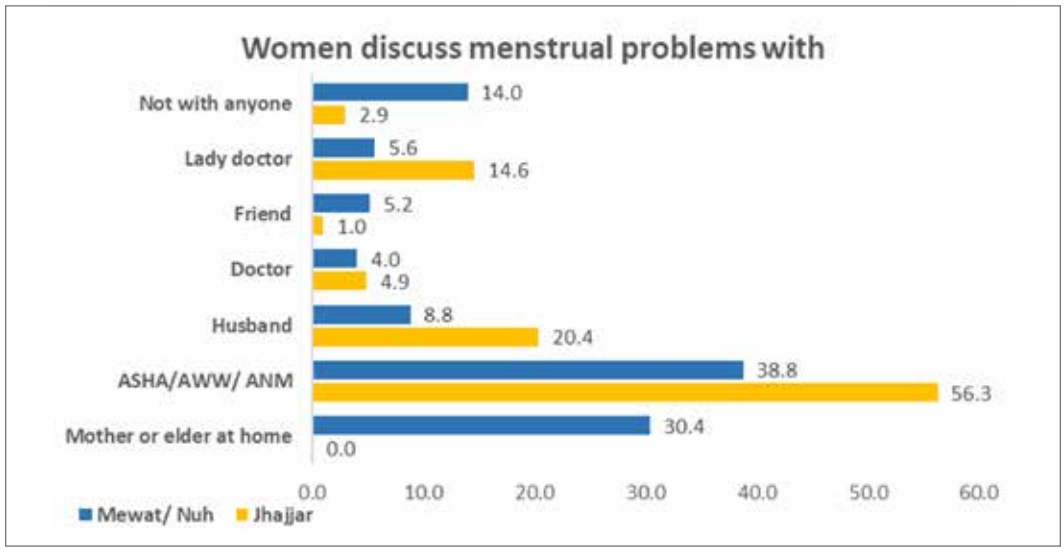


*Multiple Choice Question

Women in Mewat and Jhajjar do not experience physiological and internal problems during their menstrual cycle as much as they face topical disorders. Knowledge campaigns and adopting good practices of personal cleanliness and hygiene, appropriate use of absorbents during menstruation can relieve the women of their MHM related diseases and disorders. Lack of water and contaminated/ saline water in both the districts could be one of the reasons why women's health suffers to the extent found by our survey. Indeed, if health anomalies during menstruation are not resolved, pushed to the peripheries or remain shrouded in silence, women have much to lose in social, economic and personal spheres. For combatting health and hygiene related silences on periods in women beyond school years, to benefit the EAMW, the governmental healthcare must tune itself to hear their voices. In the last section of this Chapter, titled 'Excerpts and Voices', we bring community-based views and suggestions from women over this issue.

TALKING ABOUT MENSTRUAL PROBLEMS WITH FAMILY, FRIENDS, DOCTORS AND HEALTH WORKERS

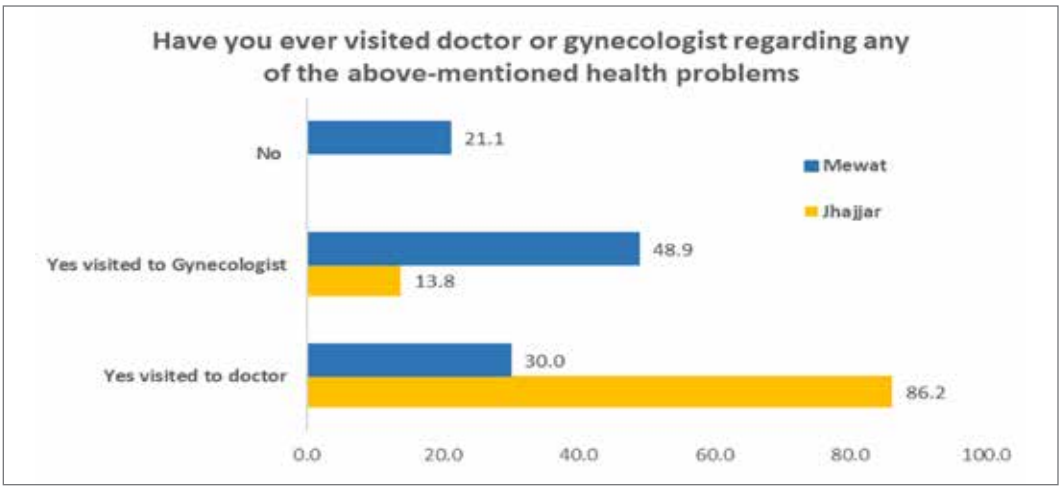
Women who did/do not approach the doctor despite treatment needed give reasons such as 'do not feel the problem is serious', bear silently, feel shy to talk to male doctors where a lady doctor is not available nearby. When medical facilities are located faraway, women refrain from accessing these as there is no one to accompany them, others use home remedies or rely on support from local health workers.

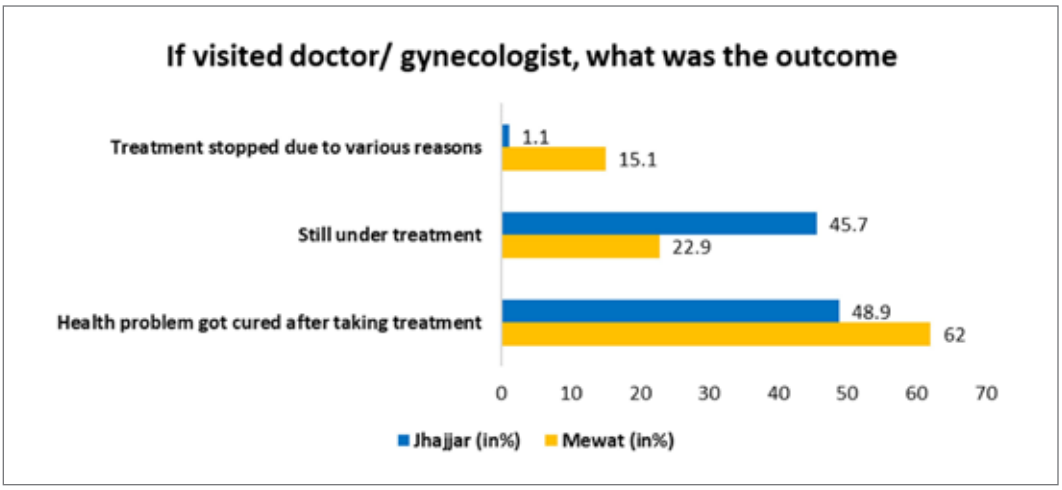


*Multiple Choice Question

- **Denial, Negligence, Silence:** Around 6 out of 10 women from Jhajjar did not report any health problem which indicates a denial or self-negation of women regarding menstrual health issues. By not reporting any health issues they escaped from giving answers of further questions or their silence is just a shield to their hesitation of speaking about their periods and intimate wellbeing in the public domain. Women and girls should be encouraged by their families (especially in Nuh) and the FLHWs (especially in Jhajjar) to articulate their concerns on menstruation with confidence and ease.
- **% Women who speak on Menstrual Issues**: % Women who speak on Menstrual Issues: Around 43.9% of the respondents from both the districts were comfortable discussing menstrual health related problems with frontline health workers like ASHA, ANM and Anganwadi workers.
- **Medical Advice/ Follow-up:** When asked if they visit a doctor or gynecologist regarding any of the above-mentioned menstrual symptoms and discomforts, 47% from Mewat and 65.7% from Jhajjar reported that as they do not think the problem is serious, they have yet to approach the health system. Only 5% of respondents out of total reached the doctor for a menstrual health related problem.

In Haryana, women rely on FLHWs more than they do on medical practitioners for seeking support on MHM. It is hence, the onus of the formal as well as the informal medical system to reach out to these women, break the ice and convince them to participate in their MHM and wellbeing and consult doctors at the right time.





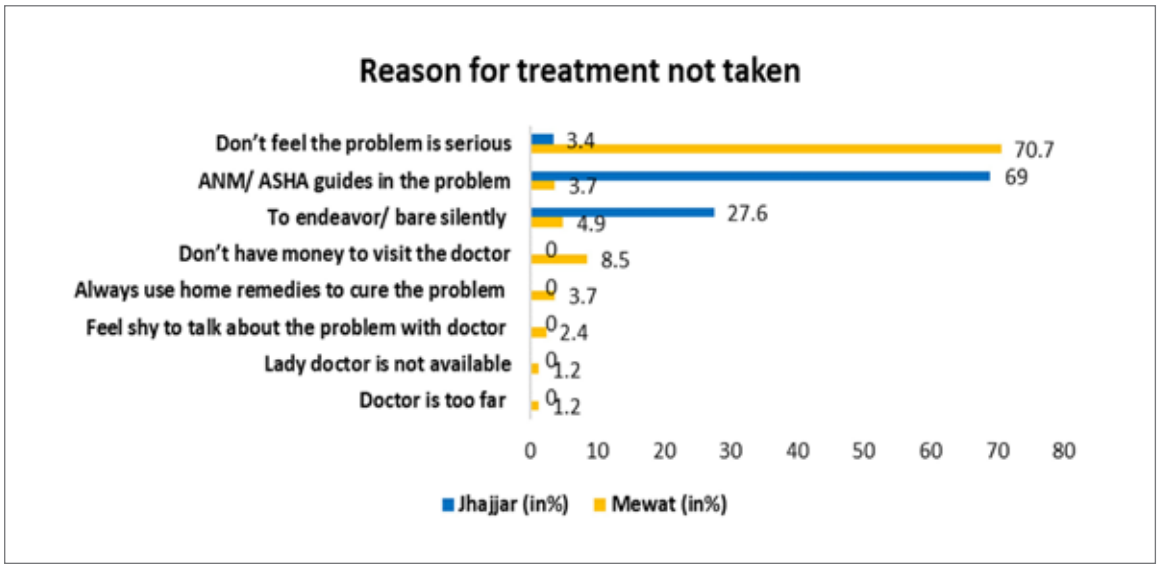
➲ Nearly half of the women from Mewat and two -thirds from Jhajjar reported not having any serious health problems to seek treatment. Around 62% of the women from Mewat (n=428) and 48.9% of women from Jhajjar (n=274) had completed their treatment medically when menstruation related issues arose in the past. Rest of the women reported that despite needing it, they dropped out of treatment due to non-affordability.

Reasons for treatment not taken (Multiple Response)	Mewat (in %)	Jhajjar (in %)	Haryana (in %)
Total Respondents	**82**	**29**	**111**
Don't feel the problem is serious	70.7	3.4	53.2
ANM/ ASHA guides in the problem	3.7	69.0	20.7
Bear silently	4.9	27.6	10.8

Reasons for treatment not taken (Multiple Response)	Mewat (in %)	Jhajjar (in %)	Haryana (in %)
Do not have money to visit the doctor	8.5	0.0	6.3
Always use home remedies to cure the problem	3.7	0.0	2.7
Feel shy to talk about the problem with doctor	2.4	0.0	1.8
Lady doctor is not available	1.2	0.0	0.9
Doctor is too far	1.2	0.0	0.9

3.2.5 REASONS FOR NON-TREATMENT

- **Ignorance:** In Mewat 70.7% women did not feel the problem was serious.
- Frontline Health Workers (FHWs): In Jhajjar 69% women received guidance from local health workers like ANM/ ASHA in the problem.
- **Attitude (Shyness and Silence):** In Mewat, the women bear silently, use home remedies to cure problems, and face shyness in discussing the problem with the doctor and mentioned monetary problems. In Jhajjar, all women reported that they bear problems silently and do not discuss with anyone.
- **Lady doctor/ Gynaecologist:** Women were not in position to discuss the availability of doctors or Gynaecologist due to the taboo and stigma about discussing problems with anybody. Merely 2.4% of our informants from Mewat refrain from seeking medical advice on MHM owing to non-availability of a lady doctor.



*Multiple Choice Question

- **Situations of Health Emergency:** In case of health emergency, women from both the districts were found inclined towards pursuing treatment. 78.9 percent of women from Mewat went to a doctor or gynaecologist for menstrual-related problems, out of which almost half the women (48.9 percent) reported that problems got resolved after taking treatment, but 12 percent of women stopped their treatment due to high treatment costs which they were not able to afford.
- **Reasons for Non-treatment:** Besides, women's attitudes and beliefs on talking about menstruation or not- lack of affordability, accessibility, and ad-hoc self-care modes (consulting traditional medical

practitioners, seeking advice from others, etc.) were the major causes found for non-treatment including the tendency to be silent on MHM, as shown in the table above. However, a positive way to look at such a finding is that even if they avoid going regularly to a doctor, when an urgent need arises, women do not shy away from seeking consultation with doctors in Nuh and Jhajjar districts in Haryana, unlike our respondents in Maharashtra, Odisha, and Bihar. Also, women in Haryana are more likely to complete their treatments.

3.3 PRACTICE ANALYSIS

Good menstruation practices start with the usage of clean menstrual absorbents followed by maintaining hygiene regularly from Menarche till Menopause. This section brings to light the prevalence of practices regarding personal hygiene such as washing hands and genitals during menstruation as well as usage and disposal patterns of menstrual hygiene products. We also bring data on how personal and community-based beliefs, customs, and taboos influence MHM outcomes and self-care regimes of our respondents. In Mewat and Jhajjar, given their circumstances women also practice traditional methods of MHM besides sanitary pads. Out of a total of 573 menstruating women interviewed, 48.5% from women from Mewat and 62.9% women from Jhajjar use sanitary pads, rest use cloth.

3.3.1 SANITARY PADS OR OTHER ABSORBENTS

- **Cloth:** Out of the total of 573 EAMW interviewed from both the districts, 39.8% women surveyed use only cloth during menstruation. because of its ready availability, affordability, durability and, lack of awareness about other menstrual products
- **Sanitary pads:** Out of 573 menstruating women, 54.3 % of women reported using sanitary pads. When asked about the reasons, they found cloth as a readily available and affordable option to use in combination of pads.
- **Other Material:** 34 women (out of 344) from Mewat i.e. 9.9% reported that they do not use any menstrual products.

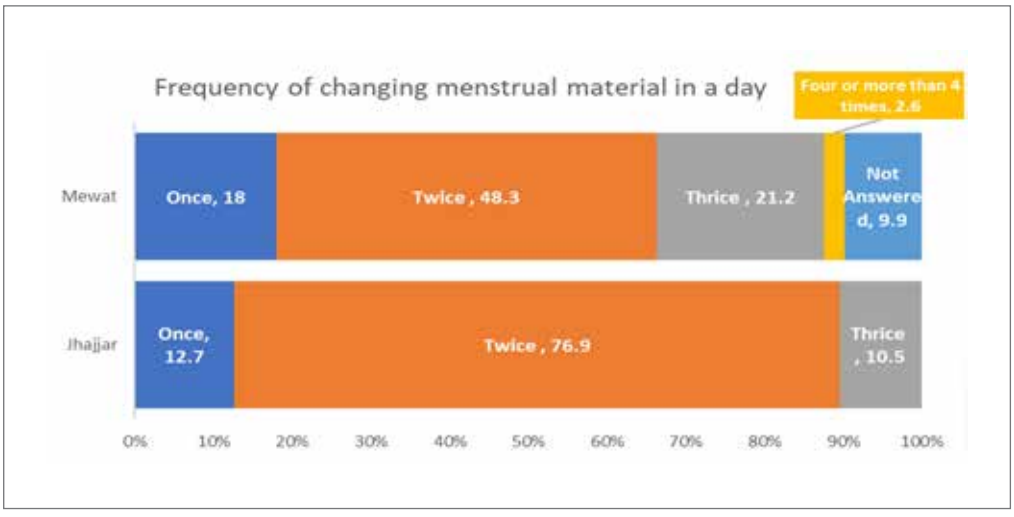
Perhaps why many EAMW (see the section on KIIs below) demand free sanitary pads is because they cannot always afford to buy these. This is surprising because most of our interviewees in Haryana (barring the ones from EWS/ BPL) expressed that they do not have financial constraints. It seems that despite their wealthy backgrounds, women cannot decide/ lack the awareness or orientation to buy pads for themselves or they fail to convince their families to include pads in the monthly budget of the families. Hence the monthly expenditure on menstrual absorbents is low in **Nuh and Jhajjar**. However, this may also be indicative of the silence which enshrouds MHM and inhibits women to take proactive and vociferous decisions towards self-care in Haryana. This study does not promote the use of any one menstrual hygiene product against another, but our findings across 7 states in India indicate that women do ask for free sanitary pads instead of buying them, even if they have the capacity to spend. Women in **Haryana** need to be supported and made aware of MHM so they can be inspired towards enlightened self-care.

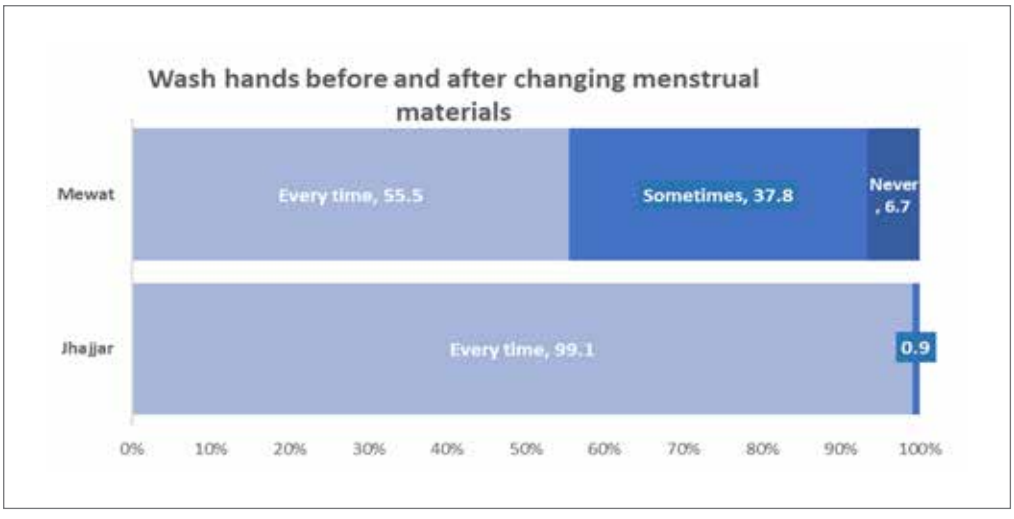
3.3.2 SPENDING CAPACITY ON MENSTRUAL HYGIENE PRODUCTS

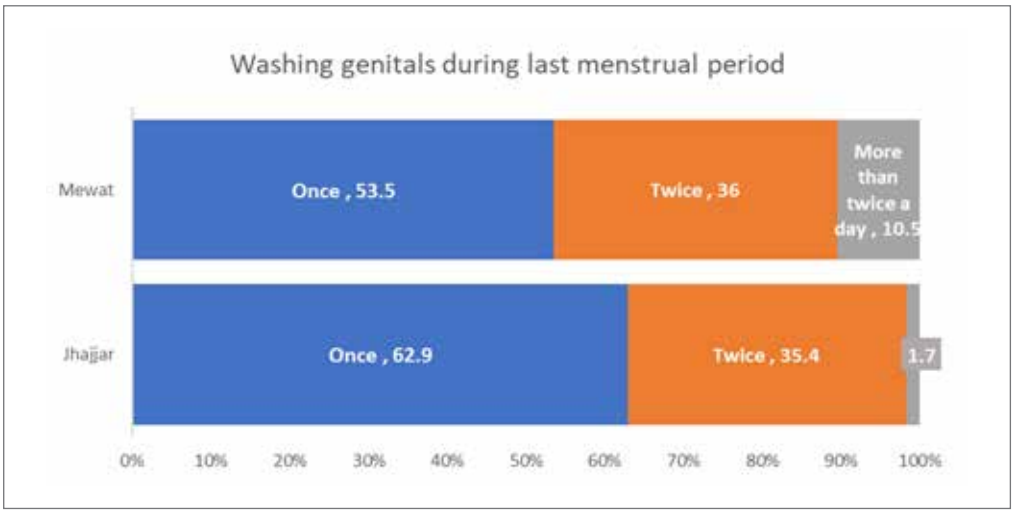
- **Spending capacity:** Though 50.3% women from Mewat and 62.4% women from Jhajjar responded that they have spending capacity on menstrual products, average spending for both districts was very less as per woman reported per month. Average spending capacity for Jhajjar was found to be more (59.54 INR) than in Mewat (32.25 INR). Data also shows that there was no relationship between spending capacity on sanitary pads and the earning of women.
- **Preference of material:** This survey clearly shows how women have specific choices w.r.t use of menstrual absorbents. Apart from affordability, responses came up like easy to use (37.8 percent), easily available

absorbents (53.2 percent), and around one-fourth of respondents were told what is to be used is decided by elders at home (39.4 percent). So lack of decision making opportunities contribute to a silence over many MHM related issues,

3.3.3 PERSONAL HYGIENE PRACTICES AND WASH DURING LAST MENSTRUAL CYCLE (MEWAT N=344 , JHAJJAR N=229)





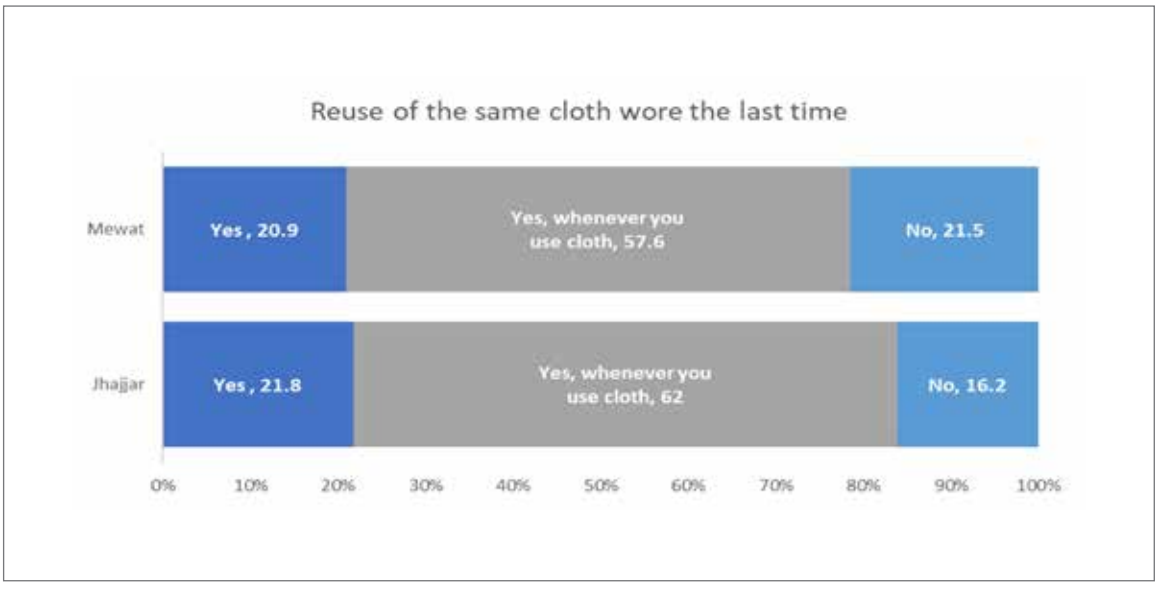


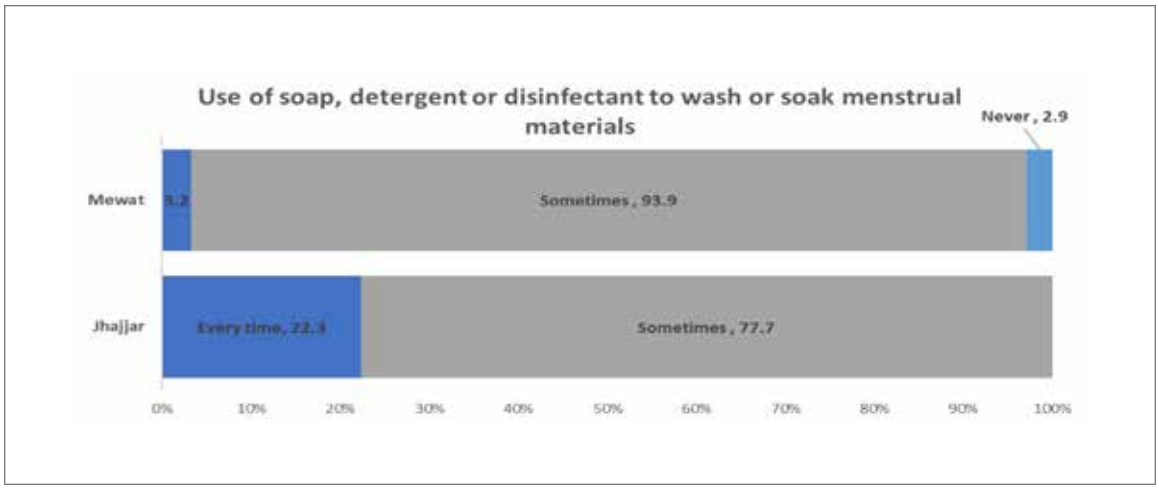
- **Frequency**: From both districts, around 75.6% of women responded that they change menstrual material twice or thrice a day.
- **Washing Hands:** Only 55.5% women from Mewat reported that they wash their hands every time they use or change menstrual material. Hygiene practices were found to be better in Jhajjar where 99.1% of the interviewed women wash hands every time they use/ change menstrual material.
- **Washing genitals during the last Menstrual Period:** From both districts, 93% of women wash their genitals once or twice a day during menstruation. 7% wash more than twice a day. Nonetheless, only 30.9% use soap while washing.

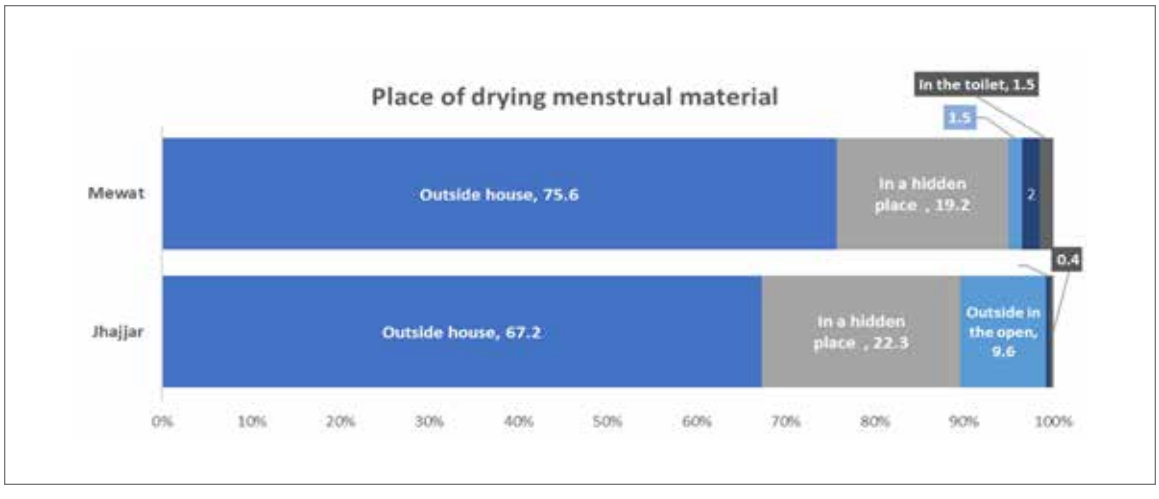
Our data indicates that more awareness towards MHM and WASH alongside provision of and access to proper WASH infrastructure and sanitation services is the most basic need for enabling EAMW and communities to take actions in the Mewat and Jhajjar districts from the state of Haryana.

3.3.4 MENSTRUAL HYGIENE PRACTICES (MEWAT N=344 , JHAJJAR N=229)

Safe hygiene practices consist of washing and timely changing of menstrual absorbents as well as their proper disposal. This may vary with the absorbent type. Personal hygiene also depends on changing the absorbent during the day, keeping genitals clean, washing hands before and after changing the menstrual absorbent. The survey assessed all practices used to follow hygiene and management of material during menstruation.







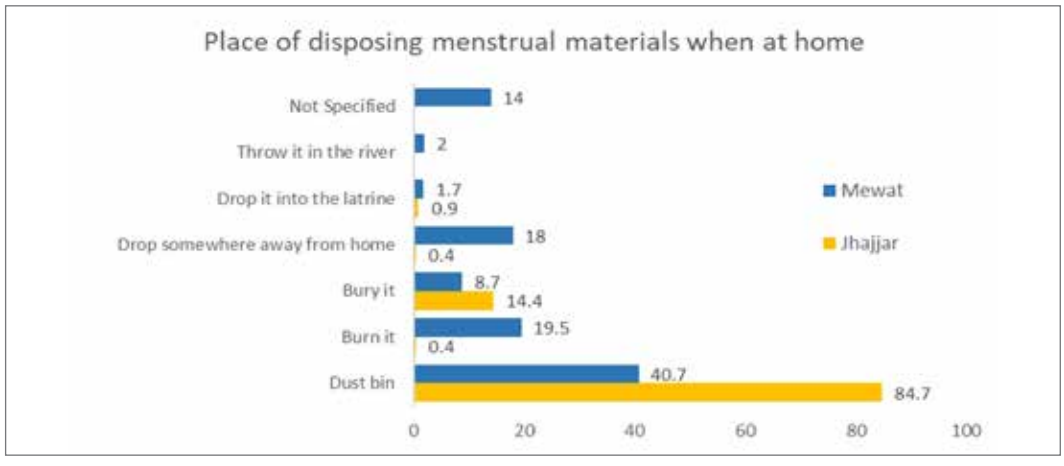
- **Reusing MHM Products:** From both districts, 80.6% of women claimed the use of clean cotton cloth during menstruation, out of which 59.3% of women **reuse the cloth**.
- **Washing MHM Products:** According to our data, 15.3% EAMW from both districts wash their menstrual clothes in toilets or bathrooms at homes as compared to 83.8% EAMW who wash their menstrual clothes outside the house, near hand pumps or a well.
- **Use soap every time:** From both districts, around 10.8% women said that they use soap while washing menstrual clothes every time.
- **Use soap sometimes:** However, owing to prevalence of WASH related hardships, seven in ten women in Jhajjar as against nine in ten women in Mewat use soap only sometimes to wash menstrual clothes.

- **Drying MHM products**: While reusing cloth during menstruation, apart from washing, one also needs to follow the practice of drying the cloth properly in sunlight. Practices related to drying reused menstrual cloth were found to be better in both districts as on an average seven out of 10 women said that they dry menstrual material outside the house. Still, it was stated that one-fifth of respondents i.e 20.4% of women dry their clothes used in menstruation in a hidden place. But 9.6% of the women from Jhajjar responded that they dry their menstrual clothes in the open.
- **Use of dry menstrual material:** 12.5% women from Mewat sometimes or never use completely dry menstrual material which is a worrisome situation and which may lead to developing various types of infections and irritations.

3.3.5 AREA-SPECIFIC DISPOSAL MECHANISMS (MEWAT N=344 , JHAJJAR N=229)

No specific Disposal Mechanism in place: When asked about the system of disposal of menstrual material in their area, it was found that women have to manage problems at their own levels. The district does not have any disposal mechanism for menstrual materials nor monitoring mechanisms to follow -up and optimize implementation of hygienic practices.

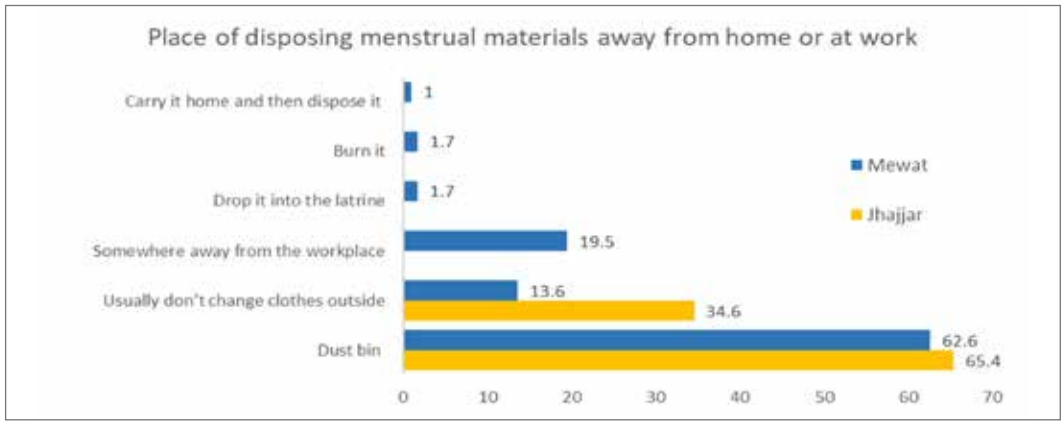
Methods of disposal in Both Districts: When at Home



*Multiple Choice Question

- **Top Practices:** When at home, 40.7% women in Mewat wrap menstrual material in a paper or plastic bag then throw used material in a dust bin, followed by 8.7% who bury or 19.5% who burn whereas most of the women in Jhajjar (84.7%) throw in the dust bin or 14.4% bury it.
- When asked about the system of disposal of menstrual material in their area, it was found that they have to manage problems at their own levels. The district does not support any disposal mechanism for menstrual material.

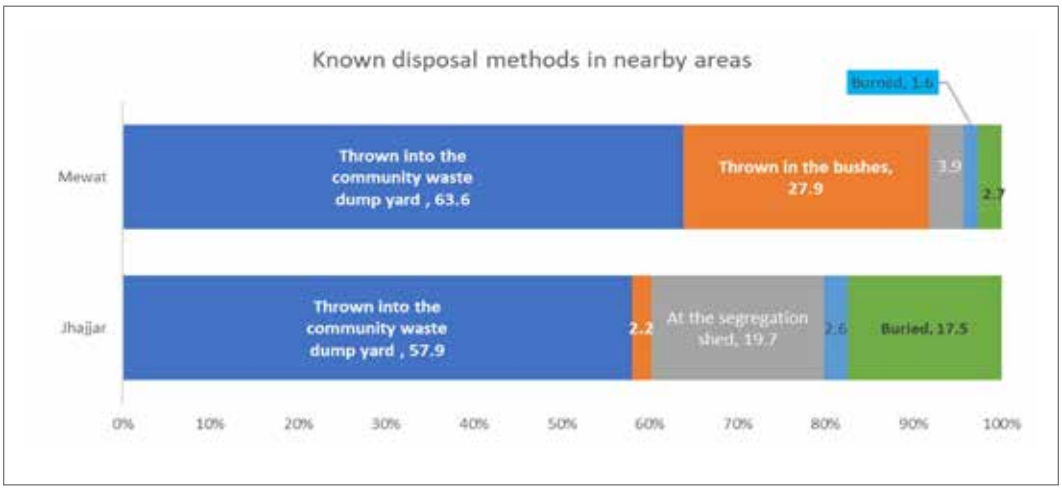
Methods of disposal in Both Districts: When away from Home



*Multiple Choice Question

- **Top Practices:** Almost two-thirds of our respondents throw their used menstrual waste in dustbins when away from home. One third of the women in Jhajjar and 13.6% from Mewat do not change menstrual material when outside home. 19.5% of women from Mewat practice throwing it somewhere in the open space.

3.3.6 KNOWN DISPOSAL METHODS IN THE COMMUNITY AS WELL AS NEARBY AREAS



- According to around 60% of our respondents, the used menstrual material is mostly thrown in the community waste dump yard in the village and nearby areas.
- **Disposal of MHM Waste and WASH concerns**: 72 (27.9%) of respondents from Mewat (n=258) throw used menstrual material somewhere away from home in bushes.

3.3.7 SOCIAL CUSTOMS, BELIEFS, MYTHS, AND TABOOS

The world of social customs, replete with its mandatory do's and don'ts in various communities represents their beliefs and mandates. Social customs, beliefs, myths and taboos contain overt and covert forms of barriers and enablers which influence MHM related practices as well as everyday experiences of menstruating women. In this respect we have quite similar findings from Haryana's Mewat and Jhajjar districts, the same being presented as follows.

Customs followed by women in reference to Menstruation: Mewat District (n=428)

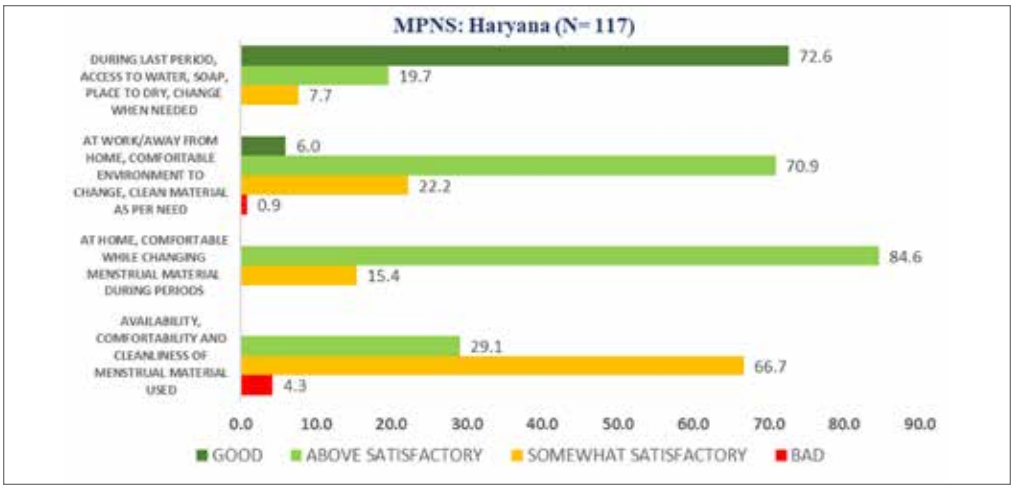
Mewat (428 respondents)	Strongly agree	Agree	Disagree	strongly disagree
I am allowed to mix with others socially during my periods.	25.2	20.3	54	0.5
I am not allowed to attend any social rituals during my periods.	0.9	40.2	58.2	0.2
I do not go to religious places during periods.	1.2	52.2	45.3	1.2
I avoid traveling during periods.	0.2	17.3	81.8	0.7
I am told to stay in the corner of the house during my periods.	0.5	11	84.8	3.7
	Yes	**No**		
I am allowed to carry out routine work at home during my periods.	98.8	1.2		
I am allowed to cook in the kitchen during my periods.	96.7	1.3		

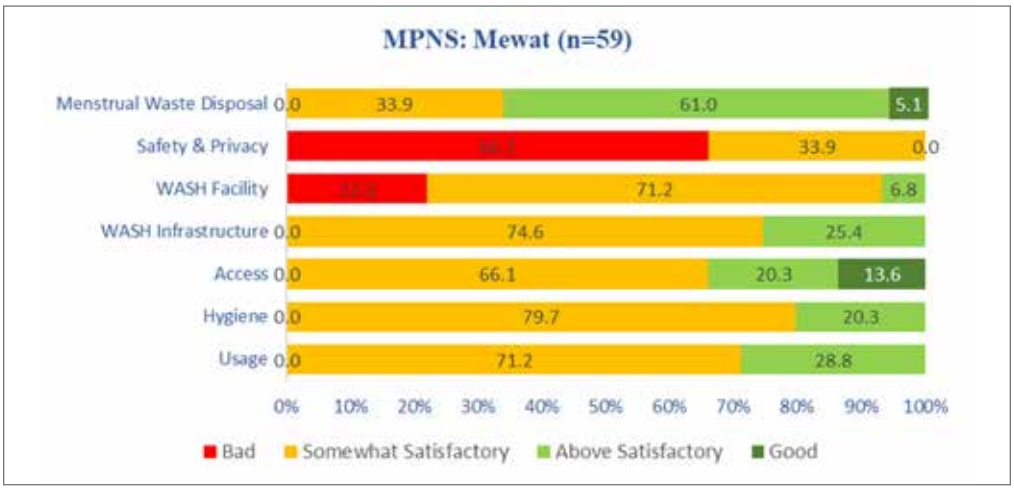
Mewat (428 respondents)	Strongly agree	Agree	Disagree	strongly disagree
Others in my family take care of me during periods.	92.1	7.9		
I have freedom to visit doctor in case of any health issue.	93.5	6.5		
I am allowed only special foods during periods.	52.3	47.7		
I sit for lunch and dinner with all my family members.	85.3	14.7		

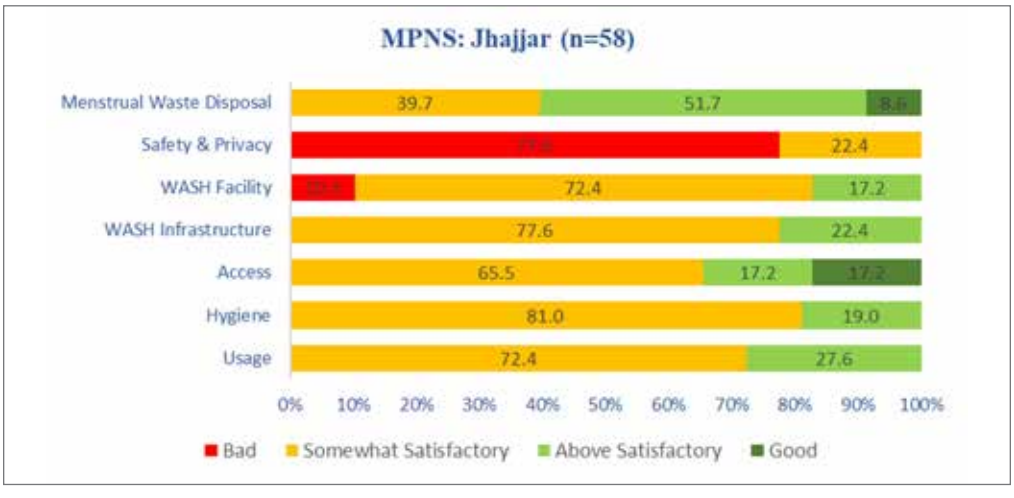
Customs followed by women in reference to Menstruation: Jhajjar District (n=274)

Jhajjar (274 respondents)	Strongly agree	Agree	Disagree	strongly disagree
I am allowed to mix with others socially during my periods.	3.3	89.4	7.3	0
I am not allowed to attend any social rituals during my periods.	0.4	34.7	63.9	1.1
I do not go to religious places during periods.	1.8	93.8	4.4	0
I avoid traveling during periods.	0	41.2	56.6	2.2
I am told to stay in the corner of the house during my periods.	0	4.4	69.3	26.3
	Yes	**No**		
I am allowed to carry out routine work at home during my periods.	98.9	1.1		
I am allowed to cook in the kitchen during my periods	96.4	3.6		
Others in my family take care of me during periods.	98.2	1.8		
I have freedom to visit a doctor in case of any health issue.	97.1	2.9		
I am allowed only special foods during periods.	11.7	88.3		
I sit for lunch and dinner with all my family members.	61.7	38.3		

- **Religious places**: 52.2% of women in Mewat (n=428) were neither allowed to go to religious places during their periods nor socialize. Similarly, more than half of the women do not visit religious places in Jhajjar or socialize during their periods.
- **Travel:** Eight in ten women said that they travel during periods and enjoy working at home, working in the kitchen without any restrictions during their periods. Also 93.5% have the freedom to visit a doctor in case of any health issue.
- **Socialise:** 89.4% of women from Jhajjar (n=274) were allowed to socialise with others during their periods, but not allowed to go to religious places during their periods. Almost one third were not allowed to attend social rituals and almost 95.6% women were not allowed to visit religious places.
- **Cook:** Almost all i.e., above 95% said that they can work in the kitchen without any restrictions and carry out routine work at home during periods.
- **Visit a doctor**: Also 97.1% have the freedom to visit a doctor in case of any health issue.







3.3.8 MENSTRUAL PRACTICE NEEDS SCALE (MPNS)

The MPNS was used to measure and assess the felt needs and experiences of women during their last menstrual period. 117 respondents from both the districts in Haryana shared their perceptions/experiences on availability of water, sanitation, hygiene, safety and privacy as well as access to menstrual absorbents. Through the use of MPNS, we were able to access the actual trends, practices and experiences w.r.t MHM, WASH, safety and privacy which form the 'menstrual everyday' of surveyed women in Mewat and Jhajjar districts in Haryana:

- **Availability, comfortability and cleanliness:** After being assessed on the MPNS, it was observed that 66.7% of respondents rated the availability, comfortability and cleanliness of menstrual material used at below satisfactory levels of comfort. The rest, i.e. three- fourth of the women rated their comfortability

and environment to change clean material as per need as well as access to water, soap, place to dry and change material when needed as above satisfactory to good level during their last menstrual period (i.e. the previous menstruation cycle).

- **Privacy:** 49 women from Mewat, when measured on the MPNS, based on their last menstrual experience about privacy, WASH infrastructure, hygiene practices and usage of menstrual material rated these at below satisfactory levels.
- **Hygiene:** 58 women from Jhajjar, when measured on the MPNS, based on their last menstrual experience about privacy, WASH infrastructure, access, usage of menstrual material and hygiene rated it as below satisfactory levels.

3.4 MHM FROM AN INTER-SECTORAL PERSPECTIVE

Reading the everyday realities of a menstruating woman requires an inter-sectoral position because her life unfolds not just at home, but in community spaces, schools, farms and workplaces during her periods. Moreover, a menstruating woman also negotiates various socio-economic and inter-sectoral circumstances such as WASH, public health facilities, migration and public policy. Hence, this part of our study examines vulnerabilities, issues, and risks pertaining to menstruation with respect to an inter-sectoral focus.

Villages selected from Nuh and Jhajjar have a varied population profile, Jhajjar is led by mainly a General Castes majority followed by the presence of OBCs. Nuh/ Mewat has BC and MBC majority communities followed by General Castes, OBCs and SCs. From these two districts, we include intersectoral aspects, issues and themes such as education, WASH, livelihood and health that impact women's MHM and wellbeing at various levels.

- **Acute Drinking Water Scarcity:** Due to the clayey soil conditions of the terrain in both the districts, water logging occurs at many land-patches. The severity of such waterlogging increases post-monsoon when excess water remains stagnant due to the absence of drainage, which is an additional challenge in Jhajjar and Nuh. Likewise, the groundwater salinity in both the districts is compounded by the extremely high TDS (Total Dissolved Solids) levels and other chemical contaminations thereby making water unfit for drinking, cooking etc as well as agricultural purposes. This results in an uneven water supply and shortage, thereby forcing households, schools and farmers to buy water through tankers once in every 15 days.
- **Interpersonal Milieus and Health**: In both Jhajjar and Nuh, menstrual well-being narratives seem suppressed in the case of younger menstruating women (till their mid-thirties) who are dominated by feelings of hesitation to speak about the phenomenon. The answers may lie in the way that older menstruating women who do visit doctors and PHCs fail to integrate younger, married women within families towards active medical care when faced with menstrual health issues. Even school teachers in Jhajjar and Nuh, often refer to menstruation as a 'problem'. Hence growing up in and moving into social milieus ridden with dearth of sensitisation on menstruation create interpersonal barriers in effective MHM and women's health, as our data in sections below indicates.
- **Income and Decision Making**: Our data (analyzed in various sections of this report) indicates that EAMW who participated in this survey come from relatively prosperous families and also have their own farm-based incomes. However, owing to family related barriers, none of the women have disposable income. They are also not able to make proactive decisions on MHM or spend on menstrual absorbent and personal menstrual care.

Against this background, we present a brief inter-sectoral data analysis on migration and MHM, WASH and MHM, Education and MHM and lastly, MHM from the perspective of awareness towards public policies. To impart an inter-sectoral focus on MHM related narratives and practices from diverse contexts and cross-sections of society, we bring analysis on ten villages, five each in the Aspirational Districts of Mewat and Jhajjar. We document the lives of farmers, farm workers, labourers, unskilled workers from MHM perspectives from menstruating women. The overall narrative of different practices on MHM in these villages mainly related to- community-based vulnerabilities, socio-economic conditions and beliefs including monetary freedom or disposable income of women besides health and education related inter-sectoral factors.

3.4.1 MIGRATION AND HEALTH

In Jhajjar and Nuh, 34 out of a total of 702 women interviewed for this study mentioned that they migrate for work with their families.

- From Jhajjar 20 families migrate for long term agricultural work, sugarcane cutting, brick-making, construction work, etc.
- In Nuh, 11 families migrated for long term agricultural work such as sugarcane cutting, tea plantation, or farm labor. Three families migrated for local farm work and daily-wage work. Some migrant families in this district migrate for stone quarrying, mining, and working in restaurants.
- Our findings indicate that 18 out of the 34 migrant women strongly feel that their seasonal work conditions and resource scarcity influences their menstrual health negatively.

3.4.2 TRADITIONAL SKILLS AND EARNING CAPACITY

Our data shows that out of the 138 women (N=702) who possessed traditional skills, more than 50% were capacitated in four main activities. namely, craft, embroidery, knitting, weaving, tailoring, and pad-making. However, out of the women possessing traditional skills and knowledge only 28.3% earn from their knowledge and customary skills.

Given that there is a possibility of augmenting family income from traditional knowledge and customary skills, vocational courses can be organized for women struggling with socio-economic vulnerabilities to enhance their disposable income alongside decision making powers. A disposable income can give women better opportunities towards an empowered wellbeing w.r.t MHM as well as personal and medical care.

3.4.3 WASH AND MHM

According to the NFHS-5 Report, 97% of households from Mewat and Jhajjar live with an improved drinking water source. If we look further at NFHS- 5 data on households, 91.7% in Jhajjar have improved sanitation facilities as compared to 71.7% from Mewat (International Institute for Population Sciences (IIPS) and ICF 2021, p. 51, 87).

WASH & MHM	Mewat (in %)	Jhajjar (in %)
Total Respondents	**428**	**274**
Water Facility at Home		
Bore well/ Tube well/ Well covered	3.3	36.5
Hand pump	10.7	36.5
Piped water/ Piped to yard/ Plot/ Public tap	40.9	26.3
Tanker/Truck / Cart with small tank	45.1	0.7
Toilet Facility at Home		
Individual household latrine	81.1	100.0
Community toilets	16.8	0.0
Open defecation	2.1	0.0
Type of House		
Kutcha	10.7	7.3

Pucca	58.4	44.5
Semi pucca	30.8	48.2

- **Facilities at home**: 54.9 percent of women from Mewat said that they have regular sources of water through piped water, public taps, hand pumps, bore wells, or tube wells. The remaining 45.1 percent of women mentioned the scarcity of water and that they have to source the water through a tanker/truck/cart with a small tank. The situation in Jhajjar regarding household facilities was found to be better than in Mewat regarding drinking water and toilet facilities.
- **Kind of House:** Housing conditions were found to be better in both the districts where almost 53% of the families have pucca houses (roof, wall and floor all are made up of pucca material) and 37.6 families interviewed live in *semi pucca* houses (roof, wall and floor all made with kutcha material). Only 9.4 families live in *kutcha* houses (either 1 or 2 from roof, wall and floor is made up of kutcha/ makeshift materials).
- **Toilet Facilities:** 89.3% families (n=428) in Mewat have semi-pucca or pucca houses . 81.1% families use Individual Household Latrines (IHHL), the rest use community toilets. 2.1 percent of families defecate in the open. In Jhajjar, 92.7% (n= 274) families live in pucca and semi-pucca houses whereas 100% of the families use IHHLs.
- **Sanitation and Access Challenges:** One of the main everyday challenges in the area emerged to be compromised access to potable water and proper drainage system. Our findings indicate that almost half of the population surveyed in Mewat needs to purchase water from tankers. Piped water coverage was stated by 40.9 % of the respondents from the district whereas three-fourth of the respondents from Jhajjar rely on tube well bore wells and handpumps. This indicates excessive reliance on private sources to extract ground water. which, given the water salinity and TDS in the region implies exposure of the people to water that is not potable as well as heavy on chemical contaminants. Poor quality of water, if used consistently, has its own overall pitfalls and health risks, but for menstrual hygiene management it presents additional challenges for EAMW in Jhajjar and Nuh

It is clear that during menstruation a woman's WASH needs are relatively higher as compared to the rest of the days of the month. When a woman experiences her periods, she needs more water to clean herself for personal and intimate hygiene, including after defecation. Besides, a regular supply of clean water, ensuring that a woman has the facility of a private and secure place to change her menstrual absorbents and clean herself are a profound part of her sense of dignity and safety. Therefore, the access to the toilet and bathroom become a critical need during periods.

3.4.4 EDUCATION AND MHM

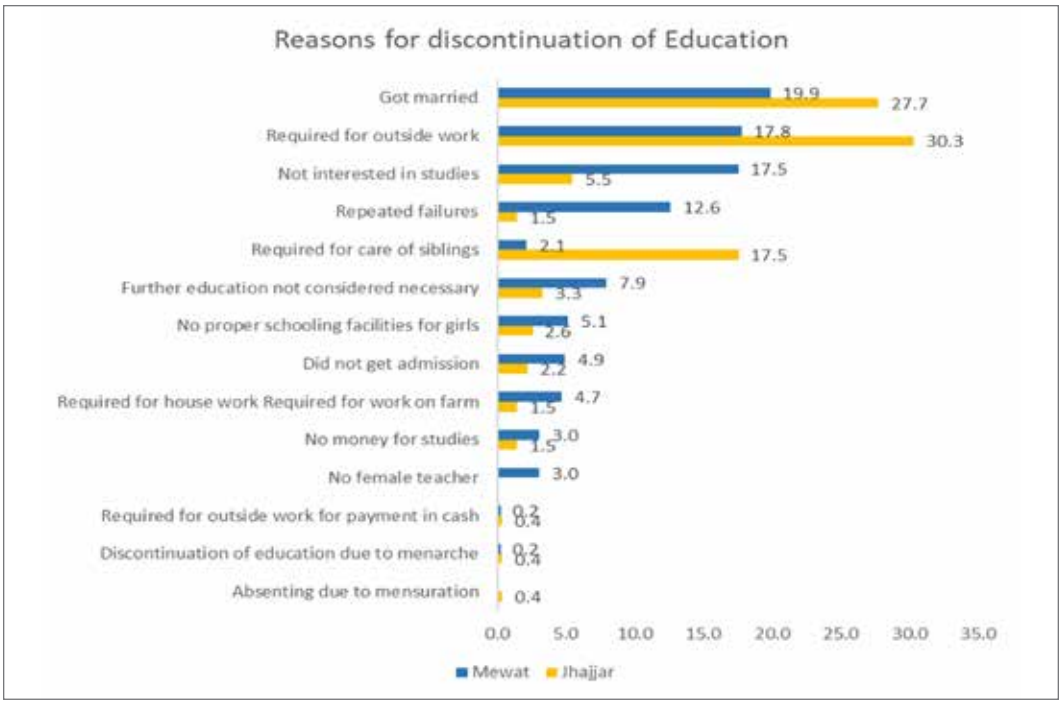
Around two-thirds of women from Mewat have completed education till secondary, whereas 57.3 percent of women from Jhajjar have completed their education beyond higher secondary. Top three barriers in the way of education reported from Mewat include education being stopped as the girl was married off (19.9%), or she was required to contribute to the family income by working against wage-labour.

Education and MHM	Mewat (in %)	Jhajjar (in %)	Haryana (in %)
Total Respondents	**428**	**274**	**702**
Education			
No education	29.9	21.2	26.5
Primary (1st -4th)	21.7	8.0	16.4

Education and MHM	Mewat (in %)	Jhajjar (in %)	Haryana (in %)
Secondary (5th-7th)	21.7	13.5	18.5
Higher Secondary (8th-10th)	16.1	34.7	23.4
12th/ Undergraduate	9.1	19.7	13.2
Graduate and above	1.4	2.9	2.0
3.4.4 Reasons for Discontinuing Education			
Family barriers	29.9	48.5	37.2
Monetary barriers	25.7	33.6	28.8
Educational barriers	30.4	7.7	21.5
Lack of facilities	13.1	4.7	9.8

- **Bottlenecks**: Bottlenecks: In Jhajjar, out of the 33.6% responded to Monetary barriers of which 30.3% of girls were required to contribute to the family income by working against wage - labour. 25.7% of the women from Mewat responded that monetary barriers were the main obstacle such as no money for studies or family priority being they help in household chores as their parents worked on farms. Family-based barriers such as further education not being considered necessary play an important role in an adolescent girl's prospects of completing education. 17.5% of women from Jhajjar reported that they were required at home to take care of their siblings. 17.5% of women had dropped out of school as they were required at home to take care of their siblings and another 17.8% reported no proper schooling facilities for girls or non-availability of female teachers (3%)
- **Schools in need of Improvement:** In Haryana, our key informants have indicated (in section 4.1 and 42.) that schools are in a bad shape, lack cleanliness and hygiene, have no maintenance staff to clean toilets in many places and in general suffer extreme shortage of water. In such a situation, it is certainly difficult for menstruating girls to attend school regularly, especially when some teachers in Haryana consider menstruation as a 'problem', (refer to Part IV below).
- **Menarche and Marriage:** Overall, in Jhajjar marriage emerged as the single most prominent reason for not being able to complete education beyond school whereas one-third of the women from Mewat reported that they had to discontinue studies as their families did not consider education necessary. The average age of marriage has been reported to be around 18 to 19 years whereas the school drop-out rate for girls is high in the areas studied. Community beliefs such as a girl being 'ready for adulthood' in early post-menarche years leads to pressure on the family to marry her off.
- **Failing/ Lack of Interest**: Girls not being interested in studies (17.5%) and repeated failures (12.6%) emerged as the next set of reasons in Mewat for the discontinuance of education. In some cases, the families did not wish for girls to continue their education as it was not considered necessary.

All these barriers show education for women has many hurdles in both the districts. Barriers range from social barriers, monetary barriers due to poverty to lack of facilities in schools such as the availability of female teachers, and availability of schools nearby. Yet, our data indicates that there are positive changes in many contexts and a little policy push can go a long way in securing MHM focus and care in the educational sector.



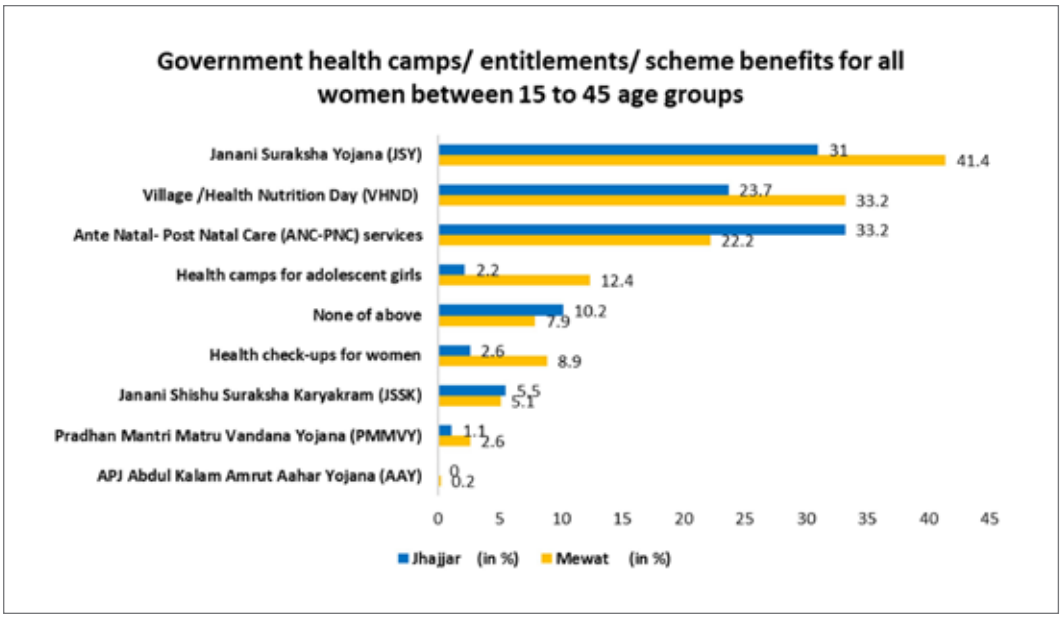
*Multiple Choice Question

Our survey affirms that there is a strong relationship between educational challenges and the onset of puberty and menstruation. However, in the case of our respondents from Haryana, the barriers to education are not related only to community attitudes post-menarche or girls absenting themselves during menstruation. It is about families needing support for augmenting their incomes, or girls being required to take hold of household chores. Moreover, in both the districts of Haryana only few women reported dropping out of the school owing to puberty or post-menarche. Majority were allowed to carry on education where schools were near and had safe MHM facilities, such as clean and functional toilets.

3.4.5 AWARENESS TOWARDS PUBLIC POLICY AND COUNSELING ON MHM PUBLIC POLICY:

Public Policy: National Health Mission runs various programs for the age group of 15 to 45 years, i.e., for adolescent girls as well as women. Most women in both the districts are aware of public policy.

- **Local Health Services:** In both districts, women respondents were informed of availing benefits from the Janani Suraksha Yojana, VHND and ANC - PNC services. The data shows that merely 14.8% of women (N=702) and adolescents participated in health check- ups. 98% of the women respondents from both the districts were not even aware of Pradhan Mantri Matru Vandana Yojana (PMMVY).
- **Engagement with Public Health Services**: Janani Surakhsna Yojna (JSY) benefits nearly 265 women in both the districts. While Antenatal Care and Postnatal Care (ANC-PNC) services are availed by 186 women. Another 207 participate and attend the Village Health Nutrition Day (VHND) on a regular basis.
- **Importance of Health Camps**: Women across various contexts are differently integrated with the national public health infrastructure and policies. Health camps, which are periodically organized in villages, are specifically important and needed in areas which are remote and cut-off or where Sub-centers are not available. Our survey findings indicate that a major chunk of the population surveyed from both the districts, JSY, VHND, ANC-PNC services were received by women. If health camps start covering the wellbeing of EAMW in remote and isolated areas, women will stand to benefit from many health based objectives and parameters of the Indian government.



*Multiple Choice Question

- **Significance of Public Health Facilities:** Health support systems in India are designed such that for every 1000 population there is Accredited Social Health Activist (ASHA) appointed, for around 5 to 6 villages, there is a Sub Centre where treatment for small illnesses as well as 24/7 facility of delivery is available. After that, for every 30000 people, there is a Primary Health Centre (PHC). And as we move further, Rural or Sub District hospitals, district hospitals in urban areas, municipal corporation health clinics, and hospitals are available.
- **Accessibility and choice:** EAMW covered in this survey were asked through IDIs about the nearest accessible public health facilities for getting treatment or pursuing their health issues. When asked whether they get accessible/ affordable treatment from government health facilities, 83.2% of women from Mewat and 88.7% from Jhajjar responded positively. Very few respondents from both the districts reported that they do not avail general treatment from public health facilities. When women (between the age group 19 to 49 years) covered in this survey through In-depth Interviews (IDIs) were asked about the nearest accessible public health facilities for getting treatment for their health issues, the nearest public health facilities reported by Mewat women were Primary Health Centre (60 .7%), Rural hospitals (22.4%) and Subcenter (9.3%). The nearest public health facilities reported by Jhajjar women were Primary Health Centers (56.2%), Rural Hospitals (24.5%), and District Hospitals (16.8 %).

Our findings indicate that women are familiar with and dependent on the services guaranteed from the public health system as well as they receive monetary benefits from the schemes such as Janani Suraksha Yojana (JSY), Pradhan Mantri Matru Vandana Yojana (PMMVY) and transportation facilities under Janani Shishu Suraksha Karyakram (JSSK) along with ANC and PNC services. Menstrual health of women beyond school years is still a long way from being actively considered as a public policy measure in India. Owing to the vast reach and significance of, as well as a substantial reliance on Public Health system in India, the MHM of EAMW can get a much required boost if the issue receives adequate attention through public policy. Even the ADP can stand to gain women's participation if MHM is piloted as an inter-sectoral intervention cutting across education, social security, WASH and livelihood.

COUNSELING

Upon being asked if they ever received any counseling on menstrual health, 64.8% of our interviewees responded in the affirmative. Counseling on MHM was received from health workers such as ASHA, ANM and AWW.

Received counseling on Menstrual Hygiene from health workers	Mewat (in %)	Jhajjar (in %)
Total Respondents	**428**	**274**
No	18.9	60.6
Yes	81.1	39.4

Yes: Upon being asked if they ever received any counseling on menstrual health, 64.8% EAMW responded in the affirmative. Counseling on MHM was received from health workers such as ASHA, ANM and AWW. Out of the total respondents, 81.1% EAMW from Mewat (n=428) and 39.4% from Jhajjar (n=274) reported that they seek counseling, guidance, and treatment on health issues from the public healthcare facilities.

No: In Haryana 247 women, out of a total of 702 had never received counseling on menstruation or MHM in their villages.

There are various maternal and child health programs designed by the government of India through which menstruating women get benefits from various services and schemes. Along with other counseling sessions, if counseling on menstrual health hygiene is given to women, they would benefit in terms of being better informed and alert on MHM.

4 VOICES, EXCERPTS AND OBSERVATIONS

As part of our research, we conducted Key Informant Interviews (KIIs) in both the selected districts from Haryana. People interviewed during this exercise were important stakeholders in communities and villages such as Anganwadi workers, ANM, Sarpanchs, Doctors, Teachers, ASHA workers etc. The voices of these stakeholders are critical for the development of the community as they give a unique point of view of the village population and in a small but significant way have helped us analyze how to combat the silence on menstrual health issues in area- specific and community -sensitive ways. The highlights of these interviews are as follows:

Nuh (Data derived from 5 villages of the district): In the Nuh district of Haryana, 7 respondents across 5 villages stated that their areas experienced water scarcity to the extent that potable water had to be bought by the residents. Five respondents informed us that free sanitary pads were distributed to the women in their villages. Two respondents added that there are strong taboos in the villages related to menstruation. ASHA in one of the villages interacted with women to counsel them on MHM, while an Anganwadi worker in another village of NUH worried about the situation of menstrual waste generation in her village.

Jhajjar (Data derived from 5 villages of the district): In Jhajjar district of Haryana, two respondents from five villages stated that women were not distributed free sanitary napkins. One respondent confirmed that two free pads were given to adolescent girls in her village every month. Another respondent informed us that government funds for toilets were not used to build toilets and as result people still had no toilets in their houses One of our respondents stated that women of Jhajjar did not have any area specific need on menstruation as the government had fulfilled all their needs.

4.1 VOICES, EXCERPTS AND OBSERVATIONS OF RESPONDENTS NUH (MEWAT)

Our respondents from the field have shared their experiences, conceptions and observations on MHM. Below are some voices and excerpts from our interactions with them.

An **ASHA worker** (Interview conducted during July-August 2022)[2] in Tapkan village of Nuh district of Haryana stated that her village had *Rashtriya Swasthya Mission, Rashtriya Swachata evam Swasthya Raksha* for women. Two meetings are held every month with ASHA workers to sensitize women about the use of sanitary pads during menstruation. *Kishori Swasthya Kendra* is run under the RKSK scheme in the village. On WASH needs

[2] HR KII1 NUH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

in the village she observed every household buys water tankers worth 1000 rupees which last only for 15 days. It was not clear how women's WASH needs were fulfilled throughout the year. She further added that women were not allowed to bathe for 4-5 days during menstruation as there was a superstition that bathing would decrease their blood flow during menstruation.

An **ASHA worker** (Interview conducted during July-August 2022)[3] in the Rewasan village of Nuh district of Haryana informed us that the village does not have proper distribution of sanitary pads. She added poverty is the main reason why women cannot spend on sanitary pads, even though they may want to buy such products. She explained ASHA workers regularly inform women about using pads, now the situation is changing positively.

An **Anganwadi worker** (Interview conducted during July-August 2022)[4] In the Rewasan village of Nuh district of Haryana added that there is Iron and calcium tablet distribution in the village, Anganwadi workers regularly conduct meetings with adolescent girls to inform them about using sanitary pads during menstruation and methods to dispose of pads after use. On WASH needs in the community she replied the village had toilet facilities in every household, but villagers had to buy water tankers for their daily needs. She further added that free sanitary pad distribution has been stopped in the village but there is a need for free pads, adequate water facility, and toilets in the village.

A **School teacher** (Interview conducted during July-August 2022)[5] from Tapkan village of Nuh district of Haryana commented sanitary pads were distributed freely in village school where teachers conducted regular meetings with adolescent girls to inform them on proper ways of using pads during menstruation. However, the school is not in a good condition, there are no rooms and no boundary wall in the school. On WASH needs, she said that the school has to buy a water tank worth 1000 rupees regularly. There is a toilet facility, but the teacher asks, "what use is a toilet without water?"

An **Anganwadi worker** (Interview conducted during July-August 2022)[6] in the Rewasan village of Nuh stated that the scheme for free sanitary pads distribution is implemented in school and three meetings are held every month to educate girls about using sanitary pads and maintaining cleanliness during menstruation. On WASH needs in school and community she answered that since the village does not have any water resource, villagers had to buy water tankers worth 9000 INR for their daily water needs. It was not clear how women and school going girls manage to fulfill their WASH needs throughout the year. On area specific requirements, she was worried that the government had stopped providing sanitary pads on subsidiary prices. She suggested that the village needed a free pad distribution drive and adequate water facility for school as well as every household in the village.

A **SHG head** (Interview conducted during July-August 2022)[7] in Dhanduka village in Nuh stated that regular meetings were held to generate awareness among women about using sanitary pads during menstruation. On WASH needs in the community, she informed that each household had to buy water from water tankers for their daily needs. On an average each family spends 1000 INR to buy water. From her account it was evident that lack of water resources is a major disabling factor in achieving proper menstrual health and hygiene in the village. She further added once women were not allowed to enter kitchens and temples but now the situation has changed.

A **village Sarpanch** (Female) (Interview conducted during July-August 2022)[8] in Nuh responded that her village had a free sanitary pad facility in school and further, pads were sold at a subsidized price in Anganwadi. There are also regular meetings with women to inform them about menstruation. From her account it was evident that the village had a toilet facility in every household but the village did not have any water. Every household had to buy a 1000 rupees water tank every month. On the area's MHM requirement she added that the village needed a free sanitary pads facility for women.

[3] HR KII2 NUH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[4] HR KII3 NUH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[5] HR KII4 NUH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[6] HR KII5 NUH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[7] HR KII6 NUH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[8] HR KII7 NUH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

An **Anganwadi helper** (Interview conducted during July-August 2022)[9] in the Tapkan village of Nuh stated that the village had a free sanitary pad distribution facility for BPL families. Two meetings every month were held with women to inform them about using pads and methods of disposing of them after use under the RKSK scheme. On WASH needs, in the community, she added there is not enough water in the households and the village school. The village worries about how to deal with the problem of menstrual waste generation.

An **Anganwadi helper** (Interview conducted during July-August 2022)[10] in the Rewasan village of Nuh stated that the village had a program of distribution of sanitary pads. Anganwadi workers regularly conduct meetings with girls to make them aware of proper ways of using pads during menstruation. From her account it was evident that every household in the village had inadequate water and toilet facilities. The village does not have a proper sewage system and setting it right was an urgent priority. On taboos related to menstruation in the village, she replied women were not allowed to enter temples and perform pooja but now 'they have freedom to cook.'

A **School Teacher** (Interview conducted during July-August 2022)[11] in the Rewasan village of Nuh told us that girls were provided sanitary pads if her periods started in school. She added, the school had inadequate water, but a

proper toilet had been built by many households. The village should be provided free sanitary pads and a pad -disposing machine.

A **Nurse** (Interview conducted during July-August 2022)[12] in a PHC in Ujjina village of Nuh confirmed that in her area, there was a passing focus on menstruation under the *Rashtriya Swasthya Mission, Jal Swacchta evam Swasthya Raksha*, celebration of Mentrual Hygiene Day on 28th May, and creating awareness through meetings on menstrual hygiene. Moreover, the village had *Kishori Swasthya Kendra, Kishori Swasthya Karyakaram,* and distribution of Iron and Folic acid tablets under RKSK. She added villagers had to buy water tankers, there is need for adequate water facility in the village, and to deal with menstrual waste there is need to equip the village with dustbins.

4.2 VOICES, EXCERPTS AND OBSERVATIONS OF RESPONDENTS: JHAJJAR

Our respondents from the field have shared their experiences, conceptions and observations on MHM. Below are some voices and excerpts from our interactions with them.

An **Anganwadi helper** (Interview conducted during July-August 2022)[13] in Dariyapur village of Jhajjar district of Haryana confirmed that the village had a program of free distribution of iron tablets to girls. An awareness program for girls about menstruation and nutrition was also held. She added the village had adequate water, toilet, and a dustbin facility. On old customs which continue in their village, she stated that some women still use cloth to manage their periods.

A **SHG leader** (Interview conducted during July-August 2022)[14] in Bazidpur village in Jhajjar informed us that the village benefitted from a programme of free pads distribution from the government. A regular awareness program to inform girls about using and disposing sanitary pads was held in the school and villages. On WASH needs in the village, she confirmed that there was adequate water and proper toilet facility in every household. On taboos regarding menstruation, she stated that, "Previously women were not allowed to perform *pooja* during menstruation but now the situation has changed, they can perform their prayers after taking a bath."

A **School Teacher** (Interview conducted during July-August 2022)[15] in Dariyapur village in Jhajjar informed us that two pads are distributed every month to adolescent girls in school. On WASH needs in school she replied

[9] HR KII9 NUH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[10] HR KII10 NUH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[11] HR KII11 NUH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[12] HR KII12 NUH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[13] HR KII1 JHA: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[14] HR KII2 JHA: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[15] HR KII4 JHA: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

that it had a toilet but no maintenance staff to sweep, mop and clean it. She further added that, "The school needs a pad-vending and pad- burning machine, a peon and staff to clean the toilet and school premises".

A **kitchen worker** (Interview conducted during July-August 2022)[16] in the Anganwadi of Dariyapur village in Jhajjar district of Haryana states that in recent years there has been a positive change about maintaining cleanliness in the school. She further added that the village has begun to make efforts to make girls aware of eating nutritious food during menstruation. On customs and taboos in Jhajjar, the kitchen worker informed us that girls are much freer to practice their personal routines during menstruation.

Our respondent, an **ASHA worker** (Interview conducted during July-August 2022)[17] in Dariyapur village in Jhajjar stated that the village distributed Iron tablets to girls and regular awareness meetings on menstruation were held. Previously sanitary pads were distributed on the subsidized price of 15 Rupees per packet but now this scheme has been stopped. Moreover, village had *Kishori Swasthya Kendra and Rashtriya Kishori Swasthya Karyakaram* under RKSK scheme. On WASH in the community she added, village had water and toilet facilities in every household and, "there is no area specific need on menstruation, the government has fulfilled all our needs."

The **Anganwadi worker** (Interview conducted during July-August 2022)[18] of Lagarpur village of Jhajjar added that *Anganwadi* workers regularly conduct awareness programs with girls to inform them about using sanitary pads and methods of disposing of them after use. She further added that the village had water and toilet facilities in every household but Anganwadi does not have a water and electricity facility.

Our respondent, an **Anganwadi worker** (Interview conducted during July-August 2022)[19] in Bazidpur village of Jhajjar commented that the village had a free sanitary pad program for girls belonging to poor families who benefited from the *Kishori Swasthya Kendra* under RKSK. On WASH in the community, she confirmed that there is water facility in every household, the government provided money to build toilets but "people do not use this money for building toilets".

An **Anganwadi helper** (Interview conducted during July-August 2022)[20] in Deverkhana village of Jhajjar informed us that the village had a free sanitary pad distribution facility for BPL families, and a regular awareness program to educate women about menstruation. But the village lacked proper sanitation facilities.

An **Anganwadi worker** (Interview conducted during July-August 2022)[21] in Deverkhana village of Jhajjar stated that the village facilitated free distribution of iron tablets for girls. On WASH she added that the village had adequate water facilities in every household but free sanitary pads were required for all women.

4.3 SALIENT FINDINGS FROM DATA

Processing through our data from Nuh and Jhajjar, we have gained some valuable insights on women's health, education, livelihood and overall community outlook on menstrual health management needs and transformations on ground.

In Nuh, a schoolteacher and an AWW referred to menstruation as a 'problem' for girls and women. Likewise, many key informants and our respondents too believed that the entire package of 'myths and taboos' around menstruation is normal and good for women. However, some voices do call out for a much-needed change in knowledge, attitude and practice around menstruation.

Aside from that, WASH requires a much-needed boost in Nuh because of water problems ranging from waterlogging to contamination, lack of potable water and severe water shortage wherein families need to buy

[16] HR KII5 JHA: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[17] HR KII6 JHA: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[18] HR KII7 JHA: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[19] HR KII8 JHA: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[20] HR KII9 JHA: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[21] HR KII10 JHA: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

a tanker. A tanker lasts for fifteen days per family, except in one case where they said that it lasts for thirty days. Schools in Nuh experience water scarcity and need to buy a tanker every seven days. This means that their WASH needs are grossly unfulfilled. In fact, that women have said they do not have water to even bathe daily. In some villages (Revakal, Dandluka and Tapkan) of Nuh District there is no water. In villages that have but they deal with a severe sewage / drainage problem.

In most villages, the government has stopped supplying free sanitary pads for adolescent girls in schools. Pads are given by school authorities as an emergency gesture only if the girls' menstrual cycle starts while attending school/ during school time. A Sarpanch and Aganwadi helper told us that since July –August 2022 (when interviews were taken for this survey) pads are no longer available at subsidized rates. In Tapkan village, however some BPL families are still availing of free pad distribution services.

National schemes like *Rashtriya Surakhsa Mission* are organised by the central government but the Haryana state government does not spend on pads. Nothing is available for helping menstruating women in NUH unlike in Odisha where state runs *Khushi, Advika* schemes. However, our salient finding is that many women want to use only cloth, while women from the Muslim community believe in the myth that, if any menstrual protection material is used, 'the heat/ from the stomach will reach the brain' or '*pet ki garmi dimaag tak pahunch jayegi*' as some of the informants think.

Like women from tribal, Dalit and OBCs and other Hindu communities, Muslim women do not go to any place of worship, nor do they offer prayers during their periods. Earlier, women from the Muslim communities in Nuh were not allowed to cook, but now the times are changing and families do have more freedom from taboos. Although women in Nuh face diseases and issues related to MHM, only older women visit PHCs. Young women from all communities do not prefer going to the hospitals which are on an average 8 to 10 kms away from these villages.

NUH families do have toilets in their house, however owing to water scarcity, no one uses these, and hence the habits still deviate towards open defecation. Four to five out of our twelve key informants have verified that people refrain from using toilets and prefer the open spaces to relieve themselves.

In Jhajjar there is more or less adequate water supply and proper toilet facility in every household according to five of our key informants. In Bajidpur village, funds to construct toilets were given under the *Pradhan Mantri Swachh Bharat Yojana*, however, people did not use these funds for building toilets. Dariyapur village of Jhajjar experiences water shortages.

Menstruating women are prohibited from bathing. Previously during periods, women were not allowed to perform Pooja, but nowadays the women can do so after bathing. Hence, a change has been noticed whereby people show the positivity to move away from taboos that do not hold significance in their lives.

In Jhajjar district, there is an awareness orientation towards maintaining cleanliness. Dariyapur village gets a quota of two free sanitary pads for adolescent girls i.e., the school going ones. Elderly women in Dariyapur used to get a sanitary pad packet at subsidized rates but now this scheme has been discontinued. Most women use cloth and the elder and older ones prefer using cloth. In DevarKhana Village, pads are distributed only for BPL families and Iron tablets given to adolescent girls.

From our interactions and databases pertaining to Haryana it clearly emerges that apart from a silence on women's menstrual health in terms of inter-sectoral hindrances and policy related negligence in India, there are community-voices that portray a negative and discriminatory attitude towards periods. These discriminatory voices and attitudes in Haryana, just as our research from some other parts of India shows, pertain to both men and women across social strata. Many EAMW as well as key informants endorse negative attitudes (as told to our surveyors and field-researchers) towards menstruation, either owing to the circumstantial difficulties that they grow up experiencing or for want of better knowledge and support system around the phenomenon. Inadvertently or otherwise,

such voices contribute to the perpetuation of a debilitating discourse on the phenomenon. The key to combating the inter-sectoral and community -based silences and barriers on MHM among women beyond school years lies in augmenting positive practices and discourses on menstruation. One of the best ways to achieve this is by involving multiple actors, key, and critical stakeholders such as EAMW, leaders, influencers, families, policy makers and implementers. Hence, gender mainstreaming MHM can ensure gender perspectives and attention to the goal of gender equality in all actions, projects and programmes.

4.4 RECOMMENDATIONS/ AREAS OF IMPROVEMENT

IMMEDIATE AREAS OF ACTION

1. **Empower EAMW on MHM themes:** According to our findings, discrimination, segregation as well as isolation and judgmental attitude from family and community creates a mental health burden for women and girls in their menstruating years. Hence, social support systems, counseling to create public awareness on social-biological knowledge around menstruation can bring relief and ease the myths, taboos and pressures around menstruation. We suggest more awareness drives on menstruation, with a special focus on EAMW in the age group of 20 to 49 years. Monthly or three-monthly compulsory and inclusive health check-ups are organized for EAMW.
2. **Inclusive Health Check-ups:** Monthly or three-monthly compulsory and inclusive health check-ups should be organized for EAMW.
3. **Equip schools for personal hygiene**: Ensure provision of liquid hand-wash or soap in schools and students be monitored as well as guided on proper usage of soaps for hand washing. Village schools lack maintenance staff to clean the premises as well as **toilets** therein. Schools need sanitation staff in school for maintenance and cleanliness of sanitation facilities and surroundings.
4. **Education and Holistic approach towards MHM:** In Jhajjar and Nuh, school teachers need training for a proper orientation towards menstruation. A positive attitude and a scientific comprehension of MHM can be ingrained in young girls with the help of aware and insightful teachers.

SHORT-TERM

5. **Pad distribution schemes and disposal mechanisms**: Ensure that free pads are adequate and need to be facilitated, regularized, monitored and revised (as need be) for sustained use as well as orientation and empowerment of women.
6. **Two pads for adolescent girls per month under the free pad distribution scheme** are not only inadequate but also do not solve the purpose of comfort and hygiene of young school-going girls from EWS of society or BPL families in both the districts of Haryana.
7. **Optimize MHM and WASH parameters:** In Mewat (Nuh), it is evident that due to inadequate water supply, people buy water through tankers (45.1% families) which last for 15 days per family on an average. Providing sustainable source, portable treatment systems and Functional Household Tap Connection under the JJM Scheme will regularize and overcome drinking water scarcity and free the villages and families from tankering issues.
8. **Participatory Monitoring by Village-committees:** Funds for building toilets under the SBM scheme are (mis)used by families for other purposes in Jhajjar, Haryana. In Assam and Odisha, our data points to a separate finding. The funds are given to a contractor through the Gram Panchayat for making toilets in the village but the contractor does not make proper ceilings, sewage systems and doors and leaves after making inferior quality toilets. We recommend active participatory monitoring by villagers to ensure fund utilisation and toilet construction mechanisms to help villages attain their WASH and MHM goals.

LONG TERM

Haryana MHM Committee: A State level Menstrual Health and Wellbeing Committee be initiated to integrate remote places, mountainous regions etc. into the state and national ADP and MHM plans.

9. **MHM at District, Block, Gram Panchayat Level**: Information, education, and communication (IEC) for menstrual hygiene education and awareness that includes information around safe menstrual hygiene products; and menstrual waste management with safe disposal facilities.
10. **Bridge the gaps between Elder and Younger Menstruating Women**: Build capacities and knowledge base of elder women by virtue of special community-oriented programmes can help the betterment of MHM outcomes of younger menstruating women in Haryana. Our data reveals that elder and/ or older women turn up for general medical check-ups and visit PHCs in Nuh and Jhajjar while younger women prefer to seek non-medical advice or practice self-medication to cope up with MHM and menstruation related distresses silently.
11. **MHM at Family level:** Ensure sustainable water source (preferably gravity schemes as per viability that are low on operations and maintenance) along with source strengthening measures and provision of Functional Household Tap Connections (FHTCs) to all households under National Jal Jeevan Mission scheme.
12. **JJM for Institutions and MHM:** Institutional water supply under JJM scheme to ensure supply of adequate running water in girls' toilets in schools.
13. **MHM friendly Toilets:** Ensure provisioning of community toilets as well as toilets in schools, work areas with washing areas, bathing cubicles, and running water under SBM(G) phase II where needed.

REFERENCES

Census 2011 Office of The Registrar General and Census Commissioner, Ministry of Home Affairs, Government of India. Available from https://www.census2011.co.in/census/district/226-mewat.html [accessed 21 January 2023]

Census 2011 Office of The Registrar General and Census Commissioner, Ministry of Home Affairs, Government of India. Available from https://www.census2011.co.in/census/district/222-jhajjar.html [accessed 20 January 2023]

Indian Brand Equity Foundation (IBEF), Ministry of Commerce and Industry, Government of India (2023) State Profile Haryana. New Delhi. Available from https://www.ibef.org/states/haryana-presentation [accessed 20 January 2023)

Indian Brand Equity Foundation (IBEF), Ministry of Commerce and Industry, Government of India (2020) Haryana the Bread Basket of India. Available from https://www.ibef.org/download/Haryana-June-2020.pdf [accessed 21 January 2023]

International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS)-5, State and District Factsheets, Haryana. Mumbai: IIPS. p. 51 & 87. Available from http://rchiips.org/nfhs/NFHS-5_FCTS/COMPENDIUM/Haryana.pdf [accessed 22 January 2023]

Kumar, Ashok. (2019) What ails Haryana's Nuh? *The Hindu,* 7 January. Available from https://www.thehindu.com/news/cities/Delhi/what-ails-nuh/article25927850.ece [accessed 21 January 2023]

Komal, *. (2019) Causes of waterlogging in Jhajjar district. *Journal of Advances and Scholarly Researches in Allied Education*, 16(1) 359-361. Available from http://ignited.in/I/a/68749 [accessed 25 January 2023]

Malhan, Pradeep Singh. (2020) Impact of Land Acquisition on Rural People: A Case Study of District: Jhajjar. *International Journal of Creative Research Thoughts,* (8)9. Available from https://ijcrt.org/papers/IJCRT2009270.pdf https://ijcrt.org/papers/IJCRT2009270.pdf [accessed 25 January 2023]

Niti Aayog, Government of India (2018) *DEEP DIVE Insights from Champions of Change The Aspirational District Dashboard.* Available from https://smartnet.niua.org/sites/default/files/resources/firstdeltaranking-of-aspirational-districts.pdf [accessed 08 january 2023]

Official Website, District Jhajjar, Government of Haryana. About District. Last updated 8 February 2023. Available from https://jhajjar.nic.in/about-district/ [accessed 10 February 2023]

The Tribune (2018) Women feel Unsafe in Jhajjar. *The Tribune*. Available from https://www.tribuneindia.com/news/archive/haryanatribune/women-feel-unsafe-in-jhajjar-598692 [accessed 22 January 2023]

The Tribune Editorial (2021) Water scarcity: Displacement of Nuh villagers should be prevented. *The Tribune*, 6 July. Available from https://www.tribuneindia.com/news/editorials/water-scarcity-278800 [accessed 21 January 2023]

ANNEXURE I

Criteria/ Reasons for Selection of Villages from Jhajjar

#	District	Block/ Town	Gram Panchayat/ Ward	Village
1	Mewat	Nuh	Dhanduka	Dhanduka
2	Mewat	Nuh	Hirmathla	Hirmathla
3	Mewat	Nuh	Rewasan	Rewasan
4	Mewat	Nuh	Tapkan	Tapkan
5	Mewat	Nuh	Ujina	Ujini
6	Jhajjar	Jhajjar	Bazidpur	Bazidpur Tappa Haveli
7	Jhajjar	Bahadurgarh	Daryapur	Daryapur
8	Jhajjar	Bahadurgarh	Devar Khana	Devar Khana
9	Jhajjar	Bahadurgarh	Lagarpur	Lagarpur
10	Jhajjar	Bahadurgarh	Lohat	Lohat

** For selection criteria for villages: See Annex I*

SR. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (refer JJM/ SBM data)	Total Households	Prevailing social issues/ issues of inclusion/ etc.
1	Bazidpur Tappa Haveli	Bazidpur Tappa Haveli	949	166	Lack of access to secondary education for girls, Early marriage for girls, Migration from the village,

SR. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (refer JJM/ SBM data)	Total Households	Prevailing social issues/ issues of inclusion/ etc.
					Scarcity of water, Concentration of calcium & Magnesium salt in water, Occurrences of menstrual hygiene related diseases
2	Bahadurgarh	Daryapur	2410	782	Lack of access to secondary education for girls, further education not considered necessary for girls, High cases of disguised unemployment in the village, Migration from the village, Scarcity of water, Concentration of calcium & Magnesium salt in water, Occurrences of menstrual hygiene related diseases
3	Bahadurgarh	Devar Khana	1227	397	High cases of disguised unemployment in the village, Migration from the village, Scarcity of water, Concentration of calcium & Magnesium salt in water, Occurrences of menstrual hygiene related diseases.
4	Bahadurgarh	Lagarpur	1188	281	No proper schooling facility for girls in the village, No female teachers in the school, Early age of marriage for girls. Cases of permanent and temporary migration in the village, Scarcity of water, Concentration of calcium & Magnesium salt in water, Occurrences of menstrual hygiene related diseases.
5	Bahadurgarh	Lohat	1358	481	No proper schooling facility for girls in the village, Cases of permanent and temporary migration in the village, Scarcity of water, Concentration of calcium & Magnesium salt in water, Occurrences of menstrual hygiene related diseases.

Reasons for selecting Villages from Mewat (Nuh)

SR. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (refer JJM/ SBM data)	Total Households	Prevailing social issues/ issues of inclusion/ etc.
1	Nuh	Dhanduka	1002	395	Lack of access to secondary education for girls, Further education not considered necessary for girls, Migration from the village, Scarcity of water, Concentration of calcium & Magnesium salt in water, Occurrences of menstrual hygiene related diseases.

SR. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (refer JJM/ SBM data)	Total Households	Prevailing social issues/ issues of inclusion/ etc.
2	Nuh	Hirmathla	1370	180	Lack of access to education, Cases of disguised unemployment, High rate of permanent and temporary migration, Scarcity of water, Concentration of calcium & Magnesium salt in water.
3	Nuh	Rewasan	3,620	485	Lack of access to education for girls as school is far away or further education is not considered necessary for girls, kutcha and semi pucca houses in the village, Regular migration from the village, Scarcity of water, Concentration of calcium & Magnesium salt in water, Occurrences of menstrual hygiene related diseases.
4	Nuh	Tapkan	3211	409	Lack of access to education for girls, Migration toward NCR from village, Scarcity of water, Concentration of calcium & Magnesium salt in water, Occurrences of menstrual hygiene related diseases.
5	Nuh	Ujina	6452	1270	High rate of disguised unemployment in the village, Regular migration from the village, Scarcity of water, Concentration of calcium & Magnesium salt in water, Occurrences of menstrual hygiene related diseases.

ANNEXURE II

Important Women-Centric Schemes in Haryana

- *Mukhyamantri Doodh Uphaar Yojana:* It was launched on 5 August 2020 by the Chief Minister Shri Manohar Lal Khattar (BJP) under the Ministry of Women, and Child Development, Government of Haryana. The objective of the scheme is that the state government will provide free fortified milk to children, pregnant women, and lactating mothers.
- *Mahila Evam Kishori Samman Yojana:* It was launched on 5 August 2020 by the Chief Minister Shri Manohar Lal Khattar (BJP) under the Ministry of Women, and Child Development, Government of Haryana with the aim that free sanitary napkins would be distributed to women / girls belonging to Below Poverty Line (BPL) category in villages.
- *Apki Beti Hamari Beti* Scheme: It was started in 2015 by the Chief Minister of Haryana Shri Manohar Lal Khattar (BJP) under the Ministry of Women, and Child Development, Government of Haryana. In this scheme a sum of 21000 INR is invested with Life Insurance Corporation LIC in the name of the 1st Girl child of SC/BPL families and 2nd child of family belonging to any caste. On attaining 18 years of age, the girl child will be paid a tentative amount. With effect from 24.08.2015 third girl child born in families belonging to any caste were also covered.

- *Ladli Social Security Allowance Scheme:* It was launched by Chief Minister Shri Bhupendra Singh Hooda (INC) on 1 January 2006 under the Department of Social Justice and Empowerment, Government of Haryana. The scheme is in the pattern of Old Age Allowance Scheme for the families having only girl child/children. Parents were provided with 2500 Rupees per month allowance.
- *Working Women Hostel:* This scheme was operationalised under the Ministry of Women, and Child Development, Government of Haryana. The objective of the scheme is to promote availability of safe and conveniently located accommodation for working women, with day care facilities for their children, wherever possible, in urban, semi urban, or even rural areas where employment opportunities for women exist.

A RESEARCH REPORT FROM

MAHARASHTRA

PART 1 INTRODUCTION

In Maharashtra, our research report on the 'Combating the Silence from Menarche to Menopause – A Comprehensive Report on Menstrual Hygiene Management in India', was conducted in the districts of Beed and Osmanabad. Beed is a backward district of Maharashtra but not characterized as an Aspirational district, Osmanabad on the other hand, falls under Niti Ayog's Aspirational District Programme (ADP)[1]. Both Beed and Osmanabad, however share the commonality of socio-economic vulnerabilities to the large number of migrant workers who earn their living through various kinds of seasonal work in the unorganized sector, poor farming communities, sexual discrimination of the women workforce and an adverse sex-ratio.

For completing our research sample in Beed and Osmanabad, ten villages were selected for field research and surveys. Research, including data collection and analysis, for this case- study on Maharashtra were done through the period of April 2022 to February 2023. Following a participatory and mixed-methods approach, information was sought and processed on the local situation on Menstrual Hygiene Management (MHM), Water Sanitation and Hygiene (WASH), education, health, livelihood, income and availability of support systems to women in the selected districts. Though both districts are doing well on many parameters under the ADP, such as education, literacy and infrastructure, our study indicates that Beed and Osmanabad have much to achieve in terms of combating the silences on MHM with inter-sectoral perspectives on wellbeing of, what we refer to as, '**Elder and Ageing Menstruating Women'** or EAMW. Nevertheless, because our interaction included women as mothers, teachers, counselors and caregivers of young girls within schools and families, we include a lateral analysis on the menstrual wellbeing requirements of school-going girls as well.

Our research has been designed to collect thick ethnographic data on actors, practices and discourses with an inter-sectoral and analytical perspective on MHM in selected research areas. WASH, availability of community support systems, schemes and education as well as felt needs of menstruating women form a vital part of this research. We bring data through field-work, interviews, Focus Group Discussions (FGDs) and observations on MHM through women's participatory voices and opinions. A total of 577 interviews were conducted by employing the Menstrual Practice Questionnaires (MPQs) wherein data was collected from 351 women from Beed and 226 women from Osmanabad. Interviews and interactions took place in the Marathi language in which women were comfortable to communicate.

Focusing primarily on the category of, **'**Elder and Ageing Menstruating Women' **(henceforth EAMW)** between the ages of 20 years to 49 years, we also share our findings on MHM related enablers and barriers for young school going girls. In an attempt to understand the well-being of menstruating women beyond their school years, this study on Maharashtra documents the various kinds of barriers and silences in the effective MHM of EAMW. Nonetheless, we also explore and explore our primary data to critically discern potential enablers towards an effective MHM of women between the ages of 20 years to 49 years.

In the final sections, our findings are examined against the voices of key informants to crystallize the salient findings from our primary data as well as delineate context- specific and community-sensitive areas of improvement. Therefore, this case-study on Maharashtra ends with suggestions on immediate, short term as well as mid-term enablers and recommendations for combating the inter-sectoral hindrances prevalent in areas observed.

[1] ADP aims to improve the socio-economic status of the citizens expeditiously. The three core principles of the program are - Convergence (of Central & State Schemes), Collaboration (among citizens and functionaries of Central & State Governments including district teams), and Competition among districts (Niti Aayog 2018).

BEED AND OSMANABAD DISTRICTS OF MAHARASHTRA

Maharashtra is one of the sugar producing states in India (Economic survey of Maharashtra,2021-22). The report states that out of total factories, more than one third of total sugar factories are sugar production factories (Economic survey of Maharashtra, 2021-22). As per the data provided by the Sugar Commission, 2016, there are more than 25 lakhs Sugarcane cultivators and that the sugar cane cutters mainly come from drought-prone areas of Marathwada and Vidarbha regions. Beed is known as the district of sugarcane workers (Munjal & Sodhi, 2021). Beed and Osmanabad districts were selected due to sugarcane cutters who are also engaged in the other occupations such as agriculture, construction, and mining as a part of their livelihood.

BEED

Beed, an administrative district in the Aurangabad division of Maharashtra, lies in the Marathwada region, bordering Karnataka and Telangana. On October 31, 2018, the government of Maharashtra declared Beed as one of the most severe drought-hit districts in the country based on indicators such as rainfall deficit, low soil quality and decline in groundwater index (Kurtkoti & Gunwati, 2019). The district has an area of 10,693 sq. km. and a population of 25,85,049 persons according to the 2011 Census. Among the 35 Districts of the State, the District ranks 10th in terms of area, 19th in terms of population and 27th in terms of density (Census 2011, p. 8-9). Beed has been notorious for its discrimination against the girl child. From 2001 to 2011, the child sex ratio (calculated as the number of girls per 1000 boys in the 0–6-year age group) dropped from 894 to 807 (Berry, 2022).

Discrimination against women on grounds of menstruation is one of the most prominent and pressing social issue faced by EAMW in their workplaces in Beed, often times prompting them to undergo hysterectomies (Chadha, 2019) to compete with the exigencies of the labour economy. Nonetheless, despite creating a cycle of biological and psychological impacts, hysterectomies are not the only issue that menstruating women face in Beed. According to a study commissioned by the Maharashtra State Commission for Women in 2018, 36% of female sugarcane labourers in the State had undergone a hysterectomy (Shukla & Kulkarni, 2019). This claim is further substantiated with the figures presented by the National Family Health Survey 4 (NFHS-4) (2015-16). The Survey notes that, while the rate of hysterectomies among women aged between 15- 49 years at the all-India level is 3.2%, the hysterectomy rate in the state of Maharashtra is 2.6%. Largely dependent on monsoon rain, Beed is an agricultural labour dominant district where majority of the farmers are poor. The female farmers find it difficult to spend money on sanitary napkins and therefore resort to using cloth during menstruation. Lack of sanitation facilities leading to improper disinfection of the menstrual cloths further increases the chance of reproductive diseases. Moreover, the increase in hysterectomies is also driven by a deeply rooted belief that the womb of a woman is futile once she has produced children, who are seen as a form of the surplus labour force.

OSMANABAD

Osmanabad district lies in the southern part of Maharashtra. Most of the district area is rocky while the remaining part is plain. The district is surrounded by a small mountain called “Balaghat”. Bhoom, Washi, Kalamb, Osmanabad & Tuljapur Tehsil lie in the range of this Balaghat mountain. Some parts of the major rivers like Godawari and Bhima come under this district. Located in the parched Marathwada region of southern Maharashtra, Osmanabad is in many ways a slave of its geography (Census, 2011, p.11-12). Sex ratio of the district is 924, which is lower than the state average (929). The literacy rate of Osmanabad district is 78.4 percent, male and female literacy rates are 85.8% and 70.5% respectively (Census, 2011, p.11-12).

Maharashtra faces the highest incidents of farmer suicides in India, and Osmanabad is one of the worst-affected districts, according to government of India data, in 2016, 3,661 farmers died by suicide in this state alone (total farmer deaths by suicide in 2016 was 11,379). Osmanabad district comes under Deccan Plateau and Hills region. It is considered as one of the most industrially backward districts in the state. This district comes under the drought prone areas of the region. Historically rainfall has shown great fluctuation. This resulted in drought and drought-like conditions (Yadav, 2018).

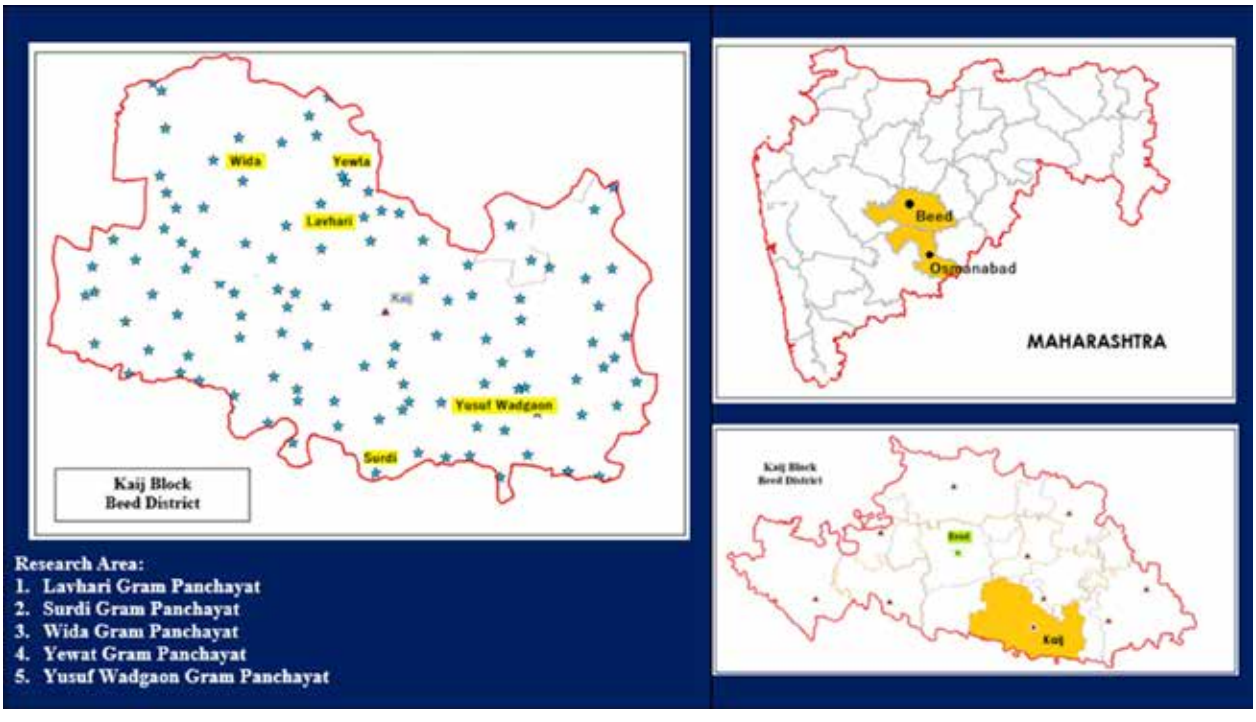
ASPIRATIONAL DISTRICT PROGRAMME: OUTCOMES AND FOCUS

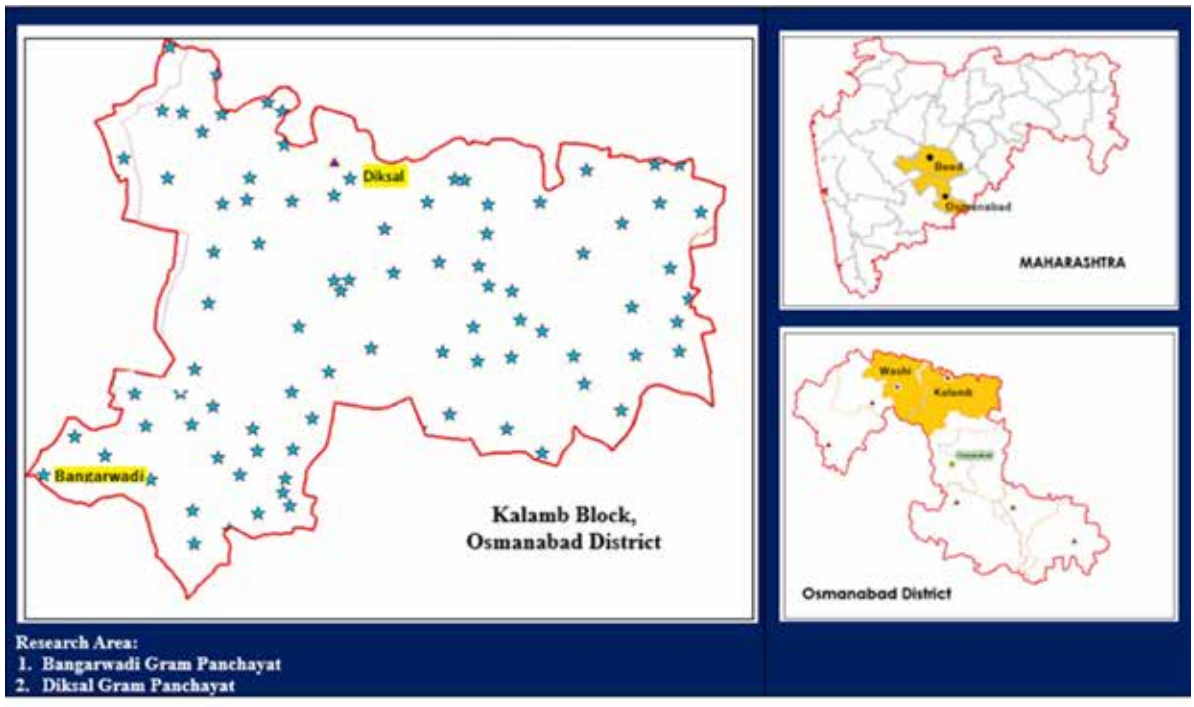
Under the ADP, NITI Aayog is implementing its mandate of promoting convergence of various Central and state schemes to mobilize and creatively use all available resources. Therefore, Khawa Cluster Bhoom in Osmanabad was established under the Government of Maharashtra's micro-small enterprises—Cluster Development Programme—as a modern food processing hub (Tripathi, 2020). A skill development center is skilling more than 1000 youth every year and integrating them in the Khawa value-chain at different levels, even as self-employed individuals (Tripathi, 2020). In Maharashtra, Beed and Osmanabad both selected districts have a large population of sugarcane cutter workers and agricultural labourers.

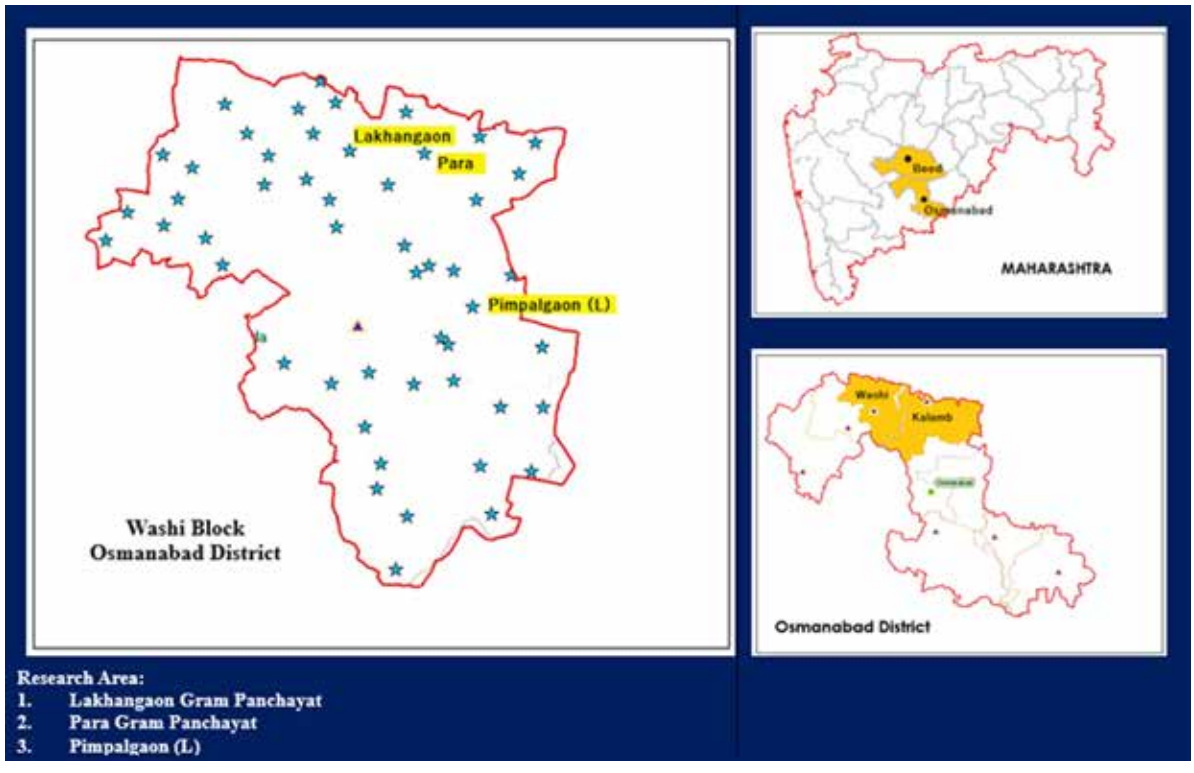
Though both districts are doing well on many parameters where improvement is needed such as education, literacy and infrastructure, our study indicates that Osmanabad as ADP and Beed as non-ADP have much to achieve in terms of combating the silences on MHM. An inter-sectoral perspective on well-being of the EAMW in particular, as well as a policy-appropriate focus on school-going menstruating girls can bring a desired positive change towards MHM in these districts.

1. LIST OF VILLAGES SELECTED FOR THE STUDY FROM BEED AND OSMANABAD

On an average, five villages were selected from each of the fourteen districts across the seven Indian states selected for this study. In Maharashtra, the population sample in Beed was taken from five Gram Panchayats of Kaij Block and in Osmanabad, it was taken from five Gram Panchayats of Kalamb and Washi Block (See Annex 1). Factors for selection of villages include socio-economic concerns relating to groups and communities practicing migration, unskilled labour as well as the prevalence of myths and taboos etc.







2. DATA TOOLS AND STRUCTURE OF THE CHAPTER

2.1 RESEARCH TOOLS, METHODS AND THEMATIC FOCUS FOR DATA COLLECTION, CORRELATIONS AND COMMUNITY-BASED ANALYSES

Types of Interviews - Tools and Focus	Data Collection and Analysis- Methods and Themes	Sample	
		Beed	Osmanabad
Tool 1 Menstrual Practice Questionnaires (MPQs)	Method 1 The MPQs were In-depth Interviews (IDIs) for- actor, discourse, and practice- analyses	351	226

Types of Interviews - Tools and Focus	Data Collection and Analysis- Methods and Themes	Sample	
		Beed	Osmanabad
Tool 2 Menstrual Practice Needs Scale (MPNS)	Method 2 Measurement of perceptions and needs based on the last menstruation cycle	30	72
Tool 3 Key Informant Interviews (KIIs)	Method 3 Voices, Excerpts, Salient Findings and Observations	12	12
Themes: WASH, Education, and Health, Livelihood	Focus: Inter-Sectoral findings and conclusion and comparisons		

3. ACTOR ANALYSIS FROM MPQS

3.1 ACTOR ANALYSIS

In this section, socio-economic profile as well as the current menstruation status of the actors is detailed.

Demographic Profile of the Respondents

Demographic Profile	Beed (in %)	Osmanabad (in %)
Total respondents (N)	**351**	**226**
Rural / Tribal	100	100
Mother Tongue		
Marathi	94	100
Hindi	3.4	0
Other (Laman, Holar, Pardhi, Urdu)	2.6	0
Religion		
Hindu	94.6	100
Muslim	5.4	0
Caste/ Tribe Type		
General	51.3	57.5
Other Backward Class (OBC)	15.1	9.7
Scheduled Caste (SC)	26.2	20.4
Most Backward Class (MBC)	1.7	0
Nomadic Tribe (NT)/ PVTG	5.7	12.4
Marital Status		
Never Married	3.1	0.9
Married	93.4	88.9
Widowed	3.1	8
Separated	0	2.2
Divorced	0.3	0

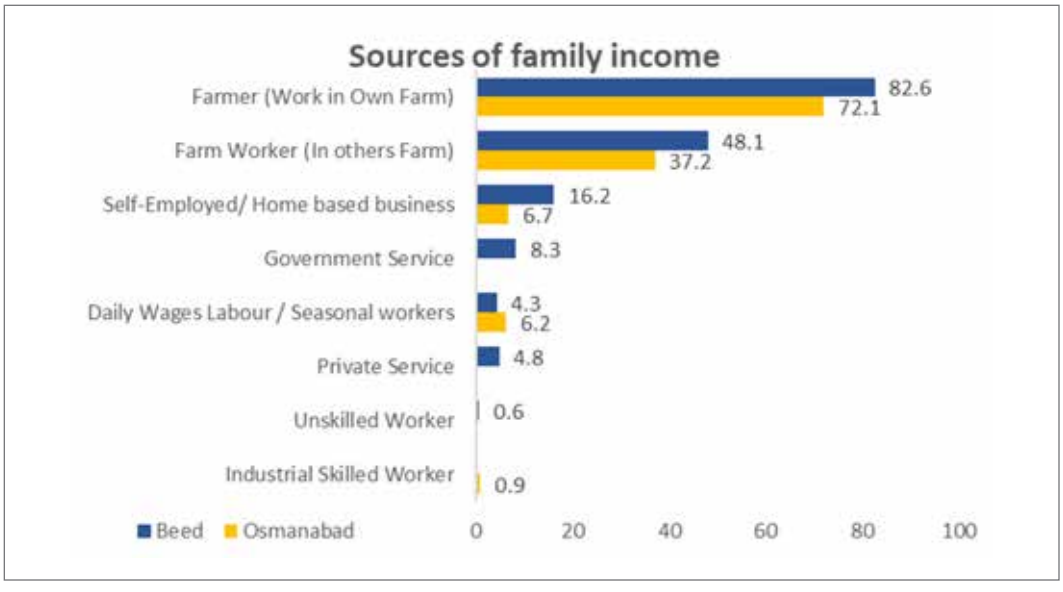
FINDINGS FROM MPQS

- **Religion:** Almost all respondents stated Hindu as their religion while 5.4% of the sample from Beed belonged to the Islam religion.
- **Community:** 53.7% of our respondents from both the districts belonged to the General category (Brahmin, Gurav, Maratha, Muslim, Vidhur) while 23.9% of them belonged to the SCs (Chamar, Harijan, Mahar, Mang, Vadar), OBCs were 13% (Dhobi, Gosavi, Kumhar, Mali, Nhavi, Teli, Vani, Varik) whereas MBC 1% (Laman and Pardhi), 8.3% PVTGs and NTs (Nathjogi, Vajnari and Dhangar) formed the rest of the population interviewed.
- **Marital Status**: 91.7% of the women interviewed were married, the average age of marriage in Beed was 17 years whereas in Osmanabad it was 18 years.
- **Children and Family Size:** Average number of children was two and average family size was four in both the districts.

3.1.1 AVERAGE INCOME

- **Earning Women:** 40.7% women out of 351 from Beed and 82.3% women out of 226 from Osmanabad go out to work and earn. The average yearly income of women in Beed was 56899 INR and for Osmanabad it was 57487 INR.
- **Family income:** The average yearly family income of families in Osmanabad was 70986 INR as compared to 164121 INR for Beed.

3.1.2 SOURCES OF INCOME



*Multiple Choice Question

INCOME TRENDS

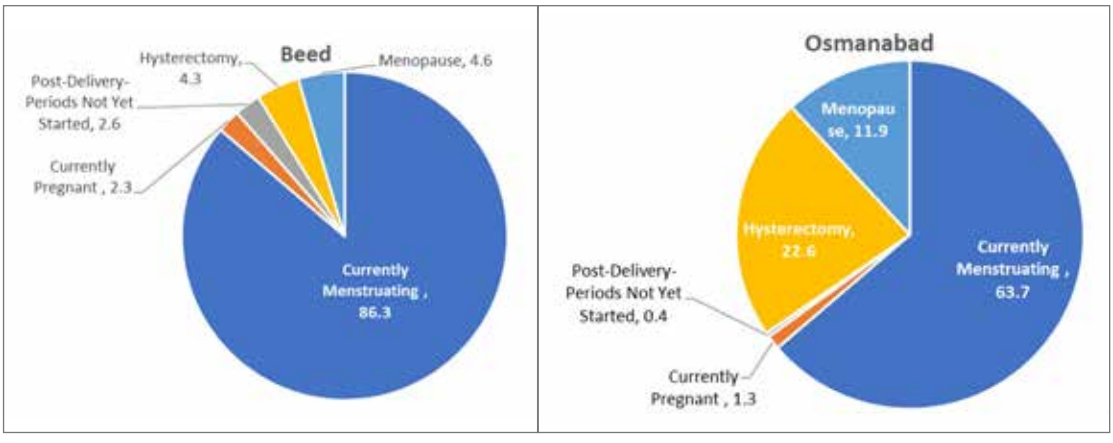
- **Farming:** Agricultural work was the main and single source of regular income for 78.5% of families of total women interviewed from Beed and Osmanabad.
- **Farm workers/ daily wages labour/ seasonal workers:** Farm work and seasonal labor formed either the main (single) or supportive (multiple) source of income for 48.8% of our interviewees, including 5% of our respondents who were contract labour in the agricultural sector.

- **Self-employed/ Home based business:** 16.2% from Beed and 6.7% families from Osmanabad were self-employed or running home-based businesses as a supportive source of income.
- **Women lack Disposable Income:** Although they worked on their own farms and their families also counted on multiple sources of income, 79.6% of the women from our sample in Osmanabad and 14% in Beed reported that they 'did not earn'. Our data indicates that women remain hamstrung in terms of disposable income for personal expenses as well as any decision making on medical care in relation to MHM.
- **Single source or multiple sources of income:** 45.3% women in Beed reported that the primary source of earning for their families was a single source, out of which 37.9% earned through a regular source of income. In Osmanabad, 78.8% women reported that their families had a single source of income. 56.2% women from Osmanabad reported that their families primarily earn from farming along with other regular sources like industrial skilled work, small businesses, and 22.6% reported irregular sources of incomes like daily wage labour, farm labour etc.

TRADITIONAL KNOWLEDGE & SKILL

- **Traditional Knowledge and Skills**: 43 women out of 351 from Beed and 54 women out of 226 from Osmanabad reported possessing traditional skills such as craft/ embroidery/ knitting and weaving. 48 out of these were able to earn from such activities. In Osmanabad only 11 (20.4%) women earned from traditional skill/s as compared to 37 (86%) women from Beed.

3.1.3 MENSTRUATION STATUS (BEED N=351, OSMANABAD N=226)



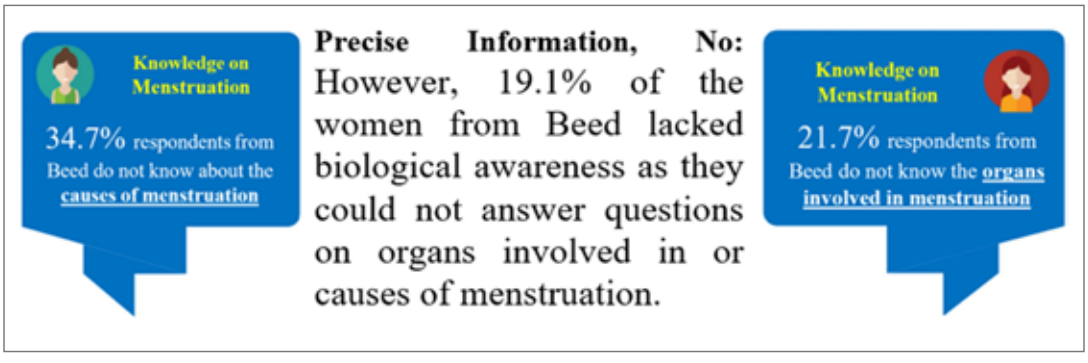
- **Total EAMW**: A total of 468 (81.1%) of our respondents were in their active menstrual years.
- **Age at Menarche:** Average age at menarche was 14 yrs, whereas the average age at attaining menopause was 41 years in both the districts.
- **Number of Hysterectomies**: 15 women from Beed and 51 from Osmanabad had undergone hysterectomy in Maharashtra, with the average age at the time of the procedure being 34 years in Beed and 39 years in Osmanabad.

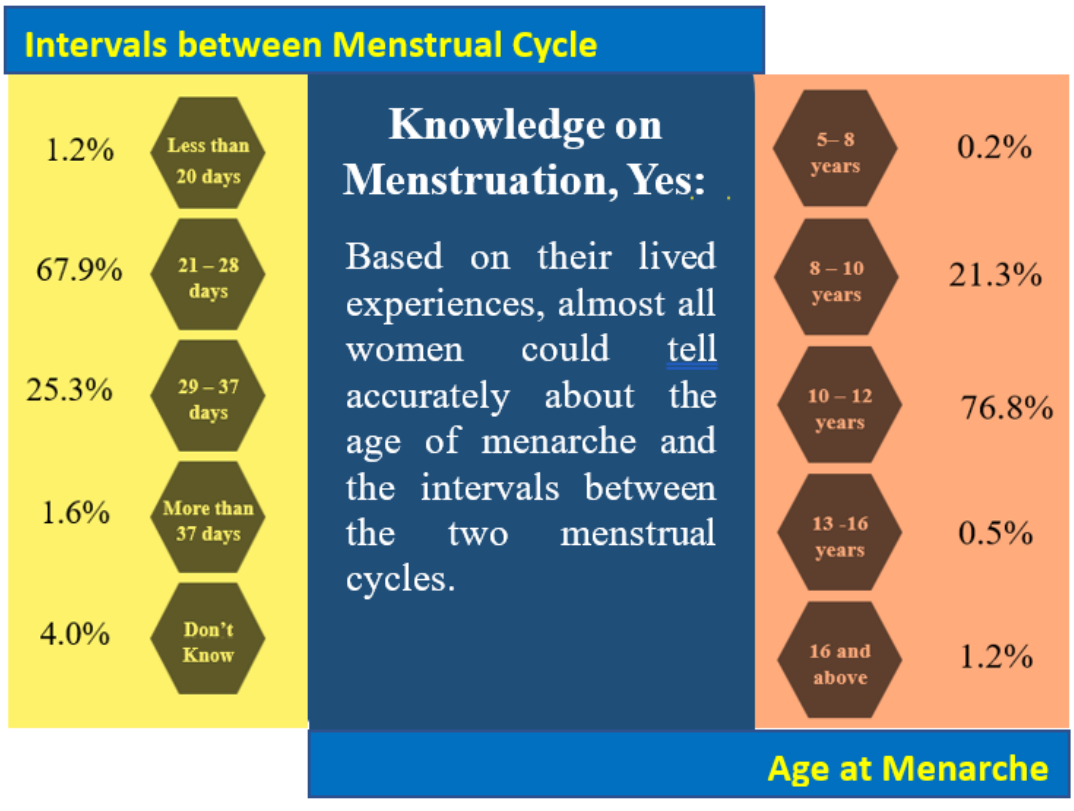
3.2 DISCOURSE ANALYSIS

3.2.1 KNOWLEDGE ABOUT MENSTRUATION:

Knowledge About Menstruation	Beed (in %)	Osmanabad (in %)
Total Respondents	351	226

Knowledge About Menstruation	Beed (in %)	Osmanabad (in %)
Causes of menstruation		
Hormonal change	65.2	99.6
Disease	3.1	0.0
Do not know	26.5	0.4
Natural process	5.1	0.0
Organs Involved in Menstruation		
1. Uterus/ Birth canal	78.3	97.3
3. Abdomen/ Bladder	2.6	0.4
Do not know/ not answered	19.1	2.2





- **Basic Understanding, Yes:** Based on their lived experiences, almost all women could tell accurately about the age of menarche and the intervals between two menstrual cycles.
- **Precise Information, No:** However, 19.1% of the women from Beed lacked biological awareness as they could not answer questions on organs involved in or causes of menstruation.

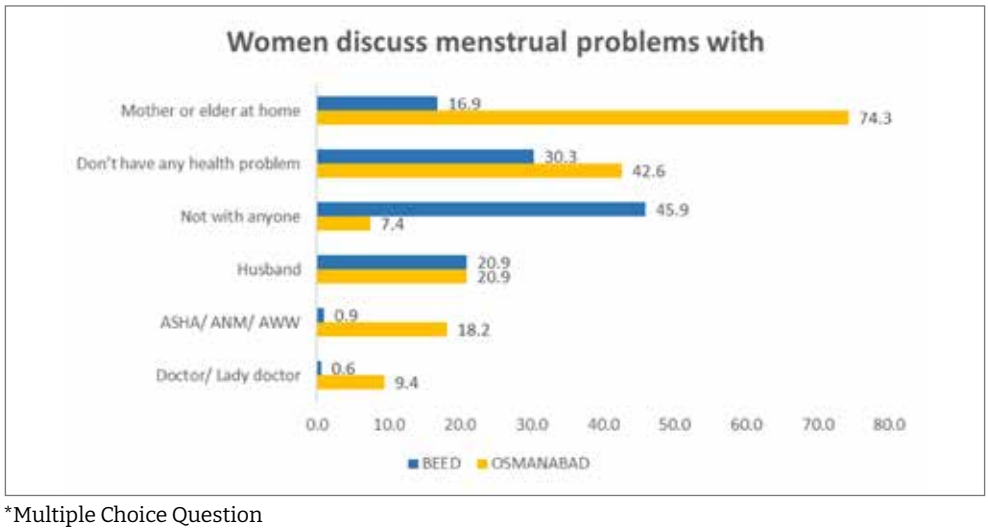
3.2.2 SOURCE OF INFORMATION ABOUT MENSTRUATION

- **For young girls the top sources of information on menstruation emerged as follows:**

  Top sources of information for young girls about menstruation at the time of menarche were parents, grandmother, sister, or sister-in-law, as reported from both the districts.

WOMEN LIKE TO DISCUSS THEIR MENSTRUAL PROBLEMS WITH THE FOLLOWING:

- **Close Relatives:** Unlike 16.9% women from Beed, 74.3% women from Osmanabad were mostly comfortable discussing menstrual problems with mother or elders at home.
- **Frontline Health Workers (FHWs)**: Out of the total of 468 EAMW surveyed, only 6.4% were more comfortable to talk about their MHM problems with the FHWs in the village such as Accredited Social Health Activist (ASHA), Auxiliary Nurse and Midwife (ANM) and Anganwadi workers (AWW).
- **Spouses:** 20.9% of Women from both the districts felt comfortable talking about menstrual problems with husbands. If men can be oriented, stay alert and helpful on their wives' MHM issues, that would bring a positive health outcome for EAMW, besides combating the silence on it.
- **Nobody:** However, 45.9% of women from Osmanabad and 7.4% of women from Beed do not prefer to talk with anyone and remain **silent** about their menstrual problems. 34.2% women from both districts **denied** having any problems w.r.t MHM.

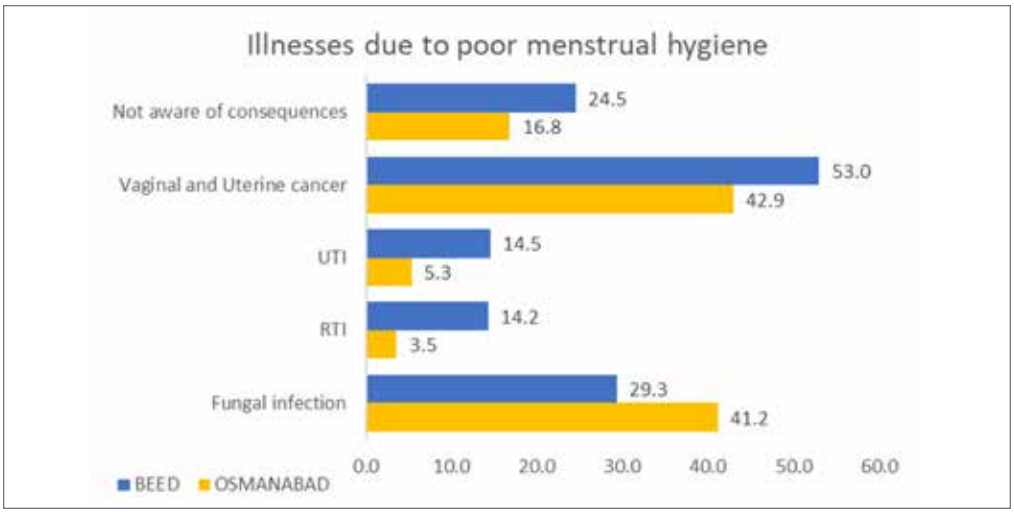


*Multiple Choice Question

3.2.3 MENSTRUAL HEALTH, EDUCATION, AND AWARENESS ON INFECTIONS

Apart from the use of different menstrual products, the study presents data on health problems which were experienced by our respondents during menstruation. It was further verified whether they visit the doctor in case of any health issues or prefer to keep quiet and bear it. Adverse health conditions while working in or outside the home may lead to rashes, urinary tract infections (UTIs), and reproductive tract infections (RTIs) for many women, as indicated by our survey findings.

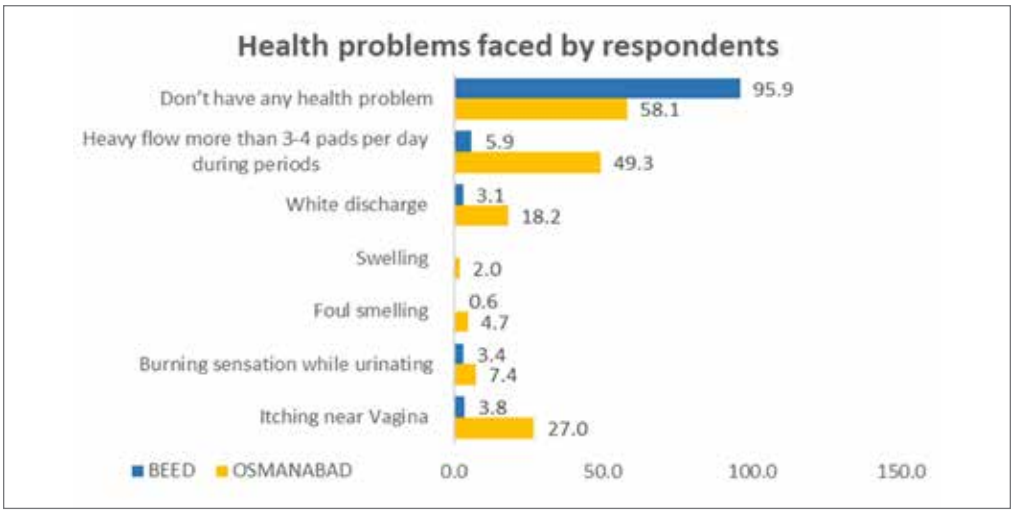
- **Widespread Ignorance**: When asked about the side effects of poor menstrual hygiene, 24.5 % of women from Beed and 16.8 % women from Osmanabad could not answer. Out of the total EAMW (N=577) from both the districts of Maharashtra, 21.5% could not answer.
- **Fungal Infections and UTIs:** Out of the 468 EAMW who knew about poor MHM and risks of infection, 196 stated that poor menstrual hygiene leads to fungal infections while 63 said it causes UTIs.



*Multiple Choice Question

- **Low knowledge on exact health risks:** Adverse health conditions while working in or outside home often lead to rashes, Urinary Tract Infections (UTIs) and Reproductive Tract Infections (RTIs). However, our findings indicate a lack of awareness on these risk factors. Not being able to understand and/or give answers on the relationship between MHM and rashes, infections and other risks indicates ignorance per se.
- **No Schooling, Taboos and Communication Barriers:** However, given that speaking about periods itself is a taboo or is a challenge due to shyness/ hesitancies, generalizations on awareness on MHM may be misleading. Community and area specific conclusions are a better way ahead. One of the most noteworthy findings from both the districts of Maharashtra has been that only 286 women from a total of 577 interviewed had attended school till grade VII. In other words, these women dropped out of school around the time they attained menarche or a year or two before that. In the face of the absence of opportunities that schooling can provide to break barriers of communication on menstrual health, it is not surprising that almost 50% of EAMW who participated in our study either remain shy to speak or know about menstruation or effectively become silent on the theme.

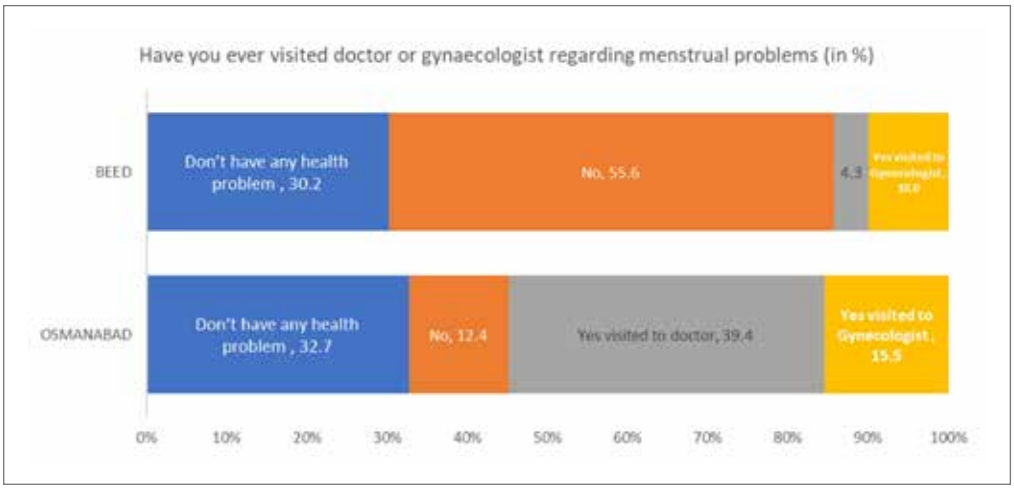
3.2.4 HEALTH SYMPTOMS DURING MENSTRUATION



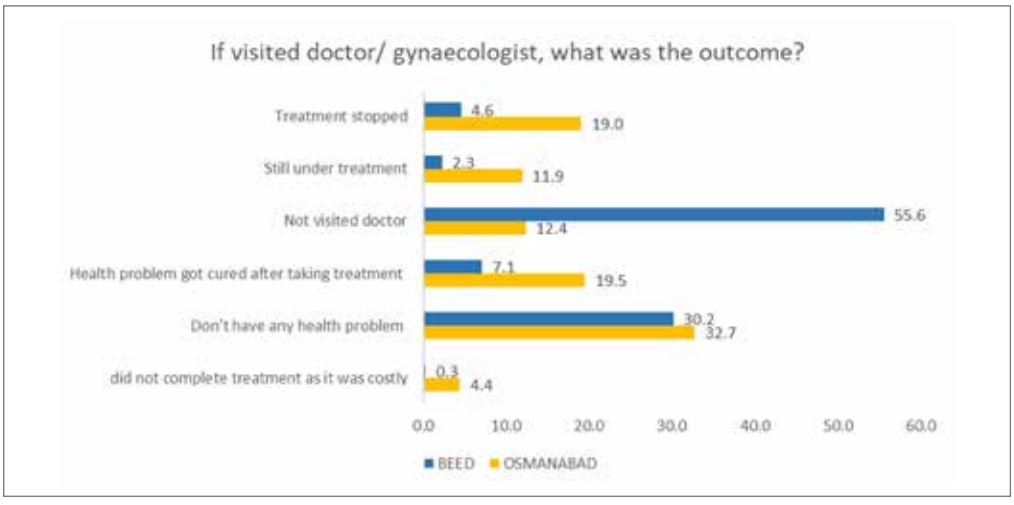
*Multiple Choice Question

- **MHM, health and accessibility to health care**: Apart from the modes as well as patterns of, and awareness on MHM, the survey imparts light on the health problems undergone by participants during menstruation. For arriving at inter-sectoral findings on health management, women were asked if they visit a medical professional to resolve menstrual health issues and reasons if they do not.

- **Vaginal symptoms, attitude and treatment, Beed:** Almost all (307) of the total EAMW (n=320) in Beed reported that they did not have any health problems in the earlier part of the survey. In the later part of the survey, however, they confirmed heavy flow, itching near vagina and burning sensation while urinating as the top three issues women faced due to poor vaginal hygiene. Despite such serious MHM issues, merely 14.3% women from Beed reported seeking medical advice and only 7.1% actually visited a doctor and got cured after completing treatment.
- **Vaginal symptoms, attitude and treatment, Osmanabad:** 86 of the total EAMW (n=148) in Osmanabad reported that they did not have any health problems in the earlier part of the survey but later confirmed heavy flow during menstruation, itching near vagina and white discharge, which emerged as the top three issues that women faced due to poor vaginal hygiene. 54.9% (148) of the women interviewed in Osmanabad (n=226) reported that they visited a doctor for seeking treatment/ advice on menstrual health problems. Only 19.5% out of these 148 women who informed us that they had visited a doctor, got cured after completing treatment.



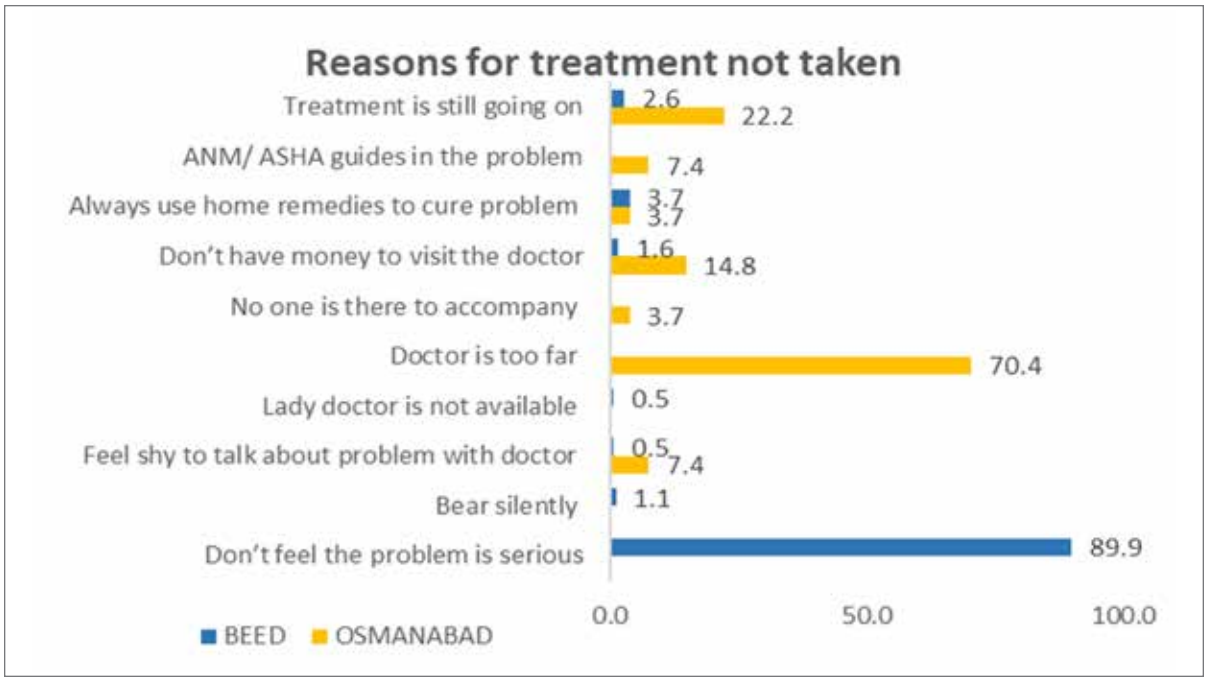
Indeed, if health anomalies during menstruation are not resolved, pushed to the peripheries or remain shrouded in silence, women have much to lose in social, economic and personal spheres. For **combating** health and hygiene related **silences** on menstrual hygiene and care for women beyond school years to benefit the EAMW, the governmental healthcare must tune itself to hear their voices. In the last section of this chapter, titled 'Excerpts and Voices', we bring community-based views and suggestions from women over this issue.



*Multiple Choice Question

- **Neglect, hesitation, and Silence:** EAMW tend to neglect health issues related to menstruation in Maharashtra's Beed and Osmanabad districts. This barrier is further exacerbated by the hesitation to speak on menstrual health and inability to seek medical advice on a regular basis owing to a number of reasons including economic encumbrances.
- **Medical Care, Access, and Unaffordability:** Merely 12% of our respondents visited a doctor to seek treatment and got cured. 18.2% of our total respondents stopped treatment due to various reasons, unaffordability and accessibility of medical care being the most prominent ones

3.2.5 REASONS FOR NON-TREATMENT



*Multiple Choice Question

- **Ignorance:** 89.9% of women from Beed did not feel that the problem was serious.
- **Doctor is far:** 70.4% of women from Osmanabad gave the reason that the doctor is too far to reach followed by monetary problems in addressing women's health. 14.8% women responded that they do not have money to visit the doctor which indicates that aside from a low household income, women also lack disposable income and decision-making powers to approach doctors.
- **No Lady doctor/ Gynaecologist:** 44.9% of our informants refrain from seeking medical advice on MHM owing to non-availability of a lady doctor.
- **Attitude (Shyness and Silence):** 7.4% of the women from Osmanabad singled out shyness as one of the causes that impedes them to discuss their menstrual health openly.

3.2.6 HYSTERECTOMIES

Cases of hysterectomy in samples across both the districts from Maharashtra was 11.4% of the total population surveyed. In other words, 66 out of 577 women interviewed in Maharashtra, had undergone hysterectomies. Out of these, 15 women were from Beed and 51 women were from Osmanabad. Overall, 40 women said that their hysterectomy was done under medical advice. Other major reasons were, weakness due to heavy bleeding, wanting to get rid of white discharge and to avoid cancer, frequent and irregular periods and uterine prolapse, severe pelvic inflammatory disease (9 cases) were also prime causes.

- **Biological Causes:** Hysterectomy causes ranged from abnormally heavy bleeding, backache during menstruation, stomachache and fibroids or other problems related to the uterus.

- **Socio-economic Causes:** Three women who had undergone hysterectomy informed us that periods become a hurdle while working away from home because of low stamina and lack of adequate hygiene facilities. Additionally, when the couple work together or in *Jodi* (Husband-Wife team), women could not afford to take a leave as none of the partners in that case get their payment.
- **Government/ Private Treatment:** Only four out of 66 hysterectomies, i.e, two from each district were done in Government hospitals. The reason for seeking treatment from private hospitals was mainly to get rid of the problem immediately or prior experience/recommendations of family or friends and convenience. The average cost of a hysterectomy was 36000 INR for Beed and 59000 INR for Osmanabad.

Our findings on hysterectomies in Beed and Osmanabad resonate with the known discriminatory situations prevailing in informal labour sector in sugarcane farming areas as well as in other unorganized sectors. Women are oppressed and treated unfairly on their MHM needs which leads to creating problems for husband-wife teams *(Jodi/s)* working together, almost in the same way as it happens elsewhere such as in Chhattisgarh. Moreover, misconceptions about uterine relevance post motherhood are abound. Further, MHM related encumbrances experienced in exploitative labour situations also subject a woman to inadequate WASH facilities. Not surprisingly, marginalized women face complex challenges and crossroads regarding their reproductive health as well as wellbeing options, oftentimes leading to hastily executed hysterectomies. MHM of EAMW should become a vital part of labour laws, public health and community -based awareness drives.

3.3 PRACTICE ANALYSIS

Good menstruation practices start with the usage of clean menstrual absorbents followed by maintenance of reproductive hygiene from menarche till menopause. This section brings to light the prevalence of practices regarding personal hygiene such as washing hands and genitals during menstruation as well as usage and disposal patterns of menstrual hygiene products. We also bring data on how personal and community-based beliefs, customs and taboos influence MHM outcomes and self-care regimes of our respondents.

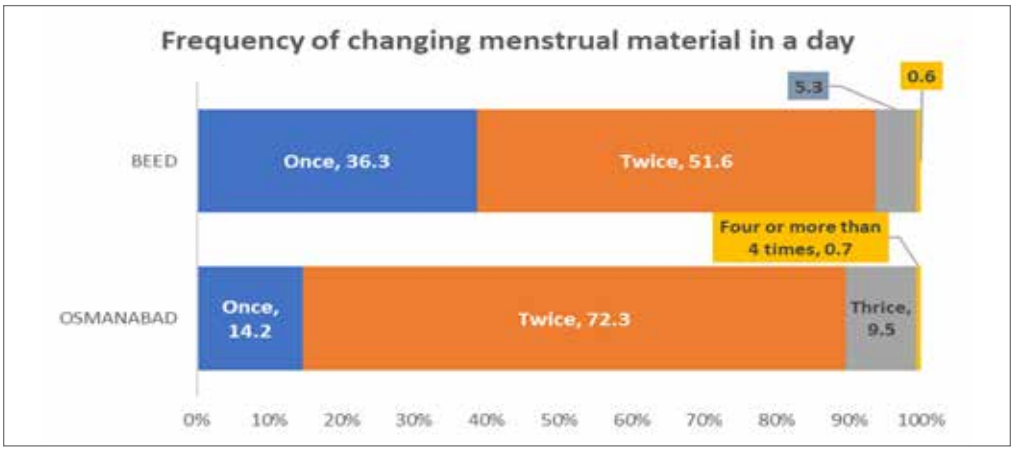
3.3.1 SANITARY PADS OR OTHER ABSORBENTS

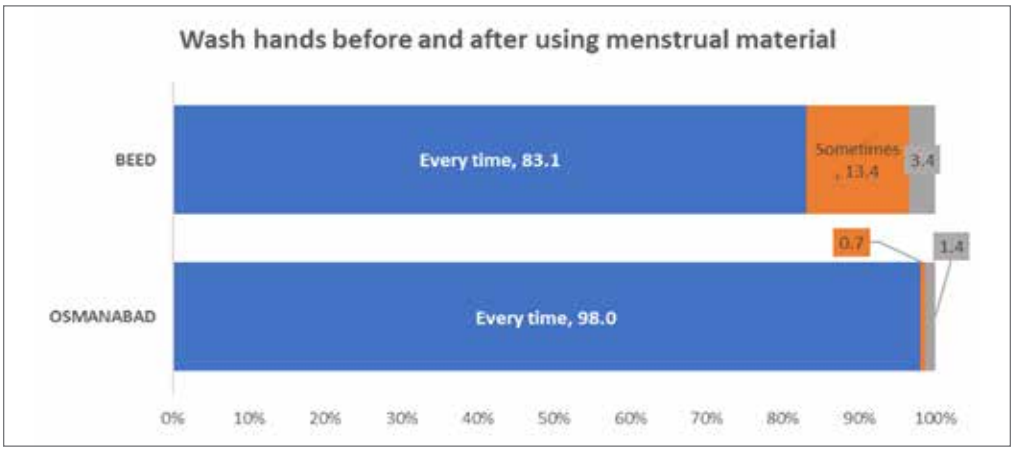
- **Cloth:** Out of the total EAMW interviewed from both districts, 30% women surveyed use only cloth during menstruation. because of its ready availability, affordability, durability as compared to other menstrual hygiene products. Being unable to decide whether to switch over to other forms of protection during periods, was the main reason for many women who continued the use of cloth.
- **Other Material**: 70.3% women (out of 320) from Beed and 66.2% women (out of 148) from Osmanabad use menstrual products other than cloth. 62.2% of women reported that they use sanitary pads in combination with cloth for saving costs.

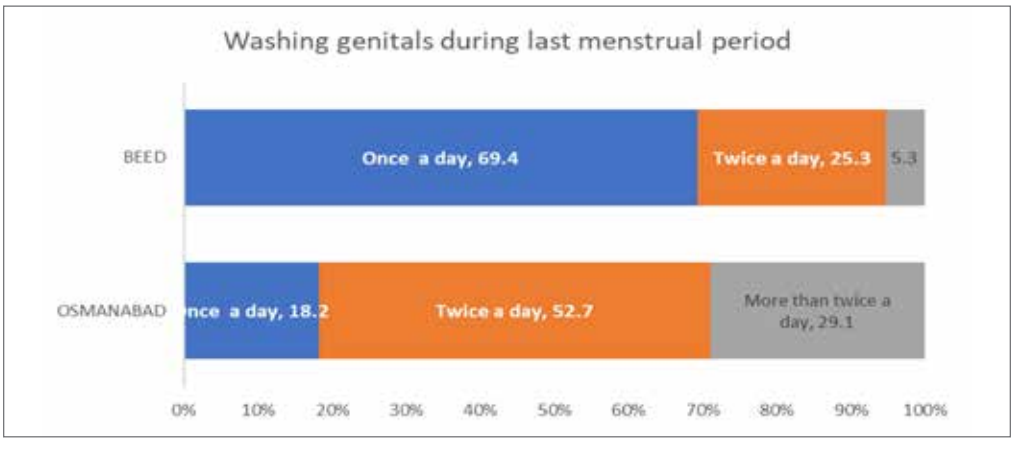
3.3.2 SPENDING CAPACITY ON MENSTRUAL HYGIENE PRODUCTS

Out of 468 menstruating women, 69% reported they used sanitary pads while 30.1% women used cloth. Though they said that they used sanitary pads, most used a pad in combination with cloth, as we found out. When asked about the reasons, they cited that cloth was easy to use, easily available, affordable, etc. Surprisingly, in Beed where menstrual awareness is lower than in Osmanabad, EAMW reported higher use of pads. Average spending capacity on menstrual products in Beed was merely 27 INR per month whereas in Osmanabad it was found to be 57 INR.

3.3.3 PERSONAL HYGIENE PRACTICES AND WASH DURING LAST MENSTRUAL CYCLE





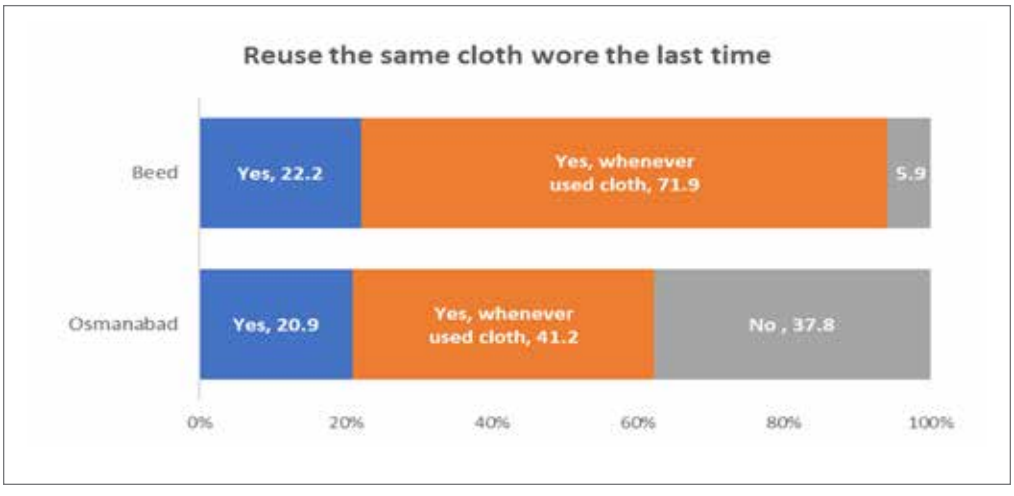


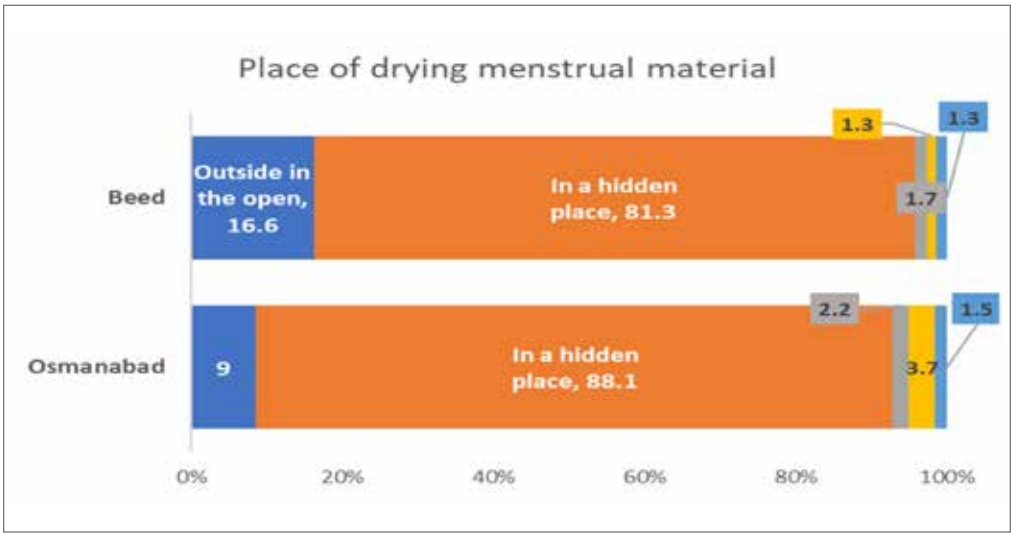
- **Frequency**: From both districts, around 87.4% of women responded that they change menstrual material twice or thrice a day.
- **Washing Hands:** 83.1% women from Beed reported that they wash their hands every time they use or change menstrual material. Hygiene practices were found to be better in Osmanabad where 98% of the interviewees wash hands every time they use/ change menstrual material.
- **Washing genitals during the last Menstrual Period:** From both districts, 87.2% of women wash their genitals twice a day during menstruation. 12.8 % wash more than twice a day, and out of those 67.9% use soap while washing. Use of soap to wash genitals was more frequent in Osmanabad than in Beed.

Our data indicates that more awareness towards MHM and WASH alongside provision of and access to proper WASH infrastructure and sanitation services is the most basic need for enabling EAMW and communities to take actions in the rural belts in Maharashtra where women agricultural labourers suffer adverse working conditions owing to menstruations.

3.3.4 MENSTRUAL HYGIENE PRACTICES

Safe hygiene practices consist of washing and timely changing menstrual absorbents as well as their proper disposal. This may vary with the absorbent type. Personal hygiene also depends on changing the absorbent during the day, keeping genitals clean, washing hands before and after changing the menstrual absorbent. The survey assessed all practices used to follow hygiene and management of material during menstruation.



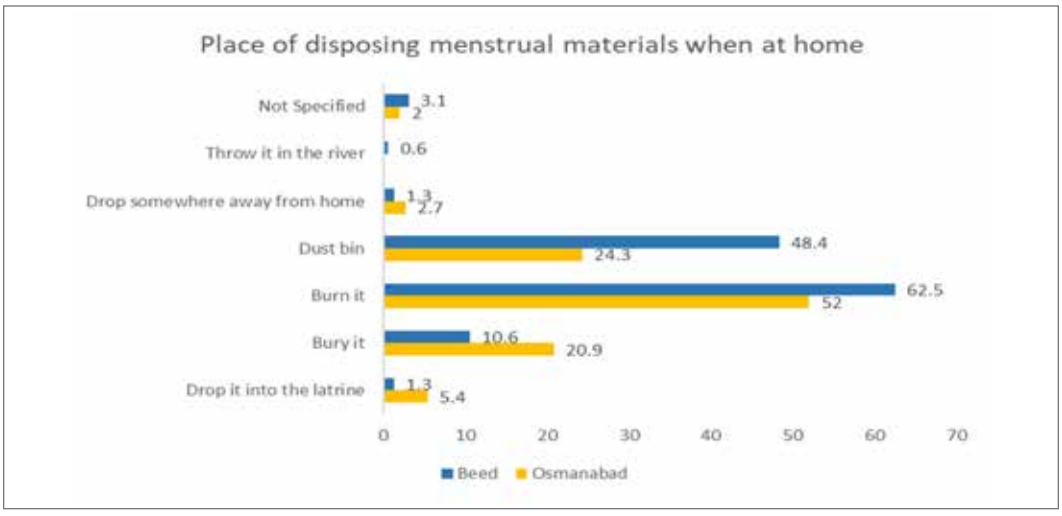


- **Reusing MHM Products:** In both the districts, nearly half of women claimed the use of clean cotton cloth during menstruation, out of which 62.2.% of women reuse the cloth.
- **Washing MHM Products:** According to our respondents, more than half of the women wash their menstrual material in the bathroom or toilet at homes in both the districts. Hence, 46.2% women wash their menstrual clothes outside the house, near hand pumps or a well.
- **Use soap every time:** 47% women from both the districts said that they use soap each time they wash their menstrual clothes.
- **Use soap sometimes:** Half the respondents from both the districts use soap only sometimes to wash menstrual clothes.
- **Drying MHM products**: While reusing cloth during menstruation, apart from washing, one also needs to follow the practice of drying the cloth properly in sunlight. 83.7% women in Maharashtra dry their menstrual clothes in hidden places but only half of the women ensure that their clothes are completely dry before using them.

3.3.5 AREA-SPECIFIC DISPOSAL MECHANISMS *

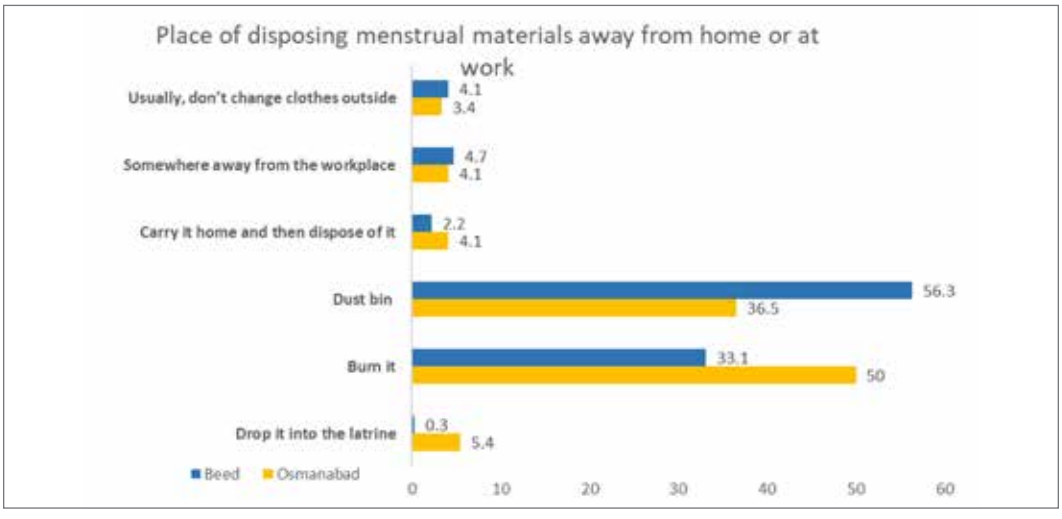
- **No specific Disposal Mechanism in place:** When asked about the system of disposal of menstrual waste material in their area, it was found that women have to manage problems at their own levels. The district does not have any disposal mechanism for menstrual waste nor monitoring mechanisms to follow -up and optimize implementation of hygienic practices.

Methods of disposal in Both the Districts: When at Home



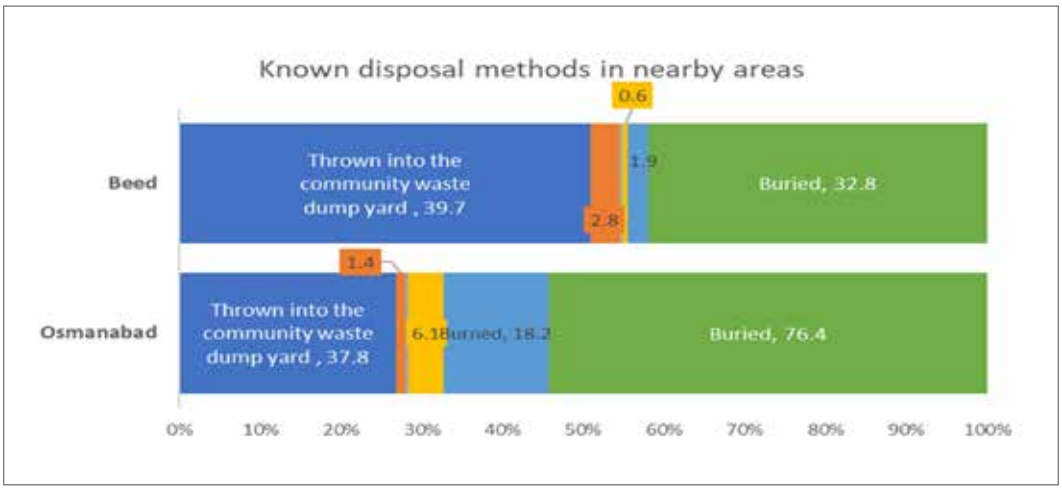
➲ **Top Practices:** When at home, most of the women from both the districts of Maharashtra either burn the used menstrual material or throw it in the dustbin.

Methods of disposal in Both the Districts: When away from Home



➲ **Top Practices:** More than half the respondents in Beed throw the menstrual waste in a dustbin when away from home whereas half the respondents in Osmanabad prefer to burn it.

3.3.6 KNOWN DISPOSAL METHODS IN THE COMMUNITY AS WELL AS NEARBY AREAS



- **Disposal practices by community:** According to our respondents from Beed, the used menstrual material is thrown into the community waste -dump yards by 121 women (n=320) in Beed whereas 105 women buried it in the village and nearby areas. In Osmanabad, 113 respondents (n=148) buried their menstrual waste followed by 46 women who threw it into community waste -dump yards.
- **Disposal of MHM Waste and WASH concerns**: 2.8% women from Beed throw their menstrual waste in the bushes whereas 6.1% women from Osmanabad throw it in the river bodies.

3.3.7 SOCIAL CUSTOMS, BELIEFS, MYTHS, AND TABOOS

The world of social customs, replete with its mandatory do's and don'ts in various communities represents their beliefs and mandates. Social customs, beliefs, myths and taboos contain overt and covert forms of barriers and enablers which influence MHM related practices as well as everyday experiences of menstruating women. In this respect we have quite similar findings from Maharashtra's Beed and Osmanabad districts, the same being presented below:

Customs followed by women in reference to menstruation: Beed District (in%)

Beed (351respondents)	Strongly agree	Agree	Disagree	strongly disagree
I am allowed to mix with others socially during my periods.	5.4	72.6	20.8	1.1
I am not allowed to attend any social rituals during my periods.	4.8	84.9	9.4	0.9
I do not go to religious places during periods.	4.0	84.6	9.7	1.7
I avoid traveling during periods.	4.0	84.0	10.8	1.1
I am told to stay in the corner of the house during my periods.	6.0	48.1	45.0	0.9
	Yes		No	
I am allowed to carry out routine work at home during my periods.	61.5		38.5	
I am allowed to cook in the kitchen during my periods.	25.1		74.9	
Others in my family take care of me during periods.	89.7		10.3	
I have freedom to visit a doctor in case of any health issue.	65.2		34.8	
I am allowed only special foods during periods.	25.9		74.1	
I sit for lunch and dinner with all my family members.t	78.1		21.9	

Customs followed by Women in reference to Menstruation: Osmanabad District (in%)

Osmanabad (226 respondents)	Strongly agree	Agree	Disagree	strongly disagree
I am allowed to mix with others socially during my periods.	34.1	52.2	9.7	4.0
I am not allowed to attend any social rituals during my periods.	33.6	58.0	6.2	2.2
I do not go to religious places during periods.	35.8	56.2	5.3	2.7

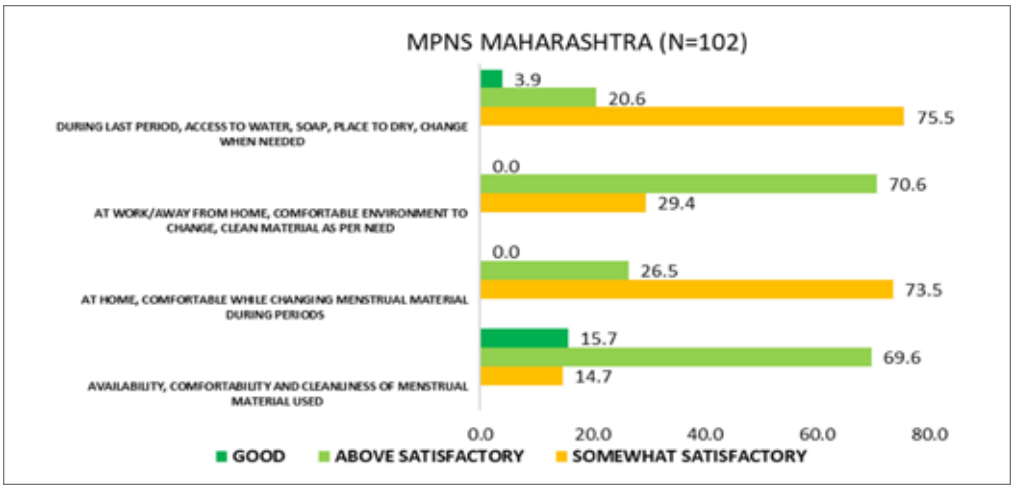
Osmanabad (226 respondents)	Strongly agree	Agree	Disagree	strongly disagree
I avoid traveling during periods.	35.8	57.5	4.0	2.7
I am told to stay in the corner of the house during my periods.	33.2	54.0	9.7	3.1
	Yes		No	
I am allowed to carry out routine work at home during my periods.	58.0		42.0	
I am allowed to cook in the kitchen during my periods.	52.7		47.3	
Others in my family take care of me during periods.	96.0		4.0	
I have freedom to visit a doctor in case of any health issue.	97.8		2.2	
I am allowed only special foods during periods.	36.7		63.3	
I sit for lunch and dinner with all family members.	98.7		1.3	

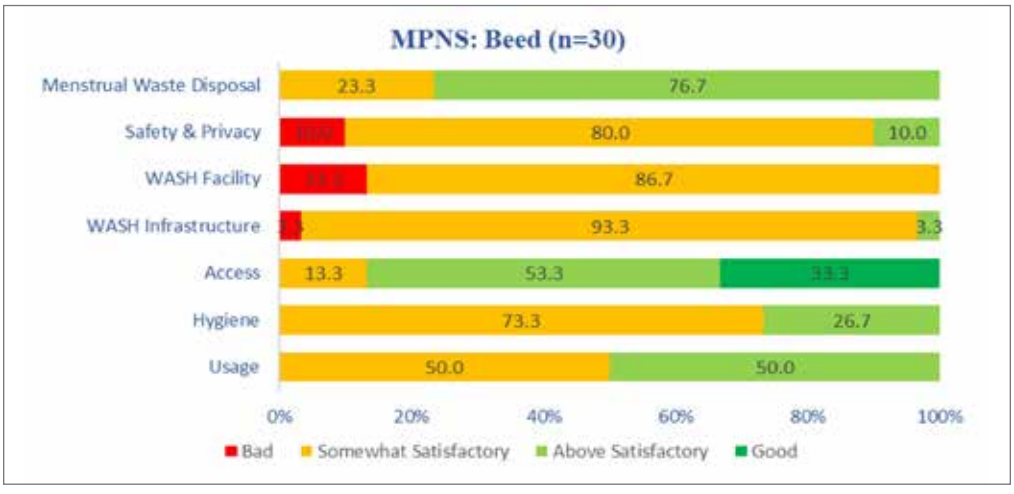
- **Socialise:** 522 EAMW from a total sample of 577 in both the districts, cannot attend religious occasions and ceremonies and are restricted from going to religious places. In Beed 33.6%. women faced restriction during periods whereas 58% women from Osmanabad were not allowed to socialize during their periods.
- **Seek Medical Advice:** One-third of the women in Beed informed us that they have the freedom to visit the doctor in case of a health issue whereas almost all the women in Osmanabad stated that they were free to consult doctors when the need be and customs do not impinge upon their medical freedom
- **Normal Routines and Family Care:** However, more than half the EAMW- survey participants across both the districts, claimed that during menstruation they carry on their routine lives at home. Additionally, almost 532 women from Beed and Osmanabad stated that their family members take care of them during periods.

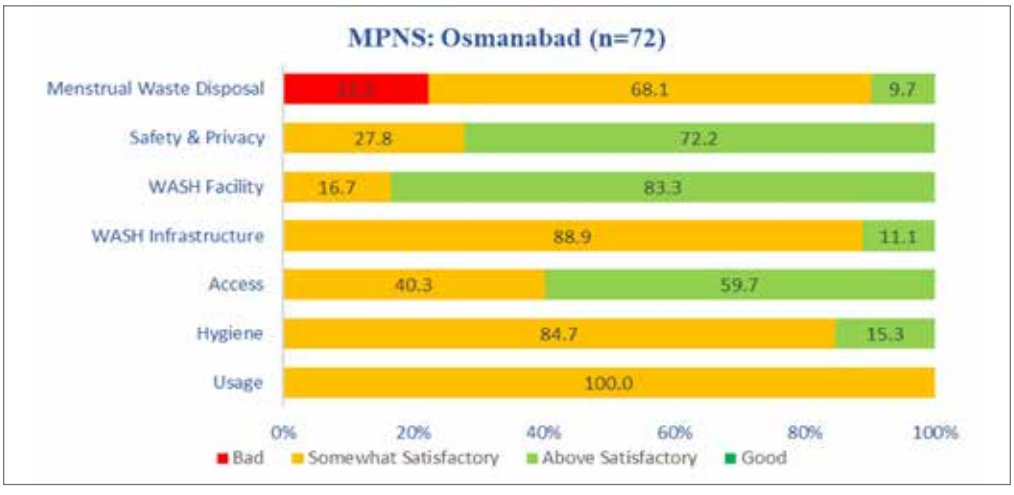
3.3.8 MENSTRUAL PRACTICE NEEDS SCALE (MPNS)

The MPNS was used to measure and assess the felt needs and experiences of women during their last menstrual period. 102 respondents from both the districts in Maharashtra shared their perceptions/experiences on availability of water, sanitation, hygiene, safety and privacy as well as access to menstrual absorbents. Through the use of MPNS, we were able to access the actual trends, practices and experiences w.r.t MHM, WASH, safety and privacy which form the 'menstrual everyday' of surveyed women in Beed and Osmanabad districts in Maharashtra:

- When measured on the MPNS, 30 women from Beed, reported that they have poor privacy. Women found the WASH facilities, WASH infrastructure poor to somewhat satisfactory. Nonetheless, access to menstrual material and menstrual waste disposal was rated at above satisfactory to good levels, which could probably be due to the practice of using cloth during periods.
- Assessed on the MPNS, 72 women from Osmanabad reported that access to menstrual material, usage of desired absorbents, hygiene and WASH infrastructure was at a poor to somewhat satisfactory level. Nonetheless, women rated privacy and WASH facilities at above satisfactory whereas half the women rated access to menstrual products at above satisfactory level.







3.4 MHM FROM AN INTER-SECTORAL PERSPECTIVE

Reading the everyday realities of a menstruating woman requires an inter-sectoral position because her life unfolds not just at home, but in community spaces, schools, farms, and workplaces during her periods. Moreover, a menstruating woman also negotiates various socio-economic and inter-sectoral circumstances such as WASH, public health facilities, migration and public policy. Hence, this part of our study examines vulnerabilities, issues, and risks pertaining to menstruation with respect to an inter-sectoral focus.

As villages selected from Beed and Osmanabad are seasonal migrant farmers dominated, we include various migration/ temporary relocation related aspects that impact women's health, MHM and wellbeing at various levels.

- Working conditions in relocation destinations, i.e., sugarcane farms, brick kilns, mining and manufacturing industries present a veritable grade of difficulty for women workers. From discriminatory wages, attitudes, exploitation to WASH facilities and leaves during periods, women farmers face unthoughtful contracts and provisions in place of work.
- Access to PDS centers, food security and continuation of basic education of their children are perpetual struggles in the life of migrant families.
- Besides, women are not proactively aware of their rights, entitlements, and privileges as workers because the seasonal work that migrants engage in belongs to the unorganized sector.

Against this background, we present a brief inter-sectoral analysis on migration and MHM, WASH and MHM, Education and MHM and lastly, MHM from the perspective of awareness towards public policies. The overall narrative of different practices on MHM in these villages related to community-based vulnerabilities, socio-economic conditions and beliefs including monetary freedom or disposable income of women besides health and education related inter-sectoral factors.

3.4.1 MIGRATION AND HEALTH

Beed and Osmanabad are known for generations of migrant labour families engaged in seasonal work for almost six months of the year. However, the work being incidental, the migrant women could not specify any set duration. Seasonal migration work is usually short-term, done for elite farmers needing large scale sugarcane cutting or for private enterprises involved in brick kilns, mining, and manufacturing. In either of the cases, this kind of work is high-risk, hazardous and involves rigorous farm labour with a bare minimal availability of basic amenities, essential life-line services and social security. Owing to the nature of their work and exploitative labour conditions, migrant families remain heavily dependent upon external support and wellbeing measures, including free pads and medical care for MHM for instance.

- Across the districts of Beed and Osmanabad, one in three women surveyed (n=577) migrate for work with their families.
- Of the 82 migrant families from Beed, 41 are engaged in seasonal farm labour. In the case of Osmanabad, 105 families migrate for work and 66 out of these rely on seasonal farm labour.
- Out of 187 total migrants from both the districts, 71 migrate to sugarcane cutting sites. Another 106 migrated as daily wage labourers for agricultural work and remaining (ten) migrant families were engaged in brick-kilns, mining, and manufacturing work.
- Our findings indicate that 177 out of the 187 migrant women strongly feel that their seasonal work conditions and resource scarcity influences their menstrual health negatively.

Seasonal migration work pertains to the unorganized sector. Oftentimes such work bases itself in completely unfair labour contracts and harsh working conditions without respite, relief, or empathy for menstruating women in the prime of their lives. Consequently both, these women and their partners (who usually work as a team) are subjected to undue monetary penalties and wage deductions for leaves against adverse menstrual health and symptoms. Complications in intimate health during and after menstruation are not uncommon given the shabby MHM prospects on farms and factories or other places of work in the unorganized sectors. If women take leaves, they suffer grave financial losses as a family and also, seldom have any recourse whatsoever to get themselves treated for upkeep of their menstrual health.

3.4.2 TRADITIONAL SKILLS AND EARNING CAPACITY

Across our sample, 43 women out of 351 from Beed and 54 women out of 226 from Osmanabad possess traditional skills like art, craft, farming, tailoring, etc. Out of these, 37 from Beed and 11 from Osmanabad earn from the skills they possess and practice.

Given that there is a possibility of augmenting family income from traditional knowledge and customary skills, vocational courses and micro-financing can be organized for women struggling with socio-economic vulnerabilities to enhance their means of livelihood and disposable income. A disposable income can give women better opportunities towards an empowered decision-making w.r.t MHM as well as personal and medical care. Our survey findings indicate a good level of education among the EAMW, whom we surveyed. Therefore, these women can be willing and knowledgeable participants in endeavors that try to hone their skills and talents through formal training and internships to expand their scope of employment. Likewise, the EAMW, especially with good levels of education can be targeted and operationalized through ongoing SHGs schemes in Maharashtra (refer to part 4.4).

3.4.3 WASH AND MHM

According to the NFHS-5 Report, 66.4% and 71.2% of households from Beed and Osmanabad, respectively, use an improved sanitation facility (International Institute for Population Sciences and ICF 2020, p. 39, 141).

WASH & MHM	Beed (in %)	Osmanabad (in %)
Total Respondents	**351**	**226**
Water Facility at Home		
Bore well/ Tube well/ Well covered	9.1	1.3
Hand pump/ Standpipe	0.3	4.9
Piped water/ Piped to yard/ Plot/ Public tap	90.3	93.8
Tanker/Truck / Cart with small tank	0.3	0.0
Toilet Facility at Home		
Individual household latrine	94.6	76.5
Community toilets	2.0	11.9
Open defecation	3.4	11.5
Type of House		
Kutcha	65.0	64.2
Pucca	20.8	2.7
Semi pucca	14.2	33.2

- **Kind of House:** In both Beed and Osmanabad 373 of our respondents (n=577) lived in Kutcha houses (roof, wall, and floor all made up with kutcha material). 73 of our respondents (n=351) from Beed live in pucca houses (roof, wall, and floor all are made up of pucca material) as compared to only six (n= 226) from Osmanabad who can afford pucca houses. However, 50 women in Beed and 75 in Osmanabad live in semi-pucca houses (either 1 or 2 from roof, wall and floor is made up of kutcha/ makeshift materials).
- **Compromised Toilet Facilities:** Pucca houses can have toilets built within as opposed to Kutcha houses where such a provision is not possible. Though toilets were constructed under Swachcha Bharat Abhiyan,

open defecation is practiced by 6.6% people surveyed in both the districts, though in Osmanabad it is higher than in Beed. Majority of the people, despite living in kutcha houses, use Individual Household Latrines (IHHLs). It is noteworthy that out of our sample (N=577), 187 families go away from Beed and Osmanabad for around six months of seasonal labour and encounter compromised toilet facilities in the relocated areas unlike in their areas of origin.

- **Sanitation and Access Challenges:** One of the main everyday challenges for migrant families of Beed and Osmanabad emerged to be compromised access to water facilities and proper sanitation. 529 women (91.7%) from both the districts reported piped water as being their primary water source. However, Beed and Osmanabad fall under rain-fed areas. During drought and drought-like situations, these districts face acute water scarcity making villages supply potable water through tankers. In such circumstances, women face additional hardships for MHM and WASH purposes.

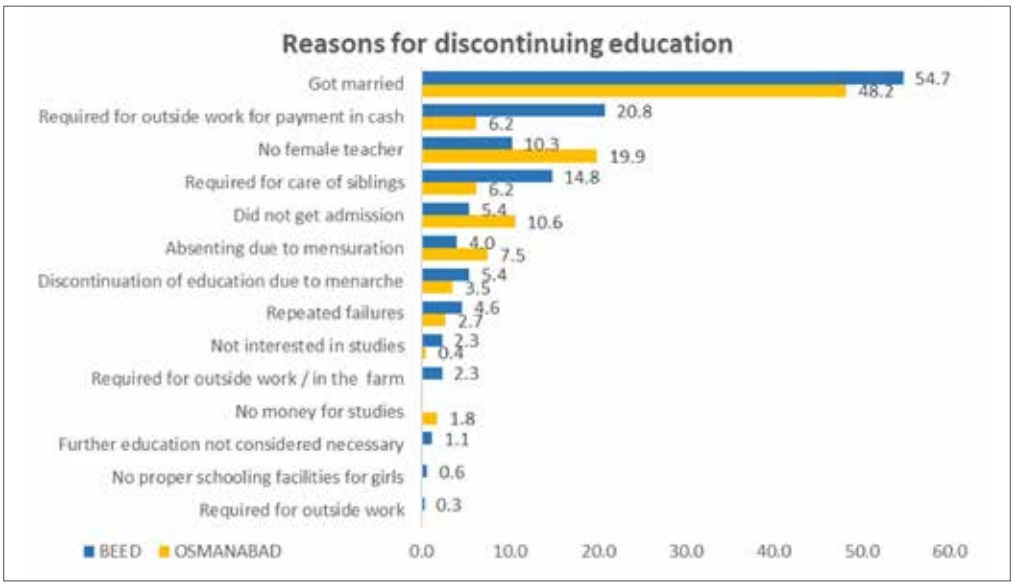
It is clear that during menstruation a woman's WASH needs are relatively higher as compared to the rest of the days of the month. When a woman experiences her periods, she needs more water to clean herself for personal and intimate hygiene, including after defecation. Besides, a regular supply of clean water, ensuring that a woman has the facility of a private and secure place to change her menstrual absorbents and clean herself are a profound part of her sense of dignity and safety. Therefore, the access to the toilet and bathroom become a critical need during periods. In Beed and Osmanabad, despite a low rate of open defecation and a good amount of IHHLs during periods of water scarcities and droughts, MHM and WASH practices of women get extremely impacted.

3.4.4 EDUCATION AND MHM

Compared to some other states included in our study, literacy rate in Maharashtra was found to be better in both the districts surveyed. Our survey participants in Beed had a higher education rate than in Osmanabad. 92 of our respondents (n=351) from Beed were educated above the 10th standard whereas only 33 (n=226) from Osmanabad went beyond matriculation. Out of the total 577 women respondents from both the districts, 130 were mainly school pass- outs and enrolled in graduate or postgraduate studies. Interestingly, in Beed where there is a higher rate of education among women, our survey found out that women were also able to capitalize on their traditional skill-sets.

Education and MHM	Beed (in %)	Osmanabad (in %)
Total Respondents	**351**	**226**
Education		
No education	8.3	17.3
Primary (1st -4th)	8.0	30.1
Secondary (5th-7th)	24.2	16.4
Higher secondary (8th-10th)	33.3	21.7
12th/ Undergraduate	19.7	14.2
Graduate and above	6.6	0.4

Reasons for Discontinuing Education		
Lack of Facilities	15.4	8.0
Monetary Barriers	35.3	33.6
Family Barriers	61.3	58.8
Educational Barriers	14.5	6.6



*Multiple Choice Question

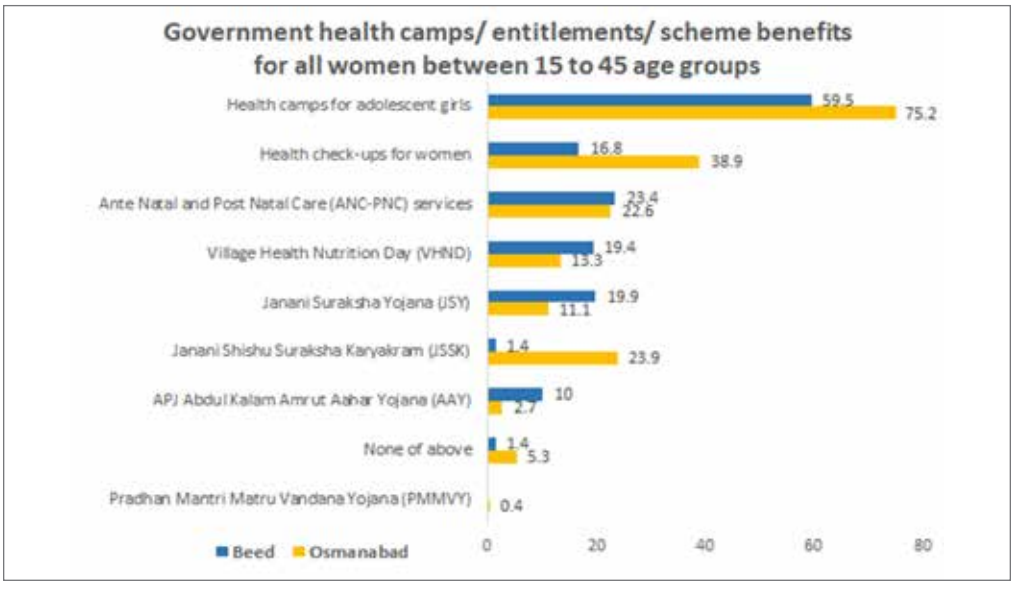
When we tried to find reasons for the discontinuance of education, the main reasons in both the districts were centered around family related and monetary barriers.

- **Socio-Economic Bottlenecks**: 97 of our total respondents (n=577) across both the districts opted out of education because there are no female teachers in schools and families disapprove of girls being taught by male teachers only. Pressures for getting married and augmenting family income were main barriers leading to educational discontinuity. To enhance family income, women were also required to work on their farms or outside of home for wage-labour which compromised their educational journeys. In many cases, families opt for early marriages of their daughters as a coping mechanism to deal with extreme poverty, indebtedness and avoid prospects of a bleak future in the parental home. Family-based barriers such as engagement in housework or taking care of siblings and further education not considered a priority influenced the rate of education amongst adolescent girls/ women.
- **Menarche and Marriage:** Menstruation is a major criterion for some parents and families to lay restrictions on the movement of a girl outside of home, including a preference that adolescents drop out from school altogether. Among those girls who do continue their schooling, being absent from school due to MHM related issues including physical symptoms such as pain etc. leads to interruption in education during post -menarche years. Community beliefs such as a girl being 'ready for adulthood' in early post-menarche years leads to pressure on the family to marry her off. In Beed and Osmanabad, 51 women (N= 577) had dropped out of school due to menarche and menstruation related reasons while in both the districts, early marriage emerged as a prominent barrier to education. 301 women out of a total of 577 EAMW surveyed got married at an early age.
- **Individual Reasons:** Other reasons that impede education emerged as repeated failures that were cited by 20 respondents and lack of interest in education which was quoted by another 6 women interviewed (n=577) in both the districts.

3.4.5 AWARENESS TOWARDS PUBLIC POLICY AND COUNSELING ON MHM

When it was asked whether they get accessible and affordable treatment from government health facilities, out of a total of 577 women surveyed, 511 responded positively. Merely 15 women from both the districts reported that they do not avail treatment from public health facilities. In general, the situation availing Government health services was found to be better in Maharashtra than in any other state.

- **Public Policy:** National Health Mission runs various programs for the age group of 15 to 45 years, i.e., for adolescent girls as well as women. Most women in both the districts are aware of public policy.
- **Local health Services:** From the survey, 59.5% of women from Beed and 75.2% of women from Osmanabad receive health check-ups at the local level in the village or at the Sub- Center level followed by Ante- Natal and Postnatal services.
- **Engagement with Public Health services**: 290 of our respondents from Beed and 204 from Osmanabad said that they have availed the benefits from Government health entitlements and schemes at different stages of life. In Beed, 82 women and in Osmanabad 51 women had received Ante-Natal Care and Post-natal Care (ANC-PNC)-related benefits such as maternal and child health, including health checkups for women and lactating mothers. Village Health Nutrition Day (VHND) scheme was availed by 68 women from Beed and 33 from Osmanabad.



*Multiple Choice Question

- **Significance of Public Health Facilities:** Public Health facilities usually play an important role in providing free and affordable treatment. Health support systems in India are designed such that for every 1000 population there is ASHA appointed, for around 5 to 6 villages, there is a Sub- Centre where treatment for small illnesses as well as 24/7 facility of delivery is available. After that, for every 30000 people, there is a Primary Health Centre (PHC). And as we move further, Rural or Sub-District hospitals, district hospitals in urban areas, municipal corporation health clinics, and hospitals are available.
- **Accessibility and choice:** EAMW covered in this survey were asked through IDIs about the nearest accessible public health facilities where they could get treatments or consult for other health issues. Sub Centre (75.2%) followed by Rural hospitals (12%) were the nearest public health facilities reported by women in Beed. Whereas, 35.8% of women in Osmanabad reported their nearest options being Sub-Centers followed by Rural Hospitals (32.7%) and PHCs (20.8%).
- **Importance of Health Camps**: Women across various contexts are differently integrated with the national public health infrastructure and policies. Health camps, which are periodically organized in villages, are specifically important and needed in areas which are remote and cut-off or where Sub-centers are not available. All EAMW in Maharashtra reported that health camps for adolescent girls are helpful. In fact,

Health Camps for adolescent girls emerged as the most availed service wherein 209 women (n=351) from Beed and 170 (n=226) from Osmanabad reported having participated in (during their youth) and benefited from health camps for adolescents. If health camps start covering the wellbeing of EAMW in remote and isolated areas, women will stand to benefit from many health based objectives and parameters of the Indian government.

Our survey revealed that women are well familiar with the local state services they get from the public health system. The proportion of women covered under schemes such as Janani Suraksha Yojana (JSY), Pradhan Mantri Matru Vandana Yojana (PMMVY) and Janani Shishu Suraksha Karyakram (JSSK), however varies in both the districts and remains towards the lower side. However, once/ if they become familiar with the schemes, women tend to become reliant on these benefits because of their socio-economic marginalisation as well as remote existences.

COUNSELING ON MHM:

Upon being asked if they ever received any counseling on menstrual health, 87.2% of our interviewees from Beed and Osmanabad responded in the affirmative. Counseling on MHM was received from health workers such as ASHA, ANM and AWW.

Received counseling on Menstrual Hygiene from health workers	Beed (in %)	Osmanabad (in %)
Total Respondents	**351**	**226**
No	9.7	17.4
Yes	90.3	82.6

Yes: Upon being asked if they ever received any counseling on menstrual health, 87.2% EAMW responded in the affirmative. Counseling on MHM was received from health workers such as ASHA, ANM and AWW. Out of the total respondents, 90.3% EAMW from Beed (n=351) and 82.6% from Osmanabad (n=226) reported that they seek counseling, guidance, and treatment on health issues from the public healthcare facilities

No: In Maharashtra 74 women, out of a total of 577 had never received counseling on menstruation or MHM in their villages.

Menstrual health of women beyond school years is still a long way from being actively considered as a public policy measure in India. Owing to the vast reach and significance of, as well as a substantial reliance on Public Health system in India, the MHM of EAMW can get a much required boost if the issue receives adequate attention through public policy. Even the ADP can stand to gain women's participation if MHM is piloted as an inter-sectoral intervention cutting across education, social security, WASH and livelihood.

4. VOICES, EXCERPTS AND OBSERVATIONS

As part of our research, we conducted approximately twelve open -ended interviews with key informants. These KIIs were taken across each district, not necessarily restricting ourselves to voices of people from villages included in our field research. People interviewed during this exercise were important stakeholders in communities/villages such as AWWs, ANM, Doctors, Teachers, ASHAs, Counselors and social workers etc. The voices of these stakeholders are critical for the development of the community as they give a unique point of view on the local village population as well as district-wide situations. In a small but significant way,

these grassroots voices help us arrive at community-sensitive and area-specific recommendations and ways forward. Highlights from these interviews are as follows:

Beed (Data derived from 5 villages of the district): In Beed, five respondents across five villages stated that communities suffer gross water scarcity. Two respondents spoke about the dearth of awareness efforts on MHM amongst the EAMW in the villages. Four respondents confirmed that taboos related to menstruation in the village are widely prevalent.

Osmanabad (Data derived from 5 villages of the district): In Osmanabad two respondents across five villages apprised us on the issue of water scarcity faced by them, two others added that their villages suffer acute water shortages. Lastly, key informants apprised us that no awareness generation initiatives are run for EAMW. in the wake of which the districts witness ample taboos around menstruation

4.1 VOICES, EXCERPTS AND OBSERVATIONS OF RESPONDENTS: BEED

Our respondents from the field have shared their experiences, conceptions and observations on MHM. Below are some voices and excerpts from our interactions with them.

Sunita (Interview: 24.08.2022)[2] , an **ASHA** worker from a village in Beed district of Maharashtra stated sanitary pads are distributed at subsidized rates for girls aged between 10 yrs-19 yrs, *Matritwa Yojana* and *Janani Suraksha Yojana* for 20-49 age women. Moreover, counseling sessions are given to adolescent girls with SHGs under *Rashtriya Kishori Suraksha Karyakaram* (RKSK). She further said there is a need to educate women about the importance of menstrual hygiene and sensitize them about the risk and kinds of diseases and / or infections that occur if hygiene is compromised. On WASH in her village and the school therein, the ASHA worker informed that people use water filters and *fitkari* (alum) to clean water. A makeshift sewer, a kind of a *gadda* (deep pit) for waste water accumulation in the village has been dug but no proper sewage facility is given. A sanitary pad disposal machine exists in the village school. Myths and taboos in her area disallow women to visit/ enter religious places.

Rekha (Interview: 24.08.2022)[3], who is a **CRPF** officer in a village in Beed district of Maharashtra confirmed that sanitary pads were distributed at a subsidized rate. Moreover, her village had an awareness program to teach women about using pads during menstruation under the RKSK scheme. On WASH needs in village and school she added that villagers use filters and alum to clean the drinking water, there is a deep pit or a 'gadda', for waste water in the village. From her account, it was not clear if women's WASH needs stand fulfilled throughout the year. Taboos regarding menstruation in the village such as isolation practices within the house and women neither being allowed to cook for daily or ritualistic food nor being allowed to enter religious places were common occurrences according to Rekha.

Kusum (Interview: 24.08.2022)[4], an **ASHA** worker in the village of Beed district in Maharashtra responded that there is an SMD programme for adolescent girls as well as an awareness programme to sensitize women about menstrual hygiene under the RKSK scheme. She stated that villagers use filters and alum to clean water. The school in the village had a functional sewage system. She expressed concerns on the urgency to educate women on menstrual hygiene. On taboos, she added women in her village were not allowed to enter religious places or touch anything religious. Women are segregated and isolated during menstruation. However, she added women would feel better if they do not isolate themselves during menstruation.

Morale (Interview: 28.08.2022)[5], a **Health Worker** in a village in Beed district of Maharashtra stated that there is distribution of sanitary pads to adolescent girls in the village, and regular health check-ups for women aged 20-49. Moreover, public health centers trained women about menstrual hygiene through posters and charts. Under *Rashtriya Kishori Suraksha Karyakaram* (RKSK) there was regular Hemoglobin test for girls and free

[2] MH KII1 BD: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[3] MH KII2 BD: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[4] MH KII3 BD: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[5] MH KII4 BD: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

distribution of oxifolid tablets. On WASH needs in school and community she explained, every school had water facility, girls were taught about using pads during menstruation, schools also had pads dispose machines. Moreover, schools were asked to allocate a separate room for pad changing. On taboos she added that girls were being isolated in dark rooms during menstruation, and not allowed to go to school till 4 days.

Alka (Interview: 22.07.2022)[6], a **Social Worker** from a village in Beed district of Maharashtra confirmed that there is free distribution of sanitary pads, iron, and folic acid tablets to women in the village. On WASH needs she explained there is an installation of a water filter by Gram panchayat in the village and their school also had a water (filter) and toilet facility. She added the need to educate women about cleanliness and using sanitary pads during menstruation was an urgent necessity. On taboos, Alka stated women were not allowed to enter temples and had to isolate themselves during menstruation. Alka thinks that customs such as four-days segregation for menstruating women, eating healthy food, and not lifting weight form good practices from a local MHM perspective.

4.2 VOICES, EXCERPTS AND OBSERVATIONS OF RESPONDENTS: OSMANABAD

Our respondents from the field have shared their experiences, conceptions and observations on MHM. Below are some voices and excerpts from our interactions with them.

Manisha (Interview: 23.08.2022)[7] , an **An Anganwadi worker** in a village in Osmanabad district of Maharashtra added that there is a health camp in village's Anganwadi to educate women about using pads during menstruation under RKSK scheme. For women between 20-49 years of age, proper toilets, adequate water supply and purity, proper awareness about menstruation in the village were basic requirements. She further added that their village and school therein had adequate water facility, but from her account it was not clear if women's WASH needs were fulfilled throughout the year. On taboos regarding menstruation she added, women were not allowed to do household work, remained isolated and were treated as if they were guilty of a sin or crime, which 'does no good to women's mental health'.

Kanchan (Interview: 28.08.2022)[8] who is an **ASHA worker** in a village in Osmanabad district of Maharashtra stated that there is a health camp to educate girls about menstruation hygiene in the village. She further added that the village needed a toilet, water facility, and an awareness program for 20-49 age women in the village. On WASH needs in the village and school she explained that the village had adequate water facility and a pad disposal machine. The school also had a water supply and a toilet but improvements were needed. About specific requirements regarding MH, she added, "everything is going well here but there is a need to educate people about menstruation." She added there were some taboos in the village such as isolating menstruating women and prohibiting them to see images of God or doing household work. In general, menstruating women are behaved badly with, treated almost as if guilty of something and face high discrimination which is not good for their 'psyche'.

4.3 SALIENT FINDINGS FROM DATA

Processing through our data from Beed and Osmanabad, we have gained some valuable insights on women's health, education, livelihood and overall community outlook on menstrual health management needs and transformations on ground.

In Maharashtra, our findings indicate that menstruating girls and women are taken care of by other family members. The EAMW understands the phenomenon of menstruation with a biological clarity. Nonetheless, social, interpersonal and inter-sectoral factors can present various context-specific challenges and ironies in the way of effective menstrual wellbeing in Beed and Osmanabad.

In Beed, although no awareness generation programmes are run by the government targeting EAMW, majority

[6] MH KII6 BD: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[7] MH KII1 OD: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[8] MH KII2 OD: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

of our respondents seem to have adequate knowledge on menstruation while in Osmanabad almost all women are aware of the causes of menstruations, its intervals and internal body parts involved in it. What is however surprising is that despite so much knowledge on menstruation, women remain out of sync with their well-being requirements in places of work be it farms, mines or manufacturing units. At home, their situation is equally distressing as the EAMW follow myths and taboos in large numbers.

Our key informants noted that during menstruation a woman was segregated, isolated as well as discriminated against as if she were guilty of a crime. This explains the silence or hushed (mis) conceptions on the relevance of 'uterus' post-childbirth, and the high prevalence of elective hysterectomies in districts such as Beed and Osmanabad. Young girls hardly get the benefit of informed elder women, who know the scientific causes of menstruation, as in many villages under this research menstruating adolescents were confined to dark rooms for four days and not allowed to go to school.

One of the main everyday challenges for migrant families of Beed and Osmanabad emerged to be compromised access to water facilities and proper sanitation. More than 90% of women from both the districts reported piped water as being their primary water source. However, Beed and Osmanabad fall under rain-fed areas. During drought and drought-like situations, these districts face acute water scarcity making villages supply potable water through tankers. In such circumstances, despite having a high level of knowledge on menstruation, in the context of MHM, women continue to face hardships for MHM and WASH purposes.

From our interactions and databases pertaining to Maharashtra, it clearly emerges that apart from a silence on women's menstrual health in terms of inter-sectoral hindrances and policy related negligence in India, there are community-voices that portray a negative and discriminatory attitude towards periods. These discriminatory voices and attitudes in Maharashtra, just as our research from some other parts of India shows, pertain to both men and women across social strata. Many EAMW as well as key informants endorse negative attitudes (as told to our surveyors and field-researchers) towards menstruation, either owing to the circumstantial difficulties that they grow up experiencing or for want of better knowledge and support system around the phenomenon. Inadvertently or otherwise, such voices contribute to the perpetuation of a debilitating discourse on the phenomenon. The key to combating the inter-sectoral and community -based silences and barriers on MHM among women beyond school years lies in augmenting positive practices and discourses on menstruation. One of the best ways to achieve this is by involving multiple actors, key and critical stakeholders such as EAMW, leaders, influencers, families, policy makers and implementers. Hence, gender mainstreaming MHM can ensure gender perspectives and attention to the goal of gender equality in all actions, projects and programmes.

4.4 RECOMMENDATIONS/ AREAS OF IMPROVEMENT

IMMEDIATE

1. **Empower EAMW on MHM themes:** According to our findings, discrimination, segregation as well as isolation and judgmental attitude from family and community creates a mental health burden for women and girls in their menstruating years. Hence social support systems, counseling to create public awareness on social-biological knowledge around menstruation can bring relief and ease the myths, taboos and pressures around menstruation. Hence, we suggest more awareness drives on menstruation, with a special focus on EAMW in the age group of 20 to 49 years. Monthly or three-monthly compulsory and inclusive health check-ups be organized for EAMW.
2. **Early MHM Interventions:** Since young menstruating girls are not allowed to go to school for four to five days during menstruation, teachers and school counselors, social workers and Frontline Workers (FLWs) themselves need to be oriented, attain voice as well as be motivated to: a) collaborate with each-other as well as jointly raise awareness among community elders and village households; b) proactively ensure

that school sanitation facilities are monitored regularly c) help raise awareness for adolescent girls for a better MHM at home and in schools such that her education be uninterrupted and menstruation is not (seen as) a hurdle in the way of going to school.

3. **Pad distribution schemes and disposal mechanisms** need to be facilitated, regularized, monitored, and revised (as need be) for sustained use as well as orientation and empowerment of women.

SHORT TERM

4. **Sanitation Facilities for Migrant families at relocated sites:** Better hygiene as well as sanitation management is required so that MHM can be given a real and regular opportunity in day –to –day life in villages as well as in areas to which migrant workers relocate. Organized shelter and settlements with provision of safe drinking water along with low cost two pit latrines could be built for the migrant workers at relocated areas along with addressing their WASH and menstrual needs.
5. **Micro- Credit facilities to MAVIM SHGs**: Women Self Help Groups (SHGs) formed under Mahila Arthik Vikas Mahamandal (MAVIM) are active in Beed and Osmanabad. Providing credit facilities to EAMW through MAVIM and other government supported credit schemes could enhance the earning capacities and therefore create a pool of disposable income whereby menstruating women can become active decision makers in self-care.

LONG TERM

6. **Maharashtra MHM Committee**: A State level Menstrual Health and Wellbeing Committee be initiated to integrate remote places, mountainous regions etc. into the state and national ADP and MHM plans.
7. **MHM at District, Block, Gram Panchayat Level**: Information, Education, and Communication (IEC) for menstrual hygiene education and awareness that includes information around safe menstrual hygiene products; and menstrual waste management with safe disposal facilities.
8. **Inter- Districts Coordination:** To ensure the health and MHM wellbeing of EAMW, the districts may develop communication, dissemination as well as monitoring mechanisms between administrative authorities in areas of origin and destination of migrants' families. This would ensure appropriate mapping of migrants and disbursement of entitlements to EAMW as well as their children.
9. **Gender Mainstreaming Provisions for EAMW**: Build capacities and knowledge of women from poor, marginalized households to make the migrating families aware of their entitlements in the unorganized sector related to seasonal agricultural and wage labour work. For instance, enablers such as, provision of rationing through Public Distribution System (PDS) in areas where migrants temporarily relocate; continuation of education/ schooling of migrant children in areas where parents migrate for seasonal labour; health camps for general medical check-ups; a special focus on EAMW because women labourers from the sugarcane farming belt suffer various atrocities w.r.t menstruation and uterine health - should all be part of the support systems around migrant labour.
10. **MHM at Family level:** Ensure sustainable water source (preferably gravity schemes as per viability that are low on operations and maintenance) along with source strengthening measures and provision of Functional Household Tap Connections (FHTCs) to all households under National Jal Jeevan Mission scheme.
11. **Jal Jeevan Mission (JJM) for Institutions and MHM:** Institutional water supply under JJM scheme to ensure supply of adequate running water in girl's toilets in schools.
12. **MHM friendly Toilets:** Ensure provisioning of community toilets as well as toilets in work areas with washing areas, bathing cubicles, and running water under SBM(G) phase II where needed.

REFERENCES

Berry, Vyomica. (2022) Women in Beed district of Maharashtra are getting their wombs removed. *Wion Media*, 30 May. Available from https://www.wionews.com/india-news/women-in-beed-district-of-maharashtra-are-getting-their-wombs-removed-483426 [accessed 20 January 2023]

Census of India (2011) *District Census Handbook BID,* Directorate of Census Operations Maharashtra, 8-9 [accessed 15 January 2023]

Census of India (2011) *District Census Handbook Osmanabad,* Directorate of Census Operations Maharashtra, 11-12 [accessed 15 January 2023]

Chadha, Naymat. (2019). *Constructing the Female Labouring Body: A Case Study of Beed District of Maharashtra,* Social and Political Research Foundation, 6-7 Available from https://sprf.in/wp-content/uploads/2021/01/Constructing-the-Female-Labouring-Body.pdf [accessed 16 January 2023]

Economic Survey of Maharashtra 2021-22, Directorate of Economics and Statistics, Planning Department, Government of Maharashtra. Available from http://mls.org.in/pdf2022/budget/ESM_2021_22/Economic%20Survey%20of%20%20Maharashtra%202021-22.pdf [accessed 07 January2023]

International Institute for Population Sciences (IIPS) and ICF. 2020. National Family Health Survey (NFHS)-5, State and District Factsheets, Maharashtra. Mumbai: IIPS. p 39 & 141. Available from http://rchiips.org/nfhs/NFHS-5_FCTS/COMPENDIUM/Maharashtra.pdf [accessed 16 January 2023]

Kurtkoti,Vinaya. Gunwati, Paraste. (2019). In India's Richest State, Drought, Farm Crisis Arrive Early. *IndiaSpend,* April 29 2019 Available from www.indiaspend.com/in-indias-richest-state-drought-farm-crisis-arrive-early [accessed 15 January 2023]

Munjal,Diksha. Sodhi, Tanishka. (2021) Covid has pushed seasonal sugarcane cutters in Maharashtra's Beed to the brink of poverty. NewsLaundry, 14 June. Available from https://www.newslaundry.com/2021/06/14/covid-has-pushed-seasonal-sugarcane-cutters-in-maharashtras-beed-to-the-brink-of-poverty [accessed 20 January 2023]

Niti Aayog, Government of India (2018) *DEEP DIVE Insights from Champions of Change The Aspirational District Dashboard.* Available from https://smartnet.niua.org/sites/default/files/resources/firstdeltaranking-of-aspirational-districts.pdf [accessed 08 january 2023]

Shukla, Abhay. Kulkarni, Seema. (2019). "Harvest of Uteruses." Economic and political weekly, 54 (39) 10-13. [accessed 20 January 2023]

Tripathi, Vishal. (2020) How the Khawa Cluster in Osmanabad is Changing Lives En Masse. National Portal of India, *Niti Ayog,* 15 January Available from https://www.niti.gov.in/how-khawa-cluster-osmanabad-changing-lives-en-masse [accessed 20 January 2023]

Yadav, Santosh. (2018) *Understanding impact of drought on farmers: case study of Takwiki village, District Osmanabad (Maharahstra).* TATA Institute of Social Sciences. Available from https://www.academia.edu/43694507/Understanding_impact_of_drought_on_farmers_case_study_of_Takwiki_village_District_Osmanabad_Maharahstra_ [accessed 20 January 2023)

ANNEXURE I

Reasons for selection of villages

#	District	Block/ Ward	Gram Panchayat/ Ward	Village
1	Beed	Kaij	Yewta	Yewta
2	Beed	Kaij	Wida	Wida
3	Beed	Kaij	Yusuf Wadgaon	Yusuf Wadgaon

#	District	Block/ Ward	Gram Panchayat/ Ward	Village
4	Beed	Kaij	Surdi	Surdi
5	Beed	Kaij	Lavhari	Lavhari
6	Osmanabad	Kalamb	Diksal	Diksal
7	Osmanabad	Kalamb	Bangarwadi	Bangarwadi
8	Osmanabad	Washi	Pimpalgaon Lingi	Pimpalgaon Lingi
9	Osmanabad	Washi	Lakhangaon	Lakhangaon
10	Osmanabad	Washi	Para	Para

Criteria/ Reasons for selection of villages in Beed district

Sr. No	Block/TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (refer JJM/ SBM data)	Total Households	Prevailing social issues/ issues of inclusion/ etc.
01	Kaij	Yewta	3882	776	High seasonal migration, high children drop out from school due to seasonal migration, high unemployment rate amongst youth, limited livelihood options in the area, agriculture is completely dependent on rainfall
2	Kaij	Wida	5030	1010	High seasonal migration, high children drop out from school due to seasonal migration, high unemployment rate amongst youth, limited livelihood options in the area, agriculture is completely dependent on rainfallpletely dependent on rainfall
03	Kaij	Yusuf Wadgaon	4947	1000	High seasonal migration, high children drop out from school due to seasonal migration, high unemployment rate amongst youth, limited livelihood options in the area, agriculture is completely dependent on rainfall
04	Kaij	Surdi	1681	340	High seasonal migration, high children drop out from school due to seasonal migration, high unemployment rate amongst youth, limited livelihood options in the area, agriculture is completely dependent on rainfall
05	Kaij	Lavhari	3324	665	High seasonal migration, high children drop out from school due to seasonal migration, high unemployment rate amongst youth, limited livelihood options in the area, agriculture is completely dependent on rainfall

Criteria/ Reasons for selection of villages in Osmanabad district

Sr. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (refer JJM/ SBM data)	Total Households	Prevailing social issues/ issues of inclusion/ etc.
1	Kalamb	Diksal	9361	1932	Employment Opportunities, Serious Issues of Employment of Landless, Disadvantaged Children, Issues of Single Women, Sanitation
2	Kalamb	Bangarwadi	1275	288	There is a need to promote agro-based businesses, provide employment opportunities to the youth, issues of single women, business opportunities and its skills, information on various government schemes should be disseminated to all stakeholders,
3	Washi	Pimpalgaon Lingi	2415	594	Employment Opportunities, Serious Issues of Employment of Landless Disadvantaged Children, Issues of Single Women, Sanitation
4	Washi	Lakhangaon	1933	455	Single women's issues, premises cleanliness, employment opportunities and skills development
5	Washi	Para	4287	934	There is a need to promote agro-based businesses, provide employment opportunities to the youth, issues of single women, business opportunities and its skills, information on various government schemes should be disseminated to all stakeholders,

ANNEXURE II

Important Women-Centric Schemes in Maharashtra

- *Asmita Yojana:* It was *launched* by Ms Pankaja munde (BJP), Minister of Rural, Women, and Child Development in March 2018 under the Ministry of Rural, Women, and Child Development, Government of Maharashtra. This program is for rural women and adolescent girls (between the ages of 11 and 19 years of age) who attend Zilla Parishad school. A bundle of eight sanitary napkins would be offered at a discounted rate of 5 INR to adolescent females. A subsidy of 15 INR per package is also available.
- *Manjhi Kanya Bhagyashree Scheme* Started in 2017 under the chief minister Shri Devendra Fadnavis (BJP), this scheme is implemented by the Department of Women and Child Development of the Government of Maharashtra. Under this scheme, Govt. shall provide Financial Assistance as follows:
  (a) One Girl Child: 50,000 INR for a period of 18 years
  (b) Two Girl Children: 25,000 INR each on the name of both the Girls
  (c) Benefits applicable only to the Families having yearly income up to 7.5 Lac INR and only after submission of Family Planning Certificate.

- *Manodhairya Scheme.* The scheme was started in 2013 by the chief minister Shri Prithviraj Chavan (INC) under the Department of Women and Child Development, Government of Maharashtra. The aim of the scheme is rehabilitation of victims of Rape and Acid Attacks (women and children) by providing them Financial Assistance. The Women and Child Development Department is implementing the Manodhairya Scheme in the State under which financial Assistance of 1 Lac INR and in special cases 10 Lac INR is provided to the victims. Based on the requirement, Rehabilitation of victims and their dependents by way of shelter, counseling, medical and legal support, Education and Vocational Education is carried out.
- *Rajmata Jijau Mother-Child Health and Nutrition Mission; The* first phase of this scheme started in 2005 by the chief minister Shri Vilasrao Deshmukh (INC) under the Ministry of Women and Child Development, Government of Maharashtra. The Role of the Mission includes the following:
  (a) Advocacy regarding the importance of the first 1000 days.
  (b) Acting as a 'think tank' and to give policy advice to the government regarding evidence-based interventions.
  (c) Achieving convergence between different departments with the common objective of reducing malnutrition.
- *Kishori Shakti Yojana:* It was started by the Government of India in 1991 under the Ministry of Women and Child Development, Government of India. The aim is to impart health and hygiene education, awareness & training to adolescent girls regarding the bad effects of early marriage to avoid frequent child births, need for balanced diet, consumption of green vegetables etc.

A RESEARCH REPORT FROM

ODISHA

PART 1 INTRODUCTION

In Odisha, our research report on the 'Combating the Silence from Menarche to Menopause – A Comprehensive Report on Menstrual Hygiene Management in India', was conducted in the districts of Malkangiri and Kalahandi. Out of these two districts, from Kalahandi the villages chosen for this study were Particularly Vulnerable Tribal Groups (PVTGs) dominated whereas in Malkangiri, villages with a tribal majority were selected. In both the districts the areas under research were remote and interior tribal villages/ PVTG hamlets, some being more accessible than the others. Kalahandi and Malkangiri both fall under Niti Ayog's Aspirational District Programme (ADP)[1].

For completing our research sample, fourteen villages/ hamlets from Malkangiri and thirteen from Kalahandi were taken up for field research and surveys. Research, data collection and analyses for this case-study on Odisha were done through the period of April 2022 to February 2023. Following a participatory and mixed-methods approach, information was sought and processed on the local situation on MHM (Menstrual Hygiene Management), WASH (Water, sanitation and Hygiene), education, health, livelihood, income and availability of support systems to women in the selected districts. Though both districts are doing well on many parameters under the ADP, such as education, literacy and infrastructure, our study indicates that Malkangiri and Kalahandi have much to achieve in terms of combating the silences on MHM with inter-sectoral perspectives on wellbeing of, what we refer to as, '**Elder and Ageing Menstruating Women'** or EAMW. Nevertheless, because our interaction included women as mothers, teachers, counselors, and caregivers of young girls within schools and families, we include a lateral analysis on the menstrual wellbeing requirements of school-going girls as well.

Our research has been designed to collect thick ethnographic data on actors, practices and discourses with an inter-sectoral and analytical perspective on Menstrual Hygiene Management (MHM) in selected research areas. Water, Sanitation and Hygiene (WASH), availability of community support systems, schemes and education as well as felt needs of menstruating women form a vital part of this research. We bring data through fieldwork, interviews, Focus Group Discussions (FGDs) and observations on MHM through women's participatory voices and opinions. A total of 738 interviews were conducted by employing the Menstrual Practice Questionnaires (MPQs) wherein data was collected from 385 women from Malkangiri and 353 women from Kalahandi. Interviews and interactions took place in local Odiya, Kui, Desia and other tribal languages in which women were comfortable to communicate in as Hindi and English were understood by none of the respondents.

Focusing primarily on the category of, what we refer to as, '**Elder and Ageing Menstruating Women'** (henceforth EAMW) between the ages of 20 years to 49 years, we also share our findings on MHM related enablers and barriers for young school going girls. To understand the well-being of menstruating women beyond their school years, this study on Odisha documents the various kinds of barriers and silences in the effective MHM of EAMW. Nonetheless, we also explore our primary data to critically discern potential enablers towards an effective MHM of women between the ages of 20 years to 49 years.

In the final sections, our findings are examined against the voices of key informants to crystallize the salient findings from our primary data as well as delineate context-specific and community-sensitive areas of improvement. Therefore, this case-study on Odisha ends with suggestions on short term as well as mid-term enablers and recommendations for combating the inter-sectoral hindrances prevalent in areas observed.

[1] ADP aims to improve the socio-economic status of the citizens expeditiously. The three core principles of the program are - Convergence (of Central & State Schemes), Collaboration (among citizens and functionaries of Central & State Governments including district teams), and Competition among districts (Niti Aayog 2018).

MALKANGIRI AND KALAHANDI DISTRICT OF ODISHA

Odisha, located at the Indian eastern coast was constituted on April 1, 1936 as the first Indian state (pre-independence) on linguistic basis predominantly of Odia-speaking regions. It is the 9th largest state by area, and the 11th largest by population. It is also the 3rd most populous state of India in terms of tribal population with 62 culturally vibrant tribes including 13 primitive tribal groups. The economy of Odisha has been witnessing structural transformation from an agriculture-based economy to services and industries driven economy. The share of the broad agriculture sector which was around 55% of GSDP in 1950-51 has come down to a level of 19.91% by 2016-17, while the combined share of Industries and Services sectors has risen from 45% to 80.09% during the same period (OSDMA, 2021, State Profile section). Odisha has extensive ranges of hilly forests, several lofty peaks, long stretches of coastline, excellent riverine system and coastal plains have endowed the state with a wide range of ecological habitats for a diverse and broad spectrum of vegetation (Kalinga Lanka Foundation, 2018, Introducing Odisha section).

The eight districts long corridor of Kalahandi-Balangir-Koraput (KBK) in Odisha encompasses both Malkangiri and Kalahandi. The corridor was once known as one of India's most backward areas. The largely rural and tribal-dominated region witnesswd deaths due to starvation and malnourishment because large sections of the population lived in extreme poverty (Krishnan, 2021). However, Report on the state of food security and nutrition in Odisha by the state government noted that the region recorded a food surplus. Kalahandi is now the second-largest producer of rice in Odisha (PHDMA, 2020).

MALKANGIRI DISTRICT

Malkangiri is a district of Odisha named after its headquarter- town, namely, Malkangiri. The district of Malkangiri is bounded by Koraput district and Visakhapatnam and East Godavari districts of Andhra Pradesh in the East, Bastar district of Chhattisgarh in the West, Koraput district on the North and East Godavari and Khaman districts of Andhra Pradesh in the South (Census, 2011, p. 10-11). In 2011, Malkangiri had a population of 613,192 of which male and female were 303,624 and 309,568 respectively. A tribal district, Malkangiri is home to around seven different tribes, each with a different language and customs. Among these, the Bonda and Didayi are two primitive tribal communities found in the district. Malkangiri deals with severe malnutrition in children, between NFHS-3 (2005-06) and NFHS-4 (2015-16) the share of malnourished children under the age group of 5 in the state declined to 34.4% from 40.4%. However, there exists an intra district disparity. Malnourishment is as high as 51.8% in Malkangiri despite it being feted as an aspirational district made by Niti Aayog. The Annual Health Survey report 2014 also reveals that 7 out of 10 children in Malkangiri are underweight (Counterview, 2021).

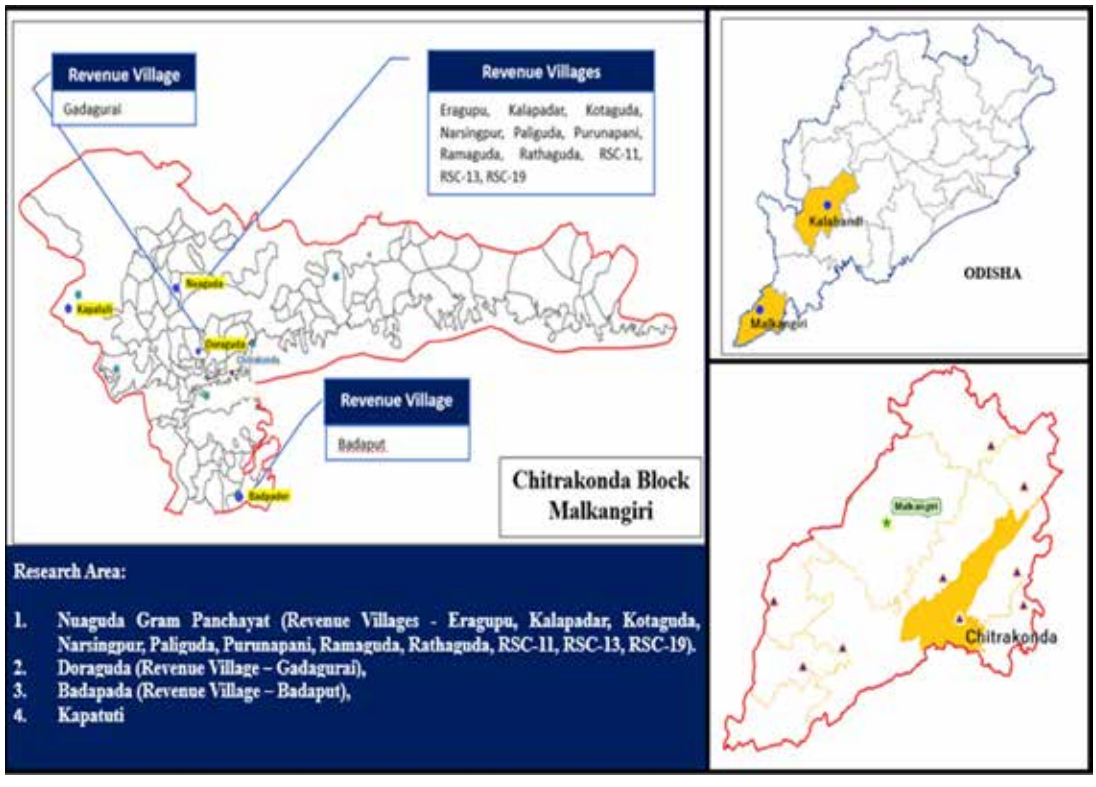
KALAHANDI DISTRICT

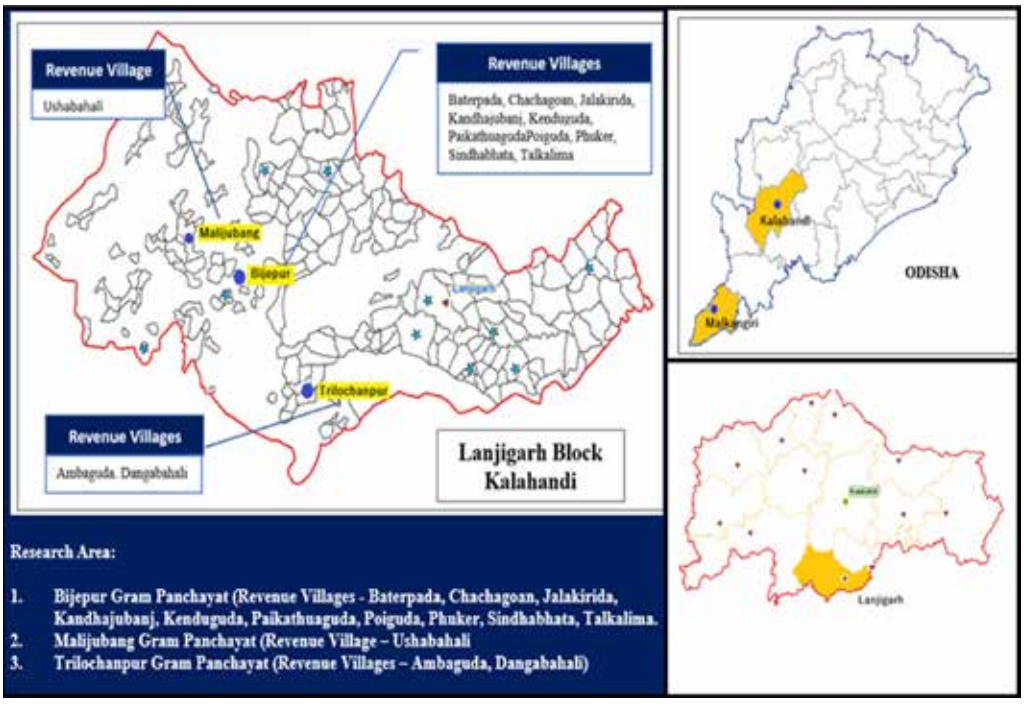
The Kalahandi district of Odisha has a total population of 1,576,869 as per the Census 2011. Out of which 787,101 are males while 789,768 are females. In 2011, there were a total 401,251 families residing in Kalahandi district. The Average Sex Ratio of Kalahandi district is 1,003. As per Census 2011 out of total population, 7.7% people live in Urban areas while 92.3% live in the Rural areas. The average literacy rate in urban areas is 81.6% while that in rural areas is 57.3%. Also, the Sex Ratio of Urban areas in Kalahandi district is 953 while that of Rural areas is 1,008. The total literacy rate of Kalahandi district is 59.22%. The male literacy rate is 61.51% and the female literacy rate is 40.25% in Kalahandi district (Census, 2011). The Kalahandi district in Odisha known for its fertile land and rich history and possesses rich cultural heritage, tribal arts and handicrafts. rich reservoirs of bauxite and Graphite. Yet, plagued with recurrent droughts, famines, widespread hunger and malnutrition, Kalahandi remains etched in public memory as one of the 250 most backward districts of the country. Despite its pristine lands and topography, for its people it constituted a world of paradoxical poverty once known as 'Kalahandi Syndrome' or a 'Resource Curse District'(Iype, 2019).

After becoming aspirational districts, Malkangiri and Kalahandi have achieved many positive outcomes in terms of health, sanitation, infrastructure, and education. Recently Malkangiri district has ranked third among the top five most improved aspirational districts in the Basic Infrastructure Sector as per NITI Aayog's Champions of Change Delta Ranking for February 2022. State government has been working to completely eradicate malnutrition in Malkangiri district with the policy of distributing rice with high vitamin-C content (Odisha Post, 2020). Kalahandi is also working with a holistic, integrated health system, addressing the interconnected challenges of accessibility, faraway settlements, maternal and infant mortality, and low institutional deliveries has been developed with the help of neatly designed bike-ambulances, consisting of a side-car bed and Ma Griha clinics. NITI Aayog's Sustainable Action for Transforming Human capital (SATH) project converging with Aspirational district programme catalyzes systemic reform in education and healthcare in the Kalahandi district, through initiatives such as optimizing school structures, organisation restructuring as well as strengthening monitoring and accountability (Iype, 2019).

1.1 LIST OF VILLAGES SELECTED FOR THE STUDY FROM MALKANGIRI AND KALAHANDI

On an average, five villages were selected from each of the fourteen districts across the seven Indian states selected for this study. In Odisha, the population sample in Malkangiri was taken from four Gram Panchayats of Chitrakonda Block and in Kalahandi, it was taken from three Gram Panchayats of Lanjigarh Block (See Annex 1). However, to complete the required number of questionnaires, we also selected twenty-one hamlets from the two districts of Odisha. Factors such as access to PVTG focused villages, remote and isolated villages cum hamlets with scarcity of safe drinking water, malnutrition, lack of electricity, migration, unskilled laborers, prevalence of myths and taboos etc. were considered.





PART 2 DATA TOOLS AND STRUCTURE OF THE CHAPTER

2.1 RESEARCH TOOLS, METHODS AND THEMATIC FOCUS FOR DATA COLLECTION, CORRELATIONS AND COMMUNITY-BASED ANALYSES

Types of Interviews- Tools and Focus	Data Collection and Analysis- Methods and Themes	Sample	
		Malkangiri	Kalahandi
Tool 1 Menstrual Practice Questionnaires (MPQs)	Method 1 The MPQs were In-depth Interviews (IDIs) for- actor, discourse and practice-analyses	385	353
Tool 2 Menstrual Practice Needs Scale (MPNS)	Method 2 Measurement of perceptions and needs based on the last menstruation cycle	43	44
Tool 3 Key Informant Interviews (KIIs)	Method 3 Voices, Excerpts, Salient Findings and Observations	12	12
Themes: WASH, Education, and Health, Livelihood	Focus: Inter-Sectoral findings and conclusion and comparisons		

PART 3 ACTOR ANALYSIS FROM MPQs

In this section, socio-economic profile as well as the current menstruation status of the actors is detailed.

DEMOGRAPHIC PROFILE OF THE RESPONDENTS

Demographic Profile	Malkangiri (in%)	Kalahandi (in%)
Total Respondents (N)	**385**	**353**

Demographic Profile	Malkangiri (in%)	Kalahandi (in%)
Rural / Tribal	100.0	100.0
Mother Tongue		
Desia	99.7	
Kui		73.9
Odia	0.3	25.2
Telugu		0.8
Religion		
Adidharma	99.7	75.4
Hindu	0.3	24.6
Caste/ Tribe Type		
OBC- Other Backward caste		6.2
SC- Scheduled caste	1.3	18.1
ST- Scheduled Tribe	98.7	0.8
PVTG- Particularly Vulnerable Tribal Group		74.8
Marital Status		
1. Never married	0.5	0.3
2. Married	98.4	94.6
3. Widowed	1.0	5.1

FINDINGS FROM MPQs

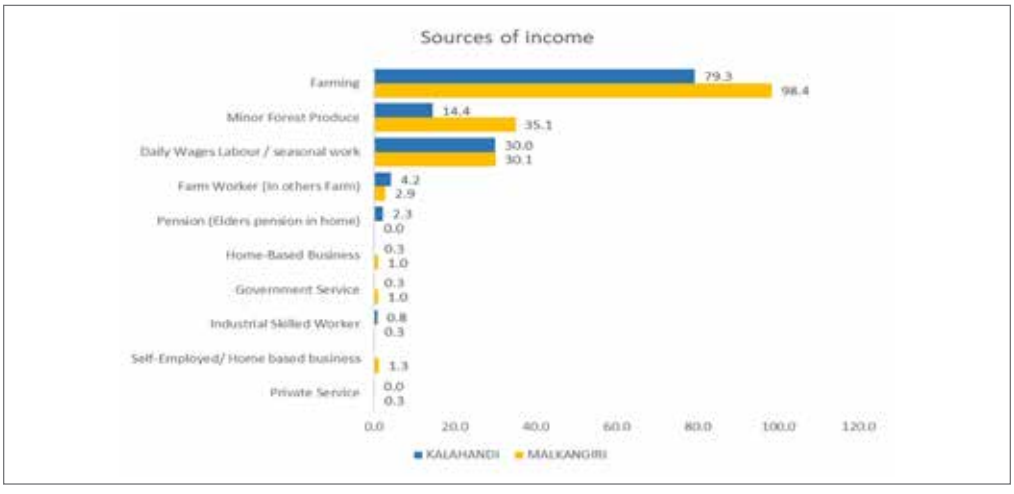
- **Religion:** 650 out of 738 respondents stated Adidharm as their religion while the rest of the interviewees belonged to the Hindu religion.
- **Community:** 380 of our respondents in Malkangiri (n=385) belonged to the ST communities (Desia, Dora, Gouda, Jodi, Kanda, Paraja, Parenga Poraja, Rana, Telura) rest all were SCs. From Kalahandi (n=385), 264 belonged to the PVTGs, 64 were SCs, 3 STs and 22 were OBCs (Paika, Paola, Sundhi, Teli) formed the interviewed group.
- **Marital Status**: 713 out of total women interviewed were married. The average age of marriage in Malkangiri was 17 years whereas in Kalahandi it was merely 15 years.
- **Children and Family Size:** Average **number** of children was three and average family size was five.

3.1.1 AVERAGE INCOME

- **Income on the lower side:** The average yearly family income of families in Malkangiri was 21150 INR, lower than compared to 22300 INR for Kalahandi.
- **Barter System Prevails:** In this entire rural and tribal area, traditional modes of exchange such as the barter system were still in place.

- **Items Exchanged:** Grains and Minor Forest Produce (MFP) are bartered at the local market places or *Haats* to compensate for essential family needs that remain unfulfilled owing to lack of means as well as access to resources.

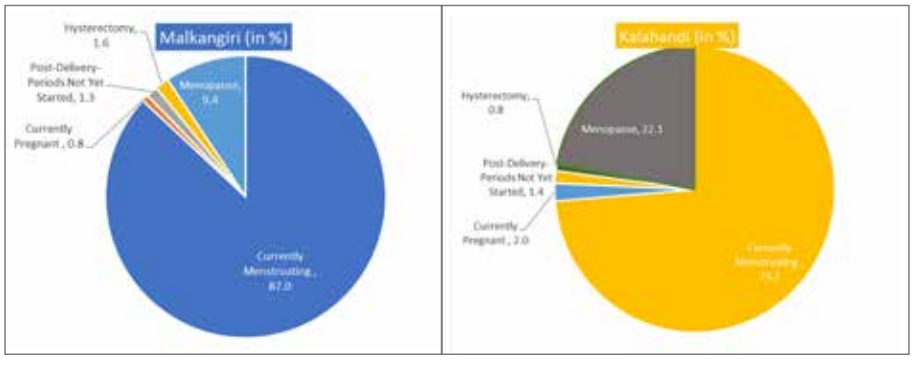
3.1.2 SOURCES OF INCOME



*Multiple Choice Question

- **Farming** was the main and single source of regular income for 659 (89.3%) families of total women interviewed from Malkangiri and Kalahandi followed by **Minor Forest Produce** (MFP) collection that formed the main (single) or supportive (multiple) source of income for 186 (25%) of our interviewees. **Contract labour** as either daily wage work or seasonal farm work emerged as the third highest source of augmenting family income for 213 (28.8%) families.
- **Traditional Knowledge and Skills**: Only 20 women out of the 385 from Malkangiri reported possessing traditional skills such as craft/Embroidery/Knitting/Weaving and eleven out of these were able to earn from such activities. In Kalahandi only one out of 353 women possessed a traditional skill by virtue of which she could earn.
- **Women lack Disposable Income:** Although they worked on their own farms and their families also counted on multiple sources of income, 677 of the women from our sample in Malkangiri and Kalahandi reported that they 'did not earn'. Our data indicates that women remain hamstrung in terms of disposable income for personal expenses as well as any decision making on medical care in relation to MHM.

3.1.3 MENSTRUATION STATUS



- **Total EAMW**: 89.1% of the total women surveyed through the MPQs were in their active menstrual years.
- **Age at Menarche:** Average age at menarche was 12, whereas the average age at attaining menopause was 45 years.
- **Number of Hysterectomies**: Only six women had undergone hysterectomy in Odisha, with the average age at the time of the procedure being forty years.

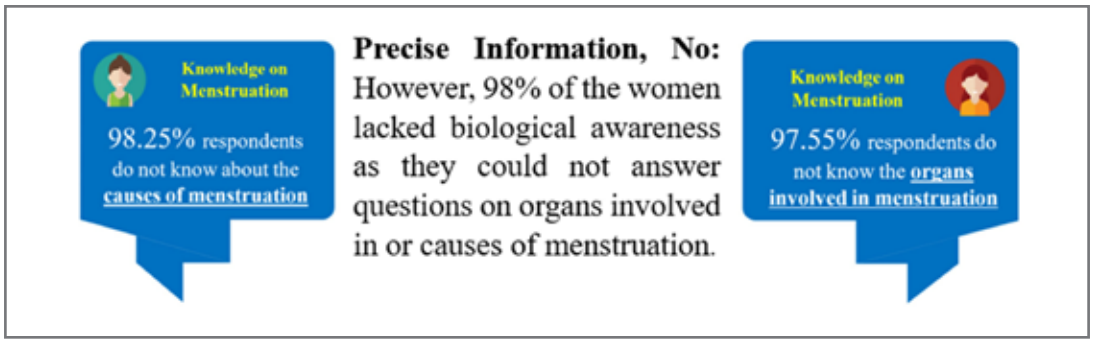
3.2 DISCOURSE ANALYSIS

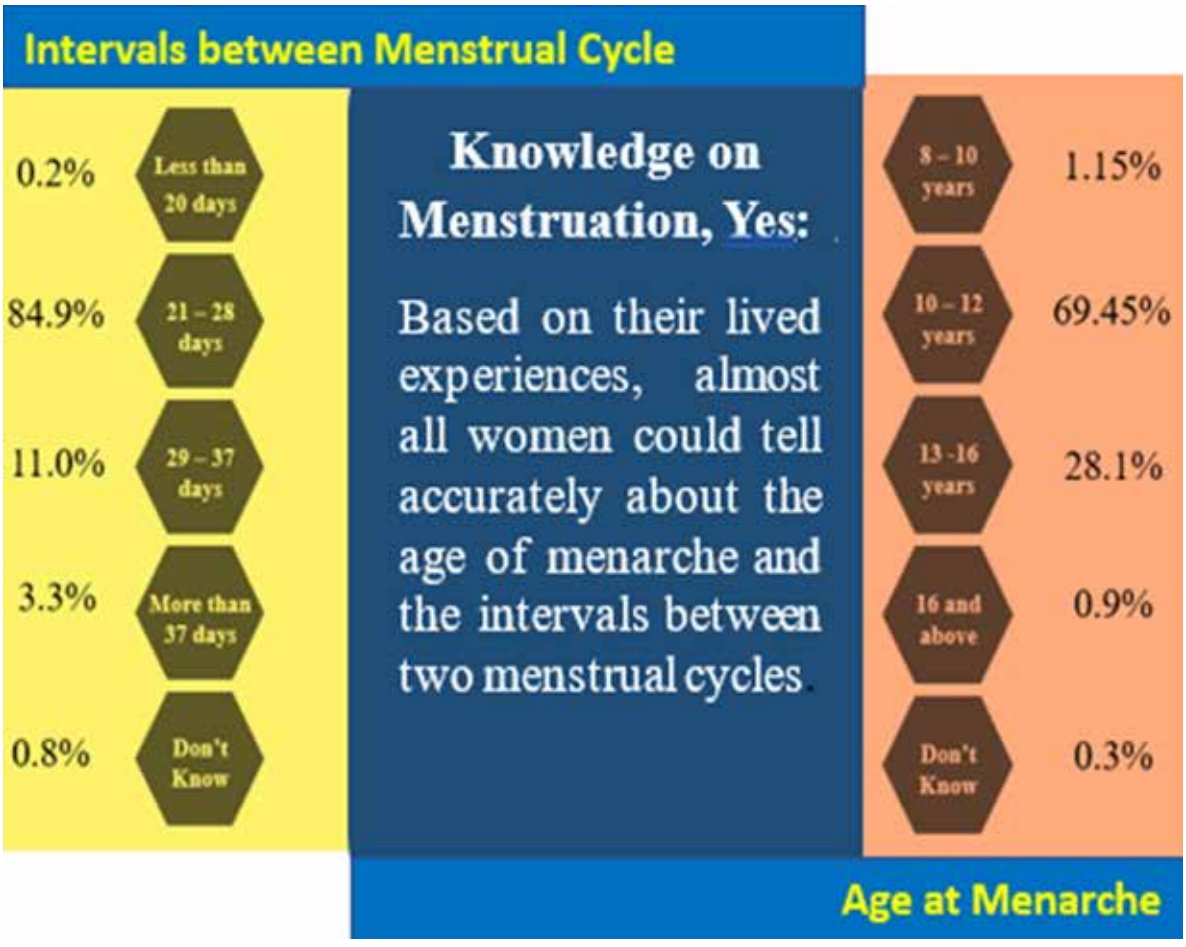
In this section, our findings relate to levels of knowledge that our respondents profess on the causes of menstruation, organs involved in it and an analysis of their discourses on the subject. In other words, we analyze the information given during the IDIs to understand how much general as well as precise comprehension women seem to have on menstruation as a monthly and bodily process. Further, we present our findings on the extent of communication as well as silence around the theme, for instance with whom and how much they chose to discuss or not discuss on issues experienced and their general observations related to MHM. We also present data on educational backgrounds of women, how the women position themselves on medical care options and facilities available/ not available and their awareness on use and disposal of menstrual absorbents, health risks as well as common disorders and symptoms they experience during menstruation and, in cases of hysterectomy, where applicable.

3.2.1 KNOWLEDGE ABOUT MENSTRUATION:

Knowledge about menstruation	Malkangiri (in %)	Kalahandi (in %)
Total Respondents	**385**	**353**
Causes of Menstruation		
Hormonal change	2.1	1.4
Do not know	97.9	98.6
Organs Involved in Menstruation		
Uterus/ Birth canal	2.4	2.3
Abdomen/ Bladder	0.3	0.0
Do not know/ not answered	97.4	97.7

- **Basic Understanding, Yes:** Based on their lived experiences, almost all women could tell accurately about the age of menarche and the intervals between two menstrual cycles.
- **Precise Information, No:** However, 98% of the women lacked biological awareness as they could not answer questions on organs involved in or causes of menstruation. Urgent awareness drives are required in both the areas to equip the EAMW towards a better MHM.





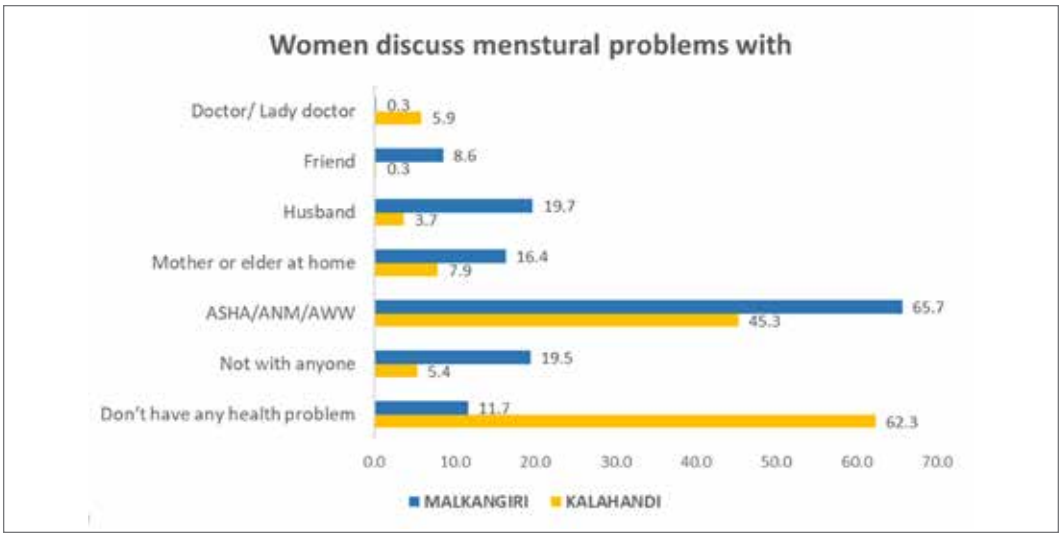
3.2.2 SOURCE OF INFORMATION AND WOMEN'S PREFERENCES ON DISCUSSING MENSTRUAL PROBLEMS

For young girls the top sources of information on menstruation emerged as follows:

- Top sources of information for young girls about menstruation at the time of Menarche were parents, grandmother, sister, or sister-in-law reported from both the districts.

Women like to discuss their menstrual problems with the following:

- **Close Relatives:** Mothers and elders were the most important source of information on menstruation for our respondents when they experienced menarche as young girls.
- **Frontline Health Workers (FHWs):** Out of the total of 738 EAMW surveyed, 413 were more comfortable to talk about their MHM problems with the FHWs in the village such as Accredited Social Health Activist (ASHA), Auxiliary Nurse and Midwife (ANM) and Anganwadi workers (AWW) rather than close relatives.
- **Spouses:** 76 Women from Malkangiri and 13 women from Kalahandi felt comfortable talking about menstrual problems with husbands. If men can be oriented, stay alert and helpful on their wive's MHM issues, that would bring a positive health outcome for EAMW, besides combating the silence on it.
- **Nobody:** However, 94 women from both the districts do not prefer to talk with anyone and remain silent about their menstrual problems. 265 denied having any problems w.r.t MHM.

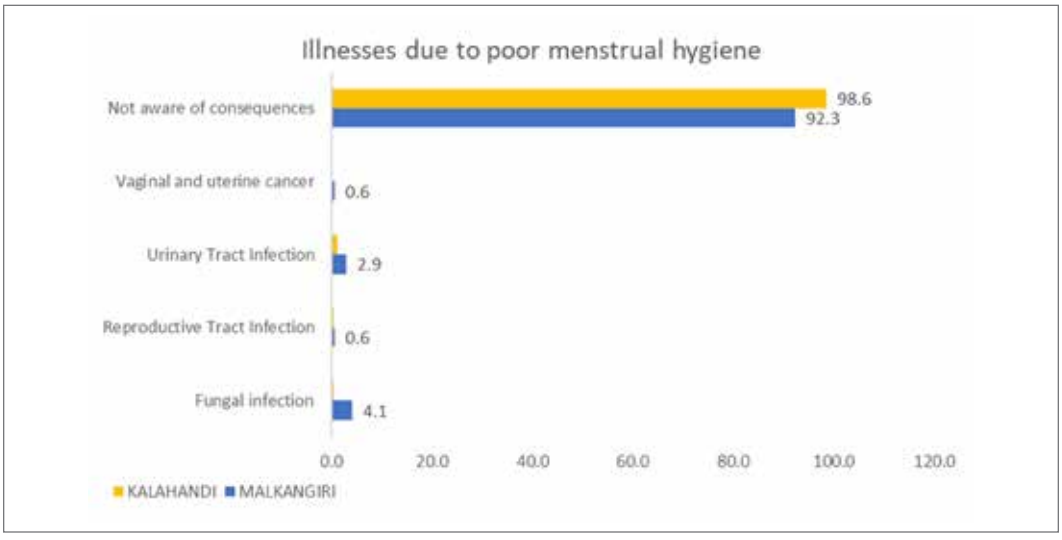


*Multiple Choice Question

3.2.3 MENSTRUAL HEALTH, EDUCATION, AND AWARENESS ON INFECTIONS

Apart from the use of different menstrual products, the study presents data on health problems which were experienced by our respondents during menstruation. It was further verified whether they visit the doctor in case of any health issues or prefer to keep quiet and bear it. Adverse health conditions while working in or outside the home may lead to rashes, urinary tract infections (UTIs), and reproductive tract infections (RTIs) for many women, as indicated by our survey findings.

- **Widespread Ignorance**: When asked about the side effects of poor menstrual hygiene, only 30 EAMW from Malkangiri and five from Kalahandi could speak about the impacts of poor menstrual hygiene. 95.7% of the menstruating women from Odisha (N=615) could not answer.

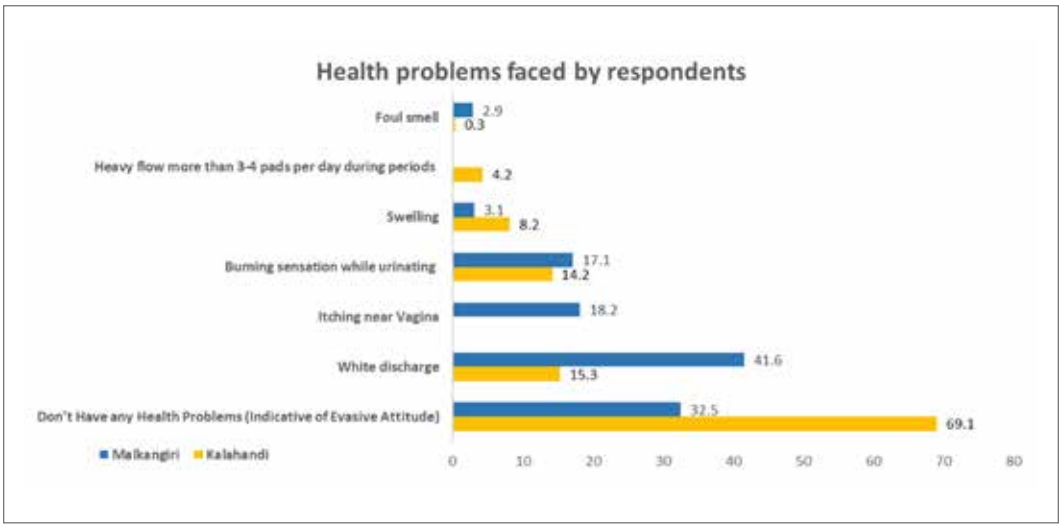


*Multiple Choice Question

- **Fungal Infections and UTIs:** Out of the 35 women who knew about lack of MHM and risks of infection, 17 stated that poor menstrual hygiene leads to fungal infections while 13 said it causes UTIs.
- **Low knowledge on exact health risks:** Adverse health conditions while working in or outside home often lead to rashes, Urinary Tract Infections (UTIs) and Reproductive Tract Infections (RTIs). However, our findings indicate a lack of awareness on these risk factors. Not being able to understand and/or give answers on the relationship between MHM and rashes, infections and other risks indicates ignorance per se.

- **No Schooling, Taboos and Communication Barriers:** However, given that speaking about periods itself is a taboo or is a challenge due to shyness/ hesitancies, generalizations on awareness on MHM may be misleading. Community and area specific conclusions are a better way ahead. One of the most noteworthy findings from both the districts of Odisha has been that 93% of our participants (from a total of 738) were women who had never gone to school or in other words, had not received formal education or been in a context where through discussions at a young age, communication barriers can be broken. EAMW who participated in our study either remain shy to speak or know about menstruation or effectively become silent on the theme.

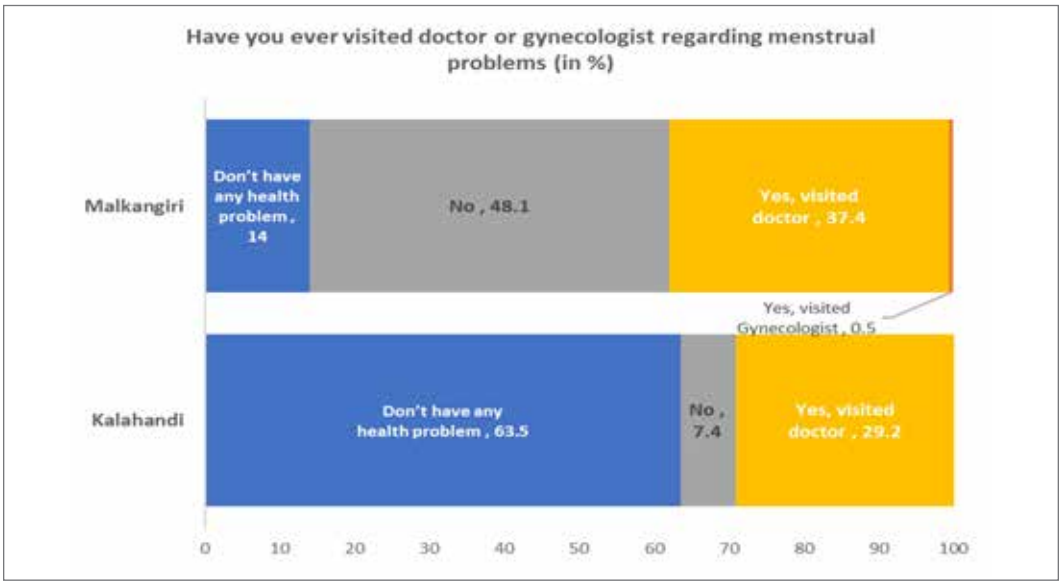
3.2.4 HEALTH SYMPTOMS DURING MENSTRUATION

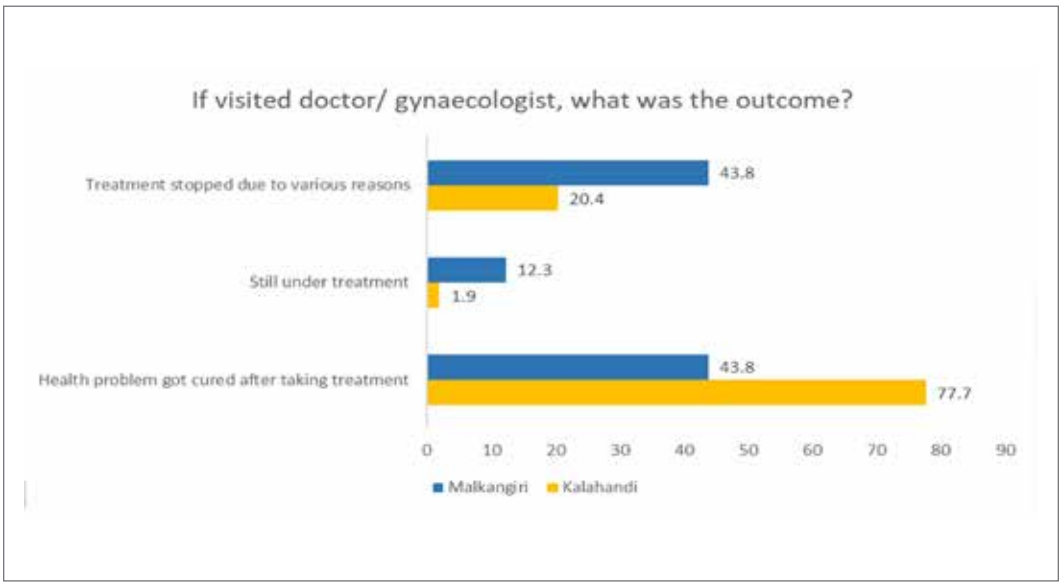


*Multiple Choice Question

- **MHM, health and accessibility to health care**: Apart from the modes as well as patterns of, and awareness on MHM, the survey imparts light on the health problems undergone by participants during menstruation. For arriving at inter-sectoral findings on health management, women were asked if they visit a medical professional to resolve menstrual health issues and reasons if they do not.
- **Vaginal symptoms, attitude, and treatment, Malkangiri:** Almost one-third of the EAMW in Malkangiri (n=343) reported that they did not have any health problems in the earlier part of the survey. In the later part of the survey, however, they confirmed white discharge, itching near vagina and burning sensation while urinating as the top three issues that women faced due to poor vaginal hygiene. Half the women reported seeking medical advice over menstrual health problems and only four out of ten visited a doctor and got cured after completing treatment.
- **Vaginal symptoms, attitude and treatment, Kalahandi:** Similarly, almost seven out of ten EAMW (n=272) from Kalahandi reported that they did not have any health problems in the earlier part of the survey but later confirmed, white discharge, burning sensation while urinating, and swelling emerged as the top three issues that women faced due to poor vaginal hygiene. One-fifth of the women in Kalahandi reported that they never went to a doctor for menstrual health problems they face. 80 out of 103 (77.4%) women who informed us that they had visited a doctor, got cured after completing treatment.

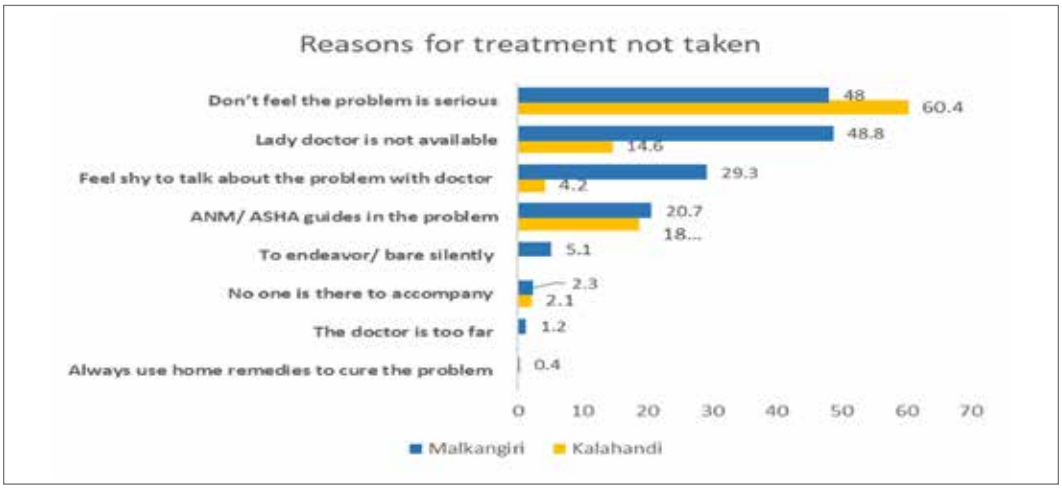
Indeed, if health anomalies during menstruation are not resolved, pushed to the peripheries, or remain shrouded in silence, women have much to lose in social, economic, and personal spheres. For **combating** health and hygiene related **silences** on menstrual hygiene and care for women beyond school years to benefit the EAMW, the governmental healthcare must tune itself to hear their voices. In the last section of this chapter, titled 'Excerpts and Voices', we bring community-based views and suggestions from women over this issue.





- **Neglect, Hesitation, and Silence:** EAMW tend to neglect health issues related to menstruation in Odisha's Kalahandi and Malkangiri districts. This barrier is further exacerbated by the hesitation to speak on menstrual health and inability to seek medical advice on a regular basis owing to several reasons including economic encumbrances.
- **Medical Care, Access, and Unaffordability:** 57.8% of our total respondents (738) visited a doctor to seek treatment and got cured. 34.1% of our total respondents stopped treatment due to various reasons, unaffordability and accessibility of medical care being the most prominent ones.
- **Ignorance:** 256 respondents from Malkangiri and 48 respondents from Kalahandi did not undergo treatment in health problem out of which 51.7% did not feel the problem was serious.
- **No Lady doctor/ Gynecologist:** 44.9% of our informants refrain from seeking medical advice on MHM owing to non-availability of a lady doctor.
- **Attitude (Shyness and Silence):** 34.4% of the women singled out shyness as one of the main causes that impedes them to discuss their menstrual health openly. Effectively this means that more than one –third of our interviewees preferred to remain silent over their menstrual health issues.

3.2.5 REASONS FOR NON-TREATMENT



*Multiple Choice Question

3.2.6 HYSTERECTOMIES

In comparison to the six other states in our study, namely, Assam, Bihar, Chhattisgarh, Haryana, Maharashtra and Tamil Nadu, cases of hysterectomy in both districts from Odisha were very low. Out of 738 women only nine women had undergone hysterectomies at an average age of 39 years. Surprisingly, only two women out of nine had received pre- and post-operative counseling. Five out of nine of our respondents were suffering from weakness, could not lift heavy objects and had anemia post-hysterectomy.

- **Biological Causes:** Hysterectomy causes ranged from abnormally heavy bleeding, stomachache and fibroids or other problems related to the uterus.
- **Socio-economic Causes:** Three women who had undergone hysterectomies informed us that periods become a hurdle while working away from home because of low stamina and lack of adequate hygiene facilities. Additionally, when the couple work together or in *Jodi,* women could not afford to take a leave as none of the partners in that case get their payment.
- **Government/ Private Treatment:** Only four out of nine hysterectomies were done in government hospitals, rest opted for private medical care. The reason for seeking treatment from private hospitals was mainly to get rid of the problem immediately or prior experience/recommendations of family or friends and convenience.

Our findings on hysterectomies in Malkangiri and Kalahandi suggest that the informal labour sector in tribal areas in Odisha discriminates against women and creates pressures on husband-wife teams (*Jodi/s*) working together, almost in the same way as it happens elsewhere such as in the case of sugarcane farming sector in Maharashtra. Moreover, misconceptions about uterine relevance post motherhood abound. Further, MHM related encumbrances experienced in exploitative labour situations are also bereft of adequate WASH facilities. Not surprisingly, marginalized women face complex challenges and crossroads regarding their reproductive health as well as wellbeing options, oftentimes leading to hastily executed hysterectomies. MHM of EAMW should become a vital part of labour laws, public health, and community-based awareness drives.

3.3 PRACTICE ANALYSIS

Good menstruation practices start with the usage of clean menstrual absorbents followed by maintenance of reproductive hygiene from menarche till menopause. This section brings to light the prevalence of practices regarding personal hygiene such as washing hands and genitals during menstruation as well as usage and disposal patterns of menstrual hygiene products. We also bring data on how personal and community-based

beliefs, customs, and taboos influence MHM outcomes and self-care regimes of our respondents. In the tribal belts of Malkangiri and Kalahandi, given their circumstances women adhere to traditional methods of MHM over pads etc. Out of a total of 615 menstruating women interviewed from Malkangiri and Kalahandi only 18 women use sanitary pads, rest use cloth.

3.3.1 SANITARY PADS OR OTHER ABSORBENTS?

- **Cloth:** Out of the total of 615 EAMW interviewed from both the districts, 97.7% women surveyed use only cloth during menstruation because of its ready availability, affordability, durability and, lack of awareness about other menstrual products.
- **Other Material**: Only 15 women (out of 343) from Malkangiri and 3 (out of 272) from Kalahandi use menstrual products other than cloth. Nonetheless, speaks of preferences as much as it does of scarcities.

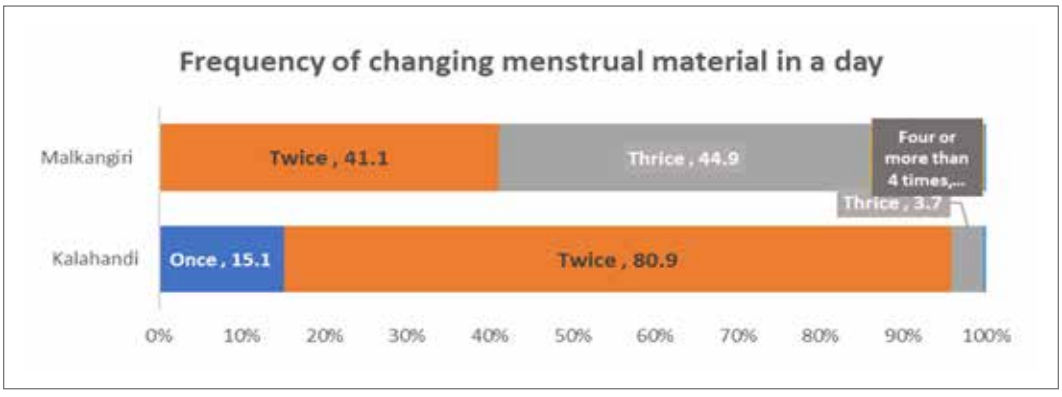
3.3.2 SPENDING CAPACITY ON MENSTRUAL HYGIENE PRODUCTS

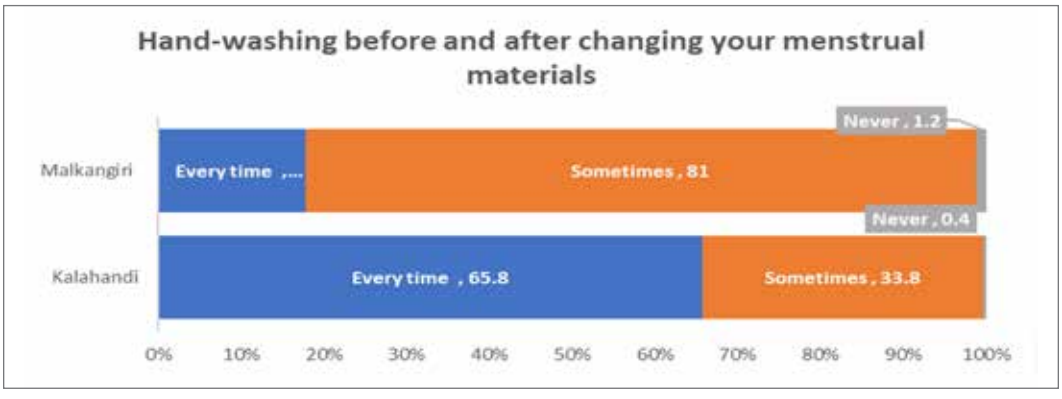
- In Malkangiri women who do not use cloth, spend above 100 INR on menstrual products each month whereas in Kalahandi they spend up to 60 INR on buying pads.

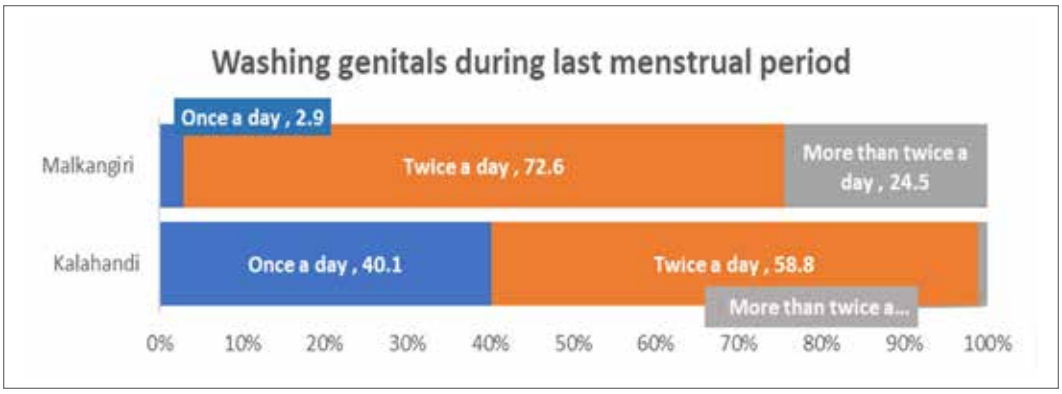
3.3.3 PERSONAL HYGIENE PRACTICES AND WASH DURING LAST MENSTRUAL CYCLE

- **Frequency**: From both the districts, around 85.4% EAMW (N=615) responded that they change menstrual material twice or thrice a day.
- **Washing Hands:** Only 61 (17.8%) women from Malkangiri (n=343) reported that they wash their hands every time they use or change menstrual material. Hygiene practices were found to be better in Kalahandi where 179 (65.8%) of the interviewed women (n=272) wash hands every time they use/ change menstrual material.
- **Washing genitals during the last Menstrual Period:** From both the districts, almost two-thirds of women wash their genitals twice a day during menstruation. 14 % wash more than twice a day. Nonetheless, hardly 14.8% use soap while washing.

Our data indicates that more awareness towards MHM and WASH alongside provision of and access to proper WASH infrastructure and sanitation services is the most basic need for enabling EAMW and communities to take actions in tribal and PVTG belts in Odisha.

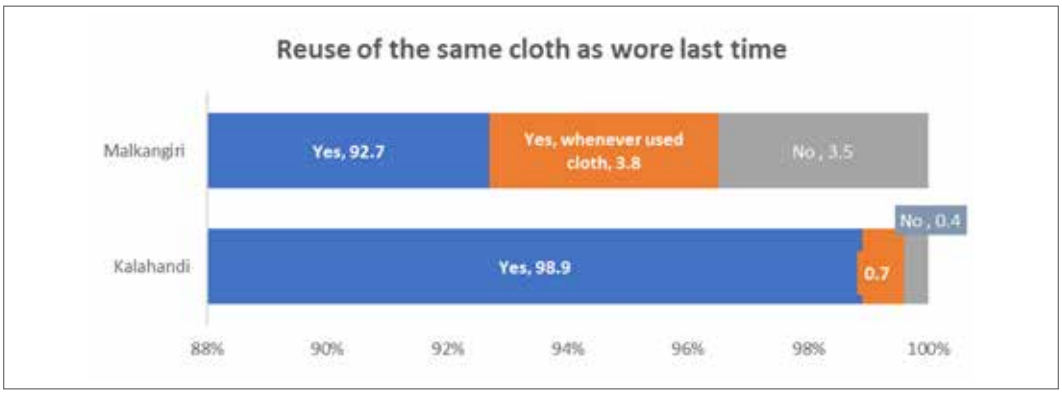


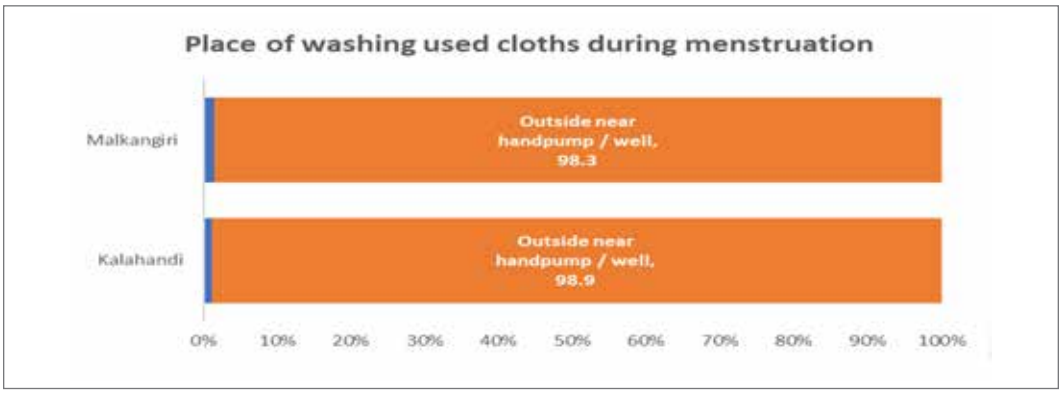


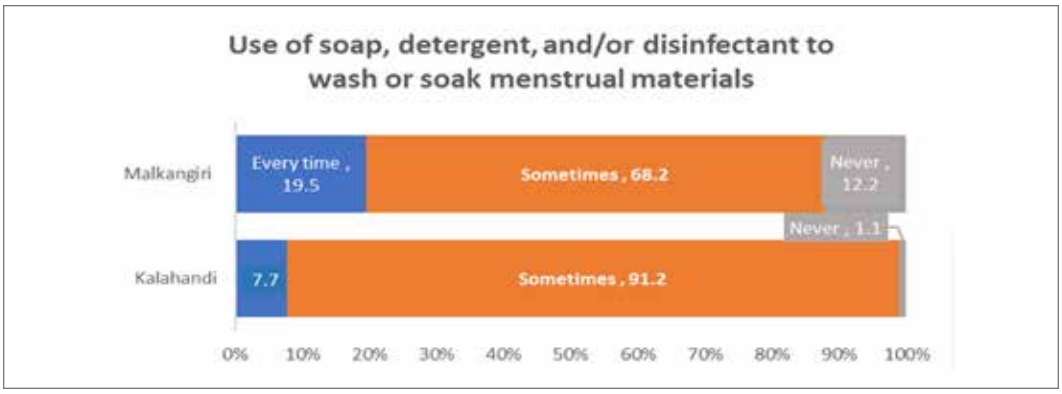


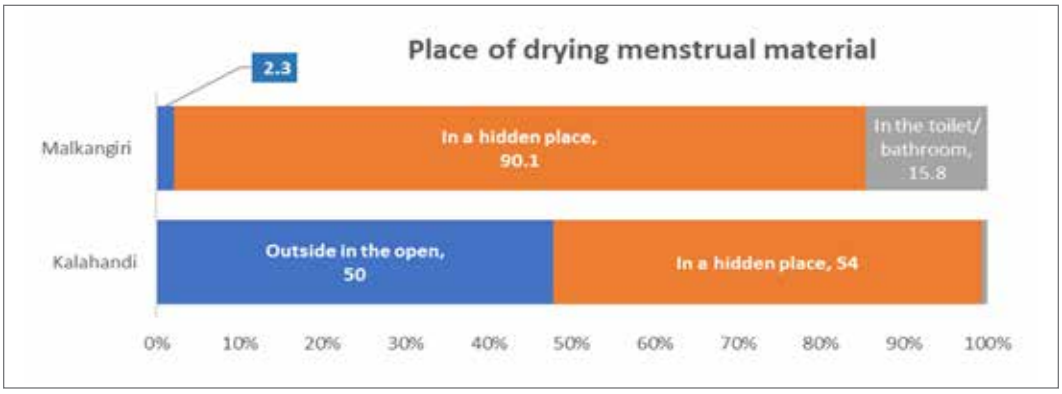
3.3.4 MENSTRUAL HYGIENE PRACTICES (MALKANGIRI N=343, KALAHANDI N=272)

Safe hygiene practices consist of washing and timely changing of menstrual absorbents as well as their proper disposal. This may vary with the absorbent type. Personal hygiene also depends on changing the absorbent during the day, keeping genitals clean, washing hands before and after changing the menstrual absorbent. The survey assessed all practices used to follow hygiene and management of material during menstruation.



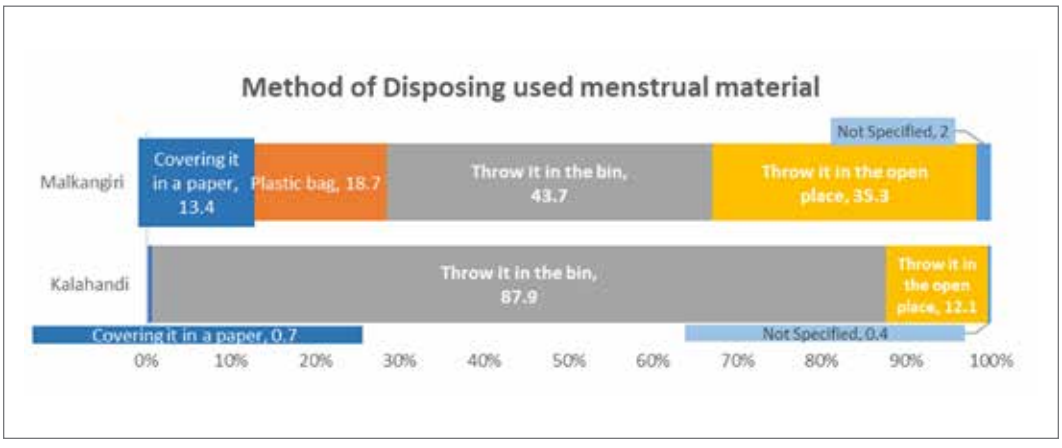






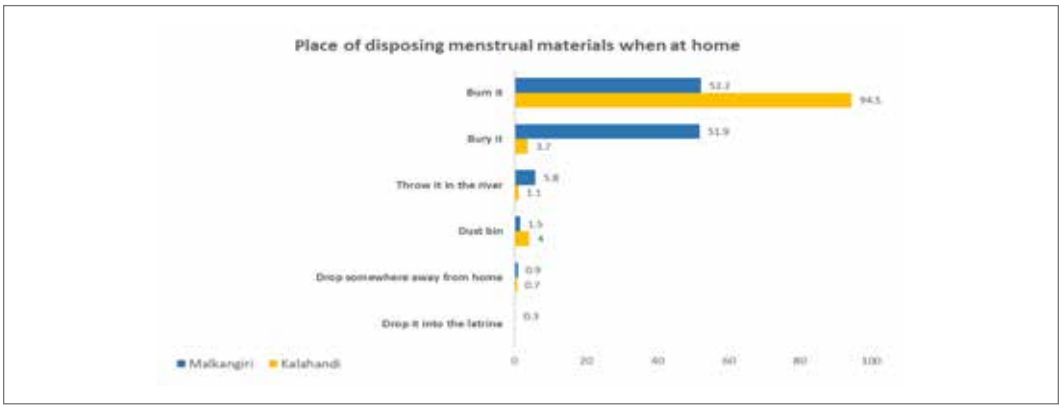
- **Reusing MHM Products:** From both districts, 97.6% of women claimed the use of clean cotton cloth during menstruation, out of which 95.4% of women **reuse the cloth.**
- **Washing MHM Products:** According to our respondents, there was hardly any water available in the toilets or bathrooms at homes in both the districts. Hence, 96.6% women wash their menstrual clothes outside the house, near hand pumps or a well.
- **Use soap every time:** From both districts, around 14.3% women said that they use soap while washing menstrual clothes every time.
- **Use soap sometimes:** However, owing to prevalence of WASH related hardships, seven in ten women in Malkangiri as against nine in ten women in Kalahandi use soap only sometimes to wash menstrual clothes.
- **Drying MHM products**: While reusing cloth during menstruation, apart from washing, one also needs to follow the practice of drying the cloth properly in sunlight. In comparison to Malkangiri, practices related to drying reused menstrual clothes were found to be better in Kalahandi.

3.3.5 AREA-SPECIFIC DISPOSAL MECHANISMS (MALKANGIRI N=385, KALAHANDI N=353)



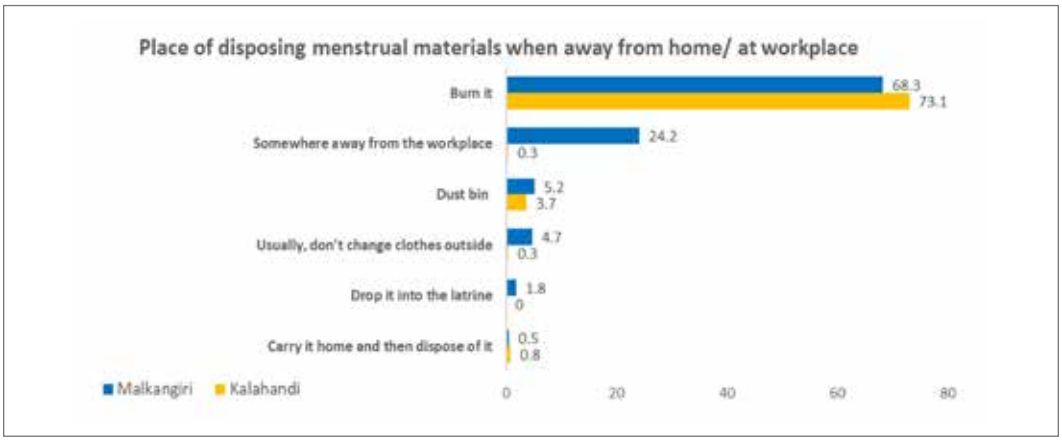
- **No specific Disposal Mechanism in place:** When asked about the system of disposal of menstrual material in their area, it was found that women have to manage problems at their own levels. The district does not have any disposal mechanism for menstrual materials nor monitoring mechanisms to follow-up and optimize implementation of hygienic practices.

Methods of disposal in Both Districts: When at Home



- **Top Practices:** When at home, women in Malkangiri either bury or burn the used menstrual material whereas most of the women in Kalahandi burn it.

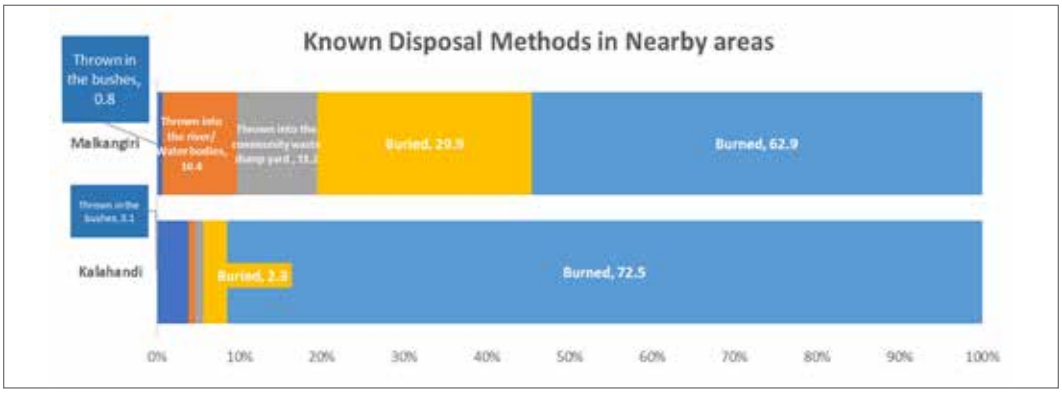
Methods of disposal in Both Districts: When away from Home



- **Top Practices:** Two-thirds of our respondents burn the used menstrual waste in both the districts. One fourth of the women in Malkangiri throw it somewhere in the open space.

3.3.6 KNOWN DISPOSAL METHODS IN THE COMMUNITY AS WELL AS NEARBY AREAS

- According to our respondents, the used menstrual material is mostly burned at the community level in the village and nearby areas.



3.3.7 SOCIAL CUSTOMS, BELIEFS, MYTHS, AND TABOOS

The world of social customs, replete with its mandatory do's and don'ts in various communities represents their beliefs and mandates. Social customs, beliefs, myths and taboos contain overt and covert forms of barriers and enablers which influence MHM related practices as well as everyday experiences of menstruating women. In this respect we have quite similar findings from Odisha's Malkangiri and Kalahandi districts, the same being presented as follows:

Customs followed by women in reference to menstruation: Malkangiri District

Malkangiri	Strongly agree	Agree	Disagree	Strongly disagree
I am allowed to mix with others socially during my periods.	0.3	0.3	99.5	
I am not allowed to attend any social rituals during my periods.	0.0	99.7	0.0	0.3
I do not go to religious places during periods.	0.0	99.7	0.0	0.0
I avoid traveling during periods.	0.0	99.2	0.5	0.3
I am told to stay in the corner of the house during my periods.	0.0	99.7	0.0	0.3
	Yes		No	
I am allowed to carry out routine work at home during my periods.	0.5		99.5	
I am allowed to cook in the kitchen during my periods.	0.0		100.0	
Others in my family take care of me during periods.	99.7		0.3	
I have the freedom to visit a doctor in case of any health issues.	0.0		100.0	
I am allowed only special foods during periods.	0.8		99.2	
I sit for lunch and dinner with all my family members.	2.3		97.7	

Customs followed by Women in reference to Menstruation: Kalahandi District

Kalahandi	Strongly agree	Agree	Disagree	Strongly Disagree
I am allowed to mix with others socially during my periods.	0.0	4.2	95.5	0.3
I am not allowed to attend any social rituals during my periods.	0.0	0.3	95.5	0.3
I do not go to religious places during periods.	0.3	99.7	0.0	0.3
I avoid traveling during periods.	0.0	96.9	2.8	0.3
I am told to stay in the corner of the house during my periods.	0.0	96	3.4	0.6

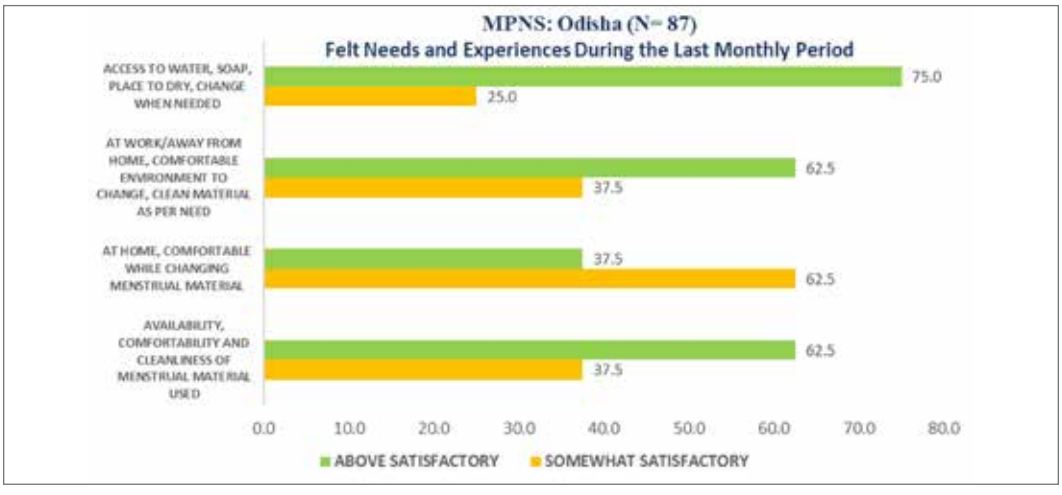
Kalahandi	Strongly agree	Agree	Disagree	Strongly Disagree
	Yes		No	
I am allowed to carry out routine work at home during my periods.	4.2		95.8	
I am allowed to cook in the kitchen during my periods.	3.1		96.9	
Others in my family take care of me during periods.	96.3		3.7	
I have the freedom to visit the doctor in case of any health issues.	2		98	
I am allowed only special foods during periods.	0.6		99.4	
I sit for lunch and dinner with all my family members.	5.1		94.9	

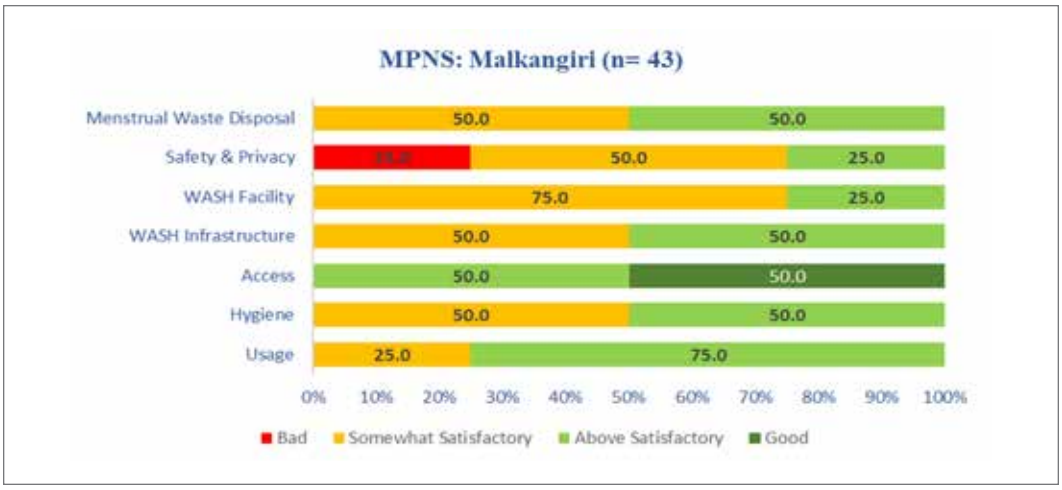
Almost all women from Malkangiri refrain from socializing during periods, avoid travel, are strictly restricted from visiting religious places or attending rituals. Moreover, nearly all the women are asked to stay in a corner of their home, thus making segregation during periods an overarching menstrual custom of the communities. Like the practices in Malkangiri, almost all women from Kalahandi avoid traveling during their periods, do not go to religious places and are told to sit in the corner at their home during periods. At the same time, they also expressed that they were allowed to mix with others socially during periods.

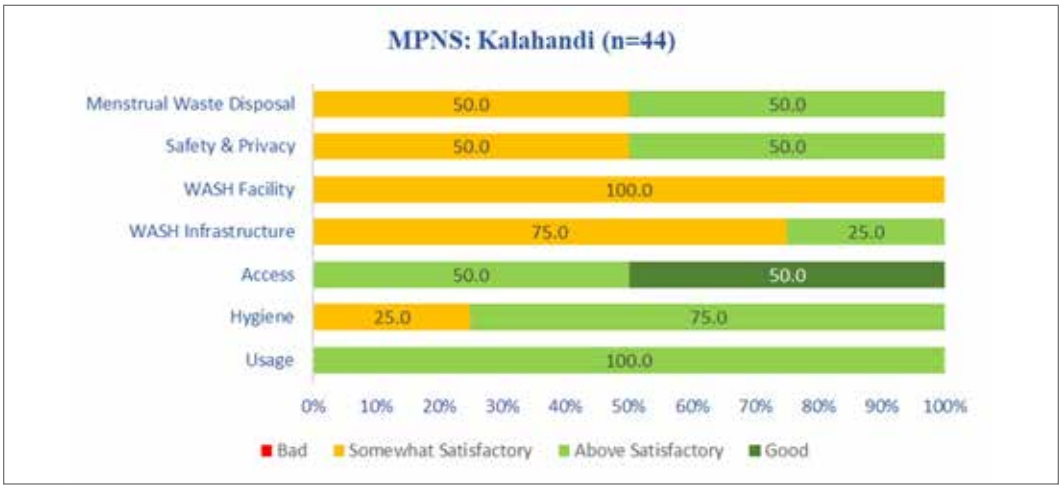
3.3.8 MENSTRUAL PRACTICE NEEDS SCALE (MPNS)

The MPNS was used to measure and assess the felt needs and experiences of women during their last menstrual period. 87 respondents from both the districts in Odisha shared their perceptions/experiences on availability of water, sanitation, hygiene, safety, and privacy as well as access to menstrual absorbents. Through the use of MPNS, we were able to access the actual trends, practices and experiences w.r.t MHM, WASH, safety and privacy which form the 'menstrual everyday' of surveyed women in Malkangiri and Kalahandi districts in Odisha:

- **Malkangiri**: When measured on the MPNS, 43 women from Malkangiri, reported that they had poor privacy in their last menstrual period. While changing menstrual materials, women found the WASH facilities somewhat satisfactory. Nonetheless, access to menstrual material was rated at above satisfactory to good level, probably because of the practice of using cloth during periods.
- **Kalahandi:** When assessed on the MPNS, 44 women from Kalahandi reported that access to menstrual material, usage of desired absorbents was at above satisfactory to good level. Nonetheless, women rated WASH infrastructure and WASH facilities as somewhat satisfactory whereas half the women rated safety and privacy at above satisfactory level.







3.4 MHM FROM AN INTER-SECTORAL PERSPECTIVE

Reading the everyday realities of a menstruating woman requires an inter-sectoral position because her life unfolds not just at home, but in community spaces, schools, farms, and workplaces during her periods. Moreover, a menstruating woman also negotiates various socio-economic and inter-sectoral circumstances such as WASH, public health facilities, migration and public policy. Hence, this part of our study examines vulnerabilities, issues, and risks pertaining to menstruation with respect to an inter-sectoral focus.

- As villages selected from Malkangiri and Kalahandi districts are tribal communities dominant, they depend on natural farming and Minor Forest Produce (MFP) collection.
- Water scarcity and increasing inaccessibility of potable water are crucial issues in these villages.
- Drinking water crisis, lack of electricity and lack of transport system, lack of education, and poor monetary gains, high rate of unemployment are issues faced by villagers in both the districts.
- Against this background, we present a brief inter-sectoral data analysis on migration and MHM, WASH and MHM, Education and MHM and lastly, MHM from the perspective of awareness towards public policies.

The overall narrative of different practices on MHM in these villages related to community-based vulnerabilities, socio-economic conditions and beliefs including monetary freedom or disposable income of women besides health and education related inter-sectoral factors.

3.4.1 MIGRATION AND HEALTH

- According to our data migration was found only in the Malkangiri district of Odisha.
- 16 families out of 385 from Malkangiri migrated for work.

- Out of which, 4 families migrated locally for farming work. 2 families migrated for brick-making and domestic work, respectively for 3-5 months. Rest all families migrate for agricultural work as daily wage laborers migrate for 1-4 months, depending on the work.
- Our findings indicate that 10 out of the 16 migrant women from Malkangiri strongly feel that their seasonal work conditions and resource scarcity influences their menstrual health negatively.

3.4.2 TRADITIONAL SKILLS AND EARNING CAPACITY.

Out of two districts, 20 women from Malkangiri and 1 from Kalahandi possess skills like art, craft, farming, tailoring, etc. Out of them, 1 from Kalahandi and eleven from Malkangiri earn from the traditional skills possessed by them.

Given that there is a possibility of augmenting family income from traditional knowledge and customary skills, vocational courses can be organized for women struggling with socio-economic vulnerabilities to enhance their means of livelihood and disposable income. A disposable income can give women better opportunities towards an empowered decision -making w.r.t MHM as well as personal and medical care.

3.4.3 WASH AND MHM

According to the NFHS-5 Report, 41.4% and 64.4% of households from Malkangiri and Kalahandi, respectively, use an improved sanitation facility (International Institute for Population Sciences (IIPS) and ICF 2021, p. 93, 129). According to our survey responses, Individual Household Latrines (IHHL) are used by only 1.6% in Malkangiri and 2.3% in Kalahandi.

WASH & MHM	Malkangiri (in %)	Kalahandi (in %)
Total Respondents	**385**	**353**
Water Facility at Home		
Bore well/ Tube well/ covered Well	8.6	0.3
Hand pump/ Standpost	86.5	97.7
Piped water/ Piped to yard/ Plot/ Public tap	0.5	0.6
Protected Spring	4.2	1.4
Tanker/Truck / Cart with small tank	0.3	
Toilet Facility at Home		
Individual household latrine	1.6	2.3
Community toilets	1.3	
Open defecation	97.1	97.7
Type of House		
Kutcha	59.5	96.9
Semi pucca	37.1	1.7
Pucca	3.4	1.4

- **Kind of House:** Housing conditions were found to be better in Malkangiri where almost 60% of the people have *pucca* houses (roof, wall and floor all are made up of pucca material) as compared to Kalahandi where almost 96.9% of the families interviewed stay in *kutcha* houses (roof, wall and floor all made up with kutcha material).
- **Compromised Toilet Facilities:** Pucca houses can have toilets built within as opposed to Kutcha houses where such a provision is not possible. Though toilets were constructed under Swachcha Bharat Abhiyan, most people opted for open defecation owing to various anomalies such as living in kutcha houses and/ or poorly constructed toilets or due to community-wide preferences for open spaces.
- **Sanitation and Access Challenges:** One of the main everyday challenges in the area emerged to be compromised access to water facilities and proper sanitation. Our findings indicate that only a handful number of surveyed families (Four) from both the districts use piped water for drinking purposes. The remaining families rely either on a bore well, tube well, or hand pump/ standpost outside of home. Almost all women from both the districts reported water scarcity and problems related to it, including constraints on availability of sufficient water for menstrual hygiene.

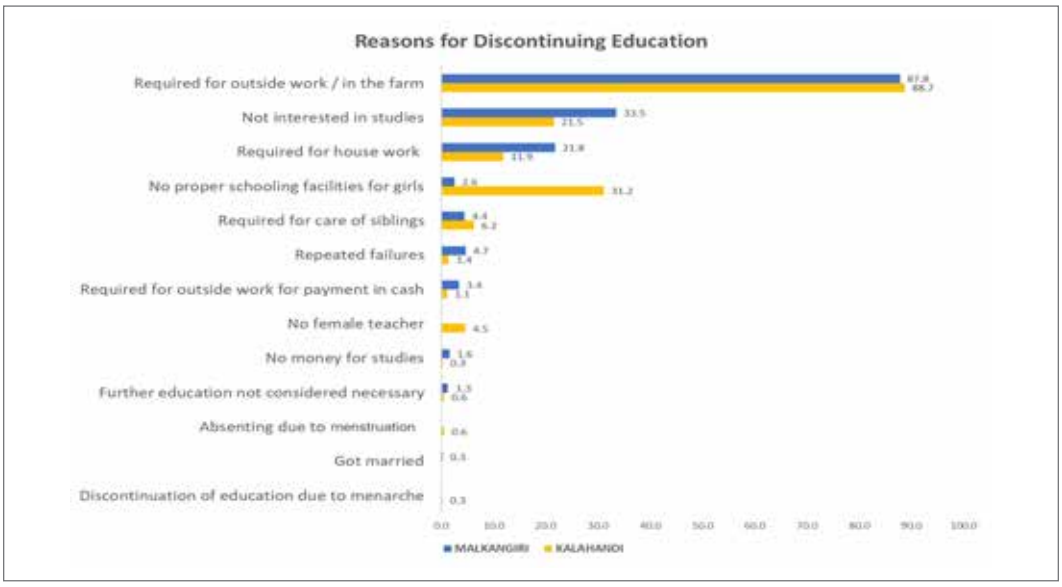
It is clear that during menstruation a woman's WASH needs are relatively higher as compared to the rest of the days of the month. When a woman experiences her periods, she needs more water to clean herself for personal and intimate hygiene, including after defecation. Besides, a regular supply of clean water, ensuring that a woman has the facility of a private and secure place to change her menstrual absorbents and clean herself are a profound part of her sense of dignity and safety. Therefore, the access to the toilet and bathroom become a critical need during periods.

3.4.4 EDUCATION AND MHM

Out of the total surveyed population (N=738), 315 women had informal education whereas 371 women were illiterate.

Education and MHM	Malkangiri (in %)	Kalahandi (in %)
Total Respondents	**385**	**353**
Education		
Informal Education/ Can read- write	17.7	70
Illiterate/ no schooling	71.7	26.9
Primary (1st -4th)	6.5	1.4
Secondary (5th-7th)	2.1	0.3
Higher secondary (8th-10th)	1	0.8
11th	0	0.3
12th	0.8	0.3
Graduate	0.3	0
Reasons for Discontinuing Education		
Lack of facilities	2.6	35.7

Education and MHM	Malkangiri (in %)	Kalahandi (in %)
Educational barriers	38.2	23.8
Family barriers	6	6.8
Monetary barriers	92.7	90.1



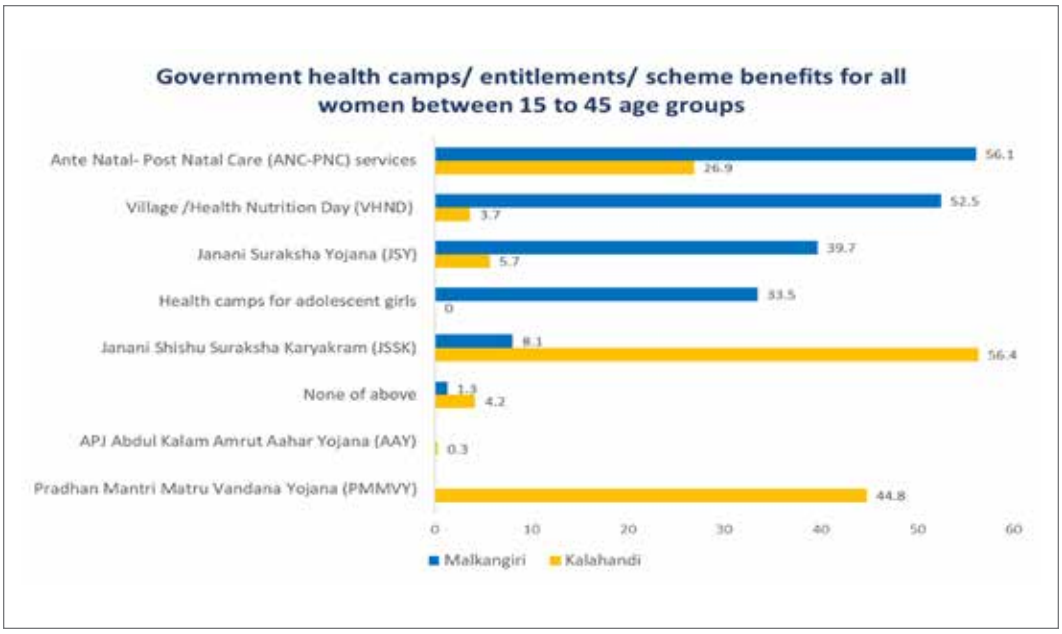
*Multiple Choice Question

- **Bottlenecks**: In both districts, monetary barriers were the primary cause for educational discontinuity. To enhance family income, women were required to work on their farms or outside of home as a laborer. As a hindsight on their educational status, women reflected that lack of proper schooling facilities in general and the non-availability of female teachers, less importance on education for girls, i.e., family-imposed responsibilities were other top reasons for them not being able to attend/ complete school.
- **Failing/ Lack of Interest**: 27.8% of our total respondents discontinued education citing the reason as not being interested in studies. Another 3.7% of women left education due to repeated failures.
- **Menarche and Marriage:** Menstruation is a major criterion for some parents and families laying restrictions on the movement of a girl outside of home, including a preference that adolescents drop from school. Girls being absent from school due to MHM related issues including physical symptoms such as pain etc. also led to interrupting education post-menarche in some cases. While community beliefs such as a girl being 'ready for adulthood' in early post-menarche years leads to pressure on the family to marry her off.

3.4.5 AWARENESS TOWARDS PUBLIC POLICY AND COUNSELING ON MHM

Public Policy: National Health Mission runs various programs for the age group of 15 to 45 years, i.e., for adolescent girls as well as women. Most women in both the districts are aware of public policy.

- **Local Health Services:** From the survey, 59.2% of women from Malkangiri and 84.7% of women from Kalahandi receive health check-ups at the local level in the village or at the Sub- Center level followed by Ante- Natal and Postnatal services.
- **Engagement with Public Health services**: 56.1% of the women from Malkangiri and 26.9% of women from Kalahandi reported receiving Antenatal Care and Postnatal Care (ANC-PNC) related services. More than half the women from Malkangiri responded that they attended Village Health Nutrition Day (VHND) on a regular basis.



*Multiple Choice Question

- **Significance of Public Health Facilities:** Public Health facilities usually play an important role in providing free and affordable treatment. Health support systems in India are designed such that for every 1000 population there is ASHA appointed, for around 5 to 6 villages, there is a Sub- Centre where treatment for small illnesses as well as 24/7 facility of delivery is available. After that, for every 30000 people, there is a Primary Health Centre (PHC). And as we move further, Rural or Sub-District hospitals, district hospitals in urban areas, municipal corporation health clinics, and hospitals are available.
- **Accessibility:** EAMW covered in this survey were asked through IDIs about the nearest accessible public health facilities for getting treatment or pursuing their health issues. The nearest public health facility reported by women from both the districts was the Sub Centre (80.2%) followed by the Primary Health Centre (26.0%).
- **Importance of Health Camps**: Women across various contexts are differently integrated with the national public health infrastructure and policies. Health camps, which are periodically organized in villages, are specifically important and needed in areas which are remote and cut-off or where Sub-centers are not available. Our survey findings indicate that a major chunk of the population surveyed in Malkangiri benefits from ANC and PNC services, VHND, JSY, health camps for adolescent girls. In Kalahandi, benefits from JSSK amd PMMVY were received. If health camps start covering the wellbeing of EAMW in remote and isolated areas, women will stand to benefit from many health based objectives and parameters of the Indian government. In total, 33.5% of women reported health camps for adolescent girls are helpful.

Our findings indicate that women are familiar with and dependent on the services guaranteed from the public health system as well as they receive monetary benefits from the schemes such as Janani Suraksha Yojana (JSY), Pradhan Mantri Matru Vandana Yojana (PMMVY) and transportation facilities under Janani Shishu Suraksha Karyakram (JSSK) along with ANC and PNC services.

COUNSELING ON MHM:

Upon being asked if they ever received any counseling on menstrual health, 96.5% of our interviewees responded in the affirmative. Counseling on MHM was received from health workers such as ASHA, ANM and AWW.

Received counseling on Menstrual Hygiene from health workers	Malkangiri (in %)	Kalahandi (in %)
Total Respondents	**385**	**353**
No	1.8	5.4
Yes	98.2	94.6

Yes: Out of the total respondents, 98.2% EAMW from Malkangiri (n=385) and 94.6% from Kalahandi (n=353) reported that they seek counseling, guidance, and treatment on health issues from the public healthcare facilities

No: In Odisha 21 women, out of a total of 738 had never received counseling on menstruation or MHM in their villages.

Menstrual health of women beyond school years is still a long way from being actively considered as a public policy measure in India. Owing to the vast reach and significance of, as well as a substantial reliance on Public Health system in India, the MHM of EAMW can get a much-required boost if the issue receives adequate attention through public policy. Even the ADP can stand to gain women's participation if MHM is piloted as an inter-sectoral intervention cutting across education, social security, WASH and livelihood.

PART 4 VOICES, EXCERPTS AND OBSERVATIONS

As part of our research, we conducted approximately twelve open -ended interviews with key informants. These KIIs were taken across each district, not necessarily restricting ourselves to voices of people from villages included in our field research. People interviewed during this exercise were important stakeholders in communities/villages such as AWWs, ANM, Doctors, Teachers, ASHAs, Counselors and social workers etc. The voices of these stakeholders are critical for the development of the community as they give a unique point of view on the local village population as well as district-wide situations. In a small but significant way, these grassroots voices help us arrive at community-sensitive and area-specific recommendations and ways forward. Highlights from these interviews are as follows:

Kalahandi (Data derived from 5 villages of the district): In Kalahandi district of Odisha, 9 respondents across 5 villages stated that people follow taboos related to menstruation in the villages. 7 respondents stated that there is water scarcity in the villages and one of them was worried over the lack of water facilities in the villages. 5 respondents informed us that there are no toilets in the villages. 3 respondents confirmed that free sanitary napkins are not distributed for girls. Villagers preferred and practiced open defecation. Two respondents stated that awareness initiatives related to menstruation were never held in their villages. They further added that respondents were not aware of any government schemes related to menstrual hygiene and felt unsafe while defecating in the open.

Malkangiri (Data derived from 5 villages of the district): In Malkangiri, 9 respondents across 5 villages informed us of acute water scarcity in the villages and stated that there were no toilets in the community. 7 respondents were informed about the various kinds of taboos related to menstruation in their villages. 4 respondents stated free sanitary napkins are not distributed in their villages. One of our respondents stated awareness generation programmes exist in the villages.

4.1 VOICES, EXCERPTS AND OBSERVATIONS OF RESPONDENTS: KALAHANDI

Our respondents from the field have shared their experiences, conceptions and observations on MHM. Below are some voices and excerpts from our interactions with them.

Janani (Interview: 13.07.2022)[2], the **Sarpanch** of a village in Kalahandi district of Odisha informed us that her village implemented the Khushi and ADVIKA programs under the RKSK scheme. Meetings of adolescent girls with ASHA and AWWs were held twice in a week on the theme of menstrual hygiene. On village WASH needs she replied the village had toilets, bathroom in the community and tube wells but no water supply. Informing us about prevalent taboos she said that menstruating girls and women were isolated in a separate place which was also used for bathing and washing. They are not allowed to touch food or participate in religious activities during menstruation.

Tadi (Interview: 13.07.2022)[3], an **ASHA** worker stated that although sanitary pads are subsidized, "no one uses sanitary pads in the village, lack of financial resources is one of the reasons". Further she confided, "we stay separately during periods, we are not allowed to touch food, not allowed to enter a place of worship but we are allowed to work in the field during menstruation."

Shantilata (Interview: 15.07.2022)[4], an **AWW** in a village in Kalahandi district of Odisha responded, the village counted on the KHUSHI program to distribute sanitary pads and VHNM program every month to sensitize women about menstruation. On WASH needs she replied, there is adequate water in the village but people depend on stream water mostly. Toilets have been constructed badly in the village. "Menstruating women were treated as 'untouchables' and ordained to stay outside their homes during their periods", informed the AWW.

Jamuna (Interview: 15.07.2022)[5], an **AWW** in a village in Kalahandi informed us that under schemes such as the ADVIKA program, every Saturday IFC tablets were distributed to adolescent girls under RKSK. Khushi Program was implemented to distribute free sanitary pads in school and pads were sold at subsidized prices to women aged 20-49 years. On WASH needs in school and community she explained the school had a water basin and toilet facility adding that, "Some NGOs had constructed water tanks in villages, but people rely on stream water for their needs". She added that education, free distribution of sanitary pads and proper toilets with hand washing facilities are the most urgent needs towards MHM and WASH.

Our respondent Lakshmi (Interview: 16.07.2022)[6] who serves as the **Sarpanch** of a village in Kalahandi stated, "there are schemes such as distribution of sanitary pads on subsidized rate and Iron tablets to adolescent girls". On requirement of women aged 20-49 she replied, health check-ups and treatment for ailments related to menstruation are important to address. On WASH needs in school and community she explained, the village had an overhead water tank, but women use stream water for bathing and washing, school also had water and toilets, but these were not maintained properly. From her account it was evident that the village had problems with privacy for women. She suggested a separate bathing and washing facility for women and toilets in the village. Moreover, the village has some taboos regarding menstruation such as isolation during menstruation and women strictly not allowed to meet with elders or be in the kitchen and temples.

Pushpalata (Interview: 20.07.2022)[7] an **ANM** in a village in Kalahandi district of Odisha informed that the village had free distribution of (Iron and Folic Acid) IFA tablets every Saturday to adolescent girls suffering from mild and severe anemia. This was done under the RKSK scheme alongside the distribution of sanitary pads on a subsidized rate of six Rupees per packet. On water supply and sanitation in community and school she added, "Stream water is the only source in many villages because hand-pumps are better suited for plains as opposed to the mountains." Open defecation is still practiced in the community. Further she said, "Construction of

[2] OD KII7 KAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[3] OD KII9 KAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[4] OD KII10 KAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[5] OD KII6 KAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[6] OD KII5 KAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[7] OD KII2 KAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

toilets, water supply with pipes is being taken up in schools and communities. But lack of running water creates problems for girls and boys both." She suggested a separate room in school to change sanitary pads. She added, the village had some taboos regarding menstruation such as isolation during menstruation, separate plate for eating, not allowed to touch elders, enter in kitchen and temple. She further explained that interior location of villages leads to slower mobility of medicines and accessibility of healthcare.

Manoj (Interview: 20.07.2022)[8], who works as a **Health Supervisor** in Health and wellness center in a village in Kalahandi district of Odisha stated, that free/ low-cost sanitary pad distribution, regular health check-ups of girls with treatment of minor ailments and referral services for high-risk girls, in addition to awareness programmes on menstruation were conducted under RKSK scheme in the village. He suggested that, "Health check-ups, treatments and referral services to secondary and tertiary level specialists are required for 20 to 49 years of women." On water and hygiene facilities, he replied that soaps were distributed to menstruating girls to wash hands in village schools that had water basins and toilet facilities, though cleanliness was a problem. Community's toilets, however, were in an unusable condition with no roof and doors. He insisted upon creating awareness among villagers and suggested separate places for washing and bathing in the village. He further added, taboos related to menstruation were practiced in villages such as complete isolation, not allowed to touch elders, not allowed to enter in kitchen and religious places. He added, "Some of it is good as the girl has less chance of getting infected by others. Restricted mobility helps her get some rest."

Sahoo (Interview: 23.07.2022)[9] who is the **In-charge of a Community Health Centre** (CHC) in a village in Kalahandi district of Odisha informed us that sanitary pads, iron as well as folic acid tablets were distributed free to adolescent girls once a week. Village Health and Nutrition Day was celebrated to make the villagers aware of child marriages. Regular health camps were organized on Mondays and Fridays. On schemes related to water and sanitation, he informed us that villagers were dependent on a single stream for their needs as some handpumps in the village did not work in summer. Community toilets in the village were in an unusable condition due to unavailability of water and shabby construction. "Open defecation', said Sahoo, "was still practiced in the village. Along with this, water scarcity and compromised purity leads to challenges in MHM for women as they have to deal with itching in private parts, white discharge, and irritation." He insisted that there should be awareness generation on menstruation and women should be encouraged to use sanitary pads. On taboos, he explained some practices such as menstruating women being treated as 'untouchable', not being allowed to, - enter the kitchen, temples and also, perform *Pooja* (worship) during menstruation. He observed that remote locations, especially mountains, are the real challenge in attaining proper menstrual health as health workers have to trek kilometers to reach villages, and the situation gets worse during rain. He added that the community's belief in black magic was a major disabling factor in the village.

Kalidash (Interview: 23.07.2022)[10], the **Headmaster** of a high school in a village of Kalahandi district of Odisha informed us that the school and hostel both had proper water and toilet facility, students were also provided with soap and detergents. On local requirements on menstrual hygiene, he suggested free distribution of sanitary pads, hand wash and soap were the most urgent needs of the village and school. In hostels and schools, there were no taboos around menstruation. The girls were allowed to do anything they did as a normal routine. However, back home amongst the community, they face customs such as isolation during menstruation, no cooking or performing Pooja etc.

Dasami (Interview: 04.08.2022)[11], a **Matron** of a girl's hostel in a village in Kalahandi district of Odisha responded, there is no scheme other than distribution of iron tablets in the school. After covid, sanitary pad distribution program has stopped due to lack of resources. The village school had water and toilet facilities, but it did not have any bathroom. Instead, they have constructed make-shift wall enclosures with tap. There is, however, a hand wash orientation program for girls and every girl is provided with 83 rupees monthly to buy soap, detergent, and other things to maintain hygiene. She insisted upon free distribution of sanitary pads to every girl. She further

[8] OD KII4 KAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[9] OD KII1 KAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[10] OD KII12 KAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[11] OD KII8 KAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

added there were no taboos in the school w.r.t menstruation and girls were allowed to everything according to their general routine.

Bijayshree (Interview: 08.09.2022)[12], a **Child Development Programme Officer** (**CDPO)** in a peri- urban area of Kalahandi district of Odisha stated that the area counted on schemes under KHUSI and ADVIKA programmes for adolescent girls. Every month sensitisation sessions were organized on different aspects of health and hygiene in villages. For menstruating women between 20-49 years of age, women regarding MHM she added, free distribution of sanitary pads, availability of lady doctors and insisted upon creating awareness through street plays, mela on menstruation, and competition among young girls regarding menstruation knowledge in villages. On WASH needs she added, every household especially under BPL are provided with toilets but tribal areas were still not open defecation free. She further said villagers practiced isolation of women during menstruation. It is time to involve influential people such as *Sarpanch* and Ward members to make people aware about menstruation.

Satyabhama (Interview: 08.09.2022)[13], an **AWW** in a village in Kalahandi district of Odisha informed us that, "there is water facility and hand wash provisions but changing rooms are not available". Taboos and restrictions on women during menstruation, not being allowed to touch other family members, and entering the kitchen were some disabling factors that affect women's health and menstrual hygiene.

4.2 VOICES, EXCERPTS AND OBSERVATIONS OF RESPONDENTS: MALKANGIRI

Our respondents from the field have shared their experiences, conceptions and observations on MHM. Below are some voices and excerpts from our interactions with them.

Shasi (Interview: 25.07.2022)[14], the **Sarpanch** of a village in Malkangiri district of Odisha confirmed the implementation of KHUSHI program for sanitary pads and IFC tablet distribution under RKSK. Menstruation related themes in the village. On WASH in community and school she answered, water facility is not good in school and community, though school had toilet facility but community toilets were not in usable condition. On the area's MH requirement, she replied the village needed free sanitary pad distribution, toilet, and water facility. She explained the specific taboos in the village such as women not allowed to draw water from common sources. Isolation during menstruation, segregation from other family members, restrains on entering the kitchen and temple were other do's and don'ts.

Saratmanjari (Interview: 13.08.2022)[15], a **Headquarter Supervisor** in a village in Malkangiri district of Odisha stated that the village had KHUSI program for free sanitary pad distribution in school. Pads were sold at a subsidized rate in the community, furthermore, the village had an IFC tablet distribution and awareness program under the RKSK scheme. On WASH needs in school and community, she answered that the village had a tube well for school and community needs. However, from her account it was not clear how women's menstrual health needs were fulfilled throughout the year. She further added "free sanitary pads for all, adequate water facility and proper toilet facility is the real need of the area." On Taboos regarding menstruation she replied, women were not allowed inside the house during menstruation, not allowed to enter the kitchen and participate in religious activities, but there are some good customs such as washing menstrual cloth with soap, detergent, and warm water.

Mamta (Interview: 13.08.2022)[16], an **ASHA** in a village in Malkangiri district of Odisha spoke of KHUSHI program, distribution of sanitary pads, nutritive food (eggs) as well as medicine supplements (Iron and Folic Acid). On WASH needs in schools and community she added, the village relied only on a single tube well facility for water needs. From her account, it was not clear that the village and school had a toilet facility or not. She further added,

[12] OD KII3 KAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[13] OD KII11 KAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[14] OD KII1 MAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[15] OD KII2 MAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[16] OD KII4 MAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

water and toilet facilities in villages and schools are highly needed. On taboos, she said "we do not interact with others during menstruation, and after completing the menstrual cycle we wash the room with cow dung."

Sukri (Interview: 26.07.2022)[17], an **ASHA** worker in a village in Malkangiri district of Odisha stated, the village had a KHUSHI program to distribute sanitary pads, and another program to distribute iron tablets and eggs to adolescent girls. Furthermore, there is also a program to readmit dropout girls in school under RKSK. On WASH needs she added that the water system in the village is not reliable, and toilets were also in unusable condition. She added the village needed a good water and toilet facility and free sanitary pads for all. On taboos she answered that the village has some customs such as women were not allowed inside the house during menstruation and not allowed to enter the kitchen, but there are some good customs such as regular bathing and washing hands during the periods. From her account it was evident that lack of financial freedom to women was a major disabling factor as she said, "Even if one wants, cannot go for medical help without finances and a person to accompany. That inhibits women very often from getting medical assistance on time."

Respondent Sumitra (Interview: 27.07.2022)[18], an **AWW** in a village in Malkangiri district of Odisha told us that iron tablets were provided to adolescent girls and pregnant women, eggs given on every Saturday, and pads sold at subsidized rates. Girls who dropped out were readmitted to schools under the RKSK. On WASH needs in school and community, she added that the water facility was not reliable in both the places: Homes and Schools, that is not surprising when the village was dependent only on one source of water, a single tube well. Open defecation is still practiced in the village as toilets are not in a good condition. She added that the village needed adequate water facilities, properly constructed toilets, and free sanitary pads for all. On taboos she answered women were allowed neither inside the house nor the kitchen. Other disabling factors related to MHM were unavailability of medicine and sanitary pads on time, no lady doctor in the village, and the long distance from village to hospital.

Kamala (Interview: 13.08.2022) [19] an **AWW** in a village in Odisha's Malkangiri confirmed the presence of schemes under KHUSHI program for pad distribution. For improving nutrition eggs were given every Saturday. VHND meetings of women with ASHA, ANM, and health workers were held every month under RKSK. On water and sanitation needs, she opined that the village needed more than one tube well and proper toilet facilities in school and village both. Further, a lady doctor should be present in the Village Health Centre (VHC). On taboos in the village, she answered, "women were not allowed inside the house till the flow dries, not allowed to touch food, and elderly wash their menstrual cloth with ash".

Shila, (Interview: 13.08.2022)[20] who worked as a **Nursing Officer** in a rural area in Malkangiri district of Odisha informed us that though adolescent girls were covered under ongoing schemes in the village wrt MHM, there was a shortage of supply. Toilets were also not functional. She voiced a concern that an MHM awareness program be held in regular intervals and a place in the village be facilitated where young girls can discuss menstrual hygiene. On taboos, she added women were not allowed inside the house during menstruation, not allowed to take part in religious activities and women avoid interacting with boys during menstruation.

Bhagabati (Interview: 27.07.2022)[21], the **Sarpanch** of a village in Malkangiri district of Odisha responded that schemes menstruation in village run under the KHUSHI program for pad distribution. Under the ADVIKA Yojana monthly meetings are conducted to teach about health and nutrition, there is also a readmission program for dropout girls under RKSK. On WASH needs she answered infrastructure on water in the village that suffered a lack of water supply and toilet facility was poor. The Sarpanch insisted upon creating awareness among women about menstruation. On taboos regarding menstruation she explained, women were being isolated during menstruation, they were not allowed to enter the kitchen and participate in religious activities. From her account it was evident that lack of transport is a disabling factor in achieving

[17] OD KII5 MAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[18] OD KII6 MAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[19] OD KII7 MAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[20] OD KII8 MAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

[21] OD KII9 MAL: Available in Data Records MHM and WASH Project (2022-2023) SSMF- Sulabh International

proper menstrual health as she said "There is no easy commuting facility to the city, there are no public transportation system to this village and many other, since transport system not good, we are unable to go and buy pads, medicines."

4.3 SALIENT FINDINGS FROM DATA

Processing through our data from Malkangiri and Kalahandi, we have gained some valuable insights on women's health, education, livelihood and overall community outlook on menstrual health management needs and transformations on ground.

In Malkangiri, besides schemes such as KHUSHI (for free sanitary pads in schools, pads at subsidized price of 6 rupees per packet to every woman) and ADVIKA (for free distribution of Iron Folic acid tablets once in a week to adolescent girls), awareness drives on MHM and distribution of eggs every Saturday are looked forward to by women. In some villages of Malkangiri, there is a focus on re-admitting girl-dropouts in schools under Rashtriya Kishori Suraksha Karyakaram (RKSK). In Malkangiri, every village had a single tube well system for water. Lack of financial resources emerges as an important reason for poor conditions on menstrual health and hygiene. Sukri, an ASHA worker in a village of Malkangiri defined the scarcity of finances with a gendered perspective when she said that, "lack of financial freedom as well as dependence on family members for seeking medical help/ traveling to the doctors become major disabling factors. Even if one wants, she cannot go seeking timely medical assistance". There are some common taboos in Malkangiri villages related to menstruation such as women not allowed to enter the kitchen and cook; they must be out of bounds of religious places. Girls cannot interact with boys and need to follow complete isolation during menstruation.

The Kalahandi district of Odisha counts on several schemes related to menstrual hygiene such as KHUSHI and ADVIKA. A Village Health Nutrition Programme (VHNP) runs every month to raise awareness amongst women. Nonetheless, post the COVID-19 pandemic, in some villages the free sanitary pad program has been stopped. On WASH related milestones, it was evident in every KII that villages face lacks water and toilet facilities. Their villages being situated on mountains where hand pumps do not work, most people depended mainly on-stream water. Toilets were poorly constructed, had no water supply and were unusable leading to the continuation of open defecation in the villages. Sahoo, a doctor-in-charge of a Community Health Centre (CHC) in a village in Kalahandi opined that, "the interior location especially mountains are the real challenge in attaining proper menstrual health as health workers have to trek many kilometers to reach villages and the situation gets worse during rain." According to Lakshmi, the Sarpanch of a village in Kalahandi, privacy for women is another major concern in her area. She demanded a separate bathing facility for women in the village. Common taboos prevalent in the villages of Kalahandi such as women not being allowed to enter religious places and be in the kitchen promote isolation during menstruation.

From our interactions and databases pertaining to Odisha, it clearly emerges that apart from a silence on women's menstrual health in terms of inter-sectoral hindrances and policy related negligence in India, there are community-voices that portray a negative and discriminatory attitude towards periods. These discriminatory voices and attitudes in Odisha, just as our research from some other parts of India shows, pertain to both men and women across social strata. Many EAMW as well as key informants endorse negative attitudes (as told to our surveyors and field-researchers) towards menstruation, either owing to the circumstantial difficulties that they grow up experiencing or for want of better knowledge and support system around the phenomenon. Inadvertently or otherwise, such voices contribute to the perpetuation of a debilitating discourse on the phenomenon. The key to combating the inter-sectoral and community -based silences and barriers on MHM among women beyond school years lies in augmenting positive practices and discourses on menstruation. One of the best ways to achieve this is by involving multiple actors, key and critical stakeholders such as EAMW, leaders, influencers, families, policy makers and implementers. Hence, gender mainstreaming MHM can ensure gender perspectives and attention to the goal of gender equality in all activities, projects, and programmes.

4.4 RECOMMENDATIONS/ AREAS OF IMPROVEMENT

IMMEDIATE INTERVENTIONS

1. **Secure bathing and washing spaces**: Safe toilets as well as bathing facilities need to be operational so that open defecation (practiced by 97% families surveyed) and ablutions both, can come to an end as they impede proper personal and environmental sanitation especially during menstruation.
2. **Water supply and MHM first- aid in schools:** Lack of running water in schools creates problems for both boys and girls, hence for the betterment of education and health of children and adolescents optimal WASH as well as MHM facilities be put in place in educational spaces.
3. **Disbursement and Disposal of Menstrual Absorbents:** Free distribution of pads/absorbent menstrual hygiene material should be continued for menstruating girls and expanded to provide for EAMW. Disposal mechanisms for menstrual waste need to be regularized and monitored as an interim measure till better systems are worked out.
4. **Monthly Meet, monitoring mechanisms and Micro planning on Periods:** A special place/ space for conversations on MHM should be ordained in each village so that women and girls can come together and talk about periods every month under guidance from ASHA, AWWs and other FLWs. Such interactions can not only raise awareness but also function as participatory thresholds for micro-planning on periods.
5. **Health-Check-ups for EAMW:** Monthly or three-monthly awareness drives on menstruation during which compulsory and inclusive health check-ups are organized for EAMW, i.e., women between the ages of 20-49 years of age.
6. **Energize ADP for MHM:** Develop IEC materials and awareness drives in the local language for increasing biological knowledge on menstrual health with a special focus on EAMW through health and wellbeing centers established under Ayushman Bharat in the aspirational districts. Community-based studies and grounded research be commissioned to experts to understand how to negotiate inclement conditions and disasters to reach out to menstruating women and girls who require medical help and knowledge on MHM.

SHORT TERM

7. **State -of - the art Disposal Management**: Undertake a study on disposal mechanisms in villages under the SBM(G) phase II through external organisations working on WASH and community-sensitive approaches, to assess the current practices and evolve context specific environment appropriate options for disposal mechanisms of menstrual waste that includes segregation, collection, transportation, and treatment.
8. **Disaster Resilience:** Ensure continuation of services for free pad distribution, medical support, and awareness to menstruating women and girls in regular times as well as during natural disasters through.
9. **Adult education and Skill development:** In Odisha, 93% of the women surveyed in Malkangiri and Kalahandi were illiterate. For a better orientation towards health and wellbeing, EAMW can be effectively engaged in adult-education/ skill development classes to enhance awareness and income capacities. In remote and impoverished tribal and PVTG villages of Odisha, traditional skills can make women self-dependent, as indeed our data from Malkangiri shows. We therefore suggest that to make positive changes in tribal and PVTG women's lives and equip them with disposable income for better MHM, livelihood programmes as well as vocational training focusing on traditional skills and knowledge.

LONG TERM

10. **Odisha MHM Committee**: A State level Menstrual Health and Wellbeing Committee be initiated to integrate remote places, mountainous regions etc. into the state and national ADP and MHM plans.
11. **MHM at District, Block, Gram Panchayat Level**: Information, education, and communication (IEC) for menstrual hygiene education and awareness that includes information around safe menstrual hygiene products; and menstrual waste management with safe disposal facilities.
12. **OLM Provisions for EAMW**: Build capacities and skills of women from poor, marginalized households and with special attention in PVTG villages through functionally effective SHGs for gainful self-employment under Odisha Livelihood Mission (OLM).
13. **Drinking Water Supply at Household level:** Ensure sustainable water source (preferably gravity schemes as per viability that are low on operations and maintenance) along with source strengthening measures and provision of Functional Household Tap Connections (FHTCs) to all households under National Jal Jeevan Mission scheme.
14. **JJM for Institutions and MHM:** Institutional water supply under JJM scheme to ensure supply of adequate running water in girl's toilets in schools.
15. **MHM friendly Toilets:** Ensure provisioning of community toilets as well as toilets in work areas with washing areas, bathing cubicles, and running water under SBM(G) phase II where needed.

REFERENCES

Census of India (2011) *District Census Handbook MALKANGIRI*. Directorate of Census Operations Odisha, 10-11 [accessed 15 January 2023]

Counterview (2021) Project launched to fight high malnutrition in Odisha's backward Malkangiri district. *Counterview*, 25 July. Available from https://www.counterview.net/2021/07/project-launched-to-fight-high.html [accessed 20 January 2023]

Iype, Sarah. (2019) Breaking the Kalahandi syndrome. *The Hindu*, 28 October. Available from https://www.thehindu.com/opinion/open-page/breaking-the-kalahandi-syndrome/article29813862.ece [accessed 1 February 2023]

International Institute for Population Sciences (IIPS) and ICF. 2021.

National Family Health Survey (NFHS)-5, State and District Factsheets, Odisha. Mumbai: IIPS. 93 & 129 Available from

https://data.opencity.in/dataset/national-family-health-survey-nfhs-5-2019-21/resource/nhfs-5-data---odisha-and-districts-combined [accessed 10 January 2023]

Kalahandi District Population, Caste, Religion Data (Odisha) - Census 2011, Available from https://www.censusindia.co.in/district/kalahandi-district-odisha-395 [accessed 10 January 2023]

Krishnan, Revathi. (2021) Hunger deaths to 'rice bowl': How Odisha's Kalahandi-Balangir-Koraput corridor turned a corner. The Print, 21 December. Available from https://theprint.in/india/hunger-deaths-to-rice-bowl-how-odishas-kalahandi-balangir-koraput-corridor-turned-a-corner/784677/ [accessed 08 January 2023]

Kalinga Lanka Foundation (2018) *Introducing Odisha*. Available from https://www.kalingalankafoundation.org/introducing-odisha.html [accessed 10 January 2023]

Niti Aayog, Government of India (2018) *DEEP DIVE Insights from Champions of Change The Aspirational District Dashboard*. Available from https://smartnet.niua.org/sites/default/files/resources/firstdeltaranking-of-aspirational-districts.pdf [accessed 08 january 2023]

Odisha State Disaster Management Authority (OSDMA), Government of Odisha (2023) State Profile. Odisha. Available from https://www.osdma.org/state-profile/#gsc.tab=0 [accessed 10 January 2023]

Odisha post (2020) Supply of Vitamin-C-Laced Rice in Malkangiri From February. *Odisha Post*, 27 November. Available from https://www.orissapost.com/supply-of-vitamin-c-laced-rice-in-malkangiri-from-february/ [accessed 1 February 2023]

Poverty and Human Development Monitoring Agency (PHDMA) Planning and Convergence Department, Government of Odisha (2020). Report on State of Food Security and Nutrition In Odisha. Bhubaneswar. Available from http://phdma.odisha.gov.in/sites/default/files/2021-01/PHDMA-Report-FSnN-Odisha-min.pdf [accessed 20 January 2023]

Official website District Malkangiri, Government of Odisha. About District. Last updated 18 January 2023. Available from https://malkangiri.nic.in/about-district/ [accessed 20 January 2023]

Official website District Kalahandi, Government of Odisha. About District. Last updated 18 January 2023. Available from https://kalahandi.nic.in/about-district/ [accessed 20 January 2023]

ANNEXURE I

Selection of villages of in Malkangiri and Kalahandi

Village Names and Details

#	District	Block	Gram Panchayat	Village
1	Malkangiri	Chitrakonda	Badapada	Badaput
2	Malkangiri	Chitrakonda	Doraguda	Gadagurai
3	Malkangiri	Chitrakonda	Kapatuti	Kapatuti
4	Malkangiri	Chitrakonda	Nuaguda	Eragupu, Kalapadar, Kotaguda, Narsingpur, Paliguda, Purunapani, Ramaguda, Rathaguda, RSC-11, RSC-13, RSC-19
1	Kalahandi	Lanjigarh	Bijepur	Baterpada, Chachagoan, Jalakirida, Kandhajubanj, Kenduguda, Paikathuaguda, Poiguda, Phuker, Sindhabhata, Talkalima
2	Kalahandi	Lanjigarh	Mali Jubang	Ushabahali
3	Kalahandi	Lanjigarh	Trilochan Pur	Ambaguda, Dangabahali

*For data on individual Paras (Hamlets), see, https://ejalshakti.gov.in/jjmreport/JJMIndia.aspx Retrieved on March 11, 2022

Criteria/ Reasons for selection of villages in Malkangiri district

Sr. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (data accessed from JJM dashboard on 11/03/23)	Total Households (data accessed from JJM dashboard on 11/03/23)	Prevailing social issues/ issues of inclusion/ etc.
1	Chitrakonda	Badapada	341	70	Tribal dominated, water scarcity, malaria prone and infertility of soil
2	Chitrakonda	Doraguda	146	35	Tribal dominated, water scarcity, malaria prone and infertility of soil
3	Chitrakonda	Kapatuti	1048	219	Tribal dominated, water scarcity, malaria prone and infertility of soil
4	Chitrakonda	Nuaguda*	600	145	Tribal dominated, water scarcity, malaria prone and infertility of soil

Criteria/ Reasons for selection of villages in Kalahandi district

Sr. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (data accessed from JJM dashboard on 11/03/23)	Total Households (data accessed from JJM dashboard on 11/03/23)	Prevailing social issues/ issues of inclusion/ etc.
1	Lanjigarh	Bijepur*	314	64	Tribal dominated, drought prone, lack of basic health facilities
2	Lanjigarh	Mali Jubang	305	63	Tribal dominated, drought prone, lack of basic health facilities
3	Lanjigarh	Trilochan Pur*	104	36	Tribal dominated, drought prone, lack of basic health facilities

*For data on individual padas and hamlets, please refer https://ejalshakti.gov.in/jjmreport/JJMIndia.aspx

ANNEXURE II

Important Women-Centric Schemes Related to Health in Odisha

- *Mamata Scheme*: This scheme was started by the Chief Minister Shri Naveen Patnayak (BJD), Ministry of Women and Child Development, Government of Odisha to provide partial wage compensation for pregnant and nursing mothers so that they are able to rest adequately during their pregnancy and after delivery, to increase utilisation of maternal and child health services, especially antenatal care, postnatal care, and immunisation and to improve mother and child care practices, especially exclusive breastfeeding, and complementary feeding of infants.
- *Biju Kanya Ratna (Ama Kanya Ama Ratna):* This scheme was launched in September 2016 by the Chief Minister Shri Naveen Patnayak (BJD), Ministry of Women and Child Development, Government of Odisha. The declining Child Sex Ratio is a cause of concern in the state of Odisha.

- *Khushi Scheme*: Started in February 2018, it was operationalised by Chief Minister Shri Naveen Patnayak (BJD). Under this scheme, the Health Department of Odisha Government aims to provide free sanitary pads to 1.7 million girl students- from grades 6th to 12th in government and government-aided schools. Also, this scheme aims to promote health and hygiene among school-going girls and higher retention of girls in school.
- *Advika- Every Girl is Unique*: This scheme was started in October 2020 by the Chief Minister Shri Naveen Patnayak (BJD), Ministry of Women and Child Development, and Mission Shakti, Government of Odisha. The objective of the program "ADVIKA" is to reduce the risks and vulnerability of all adolescent girls in the age group of 10-19 years and make them self-reliant, empowered, and sustainable by renewing commitments towards adolescent girls. It will be implemented through Anganwadi centers across 30 districts and municipal corporations of the state.
- *Odisha State Policy for Girls and Women, 2014*: It was started by the Chief Minister Shri Naveen Patnayak (BJD), Ministry of Women and Child Development, Government of Odisha. The Policy was divided into 7 key focus areas of survival, health, and nutrition; education; livelihood (women in formal sector and informal sector); asset ownership; decision making, participation and political representation; safety, security and protection, and girls and women with special needs. Each focus area considers the situation analysis, followed by policy directives and further guiding principles and action points that translate the policy into action.

A RESEARCH REPORT FROM

TAMIL NADU







PART 1 INTRODUCTION

In Tamil Nadu, our study was conducted in the districts of Ramanathapuram and Virudhunagar. Both are included in Niti Ayog's Aspirational District Programme (ADP).[1]

Ramanathapuram and Virudhunagar share socio-economic vulnerabilities such as poverty, relatively high school drop-out rates and illiteracy and both have a large number of marginalized women workers in the unorganized sector.

10 villages were selected for field research and surveys. All the research, data collection and analysis for this case studywere done from April 2022 to February 2023. Following a participatory and mixed-methods approach, information was sought and processed on Menstrual Hygiene Management (MHM), Water Sanitation and Hygiene (WASH), education, health, livelihood, income and availability of support systems to women. Though both districts are doing well on many parameters under the ADP, our study indicates that they have much to achieve in terms of combating the silences on MHM with inter-sectoral perspectives on wellbeing of the **'Elder and Ageing Menstruating Women'** (EAMW, women 20-49 years). Since the women we interacted with included mothers, teachers, counsellors and caregivers of young girls within schools and families,we have also included a lateral analysis on the menstrual wellbeing requirements of school-going girls, and their enablers and barriers, though the primary focus remained on EAMW, to understand the well-being of menstruating women beyond school years.

Our research has been designed to collect thick ethnographic data on actors, practices and discourses with an inter-sectoral and analytical perspective on MHM in selected research areas. WASH, availability of community support systems, schemes and education as well as felt needs of menstruating women form a vital part of our research. We bring data through fieldwork, interviews, Focus Group Discussions (FGDs) and observations on MHM through women's participatory voices and opinions. A total of 457 interviews were conducted by employing the Menstrual Practice Questionnaires (MPQs), wherein data was collected from 178 women from Ramnathpuram and 279 from Virudhunagar. Interviews and interactions took place in the local Tamil language in which our respondents were comfortable.

In the final sections, the findings are examined against the voices of key informants to crystallizethe significant results from our primary data as well as delineate context-specific and community-sensitive areas of improvement. Our case study ends with suggestions on immediate, short term as well as mid-term enablers and recommendations for combating the inter-sectoral hindrances prevalent.

TAMIL NADU

Tamil Nadu, which is one of the first British settlements in India, is the successor of the old Madras Presidency, which covered the bulk of the southern peninsula in 1901. The composite Madras State was later reorganized and the present Tamil Nadu was formed. Agriculture is the major occupation in Tamil Nadu, principal food crops being paddy, millets and pulses. Commercial crops include sugarcane, cotton, sunflower, coconut,

[1] ADP aims to improve the socio-economic status of the citizens expeditiously. Core principles of the programme are: Convergence (of Central & State Schemes), Collaboration (among citizens and functionaries of Central & State Governments including district teams) and Competition among districts (Niti Aayog 2018).

cashew, chilies, gingelly and groundnut (Government of Tamil Nadu, 2023). Major industries in the state are cotton, heavy commercial vehicles, auto components, railway coaches, power pumps, leather tanning industries, cement, sugar, paper, automobiles, and safety matches. Knowledge-based industries like I.T. and Biotechnology have become the thrust area of the industrial scene in Tamil Nadu (Government of Tamil Nadu, 2023). At current prices, Tamil Nadu's gross state domestic product (GSDP) is estimated to be 24.85 trillion INR (US$ 320.27 billion) in 2022-23 (IBEF, 2023).

RAMANATHAPURAM DISTRICT

Ramanathapuram district, also known as Ramnad, is one of the 38 administrative districts of Tamil Nadu state in southern India. Ramanathapuram has an area of 4,123 km2. It is bounded on the north by Sivaganga district, on the northeast by Pudukkottai district, on the east by the Palk Strait, on the south by the Gulf of Mannar, on the west by Thoothukudi district, and on the northwest by Virudhunagar District. According to the 2011 Census, Ramanathapuram district had a population of 1,353,445 with a sex-ratio of 983 females for every 1,000 males, much above the national average of 929. The average literacy of the district was 72.33%, compared to the national average of 72.99% (Census, 2011). The district has gender inequality in literacy rate, but the literacy gap was reduced to 14.29% in 2011 from 19.65% in 2001 (District Human Report Ramanathapuram, 2017, pp 5-10).

Having become an aspirational district in 2018, Ramanathapuram has shown improvement in various developmental indicators, which are much visible particularly in the health sector, such as decline in infant and maternal mortality rate, still birth rate and an ensured hundred per cent institutional delivery. Ramnad is moving towards population stability by reducing the trend of crude birth and death rate. The crude birth rate of the district was 13.9 in 2013-14 (District Human Report Ramanathapuram, 2017, pp 5-10).

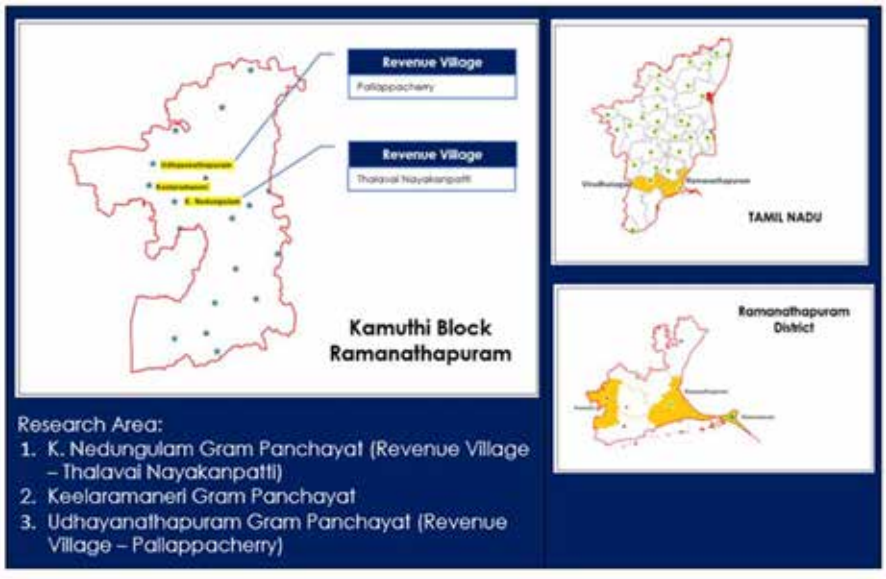
VIRUDHUNAGAR DISTRICT

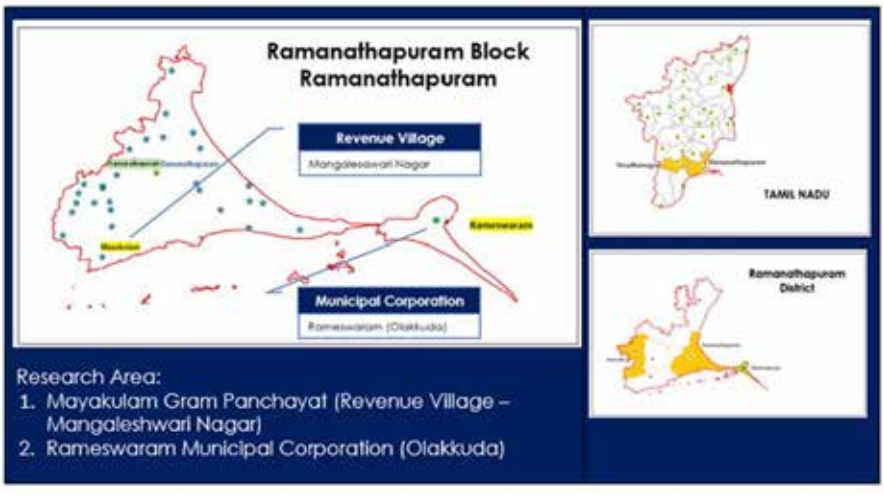
Virudhunagar district was called Virudhupatti until the beginning of the 20th century. It was one among the six important places in Ramanathapuram district. Due to the rapid growth in the field of trade and education, it was renamed as Virudhunagar on 29 October 1923. According to the 2011 Census, the total population of Virudhunagar district is 1942288, with male population as 967709 and the female population as 974579. According to the 2011 Census, Virudhunagar's total population has increased by 190987 since 2001. The percentage increase was 10.91. There is a slight decrease in the sex ratio of the district. It decreased from 1012 in the 2001 Census to 1007 in the 2011 Census (District Human Report Virudhunagar, 2017, pp 1-15). The per capita income is one of the most important indicators in estimating the development of the district and there is a gradual and continuous increase the district's per capita income. During 2004 – 2005, its per capita income was 47,514 INR, which increased to 87,361 INR during the year 2011 – 2012. Thus indicating a strong development trend in the district (District Human Report Virudhunagar, 2017, pp 1-15). Moreover, Virudhunagar district is State performing well in education with its overall rate of literacy having increased from 73.70% to 80.20% between 2001 and 2011. Both the male and female literacy rates increased between 2001 and 2011, the last available census (District Human Report Virudhunagar, 2017, pp 1-15).

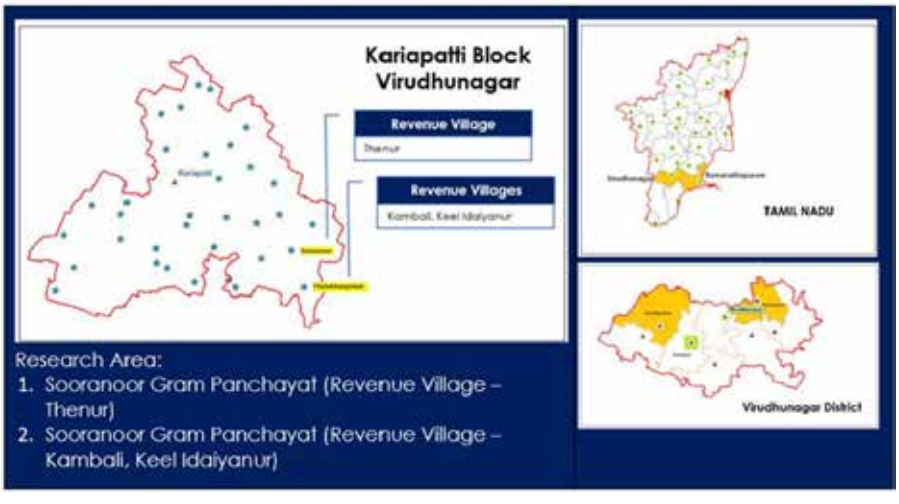
1.1 LIST OF VILLAGES SELECTED FOR THE STUDY

For the study, five villages from each district were selected on the basis of factors such as access to minority and tribal villages, vulnerable communities like fishermen and firecracker-making workers, scarcity of safe drinking water, migration due to rainfed land, unskilled labourers and rate of female literacy. While Ramnad had a dominant majority of Nayakkar, Dalit or fishing communities besides the Muslim population, the semi-urban area of Virudhunagar issignificant for the presence of migrant workers andwomen engaged in firecrackers-making units. As marginalized groups, these communities face challenges regarding access to healthcare and educational facilities.

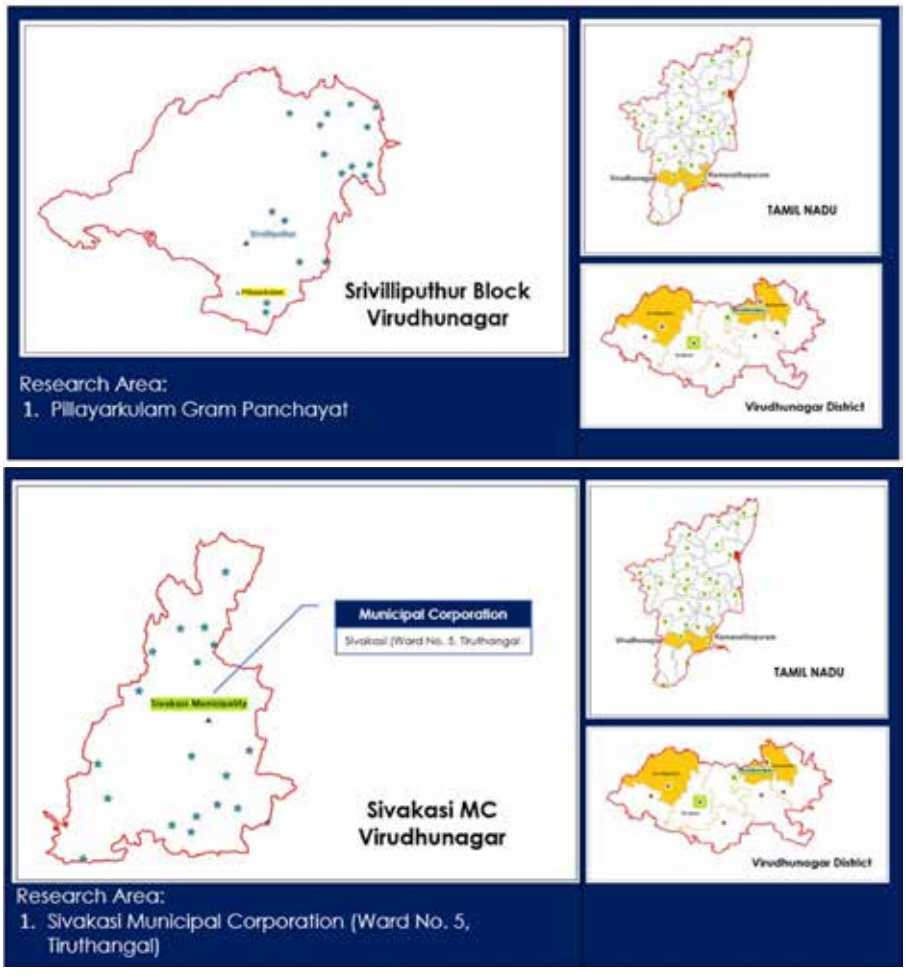
Thus, Ramnad and Vidrudhunagar villages provide views and inferences of mixed communities such as BC, MBC and Dalits who not only have a low literacy rate but are also deprived of basic amenities. Moreover, caste conflicts turn these villages into sensitive zones (*The Hindu* 2013; Quint 2021)[2].







[2] The Hindu (Special Correspondent) (2013) "One village one constable scheme to prevent caste clash in Ramnad". https://www.thehindu.com/news/national/tamil-nadu/one-village-one-constable-scheme-to-prevent-caste-clash-in-ramnad/article4262516.ece. [accessed 26 February 2023] Quint (2021) "Beheadings & Caste Wars in South Tamil Nadu: Pallar vs Thevar, the Inside Story". https://www.thequint.com/news/india/south-tamil-nadu-beheadings-the-inside-story-of-a-decades-long-caste-war [accessed 26 February 2023]



PART 2 DATA TOOLS

2.1 RESEARCH TOOLS, METHODS AND THEMATIC FOCUS FOR DATA COLLECTION, CORRELATIONS AND COMMUNITY-BASED ANALYSES:

Types of Interviews- Tools and Focus	Data Collection and Analysis- Methods and Themes	Tamil Nadu	
		Ramnad	Virudhunagar
Tool 1: Menstrual Practice Questionnaires (MPQs)	Method 1: The MPQs were In- depth Interviews (IDIs) for- actor, discourse and practice-analyses	178	279
Tool 2: Menstrual Practice Needs Scale (MPNS)	Method 2: Measurement of Perceptions and Needs Based on last Menstruation Cycle	42	47
Tool 3: Key Informant Interviews (KIIs)	Method 3: Voices, Excerpts, Salient Findings and Observations	12	12
Themes: WASH, Education, and Health, Livelihood	Focus: Inter-Sectoral findings and conclusion and comparisons		

PART 3 FINDINGS FROM MPQs AND MPNs

3.1 ACTOR ANALYSIS

3.1.1 DEMOGRAPHIC PROFILE OF THE RESPONDENTS-AT A GLANCE

Demographic Profile	Ramnad (in%)	Virudhunagar (in%)
Total Respondents	178	279
Rural / Tribal	85.4	55.2
Semi- Urban / Urban	14.6	44.8
Mother Tongue		
Tamil	100.0	100.0
Religion		
Christian	14.0	0.0
Hindu	75.8	99.3
Muslim	10.1	0.7
Caste/ Tribe type		
OBC/MBC/BC	64.6	83.5
SC- Scheduled caste	35.4	16.1
ST- Scheduled Tribe	0.0	0.4
Marital status		
Never married	9.6	7.2
Married	85.4	91.4
Widowed/ Separated/ Divorced	5.1	1.4

- **Religion:** Of those interviewed from both districts, 90.2% were Hindus. In Ramnad, besides the Hindus, 10.2% were Muslims and 14% were Christians; 99.3% of the women interviewed from Virudhunagar were Hindu.
- **Community:** Along with Muslims and Christians, more than one-third (35.4%) population of Ramnad was from SC whereas two-third population (64.6%) was BC or MBC. Similarly, in Virudhunagar, BC and MBC (Leppai, Maravar, Mukkulathore, Mutharayar, Thottiya, Valaiyar, Yadhavar, Adhithir, Agamudayar, Kadaiyan, Kammalar, Saanan, Vishwakarma etc) women interviewed were 83.5% and Scheduled Caste (Adhithiravidar, Kadaiyan, Kadaiyar, Pallan) population was 16.5%. Few interviewees (0.7%)from Virudhunagar were from Sakkiliyar tribe.
- **Marital Status:** 89.1% of the respondents were married. The average age of marriage in both districts was 19.7 years.
- **Children and Family Size:** Average number of children was two and the average family size was four persons.

3.1.2 AVERAGE INCOME

- **Family Income:** In Tamil Nadu, only half of the families have a regular income;55.1% families from Ramnad and 50.2% families from Virudhunagar earn as daily wagers and unskilled workers.
- **Earning Women:** 62.9% of 178 women from Ramnad and 24% of 279 women fromVirudhunagar go out to work and earn. But the average yearly income of women in Ramnad was as low as 13,401 INR and 42,624 INR in Virudhunagar.
- **Income Disparity in Districts:** At 100,919 INR, the average yearly family income in Virudhunagar was found to be more than in Ramnad where the families earned 74,758 INR on an average.
- **Total EAMW:** Of the total women surveyed through the MPQs, 91.5% were in their active menstrual years. The average age of hysterectomy was 41 years.

3.1.3 SOURCES OF INCOME

- **Farming** was the main and single source of regular income for only 20.1% for families of the total women interviewed from Ramnad and Virudhunagar. But in Virudhunagar, 80% of the population worked on their own farms, but earned from more than one source to survive.
- **Daily Wage Labour:** Contract labour, either as daily wage work or seasonal farm work, emerged as the highest source of supplementing family income for 52.1% of the families. In all, 75.3% women from Ramnad and 66.3% from Virudhunagar were reported working on farms owned by others or as daily wagers or as seasonal workers. Thus, half of the population from both districts had irregular annual income.
- **Profession/ Skill:** Fishing was a major source of income among Ramnad families besides the earnings from daily wages.
- **Traditional Knowledge and Skills**: 24.7% of respondents from Rammed and 13.6% of respondents from Virudhunagar possessed traditional knowledge and skills; 32% of the surveyparticipants from Virudhunagar were skilled in art and craft, while 56% practiced farming, fishing, and preservation of food; 11.7% of women practiced tailoring, cracker- making and pad- making. Of the total 457 women, only 103 women possessed traditional skills in both thedistricts and of those, 26 women from Ramnad and 14 from Virudhunagar could earn using those skills.
- **Women Lack Disposable Income**: **Although they worked on their own farms and their familiesalso counted on multiple sources of income, 60.6% of the women from our total sample in Ramnad and Virudhunagar reported that they 'did not earn'. Our data indicates that women remain hamstrung in terms of disposable income for personal expenses as well as any decision making on medical care in relation to MHM.**

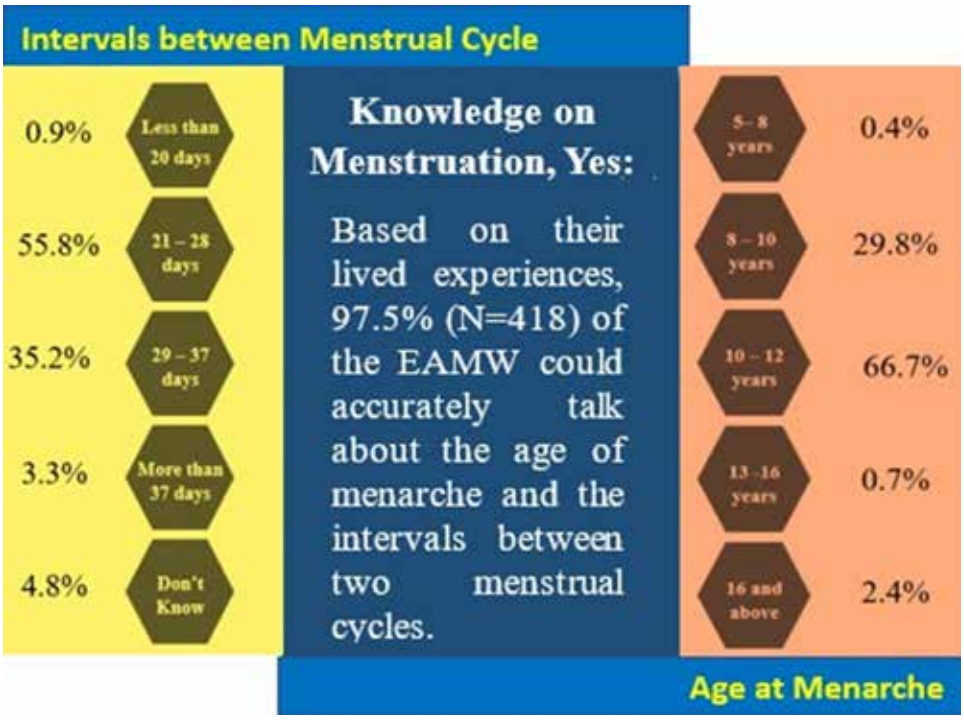
3.2 DISCOURSE ANALYSIS

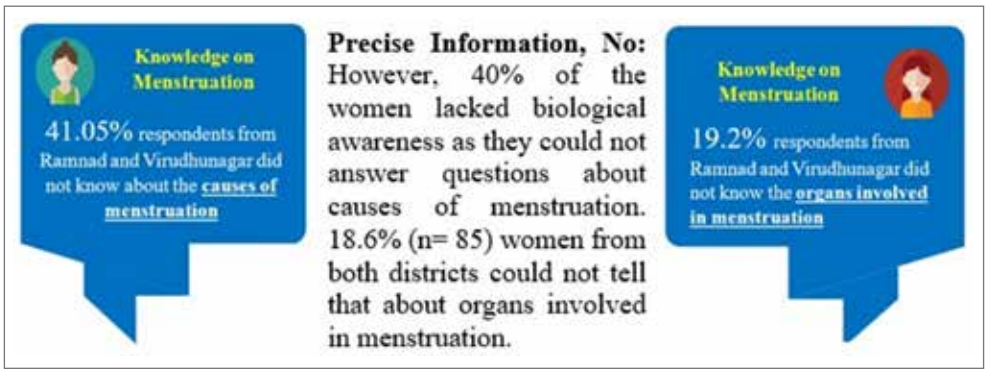
This section presents the findings about the level of knowledge that the respondents professed regarding the causes of menstruation and organs involved in it. As part of the analysis of their discourse on this subject, interpretation of the information given during the IDIs is also carried out to know how much these women understand about menstruation, both as a monthly process of the body on the one hand and in precise medical terms on the other. Furthermore, the section presents the findings about the extent of communication undertaken as well as silence maintained about menstruation. For instance, how much and with whom women chose to discuss or not discuss the topic and issues related to MHM. Also, data is presented on educational backgrounds of women; knowledge about symptoms, health risks and disorders related to menstruation or about hysterectomy; how they view the available medical care options and facilities; and awareness about use and disposal of menstrual absorbents.

3.2.1 KNOWLEDGE ON MENSTRUATION

66% of women could talk about menarche; 92.6% of women could talk about intervals betweentwo menstrual cycles based on their own experiences.

Knowledge About Menstruation	Ramnad (in %)	Virudhunagar (in %)
Total Respondents	178	279
Causes of Menstruation		
Hormonal change	59.6	58.4
Disease	0.6	0.0
Natural process	0.0	1.5
Do not know	39.9	40.1
Organs Involved in Menstruation		
Uterus/ Birth canal	78.1	83.5
Abdomen/ Bladder	4.5	3.6
Do not know/ not answered	17.4	12.9





- **Basic Understanding, Yes:** Based on their lived experiences, 97.6% (N=418) of the EAMWcould accurately talk about the age of menarche and the intervals between two menstrual cycles.
- **Precise Information, No:** However, 40% of the women lacked biological awareness as they could not answer questions about causes of menstruation. 18.6% (n= 85) women from both districts could not tell that about organs involved in menstruation.

3.2.2 SOURCE OF INFORMATION ON MENSTRUATION

- **Family and Close Relatives: For young girls, the top sources of information on menstruation** at the time of menarche were mother, grandmother, sister, or sister-in-law, as reported from both districts.
- **Frontline Health Workers (FHWs):** Of the total 418 EAMW surveyed, only 6.2% from Ramnad and 0.4% from Virudhunagar received information about menstruation from sources such as Accredited Social Health Activist (ASHA), Auxiliary Nurse and Midwife (ANM) and Anganwadi Workers (AWW).

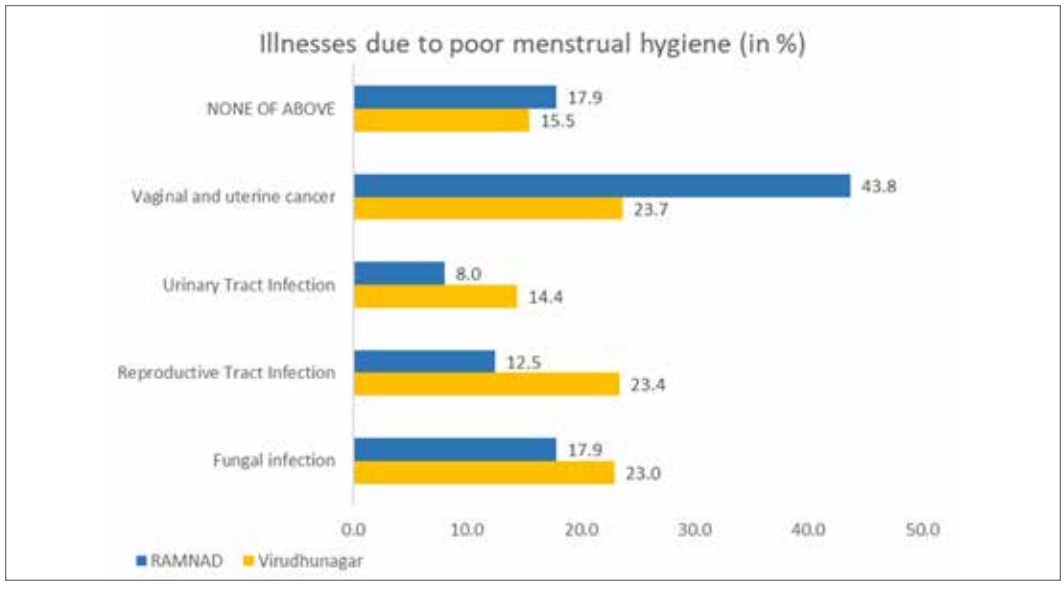
Women preferred to discuss their menstrual problems with the following:

- **Spouses:** 13.6% of women from both districts felt comfortable talking about menstrual problems with husbands. If men can be oriented, and helpful regarding their wives' MHMissues, that would bring a positive health outcome for EAMW, besides combating the silence on it.
- **Nobody:** However, 20.4% from both districts preferred to talk with no one and remain silent about their menstrual problems; 45.5% from Ramnad and 51.7% from Virudhunagar denied having any problems w.r.t MHM.

3.2.3 MENSTRUAL HEALTH, EDUCATION AND AWARENESS ABOUT INFECTIONS

The study also presents data on health problems experienced by the respondents during menstruation. It indicates that adverse health condition while working in or outside the home resulted in rashes, urinary tract infections (UTIs) and reproductive tract infections (RTIs) in case of many women. The survey verified whether the women preferred to visit a doctor or stay quiet in case of health issues.

- **Fungal Infections and UTIs:** 83.7% women knew about lack of MHM and risks of infection; 21.3% stated that poor menstrual hygiene causes fungal infections while 12.3% said it causes UTIs.

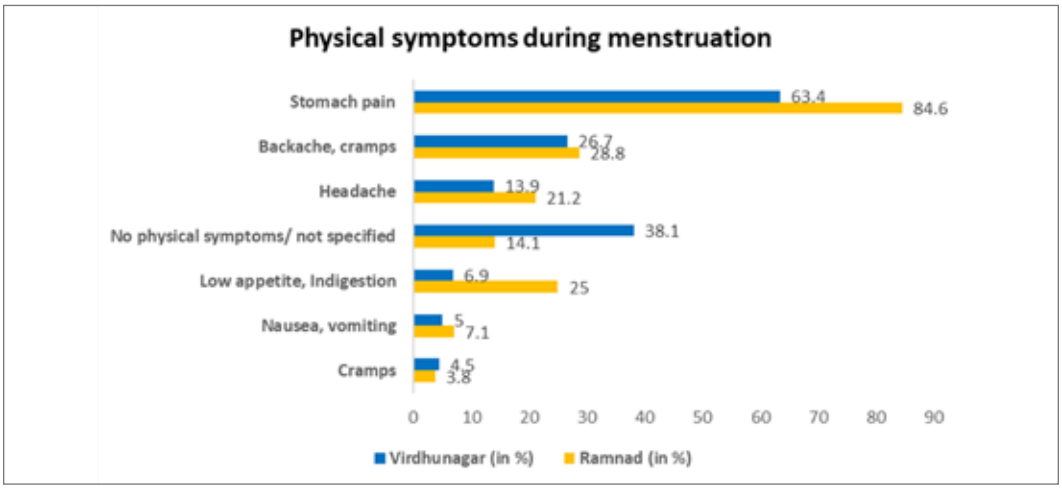


- **Poor Knowledge about Exact Health Risks**: The findings indicate a lack of awareness about the risk factors, inability to understand or offer response to queries on the relationship between rashes, infection and other related health ailments.

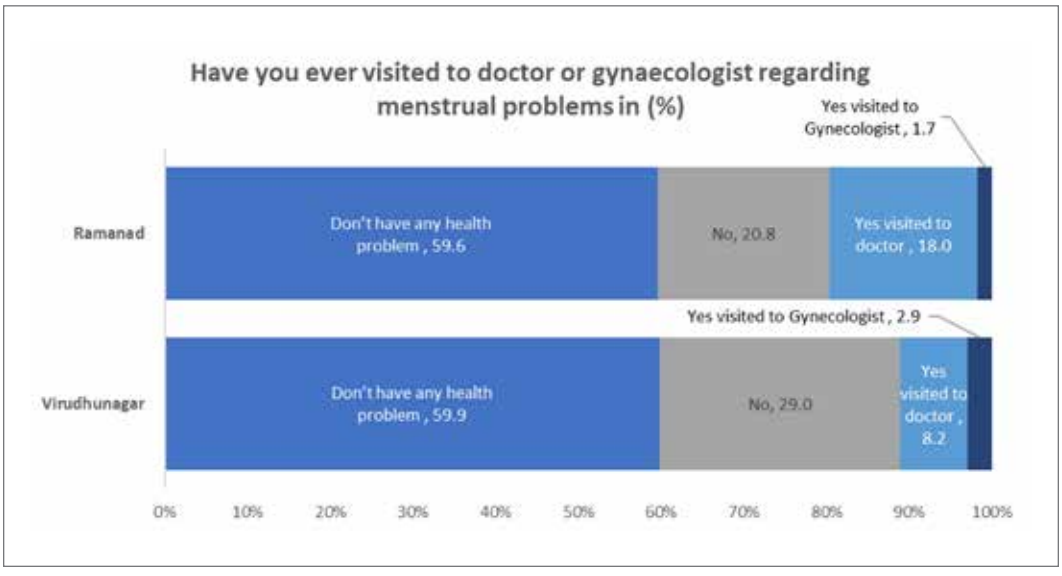
- **No Schooling, Taboos and Communication Barriers**: Since talking about menstruation is a taboo, generalization regarding awareness about MHM could be misleading. Community and area-specific conclusions are preferred. A noteworthy finding from both the districts is that around 20.4% women did not attend school; 33.9% of respondents were women who went to school up to the secondary level. Thus, women lack formal education and the EAMW who participated in the study were either too shy or preferred to remain silent on the topic.

3.2.4. HEALTH SYMPTOMS DURING MENSTRUATION

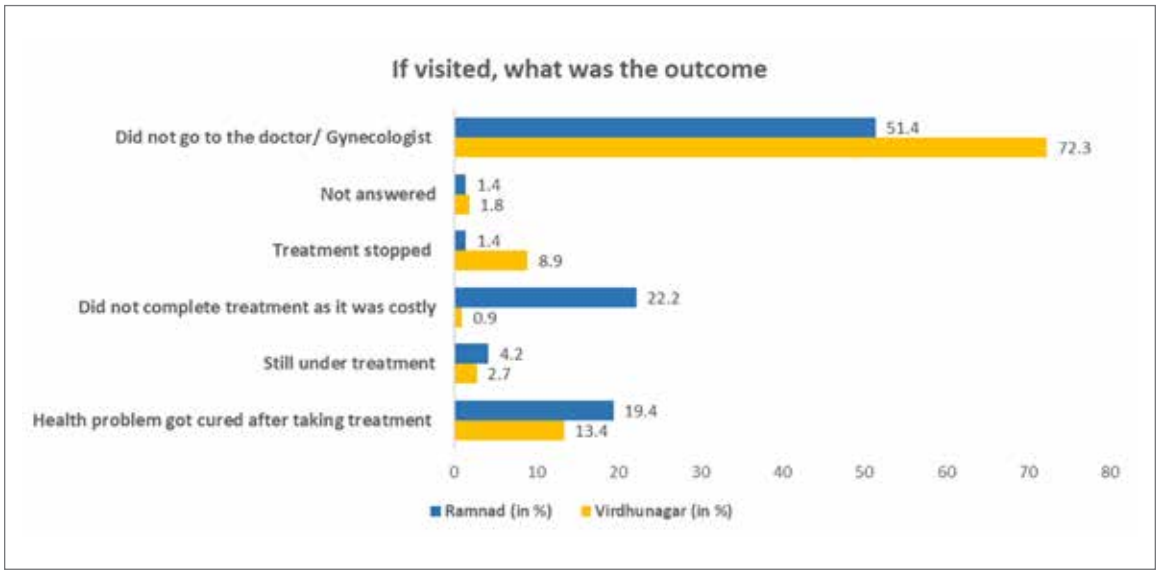
The survey questioned all participating women about any symptoms or discomfort, other than health issues, that they might have faced during or around their periods.



- **Health Symptoms**: Stomachache, backache and headache were the top-three symptoms during menstruation as reported by the respondents.
- **Remedies/Solutions**: When experiencing all or any physical symptoms, 83% of women in Ramnad take rest, while 3% take painkillers and 11% do not take rest/do not take leave from work due to wage cuts. In Virudhunagar, 85% of the women take rest, while 12% take painkillers and 5% of the respondents do not take rest or leave due to wage cuts.
- **Treatment**: In both districts, of the women who reported health problems during menstruation, 118 women, which is 25.8%, never went to a doctor, while 66 women (14.4%) said they visited a doctor for menstruation related issues for this.



- **Neglect and Silence**: The EAMW neglected the health issues related to menstruation for several reasons, but primarily due to hesitation to speak about it and fearing loss of income since missing work would lead to wage cuts or incurring extra expense by visiting a doctor.



The study further verifies the respondents' visit to the doctor for health issues during menstruation or otherwise (n=184). Of the 72 women from Ramnad, 35 reported to have visited a doctor or a gynecologist and of the 112 women from Virudhunagar, 31 did so. Almost half of these women from Ramnad underwent treatment, whereas two-third of those from Virudhunagar who visited doctor did not opt for the treatment. Indeed, if anomalies related to health, particularly during menstruation, are not resolved or are dismissed and covered by silence, then the women have much to lose in social, economic and personal spheres.

In the last section of the chapter, titled "Excerpts and Voices", we bring community-based views and suggestions over this issue from the women.

3.2.5 REASONS FOR NON-TREATMENT

- The main reason for women from Virudhunagar for not going to a doctor or a gynecologist was that they did not consider the problem as serious, followed by having no money to bear the expense of visiting a doctor as the second major reason.
- Having an access to a doctor was a challenge and in case it was not a woman doctor, they would hesitate to discuss the problems related to menstruation with a male doctor.

A total of 64.1% from Tamil Nadu did not avail a doctor's treatment. As per district-specific statistics, 72.3% from Virudhunagar and 51.4% from Ramnad did not consult a doctor. This contributes to not talking or discussing the problem with anyone unless it becomes unbearable.

3.2.6 HYSTERECTOMIES

In comparison to the six other states included in our study, cases of hysterectomy at 2.2% of total respondents in both districts of Tamil Nadu were lower. Out of 418 EAMW surveyed in both the districts, 15 women had undergone hysterectomies at an average age of 41 years, which certainly is a very young age for opting for such a procedure. Out of these 15, (9 from Ramnad and 6 from Virudhunagar), 11 had received both pre- and post-operative counselling.

- **Biological Causes:** Multiple reasons for hysterectomy identified by women who had hysterectomies included tiredness, stomach pain, heavy bleeding (9 responses) while working during menstruation. Other issues included white discharge, itching, swelling, fibroids and otherproblems relating to the uterus (13 responses).

- **Socio-Economic Causes:** One woman reported an increase in menstrual hygiene and health issues/ disorders and another said that decision for hysterectomy was taken due to loss of wages if leaves are taken.
- **Government/ Private Treatment:** Out of 9 hysterectomies, 4 from Ramnad were done at government hospitals and 5 at private hospitals. From Virudhunagar, 3 cases did not specify the place of hysterectomy. All hospitals/ clinics were chosen based on convenience to reach, treatment and facilities, and based on prior experience of family or friends. An average expense for hysterectomy in government hospitals was 10,000 INR whereas it was approximately 50,000 INR in private hospitals. Of the 15 women, 14 reported weakness post-hysterectomy; 11 further reported not being able to work like pre-hysterectomy.

The findings on hysterectomies in Ramnad and Virudhunagar suggest that the informal labour sector in Tamil Nadu discriminates against women and creates pressures on husband-wife teams (*jodis*). Moreover, misconceptions about uterine relevance post motherhood is much prevalent. Further, MHM-related inconveniences experienced in exploitative labour situations also subjects a woman to inadequate WASH facilities. Not surprisingly, marginalized women face complex challenges regarding their reproductive health as well as wellbeing options which often leads to a hastily executed hysterectomies. MHM of EAMW should become a vital part of labour laws, public health, and community-based awareness drives.

In Tamil Nadu, though there is a concern regarding wage-cuts due to leaves taken during menstruation, yet cases of removal of the uterus were found to be minimal. With better MHM and related policy coverage, there is a hope that women can fare better and be healthier.

3.3 PRACTICE ANALYSIS

Good menstruation practices start with the usage of clean menstrual absorbents followed by maintenance of reproductive hygiene. This section brings to light the prevalence of practices regarding personal hygiene such as washing hands and genitals duringmenstruation as well as usage and disposal patterns of menstrual hygiene products. Data is presented on how personal and community-based beliefs, customs and taboos influence MHM outcomes and self-care regimes of our respondents. In Ramnad and Virudhunagar, given their circumstances, many women still adhere to traditional methods of MHM over pads. Of the 418 menstruating women interviewed from Ramnad and Virudhunagar, only 75.4% women use sanitary pads, (0.7% using reusable sanitary pads) and rest all women use cloth.

3.3.1 SANITARY PADS OR OTHER ABSORBENTS

- **Cloth:** Of the 418 EAMW interviewed from both districts, 53.3% women used only cloth during menstruation. Precisely, 63.5% EAMW in Ramnad and 47.3% EAMW in Virudhunagar used cloth because of its ready availability, affordability, durability and due to lack of awareness about other menstrual products.
- **Other Material:** Reusable sanitary pads were used by only three EAMW from Virudhunagar. One woman (out of 156) from Ramnad and two (out of 262) from Virudhunagar used cotton. Such a practice speaks of preferences as much as it does of scarcities.
- **Sanitary Pads in Combination with Traditional Methods:** Sanitary pads, on the other hand, were used by 85.9% women from Ramnad and 69.1% EAMW from Virudhunagar. However, our data also indicates that pads are used in combination with a cloth as 40.2% from the total EAMW felt that the latter was easy to use and easily available, as also pointed out by another 76.8% EAMW, besides 28% EAMW who argued about its durability, with 9.1% mentioning its affordability. About one-fourth (22.7%) of the respondents said the elders at home decided what is to be used.

3.3.2 SPENDING CAPACITY ON MENSTRUAL HYGIENE PRODUCTS

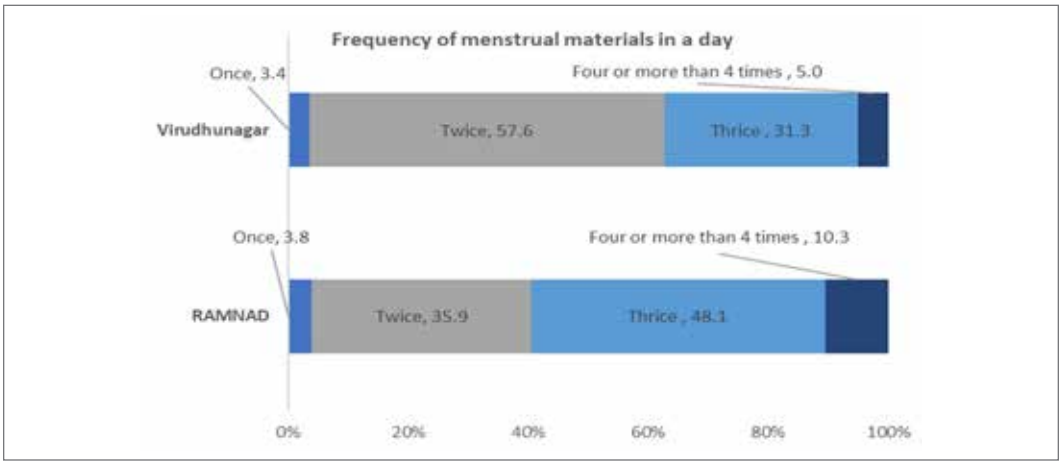
- 83.5% EAMW from Ramnad and 85.5% EAMW from Virudhunagar spent on sanitary pads. More than half (56.9%) of the women from Ramnad reported spending up to 100 INR on menstrual products, while 74.8% women from Virudhunagar reported spending upto 100 INR on it.

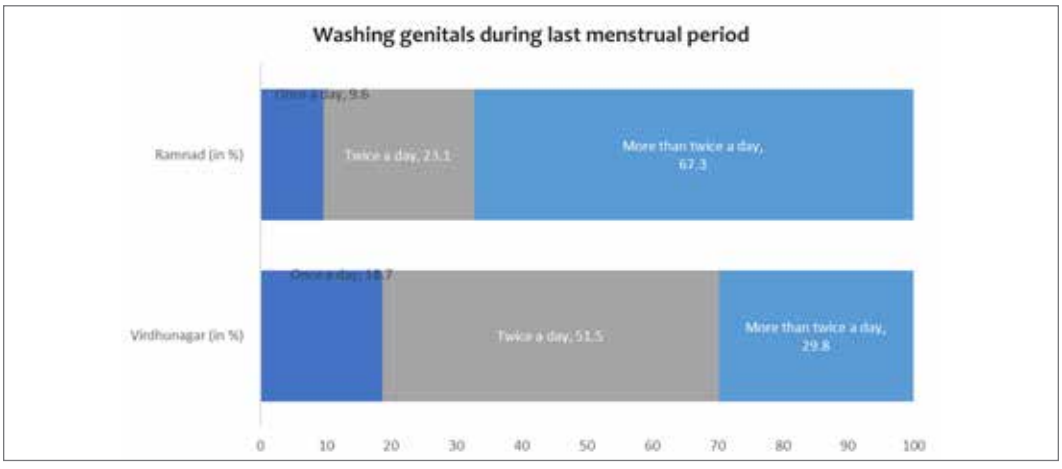
- Average monthly spending on menstrual products in case of Ramnad women was 108 INR and that for Virudhunagar women was 72 INR.
- Despite earning less, Ramnad women spend more on MHM material.

3.3.3 PERSONAL HYGIENE AND WASH DURING LAST MENSTRUAL CYCLE

Personal hygiene includes keeping genitals clean and washing hands before and after changing the menstrual absorbent. The survey assessed all practices adopted to maintain proper hygiene and management of menstrual material.

Hygiene Practices follwed by women in every menstrual cycle for reusable absorbents



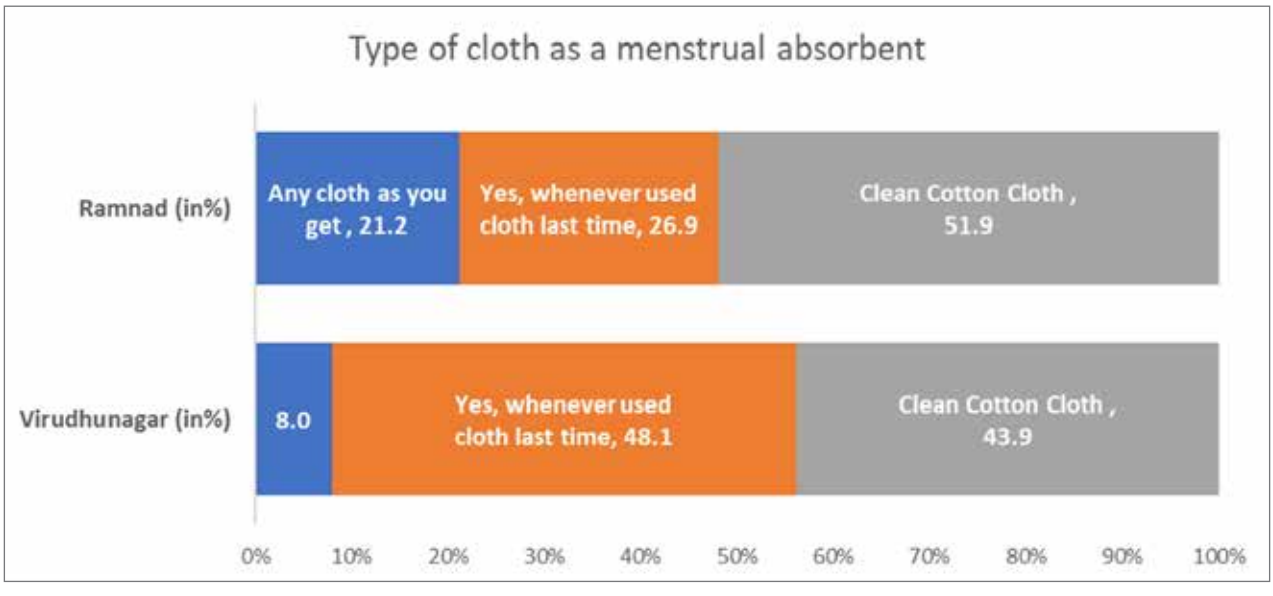


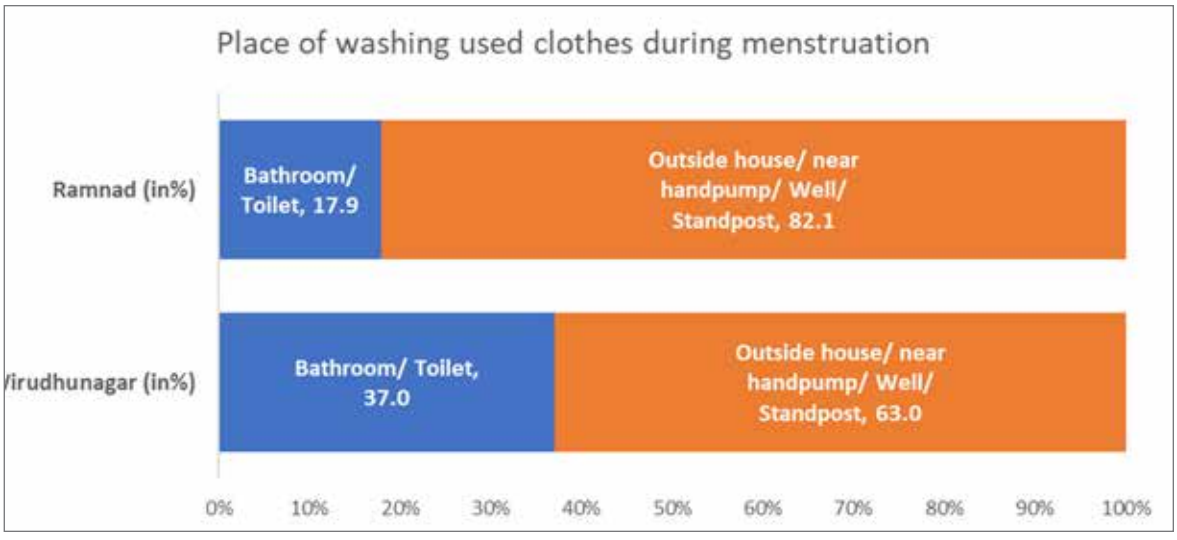
Hygiene Practices: A Summary of Personal Hygiene Practices of Women in Ramnath and Virudhunagar

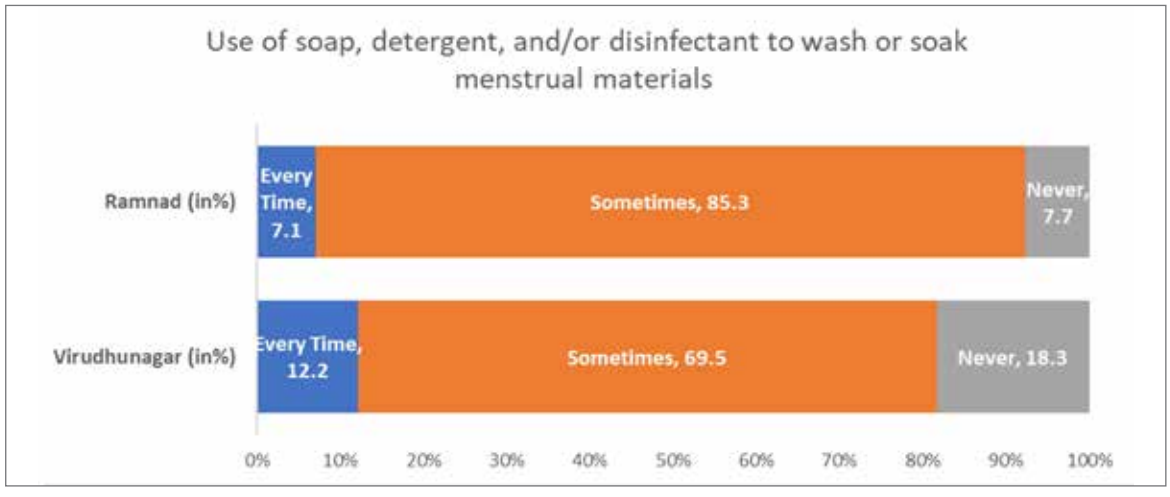
- **Changing Absorbents:** 48.1% of women from Ramnad reported changing menstrual material twice a day and 35.9% changed thrice a day. From Virudhunagar, 57.6% of women changed menstrual material twice a day and 31.3% changed it thrice a day.
- **Washing Hands:** 48.1% and 65.6% of women from Ramnad and Virudhunagar respectively washed their hands before and after changing their menstrual material, whereas 46.8% of women from Ramnad and 27.1% of women from Virudhunagar washed their hands sometimes.
- **Cleaning Genitals:** 90.4% and 81.3% of women from Ramnad and Virudhunagar respectively washed their genitals more than twice a day during their last menstrual periods; 15.4% of women from Ramnad and 22.5% of women from Virudhunagar never used soap while washing their genitals.
- **Building an Enabling Attitude:** More awareness on personal hygiene, MHM and WASH is required among menstruators between the ages of 20 and 49 years, as per our data. Behaviour, community-driven change and hygiene practices in this case run parallel not only with an enabling infrastructure and clean water but also community-sensitive drives towards an enabling attitude.

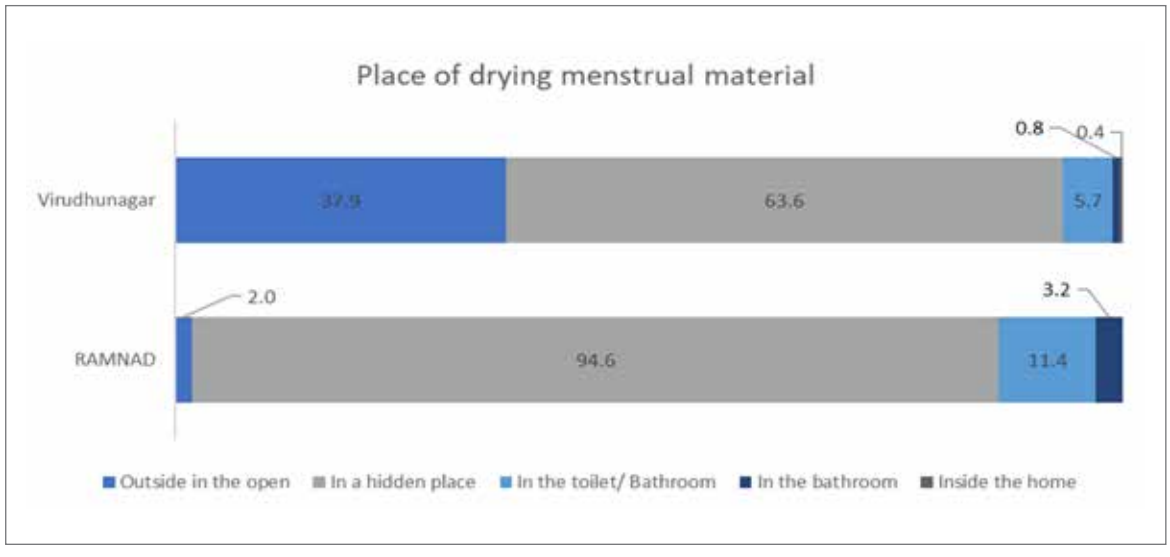
3.3.4 MENSTRUAL HYGIENE PRACTICES

Safe hygiene practices consist of washing and timely changing of menstrual absorbents as well as their proper disposal. This may vary with the absorbent type. Hygiene also depends on changing the absorbent during the day, keeping the genitals clean, washing hands before and after changing the menstrual absorbent.









Hygiene Practices: A Summary of Menstrual Hygiene Practices of Women in Ramnad and Virudhunagar

- **Reusing Adsorbents**: Of the total interviewed women, 53.1% reported using the same cloth during menstruation; 79.5% of women from Ramnad and 59.2% of women from Virudhunagar washed their menstrual clothes. However, 85.3% women from Ramnad and 69.5% from Virudhunagar used soap or detergent very sparingly. Additional 7.1% of women from Ramnad and 12.2% from Virudhunagar never used soap or detergent while washing menstrual material.

- **Disposal at and away from Home**: In Virudhunagar, 9.3% women reported that they disposed of menstrual material in the latrine at home and 7.3% women practiced the same when away from home. Such a practice is contra-indicative for it can choke toilets.
- **Area Specific Disposal Practice**: Observing larger area-specific mechanisms in the selected villages from Ramnad and Virudhunagar shows almost two-third women from Ramnad and one-third women from Virudhunagar throw menstrual material in the bushes or the water bodies. Those who disposed of menstrual waste in community waste dump yards were reported to be only 14.7% in Ramnad, but 64.1% in Virudhunagar.
- **Drying not Optimal**: 90.4% of women from Ramnad and 34% from Virudhunagar dry their menstrual clothes in a hidden place. While reusing cloth during menstruation, apart from washing properly, one must ensure that the cloth is fully dried in sunlight. The practice of drying reused menstrual clothes was better followed in Virudhunagar than in Ramnad.
- **Detrimental Indicator**: 80.8% women from Ramnad and 25.6% of them from Virudhunagar use completely dry cloths only sometimes when they change during periods. This is a detrimental indicator for maintaining personal and menstrual product hygiene and puts women at grave health risks.

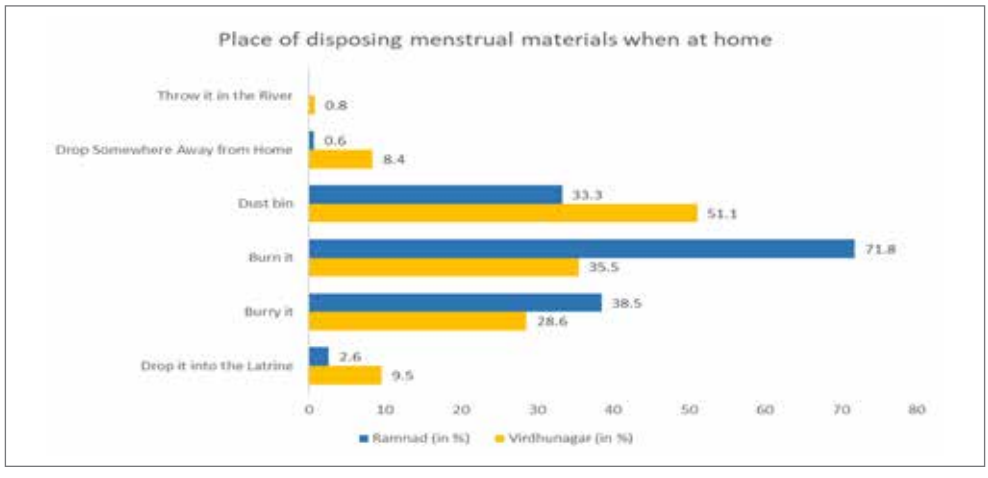
Do you ensure that your cloth is dry before using?

Given the fact that in rural, remote and economically vulnerable communities, women may, as our data indicates, not have options to consult qualified health practitioners, more awareness campaigns and door-to-door endeavours are called for.

3.3.5 AREA-SPECIFIC DISPOSAL MECHANISMS

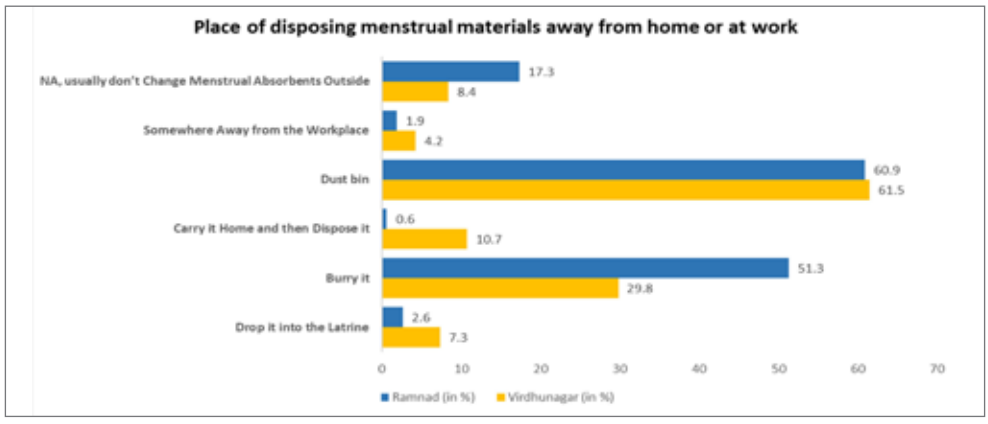
When asked about the system of disposal of menstrual material in their own area, it was found that they must manage problems at their own levels. The district does not support any disposal mechanism for menstrual material.

Methods of Disposal in both Districts when at Home



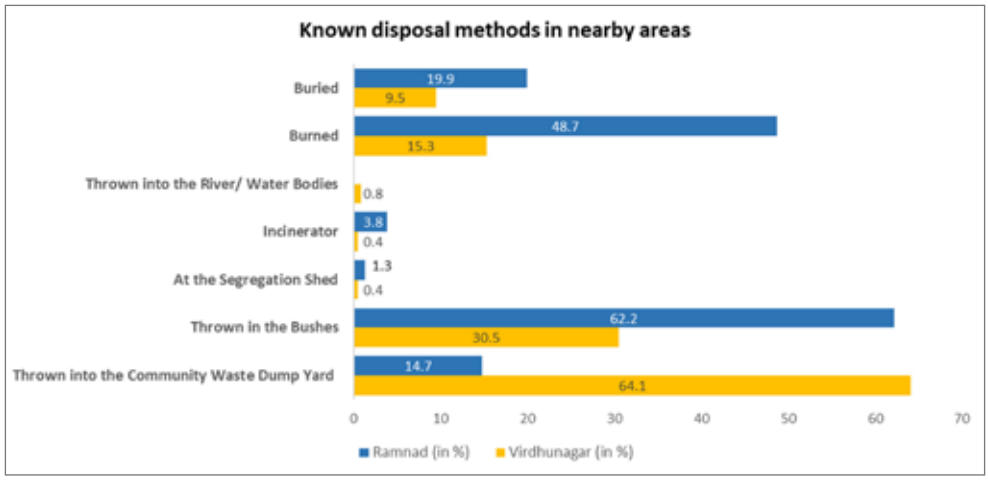
Top Practices: When at home, women in Ramnad either bury or burn the used menstrual material, whereas majority women in Virudhunagar throw it in the dustbin instead of burning it.

Methods of Disposal in both Districts when away from Home



Top Practices: When women are away from home, as per their responses, they do not prefer to change menstrual absorbent. The 61% of women, in both districts, threw the used menstrual material either in the dustbin or somewhere away from the workplace in the open; 7.3% women from Virudhunagar carried used menstrual material home and then disposed it of.

3.3.6 KNOWN DISPOSAL METHODS IN THE COMMUNITY AND NEARBY AREAS



3.3.7 SOCIAL CUSTOMS, BELIEFS, MYTHS AND TABOOS

The world of social customs, replete with its mandatory dos and don'ts in various communities represents their beliefs and mandates. Social customs, beliefs, myths and taboos contain overt and covert forms of barriers and enablers which influence MHM related practices as well as everyday experiences of menstruating women. In this respect, we have quite similar findings fromTamil Nadu's Ramnad and Virudhunagar districts, as presented below:

Customs followed by Women in Reference to Menstruation: Ramnad District

Ramnad (178 Respondents)	Strongly agree	Agree	Disagree	strongly disagree
I am allowed to mix with others socially during my periods.	3.4	65.2	31.5	0.0

Ramnad (178 Respondents)	Strongly agree	Agree	Disagree	strongly disagree
I am not allowed to attend any social rituals during my periods.	2.2	51.1	44.9	1.7
I do not go to religious places during periods.	2.8	61.2	35.4	0.6
I avoid travelling during periods.	2.2	34.8	61.8	1.1
I am told to stay in the corner of the house during my periods.	0.6	30.9	65.2	3.4
	Yes		No	
I am allowed to carry out routine work at home during my periods.	94.9		5.1	
I am allowed to cook in the kitchen during my periods.	95.5		4.5	
Others in my family take care of me during periods.	91.0		9.0	
I have freedom to visit a doctor in case of any health issue.	87.6		12.4	
I am allowed only special foods during periods.	3.4		96.6	
I sit for lunch and dinner with all my family members.	33.7		66.3	

Customs followed by Women in Reference to Menstruation: Virudhunagar District

Virudhunagar (279 Respondents)	Strongly agree	Agree	Disagree	strongly disagree
I am allowed to mix with others socially during my periods.	16.8	67.4	10.8	5.0
I am not allowed to attend any social rituals during my periods.	5.4	51.6	37.3	5.7
I do not go to religious places during periods.	4.7	73.8	12.2	9.3
I avoid travelling during periods.	2.2	44.4	41.9	11.5
I am told to stay in the corner of the house during my periods.	3.6	5.4	68.8	22.2
	Yes	No		
I am allowed to carry routine work at home during my periods.	95.0	5.0		
I am allowed to cook in the kitchen during my periods.	93.5	6.5		
Others in my family take care of me during periods.	72.8	27.2		
I have freedom to visit a doctor in case of any health issue.	85.7	14.3		

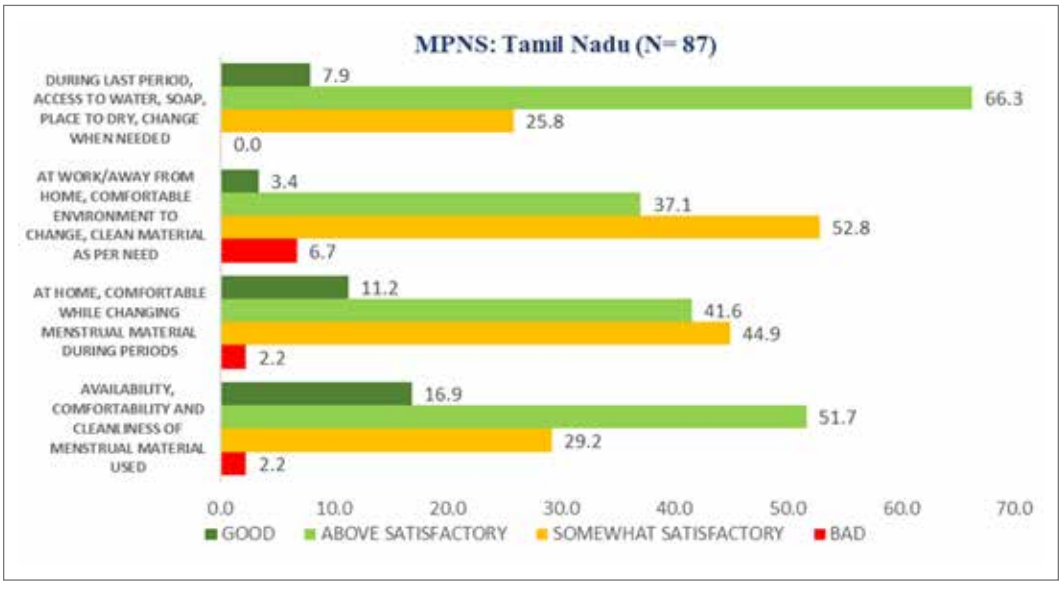
Virudhunagar (279 Respondents)	Strongly agree	Agree	Disagree	strongly disagree
I am allowed only special foods during periods.	10.4	89.6		
I sit for lunch and dinner with all my family members.	83.9	16.1		

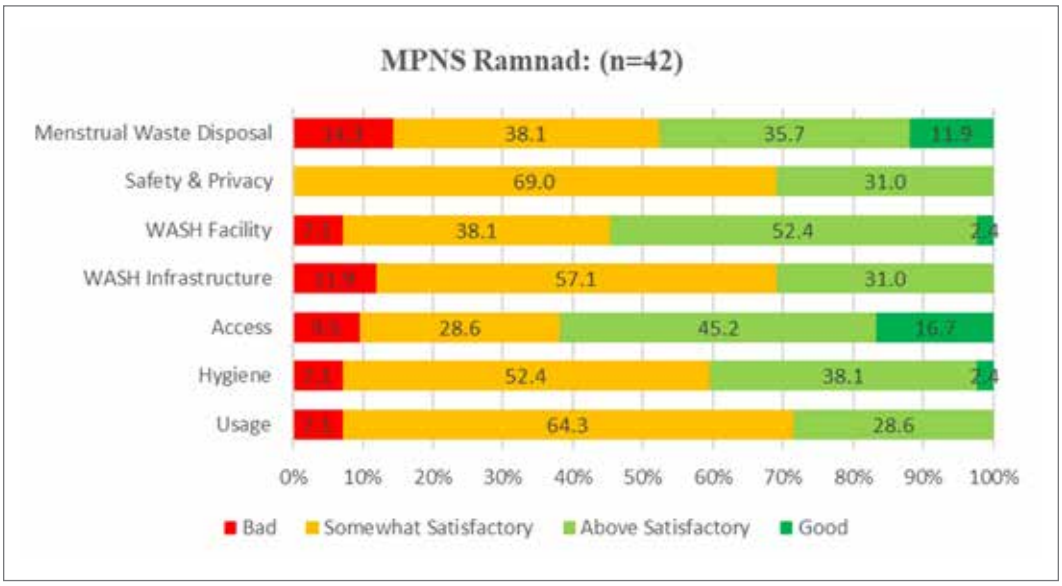
- **Socialize:** 31.5% of the women in Ramnad and 15.8% in Virudhunagar were not allowed to socialize during their menstrual cycle.
- **Worship/ Visit Temples:** In Ramnad, more than half of the women do not visit religious places. Two-third of the women do not attend any social rituals and 37% avoid travelling during periods. More than three-fourth of the women in Virudhunagar do not visit religious places, and 46.6% avoid travel during periods.
- **Segregation:** Both in Ramnad and Virudhunagar, nine in 10 women said that they did routine work and cooked in the kitchen during their periods.
- **Seeking Medical Help:** In Ramnad 87.6% and in Virudhunagar 85.7% women had the freedom to visit a doctor in case of any health issue.

3.3.8 MENSTRUAL PRACTICE NEEDS SCALE (MPNS)

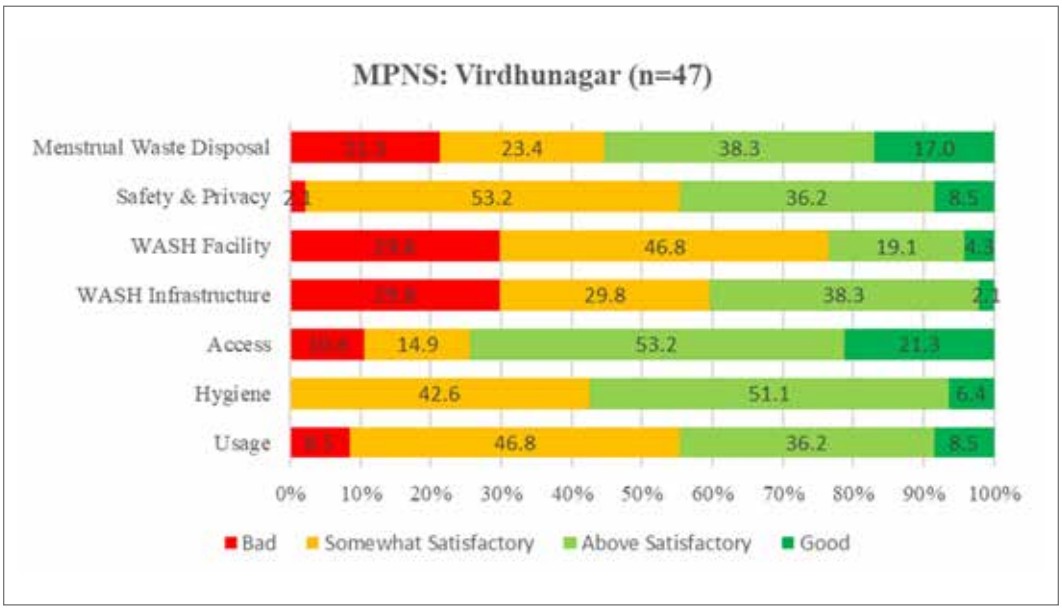
The Menstrual Practice Needs Scale (MPNS) was used to measure and assess the felt needs and experiences of women during their last menstrual period. 87 respondents from both the districts shared their perceptions/ experiences on availability of water, sanitation, hygiene, safety, and privacy as well as access to menstrual absorbents. Through the use of MPNS, we could access the actual trends, practices and experiences regarding MHM, WASH, safety and privacy which form the 'menstrual everyday' of surveyed women in Ramnad and Virudhunagar districts in Tamil Nadu.

- **Reusing MHM Products:** After being assessed on the MPNS, it was observed that 52.9% of respondents rated the surroundings to change or clean menstrual material during periods as per need during the last menstrual period as below satisfactory level.
- **Comfort:** Similarly, 44.9% respondents felt that while changing menstrual material during their last menstruation, their level of comfort was only somewhat satisfactory.
- **Clean and Dry Menstrual Material:** Two-third of the women had access to water, soap and a place to dry as well as change menstrual material at above satisfactory to good level whenever needed during their last menstrual period.





Ramnad: When measured on the MPNS scale (based on their last menstrual experience about privacy), 42 women rated WASH infrastructure, hygiene practices and usage of menstrual material at below satisfactory level.



Virudhunagar: When measured on the MPNS scale, based on their last menstrual experience about privacy, WASH facility and infrastructure, and usage of menstrual material, 47 women rated it as below satisfactory level.

3.4 INTER-SECTORAL FOCUS

This part of our study examines vulnerabilities, issues, and risks pertaining to menstruation with respect to social as well as inter-sectoral stress factors:

- To impart an inter-sectoral focus on MHM narratives and practices from diverse contexts and cross-sections of society, we bring an analysis of five villages each in these two Aspirational Districts.
- We document the lives of fishing and farming communities, textile mill workers, Dalits and factory workers in the unorganized sector and migrant populations in Virudhunagar.

- Against this background, we present a brief inter-sectoral data analysis on migration and MHM, WASH and MHM, Education and MHM, Livelihood and MHM and lastly, MHM from the perspective of awareness towards public policies.

The overall narrative of different practices on MHM in these villages related to community-based vulnerabilities, socio-economic conditions and beliefs including monetary freedom/ disposable income of women besides health and education related inter-sectoral factors.

3.4.1. MIGRATION AND HEALTH

In Ramnad and Virudhunagar, only 13 women (N=457) responded that they migrated from Virudhunagar. Out of these 13 cases, seven families constituted seasonal migrants who found work near their villages and usually migrated for less than 6 months.

- Out of these migrants, 9 were agricultural labourers and others engaged in the following work/ jobs: brick kiln (1), industrial labourer (1), worked in restaurants (1), and worked in bank(1).
- On the basis of responses from 11 women, across 13 migrant families, who acknowledged that migration causes an impact on their menstrual health, this study suggests: A closer observation and analysis of migration and MHM in Tamil Nadu districts should be done for achieving better health prospects for menstruating women of 20-49 years age.
- Our findings indicate that 11 out of the 13 migrant women strongly feel that their seasonal work conditions and resource scarcity influences their menstrual health negatively.

3.4.2 TRADITIONAL SKILLS AND EARNING CAPACITY

- Our data shows that 103 women (N= 457) in both the districts possessed traditional skills.
- 58 women had skills in farming, fishing and cattle rearing; 16 were skilled in bamboo related crafts, embroidery, knitting and weaving while 12 were into tailoring, pads-making and cracker-making.
- However, out of the women possessing traditional skills and knowledge, 63 (N=103) earned from their knowledge and customary skills. This is an encouraging indication as compared to other states of our research.
- However, EAMW across both the districts complain of poverty and scarcity of means to deal with MHM. A targeted improvement of scope of traditional skills can be a ready relief measure for those who do not earn from their skill sets and knowledge bank.

Given that there is a possibility of augmenting family income from traditional knowledge and customary skills, vocational courses could be organized for women struggling with socio-economic vulnerabilities to enhance their disposable income, alongwith decision-making powers in spending on MHM health and wellbeing.

3.4.3 WASH AND MHM

NFHS-5 shows 78.6% households from Ramnad and 59.8% from Virudhunagar used an improved sanitation facility; 55.52% families in Ramnad had improved sanitation facilities as compared to 59.8% from Virudhunagar (International Institute for Population Sciences (IIPS) and ICF 2021, p. 105, 195).

WASH & MHM	Ramnad (in%)	Virudhunagar (in%)
Total Respondents	**178**	**279**
Water Facility at Home		
Piped water	29.2	48.4
Piped to yard/ Plot/ Public tap	52.8	49.8
Bore well/ Tube well/ Well covered/ Hand pump	2.8	1.4

WASH & MHM	Ramnad (in%)	Virudhunagar (in%)
Tanker/Truck / Cart with small tank	15.2	0.4
Toilet Facility at Home		
Individual household latrine	46.6	58.8
Community toilets	0.0	19.0
Open defecation	53.4	22.2
Type of House		
Kutcha house	7.3	16.1
Pucca house	47.2	50.9
Semi pucca house	45.5	33.0

- **Acute Water Scarcity:** Our data indicates that 91.9% of respondents from both the districts said that they have regular source of water through piped water and public taps. Only 2% depended on hand pumps, bore wells or tube wells. However, both the districts face severe drinking water shortage especially in summer. The situation becomes worse due to chronic droughts, water salinity and clayey soil which restricts the availability of deep freshwater aquifers.
- **Kind of House:** Housing conditions were found to be relatively good in both the districts where almost 49.5% of the families have pucca houses (roof, wall, and floor all are made up of pucca material) and 37.9 families interviewed live in semi kutcha houses (either 1 or 2 from roof, wall and floor is made up of kutcha/ makeshift materials) and only 12.7 families live in kutcha houses (roof, wall, and floor all made up with kutcha material).
- **Toilet Facilities:** 54% families used Individual Household Latrines (IHHL) and 11.6% used community toilets. Almost 34.4% of families defecated in the open owing to various anomalies like poor living conditions, water scarcity or community-wide preferences for open spaces.

During menstruation, a woman's WASH needs are relatively higher as compared to the rest of the days of the month. During period, she needs more water to clean herself for personal and intimate hygiene, including after defecation. Besides, a regular supply of clean water and facility of a private and a secure place to change her menstrual absorbents and clean herself form a profound part of her sense of dignity and safety. Therefore, the access to the toilet and bathroom becomes a critical need during periods.

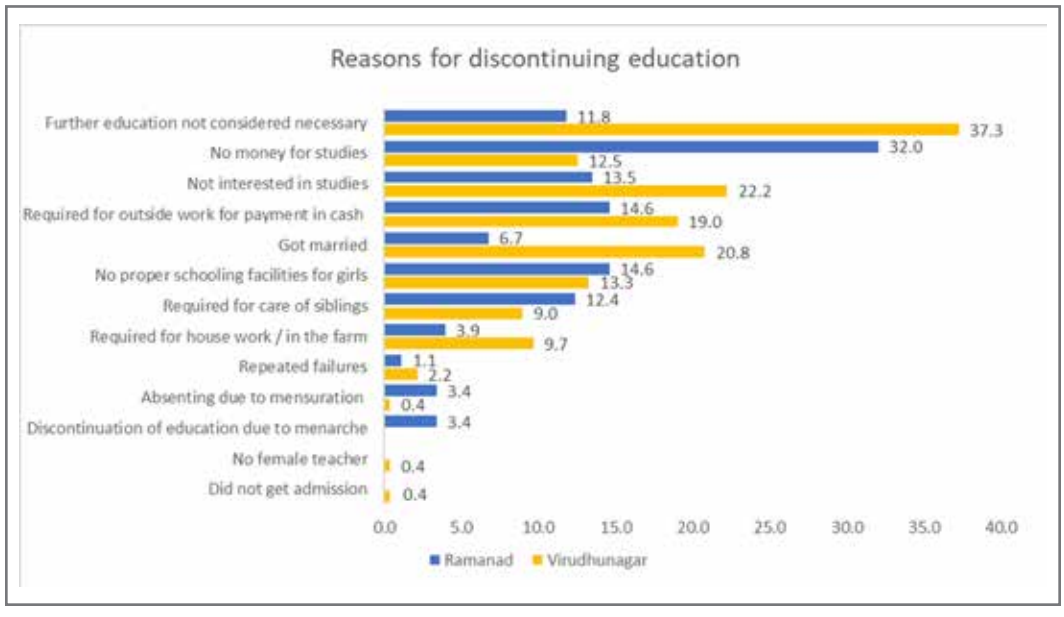
3.4.4 EDUCATION AND MHM

One in three women (N=457) in our research areas have completed education till secondary schoolwhile 20.4% of women were uneducated. The biggest obstacle in the way of education, in case of both the districts, was lack of money for schooling, and girls were needed to work outside the home to earn their livelihood.

Education & MHM	Ramnad (in%)	Virudhunagar (in%)
Total Respondents	178	279
Education		
No Education	17.4	22.2

Education & MHM	Ramnad (in%)	Virudhunagar (in%)
Primary (1st -4th)	19.1	18.6
Secondary (5th-7th)	19.1	12.5
Higher Secondary (8th-10th)	15.2	14.3
12th/ Undergraduate	19.1	20.4
Graduate and above	10.1	11.8
Reason for Discontinuing Education		
Family Barriers	30.9	67.0
Monetary Barriers	50.6	41.2
Educational Barriers	21.3	24.7
Lack of Facilities	14.6	14.0
No Response	24.7	13.6

- **Family Related Bottlenecks, Poverty and Attitudes:** 44.9% women surveyed dropped out of school owing to lack of finances, while 53% faced other family-related barriers. In Ramnad, monetary problems required girls to contribute to the family income by working as wage-labour, while in Virudhunagar girls were pulled out of school because education was not considered necessary. Both these reasons bear directly on the fate of education of the adolescent girls. Another barrier is serving as caretaker for siblings when their mother is engaged in outside work.
- **School Drop-Out Rate:** Dropping out of school at various ages was high in these districts though 20% of the women completed school and 11% pursued higher education. There is a policy of silence for providing MHM support to those who drop out of school or those who cannot go to school as compared to menstruating girls who can continue their schooling. Although our survey is primarily concerned with the wellbeing of women in their menstruation years beyond school, yet some of our findings on schooling and MHM are significant, having pan-India relevance.



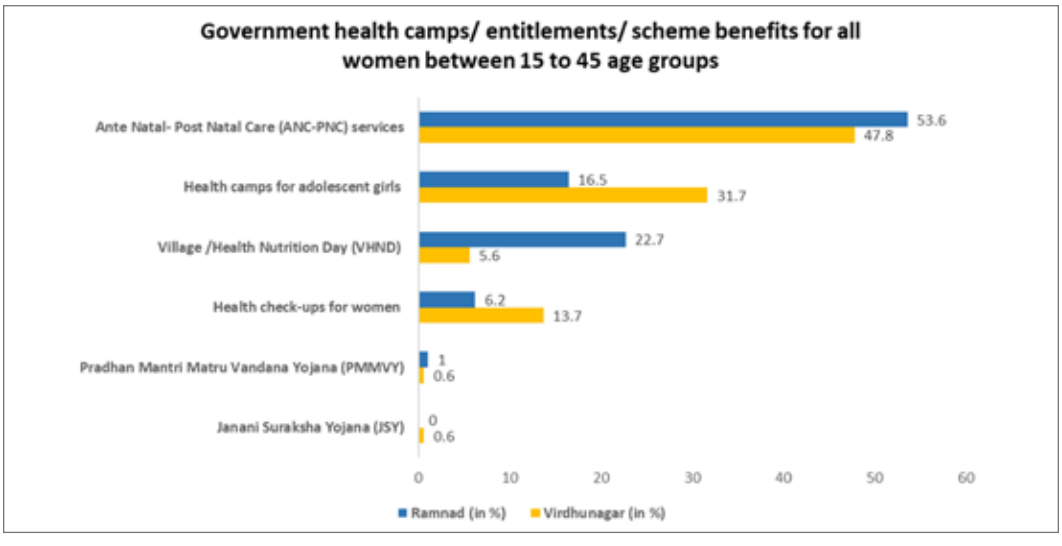
- **Menarche and Marriage**: Menarche & Menstruation is a major criterion for some parents and families to lay restrictions on the movement of a girl outside of home, including a preference that adolescents drop out from school altogether. Among those girls who continue their schooling, being absent from school due to MHM-related issues, including physical symptoms such as pain, leads to interruption in education during post- menarche years. Community believes that a girl is preparing for adulthood in early post-menarche years which leads to pressure on the family to marry her off.
- **Schools in need of Improvement**: Almost 15% of the women surveyed stated that they had dropped out owing to lack of proper toilet, water and MHM orientation in the school.

In these districts we found, barriers to education are not as much related to infrastructure at school for menstruating girls as much as they are to poverty, need for income and community attitudes towards the girl child. The family usually considers education to be unnecessary when the girl enters puberty. However, for those girls who continued education, absenting during menstruation was noted in both the districts. Our data is an indicator that despite the overall progress of a state, certain districts and pockets of groups and communities, experience unique kinds of marginalization and barriers related to puberty and menarche. Tamil Nadu seems almost a modular state in terms of MHM prospects and education when the NFHS-5 data is taken into consideration. Yet the voice of EAMW as well as young menstruating girls in Ramnad and Virudhunagar narrate a different story. Disparity remains high even in a small sample. Perhaps, a little policy push can go a long way in securing proper MHM.

3.4.5 AWARENESS TOWARDS COUNSELLING ON MHM PUBLIC POLICY:

National Health Mission runs various programmes for the age group of 15 to 45 years that is for adolescent girls as well as women. Most women in both the districts are aware of the public policy.

- **Local Health Service:** In both districts, women respondents were informed about availing PNC services and participated in the VHND. The data shows that nearly 10.9% of women (N= 457) and adolescents participated in health check-ups; 99% of the women respondents from both the districts were not even aware of Pradhan Mantri Matru Vandana Yojana (PMMVY), Janani Suraksha Yojana and Janani Shishu Suraksha Karyakram (JSSK).
- **Engagement with Public Health Services:** There was lack of awareness about schemes such as PMMVY and JSY in both the districts; 232 and 145 women respectively from both the districts benefitted from the Antenatal Care and Postnatal Care (ANC-PNC) services and attended Village Health Nutrition Day (VHND) on a regular basis.



- **Significance of Public Health Facilities:** Health support systems in India are so designed that for every 1000 population there is an Accredited Social Health Activist (ASHA) appointed, for around 5 to 6 villages,

there is a Sub Centre where treatment for small illnesses as well as 24/7 facility of delivery is available. After that, for every 30000 people, there is a Primary Health Centre (PHC). And as we move further, the availability of Rural or Sub District hospitals, district hospitals in urban areas, municipal corporation health clinics, and hospitals are available.

- **Accessibility and Choice:** EAMW covered in this survey were asked through IDIS about the nearest accessible public health facility. Regarding accessible/ affordable treatment from government health facilities, merely 20.8% of women from Ramnad and more than half i.e 56.3% from Virudhunagar responded positively. Very few respondents from both districts reported that they do not avail general treatment from public health facilities. When women (between the age group 19 to 49 years) were questioned about the nearest accessible public health facility, Ramnad women cited Primary Health Centre (87.1%), sub district hospitals (13.5%) and Municipal health clinic (11.8%) as the options available. The nearest public health facilities reported by Virudhunagar women were Primary Health Centre (73.5%) and Sub Centre (16.1%).
- **Importance of Health Camps:** Women across various contexts are differently integrated with the national public health infrastructure and policies. Health camps, which are periodically organized in villages, are specifically important and needed in areas which are remote and cut- off or where Sub Centers are not available. Our survey findings indicate that a major chunk of the population from both the districts benefitted from ANC and PNC services. If health camps start covering the wellbeing of EAMW in remote and isolated areas, women will also benefit. Our findings indicate that women are familiar with and dependent on the State-sponsored programmes such as health camps, ANC-PNC and VHND. However, our data shows almost negligible interventions from national schemes such as JSY, PMMVY and JSSK. Owing to the vast reach and significance of, as well as a substantial reliance on public health system in India, the MHM of EAMW can get a much-required boost if the issue receives adequate attention through public policy. Even the ADP can stand to gain from women's participation if MHM is piloted as an inter-sectoral intervention cutting across education, social security, WASH and livelihood.

Counselling on MHM: Upon being asked if they ever received any counselling on menstrual health, 33.3% of our women from Ramnad and Virudhunagar responded in the affirmative. Counselling on MHM was received from health workers such as ASHA, ANM and AWW.

- **Level of Integration with Policies:** In Ramnad district, the percentage of women getting benefits from government schemes was found to be very low as 75.3% of women reported that they have not ever received any benefits from the schemes and services. At the same time, contrastingly, 93.2% women from Virudhunagar availed some or the other benefit from schemes and services.
- **Need for Counselling on MHM among Working Women:** This clearly shows that working women (including farmers) who are occupied during the day do not prioritize availing/ claiming the benefits of government health services, as indicated by the data.In Virudhunagar, around 75% of women reported that they do not work outside the home (or are self-employed) in which case they could easily carve out time to reach government services.

Received Counselling on Menstrual Hygiene from Health Workers	Ramnad (in%)	Virudhunagar (in%)
Total Respondents	**178**	**279**
No	89.9	52.0
Yes	10.1	48.0

Yes: Out of the total respondents, 10.1% EAMW from Ramnad (n=178) and 48.0% from Virudhunagar (n=279) reported that they seek counselling, guidance and treatment in relation to health issues from the public healthcare facilities.

No: 305 women, out of the 457 women, had never received counselling on menstruation or MHM in their villages.

There are various maternal and child health programmes designed by the Government of India through which menstruating women get benefits from various services and schemes. Along with other counselling sessions, if counselling on menstrual health hygiene is given to women, they would benefit in terms of being better informed and alert on MHM. On the one hand working women fail to draw the benefits of welfare schemes, owing to pressures of work and income, as well as documentation hurdles to avail governmental benefits, and on the other they suffer on health grounds.

PART 4 VOICES, EXCERPTS AND OBSERVATIONS

As part of our research, we conducted approximately 12 open-ended interviews with key informants. These KIIs were taken across each district, not necessarily restricting ourselves to voices of people from villages included in our field research. People interviewed during this exercise were important stakeholders in communities/ villages such as AWWs, ANM, doctors, teachers, ASHAs, counsellors and social workers. Their voices are crucial for the development of the community as they give a unique point of view on the local village population as well as district-wide situations. In a small but significant way, these grassroot voices help us arrive at community-sensitive and area-specific recommendations and the ways forward. Highlights from these interviews are as follows:

Ramanathpuram: Eight respondents across five villages stated that there are no toilets in the villages. Out of these eight, one respondent added that their village school lacks a toilet; seven others informed about lack of provision for free sanitary napkins in the village; six respondents spoke of water scarcity and taboos related to menstruation in their villages; five shared that the village requires a disposal mechanism for menstrual waste and four respondents were not aware of any scheme related to menstruation. Three respondents informed us that no awareness generation initiatives on MHM had ever taken place in the village. According to another informant, her village was not open defecation free (ODF) and one stated that iron and folic acid tablets were not distributed in her village.

Virudhunagar: 12 respondents from five villages stated that the villages lacked toilets. Out of the 12, two specifically mentioned that the schools were in serious need of toilets; nine respondents spoke of water scarcity in the villages while one of them pointed out that the school lacked water facility. Six respondents each stated that there was no distribution of sanitary napkins and that there was no disposal mechanism for menstrual waste in the villages. Two respondents said that there were no awareness generation programmes related to menstruation. Similarly, two respondents said that they were not aware of any scheme related to MHM or implemented by the government. Two respondents said women from villages faced safety issues as they had to defecate in the open.

4.1 VOICES AND EXCERPTS: RAMANATHAPURAM

Alagarsamy (Interview 12.08.22)[3], a **Ward Member** of a village in Tamil Nadu, had knowledge about MHM but she opined, "We are not aware of any scheme available for the age group of 20- 49 years". According to her, lack of information and governmental support systems get further compounded by paucity of financial resources at the family level. When asked about WASH, she answered that the village had a pond that fills up in the rainy season and was enough to meet the water need. However, it was not clear whether the women's WASH needs could be fulfilled throughout the year from that pond. She added that a separate toilet and free sanitary napkins for all women were an urgent need of the hour. For those using pads, in the absence of disposal facilities, menstrual waste generation is a huge challenge. She also talked about taboos during menstruation as "women were not allowed to enter temples and perform *Pooja* at home, yet there were good customs such as bathing twice a day and using clean cloth during menstruation".

[3] TN KII1 RN: Available in Data Records, MHM Project (2022-2023) SSMF- Sulabh International

Shanthi (Interview 22.07.2022)[4], a **Block coordinator** of a village in Tamil Nadu, seemed well versed about menstrual hygiene. She emphasized on continuing the education of children beyond adolescent years. "Even if free pad distribution of pads becomes regularized, it should be ensured that every girl up to 18 years gets pads because some of them were living in hostels or with their parents." She felt lack of financial resources was a challenge to achieve proper menstrual health in the village and suggested that pads be sold at the rate of 1 Rupee, be provided through the Public Distribution System (PDS) and ration shops. Regarding WASH, she said that under the JJM scheme water supplied in the village was not adequate. Schools had water facilities and, "even if there is no tap in the toilet, efforts are taken to keep water in barrels or small containers". On taboos in her village, she narrated how menstruating women were segregated in their homes. She also added that the government had allocated a separate place in public toilets to burn menstrual waste. Still, menstrual waste generation in her village was much higher than the disposal facilities could manage.

V. Ramadevi (Interview 29.07.2022)[5], a **school teacher** in Ramanathapuram, stated that the village had a programme to provide pads to girls between 10 and 18 years of age. Iron tablets for children were distributed every Thursday but she had never heard of the *Rashtriye Kishori Suraksha Karyakaram* (RKSK). Moreover, she added that the village needed napkin facilities at public places and toilets for women between 20 and 49 years. To WASH queries, she replied that the village did not have enough potable water. Her village school had a water supply but no disposal machine for menstrual hygiene materials, which should be installed in every *Anganwadi* and for every SHG. She said that families do not allow their women to enter temples or celebrate festivals during menstruation in accordance with local beliefs and taboos. Bathing twice and use of sanitary napkins were two prominent measures adopted by the village women to maintain menstrual hygiene, but organizing more awareness drives for women was important.

Anujuya (Interview: 25.07.2022)[6], a village **Health Nurse** in Tamil Nadu, stated that the village had a programme for protecting adolescent girls from anemia by distributing IFAtablets and free sanitary napkins to girls. But the village required a programme for providing free sanitary napkins to every menstruating woman. On women's WASH requirements in the village, she demanded individual as well as community toilets for women, dustbins in public places, and a place to burn menstrual waste. The village nursewas unaware of any 'WASH' programmes but added, "we have water in our village. Village is properly cleaned all around".

Fatima (Interview: 19.07.2022)[7] an ***E ÐÉÃÐÚ ÃÆÖ*worker** (AWW) in Tamil Nadu responded that a programme for providing IFSC tablets and sanitary napkins to girls was implemented. However, she suggested that sanitary napkins be provided to all menstruating women. She emphasized upon creating awareness and educating women on menstruation. On women's WASH requirements in the village, she demanded toilets and menstrual waste disposal machines. She insisted that the Panchayat should be responsible for keeping the village clean.

Sreedevi (Interview: 08.07.2022)[8], a **school teacher** in Tamil Nadu, was well aware about the programme of free sanitary napkins to adolescent girls, importance of personal MHM and the celebration of a menstrual hygiene day in the village. The school teacher said, "Women had to travel 10 kms-15 kms to buy pads, hence free sanitary napkins, pain killers, and nutrient tablets for all menstruating women were basic and important necessities that should no longer be ignored." She also demanded public toilets and waste disposal machines for women in the village.One of the prominent village taboos, she informed us, was not allowing menstruating women to enter temples.

Shanthi (Interview: 08.07.2022)[9], an **Anganwadi Worker** (AWW) in a village in Tamil Nadu, talked about the provision of free sanitary napkins for girls in the village school. A play on menstrual hygiene was held in the

[4] TN KII2 RN: Available in Data Records, MHM Project (2022-2023) SSMF- Sulabh International

[5] TN KII3 RN: Available in Data Records, MHM Project (2022-2023) SSMF- Sulabh International

6 TN KII4 RN: Available in Data Records, MHM Project (2022-2023) SSMF- Sulabh International

7 TN KII5 RN: Available in Data Records, MHM Project (2022-2023) SSMF- Sulabh International

8 TN KII6 RN: Available in Data Records, MHM Project (2022-2023) SSMF- Sulabh International

9 TN KII8 RN: Available in Data Records, MHM Project (2022-2023) SSMF- Sulabh International

school but she was unaware of any scheme on adolescents or for EAMW in her village. On women's needs in the village, she said that providing free sanitary pads and nutrient tablets to every menstruating woman would be steps in the right direction. She also insisted upon creating awareness among women about proper use and disposal of sanitary napkins. On prevalent taboos she replied that one of the most prominent was not being allowed to enter temples during menstruation.

Jeyarani (Interview: 14.08.2022)[10], who is a **SHG leader** in a village in Tamil Nadu, was aware of free sanitary napkin and iron tablets distribution programme for the age group of 10-19 years, but she said, "We are not aware of any scheme available for the age group of 20-49 years." On the requirements of menstruating women, she responded, "all of them are not in a position to buy sanitary napkins. The government should provide them with free sanitary napkins like these are provided to adolescent girls." Even the village school lacks a water facility because it is a primary school. On women's infrastructural requirements for MHM, she emphasized that villages must have public toilets and disposal machines to create menstrual hygiene in the village. Families adhere to usual taboos such as restrictions on performing *pooja,* entering temples and celebrating festivals during menstruation.

Pushpam (Interview: 09.07.2022)[11], a village **counsellor** in Ramanathapuram district of Tamil Nadu, responded, "I do not know about government schemes/programmes for adolescents that are related to menstrual hygiene, most of the people are unaware about any such services in my village." She added that creating awareness about menstrual hygiene infrastructure in public places where women gathered could be an important change. On WASH queries, she informed that she was "unaware of the term and had no knowledge about this scheme." Besides, the village lacks proper water and toilet facilities and people still follow open defecation. On the requirements of EAMW, she demanded free sanitary napkins for every household and an incinerator to burn menstrual waste in each village. Pushpam mentioned 'good customs' followed in the village such as stocking up on sanitary pads in advance to be used in emergency and complete disposal of menstrual waste.

Sornam (Interview: 11.07.2022)[12], the **President of Fisherwomen Association** of a village in Tamil Nadu, informed us of provisions of sanitary napkins, iron and folic acid tablets free of cost to adolescent girls in the village school. She emphasized on creating awareness about the proper usage and disposal of sanitary napkins. However, women still used cloth in her village. On WASH queries, she was not aware of any specific schemes or programmes around the theme. However, she added her village does not have a water supply and people had to buy drinking water. Though the village school has water supply, "there is no adequate toilet facility for girls to use during the menstruation". She suggested that free sanitary pads be supplied throughout to young girls as they were unable to buy napkins during school holidays due to financial constraints. A specific taboo practiced in the village related to not holding children during menstruation besides the common restrictions around worshipping and entering temples.

Nirmala Devi (19.07.2022)[13] who is a **School Headmistress** in a coastal village in Tamil Nadu informed us of a training programme for menstruating girls in her school and an ongoing free sanitary pads scheme too. She insisted upon educating women on using pads instead of cloth and taking enough rest during menstruation suggesting that there must be a separate restroom for menstruating women at workplaces too. She added that schools needed a separate toilet facility along with required instructions on how to use the toilet and dispose of the napkins during menstruation. Installing a napkin disposal machine would be a good idea.

4.2 VOICES AND EXCERPTS: VIRUDHUNAGAR

Sudha (Interview: 08.07.2022)[14], the village **Sarpanch** in Tamil Nadu's Virudhunagar, informed us that a programme for providing free sanitary napkins and nutrient tablets was implemented regularly in her village.

[10] TN KII9 RN: Available in Data Records, MHM Project (2022-2023) SSMF- Sulabh International

[11] TN KII10 RN: Available in Data Records, MHM Project (2022-2023) SSMF-Sulabh International

[12] TN KII11 RN: Available in Data Records, MHM Project (2022-2023) SSMF-Sulabh International

[13] TN KII12 RN: Available in Data Records, MHM Project (2022-2023) SSMF-Sulabh International

[14] TN KII1 VN: Available in Data Records, MHM Project (2022-2023) SSMF-Sulabh International

Moreover, she provided counselling to young girls under *Rashtriya Kishori Suraksha Karyakaram* (RKSK). On the requirements of women in the age group of 20 to 49 years, regarding MHM, she opined that providing free sanitary pads to all menstruating women and installing functional public toilets were prime needs. This should be followed by providing menstrual waste disposing machines and regular health check-ups for women every thirty to ninety days. This compromised their safety, privacy as well as hygiene. It was evident that she was unaware of schemes and concepts such as WASH but she responded that villages had water facilities and some villagers had toilets in their houses. The village school does not have toilets. School going menstruating girls clearly have a challenge in fulfilling their WASH needs. On women's infrastructural needs, she demanded public toilets.

Indira (Interview: 26.07.2022),[15] a **SHG Head** in an urban area of Virudhunagar, stated that free sanitary napkins and nutrient tablets were provided to adolescents in her village and health check-ups were done at the Primary Health Center (PHC). Due to poverty, women were unable to buy sanitary pads so free sanitary pads, functional toilets and regular water provided for every menstruating woman for better MHM. On WASH queries and MHM, she informed that the village school lacked water supply and toilet.

Gomathi (Interview: 25.07.2022),[16] a **School Teacher** in a village in Tamil Nadu, said that free sanitary napkins and iron tablets were given to adolescent girls in the village school. According to her poverty was a challenge in achieving proper menstrual health management. Like many of our other respondents, she suggested free sanitary napkins, clean toilets, and rest facilities for women in the age group of 20 to 49 years. In response to queries on WASH and MHM in schools and communities she answered, "In government schools we do not have water facilities, students fear using the toilets. Girls were in a very difficult situation during menstruation." She also suggested free health check-ups for all women be organized regularly as the cases of uterus cancer have increased.

Kalaiselvi (Interview: 12.07.2022)[17], an **AWW** in a village in Tamil Nadu was happy with the ongoing schemes and programmes such as conducting PNC-ANC meetings, awareness camp on anemia and meetings with adolescent girls. On specific requirements regarding menstrual hygiene, she suggested separate toilet facilities, menstrual waste disposal machines and clean water for women. Opening up on taboos and constraints that women in her community faced, she narrated, "We have to use separate space at home, separate plates and tumblers. There is a restriction to bathe in the pond (or in open spaces) during menstruation. Others do not allow us in their home during menstruation." But the village counts on some good customs such as 'burning of menstrual waste' in a bid to dispose of it properly.

Respondent Umakani (Interview: 09.07.2022),[18] a **Village Health Nurse (VHN)**, talked about providing free sanitary napkins to women under *Rashtriya Kishori Suraksha Karyakaram*. She also added that iron and folic acid tablets be provided to women in the age group of 20-30 years. On WASH, she is unaware about any such 'scheme'. Nonetheless, she added that every village had acommon tap to collect water. Moreover, *Jaldhan Kisan* scheme also provided water tap to every household. She added that the village school does not have water and sanitation provisions. She emphasized on creating awareness in the society about menstrual hygiene and suggested that sanitary napkins should be provided to every girl on the first day of menarche.

Velli (Interview: 08.07.2022)[19], a village **Sarpanch**, said that under RKSK there is a programme for providing sanitary napkins and nutrient tablets to adolescent girls. She suggested free sanitary napkins and free medical examination for uterus and breast cancer for everymenstruating woman in the village. On menstrual hygiene in school, she said the school hada separate dustbin to dispose of used sanitary pads. Regarding the menstrual hygiene requirements of the EAMW, she stressed the need for public toilets for working women and safe community spaces for disposal of menstrual waste. On WASH, a tap in every household, and a menstrual waste

[15] TN KII2 VN: Available in Data Records, MHM Project (2022-2023) SSMF-Sulabh International

[16] TN KII3 VN: Available in Data Records, MHM Project (2022-2023) SSMF-Sulabh International

[17] TN KII4 VN: Available in Data Records, MHM Project (2022-2023) SSMF-Sulabh International

[18] TN KII5 VN: Available in Data Records, MHM Project (2022-2023) SSMF-Sulabh International

[19] TN KII6 VN: Available in Data Records, MHM Project (2022-2023) SSMF-Sulabh International

disposal machinein institutions and community spaces was an urgent need. She added that the village had a good custom of providing fish oil to menstruating women.

Vijayalakshmi (Interview: 24.08.2022),[20] a **Medical Adviser** in a village in Virudhunagar district, began with a free sanitary napkin scheme for girls. She added the village had programmes under RKSK such as counselling for adolescent girls and whoever is under stress during menstruation, the village has also set up a RKSK counselling centre in the government hospital. She stressed upon creating awareness about menstruation. Regarding WASH, she said, the village had a water facility but the school does not have water and toilet facility. It was not clear how school-going girls fulfil their menstrual needs.

A **Village Health Nurse (VHN)**, Thannammal (Interview: 21.08.2022)[21] was acquainted with functional schemes such as providing nutrient tablets and organizing camps on menstruation. In her opinion, provision of free sanitary napkins for women in the age group of 20-49 years should be considered urgently by the government. On menstrual hygiene schemes, she replied, "So far all the schemes are available at school level but not implemented in the community." From her account it was evident that the village needs a public toilet with clean water facility and menstrual waste disposal machine/s.

A **SHG Head** in a village, Divya (Interview: 08.072022),[22] informed us that underRKSK, free sanitary napkins and nutrient tablets were distributed to adolescent girls. She added, "WIFS, Albendazole tablets are provided for girls in the age group of 10 to 19 years. Tablets are also given to women in the age group of 20 -49years." Women used to get free sanitary napkins through government schemes but since January 2022 (past six months), this scheme was discontinued. On sanitation and hygiene in the village, she added that the village relied on a common pond for water. A separate toilet for women and proper disposal as well as sanitation mechanisms for menstrual products is an urgent requirement for common welfare.

Annavelli (Interview: 29.07.2022),[23] the **SHG Head** in Virudhunagar, knew about schemes such as free sanitary napkins and nutrient tablets. She stated that the village had a water facility provided by the Panchayat. On menstrual hygiene requirements, she added that the village needed proper toilets and waste disposal mechanisms. The village school, however, had a proper water supply and toilet facility.

Divya (Interview: 09.07.2022),[24] who works as a **School Teacher,** informed that in her village free sanitary napkins were provided to adolescent girls and that the village conducted awareness camps on menstrual hygiene under RKSK. She said that in the absence of proper toilets, the village women experienced safety and privacy issues since they had to go behind thornbush trees to change their pads. Therefore, she pitched strongly for proper toilet facilities with adequate water supply as well as menstrual waste disposal machines, besides regular health check-ups for menstruating women.

Annakili (Interview: 09.07.2022)[25], who is an **Integrated Child Development Service (ICDS) worker** in a village, confirmed that free sanitary napkins, nutrient tablets as well awareness camps regarding menstrual hygiene were facilitated regularly in the village. She emphasized on creating awareness about menstrual hygiene in the age group of 20-49 years. She added, "Due to poverty many of them are not able to buy sanitary napkins. They need to buy the pads for being at work." It was evident that waste disposal was also a challenge in the village.

4.3 SALIENT OBSERVATIONS FROM DATA

Processing through our data from Ramnad and Virudhunagar, we have gained some valuable insights on women's health, education, livelihood and overall community outlook on menstrual health management needs and transformations on ground. In Tamil Nadu's Ramanathapuram, our key informants speak of a lack of

[20] TN KII7 VN: Available in Data Records, MHM Project (2022-2023) SSMF-Sulabh International

[21] TN KII8 VN: Available in Data Records, MHM Project (2022-2023) SSMF-Sulabh International

[22] TN KII9 VN: Available in Data Records, MHM Project (2022-2023) SSMF-Sulabh International

[23] TN KII10 VN: Available in Data Records, MHM Project (2022-2023) SSMF-Sulabh International

[24] TN KII11 VN: Available in Data Records, MHM Project (2022-2023) SSMF-Sulabh International

[25] TN KII12 VN: Available in Data Records, MHM Project (2022-2023) SSMF-Sulabh International

financial resources which impedes wellbeing options towards menstrual health. Though schools are providing pads, iron tablets as well as folic acid tablets to adolescent girls in the district, for menstruating women in the age bracket of 20 to 49 years, no specific schemes exist. For hygiene purposes, most villages and schools have no toilets.

Nonetheless, parents, elders and key informants opine that education of all children must continue beyond puberty and at the school level all hindrances should be overcome. Pad**s** for menstruation girls are provided in many schools but during holidays families must purchase pads which is untenable for most owing to extreme financial hardships and constraints. At the same time, pads being available at 10-12 km away from the villages, on an average, makes it equally hard for those who can afford the pads. All key informants suggested that pads/ absorbent material should also be made available for women beyond the age of adolescence.

Ramanathapuram women register their demand for a pad's disposal machine/ mechanisms quite often in our interviews as dispensing of menstrualwaste properly is a big challenge.

Interviews and interactions in Virudhunagar indicate the existence of customs that the women feel are good local practices. Adolescent girls receive nutrient tablets and sanitary napkins from schools along with regular health check-ups in PHCs, but sanitary pads are no longer available for women since the beginning of 2022. There is a scheme announced called Jal Dhan Kisan Yojana, but still not functional as taps, etc. are still under construction. Akin to Ramnathpuram, poverty remains a challenge in Virudhunagar too.

Factories as well as schools have a water scarcity that challenges sanitation and hygiene. Even where water supply exists, villages are equipped only with a single tap. Toilets for working women are non-existent and so is the case in almost all village homes. In the case of village schools having toilets, the conditions for use are below optimal.

From our interactions and databases pertaining to these two districts of Tamil Nadu, it clearly emerged that apart from a silence on women's menstrual health in terms of inter-sectoral hindrances and policy related negligence in India, there are community-voices that portray a negative and discriminatory attitude towards periods. Many EAMW as well as key informants endorse negative attitudes (as told to our surveyors and field-researchers) towards menstruation, either owing to the circumstantial difficulties that they grow up experiencing or for want of better knowledge and support system around the phenomenon. The key to combating the inter-sectoral and community-based silences and barriers on MHM among women beyond school years lies in augmenting positive practices and discourses on menstruation. One of the best ways to achieve this is by involving multiple actors, key and critical stakeholders such as EAMW, leaders, influencers, families, policy-makers and implementers. Hence, gender mainstreaming MHM can ensure gender perspectives and attention to the goal of gender equality in all activities, projects and programmes.

4.4 RECOMMENDATIONS/ AREAS OF IMPROVEMENT

IMMEDIATE

1. **EAMW, MHM and Health Checkups:** According to our findings, villages in Virudhunagar and Ramnad require intervention to bring relief to EAMW, who raised the demand of being provided free sanitary pads or priced at a token amount of 1 Rupee per pad, including for young menstruating girls during school vacation. They also proposed that monthly or three-monthly compulsory and inclusive health check-ups be organized in their villages.
2. **MHM Interventions for Young Girls:** 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 and school counsellors, social workers and FLWs themselves need to be oriented, as well as be motivated to: a) collaborate with each-other to propose infrastructuralinterventions 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 a better MHM at home and in schools such that her menstruation is not a hurdle in continuation of her education.

3. **Pad/ Menstrual Absorbent Dispensing and Disposal Mechanisms:** Our data indicates that EAMW not only demand that pads/ absorbents be available within reach for marginalized communities but they be given the right infrastructure and system for disposal of menstrual waste. We suggest that disposal systems be urgentlyfacilitated, standardized and monitored ensuring sustainability as well as orient and empower young girls and women in these to dispose menstrual waste in dignified secure ways. Installation of Pad-Vending Machines at every Anganwadi and SHG premises will further help MHM goals.

SHORT TERM

1. **Prevent School Drop-Outs, Make Schools MHM Friendly:** Capacity building of young girls in MHM enabling them to continue education can happen only if schools have proper facilities. Educating children entering puberty is a prime need that EAMW firmly point out in all villages. If menstruation is not given a proper introduction and interactive space in an adolescents' life, they go through feelings of isolation, stress, embarrassment and confusion over the issue. Making schools period-safe, in terms of knowledge and skill proliferation, sanitation and care will ensure continuity in education.
2. **WASH in Schools and Community**: Schools to be provided with separate toilets for girls with running water either through tap connection and installation of storage tanks under the JJM Scheme. Toilets should be constructed, operationalized and have regular water supply in homes, public spaces and workplace.
3. **Micro-Credit Facilities through SHGs**: Women Self Help Groups (SHGs) formed under the Mahalir Thittam Scheme shall be provided with 10000 INR as revolving fund. Further providing credit facilities to EAMV through TNSRLM and other government supported creditschemes could enhance the earning capacities whereby menstruating women can become active decision-makers in self-care.

LONG TERM

1. **Tamil Nadu MHM Committee**: A state-level Menstrual Health and Wellbeing Committee be initiated to integrate MHM issues of remote places, mountainous regions, etc. into the State, ADP and MHM plans.
2. **MHM at District, Block, Gram Panchayat Level**: Information, education, and communication (IEC) for menstrual hygiene should be imparted at various levels.
3. **Mahalir Thittam Scheme Provisions for EAMW**: Build capacities and skills of women from poor, marginalized households through functionally effective SHGs for gainful self- employment under TNSRLM.
4. **MHM at Family level:** Ensure sustainable water source along with source strengthening measures and provision of Functional Household Tap Connections (FHTCs) to all households under National Jal Jeevan Mission scheme.
5. **Water supply under Jal Jeevan Mission (JJM) for MHM:** Water supply be provided under JJM scheme in girl's toilets in schools.
6. **MHM friendly Toilets:** Provide community toilets as well as toilets in workplaces with washing areas, bathing cubicles, and running water under SBM(G) phase II to facilitate better MHM.

REFERENCES

Census 2011 Office of The Registrar General and Census Commissioner, Ministry of Home Affairs, Government of India. Available from "Census Info 2011 Final population totals - Ramanathapuram district" [accessed 02 January 2023]

District Human Development Report (2017) *Ramanathapuram District Profile*. State Planning Commission, Government of Tamil Nadu 5-10. Available from https://spc.tn.gov.in/Exe_Summary_DHDR/Ramnad.pdf [accessed 02 January 2023

District Human Development Report (2017) *Virudhunagar District profile*. Sivakasi: State Planning Commission,

Government of Tamil Nadu 1-15. Available from https://spc.tn.gov.in/DHDR/Virudhunagar.pdf [accessed 3 January 2023]

Government of Tamil Nadu (2023) *About Tamil Nadu*. Chennai: Information Technology Department Secretariat. Available from https://www.tn.gov.in/tamilnadustate [accessed 30 January 2023]

Green, Michael. Kapoor, Amit. (2021) An Assessment of Aspirational District Programme, *Social Progress Imperative and Institute of competitiveness,* 69-70. Available from https://www.niti.gov.in/sites/default/files/2022-09/Institute-of-Competitiveness-Assessment-of-ADP- August-2020.pdf [accessed 25 January 2023]

India Brand Equity Foundation(IBEF), Ministry of Commerce and Industry, Government of India (2023) About Tamil Nadu: Tourism, Economy, Industry, Agriculture. New Delhi. Available from https://www.ibef.org/states/tamil-nadu [accessed 10 January 2023]

India Brand Equity Foundation(IBEF), Ministry of Commerce and Industry, Government of India (2023) About Tamil Nadu: Tourism, Economy, Industry, Agriculture. New Delhi. Available from https://www.ibef.org/states/tamil-nadu [accessed 10 January 2023]

International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS)-5,State and District Factsheets, Tamil Nadu. Mumbai: IIPS. 105 & 195. Available from https://data.opencity.in/dataset/national-family-health-survey-nfhs-5-2019-21/resource/nhfs-5-data---tamil-nadu-and-districts-combined [accessed 20 January 2023]

Niti Aayog, Government of India (2018) DEEP DIVE Insights from *Champions of Change The Aspirational District Dashboard*. Available from https://smartnet.niua.org/sites/default/files/resources/firstdeltaranking-of-aspirational-districts.pdf [accessed 08 january 2023]

ANNEXURE I

Criteria / Reasons for Selection of Villages

Sr. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/hamlet/ward	Total Population (refer JJM/ SBM data)	Total Households	Prevailing social issues/ issues of inclusion/ etc.
Ramanathapuram District (Ramnad)					
1	Kamudhi Block	K. Nedungulam panchayat /Thalavai Nayakanpatti village	2,132	472	Adolescent girls are taken out of school and sent to textile mills for work
2.	Kamudhi Block	Keelaramaneri village and Panchayat	2000	362	Area is majorly occupied by Nayakkar community, Muslims
3.	Kamudhi Block	Udhayanathapuram Panchayat /Pallappa cherry village,	1,500	489	Dalit community does not have access to healthcare services.

Sr. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/hamlet/ward	Total Population (refer JJM/ SBM data)	Total Households	Prevailing social issues/ issues of inclusion/ etc.
4.	Ramanathapuram Block	Mayakulam Panchayat /Mangalesawari Nagar	1,987	609	Fishing is the primary occupation
5.	Rameshwaram Municipality	Olakkuda area	2073	457	Semi urban area under municipality
Virudhunagar District					
1.	Kariapatti block	Sooranur Panchayat/ Thenur village	2252	609	Mixed community with the representation of BC/MBC
2.	Kariapatti block	Thulukkankulam panchayat/Kambali village	2701	706	Dalit community does not have access to basic amenities
3.	Kariapatti block	Thulukkankulam panchayat/Keel Idaiyanur village	531	166	Dalit community does not have access to basic amenities
4.	Srivilliputhur block	Pillaiyarkulam Panchayat and village	2634	1045	Poor female literacy rate. 25% as per census.
5.	Sivakasi Municipal Corporation	Ward No.5, Thiruthangal	71040	15519	Migrant workers and women workers engaged in making firecrackers

#	District	Block/ Ward	Gram Panchayat/ Ward	Village
1	Ramnad	Kamudhi Block	K. Nedungulam panchayat	Thalavai Nayakanpatti
2	Ramnad	Kamudhi Block	Keelaramanathi Panchayat	Keelaramanathi village
3	Ramnad	Thiruppulani Block	Panikulam panchayat	Pallapatcherry village
4	Ramnad	Thirupulani Block	Kalari panchayat	Kallupatti village
5	Ramnad	Rameshwaram Municipality	Ollakkuda area	Ollakkuda Ward

#	District	Block/ Ward	Gram Panchayat/ Ward	Village
6	Virudhunagar	Kariapatti Block	Sooranur panchayat	Thenur village
7	Virudhunagar	Kariapatti Block	Thulukkankulam panchayat	Kambali village
8	Virudhunagar	Kariapatti Block	Thulukkankulam panchayat	Keel Idaiyanur village
9	Virudhunagar	Kariapatti Block	Thulukkankulam panchayat	Karaikulam village
10	Virudhunagar	Kariapatti Block	Thulukkankulam panchayat	Gundukulam village

** For selection criteria for villages: See Annexure I*

ANNEXURE II

Important Women-Centric Schemes in Tamil Nadu

- *Moovalur Ramamirtham Ammaiyar Higher Education Assurance*. Started in 2022, this scheme was announced by Chief Minister Shri M K Stalin (DMK) under provisions of the Social Welfare Department, Government of Tamil Nadu. The objective of this scheme is to enhance the enrollment ratio of girls from government schools to Higher Education institutions. Through this scheme, the financial assistance of 1000 INR/month will be provided to the girls till they complete their Undergraduate (UG) degree/Diploma/ ITI/any other recognized course. The incentive amount under this scheme is to be disbursed directly into the student's Bank Account.
- *Chief Minister's Girl Child Protection Scheme:* This scheme was started by the Chief Minister, J. Jayalalithaa (AIADMK), in August 2011 under the Ministry of Women and Child Development, Government of Tamil Nadu. The objective of **Scheme-I**: An amount of 50,000 INR is deposited in the name of the girl child born on or after 01/08/2011, in the form of fixed deposit, with the Tamil Nadu Power Finance and Infrastructure Development Corporation Limited, for 18 years for a family with one girl child only. The copy of the fixed deposit receipt is given to the family of the girl child. **Scheme-II**: An amount of 25,000 INR each is deposited in the names of two girl children, where the second girl child's born on or after 01.08.2011 in the form of fixed deposit with the Tamil Nadu Power Finance and Infrastructure Development Corporation Limited, for 18 years for a family with two girl children only. The copy of the fixed deposit receipt is given to the family of the girl children.
- *Tamil Nadu Free Sanitary Napkin Scheme:* This scheme was started by AIADMK Chief Minister, J. Jayalalithaa, in 2011 under the Ministry of Health and Family Welfare, Government of Tamil Nadu. The objective of the scheme is to provide free-of-cost sanitary napkins to government school girls and women in-patients at Government Medical Institutions (GMIs) under the menstrual hygiene programme.
- *Dr Dharmambal Ammaiyar Ninaivu Widow Remarriage Assistance Scheme:* This scheme was started by the Chief Minister of state, Shri M. Karunanidhi, in 1972-73 under the Ministry of Women and Child Development, Government of Tamil Nadu, to encourage widow remarriage and to rehabilitate widows. Under this scheme, financial assistance of 15,000 INR is given through ECS and 10,000 INR as National Savings Certificate along with 4 gram 22-carat gold coin for making Thirumangalyam. The degree/ diploma holders are given 50,000 INR, out of which, 30,000 INR is given through ECS and 20,000 INR is given as National Savings Certificate along with 4 gram 22-carat gold coin for making Thirumangalyam.

NOTES

NOTES

Sulabh Sanitation Mission Foundation (SSMF)
Registered Office: A-34 Palam Extension, Sector 07, Dwarka, New Delhi-110077
Tel: 011-40542735, Mobile 9582825031
Emil: ssmfnd@gmail.com

ISBN 978-93-5996-853-7