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.

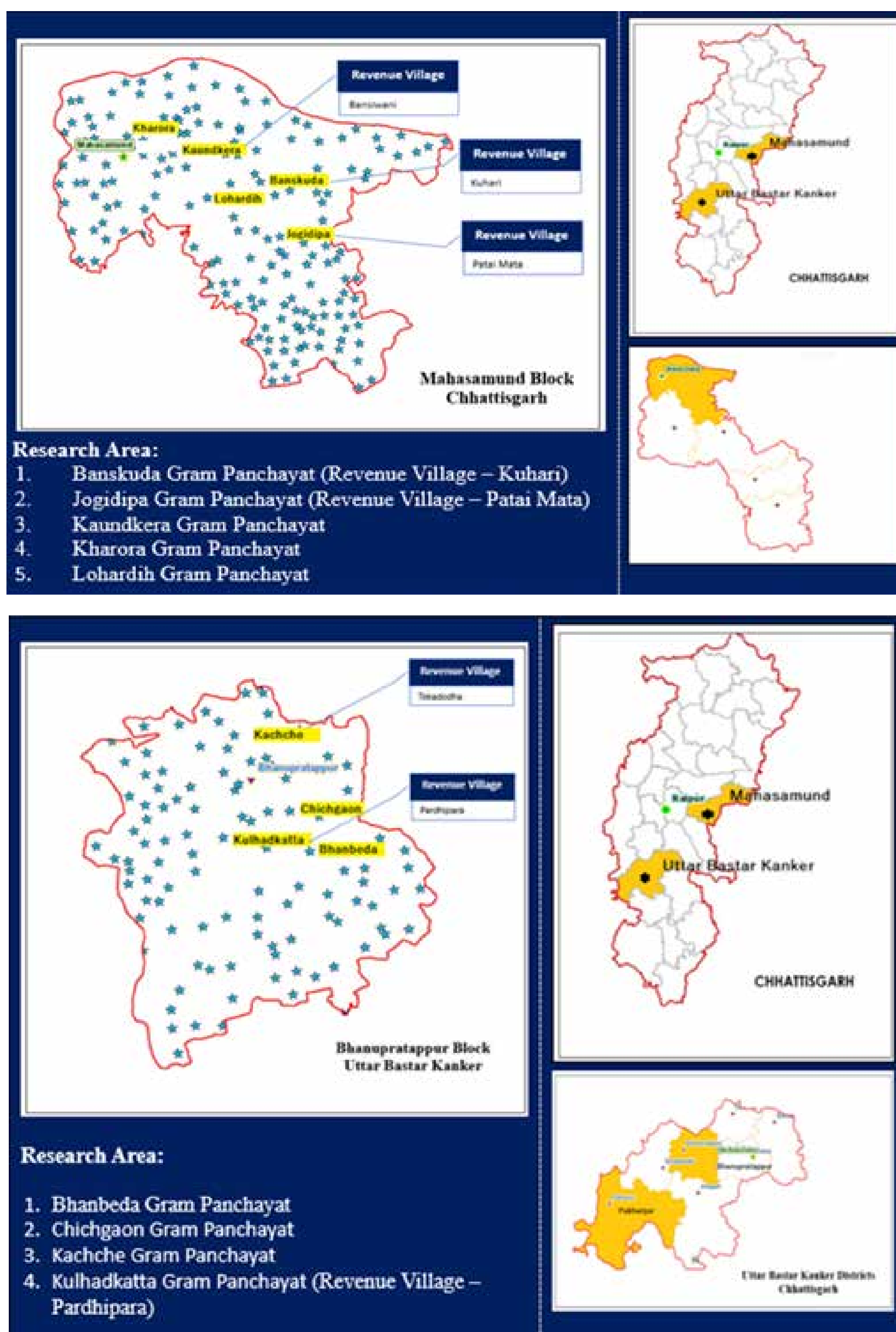
Aspirational district programme under Government of India came with great hope for Mahasamund and Uttar Bastar Kanker districts of Chhattisgarh. Since being selected as an aspirational district, Mahasamund has made significant progress in various areas. For instance, the district has developed a 'Model 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

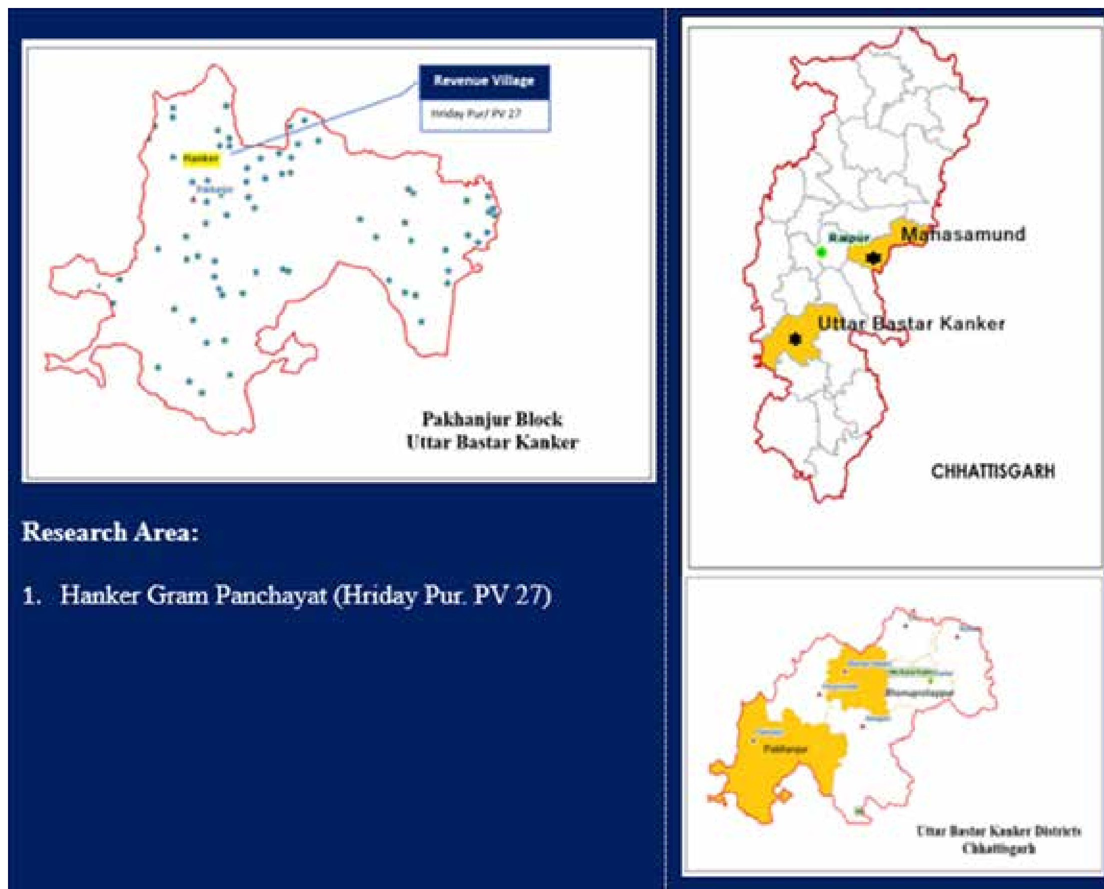
[2] Chhattisgarh is in the central part of India. The state shares its border with Madhya Pradesh and Maharashtra in the west, Uttar Pradesh in the north, Odisha and Jharkhand in the east, and Andhra Pradesh in the south. At current prices, Gross State Domestic Product (GSDP) of Chhattisgarh stood at 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.





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

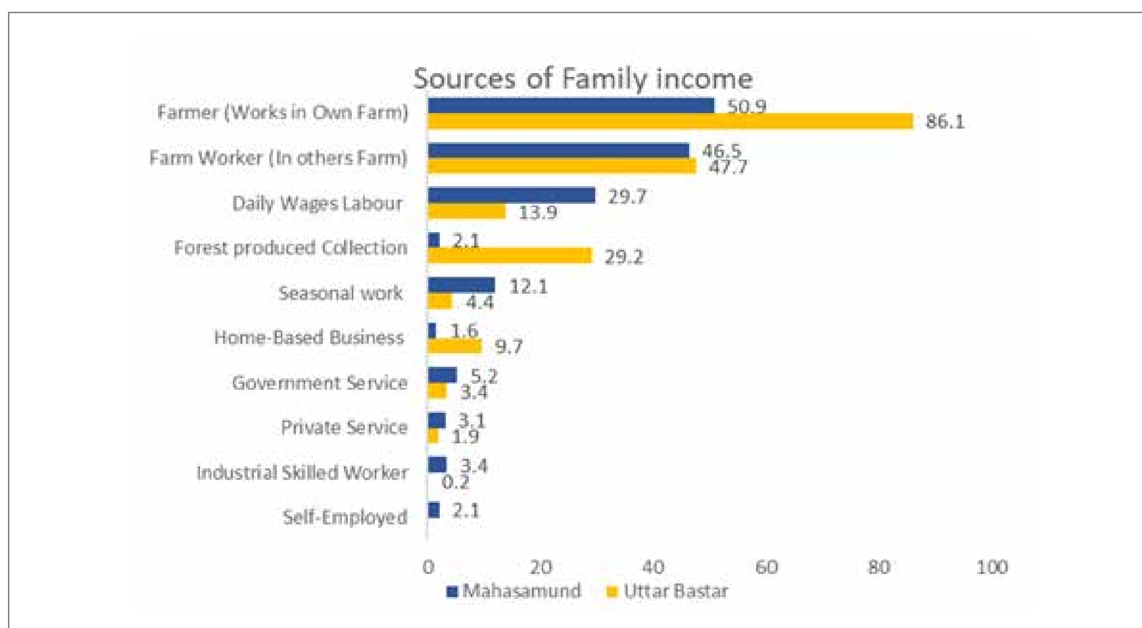
- **Religion:** Out of 792 of our respondents, 98.7% stated Hinduism as their religion while the rest of the sample pertained to Adidharm and Islam.

- **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

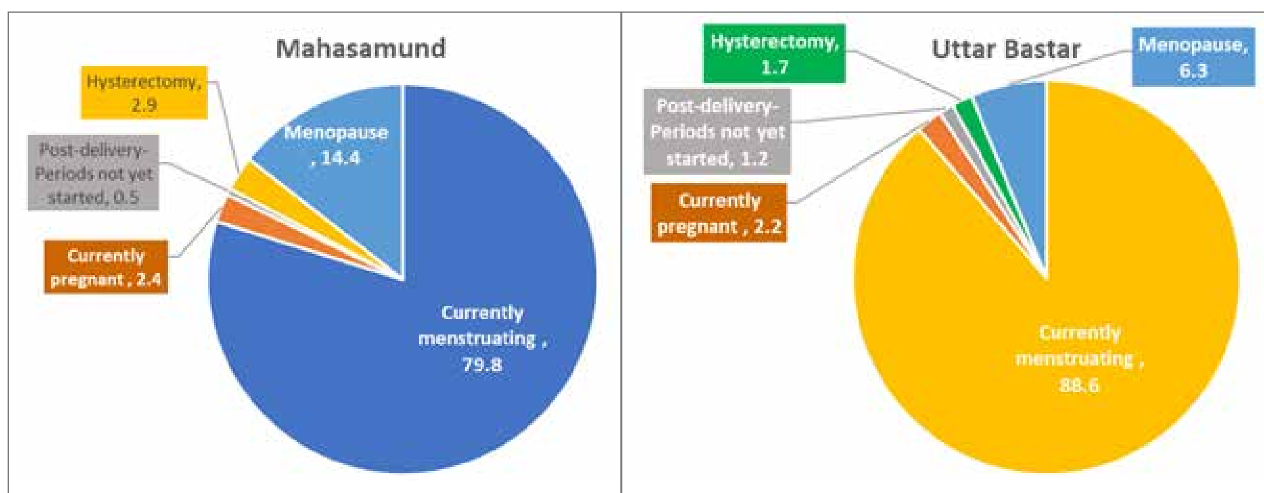
INCOME TRENDS: (MAHASAMUND N= 381, UTTAR BASTAR N=411)

- **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.



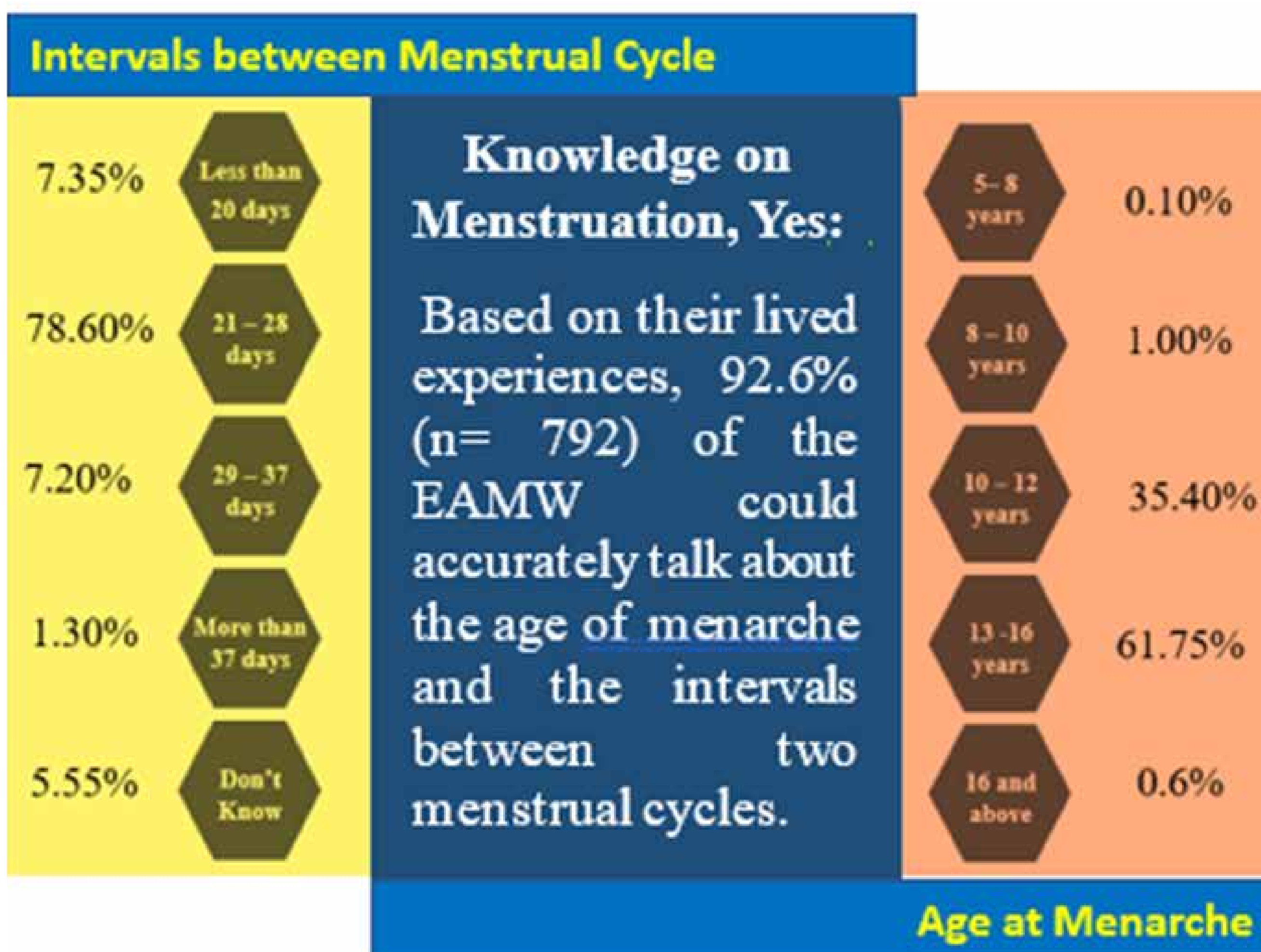
3.2 DISCOURSE ANALYSIS

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



Knowledge on Menstruation

66% respondents do not know about the **causes of menstruation**

Precise Information, No: However, 66% of the women lacked biological awareness as they could not answer questions about causes of menstruation. 58.3% (n= 381) women from Mahasamund and 29.9% (n=411) from Kanker could tell that organs involved in menstruation are uterus or birth canal. Even though women in Mahasamund had a better understanding of causes of and organs involved in menstruation than those in Kanker, still more awareness drives are required in both the areas to equip the EAMW towards a better MHM.

Knowledge on Menstruation

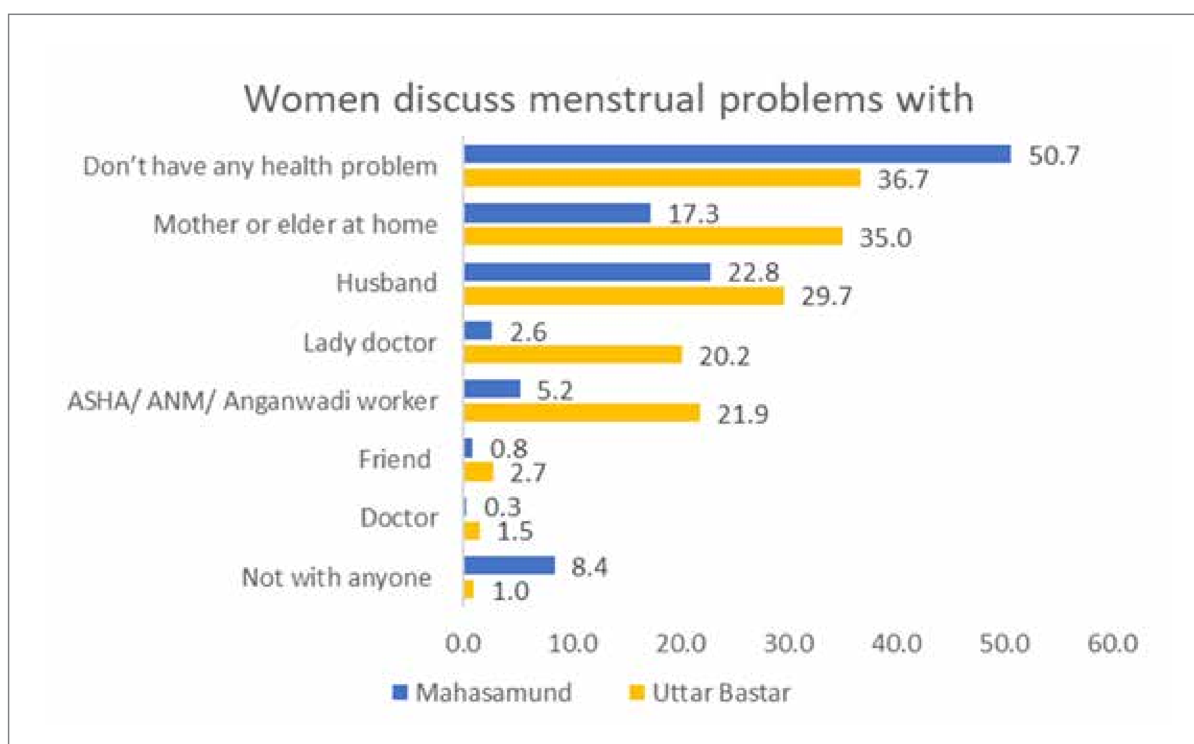
56.4% respondents do not know the **organs involved in menstruation**

- **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.



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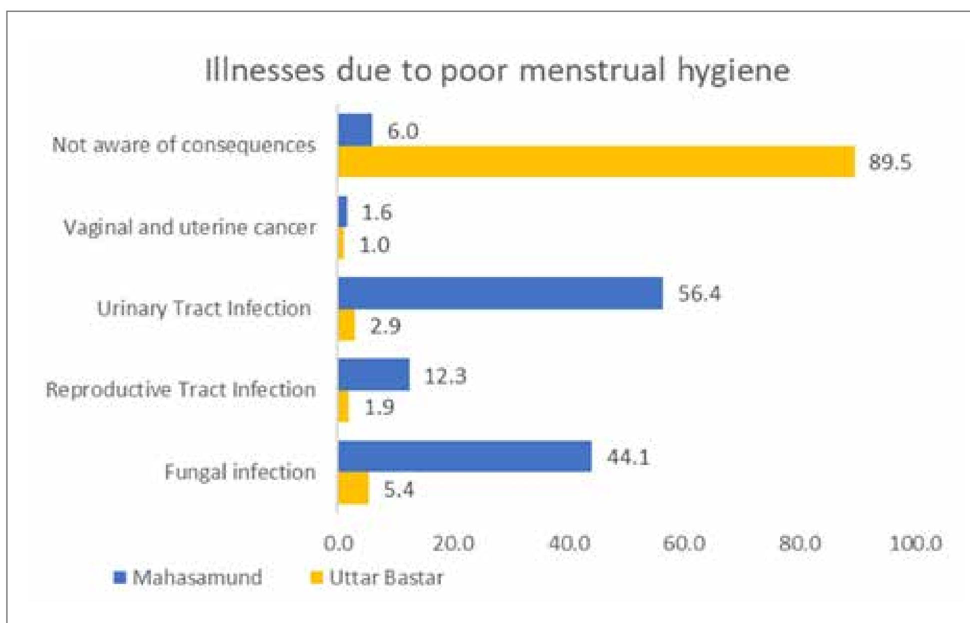
WOMEN LIKE TO DISCUSS THEIR MENSTRUAL PROBLEMS WITH THE FOLLOWING:

- **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.



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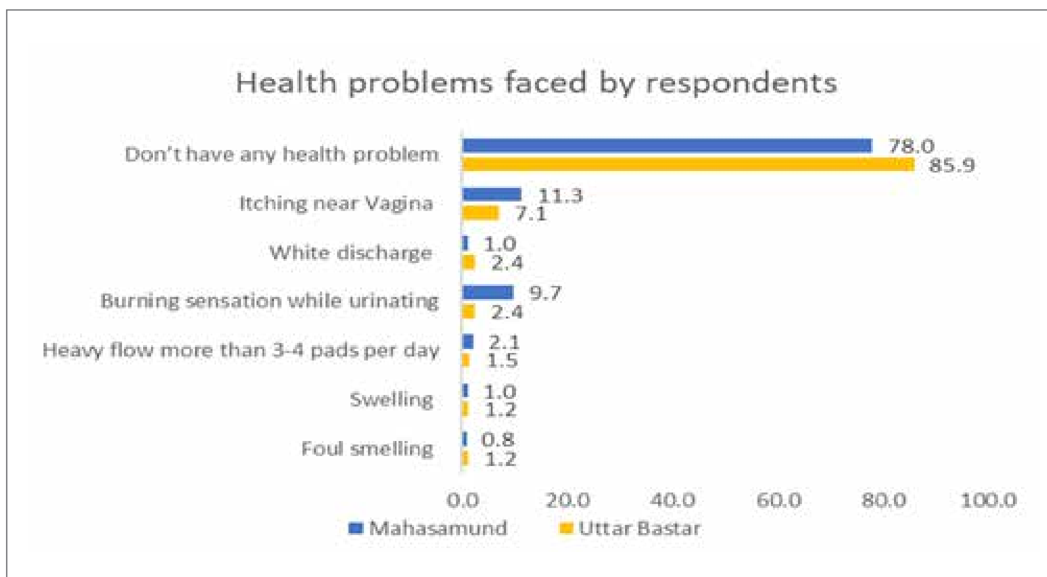
- **Widespread Ignorance**: When asked about the side effects of poor menstrual hygiene, only 46 EAMW from Uttar Bastar (n= 414) could speak about the impacts of poor menstrual hygiene. 368 women could not answer. Situation in Mahasamund about awareness was the exact opposite. 93.9% women out of 381 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



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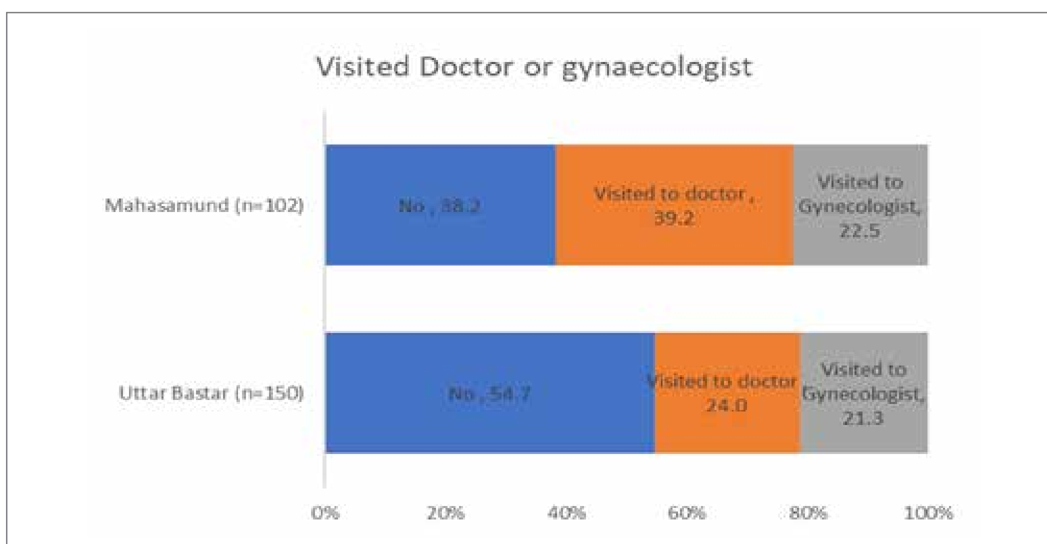
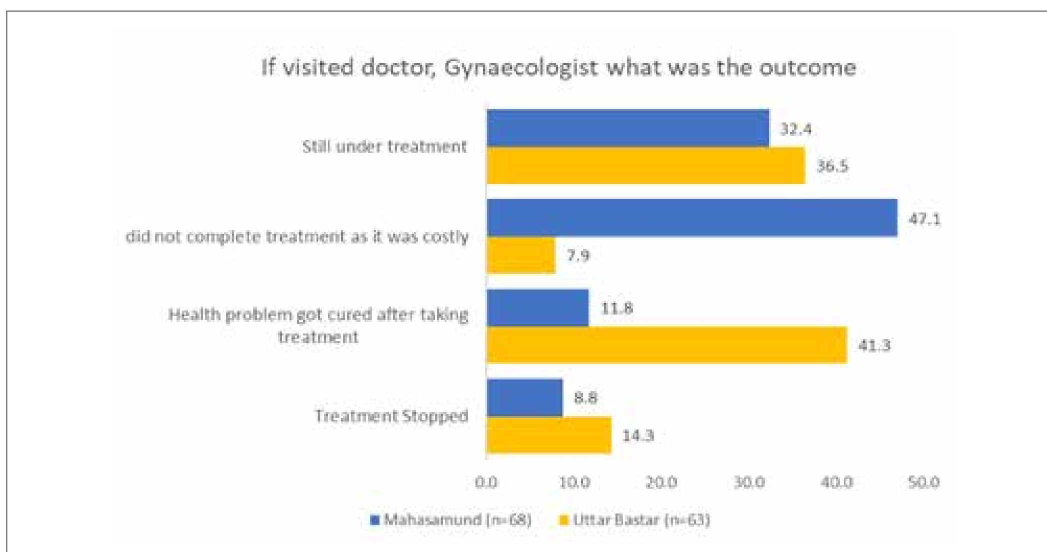
- **MHM, health and accessibility to health care**: Apart from the modes as well as patterns of and awareness on MHM, the survey imparts light on the health problems undergone by participants during menstruation. For arriving at inter-sectoral findings on health management, women were asked if they visit 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.



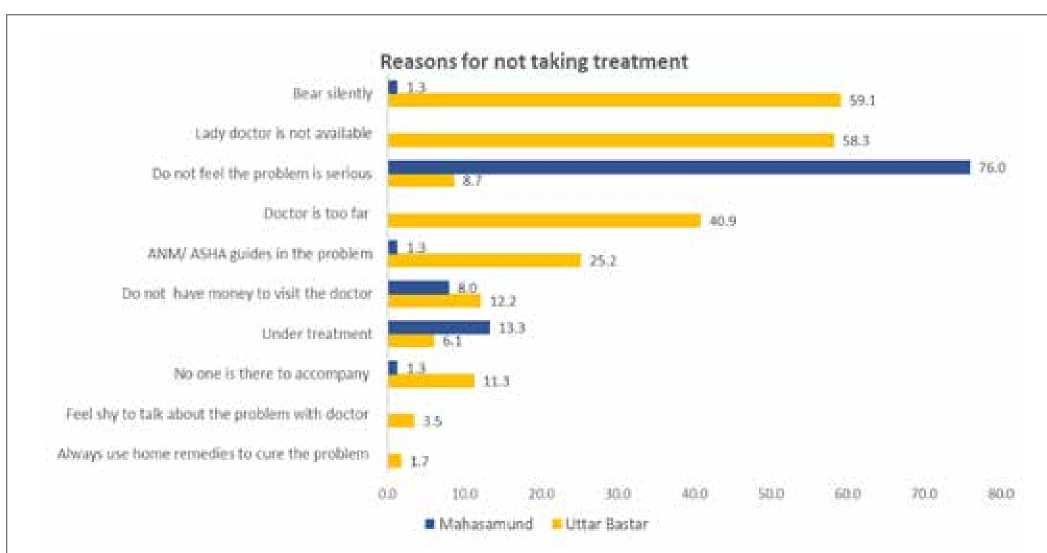
- **Treatment:** Out of 252 women from both districts who reported health problems during menstruation, 121 women i.e., 48% reported that they never went to a doctor for menstrual health problems they face. Only 34 (13.5%) women who informed us that they had visited a doctor, got cured after completing 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)



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- **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.

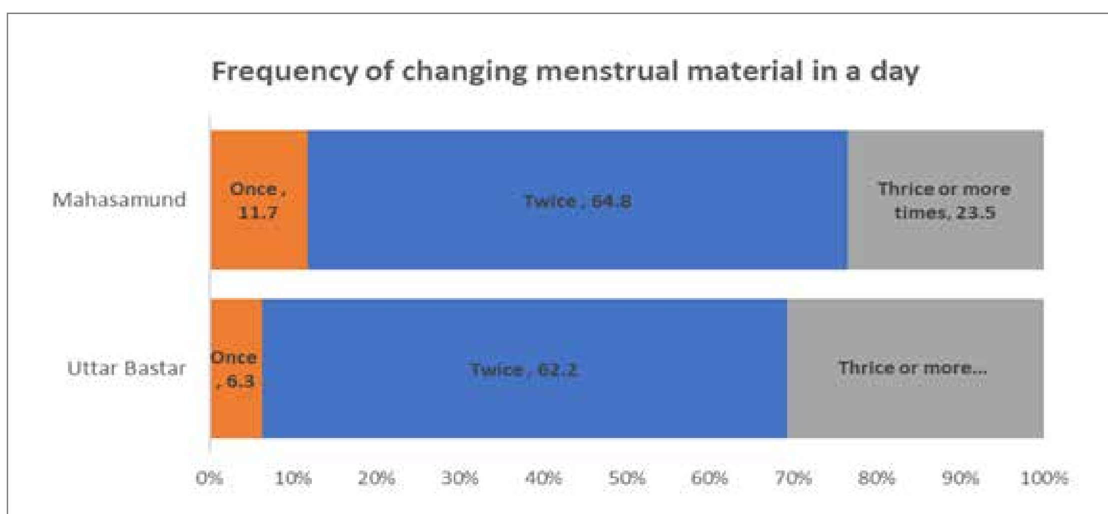
4.2.1 SANITARY PADS OR OTHER ABSORBENTS

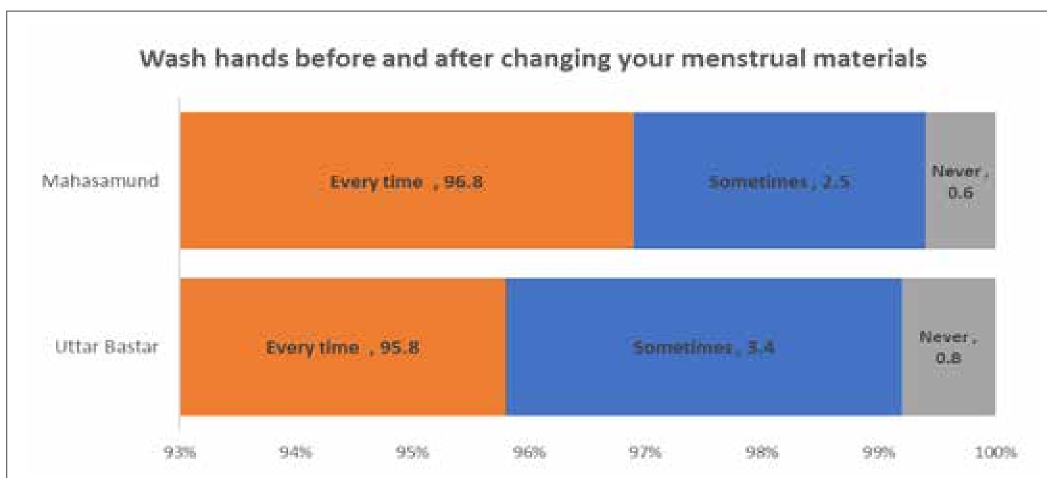
- **Cloth:** Out of the total of 693 EAMW interviewed from both districts, 69.7% women surveyed use only cloth during menstruation. Precisely, 83.5% EAMW in Mahasamund and 58.2% EAMW in Uttar Bastar use cloth because of its ready availability, affordability, durability and also, lack of awareness about 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)

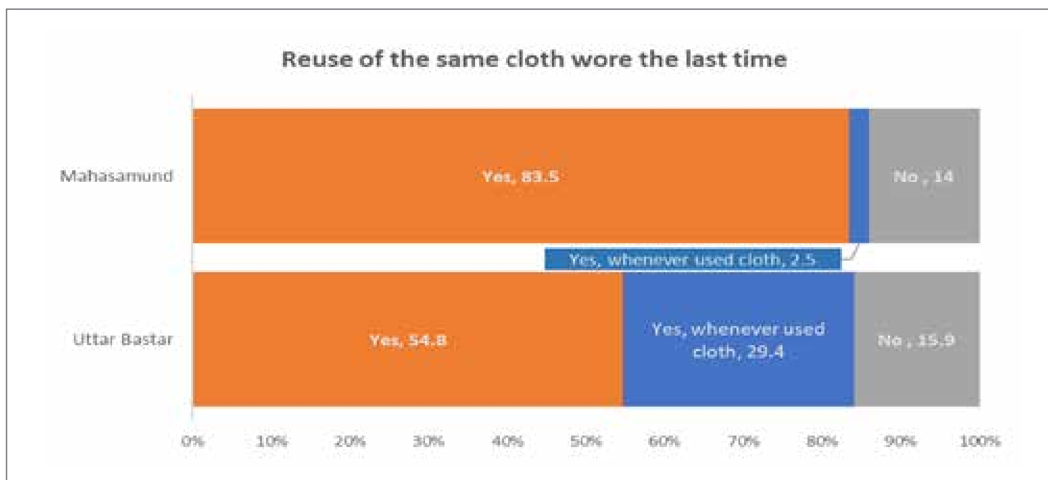


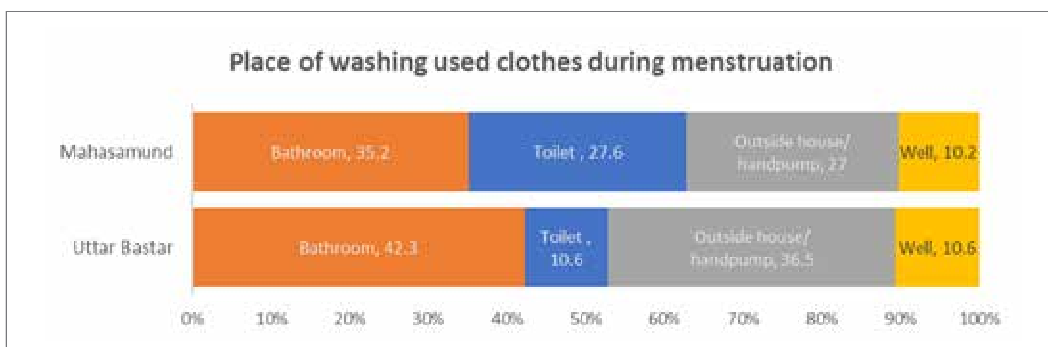


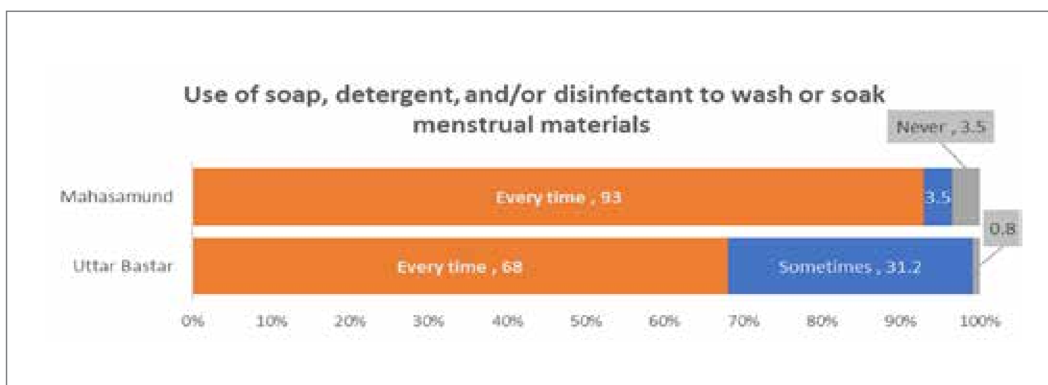
Our data indicates adequate awareness towards MHM and WASH alongside provision of and access to proper WASH infrastructure and sanitation services in both districts of Chhattisgarh

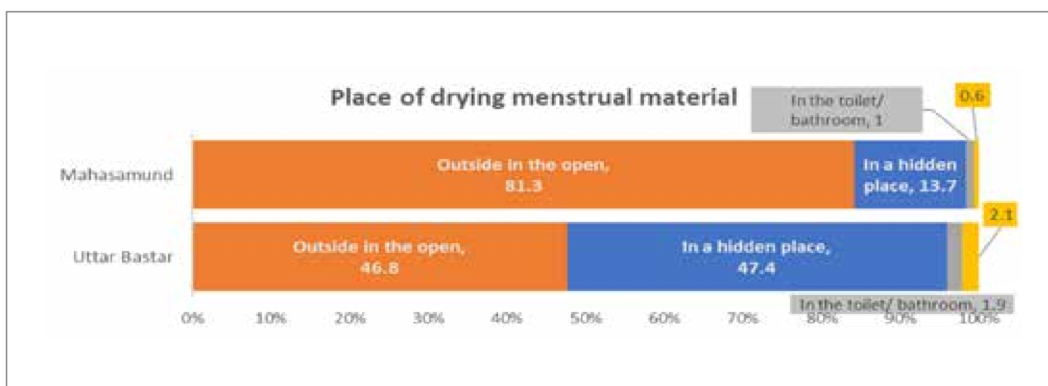
4.2.4 MENSTRUAL HYGIENE PRACTICES

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.

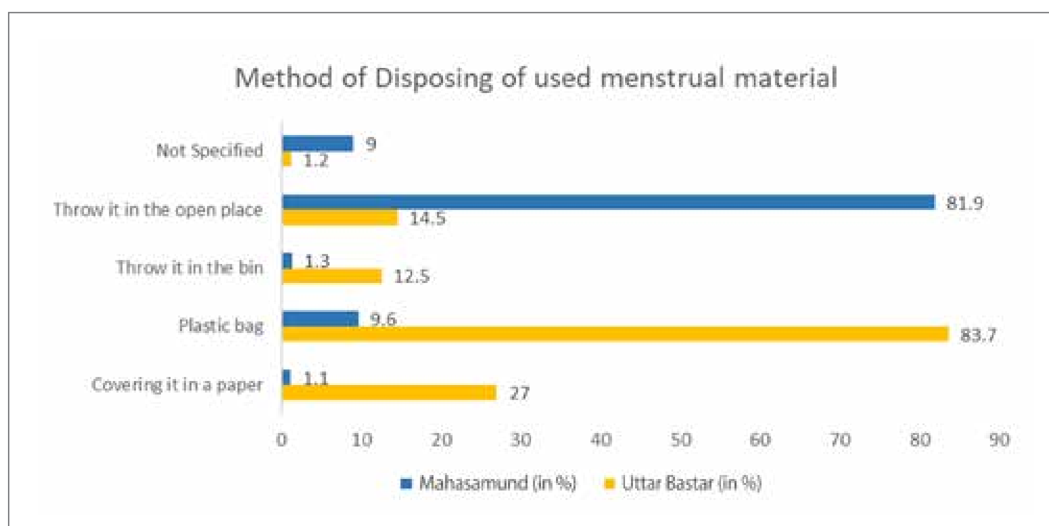
All the above findings depict that almost all women have basic facilities like water, toilets, and an affordable environment to use soap and clean clothes in both districts in Chhattisgarh. In case they lack these facilities, it is apparent that the EAMW in Chhattisgarh try to arrive at some makeshift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

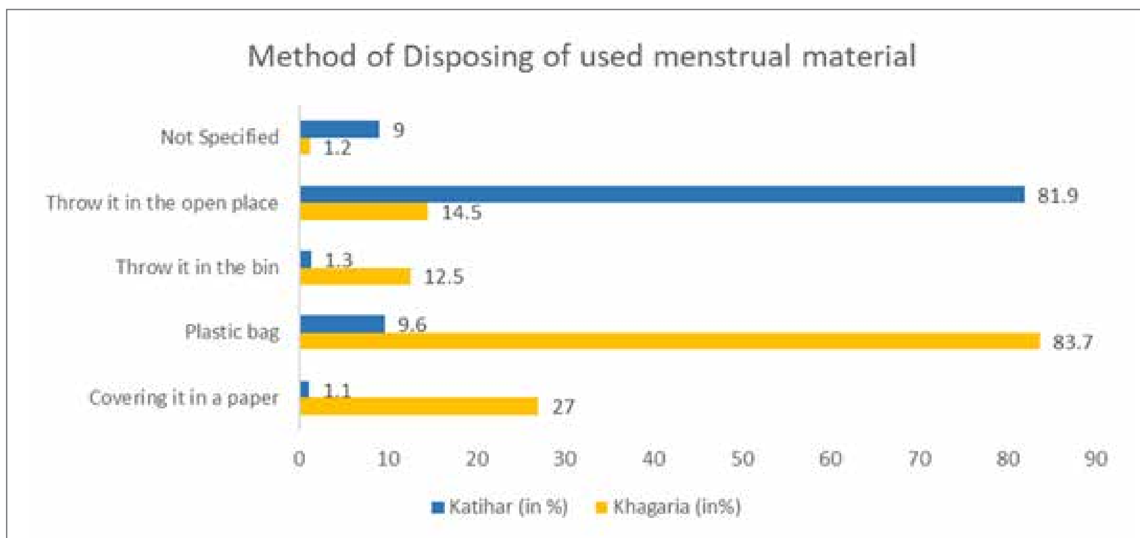
Common Practices for disposing of menstrual material were found to be different in Mahasamund than in Uttar Bastar. In Mahasamund, when women are away from home, they usually prefer not to change the menstrual material during periods until they return.



*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.

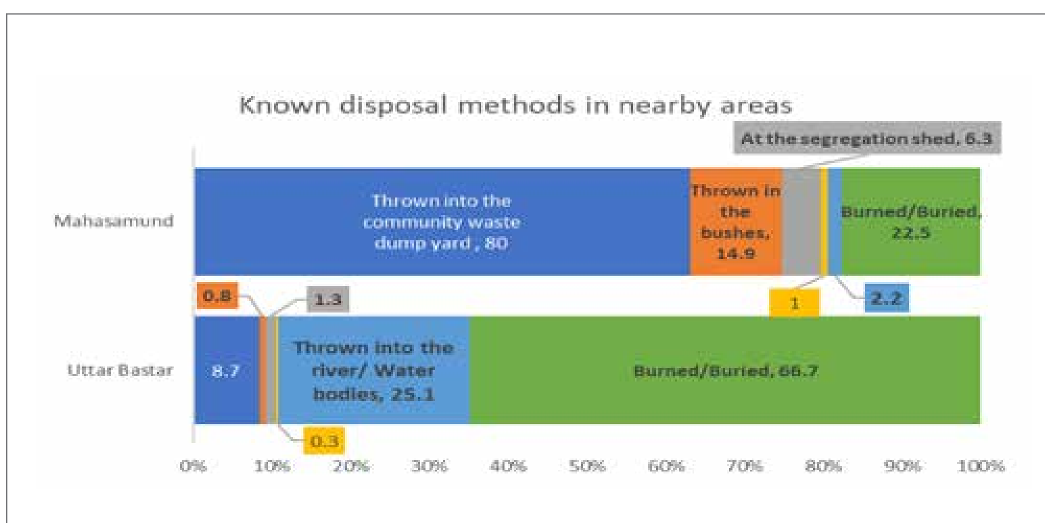


*Multiple Choice Question

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

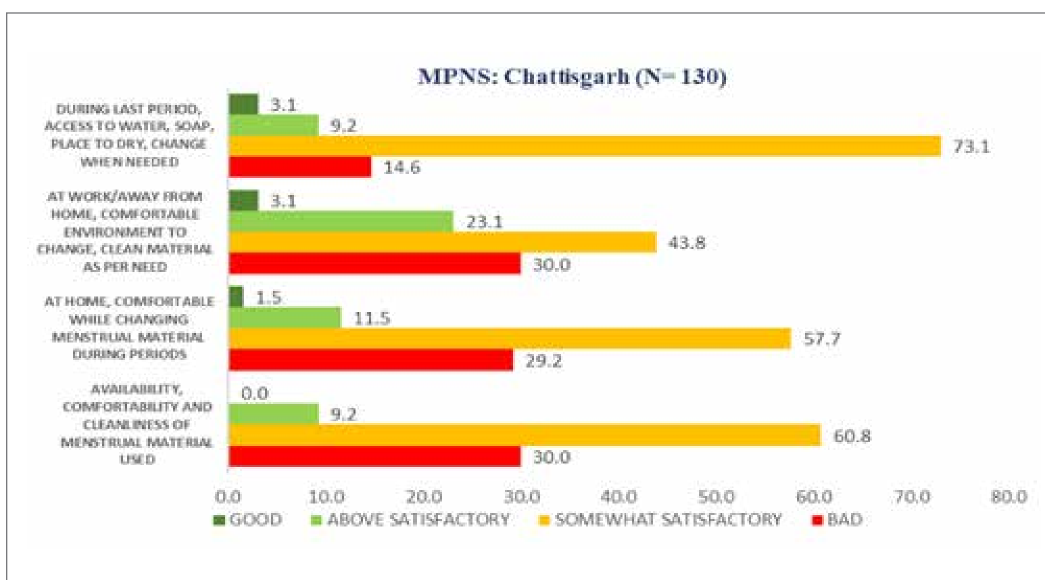
Customs followed by women in reference to menstruation: Uttar Bastar District

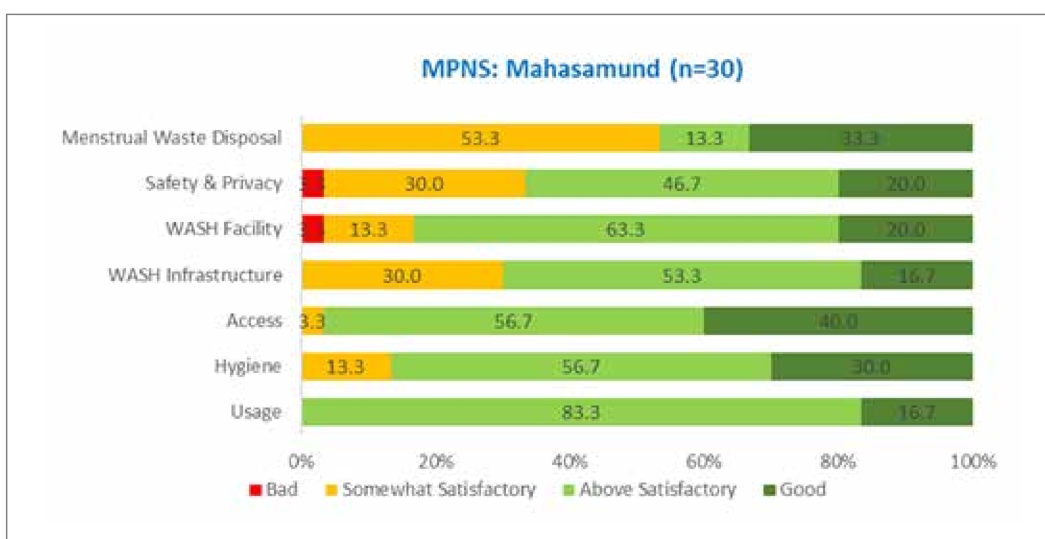
Uttar Bastar (411 respondents)	Strongly agree	Agree	Disagree	strongly disagree
I am allowed to mix with others socially during my periods.	65.2	34.8	0.0	0.0
I am not allowed to attend any social rituals during my periods.	55.7	42.1	1.9	0.2
I do not go to religious places during periods.	54.7	44.8	0.2	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

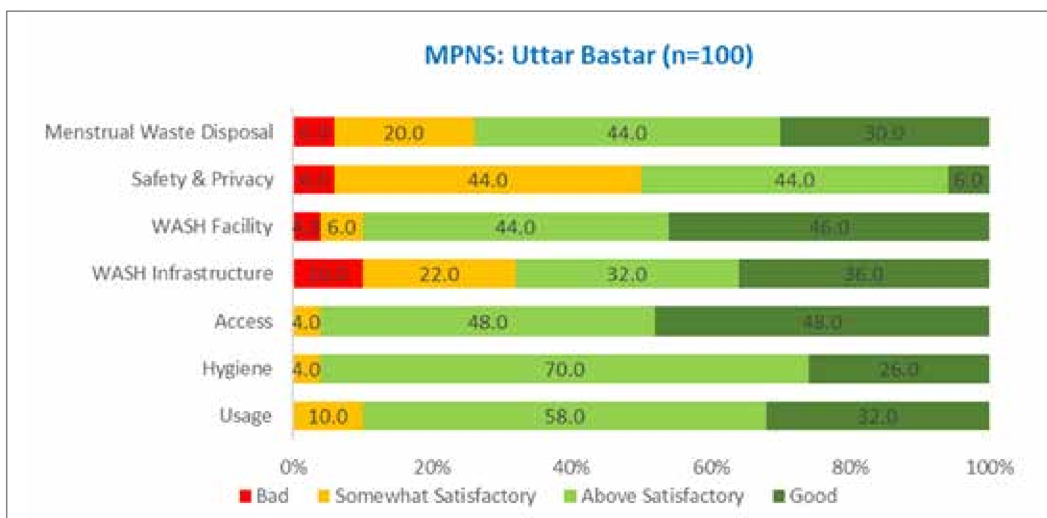
4.2.7 MENSTRUAL PRACTICE NEEDS SCALE (MPNS)

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.

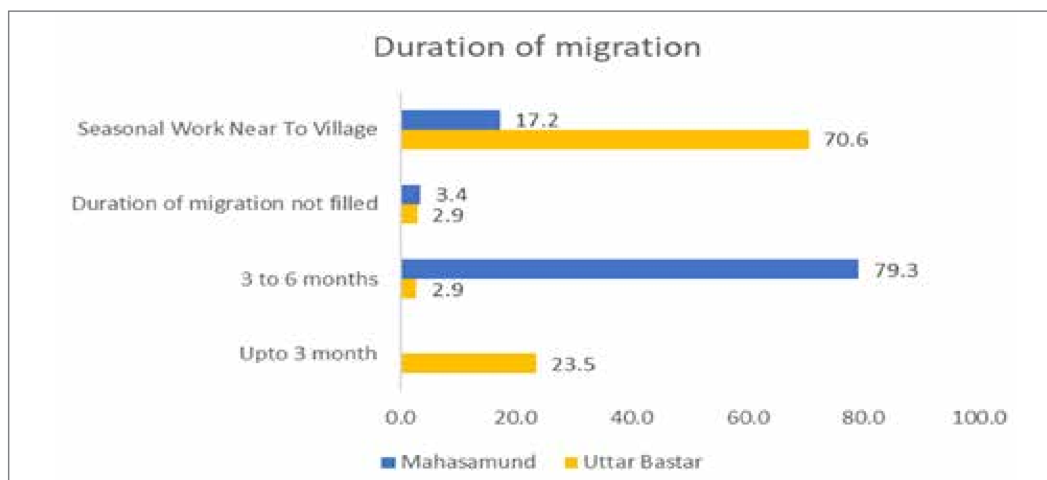
- Water scarcity and increasing inaccessibility of potable water are crucial issues in these villages.
- Drinking water crisis, lack of electricity and lack of transport system, lack of education, and poor monetary gains, high rate of unemployment are issues faced by villagers in both the districts.
- 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.

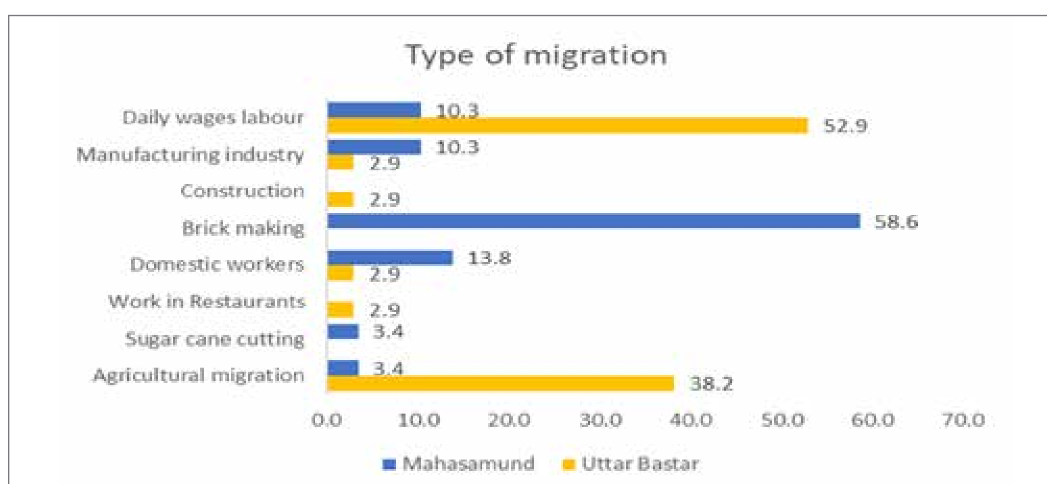
Against this background, we present a brief inter-sectoral data analysis on migration and MHM, WASH and MHM, Education and MHM and lastly, MHM from the perspective of awareness towards public policies. The analyses focus on vulnerabilities, issues, and risks pertaining to menstruation and social as well 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.

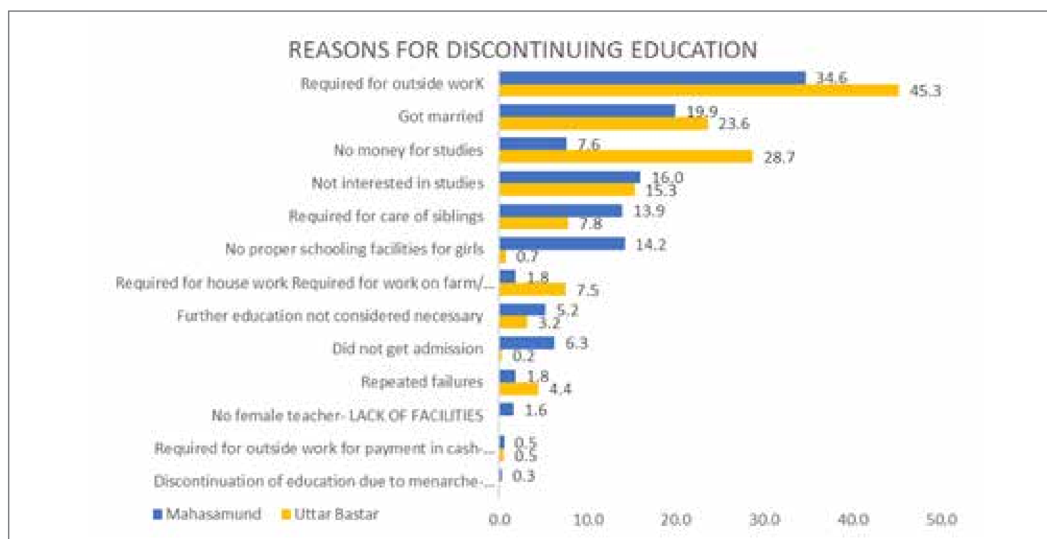
It is clear that during menstruation a woman's WASH needs are relatively higher as compared to the rest of the days of the month. When a woman experiences her periods, she needs more water to clean herself for personal and intimate hygiene, including after defecation. Besides, a regular supply of clean 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

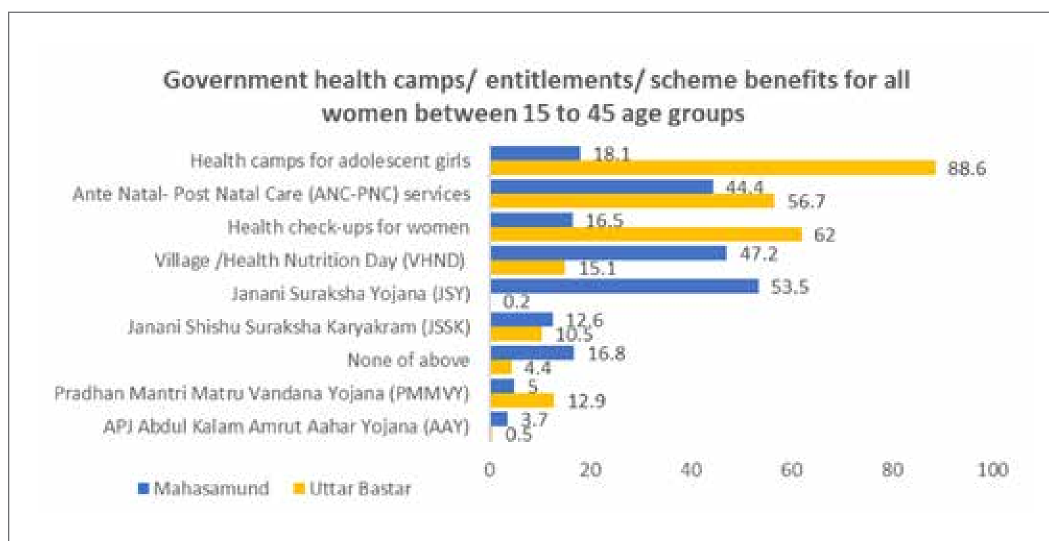
- **Bottlenecks**: Both in Mahasamund and Kanker women discontinued their education mainly due to monetary and family related barriers such as lack of financial resources, girls being required to work for daily wages to supplement family income or look after siblings and so on. As a hindsight on their 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.

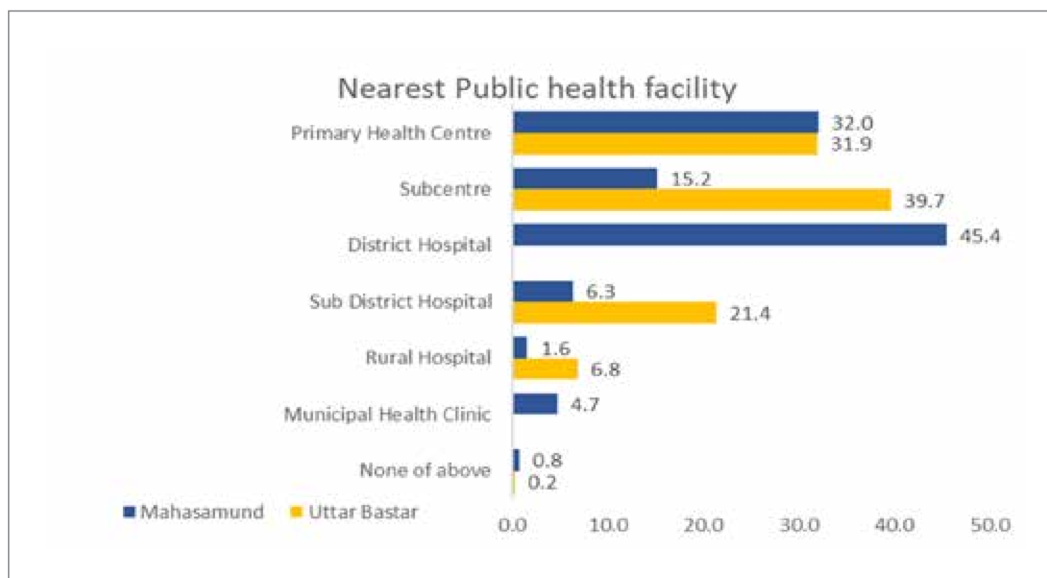
- **Local Health Services:** 50.8% of the total respondents availed the Ante- Natal and Postnatal services in both the districts whereas 16.5 % of women from Mahasamund and 62% of women from Kanker receive health check-ups at the village or at the Sub- Center level.
- **Engagement with Public Health 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.

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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.