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).

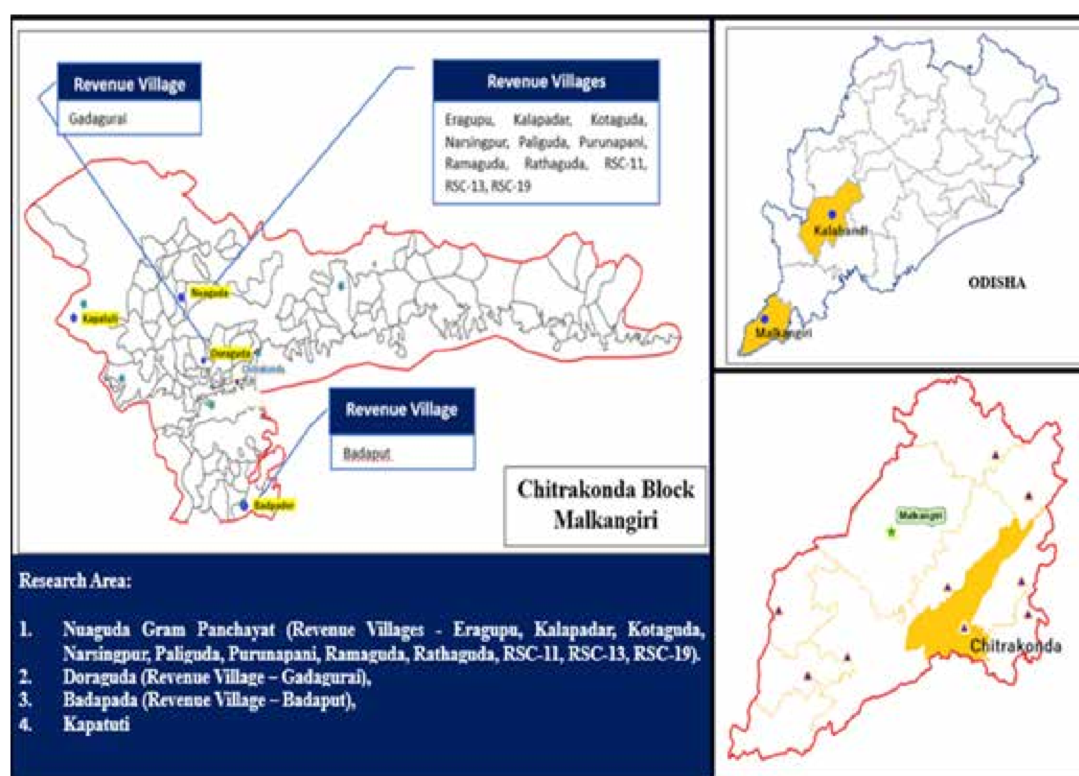
KALAHANDI DISTRICT

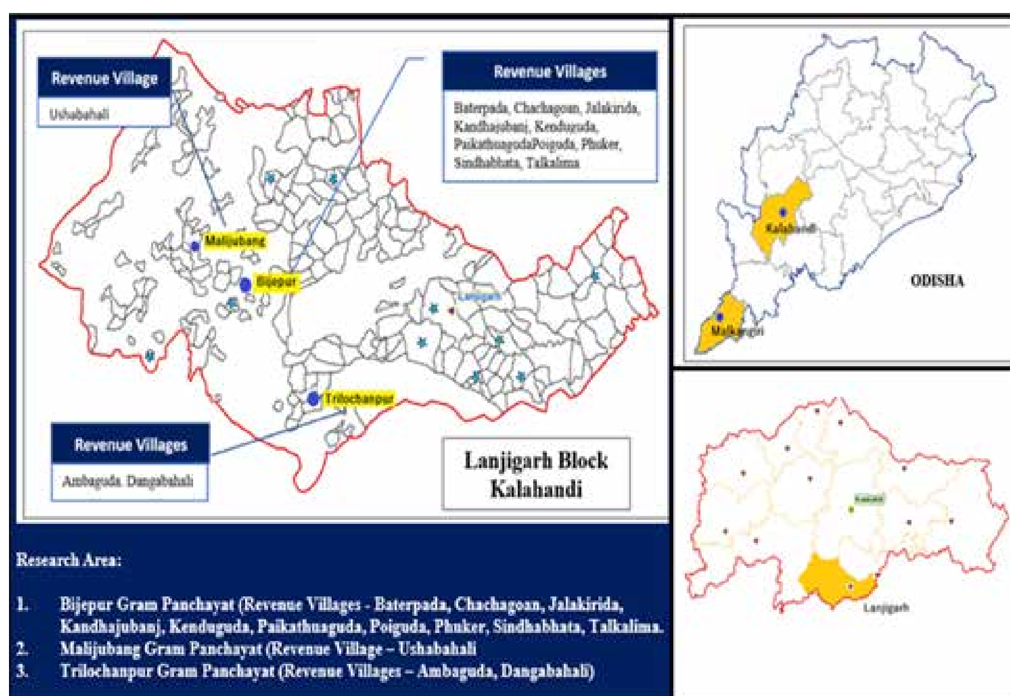
The Kalahandi district of Odisha has a total population of 1,576,869 as per the Census 2011. Out of which 787,101 are males while 789,768 are females. In 2011, there were a total 401,251 families residing in Kalahandi district. The Average Sex Ratio of Kalahandi district is 1,003. As per Census 2011 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

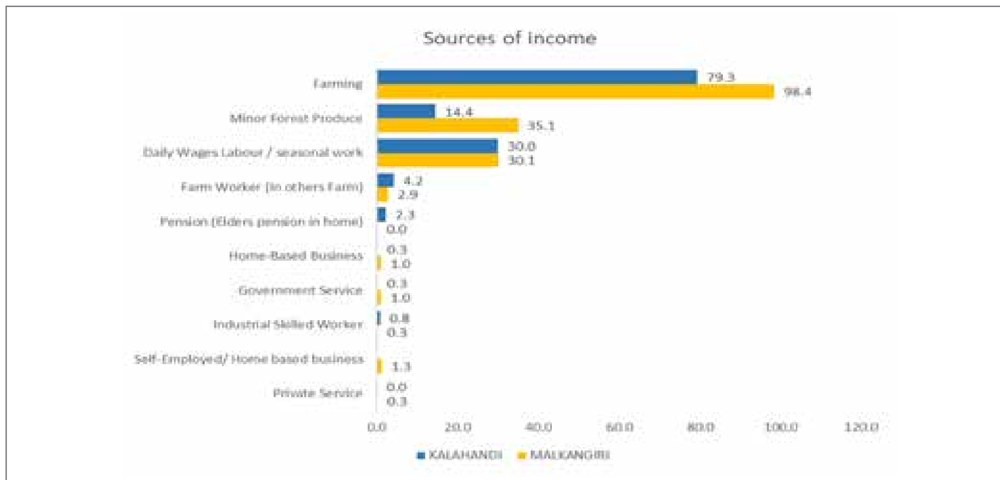
- **Religion:** 650 out of 738 respondents stated Adidharm as their religion while the rest of the interviewees belonged to the Hindu religion.
- **Community:** 380 of our respondents in Malkangiri (n=385) belonged to the ST communities (Desia, Dora, Gouda, Jodi, Kanda, Paraja, Parenga Poraja, Rana, 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.

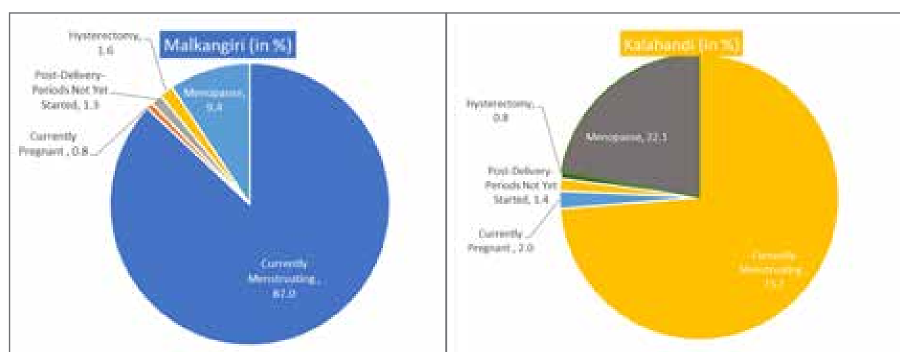
3.1.2 SOURCES OF INCOME



*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.

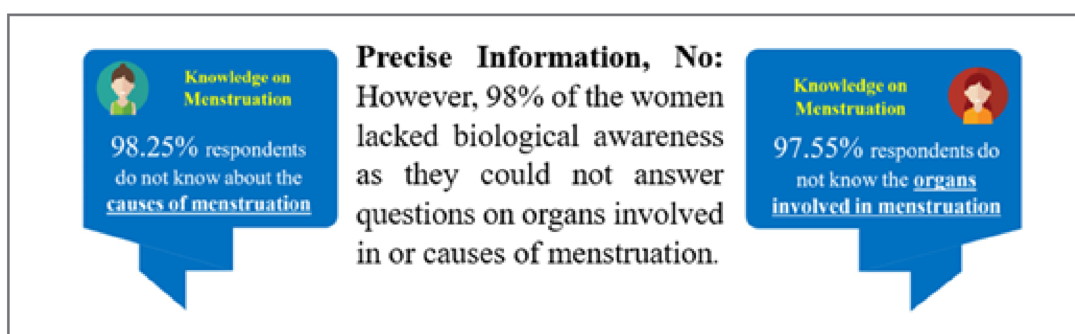
3.2 DISCOURSE ANALYSIS

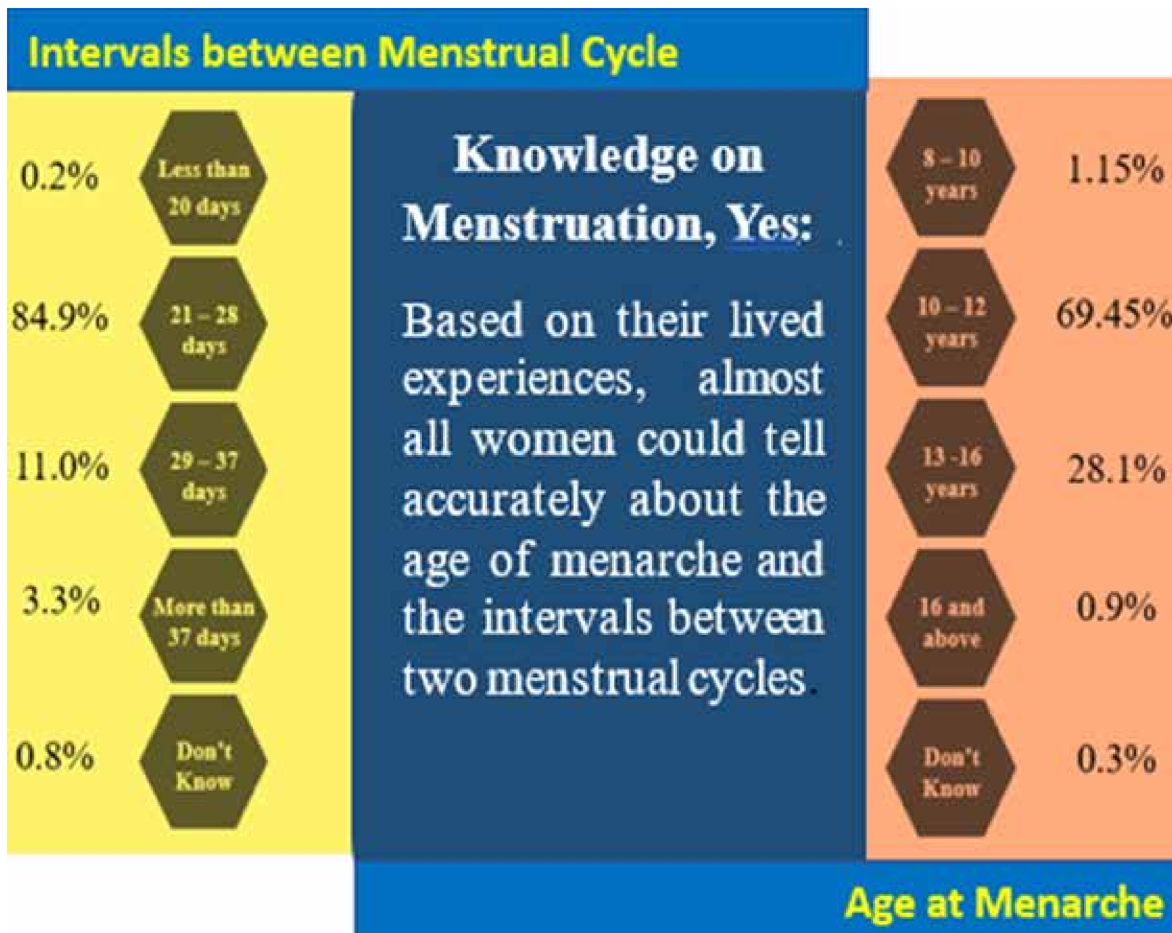
In this section, our findings relate to levels of knowledge that our respondents profess on the causes of menstruation, organs involved in it and an analysis of their discourses on the subject. In other words, we analyze the information given during the IDIs to understand how much general as well as 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.





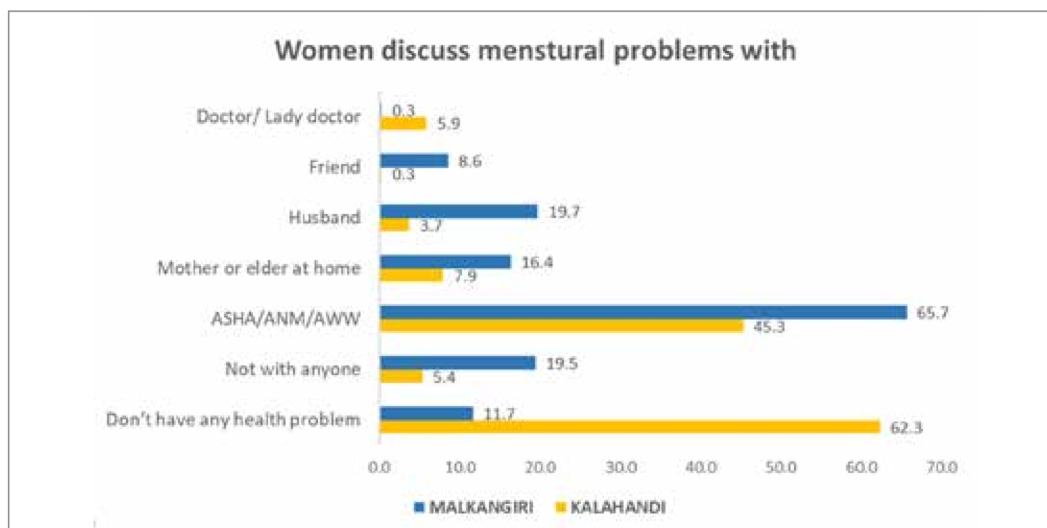
3.2.2 SOURCE OF INFORMATION AND WOMEN'S PREFERENCES ON DISCUSSING MENSTRUAL PROBLEMS

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.

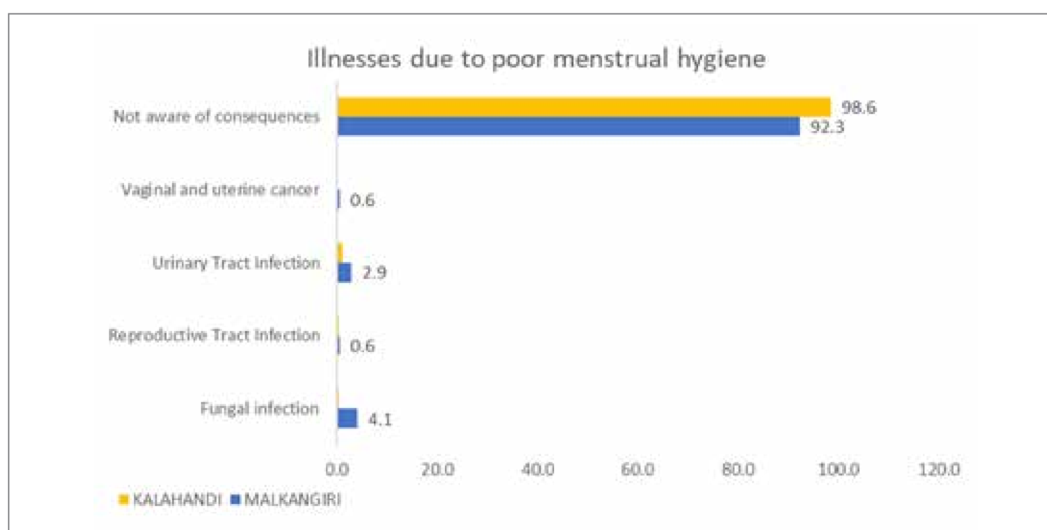


*Multiple Choice Question

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.

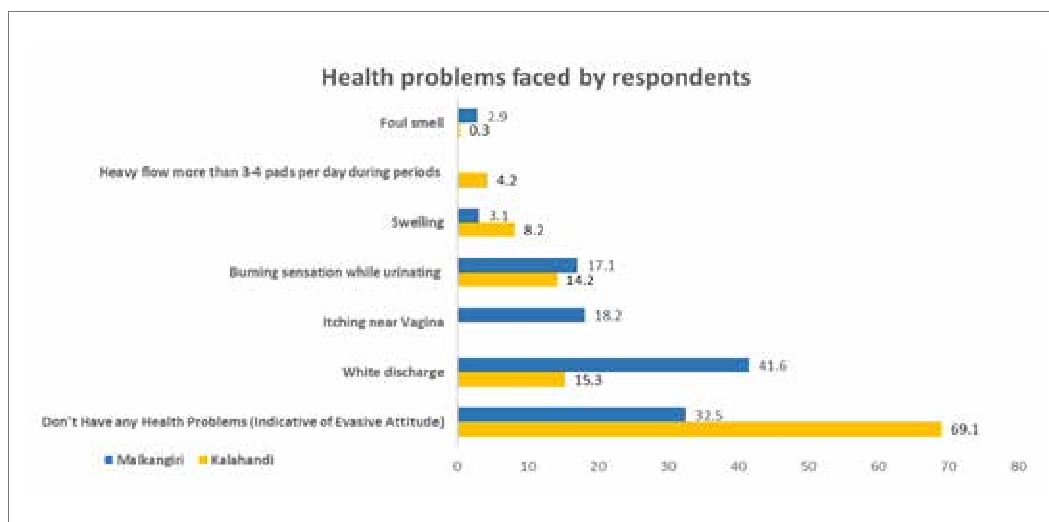


*Multiple Choice Question

- **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.

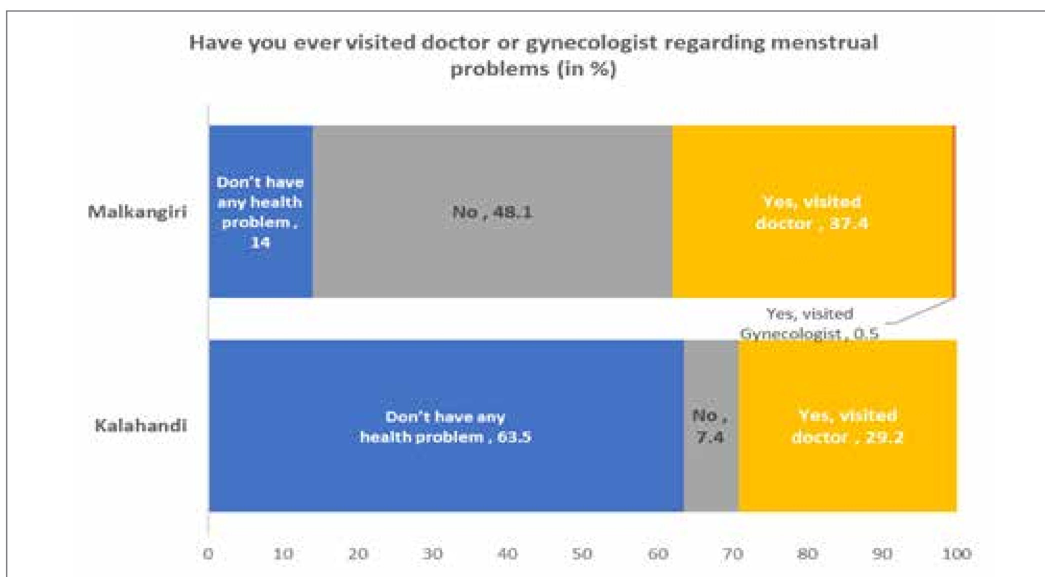
3.2.4 HEALTH SYMPTOMS DURING MENSTRUATION

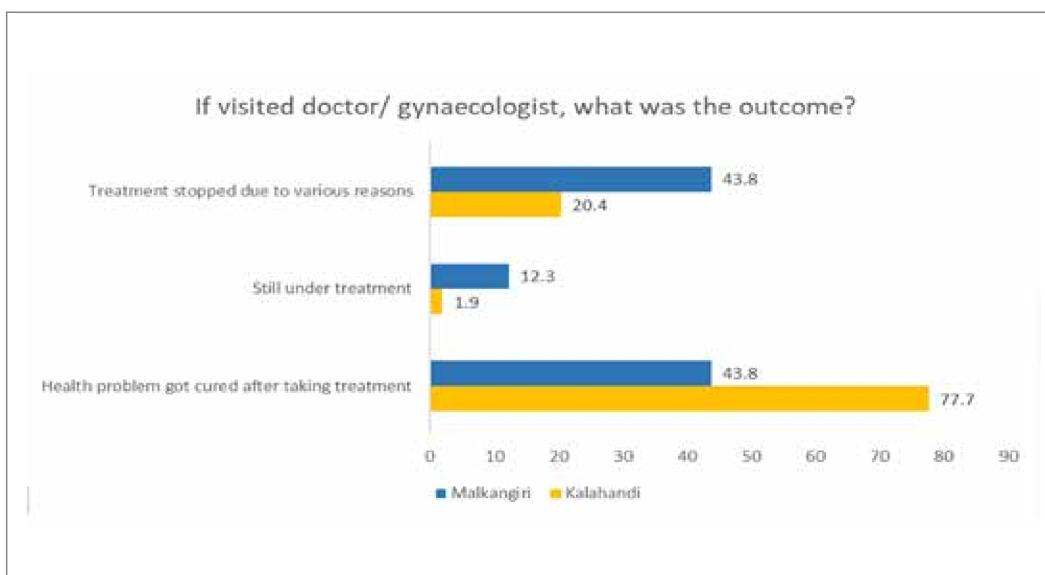


*Multiple Choice Question

- **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.

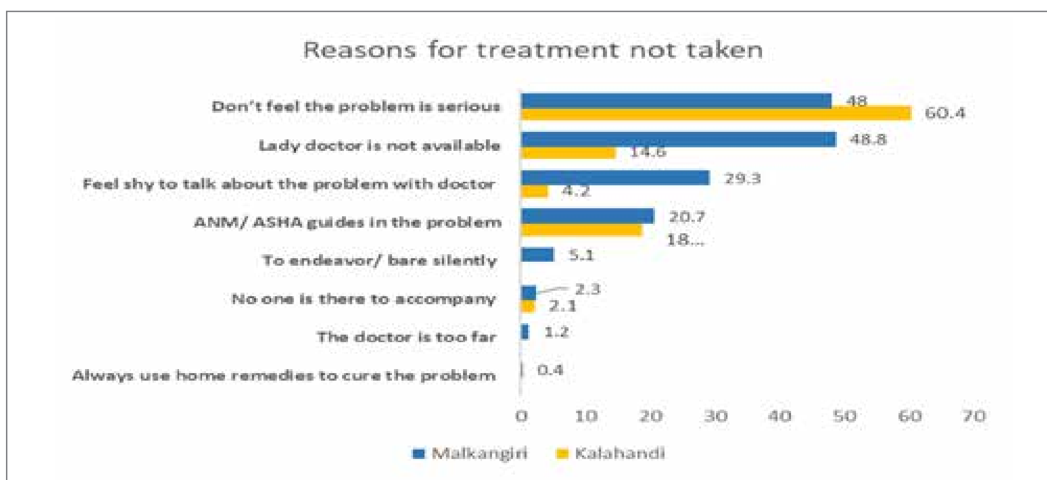
Indeed, if health anomalies during menstruation are not resolved, pushed to the peripheries, or remain shrouded in silence, women have much to lose in social, economic, and personal spheres. For **combating** health and hygiene related **silences** on menstrual hygiene and care for women beyond school 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.

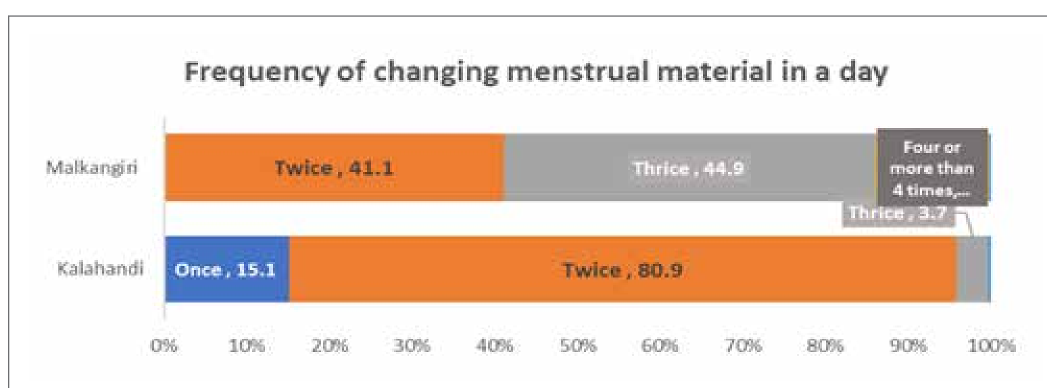
3.3.2 SPENDING CAPACITY ON MENSTRUAL HYGIENE PRODUCTS

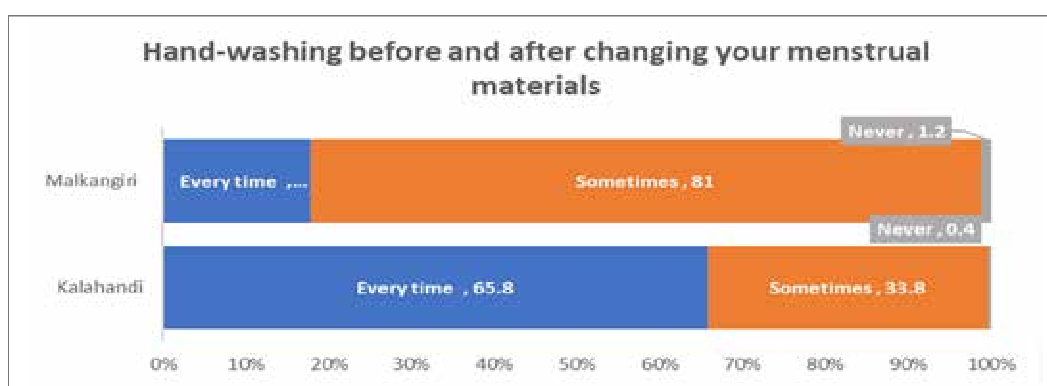
- In Malkangiri women who do not use cloth, spend above 100 INR on menstrual products each month whereas in Kalahandi they spend up to 60 INR on buying pads.

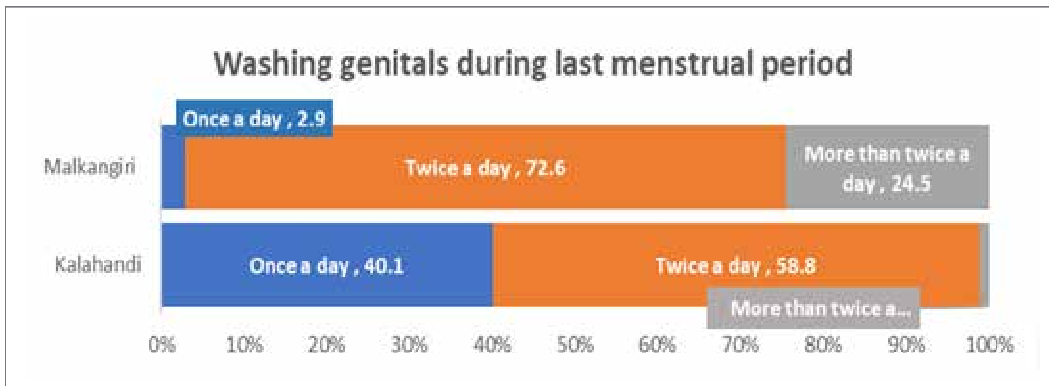
3.3.3 PERSONAL HYGIENE PRACTICES AND WASH DURING LAST MENSTRUAL CYCLE

- **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.

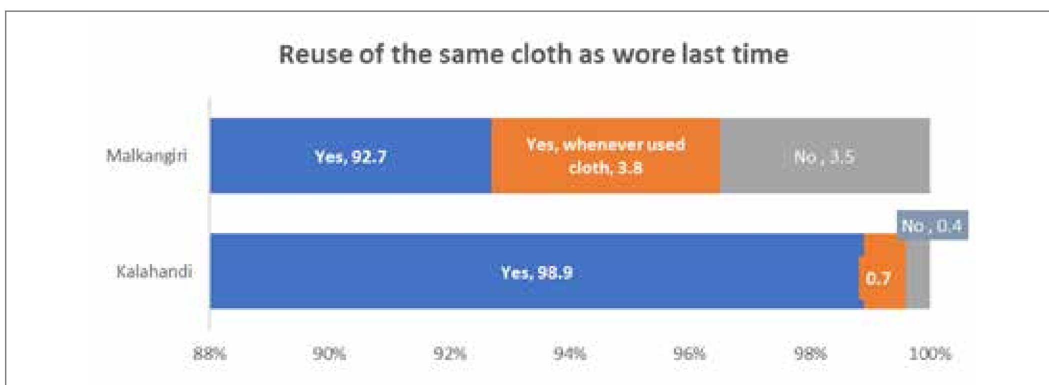


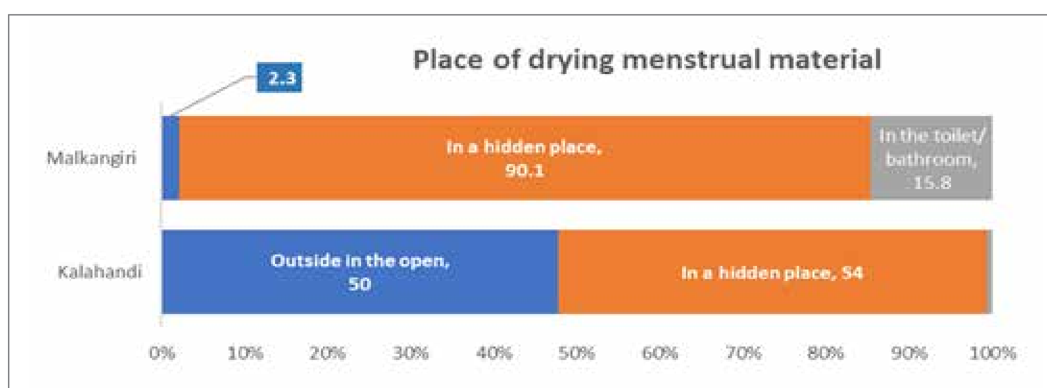




3.3.4 MENSTRUAL HYGIENE PRACTICES (MALKANGIRI N=343, KALAHANDI N=272)

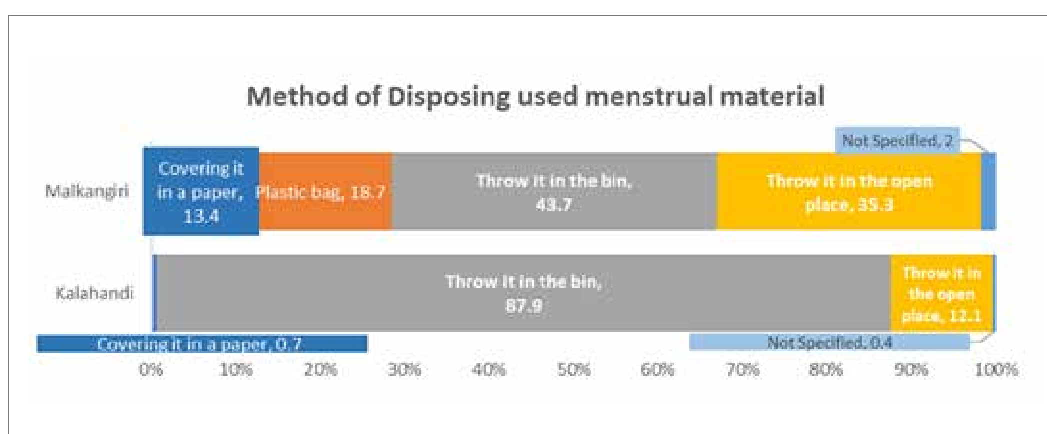
Safe hygiene practices consist of washing and timely changing of menstrual absorbents as well as their proper disposal. This may vary with the absorbent type. Personal hygiene also depends on changing the absorbent during the day, keeping genitals clean, washing hands before and after changing the menstrual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





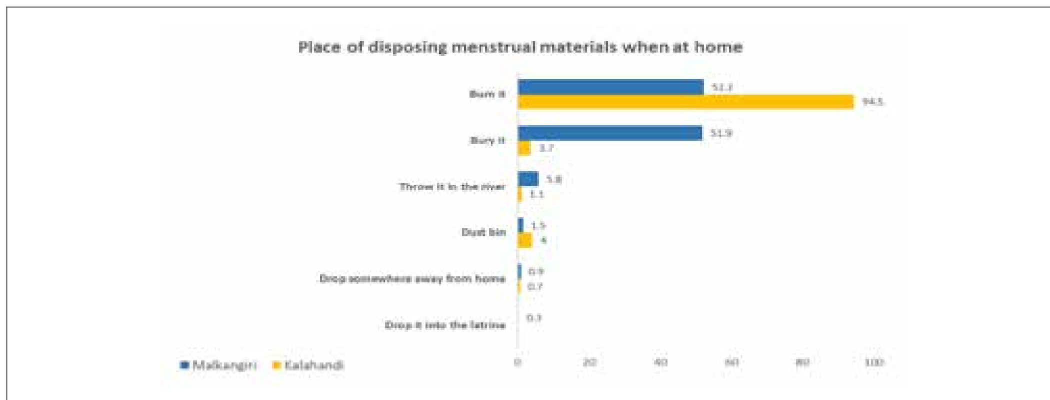
- **Reusing MHM Products:** From both districts, 97.6% of women claimed the use of clean cotton cloth during menstruation, out of which 95.4% of women **reuse the cloth.**
- **Washing MHM Products:** According to our respondents, there was hardly any water available in the toilets or bathrooms at homes 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)



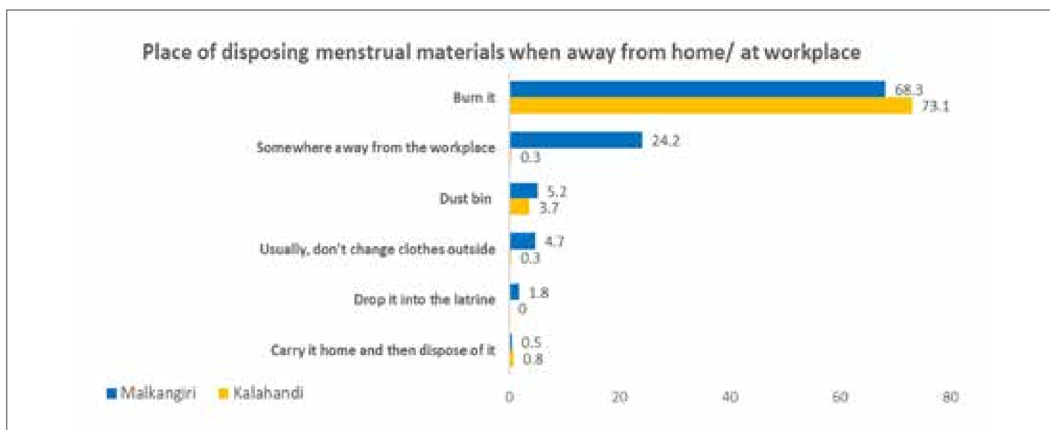
- **No specific Disposal Mechanism in place:** When asked about the system of disposal of menstrual material in their area, it was found that women have to manage problems at their own levels. The district does not have any disposal mechanism for menstrual materials nor monitoring mechanisms to follow-up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

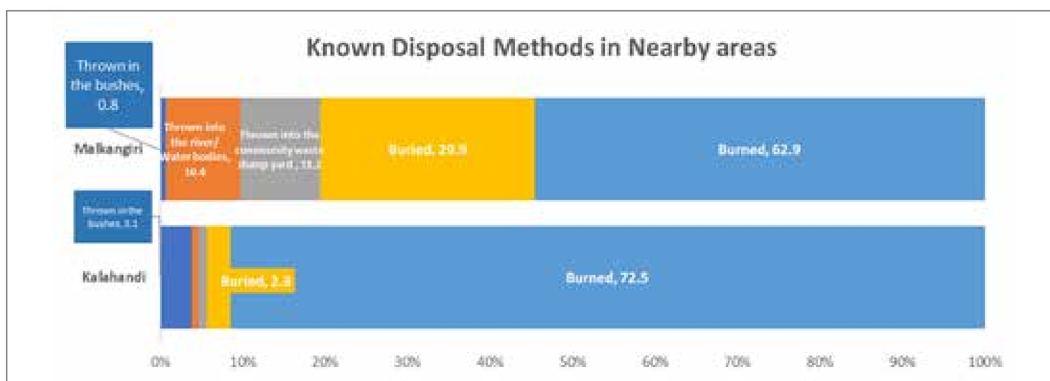
Methods of disposal in Both Districts: When away from Home



- **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

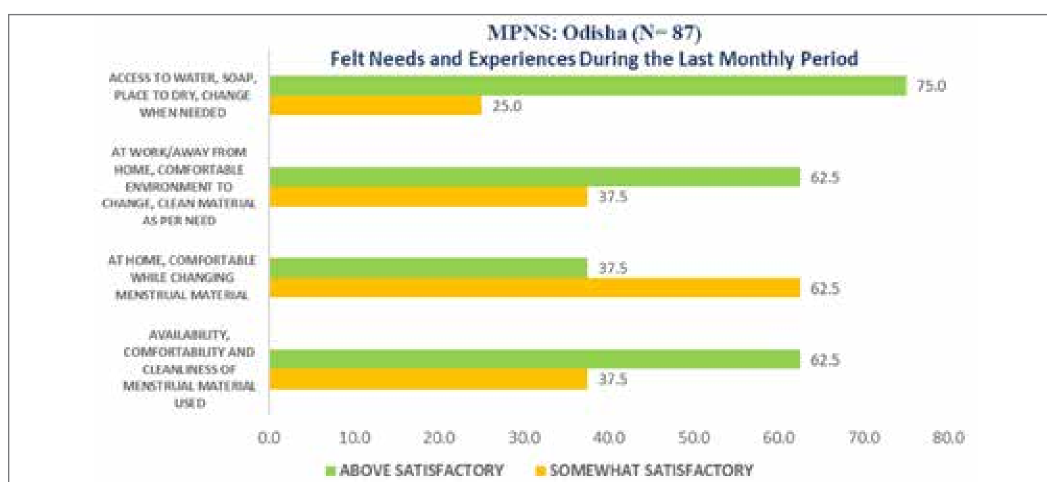
Kalahandi	Strongly agree	Agree	Disagree	Strongly Disagree
	Yes		No	
I am allowed to carry out routine work at home during my periods.	4.2		95.8	
I am allowed to cook in the kitchen during my periods.	3.1		96.9	
Others in my family take care of me during periods.	96.3		3.7	
I have the freedom to visit 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	

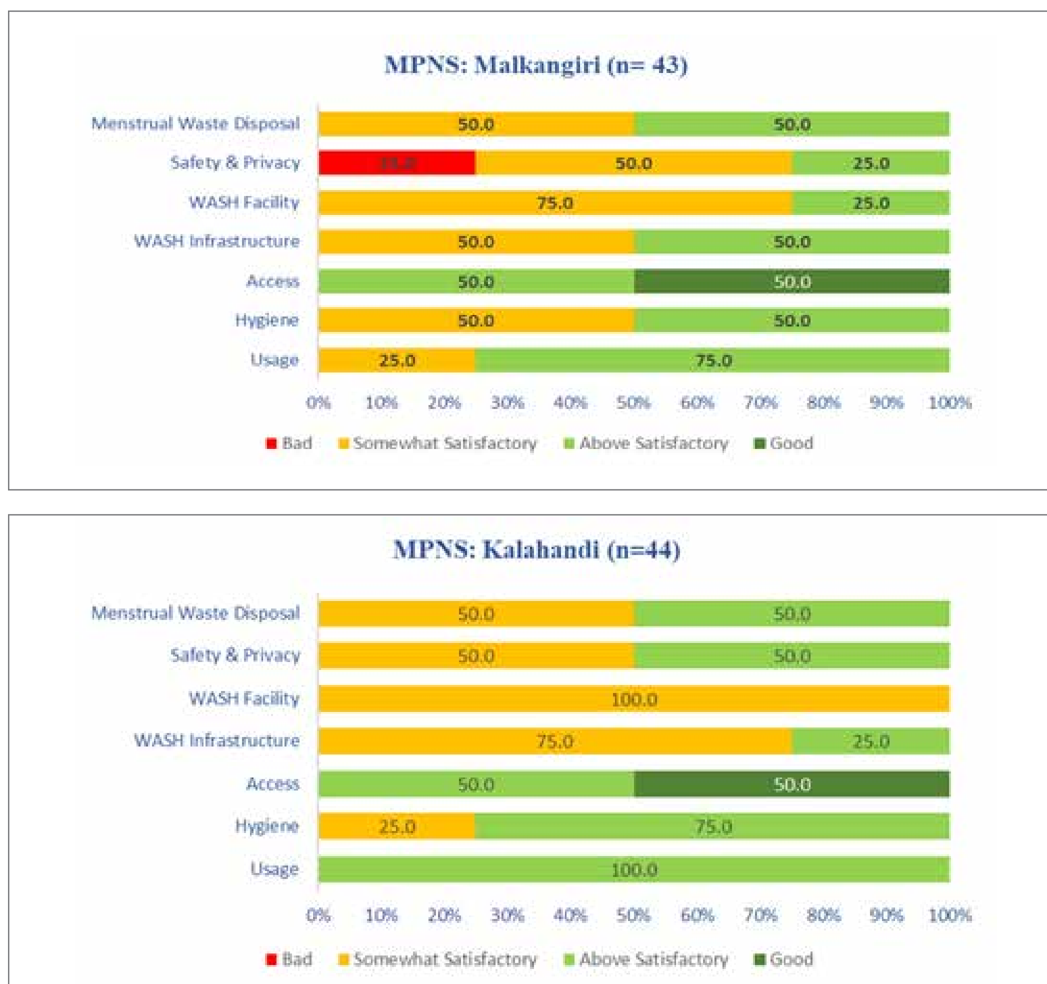
Almost all women from Malkangiri refrain from socializing during periods, avoid travel, are strictly restricted from visiting religious places or attending rituals. Moreover, nearly all the women are asked to stay in a corner of their home, thus making segregation during periods an overarching menstrual 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.

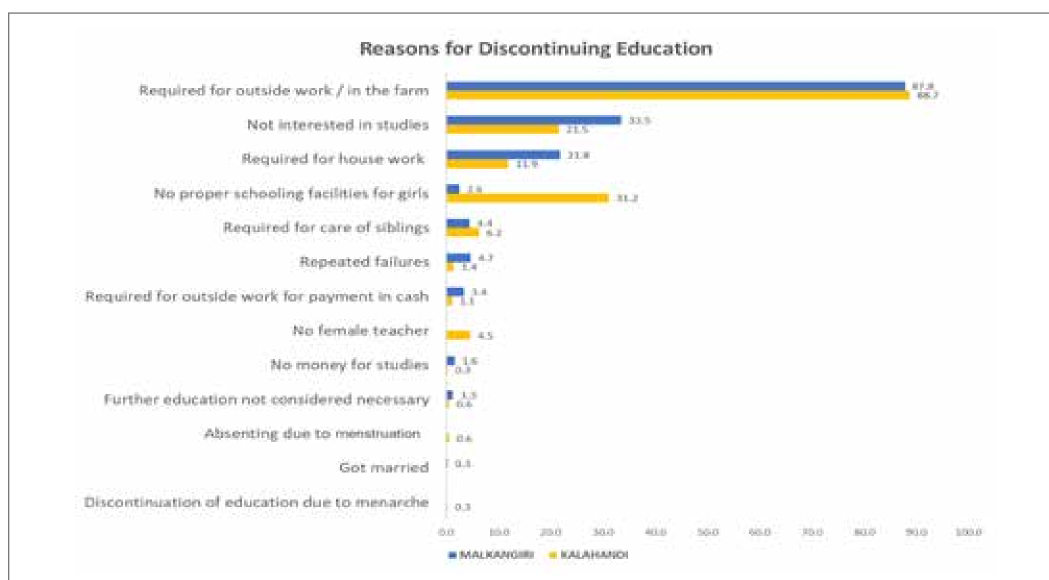
It is clear that during menstruation a woman's WASH needs are relatively higher as compared to the rest of the days of the month. When a woman experiences her periods, she needs more water to clean herself for personal and intimate hygiene, including after defecation. Besides, a regular supply of clean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



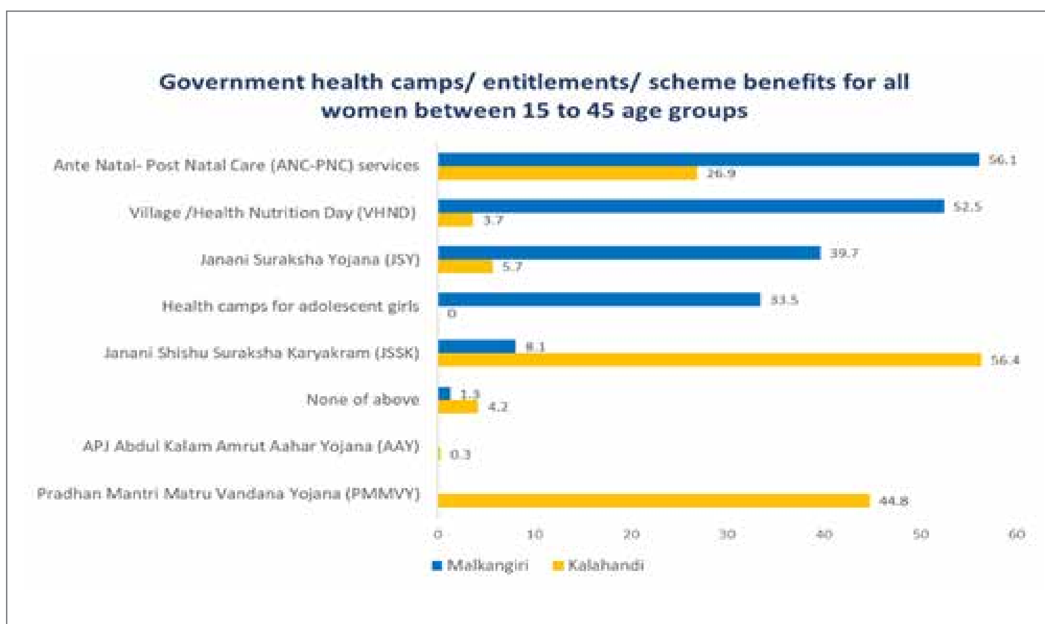
*Multiple Choice Question

- **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.