A RESEARCH REPORT FROM

MAHARASHTRA

MH.25.AL.1

PART 1 INTRODUCTION

In Maharashtra, our research report on the 'Combating the Silence from Menarche to Menopause – A Comprehensive Report on Menstrual Hygiene Management in India', was conducted in the districts of Beed and Osmanabad. Beed is a backward district of Maharashtra but not characterized as an Aspirational district, Osmanabad on the other hand, falls under Niti Ayog's Aspirational District Programme (ADP)[1]. Both Beed and Osmanabad, however share the commonality of socio-economic vulnerabilities to the large number of migrant workers who earn their living through various kinds of seasonal work in the unorganized sector, poor farming communities, sexual discrimination of the women workforce and an adverse sex-ratio.

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

Our research has been designed to collect thick ethnographic data on actors, practices and discourses with an inter-sectoral and analytical perspective on MHM in selected research areas. WASH, availability of community support systems, schemes and education as well as felt needs of menstruating women form a vital part of this research. We bring data through field-work, interviews, Focus Group Discussions (FGDs) and observations on MHM through women's participatory voices and opinions. A total of 577 interviews were conducted by employing the Menstrual Practice Questionnaires (MPQs) wherein data was collected from 351 women from Beed and 226 women from Osmanabad. Interviews and interactions took place in the Marathi language in which women were comfortable to communicate.

Focusing primarily on the category of, 'Elder and Ageing Menstruating Women' **(henceforth EAMW)** between the ages of 20 years to 49 years, we also share our findings on MHM related enablers and barriers for young school going girls. In an attempt to understand the well-being of menstruating women beyond their school years, this study on Maharashtra documents the various kinds of barriers and silences in the effective MHM of EAMW. Nonetheless, we also explore and explore our primary data to critically discern potential enablers towards an effective MHM of women between the ages of 20 years to 49 years.

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

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

BEED AND OSMANABAD DISTRICTS OF MAHARASHTRA

Maharashtra is one of the sugar producing states in India (Economic survey of Maharashtra,2021-22). The report states that out of total factories, more than one third of total sugar factories are sugar production factories (Economic survey of Maharashtra, 2021-22). As per the data provided by the Sugar Commission, 2016, there are more than 25 lakhs Sugarcane cultivators and that the sugar cane cutters mainly come from drought-prone areas of Marathwada and Vidarbha regions. Beed is known as the district of sugarcane workers (Munjal & Sodhi, 2021). Beed and Osmanabad districts were selected due to sugarcane cutters who are also engaged in the other occupations such as agriculture, construction, and mining as a part of their livelihood.

BEED

Beed, an administrative district in the Aurangabad division of Maharashtra, lies in the Marathwada region, bordering Karnataka and Telangana. On October 31, 2018, the government of Maharashtra declared Beed as one of the most severe drought-hit districts in the country based on indicators such as rainfall deficit, low soil quality and decline in groundwater index (Kurtkoti & Gunwati, 2019). The district has an area of 10,693 sq. km. and a population of 25,85,049 persons according to the 2011 Census. Among the 35 Districts of the State, the District ranks 10th in terms of area, 19th in terms of population and 27th in terms of density (Census 2011, p. 8-9). Beed has been notorious for its discrimination against the girl child. From 2001 to 2011, the child sex ratio (calculated as the number of girls per 1000 boys in the 0–6-year age group) dropped from 894 to 807 (Berry, 2022).

Discrimination against women on grounds of menstruation is one of the most prominent and pressing social issue faced by EAMW in their workplaces in Beed, often times prompting them to undergo hysterectomies (Chadha, 2019) to compete with the exigencies of the labour economy. Nonetheless, despite creating a cycle of biological and psychological impacts, hysterectomies are not the only issue that menstruating women face in Beed. According to a study commissioned by the Maharashtra State Commission for Women in 2018, 36% of female sugarcane labourers in the State had undergone a hysterectomy (Shukla & Kulkarni, 2019). This claim is further substantiated with the figures presented by the National Family Health Survey 4 (NFHS-4) (2015-16). The Survey notes that, while the rate of hysterectomies among women aged between 15- 49 years at the all-India level is 3.2%, the hysterectomy rate in the state of Maharashtra is 2.6%. Largely dependent on monsoon rain, Beed is an agricultural labour dominant district where majority of the farmers are poor. The female farmers find it difficult to spend money on sanitary napkins and therefore resort to using cloth during menstruation. Lack of sanitation facilities leading to improper disinfection of the menstrual cloths further increases the chance of reproductive diseases. Moreover, the increase in hysterectomies is also driven by a deeply rooted belief that the womb of a woman is futile once she has produced children, who are seen as a form of the surplus labour force.

OSMANABAD

Osmanabad district lies in the southern part of Maharashtra. Most of the district area is rocky while the remaining part is plain. The district is surrounded by a small mountain called “Balaghat”. Bhoom, Washi, Kalamb, Osmanabad & Tuljapur Tehsil lie in the range of this Balaghat mountain. Some parts of the major rivers like Godawari and Bhima come under this district. Located in the parched Marathwada region of southern Maharashtra, Osmanabad is in many ways a slave of its geography (Census, 2011, p.11-12). Sex ratio of the district is 924, which is lower than the state average (929). The literacy rate of Osmanabad district is 78.4 percent, male and female literacy rates are 85.8% and 70.5% respectively (Census, 2011, p.11-12).

Maharashtra faces the highest incidents of farmer suicides in India, and Osmanabad is one of the worst-affected districts, according to government of India data, in 2016, 3,661 farmers died by suicide in this state alone (total farmer deaths by suicide in 2016 was 11,379). Osmanabad district comes under Deccan Plateau and Hills region. It is considered as one of the most industrially backward districts in the state. This district comes under the drought prone areas of the region. Historically rainfall has shown great fluctuation. This resulted in drought and drought-like conditions (Yadav, 2018).

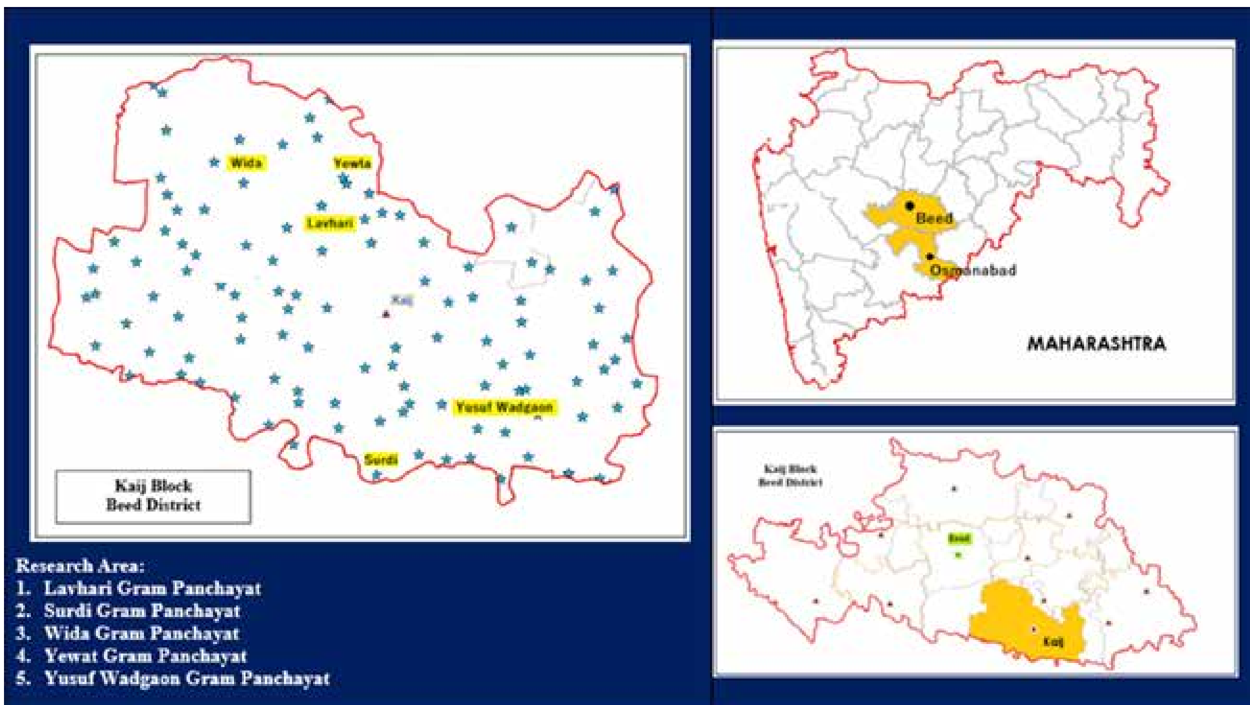
ASPIRATIONAL DISTRICT PROGRAMME: OUTCOMES AND FOCUS

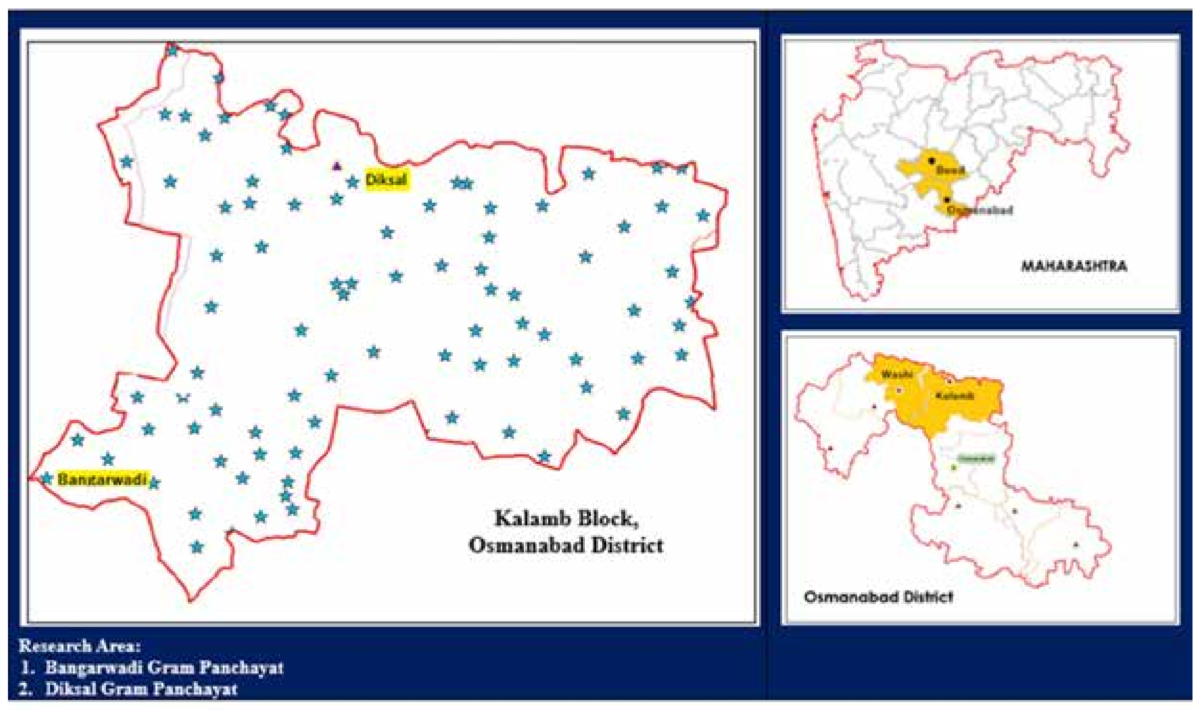
Under the ADP, NITI Aayog is implementing its mandate of promoting convergence of various Central and state schemes to mobilize and creatively use all available resources. Therefore, Khawa Cluster Bhoom in Osmanabad was established under the Government of Maharashtra's micro-small enterprises—Cluster Development Programme—as a modern food processing hub (Tripathi, 2020). A skill development center is skilling more than 1000 youth every year and integrating them in the Khawa value-chain at different levels, even as self-employed individuals (Tripathi, 2020). In Maharashtra, Beed and Osmanabad both selected districts have a large population of sugarcane cutter workers and agricultural labourers.

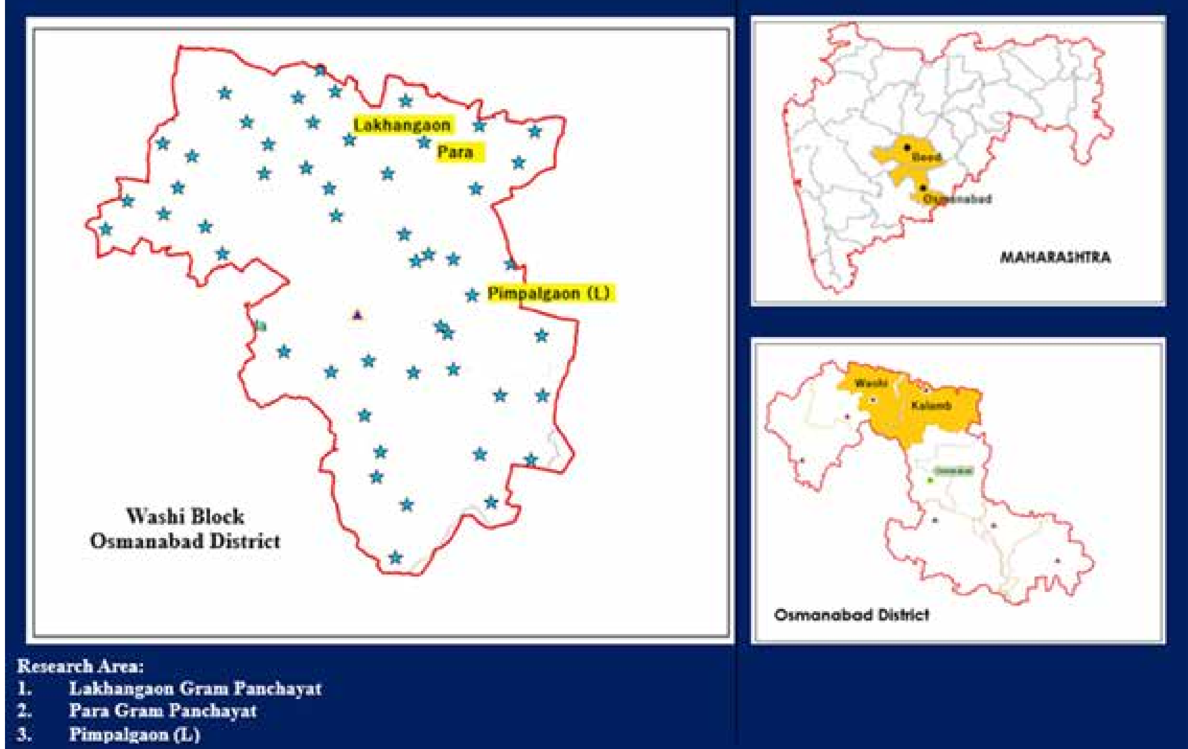
Though both districts are doing well on many parameters where improvement is needed such as education, literacy and infrastructure, our study indicates that Osmanabad as ADP and Beed as non-ADP have much to achieve in terms of combating the silences on MHM. An inter-sectoral perspective on well-being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

1. LIST OF VILLAGES SELECTED FOR THE STUDY FROM BEED AND OSMANABAD

On an average, five villages were selected from each of the fourteen districts across the seven Indian states selected for this study. In Maharashtra, the population sample in Beed was taken from five Gram Panchayats of Kaij Block and in Osmanabad, it was taken from five Gram Panchayats of Kalamb and Washi Block (See Annex 1). Factors for selection of villages include socio-economic concerns relating to groups and communities practicing migration, unskilled labour as well as the prevalence of myths and taboos etc.







2. DATA TOOLS AND STRUCTURE OF THE CHAPTER

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

Types of Interviews - Tools and Focus	Data Collection and Analysis- Methods and Themes	Sample	
		Beed	Osmanabad
Tool 1 Menstrual Practice Questionnaires (MPQs)	Method 1 The MPQs were In-depth Interviews (IDIs) for- actor, discourse, and practice- analyses	351	226

Types of Interviews - Tools and Focus	Data Collection and Analysis- Methods and Themes	Sample	
		Beed	Osmanabad
Tool 2 Menstrual Practice Needs Scale (MPNS)	Method 2 Measurement of perceptions and needs based on the last menstruation cycle	30	72
Tool 3 Key Informant Interviews (KIIs)	Method 3 Voices, Excerpts, Salient Findings and Observations	12	12
Themes: WASH, Education, and Health, Livelihood	Focus: Inter-Sectoral findings and conclusion and comparisons		

3. ACTOR ANALYSIS FROM MPQS

3.1 ACTOR ANALYSIS

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

Demographic Profile of the Respondents

Demographic Profile	Beed (in %)	Osmanabad (in %)
Total respondents (N)	**351**	**226**
Rural / Tribal	100	100
Mother Tongue		
Marathi	94	100
Hindi	3.4	0
Other (Laman, Holar, Pardhi, Urdu)	2.6	0
Religion		
Hindu	94.6	100
Muslim	5.4	0
Caste/ Tribe Type		
General	51.3	57.5
Other Backward Class (OBC)	15.1	9.7
Scheduled Caste (SC)	26.2	20.4
Most Backward Class (MBC)	1.7	0
Nomadic Tribe (NT)/ PVTG	5.7	12.4
Marital Status		
Never Married	3.1	0.9
Married	93.4	88.9
Widowed	3.1	8
Separated	0	2.2
Divorced	0.3	0

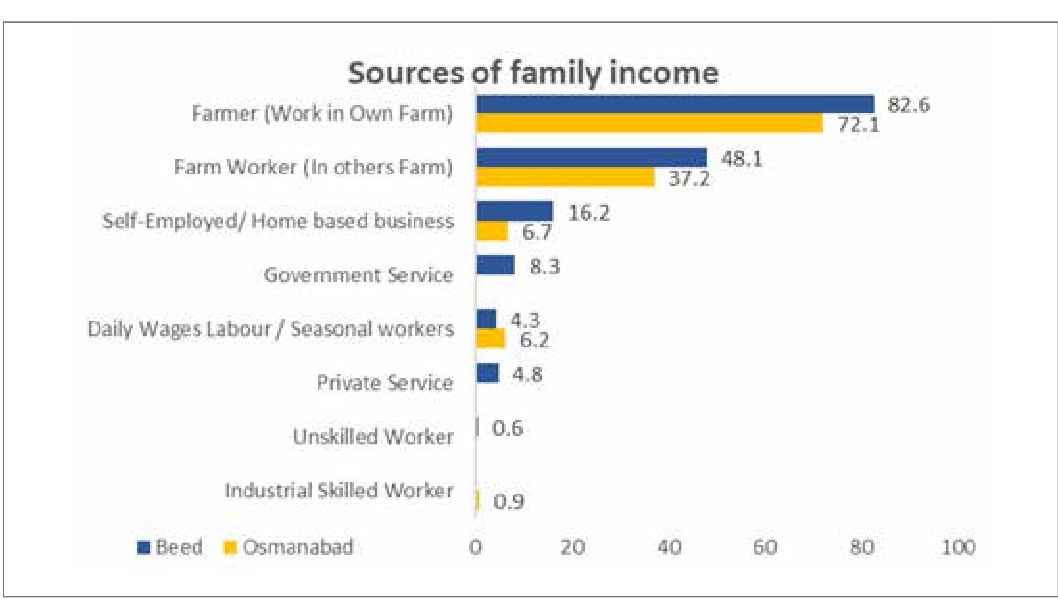
FINDINGS FROM MPQS

- **Religion:** Almost all respondents stated Hindu as their religion while 5.4% of the sample from Beed belonged to the Islam religion.
- **Community:** 53.7% of our respondents from both the districts belonged to the General category (Brahmin, Gurav, Maratha, Muslim, Vidhur) while 23.9% of them belonged to the SCs (Chamar, Harijan, Mahar, Mang, Vadar), OBCs were 13% (Dhobi, Gosavi, Kumhar, Mali, Nhavi, Teli, Vani, Varik) whereas MBC 1% (Laman and Pardhi), 8.3% PVTGs and NTs (Nathjogi, Vajnari and Dhangar) formed the rest of the population interviewed.
- **Marital Status**: 91.7% of the women interviewed were married, the average age of marriage in Beed was 17 years whereas in Osmanabad it was 18 years.
- **Children and Family Size:** Average number of children was two and average family size was four in both the districts.

3.1.1 AVERAGE INCOME

- **Earning Women:** 40.7% women out of 351 from Beed and 82.3% women out of 226 from Osmanabad go out to work and earn. The average yearly income of women in Beed was 56899 INR and for Osmanabad it was 57487 INR.
- **Family income:** The average yearly family income of families in Osmanabad was 70986 INR as compared to 164121 INR for Beed.

3.1.2 SOURCES OF INCOME



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INCOME TRENDS

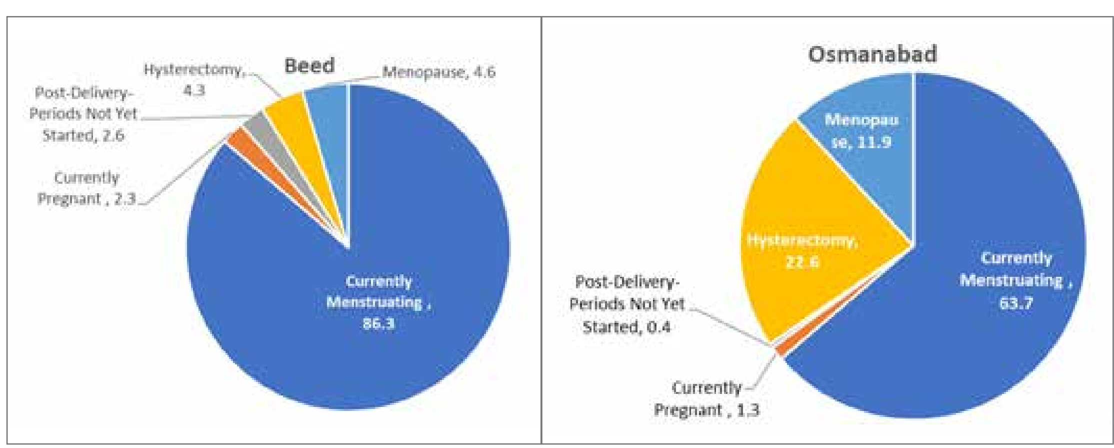
- **Farming:** Agricultural work was the main and single source of regular income for 78.5% of families of total women interviewed from Beed and Osmanabad.
- **Farm workers/ daily wages labour/ seasonal workers:** Farm work and seasonal labor formed either the main (single) or supportive (multiple) source of income for 48.8% of our interviewees, including 5% of our respondents who were contract labour in the agricultural sector.

- **Self-employed/ Home based business:** 16.2% from Beed and 6.7% families from Osmanabad were self-employed or running home-based businesses as a supportive source of income.
- **Women lack Disposable Income:** Although they worked on their own farms and their families also counted on multiple sources of income, 79.6% of the women from our sample in Osmanabad and 14% in Beed reported that they 'did not earn'. Our data indicates that women remain hamstrung in terms of disposable income for personal expenses as well as any decision making on medical care in relation to MHM.
- **Single source or multiple sources of income:** 45.3% women in Beed reported that the primary source of earning for their families was a single source, out of which 37.9% earned through a regular source of income. In Osmanabad, 78.8% women reported that their families had a single source of income. 56.2% women from Osmanabad reported that their families primarily earn from farming along with other regular sources like industrial skilled work, small businesses, and 22.6% reported irregular sources of incomes like daily wage labour, farm labour etc.

TRADITIONAL KNOWLEDGE & SKILL

- **Traditional Knowledge and Skills**: 43 women out of 351 from Beed and 54 women out of 226 from Osmanabad reported possessing traditional skills such as craft/ embroidery/ knitting and weaving. 48 out of these were able to earn from such activities. In Osmanabad only 11 (20.4%) women earned from traditional skill/s as compared to 37 (86%) women from Beed.

3.1.3 MENSTRUATION STATUS (BEED N=351, OSMANABAD N=226)



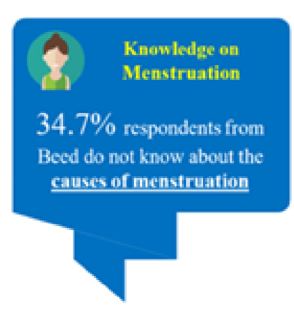
- **Total EAMW**: A total of 468 (81.1%) of our respondents were in their active menstrual years.
- **Age at Menarche:** Average age at menarche was 14 yrs, whereas the average age at attaining menopause was 41 years in both the districts.
- **Number of Hysterectomies**: 15 women from Beed and 51 from Osmanabad had undergone hysterectomy in Maharashtra, with the average age at the time of the procedure being 34 years in Beed and 39 years in Osmanabad.

3.2 DISCOURSE ANALYSIS

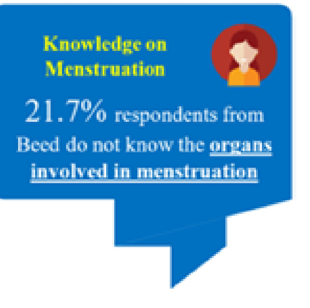
3.2.1 KNOWLEDGE ABOUT MENSTRUATION:

Knowledge About Menstruation	Beed (in %)	Osmanabad (in %)
Total Respondents	351	226

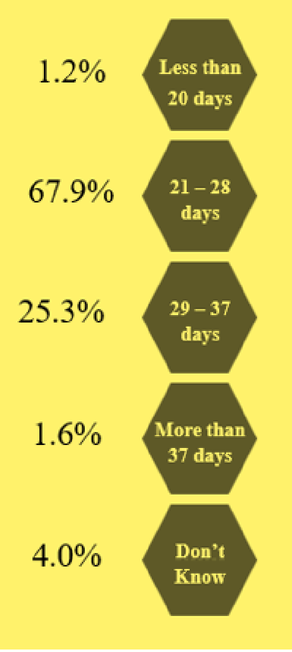
Knowledge About Menstruation	Beed (in %)	Osmanabad (in %)
Causes of menstruation		
Hormonal change	65.2	99.6
Disease	3.1	0.0
Do not know	26.5	0.4
Natural process	5.1	0.0
Organs Involved in Menstruation		
1. Uterus/ Birth canal	78.3	97.3
3. Abdomen/ Bladder	2.6	0.4
Do not know/ not answered	19.1	2.2



Precise Information, No: However, 19.1% of the women from Beed lacked biological awareness as they could not answer questions on organs involved in or causes of menstruation.

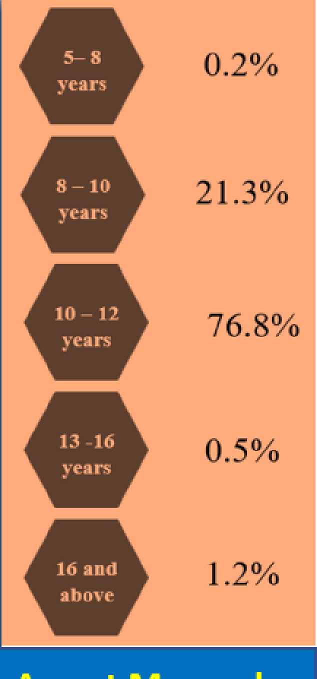


Intervals between Menstrual Cycle



Knowledge on Menstruation, Yes:

Based on their lived experiences, almost all women could tell accurately about the age of menarche and the intervals between the two menstrual cycles.



Age at Menarche

- **Basic Understanding, Yes:** Based on their lived experiences, almost all women could tell accurately about the age of menarche and the intervals between two menstrual cycles.
- **Precise Information, No:** However, 19.1% of the women from Beed lacked biological awareness as they could not answer questions on organs involved in or causes of menstruation.

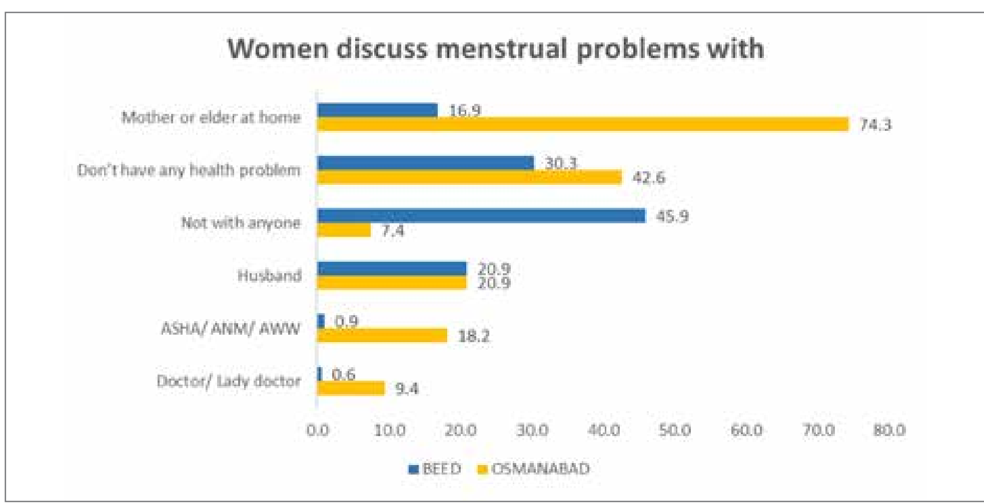
3.2.2 SOURCE OF INFORMATION ABOUT MENSTRUATION

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

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

WOMEN LIKE TO DISCUSS THEIR MENSTRUAL PROBLEMS WITH THE FOLLOWING:

- **Close Relatives:** Unlike 16.9% women from Beed, 74.3% women from Osmanabad were mostly comfortable discussing menstrual problems with mother or elders at home.
- **Frontline Health Workers (FHWs)**: Out of the total of 468 EAMW surveyed, only 6.4% were more comfortable to talk about their MHM problems with the FHWs in the village such as Accredited Social Health Activist (ASHA), Auxiliary Nurse and Midwife (ANM) and Anganwadi workers (AWW).
- **Spouses:** 20.9% of Women from both the districts felt comfortable talking about menstrual problems with husbands. If men can be oriented, stay alert and helpful on their wives' MHM issues, that would bring a positive health outcome for EAMW, besides combating the silence on it.
- **Nobody:** However, 45.9% of women from Osmanabad and 7.4% of women from Beed do not prefer to talk with anyone and remain **silent** about their menstrual problems. 34.2% women from both districts **denied** having any problems w.r.t MHM.



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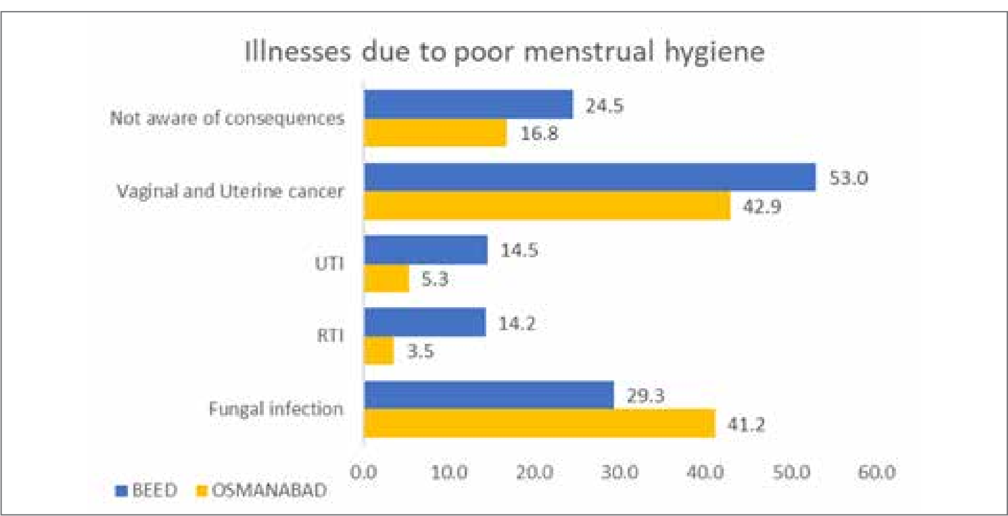
3.2.3 MENSTRUAL HEALTH, EDUCATION, AND AWARENESS ON INFECTIONS

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

- **Widespread Ignorance**: When asked about the side effects of poor menstrual hygiene, 24.5 % of women from Beed and 16.8 % women from Osmanabad could not answer. Out of the total EAMW (N=577) from both the districts of Maharashtra, 21.5% could not answer.
- **Fungal Infections and UTIs:** Out of the 468 EAMW who knew about poor MHM and risks of infection, 196 stated that poor menstrual hygiene leads to fungal infections while 63 said it causes UTIs.



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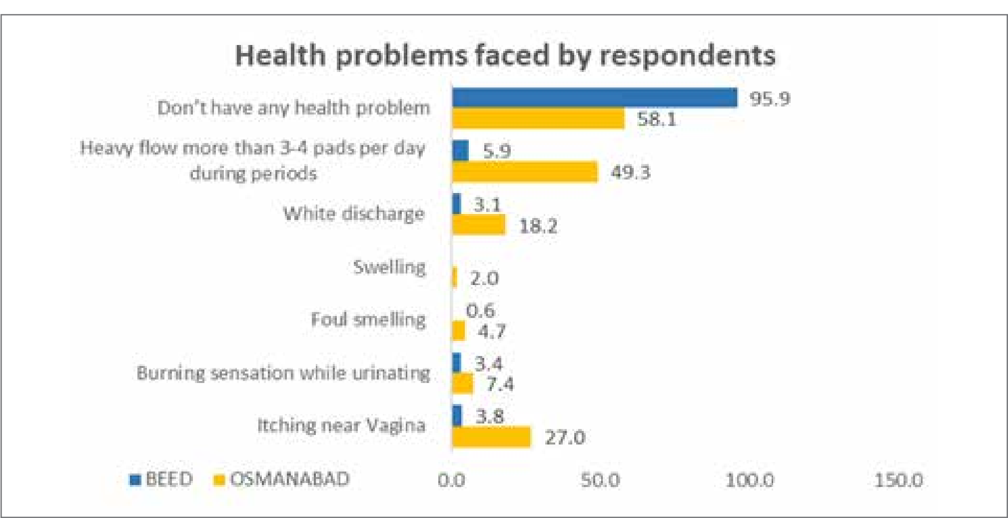
- **Low knowledge on exact health risks:** Adverse health conditions while working in or outside home often lead to rashes, Urinary Tract Infections (UTIs) and Reproductive Tract Infections (RTIs). However, our findings indicate a lack of awareness on these risk factors. Not being able to understand and/or give answers on the relationship between MHM and rashes, infections and other risks indicates ignorance per se.
- **No Schooling, Taboos and Communication Barriers:** However, given that speaking about periods itself is a taboo or is a challenge due to shyness/ hesitancies, generalizations on awareness on MHM may be misleading. Community and area specific conclusions are a better way ahead. One of the most noteworthy findings from both the districts of Maharashtra has been that only 286 women from a total of 577 interviewed had attended school till grade VII. In other words, these women dropped out of school around the time they attained menarche or a year or two before that. In the face of the absence of opportunities that schooling can provide to break barriers of communication on menstrual health, it is not surprising that almost 50% of EAMW who participated in our study either remain shy to speak or know about menstruation or effectively become silent on the theme.

3.2.4 HEALTH SYMPTOMS DURING MENSTRUATION



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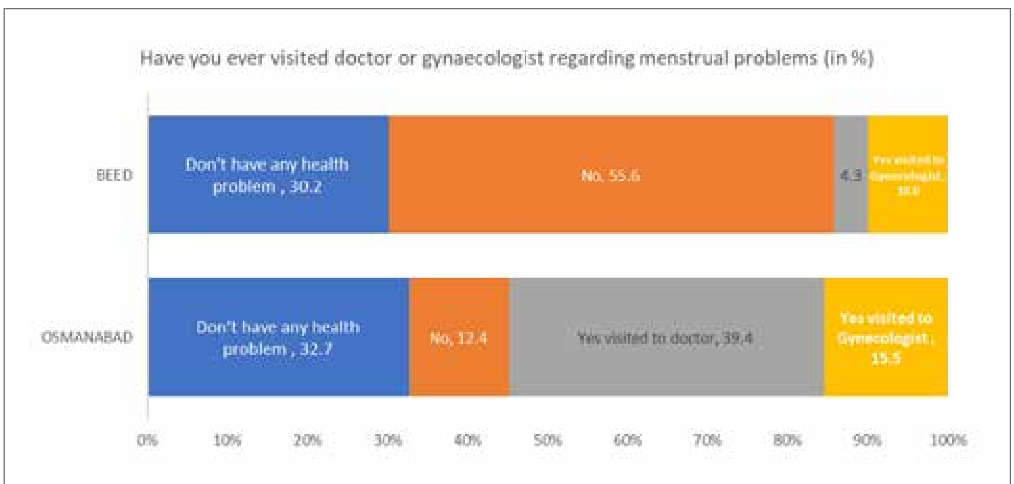
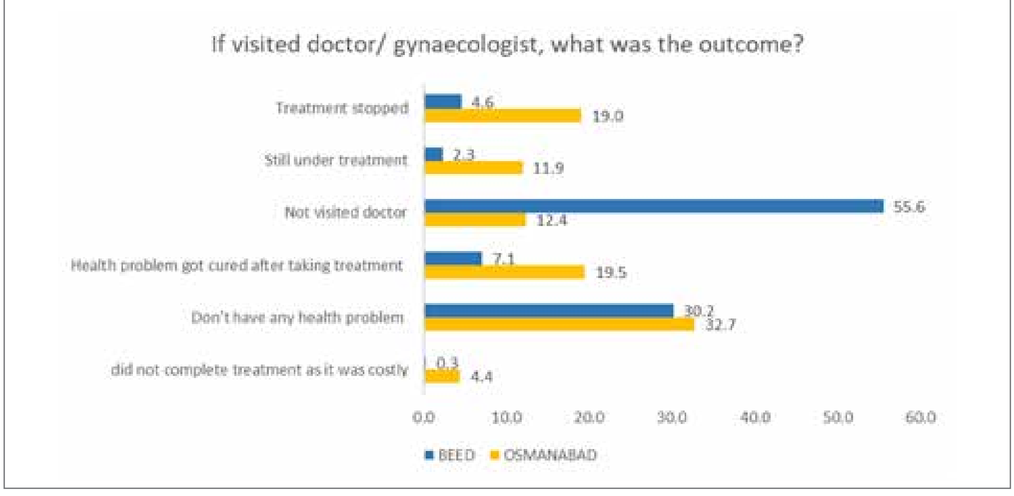
- **MHM, health and accessibility to health care**: Apart from the modes as well as patterns of, and awareness on MHM, the survey imparts light on the health problems undergone by participants during menstruation. For arriving at inter-sectoral findings on health management, women were asked if they visit a medical professional to resolve menstrual health issues and reasons if they do not.

- **Vaginal symptoms, attitude and treatment, Beed:** Almost all (307) of the total EAMW (n=320) in Beed reported that they did not have any health problems in the earlier part of the survey. In the later part of the survey, however, they confirmed heavy flow, itching near vagina and burning sensation while urinating as the top three issues women faced due to poor vaginal hygiene. Despite such serious MHM issues, merely 14.3% women from Beed reported seeking medical advice and only 7.1% actually visited a doctor and got cured after completing treatment.
- **Vaginal symptoms, attitude and treatment, Osmanabad:** 86 of the total EAMW (n=148) in Osmanabad reported that they did not have any health problems in the earlier part of the survey but later confirmed heavy flow during menstruation, itching near vagina and white discharge, which emerged as the top three issues that women faced due to poor vaginal hygiene. 54.9% (148) of the women interviewed in Osmanabad (n=226) reported that they visited a doctor for seeking treatment/ advice on menstrual health problems. Only 19.5% out of these 148 women who informed us that they had visited a doctor, got cured after completing treatment.



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



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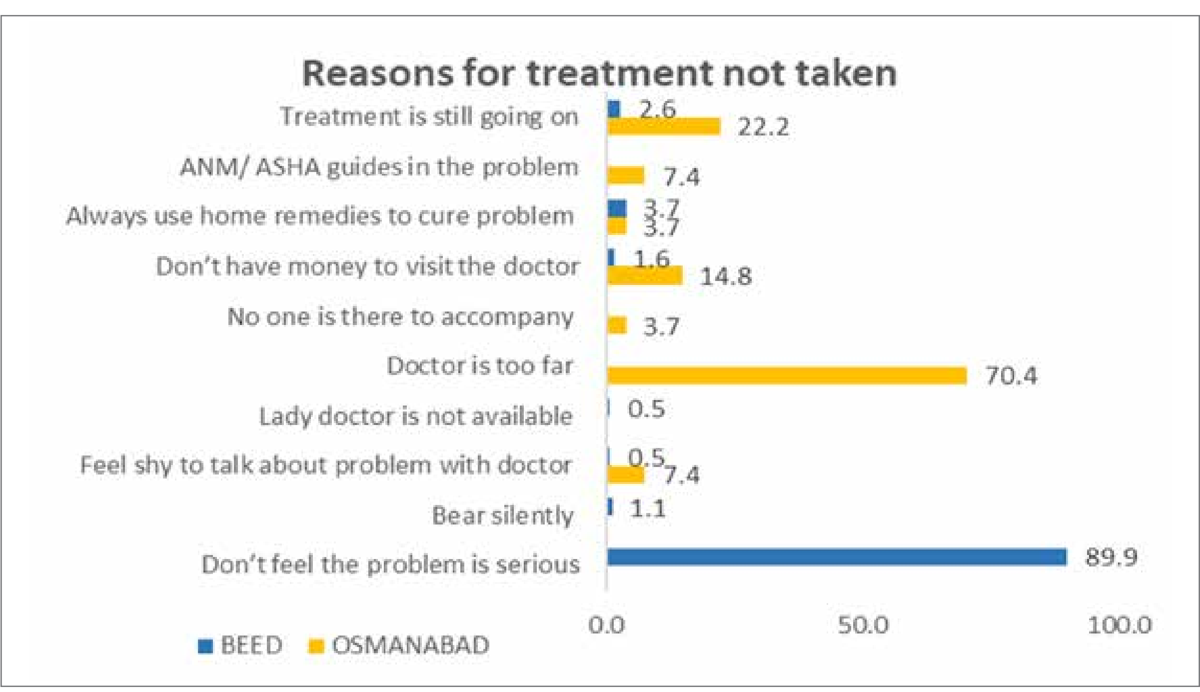
- **Neglect, hesitation, and Silence:** EAMW tend to neglect health issues related to menstruation in Maharashtra's Beed and Osmanabad districts. This barrier is further exacerbated by the hesitation to speak on menstrual health and inability to seek medical advice on a regular basis owing to a number of reasons including economic encumbrances.
- **Medical Care, Access, and Unaffordability:** Merely 12% of our respondents visited a doctor to seek treatment and got cured. 18.2% of our total respondents stopped treatment due to various reasons, unaffordability and accessibility of medical care being the most prominent ones

3.2.5 REASONS FOR NON-TREATMENT



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- **Ignorance:** 89.9% of women from Beed did not feel that the problem was serious.
- **Doctor is far:** 70.4% of women from Osmanabad gave the reason that the doctor is too far to reach followed by monetary problems in addressing women's health. 14.8% women responded that they do not have money to visit the doctor which indicates that aside from a low household income, women also lack disposable income and decision-making powers to approach doctors.
- **No Lady doctor/ Gynaecologist:** 44.9% of our informants refrain from seeking medical advice on MHM owing to non-availability of a lady doctor.
- **Attitude (Shyness and Silence):** 7.4% of the women from Osmanabad singled out shyness as one of the causes that impedes them to discuss their menstrual health openly.

3.2.6 HYSTERECTOMIES

Cases of hysterectomy in samples across both the districts from Maharashtra was 11.4% of the total population surveyed. In other words, 66 out of 577 women interviewed in Maharashtra, had undergone hysterectomies. Out of these, 15 women were from Beed and 51 women were from Osmanabad. Overall, 40 women said that their hysterectomy was done under medical advice. Other major reasons were, weakness due to heavy bleeding, wanting to get rid of white discharge and to avoid cancer, frequent and irregular periods and uterine prolapse, severe pelvic inflammatory disease (9 cases) were also prime causes.

- **Biological Causes:** Hysterectomy causes ranged from abnormally heavy bleeding, backache during menstruation, stomachache and fibroids or other problems related to the uterus.

- **Socio-economic Causes:** Three women who had undergone hysterectomy informed us that periods become a hurdle while working away from home because of low stamina and lack of adequate hygiene facilities. Additionally, when the couple work together or in *Jodi* (Husband-Wife team), women could not afford to take a leave as none of the partners in that case get their payment.
- **Government/ Private Treatment:** Only four out of 66 hysterectomies, i.e, two from each district were done in Government hospitals. The reason for seeking treatment from private hospitals was mainly to get rid of the problem immediately or prior experience/recommendations of family or friends and convenience. The average cost of a hysterectomy was 36000 INR for Beed and 59000 INR for Osmanabad.

Our findings on hysterectomies in Beed and Osmanabad resonate with the known discriminatory situations prevailing in informal labour sector in sugarcane farming areas as well as in other unorganized sectors. Women are oppressed and treated unfairly on their MHM needs which leads to creating problems for husband-wife teams *(Jodi/s)* working together, almost in the same way as it happens elsewhere such as in Chhattisgarh. Moreover, misconceptions about uterine relevance post motherhood are abound. Further, MHM related encumbrances experienced in exploitative labour situations also subject a woman to inadequate WASH facilities. Not surprisingly, marginalized women face complex challenges and crossroads regarding their reproductive health as well as wellbeing options, oftentimes leading to hastily executed hysterectomies. MHM of EAMW should become a vital part of labour laws, public health and community -based awareness drives.

3.3 PRACTICE ANALYSIS

Good menstruation practices start with the usage of clean menstrual absorbents followed by maintenance of reproductive hygiene from menarche till menopause. This section brings to light the prevalence of practices regarding personal hygiene such as washing hands and genitals during menstruation as well as usage and disposal patterns of menstrual hygiene products. We also bring data on how personal and community-based beliefs, customs and taboos influence MHM outcomes and self-care regimes of our respondents.

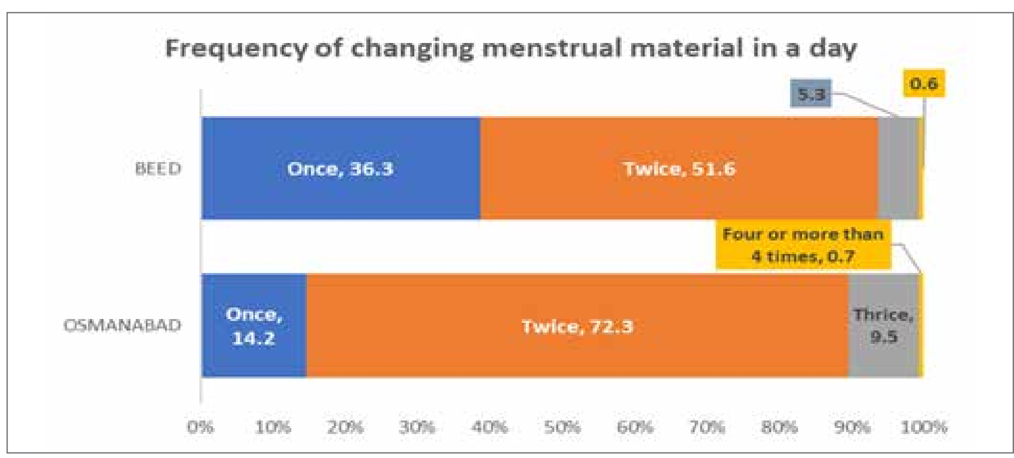
3.3.1 SANITARY PADS OR OTHER ABSORBENTS

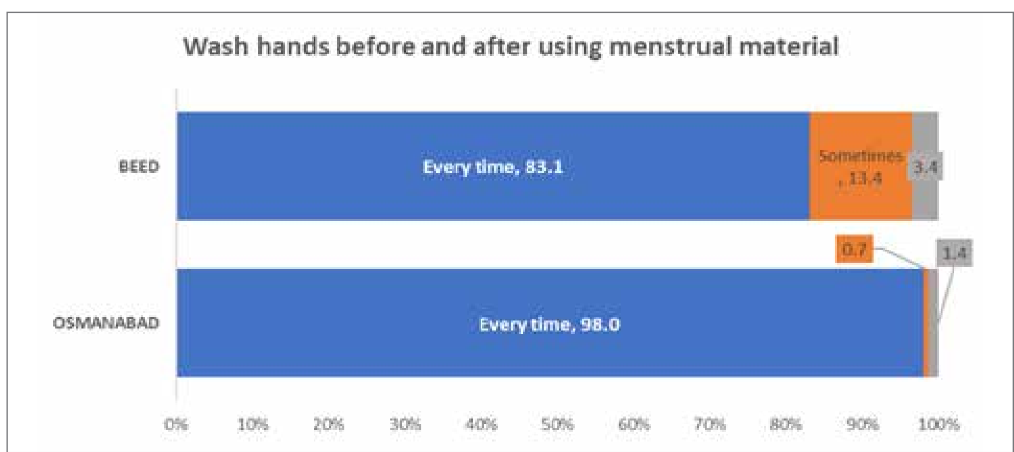
- **Cloth:** Out of the total EAMW interviewed from both districts, 30% women surveyed use only cloth during menstruation. because of its ready availability, affordability, durability as compared to other menstrual hygiene products. Being unable to decide whether to switch over to other forms of protection during periods, was the main reason for many women who continued the use of cloth.
- **Other Material**: 70.3% women (out of 320) from Beed and 66.2% women (out of 148) from Osmanabad use menstrual products other than cloth. 62.2% of women reported that they use sanitary pads in combination with cloth for saving costs.

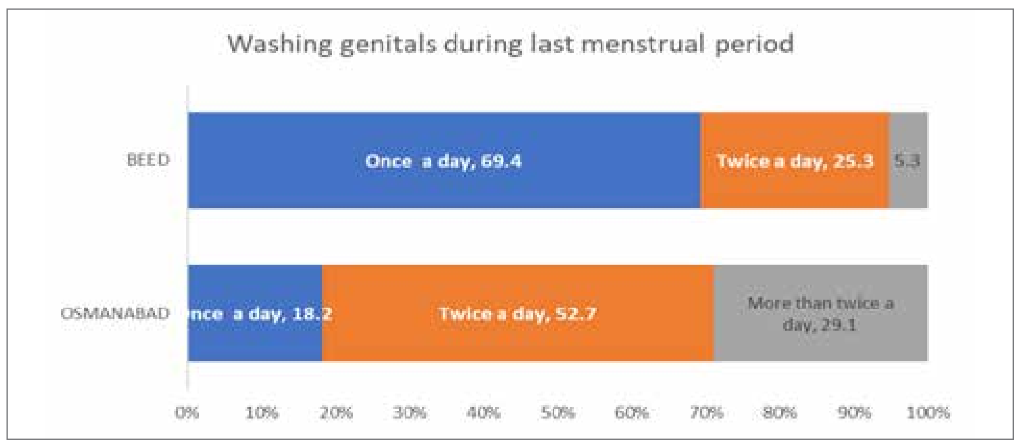
3.3.2 SPENDING CAPACITY ON MENSTRUAL HYGIENE PRODUCTS

Out of 468 menstruating women, 69% reported they used sanitary pads while 30.1% women used cloth. Though they said that they used sanitary pads, most used a pad in combination with cloth, as we found out. When asked about the reasons, they cited that cloth was easy to use, easily available, affordable, etc. Surprisingly, in Beed where menstrual awareness is lower than in Osmanabad, EAMW reported higher use of pads. Average spending capacity on menstrual products in Beed was merely 27 INR per month whereas in Osmanabad it was found to be 57 INR.

3.3.3 PERSONAL HYGIENE PRACTICES AND WASH DURING LAST MENSTRUAL CYCLE





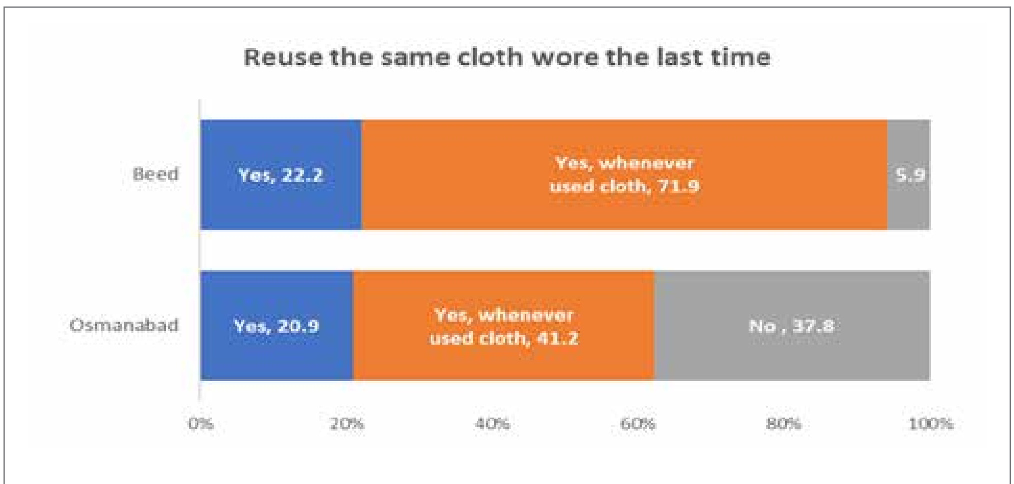


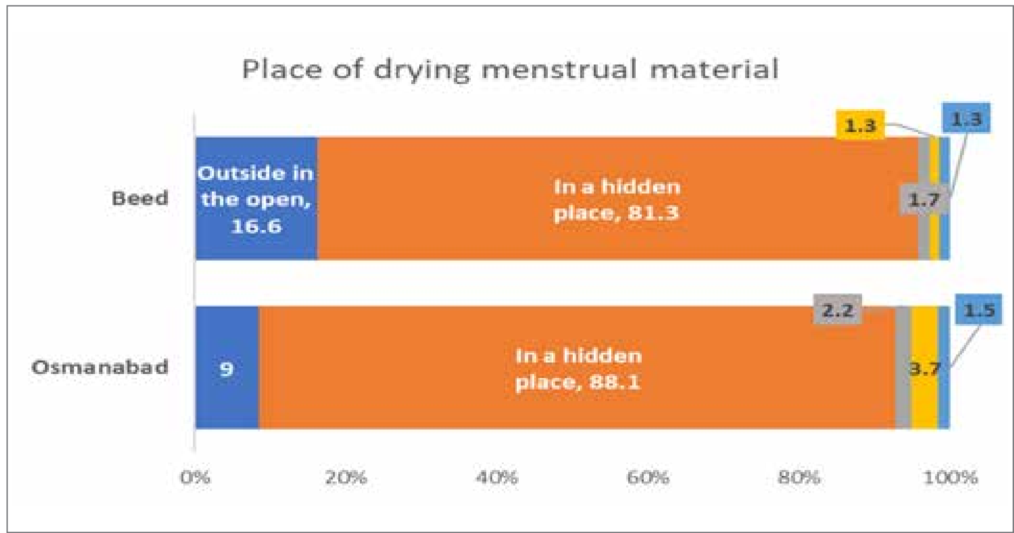
- **Frequency**: From both districts, around 87.4% of women responded that they change menstrual material twice or thrice a day.
- **Washing Hands:** 83.1% women from Beed reported that they wash their hands every time they use or change menstrual material. Hygiene practices were found to be better in Osmanabad where 98% of the interviewees wash hands every time they use/ change menstrual material.
- **Washing genitals during the last Menstrual Period:** From both districts, 87.2% of women wash their genitals twice a day during menstruation. 12.8 % wash more than twice a day, and out of those 67.9% use soap while washing. Use of soap to wash genitals was more frequent in Osmanabad than in Beed.

Our data indicates that more awareness towards MHM and WASH alongside provision of and access to proper WASH infrastructure and sanitation services is the most basic need for enabling EAMW and communities to take actions in the rural belts in Maharashtra where women agricultural labourers suffer adverse working conditions owing to menstruations.

3.3.4 MENSTRUAL HYGIENE PRACTICES

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



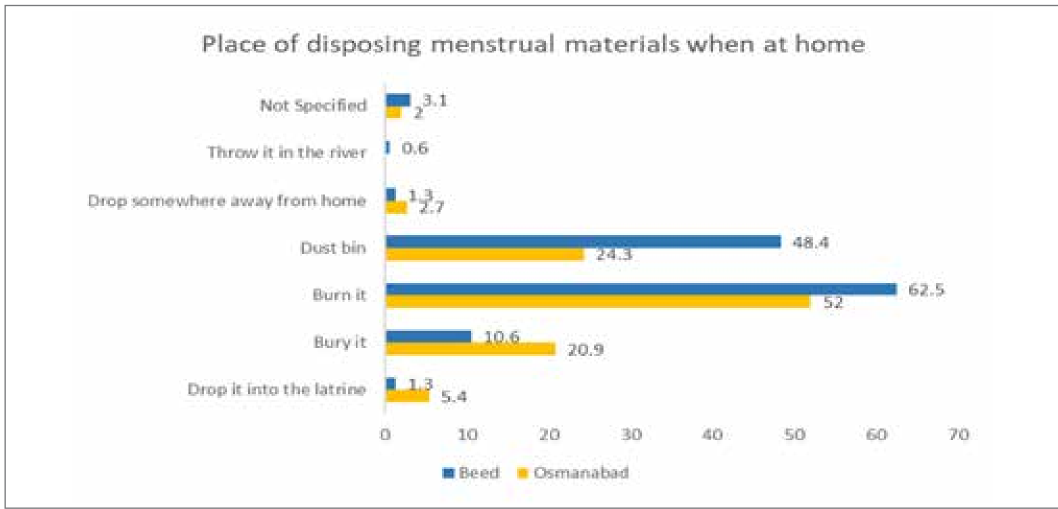


- **Reusing MHM Products:** In both the districts, nearly half of women claimed the use of clean cotton cloth during menstruation, out of which 62.2.% of women reuse the cloth.
- **Washing MHM Products:** According to our respondents, more than half of the women wash their menstrual material in the bathroom or toilet at homes in both the districts. Hence, 46.2% women wash their menstrual clothes outside the house, near hand pumps or a well.
- **Use soap every time:** 47% women from both the districts said that they use soap each time they wash their menstrual clothes.
- **Use soap sometimes:** Half the respondents from both the districts use soap only sometimes to wash menstrual clothes.
- **Drying MHM products**: While reusing cloth during menstruation, apart from washing, one also needs to follow the practice of drying the cloth properly in sunlight. 83.7% women in Maharashtra dry their menstrual clothes in hidden places but only half of the women ensure that their clothes are completely dry before using them.

3.3.5 AREA-SPECIFIC DISPOSAL MECHANISMS *

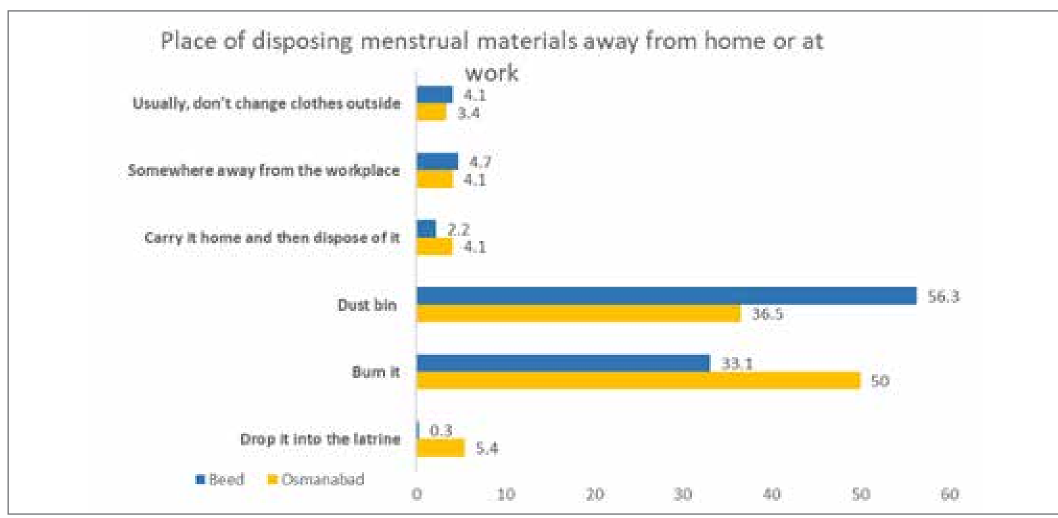
- **No specific Disposal Mechanism in place:** When asked about the system of disposal of menstrual waste material in their area, it was found that women have to manage problems at their own levels. The district does not have any disposal mechanism for menstrual waste nor monitoring mechanisms to follow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

Methods of disposal in Both the Districts: When at Home



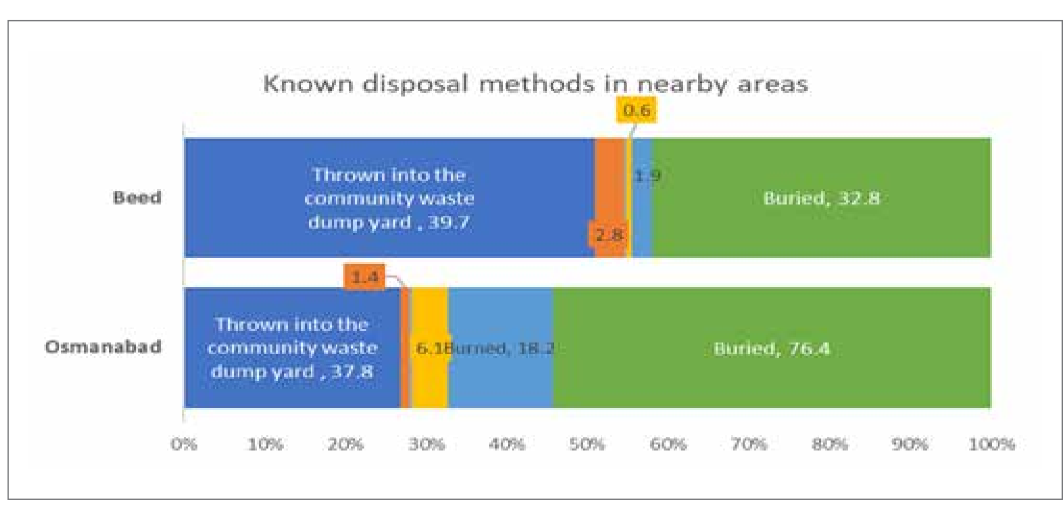
➲ **Top Practices:** When at home, most of the women from both the districts of Maharashtra either burn the used menstrual material or throw it in the dustbin.

Methods of disposal in Both the Districts: When away from Home



➲ **Top Practices:** More than half the respondents in Beed throw the menstrual waste in a dustbin when away from home whereas half the respondents in Osmanabad prefer to burn it.

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



- **Disposal practices by community:** According to our respondents from Beed, the used menstrual material is thrown into the community waste -dump yards by 121 women (n=320) in Beed whereas 105 women buried it in the village and nearby areas. In Osmanabad, 113 respondents (n=148) buried their menstrual waste followed by 46 women who threw it into community waste -dump yards.
- **Disposal of MHM Waste and WASH concerns**: 2.8% women from Beed throw their menstrual waste in the bushes whereas 6.1% women from Osmanabad throw it in the river bodies.

3.3.7 SOCIAL CUSTOMS, BELIEFS, MYTHS, AND TABOOS

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

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

Beed (351respondents)	Strongly agree	Agree	Disagree	strongly disagree
I am allowed to mix with others socially during my periods.	5.4	72.6	20.8	1.1
I am not allowed to attend any social rituals during my periods.	4.8	84.9	9.4	0.9
I do not go to religious places during periods.	4.0	84.6	9.7	1.7
I avoid traveling during periods.	4.0	84.0	10.8	1.1
I am told to stay in the corner of the house during my periods.	6.0	48.1	45.0	0.9
	Yes		No	
I am allowed to carry out routine work at home during my periods.	61.5		38.5	
I am allowed to cook in the kitchen during my periods.	25.1		74.9	
Others in my family take care of me during periods.	89.7		10.3	
I have freedom to visit a doctor in case of any health issue.	65.2		34.8	
I am allowed only special foods during periods.	25.9		74.1	
I sit for lunch and dinner with all my family members.t	78.1		21.9	

Customs followed by Women in reference to Menstruation: Osmanabad District (in%)

Osmanabad (226 respondents)	Strongly agree	Agree	Disagree	strongly disagree
I am allowed to mix with others socially during my periods.	34.1	52.2	9.7	4.0
I am not allowed to attend any social rituals during my periods.	33.6	58.0	6.2	2.2
I do not go to religious places during periods.	35.8	56.2	5.3	2.7

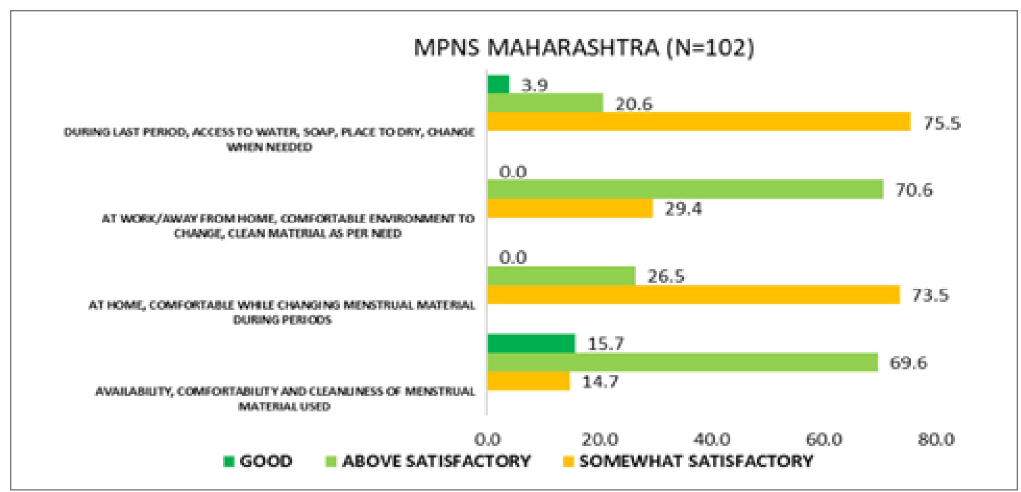
Osmanabad (226 respondents)	Strongly agree	Agree	Disagree	strongly disagree
I avoid traveling during periods.	35.8	57.5	4.0	2.7
I am told to stay in the corner of the house during my periods.	33.2	54.0	9.7	3.1
	Yes		No	
I am allowed to carry out routine work at home during my periods.	58.0		42.0	
I am allowed to cook in the kitchen during my periods.	52.7		47.3	
Others in my family take care of me during periods.	96.0		4.0	
I have freedom to visit a doctor in case of any health issue.	97.8		2.2	
I am allowed only special foods during periods.	36.7		63.3	
I sit for lunch and dinner with all family members.	98.7		1.3	

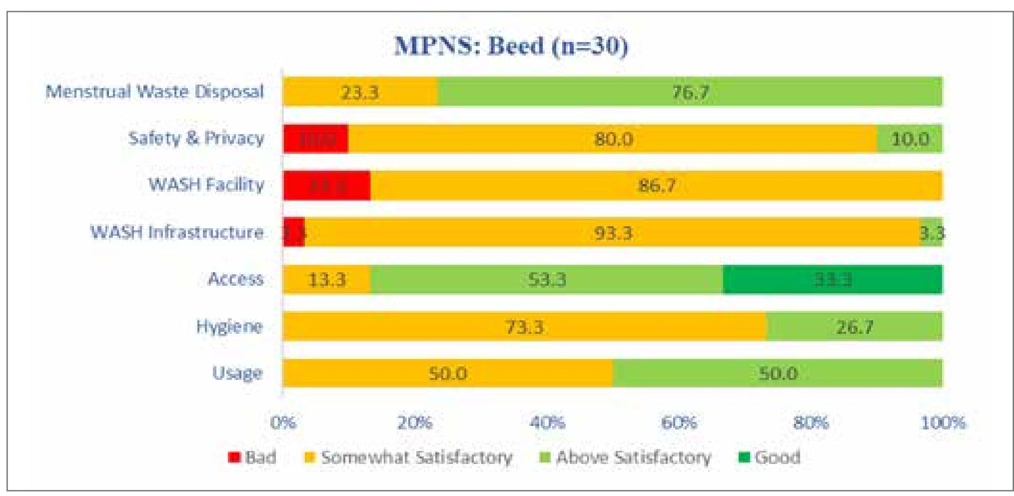
- **Socialise:** 522 EAMW from a total sample of 577 in both the districts, cannot attend religious occasions and ceremonies and are restricted from going to religious places. In Beed 33.6%. women faced restriction during periods whereas 58% women from Osmanabad were not allowed to socialize during their periods.
- **Seek Medical Advice:** One-third of the women in Beed informed us that they have the freedom to visit the doctor in case of a health issue whereas almost all the women in Osmanabad stated that they were free to consult doctors when the need be and customs do not impinge upon their medical freedom
- **Normal Routines and Family Care:** However, more than half the EAMW- survey participants across both the districts, claimed that during menstruation they carry on their routine lives at home. Additionally, almost 532 women from Beed and Osmanabad stated that their family members take care of them during periods.

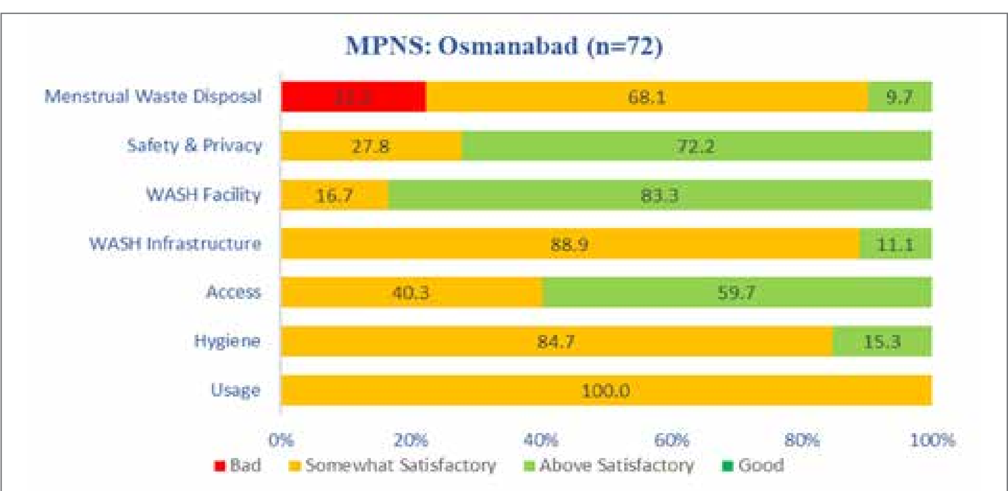
3.3.8 MENSTRUAL PRACTICE NEEDS SCALE (MPNS)

The MPNS was used to measure and assess the felt needs and experiences of women during their last menstrual period. 102 respondents from both the districts in Maharashtra shared their perceptions/experiences on availability of water, sanitation, hygiene, safety and privacy as well as access to menstrual absorbents. Through the use of MPNS, we were able to access the actual trends, practices and experiences w.r.t MHM, WASH, safety and privacy which form the 'menstrual everyday' of surveyed women in Beed and Osmanabad districts in Maharashtra:

- When measured on the MPNS, 30 women from Beed, reported that they have poor privacy. Women found the WASH facilities, WASH infrastructure poor to somewhat satisfactory. Nonetheless, access to menstrual material and menstrual waste disposal was rated at above satisfactory to good levels, which could probably be due to the practice of using cloth during periods.
- Assessed on the MPNS, 72 women from Osmanabad reported that access to menstrual material, usage of desired absorbents, hygiene and WASH infrastructure was at a poor to somewhat satisfactory level. Nonetheless, women rated privacy and WASH facilities at above satisfactory whereas half the women rated access to menstrual products at above satisfactory level.







3.4 MHM FROM AN INTER-SECTORAL PERSPECTIVE

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

As villages selected from Beed and Osmanabad are seasonal migrant farmers dominated, we include various migration/ temporary relocation related aspects that impact women's health, MHM and wellbeing at various levels.

- Working conditions in relocation destinations, i.e., sugarcane farms, brick kilns, mining and manufacturing industries present a veritable grade of difficulty for women workers. From discriminatory wages, attitudes, exploitation to WASH facilities and leaves during periods, women farmers face unthoughtful contracts and provisions in place of work.
- Access to PDS centers, food security and continuation of basic education of their children are perpetual struggles in the life of migrant families.
- Besides, women are not proactively aware of their rights, entitlements, and privileges as workers because the seasonal work that migrants engage in belongs to the unorganized sector.

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

3.4.1 MIGRATION AND HEALTH

Beed and Osmanabad are known for generations of migrant labour families engaged in seasonal work for almost six months of the year. However, the work being incidental, the migrant women could not specify any set duration. Seasonal migration work is usually short-term, done for elite farmers needing large scale sugarcane cutting or for private enterprises involved in brick kilns, mining, and manufacturing. In either of the cases, this kind of work is high-risk, hazardous and involves rigorous farm labour with a bare minimal availability of basic amenities, essential life-line services and social security. Owing to the nature of their work and exploitative labour conditions, migrant families remain heavily dependent upon external support and wellbeing measures, including free pads and medical care for MHM for instance.

- Across the districts of Beed and Osmanabad, one in three women surveyed (n=577) migrate for work with their families.
- Of the 82 migrant families from Beed, 41 are engaged in seasonal farm labour. In the case of Osmanabad, 105 families migrate for work and 66 out of these rely on seasonal farm labour.
- Out of 187 total migrants from both the districts, 71 migrate to sugarcane cutting sites. Another 106 migrated as daily wage labourers for agricultural work and remaining (ten) migrant families were engaged in brick-kilns, mining, and manufacturing work.
- Our findings indicate that 177 out of the 187 migrant women strongly feel that their seasonal work conditions and resource scarcity influences their menstrual health negatively.

Seasonal migration work pertains to the unorganized sector. Oftentimes such work bases itself in completely unfair labour contracts and harsh working conditions without respite, relief, or empathy for menstruating women in the prime of their lives. Consequently both, these women and their partners (who usually work as a team) are subjected to undue monetary penalties and wage deductions for leaves against adverse menstrual health and symptoms. Complications in intimate health during and after menstruation are not uncommon given the shabby MHM prospects on farms and factories or other places of work in the unorganized sectors. If women take leaves, they suffer grave financial losses as a family and also, seldom have any recourse whatsoever to get themselves treated for upkeep of their menstrual health.

3.4.2 TRADITIONAL SKILLS AND EARNING CAPACITY

Across our sample, 43 women out of 351 from Beed and 54 women out of 226 from Osmanabad possess traditional skills like art, craft, farming, tailoring, etc. Out of these, 37 from Beed and 11 from Osmanabad earn from the skills they possess and practice.

Given that there is a possibility of augmenting family income from traditional knowledge and customary skills, vocational courses and micro-financing can be organized for women struggling with socio-economic vulnerabilities to enhance their means of livelihood and disposable income. A disposable income can give women better opportunities towards an empowered decision-making w.r.t MHM as well as personal and medical care. Our survey findings indicate a good level of education among the EAMW, whom we surveyed. Therefore, these women can be willing and knowledgeable participants in endeavors that try to hone their skills and talents through formal training and internships to expand their scope of employment. Likewise, the EAMW, especially with good levels of education can be targeted and operationalized through ongoing SHGs schemes in Maharashtra (refer to part 4.4).

3.4.3 WASH AND MHM

According to the NFHS-5 Report, 66.4% and 71.2% of households from Beed and Osmanabad, respectively, use an improved sanitation facility (International Institute for Population Sciences and ICF 2020, p. 39, 141).

WASH & MHM	Beed (in %)	Osmanabad (in %)
Total Respondents	**351**	**226**
Water Facility at Home		
Bore well/ Tube well/ Well covered	9.1	1.3
Hand pump/ Standpipe	0.3	4.9
Piped water/ Piped to yard/ Plot/ Public tap	90.3	93.8
Tanker/Truck / Cart with small tank	0.3	0.0
Toilet Facility at Home		
Individual household latrine	94.6	76.5
Community toilets	2.0	11.9
Open defecation	3.4	11.5
Type of House		
Kutcha	65.0	64.2
Pucca	20.8	2.7
Semi pucca	14.2	33.2

- **Kind of House:** In both Beed and Osmanabad 373 of our respondents (n=577) lived in Kutcha houses (roof, wall, and floor all made up with kutcha material). 73 of our respondents (n=351) from Beed live in pucca houses (roof, wall, and floor all are made up of pucca material) as compared to only six (n= 226) from Osmanabad who can afford pucca houses. However, 50 women in Beed and 75 in Osmanabad live in semi-pucca houses (either 1 or 2 from roof, wall and floor is made up of kutcha/ makeshift materials).
- **Compromised Toilet Facilities:** Pucca houses can have toilets built within as opposed to Kutcha houses where such a provision is not possible. Though toilets were constructed under Swachcha Bharat Abhiyan,

open defecation is practiced by 6.6% people surveyed in both the districts, though in Osmanabad it is higher than in Beed. Majority of the people, despite living in kutcha houses, use Individual Household Latrines (IHHLs). It is noteworthy that out of our sample (N=577), 187 families go away from Beed and Osmanabad for around six months of seasonal labour and encounter compromised toilet facilities in the relocated areas unlike in their areas of origin.

➲ **Sanitation and Access Challenges:** One of the main everyday challenges for migrant families of Beed and Osmanabad emerged to be compromised access to water facilities and proper sanitation. 529 women (91.7%) from both the districts reported piped water as being their primary water source. However, Beed and Osmanabad fall under rain-fed areas. During drought and drought-like situations, these districts face acute water scarcity making villages supply potable water through tankers. In such circumstances, women face additional hardships for MHM and WASH purposes.

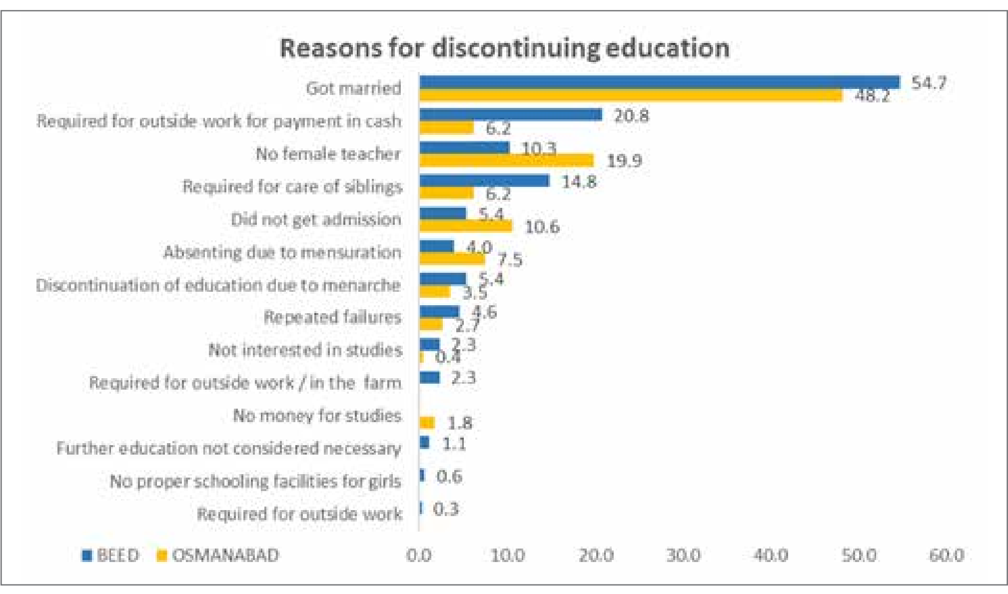
It is clear that during menstruation a woman's WASH needs are relatively higher as compared to the rest of the days of the month. When a woman experiences her periods, she needs more water to clean herself for personal and intimate hygiene, including after defecation. Besides, a regular supply of clean water, ensuring that a woman has the facility of a private and secure place to change her menstrual absorbents and clean herself are a profound part of her sense of dignity and safety. Therefore, the access to the toilet and bathroom become a critical need during periods. In Beed and Osmanabad, despite a low rate of open defecation and a good amount of IHHLs during periods of water scarcities and droughts, MHM and WASH practices of women get extremely impacted.

3.4.4 EDUCATION AND MHM

Compared to some other states included in our study, literacy rate in Maharashtra was found to be better in both the districts surveyed. Our survey participants in Beed had a higher education rate than in Osmanabad. 92 of our respondents (n=351) from Beed were educated above the 10th standard whereas only 33 (n=226) from Osmanabad went beyond matriculation. Out of the total 577 women respondents from both the districts, 130 were mainly school pass- outs and enrolled in graduate or postgraduate studies. Interestingly, in Beed where there is a higher rate of education among women, our survey found out that women were also able to capitalize on their traditional skill-sets.

Education and MHM	Beed (in %)	Osmanabad (in %)
Total Respondents	**351**	**226**
Education		
No education	8.3	17.3
Primary (1st -4th)	8.0	30.1
Secondary (5th-7th)	24.2	16.4
Higher secondary (8th-10th)	33.3	21.7
12th/ Undergraduate	19.7	14.2
Graduate and above	6.6	0.4

Reasons for Discontinuing Education		
Lack of Facilities	15.4	8.0
Monetary Barriers	35.3	33.6
Family Barriers	61.3	58.8
Educational Barriers	14.5	6.6



*Multiple Choice Question

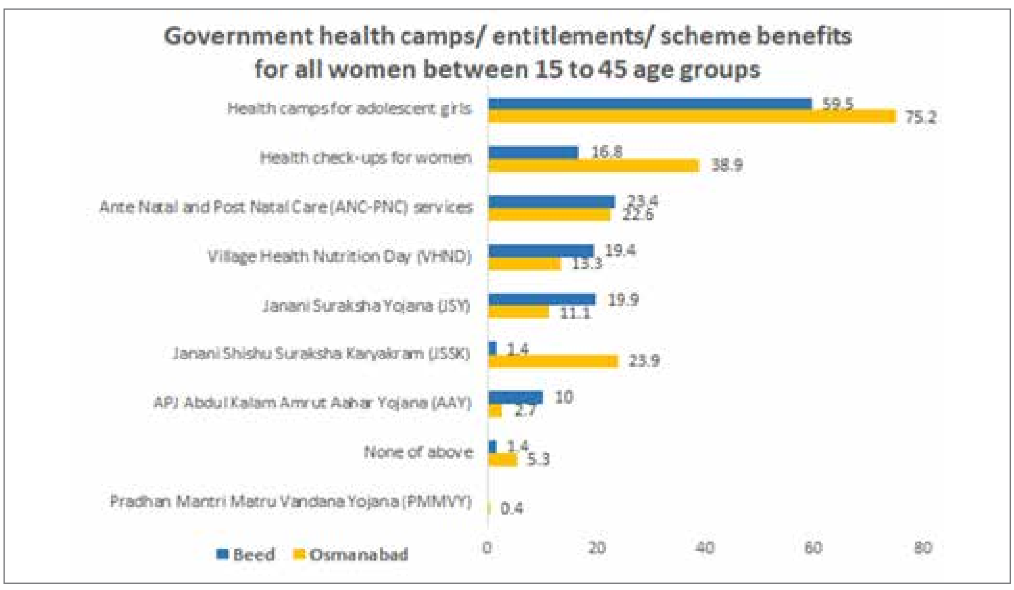
When we tried to find reasons for the discontinuance of education, the main reasons in both the districts were centered around family related and monetary barriers.

- **Socio-Economic Bottlenecks**: 97 of our total respondents (n=577) across both the districts opted out of education because there are no female teachers in schools and families disapprove of girls being taught by male teachers only. Pressures for getting married and augmenting family income were main barriers leading to educational discontinuity. To enhance family income, women were also required to work on their farms or outside of home for wage-labour which compromised their educational journeys. In many cases, families opt for early marriages of their daughters as a coping mechanism to deal with extreme poverty, indebtedness and avoid prospects of a bleak future in the parental home. Family-based barriers such as engagement in housework or taking care of siblings and further education not considered a priority influenced the rate of education amongst adolescent girls/ women.
- **Menarche and Marriage:** Menstruation is a major criterion for some parents and families to lay restrictions on the movement of a girl outside of home, including a preference that adolescents drop out from school altogether. Among those girls who do continue their schooling, being absent from school due to MHM related issues including physical symptoms such as pain etc. leads to interruption in education during post -menarche years. Community beliefs such as a girl being 'ready for adulthood' in early post-menarche years leads to pressure on the family to marry her off. In Beed and Osmanabad, 51 women (N= 577) had dropped out of school due to menarche and menstruation related reasons while in both the districts, early marriage emerged as a prominent barrier to education. 301 women out of a total of 577 EAMW surveyed got married at an early age.
- **Individual Reasons:** Other reasons that impede education emerged as repeated failures that were cited by 20 respondents and lack of interest in education which was quoted by another 6 women interviewed (n=577) in both the districts.

3.4.5 AWARENESS TOWARDS PUBLIC POLICY AND COUNSELING ON MHM

When it was asked whether they get accessible and affordable treatment from government health facilities, out of a total of 577 women surveyed, 511 responded positively. Merely 15 women from both the districts reported that they do not avail treatment from public health facilities. In general, the situation availing Government health services was found to be better in Maharashtra than in any other state.

- **Public Policy:** National Health Mission runs various programs for the age group of 15 to 45 years, i.e., for adolescent girls as well as women. Most women in both the districts are aware of public policy.
- **Local health Services:** From the survey, 59.5% of women from Beed and 75.2% of women from Osmanabad receive health check-ups at the local level in the village or at the Sub- Center level followed by Ante- Natal and Postnatal services.
- **Engagement with Public Health services**: 290 of our respondents from Beed and 204 from Osmanabad said that they have availed the benefits from Government health entitlements and schemes at different stages of life. In Beed, 82 women and in Osmanabad 51 women had received Ante-Natal Care and Post-natal Care (ANC-PNC)-related benefits such as maternal and child health, including health checkups for women and lactating mothers. Village Health Nutrition Day (VHND) scheme was availed by 68 women from Beed and 33 from Osmanabad.



*Multiple Choice Question

- **Significance of Public Health Facilities:** Public Health facilities usually play an important role in providing free and affordable treatment. Health support systems in India are designed such that for every 1000 population there is ASHA appointed, for around 5 to 6 villages, there is a Sub- Centre where treatment for small illnesses as well as 24/7 facility of delivery is available. After that, for every 30000 people, there is a Primary Health Centre (PHC). And as we move further, Rural or Sub-District hospitals, district hospitals in urban areas, municipal corporation health clinics, and hospitals are available.
- **Accessibility and choice:** EAMW covered in this survey were asked through IDIs about the nearest accessible public health facilities where they could get treatments or consult for other health issues. Sub Centre (75.2%) followed by Rural hospitals (12%) were the nearest public health facilities reported by women in Beed. Whereas, 35.8% of women in Osmanabad reported their nearest options being Sub-Centers followed by Rural Hospitals (32.7%) and PHCs (20.8%).
- **Importance of Health Camps**: Women across various contexts are differently integrated with the national public health infrastructure and policies. Health camps, which are periodically organized in villages, are specifically important and needed in areas which are remote and cut-off or where Sub-centers are not available. All EAMW in Maharashtra reported that health camps for adolescent girls are helpful. In fact,

Health Camps for adolescent girls emerged as the most availed service wherein 209 women (n=351) from Beed and 170 (n=226) from Osmanabad reported having participated in (during their youth) and benefited from health camps for adolescents. If health camps start covering the wellbeing of EAMW in remote and isolated areas, women will stand to benefit from many health based objectives and parameters of the Indian government.

Our survey revealed that women are well familiar with the local state services they get from the public health system. The proportion of women covered under schemes such as Janani Suraksha Yojana (JSY), Pradhan Mantri Matru Vandana Yojana (PMMVY) and Janani Shishu Suraksha Karyakram (JSSK), however varies in both the districts and remains towards the lower side. However, once/ if they become familiar with the schemes, women tend to become reliant on these benefits because of their socio-economic marginalisation as well as remote existences.

COUNSELING ON MHM:

Upon being asked if they ever received any counseling on menstrual health, 87.2% of our interviewees from Beed and Osmanabad responded in the affirmative. Counseling on MHM was received from health workers such as ASHA, ANM and AWW.

Received counseling on Menstrual Hygiene from health workers	Beed (in %)	Osmanabad (in %)
Total Respondents	**351**	**226**
No	9.7	17.4
Yes	90.3	82.6

Yes: Upon being asked if they ever received any counseling on menstrual health, 87.2% EAMW responded in the affirmative. Counseling on MHM was received from health workers such as ASHA, ANM and AWW. Out of the total respondents, 90.3% EAMW from Beed (n=351) and 82.6% from Osmanabad (n=226) reported that they seek counseling, guidance, and treatment on health issues from the public healthcare facilities

No: In Maharashtra 74 women, out of a total of 577 had never received counseling on menstruation or MHM in their villages.

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

4. VOICES, EXCERPTS AND OBSERVATIONS

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

these grassroots voices help us arrive at community-sensitive and area-specific recommendations and ways forward. Highlights from these interviews are as follows:

Beed (Data derived from 5 villages of the district): In Beed, five respondents across five villages stated that communities suffer gross water scarcity. Two respondents spoke about the dearth of awareness efforts on MHM amongst the EAMW in the villages. Four respondents confirmed that taboos related to menstruation in the village are widely prevalent.

Osmanabad (Data derived from 5 villages of the district): In Osmanabad two respondents across five villages apprised us on the issue of water scarcity faced by them, two others added that their villages suffer acute water shortages. Lastly, key informants apprised us that no awareness generation initiatives are run for EAMW. in the wake of which the districts witness ample taboos around menstruation

4.1 VOICES, EXCERPTS AND OBSERVATIONS OF RESPONDENTS: BEED

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

Sunita (Interview: 24.08.2022)[2] , an **ASHA** worker from a village in Beed district of Maharashtra stated sanitary pads are distributed at subsidized rates for girls aged between 10 yrs-19 yrs, *Matritwa Yojana* and *Janani Suraksha Yojana* for 20-49 age women. Moreover, counseling sessions are given to adolescent girls with SHGs under *Rashtriya Kishori Suraksha Karyakaram (*RKSK). She further said there is a need to educate women about the importance of menstrual hygiene and sensitize them about the risk and kinds of diseases and / or infections that occur if hygiene is compromised. On WASH in her village and the school therein, the ASHA worker informed that people use water filters and *fitkari* (alum) to clean water. A makeshift sewer, a kind of a *gadda* (deep pit) for waste water accumulation in the village has been dug but no proper sewage facility is given. A sanitary pad disposal machine exists in the village school. Myths and taboos in her area disallow women to visit/ enter religious places.

Rekha (Interview: 24.08.2022)[3], who is a **CRPF** officer in a village in Beed district of Maharashtra confirmed that sanitary pads were distributed at a subsidized rate. Moreover, her village had an awareness program to teach women about using pads during menstruation under the RKSK scheme. On WASH needs in village and school she added that villagers use filters and alum to clean the drinking water, there is a deep pit or a 'gadda', for waste water in the village. From her account, it was not clear if women's WASH needs stand fulfilled throughout the year. Taboos regarding menstruation in the village such as isolation practices within the house and women neither being allowed to cook for daily or ritualistic food nor being allowed to enter religious places were common occurrences according to Rekha.

Kusum (Interview: 24.08.2022)[4], an **ASHA** worker in the village of Beed district in Maharashtra responded that there is an SMD programme for adolescent girls as well as an awareness programme to sensitize women about menstrual hygiene under the RKSK scheme. She stated that villagers use filters and alum to clean water. The school in the village had a functional sewage system. She expressed concerns on the urgency to educate women on menstrual hygiene. On taboos, she added women in her village were not allowed to enter religious places or touch anything religious. Women are segregated and isolated during menstruation. However, she added women would feel better if they do not isolate themselves during menstruation.

Morale (Interview: 28.08.2022)[5], a **Health Worker** in a village in Beed district of Maharashtra stated that there is distribution of sanitary pads to adolescent girls in the village, and regular health check-ups for women aged 20-49. Moreover, public health centers trained women about menstrual hygiene through posters and charts. Under *Rashtriya Kishori Suraksha Karyakaram* (RKSK) there was regular Hemoglobin test for girls and free

[2] MH KII1 BD: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[3] MH KII2 BD: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

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

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

distribution of oxifolid tablets. On WASH needs in school and community she explained, every school had water facility, girls were taught about using pads during menstruation, schools also had pads dispose machines. Moreover, schools were asked to allocate a separate room for pad changing. On taboos she added that girls were being isolated in dark rooms during menstruation, and not allowed to go to school till 4 days.

Alka (Interview: 22.07.2022)[6], a **Social Worker** from a village in Beed district of Maharashtra confirmed that there is free distribution of sanitary pads, iron, and folic acid tablets to women in the village. On WASH needs she explained there is an installation of a water filter by Gram panchayat in the village and their school also had a water (filter) and toilet facility. She added the need to educate women about cleanliness and using sanitary pads during menstruation was an urgent necessity. On taboos, Alka stated women were not allowed to enter temples and had to isolate themselves during menstruation. Alka thinks that customs such as four-days segregation for menstruating women, eating healthy food, and not lifting weight form good practices from a local MHM perspective.

4.2 VOICES, EXCERPTS AND OBSERVATIONS OF RESPONDENTS: OSMANABAD

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

Manisha (Interview: 23.08.2022)[7] , an **An Anganwadi worker** in a village in Osmanabad district of Maharashtra added that there is a health camp in village's Anganwadi to educate women about using pads during menstruation under RKSK scheme. For women between 20-49 years of age, proper toilets, adequate water supply and purity, proper awareness about menstruation in the village were basic requirements. She further added that their village and school therein had adequate water facility, but from her account it was not clear if women's WASH needs were fulfilled throughout the year. On taboos regarding menstruation she added, women were not allowed to do household work, remained isolated and were treated as if they were guilty of a sin or crime, which 'does no good to women's mental health'.

Kanchan (Interview: 28.08.2022)[8] who is an **ASHA worker** in a village in Osmanabad district of Maharashtra stated that there is a health camp to educate girls about menstruation hygiene in the village. She further added that the village needed a toilet, water facility, and an awareness program for 20-49 age women in the village. On WASH needs in the village and school she explained that the village had adequate water facility and a pad disposal machine. The school also had a water supply and a toilet but improvements were needed. About specific requirements regarding MH, she added, "everything is going well here but there is a need to educate people about menstruation." She added there were some taboos in the village such as isolating menstruating women and prohibiting them to see images of God or doing household work. In general, menstruating women are behaved badly with, treated almost as if guilty of something and face high discrimination which is not good for their 'psyche'.

4.3 SALIENT FINDINGS FROM DATA

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

In Maharashtra, our findings indicate that menstruating girls and women are taken care of by other family members. The EAMW understands the phenomenon of menstruation with a biological clarity. Nonetheless, social, interpersonal and inter-sectoral factors can present various context-specific challenges and ironies in the way of effective menstrual wellbeing in Beed and Osmanabad.

In Beed, although no awareness generation programmes are run by the government targeting EAMW, majority

[6] MH KII6 BD: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[7] MH KII1 OD: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[8] MH KII2 OD: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

of our respondents seem to have adequate knowledge on menstruation while in Osmanabad almost all women are aware of the causes of menstruations, its intervals and internal body parts involved in it. What is however surprising is that despite so much knowledge on menstruation, women remain out of sync with their well-being requirements in places of work be it farms, mines or manufacturing units. At home, their situation is equally distressing as the EAMW follow myths and taboos in large numbers.

Our key informants noted that during menstruation a woman was segregated, isolated as well as discriminated against as if she were guilty of a crime. This explains the silence or hushed (mis) conceptions on the relevance of 'uterus' post-childbirth, and the high prevalence of elective hysterectomies in districts such as Beed and Osmanabad. Young girls hardly get the benefit of informed elder women, who know the scientific causes of menstruation, as in many villages under this research menstruating adolescents were confined to dark rooms for four days and not allowed to go to school.

One of the main everyday challenges for migrant families of Beed and Osmanabad emerged to be compromised access to water facilities and proper sanitation. More than 90% of women from both the districts reported piped water as being their primary water source. However, Beed and Osmanabad fall under rain-fed areas. During drought and drought-like situations, these districts face acute water scarcity making villages supply potable water through tankers. In such circumstances, despite having a high level of knowledge on menstruation, in the context of MHM, women continue to face hardships for MHM and WASH purposes.

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

4.4 RECOMMENDATIONS/ AREAS OF IMPROVEMENT

IMMEDIATE

1. **Empower EAMW on MHM themes:** According to our findings, discrimination, segregation as well as isolation and judgmental attitude from family and community creates a mental health burden for women and girls in their menstruating years. Hence social support systems, counseling to create public awareness on social-biological knowledge around menstruation can bring relief and ease the myths, taboos and pressures around menstruation. Hence, we suggest more awareness drives on menstruation, with a special focus on EAMW in the age group of 20 to 49 years. Monthly or three-monthly compulsory and inclusive health check-ups be organized for EAMW.
2. **Early MHM Interventions:** Since young menstruating girls are not allowed to go to school for four to five days during menstruation, teachers and school counselors, social workers and Frontline Workers (FLWs) themselves need to be oriented, attain voice as well as be motivated to: a) collaborate with each-other as well as jointly raise awareness among community elders and village households; b) proactively ensure

that school sanitation facilities are monitored regularly c) help raise awareness for adolescent girls for a better MHM at home and in schools such that her education be uninterrupted and menstruation is not (seen as) a hurdle in the way of going to school.

3. **Pad distribution schemes and disposal mechanisms** need to be facilitated, regularized, monitored, and revised (as need be) for sustained use as well as orientation and empowerment of women.

SHORT TERM

4. **Sanitation Facilities for Migrant families at relocated sites:** Better hygiene as well as sanitation management is required so that MHM can be given a real and regular opportunity in day –to –day life in villages as well as in areas to which migrant workers relocate. Organized shelter and settlements with provision of safe drinking water along with low cost two pit latrines could be built for the migrant workers at relocated areas along with addressing their WASH and menstrual needs.

5. **Micro- Credit facilities to MAVIM SHGs**: Women Self Help Groups (SHGs) formed under Mahila Arthik Vikas Mahamandal (MAVIM) are active in Beed and Osmanabad. Providing credit facilities to EAMW through MAVIM and other government supported credit schemes could enhance the earning capacities and therefore create a pool of disposable income whereby menstruating women can become active decision makers in self-care.

LONG TERM

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

7. **MHM at District, Block, Gram Panchayat Level**: Information, Education, and Communication (IEC) for menstrual hygiene education and awareness that includes information around safe menstrual hygiene products; and menstrual waste management with safe disposal facilities.

8. **Inter- Districts Coordination:** To ensure the health and MHM wellbeing of EAMW, the districts may develop communication, dissemination as well as monitoring mechanisms between administrative authorities in areas of origin and destination of migrants' families. This would ensure appropriate mapping of migrants and disbursement of entitlements to EAMW as well as their children.

9. **Gender Mainstreaming Provisions for EAMW**: Build capacities and knowledge of women from poor, marginalized households to make the migrating families aware of their entitlements in the unorganized sector related to seasonal agricultural and wage labour work. For instance, enablers such as, provision of rationing through Public Distribution System (PDS) in areas where migrants temporarily relocate; continuation of education/ schooling of migrant children in areas where parents migrate for seasonal labour; health camps for general medical check-ups; a special focus on EAMW because women labourers from the sugarcane farming belt suffer various atrocities w.r.t menstruation and uterine health - should all be part of the support systems around migrant labour.

10. **MHM at Family level:** Ensure sustainable water source (preferably gravity schemes as per viability that are low on operations and maintenance) along with source strengthening measures and provision of Functional Household Tap Connections (FHTCs) to all households under National Jal Jeevan Mission scheme.

11. **Jal Jeevan Mission (JJM) for Institutions and MHM:** Institutional water supply under JJM scheme to ensure supply of adequate running water in girl's toilets in schools.

12. **MHM friendly Toilets:** Ensure provisioning of community toilets as well as toilets in work areas with washing areas, bathing cubicles, and running water under SBM(G) phase II where needed.

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ANNEXURE I

Reasons for selection of villages

#	District	Block/ Ward	Gram Panchayat/ Ward	Village
1	Beed	Kaij	Yewta	Yewta
2	Beed	Kaij	Wida	Wida
3	Beed	Kaij	Yusuf Wadgaon	Yusuf Wadgaon

#	District	Block/ Ward	Gram Panchayat/ Ward	Village
4	Beed	Kaij	Surdi	Surdi
5	Beed	Kaij	Lavhari	Lavhari
6	Osmanabad	Kalamb	Diksal	Diksal
7	Osmanabad	Kalamb	Bangarwadi	Bangarwadi
8	Osmanabad	Washi	Pimpalgaon Lingi	Pimpalgaon Lingi
9	Osmanabad	Washi	Lakhangaon	Lakhangaon
10	Osmanabad	Washi	Para	Para

Criteria/ Reasons for selection of villages in Beed district

Sr. No	Block/TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (refer JJM/ SBM data)	Total Households	Prevailing social issues/ issues of inclusion/ etc.
01	Kaij	Yewta	3882	776	High seasonal migration, high children drop out from school due to seasonal migration, high unemployment rate amongst youth, limited livelihood options in the area, agriculture is completely dependent on rainfall
2	Kaij	Wida	5030	1010	High seasonal migration, high children drop out from school due to seasonal migration, high unemployment rate amongst youth, limited livelihood options in the area, agriculture is completely dependent on rainfallpletely dependent on rainfall
03	Kaij	Yusuf Wadgaon	4947	1000	High seasonal migration, high children drop out from school due to seasonal migration, high unemployment rate amongst youth, limited livelihood options in the area, agriculture is completely dependent on rainfall
04	Kaij	Surdi	1681	340	High seasonal migration, high children drop out from school due to seasonal migration, high unemployment rate amongst youth, limited livelihood options in the area, agriculture is completely dependent on rainfall
05	Kaij	Lavhari	3324	665	High seasonal migration, high children drop out from school due to seasonal migration, high unemployment rate amongst youth, limited livelihood options in the area, agriculture is completely dependent on rainfall

Criteria/ Reasons for selection of villages in Osmanabad district

Sr. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (refer JJM/ SBM data)	Total Households	Prevailing social issues/ issues of inclusion/ etc.
1	Kalamb	Diksal	9361	1932	Employment Opportunities, Serious Issues of Employment of Landless, Disadvantaged Children, Issues of Single Women, Sanitation
2	Kalamb	Bangarwadi	1275	288	There is a need to promote agro-based businesses, provide employment opportunities to the youth, issues of single women, business opportunities and its skills, information on various government schemes should be disseminated to all stakeholders,
3	Washi	Pimpalgaon Lingi	2415	594	Employment Opportunities, Serious Issues of Employment of Landless Disadvantaged Children, Issues of Single Women, Sanitation
4	Washi	Lakhangaon	1933	455	Single women's issues, premises cleanliness, employment opportunities and skills development
5	Washi	Para	4287	934	There is a need to promote agro-based businesses, provide employment opportunities to the youth, issues of single women, business opportunities and its skills, information on various government schemes should be disseminated to all stakeholders,

ANNEXURE II

Important Women-Centric Schemes in Maharashtra

- *Asmita Yojana:* It was *launched* by Ms Pankaja munde (BJP), Minister of Rural, Women, and Child Development in March 2018 under the Ministry of Rural, Women, and Child Development, Government of Maharashtra. This program is for rural women and adolescent girls (between the ages of 11 and 19 years of age) who attend Zilla Parishad school. A bundle of eight sanitary napkins would be offered at a discounted rate of 5 INR to adolescent females. A subsidy of 15 INR per package is also available.
- *Manjhi Kanya Bhagyashree Scheme* Started in 2017 under the chief minister Shri Devendra Fadnavis (BJP), this scheme is implemented by the Department of Women and Child Development of the Government of Maharashtra. Under this scheme, Govt. shall provide Financial Assistance as follows:
  - (a) One Girl Child: 50,000 INR for a period of 18 years
  - (b) Two Girl Children: 25,000 INR each on the name of both the Girls
  - (c) Benefits applicable only to the Families having yearly income up to 7.5 Lac INR and only after submission of Family Planning Certificate.

- *Manodhairya Scheme.* The scheme was started in 2013 by the chief minister Shri Prithviraj Chavan (INC) under the Department of Women and Child Development, Government of Maharashtra. The aim of the scheme is rehabilitation of victims of Rape and Acid Attacks (women and children) by providing them Financial Assistance. The Women and Child Development Department is implementing the Manodhairya Scheme in the State under which financial Assistance of 1 Lac INR and in special cases 10 Lac INR is provided to the victims. Based on the requirement, Rehabilitation of victims and their dependents by way of shelter, counseling, medical and legal support, Education and Vocational Education is carried out.
- *Rajmata Jijau Mother-Child Health and Nutrition Mission; The* first phase of this scheme started in 2005 by the chief minister Shri Vilasrao Deshmukh (INC) under the Ministry of Women and Child Development, Government of Maharashtra. The Role of the Mission includes the following:
  (a) Advocacy regarding the importance of the first 1000 days.
  (b) Acting as a 'think tank' and to give policy advice to the government regarding evidence-based interventions.
  (c) Achieving convergence between different departments with the common objective of reducing malnutrition.
- *Kishori Shakti Yojana:* It was started by the Government of India in 1991 under the Ministry of Women and Child Development, Government of India. The aim is to impart health and hygiene education, awareness & training to adolescent girls regarding the bad effects of early marriage to avoid frequent child births, need for balanced diet, consumption of green vegetables etc.