TATA TRUSTS

Final Report

Baseline Assessment:

Menstrual Health & Hygiene Management Programme

July 2024

Study Name

Baseline Assessment: Menstrual Health and Hygiene Management Programme

Study Duration

February 2024 – June 2024

Study Location

Assam, Maharashtra, Uttar Pradesh and Rajasthan

Study Conducted by:

Athena Infonomics India Private Ltd

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Study Commissioned by:

TATA TRUSTS

Submitted by Athena Infonomics India Private Limited (AIIPL) July 2024

ABOUT TATA TRUSTS

Since inception in 1892, Tata Trusts — India's oldest philanthropic organisation — have played a pioneering role in bringing about an enduring difference in the lives of communities across the country. Guided by the principles and the vision of proactive philanthropy of Tata group founder Jamsetji Tata, the Trusts' purpose is to catalyse development in the areas of health, nutrition, education, water, sanitation and hygiene, livelihood, digital transformation, migration and urban habitat, social justice and inclusion, environment and energy, skill development, sports, and arts and culture. The Trusts' interventions, achieved through a strategic mix of direct implementation, partnerships and grant making, are made sustainable by technology, advocacy and community engagement.

ABOUT TATA WATER MISSION

Tata Water Mission (TWM) is a programme initiated by the Tata Trusts in 2015 to tackle the country's water crisis with a multi-pronged approach. The Mission aims to address the critical need for Water, Sanitation and Health (WaSH), including menstrual health.

The Tata Water Mission team aims for sustainable change at scale by using the traditional strengths of community mobilisation and capacity building, along with the power of innovative approaches and technological solutions.

Today, Tata Water Mission has a direct presence in 15 Indian states that have been identified as having high-to-extremely-high water stress areas. The programmes cover more than 5,500 villages and benefit around four million people through initiatives for safe drinking water, assured water sources, improved sanitation services and hygiene practices.

This report aims to document valuable findings, learnings and experiences of the Tata Water Mission's interventions for Menstrual Health & Hygiene Management in several Indian states.

ACKNOWLEDGEMENT

This report presents the findings from the baseline study conducted on the Menstrual Health and Hygiene Management Programme (MHHMP) across seven districts of Assam, Rajasthan, Maharashtra, and Uttar Pradesh. The research aimed to understand the Knowledge, Attitude, and Behavior of the community members regarding Menstrual Health Management and to understand the various enablers and barriers to it. The current study captured various indicators around MHHM and benchmarked the key outcome indicators for the planned intervention.

The team conducting the study wishes to acknowledge the contribution and support of all those involved in this operational research. The team especially wishes to acknowledge Mr. Divyang Waghela (Head, WaSH), Dr. Tanvi Aher (MHM – Lead, WaSH), Mr. Paresh J M (Senior Manager, Analytics, Insights & Impact), Mr. Dnyanesh Renguntwar (Manager, Analytics, Insights & Impact), Mr. Niteen Nadkarni (Manager, Analytics, Insights & Impact), and Ms. Aakansha Vaishya (Assistant Manager, Analytics, Insights & Impact) from Tata Trusts without whose valuable input this study would not have been completed.

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LIST OF ACRONYMS

AG	Adolescent Girls
AKF	Aga Khan Foundation
APPL	Amalgamated Plantation Private Limited
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Heal Activist
AW	Adult Women
AWC	Anganwadi Centres
AWW	Anganwadi Workers
CAPI	Computer Aided Personal Interviewing
CHC	Community Health Centre
FGD	Focused Group Discussion
FLW	Front Line Workers
GoI	Government of India
ICDS	Integrated Child Development Services
IDI	In Depth Interview
IEC	Information Education Communication
INGO	International Non-Governmental Organization
KAP	Knowledge Attitude and Practice
KII	key Informant Interview
KSWDC	Kerala State Women's Development Corporation
MHM	Menstrual Health Management
MHP	Menstrual Health Policy
MHP	Menstrual Health Policy
MoHFW	Ministry of Health and Family Welfare
MoHRD	Ministry of Human Resource Development
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NHM	National Health Mission
NSDP	National Skill Development Programme

LIST OF ACRONYMS (CONT.....)

PHC	Primary Health Centre
PRI	Panchayati Raj Institutions
PSU	Public Sector Undertaking
RGSEAG	Rajiv Gandhi Scheme for Empowerment of Adolescent Girls
RKSK	Rashtriya Kishor Swasthya Karyakram
RTI	Reproductive Tract Infection
SABLA	Scheme for Empowerment of Adolescent Girls
SBA	Swachh Bharat Abhiyan
SBM-G	Swachh Bharat Mission (Gramin)
SDG	Sustainable Development Goals
SHGs	Self Help Group
SMC	School Management Committee
SMKC	Sustainable Menstruation Kerala Collective
SPSS	Statistical Package for Social Sciences
SRHR	Sexual and Reproductive Health Rights
SWOT	Strength Weakness Opportunities and Threats
TEDT	Tata Education and Development Trusts
TWM	Tata Water Mission
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UTI	Urinary Tract Infections
WASH	Water Sanitation and Hygiene
WIFS	Weekly Iron-Folic Acid Supplementation

EXECUTIVE SUMMARY

The baseline assessment conducted by Athena Infonomics India Private Limited provides a comprehensive overview of the Menstrual Health and Hygiene Management Programme (MHHMP) across Assam, Maharashtra, Uttar Pradesh, and Rajasthan. Commissioned by Tata Trusts the study aims to understand the knowledge, attitudes, and practices (KAP) related to menstrual health among adolescent girls and adult women, benchmarking key indicators for the planned intervention.

Project and Study Overview:

The Menstrual Health and Hygiene Management Programme (MHHMP) by Tata Trust seeks to address socio-cultural and infrastructural barriers to safe and effective menstrual health management (MHM). The key activities that the project envision are as follows:

- Awareness and Addressing Gender Inequitable Norms
- Access
- Hygienic Use
- Menstrual Waste Management
- Capacity building of stakeholder and policy advocacy
- Awareness and Addressing Gender Inequitable Norms

Before implementing the project, the Tata Trust team wanted to understanding the KAP of the target beneficiaries (AWs and AGs), their culture, belief, challenges and existing infrastructure and resources and in order to benchmark the project indicators at the baseline level for monitoring and evaluation purpose. The baseline study, conducted between May and June 2024, covered seven districts across the four states, focusing on both quantitative and qualitative data collection methods.

Respondent Demographics:

The study surveyed 755 adolescent girls (AGs) and 749 adult women (AWs). Among AGs, 24.9% were up to 14 years old, 64.1% were aged 15 to 17 years, and 11.0% were between 17 to 19 years. For AWs, 40.6% were aged 18 to 28 years, 44.9% were between 29 to 38 years, and 10.5% were in the 39 to 49 years category. In addition to this 57 FLWs and 59 Teachers were also interviewed to understand their approach and practice towards MHM across the study districts.

Baseline Insights:

1. **Menstrual Hygiene Practices:** 53% of AGs and 52% of AWs reported using sanitary napkins, while 41% of AGs and 44% of AWs used cloth. Disposal methods varied, with 35% of AGs and 36% of AWs burying used materials in soil and 36% of AGs and 34% of AWs burning them. Most respondents dried reusable menstrual cloths in sunlight (61% AGs, 50% AWs), although some preferred covering it (38% AGs, 42% AWs).
2. **Hygiene Awareness and Practices:** About 78% of AGs and 84% of AWs approved of washing menstrual cloth with soap and water. Drying cloths in the sun was preferred by 73% of AGs and 81% of AWs. However, approval rates for attending social functions during menstruation were lower, at 50% for AGs and 49% for AWs, and only 10% of AGs and 8% of AWs approved of visiting religious places during menstruation.
3. **Impact on Daily Life:** Menstruation affected the daily activities of 53% of AGs and 52% of AWs. Around 33% of AGs and 40% of AWs reported missing school or work due to menstruation. Comfort levels in discussing menstrual health with family were high, with 85% of AGs and 81% of AWs feeling comfortable.

4. **Social Norms and Restrictions:** Significant social restrictions were observed, with 41% of AGs and 44% of AWs reporting an inability to participate in religious activities during menstruation. Restrictions were also noted for entering the kitchen (20% AGs, 22% AWs) and cooking food (22% AGs, 25% AWs).
5. **Income and Occupation:** Among AWs, 18% were involved in income-generating activities, with an average monthly income of ₹5633. Occupations varied, with 50% being daily wage earners, 25% involved in farming, and 10% engaged in trade.
6. **Knowledge and Awareness:** Awareness of reproductive tract infections (RTIs) was low, with only 11.7% of AGs and 16.3% of AWs being aware. Additionally, knowledge regarding the environmental impact of improper disposal of menstrual products was limited, with only 16% of AGs and 13% of AWs aware of water contamination risks.

Benchmarking of key indicators:

	Programme Indicators	Baseline Question	BL-AG (Baseline-Adolescent Girls)	BL- AW (Baseline-Adult Women)
Impact	Percentage of AGs and AWs considering menstruation impure	B3. Do you know what menstruation is? (Option-Shedding of impure blood)	43.7%	43.4%
	Menstruating female can cook food	C3. Can you cook food while menstruating?	54.6%	54.1%
	Menstruating female can visit temple/ mosque/Church	C3_1. Can you offer prayers or visit temple/mosque/church while menstruating?	13%	13%
	Awareness of RTI	E15.Are you aware about Reproductive Tract Infection (RTI)?	11.7%	16.3%
	Health seeking behaviour pertaining to RTI	E 17. Have you ever sought treatment for reproductive tract infection?	13.6%	26.2%
Output	Washing reusable products with soap and water	D18 - How do you clean your menstrual hygiene products? (Option- Soap and Water)	93.5%	93.1%
	Drying reusable products under direct sunlight	D19. If you are using cloth, how do you dry the cloth? (Option: Directly under sunlight)	38.8%	36.1%
	Frequency of changing absorbent	D17. How often do you change your menstrual hygiene products during your period in 24 hours? (Option 3 times)	33%	31.60%
	Hand wash after Changing absorbent	B12.What are the good hygiene practices that a girl/women should adopt during menstruation? (Option-Wash hands with soap and water before and after changing absorbent)	27.5%	26.8%

	Programme Indicators	Baseline Question	BL-AG (Baseline-Adolescent Girls)	BL- AW (Baseline-Adult Women)
	Use of clean menstrual absorbent (quantitative)	D11. 1.Use and Throw Sanitary Pads	91.3%	73.8
		2.New cloth washed and reused	20.9%	23%
		3.Old cloth (saree or used cloth etc.) every time	16%	23.90%
		4.Tampons	1.70%	0.80%
		5. Menstrual cup	4.80%	2.70%
	Percentage of AGs and AWs talking to health care providers on symptoms related to menstrual	D10. How do you manage pain and discomfort during menstruation?	4%	4.80%
	Increase in number of healthcare providers, teachers, FLWs with enhanced awareness levels on MHM	C2./E2. Have you received any formal training on Menstrual Hygiene Management?	42.1% (FLWs)	28.8% (Teachers)
	Number of women and girls trained to stitch cloth pads	E4. Have you received any training for stitching and making cloth-based pads?	1.60%	4.4%
	Number of schools with functional MHM friendly toilets	E10. Does the school toilet contain appropriate latches, hooks and shelves that facilitate changing and cleansing of absorbents	76.9%	NA

Recommendations:

A. Enhance Awareness and Education on Menstrual Health and RTIs

1. Develop and implement comprehensive educational programs targeting both adolescent girls and adult women.
2. Include RTI awareness and menstrual hygiene management in school curricula and community health programs.
3. Conduct regular workshops and training sessions for FLWs and Teachers to ensure they have the latest information and skills to educate their communities.

B. Strengthen School Based Intervention for Menstrual Hygiene Management

1. Provide adequate sanitary facilities in schools, including clean toilets, water, soap, latches, hooks, and shelves.
2. Implement school health programs that include menstrual hygiene education and support systems.
3. Train Teachers and school staff to create a supportive environment for girls during their menstrual periods.

C. Promote Access to Healthcare for Menstrual Health Issues

1. Establish accessible healthcare facilities where women and girls can seek treatment for menstrual health issues without fear of stigma.
2. Train healthcare providers to offer sensitive and non-judgmental care for menstrual health issues.
3. Conduct community health campaigns to raise awareness about the importance of seeking treatment for RTIs.

D. Adress Cultural Barriers and Stigma Around Menstruation

1. Conduct community engagement programs to challenge and change cultural beliefs and societal stigma around menstruation.
2. Involve community leaders, parents, and other key influencers in promoting open discussions about menstrual health.
3. Use mass media campaigns to normalize menstruation and reduce stigma

E. Support and Train FLWs and Teachers

1. Develop and provide comprehensive training programs for FLWs and Teachers on menstrual health and hygiene.
2. Equip FLWs and Teachers with educational materials and resources to support their community outreach efforts.
3. Establish peer support networks for FLWs and Teachers to share experiences and best practices.

F. Improve Menstrual Hygiene Infrastructure

1. Invest in upgrading and maintaining sanitary facilities in schools and communities.
2. Ensure that toilets are equipped with essential amenities such as water, soap, latches, hooks, and shelves.
3. Regularly monitor and evaluate the condition of sanitary facilities to ensure they meet the required standards.

G. Monitor and Evaluate Progress

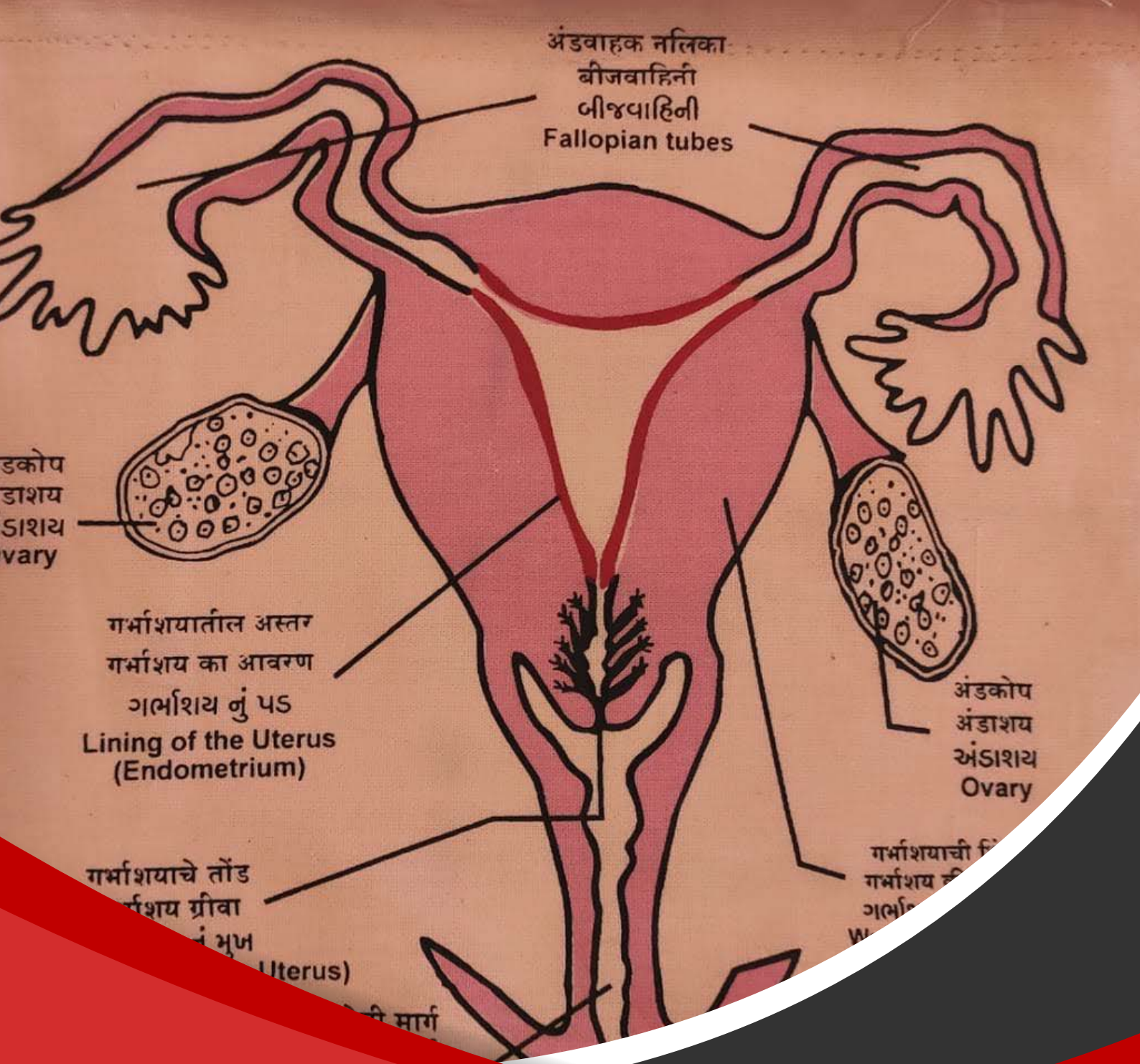
1. Develop and implement a comprehensive monitoring and evaluation framework for MHM interventions.
2. Set clear benchmarks and indicators to measure improvements in awareness, practices, healthcare-seeking behavior, and impact on daily activities and school attendance.
3. Conduct regular evaluations to assess the effectiveness of interventions and make necessary adjustments.

H. Foster Collaboration and Partnership

1. Actively engage with various stakeholders to enhance the partnership and work towards introducing synergy in the efforts of all stakeholders.

I. Adopt state specific strategies to address challenges around MHM

1. Develop strategies on MHM adoption during disaster/flood situations.
2. Integrate MHM within the disaster management and rehabilitation strategies to enable the adoption of correct MHM practices during displacement.



01

Menstrual Hygiene Management (MHM) Landscape in India

1. MENSTRUAL HYGIENE MANAGEMENT (MHM) LANDSCAPE IN INDIA

1.1 Overview of MHM in India and Study States

This section of the report provides a detailed analysis of the MHM landscape in India, focusing on key challenges, policies, and initiatives. The concept of MHM is critical to the UN SDGs (Sustainable Development Goals), as Goal 6.2 of the Sustainable Development Goals advocates explicitly for "access to adequate and equitable sanitation and hygiene for all paying special attention to the needs of women and girls and those in vulnerable situations."

Menstruation is a normal physiological phenomenon that women and adolescent girls experience every month. The ability to manage menstruation hygienically is fundamental to the dignity and well-being of women and constitutes an integral component of basic hygiene, sanitation, and reproductive health services. Menstrual Hygiene Management (MHM) is defined[1] as the "use of clean menstrual material to absorb or collect blood that can be changed in privacy as often as necessary for the duration of the menstruation period, using soap and water for washing the body facilities as required and having access to dispose of used menstrual management materials." MHM is critical for ensuring that women and girls can manage their menstruation with dignity, safety, and privacy. Poor menstrual hygiene can pose serious health risks, like reproductive and urinary tract infections, and in future, it may result in infertility and birth complications. Neglecting to wash hands after changing menstrual products can spread infections, such as hepatitis B and thrush[2]. India is home to the largest number of adolescents in the world; nearly one-fourth of its total population[3] (Census, 2011). Hygiene-related practices during menstruation are of considerable importance as effective MHM significantly affects education, economic opportunities, and social engagement. A testimony to that would be the introduction of MHM labs at 500 general schools and 200 Kasturba Gandhi Balika Vidyalaya (KGBV) where students have access to healthcare services during periods which significantly improved their attendance.[4]

India is a vast country with lots of cultural and regional differences. Therefore, the knowledge, attitude and practice of women across the country vary a lot in the context of MHM. In the Indian context, approximately 54.5 per cent of the female population is in the reproductive age of 15-49 years and requires access to safe menstrual hygiene practices.[5] Adolescent females represent a vulnerable demographic with regard to both their health and social standing. Menstrual Health Management is something which is still stigmatized in our society, and people generally don't openly discuss the issues pertaining to it. Menstruation has always been surrounded by taboos and myths in India that exclude women from many aspects of socio-cultural life. Such taboos about menstruation present in many societies impact on girls and women's emotional state, mentality and lifestyle and, most importantly, health[6]. Menstruation is,

1. Sommer M, Sahin M. Overcoming the taboo: Advancing the global agenda for menstrual hygiene management for schoolgirls.
2. https://www.worldbank.org/en/topic/water/brief/menstrual-health-and-hygiene#:~:text=Poor%20menstrual%20hygiene%2C%20however%2C%
3. https://india.unfpa.org/sites/default/files/pub-pdf/AProfileofAdolescentsandYouthinIndia_0.pdf
4. https://timesofindia.indiatimes.com/city/ranchi/70-of-state-schools-have-menstrual-hygiene-facilities-says-education-dept/articleshow/100562558.cms
5. Census 2011
6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4408698/

seen as impure or unclean in society. Almost every society on the planet has a cultural taboo around menstruation. It can appear as a feeling of uncleanliness, and the stigma that follows makes talking about periods, when it happens at all, euphemistic[7].

The National Family Health Survey (NFHS-5) provides a deeper understanding of menstrual hygiene practices among adolescent girls (15-24 years) in India. The data indicates a significant increase in the use of sanitary napkins among adolescent girls, from 41.8% in NFHS-4 to 64.4% in NFHS-5. Overall, 78% of adolescent girls use a hygienic method of protection during their menstrual cycle, up from 57.7% five years earlier[8]. Among these women only 64% use sanitary napkins, 50% use cloth, and 15% use locally prepared napkins.

Looking at the NFHS-5 data, Menstrual Health and Hygiene across the states of intervention varied; use of hygienic methods of protection during menstruation was reported low in Assam (67%), followed by Uttar Pradesh (72.9%), Rajasthan (84.3%) and Maharashtra (85.3%). Furthermore, the use of cloth as a protection against menstruation has been varied across the states with the highest adoption being in Uttar Pradesh (69.4%), followed by Assam (69.1%), Rajasthan (43.6%), and Maharashtra (26%).

If we examine the NFHS-5 dataset, the disparity between rural and urban areas becomes strikingly evident. The proportion of rural women using hygienic methods of protection during menstrual period is significantly lesser that the practice in urban areas. The following table provides the rural-urban segregation across the intervention states.

Table 1: Percentage of women using hygenic protection methods during menstruation (NFHS-5)

States	Urban	Rural
Assam	82.9	63.8
Maharashtra	90.2	80.1
Rajasthan	92.2	81.9
Uttar Pradesh	86.7	68.4
India	**89.4**	**72.3**

* *Source: NFHS-5 (2019-21) India Report*

The rural and urban divide at the national level is 17 percentage points, and across Assam and Uttar Pradesh, the difference is even above the national level, at 19 and 18 percentage points, respectively.

7. Cronje HS, Kritzinger IE. Menstruation: symptoms, management and attitudes in university students. Int J Gynaecol Obstet. 1991;35(2):147-50.
8. https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1945842#:~:text=The%20positive%20results%20of%20the,to%2078%20%25%20in%20NFHS%205%20

1.2 Key Challenges and Gaps in MHM

India's approach to MHM is evolving, with increasing recognition of its importance in public health and gender equality. However, significant gaps remain. Cultural stigmas, economic barriers, inadequate sanitation facilities, and limited education hinder effective MHM practices. In general, MHM is poor in India, with low levels of knowledge and many misconceptions, varied use of menstrual absorbents, and unhygienic practices among adolescent girls[9].

- **Cultural Taboos and Stigma:** Deep-rooted cultural norms view menstruation as impure, leading to restrictions on daily activities and social participation[10]. The deep-rooted cultural taboos and social stigmas around menstruation are not sufficiently addressed in policy frameworks. Women and girls face discrimination, isolation, and restrictions during their menstrual periods, affecting their physical and mental well-being[11]. In India, cultural and social influences appear to be a hurdle for the advancement of knowledge on the subject[12]. Cultural norms and religious taboos on menstruation are often compounded by traditional associations with evil spirits, shame and embarrassment surrounding sexual reproduction.[13] Based on the available evidence, it is important to follow a strategic approach for combating the myths and social taboos associated with menstruation in order to improve the reproductive health of adolescent girls and women. The first and foremost strategy in this regard is raising awareness among adolescent girls related to menstrual health and hygiene. Young girls often grow up with limited knowledge of menstruation because their mothers and other women shy away from discussing the issues with them. Adult women may themselves not be aware of the biological facts or good hygienic practices, instead passing on cultural taboos and restrictions to be observed [14].
- **Economic Barriers:** According to a 2014 United Nations Educational, Scientific and Cultural Organization (UNESCO) report[15] one out of every 10 menstruating youth misses school during their menstrual cycle due to lack of access to menstrual products and resources. 'Period poverty' is a continuing issue in India due to the cultural stigma surrounding menstruation. Period poverty involves a lack of access to sanitary products, menstrual education and hygiene and sanitation facilities necessary to properly manage menstruation.[16] High costs and limited availability of menstrual products, especially in rural areas, restrict access.[17] Despite initiatives to provide free or subsidized sanitary products, many girls and women, especially in rural and marginalized communities, still lack access to affordable and quality menstrual hygiene products. Furthermore, use of unhygienic alternatives, increased risk of infections, and school absenteeism among adolescent girls[18].
- **Infrastructure Deficiencies:** Lack of clean and private sanitation facilities in schools and

9. https://practicalactionpublishing.com/article/2742/unpacking-the-policy-landscape-for-menstrual-hygiene-management-implications-for-school-wash-programmes-in-india
10. https://unesdoc.unesco.org/ark:/48223/pf0000385512
11. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4408698/#:~:text=Many%20girls%20and%20women%20are,the%20rural%20girls%20during%20menstruation.
12. Menstruation related myths in India: strategies for combating it - PMC (nih.gov)
13. Menstrual Hygiene Management | SSWM - Find tools for sustainable sanitation and water management!
14. WaterAid Global
15. Teaching and learning: achieving quality for all | Global Education Monitoring Report (unesco.org)
16. Addressing Period Poverty in India - The Borgen Project
17. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10651805/
18. https://www.dfc.gov/investment-story/increasing-access-hygiene-products-women-india#:~:text=Limited%20access%20to%20affordable%20hygiene,quality%20of%20life%20and%20education.

public places hampers effective MHM[19]. There is a lack of adequate sanitation facilities, including clean and private toilets with running water and proper disposal mechanisms for menstrual waste in schools and public places. Many girls avoid attending school during menstruation due to inadequate facilities, leading to decreased educational attainment and participation[20].

- **Insufficient Focus on Disposal and Waste Management:** Inadequate infrastructure and policies for the safe disposal of menstrual waste led to environmental and health issues. Improper disposal methods, such as burning or burying, are adopted, which can harm the environment and public health[21]. There is insufficient national coordination of sanitary waste collection, disposal, and transportation, which are compounded by social stigmas associated with menstruation[22,23]. People who menstruate are then forced to develop their own strategies of disposing of period products, with detrimental consequences. Products are thrown into nearby fields and unused wells; flushed down toilets; buried; or burned in people's backyards. According to a study titled 'Menstrual Products and their Disposal,' India discards 12.3 billion or 113,000 tonnes of used sanitary pads each year, contributing to the country's already high levels of plastic pollution. (Ganesh and Rosencranz, 2020)[24]

  A study on 484 college going girls in Maharashtra reveals that the most (84%) common method employed by these girls for disposing sanitary napkins was dumping them in the bin. About 63% of them had no knowledge about incinerators or napkin burning machines[25]. Despite inadequate sanitary waste management being publicly acknowledged, little is being done on a national level to solve this issue[26].

- **Educational Gaps:** Insufficient education on menstrual health contributes to misinformation and poor practices[27]. Around the world, menstrual health and hygiene needs are being overlooked due to limited access to information, education, products and services, as well as inadequate facilities and inequalities. Millions around the world are even unaware or unprepared for menstruation before having their first period. Studies have shown that stigma related to menstruation remains widespread, with adolescents often feeling ashamed or unable to openly discuss the topic. This shame can affect their mental health and school attendance[28]. Insufficient integration of menstrual health education in school curriculums and lack of teacher training on the subject key reasons of gap in correct practices on the subject. This leads to perpetuation of myths and stigmas surrounding menstruation, leading to misinformation and negative attitudes[29].

- **Coordination and Implementation Challenges:** Lack of coordination between various government departments and between the government and NGOs, along with gaps in implementing existing policies. Fragmented efforts lead to inefficiencies and reduced impact of MHM initiatives[30].

19. https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1576629
20. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9051715/
21. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5838436/
22. Journal of Family Medicine and Primary Care (lww.com)
23. Socio-cultural aspects of menstruation in an urban slum in Delhi, India: Reproductive Health Matters: Vol 9, No 17 (tandfonline.com)
24. https://www.researchgate.net/publication/360285550_MENSTRUAL_WASTE_DISPOSAL_A_COMPARATIVE_STUDY_BETWEEN_TRIBAL_AND_NON-TRIBAL_COMMUNITIES_OF_SELECTED_DISTRICTS
25. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11000925/
26. Period product disposal in India: the tipping point - The Lancet Regional Health - Southeast Asia
27. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10898167/
28. Progress on drinking water, sanitation and hygiene in schools 2015-2023: special focus on menstrual health (who.int)
29. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5629899/
30. https://www.researchgate.net/publication/374090337_Challenges_Faced_by_the_Indian_NGOs_In_Present_Context

1.2.1. Status of Critical Data Points/Indicators

Table 2: Critical data points on MHM (secondary studies)

Indicators	Data	Source
Pre-menarche awareness	48%	"Menstrual hygiene management among adolescent girls in India: a systematic review and meta-analysis" Link: https://bmjopen.bmj.com/content/6/3/e010290
Adolescent girls aged 15 to 19 years reported utilizing cloths to meet menstrual needs	49.3%	https://rchiips.org/nfhs/NFHS-5Reports/NFHS-5_India_Report.pdf
90% of post-menarche girls were unaware of the necessity of washing menstrual cloths, and 86% felt unprepared, and 70% had low self-confidence	90% 86% 70%	https://www.frontiersin.org/journals/reproductive-health/articles/10.3389/frph.2022.1025376/full
Due to poor menstrual hygiene practices more than 70% of women are diagnosed with serious vaginal and urinary tract infections each year	70%	A_Study_on_Menstrual_Hygiene_Management_at_the_Bottom_of_Pyramid_in_India Link: https://www.researchgate.net/publication/352283708_A_Study_on_Menstrual_Hygiene_Management_at_the_Bottom_of_Pyramid_in_India
Out of a total of 122 girls, 68 (55.7%) girls used soap and water and the rest 54 (44.3%) used only water. Health issues faced during menstruation by adolescent girls	55% girls used soap and water for washing reusable cloth Abdominal pain (65.6%), back pain/ lower back pain (47.5%), weakness (31.1%), headache (15.6%), Vomiting (6.6%), nausea (38.5%), mood swings (18%), Mastalgia (3.3%)	Menstrual Hygiene Practices of Adolescent Girls in Rural Maharashtra Link: https://journals.sagepub.com/doi/10.1177/0971521520974879

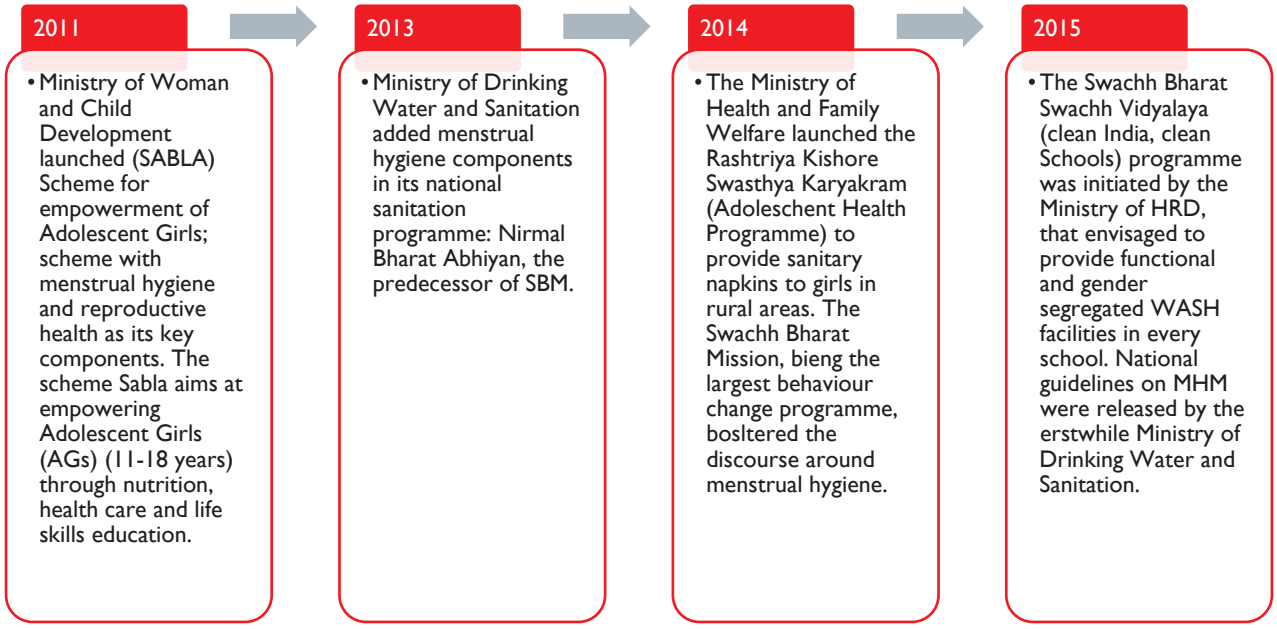
1.3. MHM Related Policies and Schemes

Menstruation has traditionally been surrounded by taboos and stigma in many Indian cultures. Practices often involved seclusion and restrictions on activities for menstruating women[31]. There were no formal policies or government-led initiatives focusing on menstrual health and hygiene. The issue of MHM gained traction only after 2000s in India with the NGOs and women health organisation making it an issue. In the early 2000s the initiatives focused on raising awareness about menstrual hygiene. In 2004 Mr. Arunachalam Muruganantham innovated low-cost sanitary napkins and introduced a machine to produce affordable sanitary pads at the grassroots. Post 2007, UNICEF and other INGOs started collaborating with local NGOs to promote MHM through school programs and community outreach. MHM has been receiving policy attention from the central government since 2011, with each ministry bringing its unique approach to addressing this cross-cutting topic.

31. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4408698/

The Figure below shows the timeline of initiatives undertaken by the government on a national level to prioritize and create awareness of menstrual health[32]. Several ministries such as the Ministry of Drinking Water and Sanitation, Human Resource Development (MoHRD), Health and Family Welfare (MoHFW), and Women and Child Development, contributed to the national policy and advocacy efforts in addressing school WASH needs in an equitable and gender-inclusive way by giving special emphasis to MHM. The nationwide launch of the Swachh Bharat Mission (Clean India Mission) in 2014 elevated the urgency to adopt an integrated approach to improve MHM for adolescent girls and women country-wide. The subsequent release of the National MHM Guidelines by the Ministry of Drinking Water and Sanitation (now renamed as Ministry of Jal Shakti) the year 2015 was a breakthrough in the policy landscape for gender and sanitation in India. A dedicated funding was allocated for MHM within the SBM budget for providing sanitary pads, creating awareness, and managing waste generated.

Figure 1: Genesis of MHM programming at National Level



The year 2011 also witnessed the launch of The National Menstrual Hygiene Scheme under the Ministry of Health and Family Welfare. This marked the first large-scale government initiative specifically targeting menstrual health. Distribution of subsidized sanitary napkins, education on menstrual hygiene, and training of health workers were the major components of the scheme. In between, several other schemes were launched to address the concerns of menstruating women and adolescent girls.

Recently in 2023 after consulting with all relevant parties, the Ministry of Health & Family Welfare developed a draft menstrual hygiene policy[33]. The draft policy on MHM 2023 emphasizes the need for comprehensive education, improved access to sanitary products, and the establishment of proper sanitation facilities. The proposed Menstrual Hygiene Policy (MHP) prioritizes underserved and vulnerable populations, ensures equitable access to menstrual hygiene resources, and addresses their

32. file (unicef.org)
33. https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1986698#:~:text=The%20draft%20Menstrual%20Hygiene%20Policy,to%20menstrual%20hygiene%20resources%20and

specific needs. It also guarantees comprehensive support throughout the entire menstrual journey, acknowledging the unique needs of individuals from menarche to menopause. The policy acts as a catalyst to dispel stereotypes, increase public understanding, and promote a culture that accepts menstruation hygiene as a healthy and normal aspect of life. The draft MHP seeks to advance the empowerment, well-being, and health of those who menstruate. The draft also discusses addressing the challenges associated with menstruation in the country. It also aligns with the SDG- Goal 3 (Good Health and Well Being) to which India is committed.

The Menstrual hygiene policy[34] - 2023 aims at:

- Ensuring access to affordable and safe menstrual hygiene products
- Promoting Quality Standards and Regulatory Framework
- Availability of Clean and Dignified Menstrual Hygiene Facilities
- Promotion of education and awareness on menstrual hygiene
- Collaboration with Non-Government Sector/ Engagement with private sector
- Foster research and innovation in menstrual hygiene management

The Government of India (GOI) has engaged four ministries to roll out policies on MHM[35].

1. Ministry of Health and Family Welfare, GoI
2. Ministry of Jal Shakti, GoI
3. Ministry of Women and Child Development, GoI
4. Ministry of Human Resource Development, GoI

Different ministries have been allocated different responsibilities to formulate and implement the schemes across the country.

FGD with adolescent boys in progress at Sadarba, Amravati, Maharashtra (June 2024)

34. https://main.mohfw.gov.in/sites/default/files/Draft%20Menstrual%20Hygiene%20Policy%202023%20-For%20Comments.pdf
35. https://unesdoc.unesco.org/ark:/48223/pf0000385512

Table 3: Roles and Responsibilities of Various Ministries as per the Draft MHM Policy

Ministry of Health and Family Welfare	Ministry of Women and Child Development	Ministry of Human Resource Development	Ministry of Jal Shakti[36]
Rashtriya Kishor Swasthya Karyakram Counselling of adolescent girls on puberty and Menstrual Hygiene Management	Training of Anganwadi Workers (AWW) and supervisors	Training of nodal teachers for providing support to girls and boys, puberty-related issues and support to girls with regards to MHM in schools and Kasturba Gandhi Balika Vidyalaya	Menstrual Hygiene Management promotional activities
Educational Sessions with school-going girls and boys by the medical teams of Rashtriya Bal Swasthya Karyakram(RBSK) by visiting the schools	Reaching out to out of schoolgirls through Scheme for Empowerment of Adolescent Girls (SABLA), Integrated Child Development Services, and self-help groups, under Mahila Arthik Vikas Mahamandhal	Water Sanitation and Hygiene related facilities supporting Menstrual Hygiene Management	Water Sanitation and Hygiene related facilities supporting Menstrual hygiene Management
The Adolescent Girls Anaemia Control Programme Counselling Support to adolescent girls on how to improve their diets: Weekly Iron and folic acid supplementation (WIFS) for out-of-school girls through Integrated Child Development Services (ICDS) and schoolgirls within educational institutions		School Management Committee Sensitized to enable gender-sensitive decisions supporting coping of girls to puberty and menstruation; reaching out to fathers and sensitizing them on menstrual health management, so they can be supportive and make appropriate decisions	School Management Committee Sensitized to enable gender-sensitive decisions supporting coping of girls to puberty and menstruation; reaching out to fathers and sensitizing them on menstrual health management, so they can be supportive and make appropriate decisions
Menstrual Hygiene Scheme: Menstrual Management promotional activities in the community; disposal mechanism established; training of ASHAs. Funds are allocated under this scheme	Shelter homes: Menstrual Hygiene Management promotional activities and supply of sanitary napkins; disposal mechanisms established; trained staff; Water, Sanitation and Hygiene related facilities supporting Menstrual Hygiene Management	MRMS Trained on Menstrual Hygiene Management acts as peers to promote menstrual hygiene practices and management	Provisions for funding for IEC and training

36. https://pdf.usaid.gov/pdf_docs/PA00W863.pdf

1.4. Central Government Initiatives

Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) 'Sabla' (2010)

The scheme was implemented in 2010 utilizing the Integrated Child Development Service. The objectives of the scheme were to enable adolescent girls for self-development and empowerment, improve their nutrition and health status, promote awareness about health, hygiene, nutrition, Adolescent Reproductive and Sexual Health (ARSH) and family and child care, mainstream out-of-school adolescent girls, upgrade their home-based skills, life skills and tie up with National Skill Development Programme (NSDP) for vocational skills and provide information about existing public services such as Primary Health Centers (PHC) , Community Health Centers (CHC), Post Office, Bank and Police Station etc. The scheme also aimed to provide free or subsidized sanitary napkins to adolescent girls and health education including menstrual hygiene management to the adolescent girls.

Scheme for Promotion of Menstrual Hygiene (2011): In 2011, the Ministry of Health and Family Welfare rolled out this scheme for adolescent girls (10-19 years) with the following objectives of increasing awareness around menstrual hygiene, to increase access and use of high-quality sanitary napkins and to ensure safe disposal of napkins in an environment-friendly manner[37]. The scheme was initially implemented across 17 states in 117 districts wherein napkins packs were provided at Rs 6 to the rural adolescent girls. Similarly, the Ministry of Drinking Water and Sanitation under Swachh Bharat Mission (Grameen) has developed National Guidelines on Menstrual Hygiene Management (MHM) for creating awareness on Menstrual Hygiene Management (MHM) in rural areas as part of its overall interventions related to behavior change on sanitation hygiene aspect[38]. The guidelines outline the role and responsibilities of state government, district administrations, engineers and technical experts in the line departments and school principals and teachers to support all adolescent girls and women.

National Guidelines for Menstrual Hygiene Management (2015): The Ministry of Drinking Water and Sanitation released guidelines in 2015 to ensure menstrual hygiene is managed effectively across the country. These guidelines address the need for menstrual hygiene education, access to menstrual products, and proper disposal methods. Under this initiative guidelines were issued for awareness programs, infrastructure requirements, and safe disposal methods. The significance of this program is that it standardized MHM practices across various sectors and provided clear directives for implementation.

Rashtriya Kishor Swasthya Karyakram (RKSK) (2014): The program was launched on January 7th, 2014. Taking cognizance of the need to respond to health and development requirements of adolescents in a holistic manner, the Ministry of Health and Family Welfare (MoHFW) has developed a comprehensive strategy, based on the principles of participation, rights, inclusion, gender equity and strategic partnerships. The strategy envisions that all adolescents in India can realize their full potential by making informed and responsible decisions related to their health and well-being. The implementation of this vision requires a concerted effort by all stakeholder ministries and institutions, including health, education, women and child

37. https://pib.gov.in/PressReleasePage.aspx?PRID=1846147
38. https://pib.gov.in/PressReleasePage.aspx?PRID=1846147

development, and labor as well as the adolescents' own families and communities. The Ministry of Health and Family Welfare rolled out this program to address the health and development needs of the girls. RKSK aims to improve menstrual hygiene practices among adolescent girls, training peer educators to disseminate information on menstrual health, and engaging communities to break taboos and myths related to menstruation. The program operates through adolescent-friendly health clinics and school-based interventions[39].

Swachh Bharat Mission (Gramin) (2014): On 2nd October 2014, the government of India launched Swachh Bharat Mission (Gramin). The objective of this mission was to improve sanitation coverage and improve cleanliness. The mission underlined the need for construction of toilets in the households and schools which is integral to menstrual hygiene and encourages safe menstrual hygiene practices. It further calls for skill development and sanitary napkins dispensers and incinerators in school and public toilets. Under SBM-G program, funds are available under the IEC component to raise awareness and skills on Menstrual Hygiene Management, and self-help groups help in propagating such efforts[40].

1.5. State Government Initiatives

Tamil Nadu: TN Free Sanitary Scheme: Under this scheme, free-of-cost sanitary napkin are being provided to government schoolgirls and women inpatients at Government Medical Institutions under the menstrual hygiene program. This is quite a great step that has been taken by the government of Tamil Nadu to provide hygienic life in the urban areas. This scheme not only provides a free sanitary napkin but also saves the lives of girls by providing sanitary pads during their menstrual cycle. This scheme has been implemented in Tamil Nadu for about 9 years and the government has decided to extend it more to the urban areas at the cost of Rs. 44 crores. The objective of this scheme is to provide access to free sanitary products to the underserved and marginalized women and adolescent girls belonging to urban areas of Tamil Nadu.

Additionally, the government of Tamil Nadu is providing dignity kits to women and adolescent girls of communities under the Menstrual Hygiene Scheme. The scheme is already under implementation in rural areas and now it is being extended to urban areas as well. The main objective of providing dignity kits is to give generic hygiene to the people in the urban areas to save them from sickness and various medicines[41].

Kerala: (She Pad scheme) The state's 'She Pad' scheme offers free sanitary napkins to school students. The project was flagged off on 8th November 2017 by the Minister for Health, Social Justice and Women and Child Development with the active support of Local Self-Governing bodies at Janardhanapuram HSS, Ottasekharamangalam, Thiruvananthapuram. The Government of Kerala designed and implemented a set of targeted interventions aimed at girl children to spearhead the adoption of safe and hygienic menstrual practices. At the onset of puberty, health education is provided in order to empower girls to take control of their own bodies. It is expected that targeted intervention at the adolescent stage could impact not only hygienic practices but also

39. https://vikaspedia.in/health/nrhm/national-health-programmes-1/rashtriya-kishor-swasthya-karyakram-rksk
40. https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1837524#:~:text=MHM%20in%20SBM%2DG%3A&text=It%20underlines%20the%20need%20for,in%20schools%20and%20public%20toilets.
41. https://rajbhavanmp.in/tamil-nadu-free-sanitary-napkin-scheme/

social behaviour of girls by removing the stigma attached to menstruation. The program will raise the confidence level of girl students, and positively impact attendance and academic performance. Aiming at the holistic development and well-being of the girl child, The Kerala State Women's Development Corporation Limited (KSWDC), a public sector undertaking (PSU) under the Government of Kerala, has initiated "MHM" and its component, 'SHE-PAD' Project to ensure that girl students gain awareness about menstrual hygiene and get easy access to free Sanitary Pads and Incinerators and provide Menstrual Awareness Classes[42].

Rajasthan: I am Shakti Udaan Scheme- Under the Udaan scheme, the Rajasthan government distributes free sanitary napkins to girls in government schools. This program also includes awareness sessions on menstrual health and hygiene. on December 19, 2021, had launched 'I M Shakti Udaan Scheme' under which sanitary napkins are distributed free of cost. Chief Minister Shri Ashok Gehlot in his budget announcement for 2021-22 had announced to provide sanitary napkins to adolescent girls taking care of their 'Health and Hygiene'. In the first phase, around 26 lakh girl students studying in government's middle, secondary and senior secondary schools in the State are being benefitted. In the rural areas, around 3 lakh adolescent girls and women aged 18-45 years in the identified 1410 Anganwadi centres in 282 blocks are getting free sanitary pads. These 29 lakh women are being given 12 sanitary pads each per month. More than 1.20 crore women will be linked to this scheme in a phased manner[43].

Maharashtra: Maharashtra became the first state in India to prioritize MHM by introducing state-specific guidelines in 2016[44]. The guidelines served as a strategic note that establishes a state-level action plan for mainstreaming MHM in ongoing programmes that have been operational for a decade. It indicated a broad framework for convergence and collaboration with various stakeholders for strengthening MHM programming in the state.

Asmita Scheme- The Asmita Yojana was launched in 2017 with the aim of providing sanitary napkins at subsidized rates to rural women and girls in Maharashtra. In the same years the government of Maharashtra also made the menstrual hygiene education mandatory in school. This scheme also involves self-help groups in the distribution process to ensure wider reach and effective implementation. the scheme is run through self-help groups to enable schoolgirls and women to buy sanitary napkins at a modest cost. Self-help groups are required to obtain identity cards provided to schoolgirls by the school and show it to the self-help group representative while purchasing napkins from the self-help group. By taking on the urgent need to tackle the environmental challenges that accompany menstrual waste management, the State Water and Sanitation Department has invested INR 200 million to install adequate disposal facilities in the schools of 27,668 villages of the state.

Odisha: Khushi Scheme- In order to address the issue of low usage of sanitary pads the government of Odisha rolled out Khushi Scheme under which free sanitary napkins are provided to all girls from class 6th-12th at government and government aided schools. The other objective of this scheme is to reduce the dropout rates of girls from the school. The scheme is being implemented by health and family welfare department of the state at a cost of 70 crores per years. In addition to this the government of Odisha is providing sanitary napkins

42. https://kswdc.org/finishing-school/
43. https://govtschemes.in/sites/default/files/2023-02/Rajasthan%20Indira%20Mahila%20Shakti%20Udaan%20Yojna%20Guidelines.pdf
44. file (unicef.org)

to rural women at subsidised rates of Rs.6 for six napkins through ASHA (Accredited Social Health Activist) worker[45].

1.6. Analysis of Policy Gaps

An increasing number of governments across the globe have turned to policies and regulations in an effort to make menstrual products affordable, accessible, and safe. Effective policies complement broader efforts to expand information and knowledge on menstrual health and hygiene and help to overcome stigma and taboos. The Swachh Bharat Mission (SBA) is the first large-scale government program that includes a strategy to bring out the taboo subject of menstruation. A thorough analysis of the Swachh Bharat Abhiyan (SBA) guidelines for Menstrual Hygiene Management (MHM) reveals two significant gaps[46]: (1) a lack of culturally embedded, gender-specific understandings of menstruation, and (2) insufficient connections to public health. These gaps have profound implications for the menstrual health of girls and women. The feelings of shame, guilt, and negativity experienced by Indian adolescent girls are not solely related to the biological aspects of menstruation but are deeply intertwined with the complex web of sociocultural and religious beliefs and practices. This intersection results in indignity and injustice, exacerbating menstrual health challenges. The SBA does not include any programmatic interventions to address these core gender-specific aspects of menstruating adolescent girls. As argued in a 2016 landscape analysis of menstrual health in India[47], "the lack of psycho-social support and limited facilitator capacities miss the opportunity to build the girl's confidence and shift inherent discriminatory social norms that define a girl's role in Indian society". The SBA missed the opportunity to link the MHM and WASH agenda with the public health agenda. The focus on 'hygiene' rather than 'health' means a lost chance to address health issues associated with the disorders of the menstrual cycle, such as dysmenorrhea, amenorrhea, menorrhagia, pelvic infections, and endometriosis, among others. The inextricable linkage between menstrual stigma and women's basic health are not properly addressed by various policies in India[48].

FGD with adolescent girls in progress at Nagaraurua, Gilaulia, Sharvasti, Uttar Pradesh (June 2024)

45. https://khushi.nic.in/?p=khushi
46. Menstrual Justice: A Missing Element in India's Health Policies - The Palgrave Handbook of Critical Menstruation Studies - NCBI Bookshelf (nih.gov)
47. Menstrual Health in India | Country Landscape Analysis - DocsLib
48. Menstrual Justice: A Missing Element in India's Health Policies - The Palgrave Handbook of Critical Menstruation Studies - NCBI Bookshelf (nih.gov)

1.7. MHM Related Programs/ Projects (Past and Current)

Following are few interventions that have been implemented across various states of India with an aim to instil awareness and sensitize women and adolescent girls and by large the community about the Menstrual Health Management. The list includes INGOs and NGOs implementing their projects on MHM.

Table 4: Programs/Projects on MHM in India

S. No.	Name of the project	Implementer*
1	Paheli Ki Saheli	UNICEF
2	Comprehensive Sanitation Initiative- Aga Khan Foundation	Aga Khan Foundation
3	Menstrual Health Program	Myna Mahila Foundation
4	Project Swadhin	APPL Foundation
4	Breaking the silence- WASH United	Water Aid
6	Project Baala	Project Baala
7	Sakhi Project	Rnisarg Foundation
8	The Project	The Pad Project
9	Not Just A piece of Cloth	Goonj
10	Baalika Manch	Breakthrough
11	Ab Meri Baat-Podcast	Dasra
12	Sustainable Menstruation Kerala Collective	SMKC
13	Menstrual Health and Uger Cloth Pads	Jatan Sansthan
14	Mobileshaala	Procter & Gamble (CSR)
15	Kadam Sapno Ki Aur	Kent Foundation
16	The Niine Movement	Niine Sanitary Napkins

This project list is not exhaustive but are indicative of some of the projects undertaken by various NGOs across India.

A. Paheli ki Paheli

This UNICEFs project was rolled out in Uttar Pradesh, Bihar and Jharkhand with an objective of creating awareness around menstrual health and its management through sensitizing and awareness generation methods using social behaviour change communication techniques (SBCC) at the community level. The communication strategy envisioned to use of a mix of communication approaches including interpersonal communication, community dialogue, social mobilization, mass media and capacity building to engage with the different audience groups.

B. Comprehensive Sanitation Initiative

Aga Khan foundation launched comprehensive sanitation initiative in parallel to Swachh Bharat Mission in 2015. One of the core components of the programme was to address the gaps on access and information on Menstrual Health. The programe team of Aga Khan Foundation (AKF) formed women led committees (SHGs) at the grassroot which used to hold weekly meetings on awareness generation and sensitization around menstrual health and its management across the 8 project districts of Bihar, Uttar Pradesh, Madhya Pradesh and Gujarat.

C. Menstural Health Programme

Manya Mahila Foundation is a Mumbai-based organization working in the urban slums of Mumbai and neighboring areas. The programme has different components, one of which is producing high quality low-cost sanitary pads, and they sell it directly in the community as well as at the health facility. This unique initiative has a women of pad production facility, which also helps the women from the community to seek employment at the production facility[49].

D. Project Swadhin

Project 'SWADHIN', the Menstrual Health Management (MHM) Programme of APPL Foundation is implemented in the four estates of Amalgamated Plantation Pvt. Ltd. (APPL)- Borhat, Achabam, Nahorkutia, and Namroop, in the state of Assam'. SWADHIN aims to generate awareness on menstrual hygiene and make quality affordable menstrual absorbents accessible and affordable. It also aims to give the women of the tea estates dignified menstrual days in the workplace and encourage hygiene health practices. One coordinator –'Sakhi' from the tea community is selected for each of the four gardens. She is handling the access of the sanitary pads and awareness generation process. This is an entrepreneurial model of APPL which provides the Sakhis with a monthly allowance and with a basic incentive[50].

E. MHM Programme- Water Aid India

The programme comes under the hygiene vertical of the organization, wherein young adolescent girls are provided with comprehensive knowledge about menstruation, dispelling myths and taboos associated with it. The programme is being implemented across 11 states of India.

F. Project Sakhi- Rinisarg Foundation

Project Sakhi is an initiative to educate women for a Healthy & Safe period and empower them to make the right choice of sustainable menstrual products. It is being implemented across the state of Maharashtra. The programme is rolled out using workshops-it is conducted by medical professionals who educate women about MHM and promote the usage of sustainable menstrual products[51].

G. The Pad Project

The organization collaborates with local NGOs and grassroots organsation to fund the placement of pad machines, implement washable pad programs, and conduct menstrual hygiene management workshops in communities. The goal of the project is to ensure every menstruator can attend school and is provided with comprehensive sexual and reproductive health and rights (SRHR).

H. Project Baala

The program envisions empowering young adolescent girls and women from underserved communities through innovation and education. The organization regularly conducts community awareness programs to educate and inform women about menstruation, menstrual health, and hygiene while combating harmful myths and taboos.

49. https://mynamahila.com/our-initiatives/
50. https://applfoundation.in/en/projects/project-%E2%80%98swadhin%E2%80%99-menstrual-health-management-mhm-programme
51. https://sway.cloud.microsoft/mfslexQgAs71N5EU?ref=Link&loc=mysways

I. Not Just a Piece of Cloth

This initiative is led by the grassroots organization, Goonj. It addresses the gaps and challenges of menstrual hygiene and management for the last women by engaging comprehensively with all key stakeholders. The intervention revolves around the triple A approach, Access, Awareness and Affordability to make people understand menstrual health better. The organisation has a pan-India presence[52].

J. MHM Programme- Action Aid

The organization works on MHM through its collectives across the 24 states it works in. The collectives are women-led and regularly organize knowledge dissemination meetings/workshops around MHM. They even conduct campaigns in the community to generate awareness and sensitize the members of the community at large.

K. Mobileshaala

Moving forward with their #KeepGirlsInSchool movement, Whisper launched 'Mobileshaala' in May 2020, an initiative to provide free education while schools across the country remain closed. It is a phone-based learning system that gives free access to curriculum-based education modules on key subjects like English, Science and menstrual hygiene education.

L. Kadam Sapno Ki Aur

The implementation of the menstrual hygiene education and awareness programme – Kadam Sapno Ki Aur is likely to benefit over 1.20 lakh women and girls in rural India. In an endeavor to educate and make women and adolescent girls aware of this issue, Kent Foundation has adopted a multipronged approach to educate and provide them with sanitary napkins. The foundation has chosen three critical pathways:

- social mobilization, education & awareness.
- creating in-house infrastructure to fulfil the demand of sanitary napkins and
- supplying these sanitary napkins free of cost to those sections of society who have not any access and means to buy sanitary napkins.

M. The Niine Movement

The Niine Movement is an ambitious 5-year plan that began in 2018. It aims to tackle the taboos associated with menstruation by engaging all genders and ages to step forward and join hands to promote the importance of menstrual hygiene awareness. To achieve its vision, the Niine Movement's theory of change adopts a three-pronged approach by:

- Educating girls, women, boys and men of good menstrual hygiene practices.
- Enrolling citizens and existing menstrual hygiene product users in a supportive, taboo-free environment to create an open forum for discussion and deliberation.
- Enhancing the sanitation sector of India by providing the best quality menstrual hygiene products at appropriate prices.

52. https://goonj.org/mh-day-2024/

1.8 About the MHM Project of Tata Trusts

Tata Water Mission (TWM), initiated by Tata Trusts in 2015, is a pioneering program addressing India's water, sanitation, and hygiene crisis through a multi-faceted strategy. Within TWM, a crucial focus area is Menstrual Hygiene Management (MHM), recognizing the socio-cultural and infrastructural challenges hindering safe and effective practices among women and adolescent girls. The project acknowledges menstruation as a natural biological process but emphasizes the need to overcome societal barriers for safe MHM.

1.8.1 Key Project Activities

- Awareness and Addressing Gender Inequitable Norms: Women and girls understand the basic facts linked to the biology of menstruation, how to manage it with dignity and without discomfort or fear, have the agency and skills to seek support and have a supportive socio-cultural environment for safe and hygienic management of menstruation.
- Access: Women and girls are using a clean (preferably reusable, environment-friendly) menstrual absorbent material to collect menstrual blood.
- Hygienic Use: Women and girls can change absorbents in privacy as often as necessary, have access to safe and convenient facilities with soap and water to manage their menstruation hygienically, and improve their hygienic practices and self-care to reduce the risk of infection or illness.
- Menstrual Waste Management: Menstrual waste is disposed of and managed in a safe and effective manner.
- Capacity building of stakeholders and Policy advocacy: Engage with state/district and local government to promote integration of MHM intervention in the existing health eco-system and build the capacity of ASHA and Anganwadi workers to ensure continuous support to targeted communities.

FGD with adolescent girls in progress at Zilpi, Amravati, Maharashtra (June 2024)

1.8.2 Theory of Change

The following table describes the theory of change adopted for implementing the MHM project.

Table 5: Programs/Projects on MHM in India

Strategic Objectives	Key Activities	Expected Outcomes	Impact
Awareness and Addressing Gender Inequitable Norms	Awareness on biology of menstruation and gender equitable norms	Knowledge, adoption, and sustained practice of safe and hygienic MHM behaviours by girls and women reinforced by a supportive socio-cultural environment	**Long Term Goal:** Sustained practice of safe and hygienic MHM behaviours by girls and women **Goal 1:** Changed perceptions regarding menstruation being impure and inequitable gender norms and practices **Goal 2:** Increased reporting and health seeking for cases of urogenital infections (RTI/UTI)
	Development of sustained channels for information on MHM (peer educators, entrepreneurs, FLWs, teachers etc.)		
	Awareness to improve health-seeking behaviour for RTI symptoms		
	Sensitization of government officials to influence MHM policy		
Access	Awareness on basket of MHM products and their pros and cons		
	Availability of sustainable MHM products through a retail entrepreneur model		
	Offer innovative financing solutions for making alternative MHM products affordable		
	Capacity building of girls and women on making own products		
Hygienic Use	Awareness on hygienic use and maintenance of products		
	Stakeholder-wide awareness on importance of MHM friendly WASH facility for safe and effective MHM		
	Integration of key design elements into awareness and implementation of toilets constructed through sanitation program		
Menstrual Waste Management	Awareness of the environmental impact of various MHM products		
	Awareness of safe segregation and disposal of menstrual waste		
	Implement models for menstrual waste management within larger solid waste management implemented by TWM		

02

Research Approach & Methodology

2. RESEARCH APPROACH & METHODOLOGY

2.1 Study Rationale

In the landscape of social and developmental initiatives, a baseline study serves as the foundational compass, illuminating the path toward meaningful, evidence-based interventions. Often marking the initiation of a project, a baseline study is a systematic investigation designed to capture the status, challenges, and opportunities within a specific context. In the context of TWM's menstrual hygiene management (MHM) program, the baseline study acts as the lens through which the existing scenario assessed, enabling the program to craft targeted and effective strategies for improvement. The relevance of the study is based on the following key points:

- Informed Decision-Making: The baseline study provides the essential data points necessary for informed decision-making. By meticulously assessing the knowledge, attitudes, and practices related to menstrual hygiene among target beneficiaries, the program can gain a clear understanding of their needs and challenges.
- Identifying Challenges and Gaps: Through quantitative and qualitative research methods, the study helps to identify existing challenges, gaps in infrastructure, socio-cultural norms, and barriers faced by communities. These insights are pivotal in designing interventions that are tailored to address the specific challenges faced by different regions and demographics within intervention states.
- Establishing Baseline Indicators: The study helps establish baseline indicators, providing a benchmark against which the impact of the MHM program can be measured. By quantifying the current scenario, the program can track progress over time, ensuring that the interventions are making a tangible difference in the lives of the beneficiaries.
- Ensuring Cultural Sensitivity: Understanding the socio-cultural fabric through the baseline study is essential. It allows the program to navigate the delicate nuances of various communities, ensuring the interventions are culturally sensitive and respectful of local traditions.
- Enhancing Program Effectiveness: Armed with the insights from the baseline study, the MHM program can be tailored with precision. It allows the team to design interventions that are not only evidence-based but are also contextually relevant and responsive to the unique needs of the communities the program aims to serve.

2.2 Study Objectives

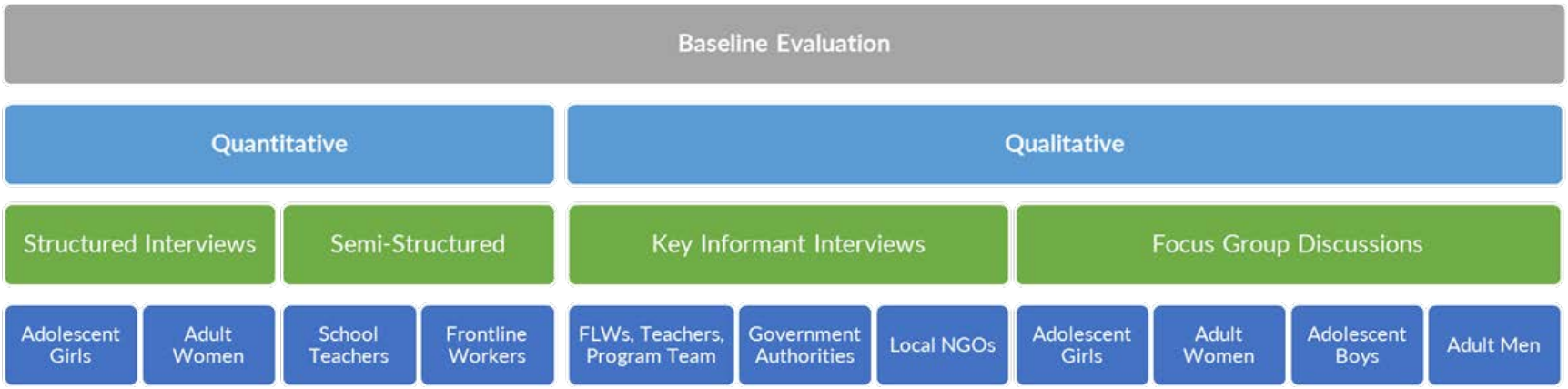
The objectives of the baseline assessment are:

1. To assess the knowledge, attitudes, and practices related to menstrual hygiene among the target beneficiaries such as adolescent girls, adult women, parents, FLWs and teachers.
2. To identify the existing facilities, infrastructure, and resources available for menstrual hygiene management in the project areas.
3. To understand the menstrual hygiene-related challenges faced by adolescent girls and adult women.
4. To understand socio-cultural norms related to menstrual hygiene and its impact on practices being followed by the communities.
5. To determine the baseline indicators for monitoring and evaluating the impact of the MHM Programme.
6. To develop actionable recommendations based on the findings to inform the design and implementation of the MHM Programme.

2.3. Research Methodology

Athena adopted a pre-post research design (sequential cross-sectional analytical design) for the baseline evaluation. The design adopted a mixed-method approach to collate both qualitative and quantitative primary data as well as data from secondary data sources. The primary data collection consisted of quantitative survey and qualitative methods such as Key Informants Interviews (KIIs) and Focus Group Discussions (FGDs). A lot of emphasis was given to triangulation to generate the findings and to achieve that the research activities within the baseline evaluation would follow a sequence. The research design is illustrated below:

Figure 2: Research Design



2.3.1 Specific Target Groups

The baseline evaluation covered all the program's stakeholders and intended beneficiaries. The table below presents the various target groups covered and the research methods adopted for each.

Table 6: Target groups for the study

Research Method	Target Group
Structured Interviews	Adolescent Girls (Ages 13-17)
	Adult Women (Ages 18-49)
Semi-Structured	Teachers
	Frontline Workers
KIIs	Government Authorities
	Local NGO/ Community Resource Person
	Program Team
	Frontline Workers
	Teachers
FGDs	Adolescent Girls (Ages 13-17)
	Adult Women (Ages 18-49)
	Adolescent Boys (Ages 13-17)
	Adult Men (Husbands, Fathers)

2.3.2 Research Log-Frame

This section details a structured framework for evaluating the baseline status of the Menstrual Hygiene Management (MHM) initiative.The log frame integrates the strategic objectives, key areas of enquiry, and source of information from both quantitative and qualitative data collected from diverse stakeholder groups. including adolescent girls, adult women, frontline workers, teachers, local NGOs, and government authorities. By systematically capturing data on knowledge, attitudes, practices, support systems, and policy engagement, this log frame ensures a comprehensive assessment of the program's impact and identifies areas for improvement.

Table 7: Research Log frame

Strategic Objective	Key Areas of Enquiry	Quantitative				Qualitative					
		AG	AW	Teachers	FLWs	AG	AW	FLW	Teacher	Local NGOs/ Program Team	Government Authorities
Awareness and Addressing Gender Inequitable Norms	Knowledge about menstruation	■	■	■	■	■	■				
	Attitude and awareness	■	■								
Health-seeking Behavior for RTI Symptoms	Frontline worker practices	■	■		■			■			
	Integration of menstrual health and hygiene into community outreach activities	■	■		■			■			
Menstrual Hygiene Management Practices	Teacher practices	■		■					■	■	
	Integration of menstrual health and hygiene into school activities	■		■					■		
Access to Menstrual Hygiene Products	Menstrual practices and access	■	■			■	■	■	■	■	
	Availability and affordability of MHM products	■	■			■	■	■	■		
Support Systems and Infrastructure	Experiences	■	■			■	■	■	■		
	Functionality of WASH facilities	■	■	■	■			■	■	■	■
Policy and Advocacy	Collaboration					■	■	■	■	■	■
	Government support for MHM initiatives							■	■	■	■

2.3.3 Sample Size

The minimum number of respondents required for a statistically valid sample with the power to measure an estimated difference test results among target group was computed using the following formula4:

$$n = \frac{deff \times \left[Z_{1-\alpha}\sqrt{2P(1-P)} + Z_{1-\beta}\sqrt{P_1(1-P_1)+P_2(1-P_2)}\right]^2}{(P_2-P_1)^2}$$

Where:

P1 is the hypothesised value of the outcome indicator before intervention.

P2 is the hypothesised value of the outcome indicator after intervention.

$$P = \frac{P1 + P2}{2}$$

Z1-a is the standard normal deviate value for a type I error (1.96)

Z1-b is the standard normal deviate value for a type II error (0.842)

deff is the design effect (1.5)

The quantitative sample size is derived based on the following measures:

Table 8: Datapoint Selected for Sample Size Estimation

Prevalence	Data Points[5]
Hygienic Menstrual Practices	According to NFHS-5, the percentage of hygienic methods of protection used by Women aged 15-24 years during menstrual period is as follows: • Rural Areas: 72.3%

For the sample size estimation, the rural prevalence has been considered as P1. A conservative change of 20% is considered based on the trends observed throughout the NFHS data. This provided a sample size of 85 for the rural areas. Taking an 18% non-response rate, a total sample size of 100 is derived at the district level. Since the study includes two respondent groups, the overall sample size at the household level per district are follow:

- Adolescent Girls (Ages 13-17): **100**
- Adult Women (Ages 18-49): **100**

Semi-structured interviews were conducted with frontline workers and schoolteachers to assess their KAP on the subject.

Key-Informant Interviews (KIIs) were conducted with other stakeholders of the projects while **Focus-Group Discussions** (FGDs) were conducted with primary beneficiary groups.

The tables below present the sample size targeted and achieved in the baseline evaluation.

Table 9: Quantitative sample size (Targeted Vs Achieved)

Approach	Structured Interview				Semi-Structured Interview			
TG	Adolescent Girls (Ages 13-17)		Adult Women (Ages 18-49)		Teachers		FLWs	
Sample	Target	Achieved	Target	Achieved	Target	Achieved	Target	Achieved
Uttar Pradesh	200	211	200	212	16	17	16	16
Assam	100	101	100	100	8	8	8	8
Rajasthan	200	231	200	226	16	17	16	17
Maharashtra	200	212	200	211	16	17	16	16
Total	**700**	**755**	**700**	**749**	**56**	**59**	**56**	**57**

Table 10: Qualitative Sample Size (Targeted Vs Achieved)

Approach	KIIs										FGDs							
TG	Program Team		Government Authorities (District)		Local NGO/ Community Resource Persons (CRP)		FLWs		Teachers		Adolescent Girls (Ages 13-17)		Adult Women (Ages 18-49)		Adolescent Boys (Ages 13-17)		Adult Men	
	Target	Achieved	Target	Achieved	Target	Achieved	Target	Achieved	Target	Achieved	Target	Achieved	Target	Achieved	Target	Achieved	Target	Achieved
Uttar Pradesh	1	1	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2
Assam	1	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Rajasthan	1	1	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2
Maharashtra	1	1	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2
Total	**4**	**4**	**4**	**5**	**4**	**4**	**4**	**4**	**4**	**4**	**7**	**7**	**7**	**7**	**7**	**7**	**7**	**7**

2.3.4 Sampling Methodology

Selection of States- The selection of states is determined by Tata Trusts based on the planned phase - 2 intervention. The selected states for the baseline study are Uttar Pradesh, Assam, Rajasthan, and Maharashtra.

Selection of Districts- The districts were selected for the baseline basis on 1) plan for phase 2 intervention, 2) availability of varied socio-demographic populace, and 3) intervention is yet to begin. The table below shows the intervention districts and the districts selected for the baseline study across the four states.

Table 11: Intervention district selected for the study

State	Districts -Phase -II Intervention Planned	Districts Selected for Baseline Study
Uttar Pradesh	Lucknow	Bahraich
	Bahraich	
	Shrawasti	Shrawasti
Assam	Kamrup rural	Kamrup rural
Rajasthan	Sirohi	Sirohi
	Pali	Pali
Maharashtra	Nandurbar	Amaravati
	Amaravati	

A total of seven districts were selected for the baseline evaluation.

Selection of Blocks- The study blocks were selected randomly, taking into account the intervention plan and prevalence of varied socio-demographic populace. The table below lists the selected blocks within their respective districts.

Table 12: Blocks selected for the study

State	Selected Districts	Blocks: Phase-II Intervention Planned	Blocks Selected for Baseline Study
Uttar Pradesh	Bahraich	Phakarpur,Kaiserganj,Tejwapur & Mahasi	Tejwapur
			Phakarpur
	Shrawasti	Gilaula	Gilaula
Assam	Kamrup rural	Chaygaon & Boko	Chaygaon & Boko
Rajasthan	Sirohi	Sirohi, Reodar & Sheoganj	Sirohi & Sheoganj
	Pali	Sumerpur	Sumerpur
Maharashtra	Amaravati	Dharni &Teosa	Dharni & Teosa

Selection of Villages- The list of intervention villages from the selected block was provided to Athena and the study villages were randomly selected with the inputs from the block project team. In each district a total of eight villages were selected and an additional two to three buffer villages were also selected to offset any challenges or short fall. The list of selected villages is provided in Annexure.

Selection of Respondents- The overall household sample was dispersed among the selected villages for an average of 25 respondents per village. The selection of households was done by cluster sampling as elaborated below:

1. The major lanes and by-lanes of the village were mapped (with the help of a frontline worker/ PRI member/CRP). This helped the team divide the village into roughly five equal sects (clusters). The total number of households in each cluster was noted.
2. The total number of households in a cluster was divided by the cluster sample of 5 (a sample of 25 in a village is divided by 5 clusters) to determine the required sampling interval.
3. Thereafter, in each of the clusters, one of the lanes/ by-lanes was selected randomly.
4. In the selected lane/ by-lane, the enumerator reached the first household and conducted a screening to determine the availability of eligible respondents. If eligible respondents were available, the enumerator sought consent before proceeding to conduct the survey with the identified person. From one household, only one eligible respondent was considered.
5. Once the interview in the first household was completed, the enumerator selected the next households for the subsequent interviews using the sampling interval derived.
6. In the event that the enumerators were unable to locate adolescents in the village due to them attending school, the team reached out to the school and, with the proper permission from the school authority, the required number of adolescents in the selected villages was selected for interview. However, if any school dropouts were present in the household selected as explained in point 4 & 5 above, they were included in the survey.

Semi-structured interviews were conducted with teachers and frontline workers (ASHA or AWW). The initial plan was to cover one of both target groups per village. However, due to the absence of schools in all the selected villages, the teacher interviews were conducted only in those schools suggested by the block project team based on their school intervention plan. The interviews with FLWs were, however, done one per village.

All the **FGDs** were conducted at the village level based on the availability of respondents. At least six eligible respondents participated in each FGD. The respondents for the other qualitative interactions were selected purposively in consultation with the project team.

KII with FLW in progress at Gilaulia, Shravasti Uttar Pradesh(June 2024)

2.4 Pre- Data Collection Preparation

2.4.1 Desk Review and Secondary Data Analysis

The Athena core team had undertaken an exhaustive study of the relevant material and especially program documents to base their understanding of the broad thematic areas of the evaluation. The team further had multiple interactions with the project team to understand the program in detail before getting into the planning and preparation of the evaluation and the research tools.

2.4.2 Development, Piloting and Finalization of Research Tools

The research tools were developed based on the indicators mapped in the inception phase. The first draft of the tools is developed in English and then sent to Tata Trusts for review and feedback. Based on the feedback received, the tools were finalized and translated to the local languages by the experts. Once the draft tools were approved by the Tata Trusts team, a pilot testing of research tools was carried out in Jalalabad Muradnagar, Ghaziabad, Uttar Pradesh on the 27th of May 2024 by the core team members to check the usability and appropriate sequencing of questions in the research tools. The structured and semi-structured tools were finalized after incorporating the observations from pilot testing and submitted to Tata Trusts for final approval. After following the due procedures of translation, pilot testing, and feedback from Tata Trusts, the research tools were finalized and shared for CAPI (Computer Assisted Personal Interviewing) scripting.

2.4.3 Data Collection Team Recruitment and Training

Athena Infonomics selected a team of researchers and supervisors from its pool of resources. We deployed one team per district i.e. two teams in Maharashtra, Uttar Pradesh and Rajasthan and one team in Assam. Each team comprised of 4 enumerators and one supervisor cum moderator.

Before deployment for the collection of data and evidence, the teams participated in 2 days classroom training in each state. The training was rigorous to ensure that the interviewers could obtain relevant information without being intrusive. The training focused on ethical aspects, understanding of the research tools, understanding of the CAPI and getting hands-on experience. This training included mock interviews to make field interviewers understand the questionnaires completely and help them in posing the questions in the right manner to the respondents.

2.4.4 Ethical Protocol Followed

The study's research approach involved qualitative and quantitative data collection. All interactions with primary data collection stakeholders were carried out with informed consent. Interviewers and moderators emphasized the voluntary nature of participation in the evaluation activities. Also, participants who wished to withdraw from the study after providing consent were allowed to do so. All results were reported at an aggregate level, and no identifying information was disclosed. The following table outlines the fundamental ethical principles followed for this baseline evaluation.

Table 13: Ethical Protocol Adopted

Ethical Principles	Details
Informed Consent	Informed consent of the participant in the fullest meaning, including of genuine choice, and is central to the consultations.
Do No Harm	The principle of non-maleficence is sacrosanct to avoid harm to the respondents of the research, both through acts of commission and omission. Therefore, extensive training of the researchers with clear instructions for engagement and exit strategies in case of even perceived harm during data collection is inbuilt into the methodology.
Privacy and Confidentiality	Privacy and confidentiality are critical considerations in the ethical collection of data on individuals. Risks associated with privacy and confidentiality may occur and need to be considered throughout the research process. With regards to the collection, transmission, storage, analysis, and destruction of data, clear and strict security protocols will be developed, minimizing those who have access, ensuring physical or electronic safeguards, and encryption keys, methods of destruction of the data, including the security of the cloud storage. All information gained from the interviews was treated confidentially. To protect confidentiality, the records contain no names or personal identifiers. Throughout, care was taken not to raise expectations on the potential benefits that participants gained from the project.
Respect and Justice	The principle of respect implies valuing humans and their lived realities. It requires recognition that their decisions exist within broader personal, relational, social, cultural, legal and environmental contexts.

2.5. Data Collection Stage

The initial plan was to conduct the state level training and data collection in the beginning of April and conclude the data collection before the 1st phase of polling in the General Election 2024. A decision was taken to phase out the data collection in the states considering 1) the challenges in primary data collection due to the implementation of Model Code of Conduct for the election, and 2) the conflict with polling dates. The table below details the two-phase data collection plan followed for the primary data collection for the baseline evaluation.

Table 14: Training Dates and Data Collection Plan

State	Phase 1 of Data Collection			Phase 2 of Data Collection		
	Training Date	Training Location	Data Collection Start Date	Training Date	Training Location	Data Collection Start Date
Uttar Pradesh	03-04-2024 and 04-04-2024	Shrawasti	05-04-2024	07-06-2024 (Half Day)	Online debriefing	10-06-2024
Assam	13-05-2024 and 14-05-2024	Guwahati	15-05-2024			
Rajasthan	01-05-2024 and 02-05-2024	Sirohi	03-05-2024			
Maharashtra	01-04-2024 and 02-04-2024	Amaravati	03-04-2024	07-06-2024 (Half Day)	Online debriefing	10-06-2024

2.5.1 Challenges in Data Collection

Conducting the baseline survey on Menstrual Hygiene Management (MHM) across Rajasthan, Maharashtra, Uttar Pradesh, and Assam presented several significant challenges. The **Union Election 2024** severely disrupted the data collection schedule. In Assam and Rajasthan, the entire data collection process had to be postponed due to election activities, while in Maharashtra and Uttar Pradesh, data collection had to be completed in phases to accommodate the election schedule. This political climate made it difficult to secure the availability of key respondents and officials, particularly those involved in key informant interviews (KIIs), who were often occupied with election duties.

Reaching rural areas, particularly in Rajasthan and Assam, posed **logistical challenges** due to poor infrastructure and long travel distances. Adverse weather, such as heavy rains in Assam, further hindered data collection efforts and affected team mobility and respondent availability.

The sensitivity of the topic of MHM, particularly in rural and conservative communities, added another layer of complexity. Cultural taboos and stigma around menstruation made it difficult for respondents to openly discuss their menstrual health experiences and practices. Both adolescent girls and adult women exhibited discomfort, leading to potential underreporting of issues and behaviors. Adolescent boys and adult men showed greater level of hesitation in participating in discussions on MHM, impacting the depth of information gathered during focus group discussions (FGDs). A major challenge was the lack of **knowledge or awareness about MHM among male participants**. Most of the queries posed during the discussions remained unanswered due to their unfamiliarity with the topic, as for many, this was their first exposure to such discussions on the topic.

Participant engagement was another critical challenge. Ensuring the active participation of adolescent girls was difficult due to their shyness and the presence of older women or authority figures, such as teachers, during interviews. Creating a safe and comfortable environment was crucial to encourage participants to engage openly in discussions on the topic. Many adult women had limited availability due to household responsibilities and work commitments, making it challenging to schedule and conduct interviews and FGDs.

Ethical considerations were paramount in this survey. Obtaining informed consent, particularly from younger participants, required careful explanation of the survey's purpose and assurance of confidentiality. Ensuring understanding and voluntary participation was a time-consuming process. Maintaining privacy during interviews and FGDs was challenging, especially in densely populated areas where private spaces were limited.

Adverse weather conditions, such as heavy rains or extreme heat, further hindered field activities and affected the availability of respondents. Despite these challenges, the survey team adapted by implementing flexible schedules, employing technology for remote coordination, and ensuring robust training and support mechanisms for field staff. These efforts, although resource-intensive, were essential to successfully navigate the complex landscape of field implementation during a politically charged period, ultimately ensuring the collection of valuable data on menstrual hygiene management practices across the target states.

03

Menstrual Hygiene Management: Baseline Insights

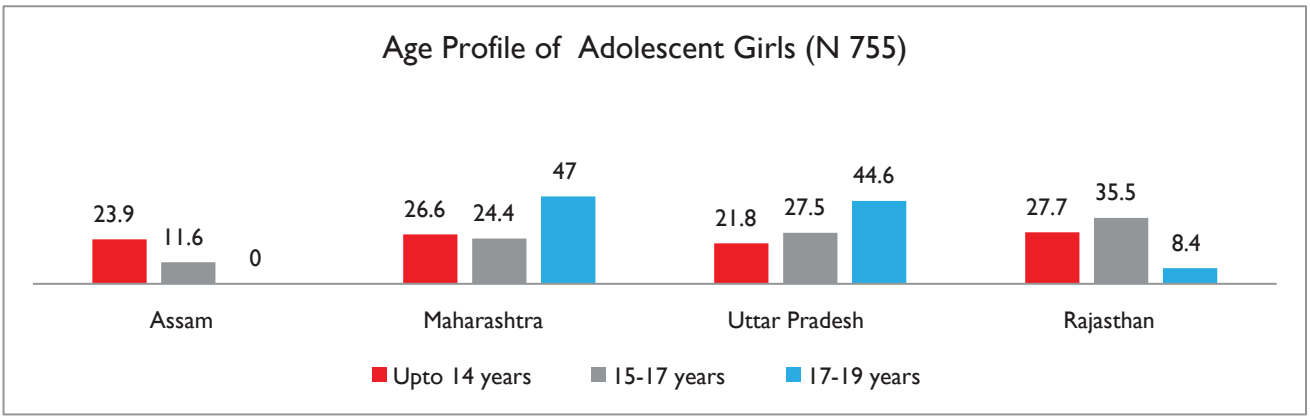
3. MENSTRUAL HYGIENE MANAGEMENT: BASELINE INSIGHTS

3.1 Demographics

3.1.1 Age Profiles of Respondents

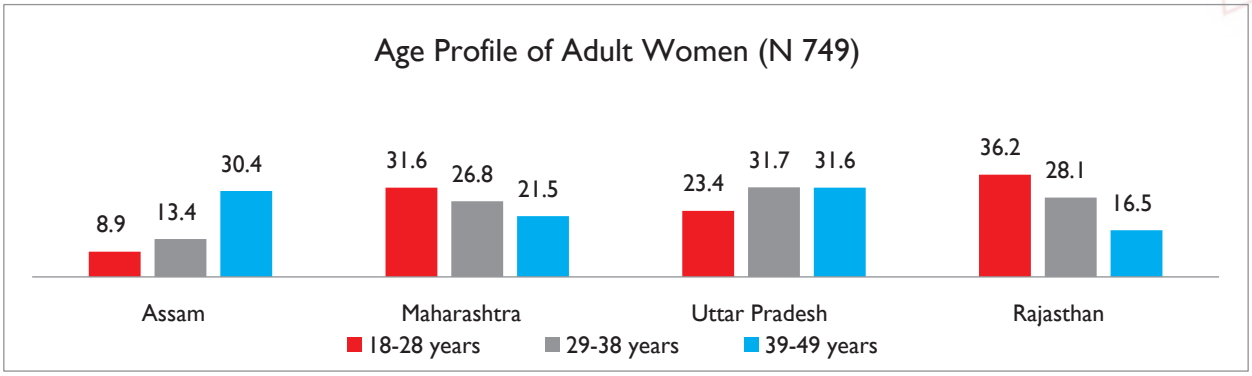
The survey captures the age demographics of adolescent girls (AG) and adult women (AW) to understand the distribution and representation of different age groups. Among the adolescent girls, 24.9% are up to 14 years old, 64.1% fall within the 15 to 17 years age group, and 11.0% are between 17 to 19 years old. For adult women, 40.6% are aged 18 to 28 years, 44.9% are between 29 to 38 years, and 10.5% are in the 39 to 49 years category.

Figure 3: Age profile of adolescent girls (overall)



Among the states, Maharashtra has a higher percentage of AGs aged 17 to 19 years (47.0%), and Rajasthan shows a significant representation of AGs in the 15 to 17 years group (35.5%). For AWs, Rajasthan has a notable percentage in the 18 to 28 years category (36.2%), and Assam has a higher representation in the 39 to 49 years group (30.4%).

Figure 4: Age profile of adult women (overall)



3.1.1. Educational Profile of Respondents

Most adolescent girls are attending school, with only 6.5% not going to school at the overall level. Notably, 10% of adolescent girls are not attending school in Uttar Pradesh followed by Rajasthan (7.8%), which is significantly higher compared to other states.

Figure 5: Overall educational profile of AGs

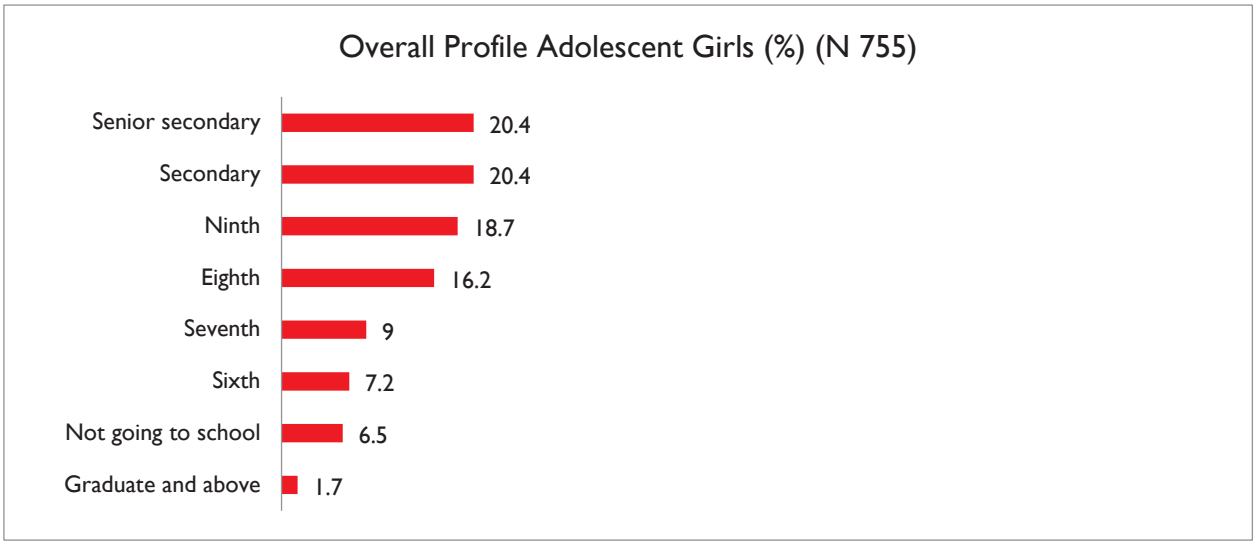


Table 15: Educational profile of adolescent girls by state (%)

State	Assam	Maharashtra	Uttar Pradesh	Rajasthan
N	**101**	**212**	**211**	**231**
Sixth	11.9	2.4	12.8	4.3
Seventh	16.8	5.2	12.3	6.1
Eighth	11.9	13.2	21.3	16
Ninth	17.8	16.5	18	21.6
Secondary	28.7	25	11.8	20.3
Senior secondary	12.9	32.1	14.2	18.6
Graduate and above	0	0.5	0	5.2
Not going to school	0	5.2	9.5	7.8

Figure 6: Overall educational profile of AWs

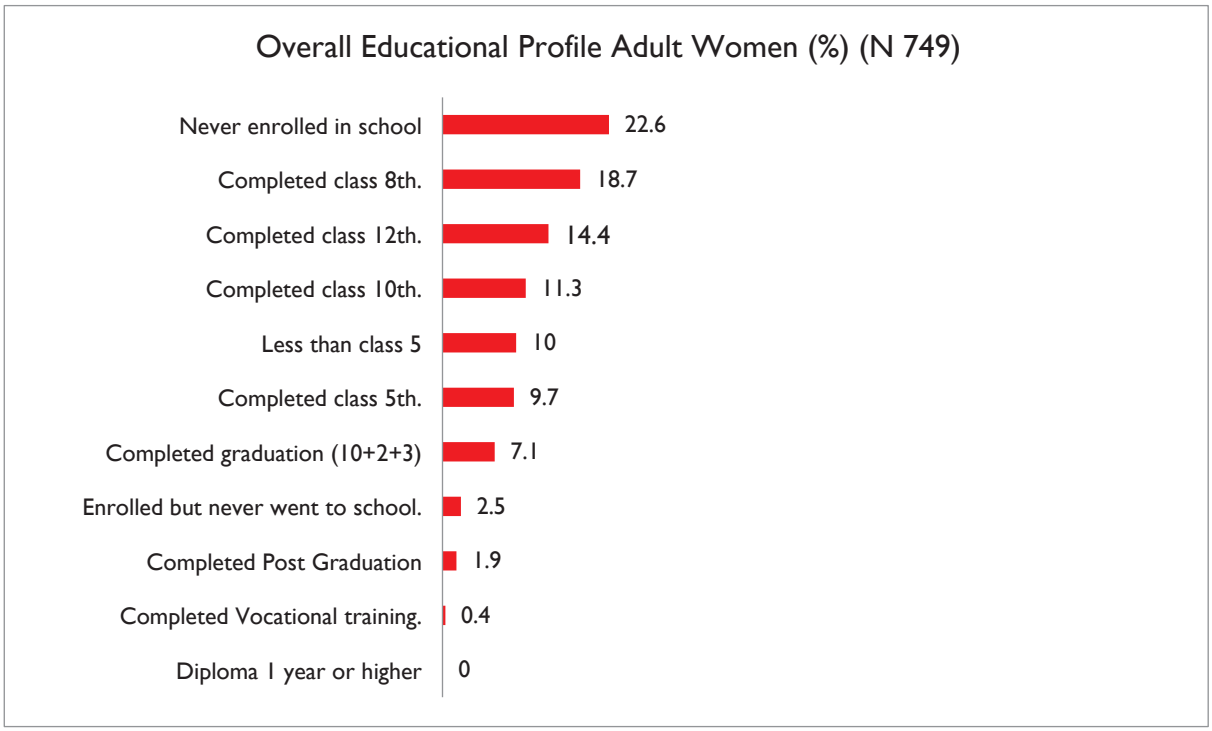
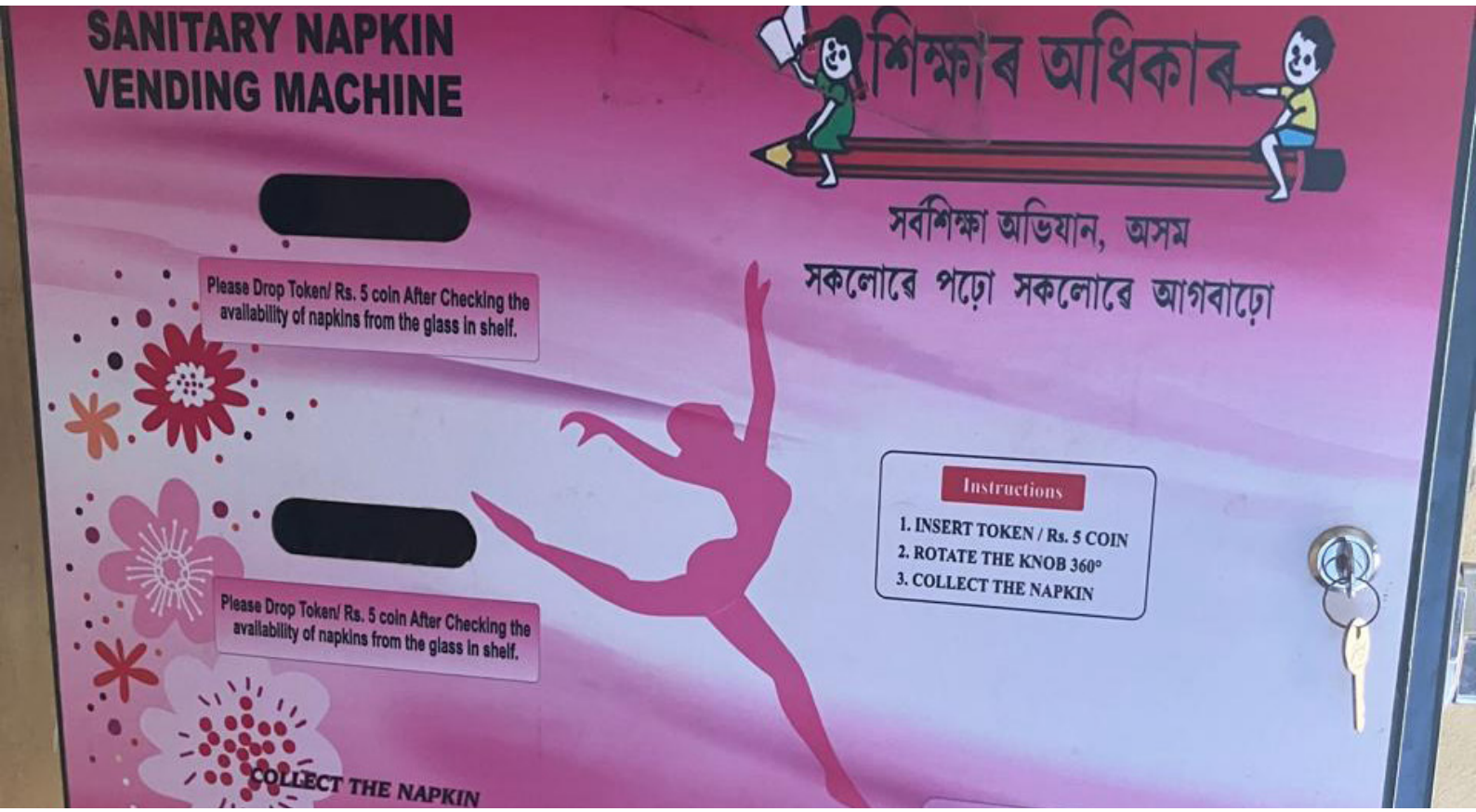


Table 16: Educational profile of adult women by state (%)

States	Assam	Maharashtra	Uttar Pradesh	Rajasthan
N	**100**	**211**	**212**	**226**
Never enrolled in school	2	9.5	31.6	35.4
Enrolled but never went to school.	6	1.4	3.8	0.9
Less than class 5	10	4.7	16.5	8.8
Completed class 5th.	11	6.6	9	12.8
Completed class 8th.	36	13.7	20.3	14.2
Completed class 10th.	19	18	5.2	7.5
Completed class 12th.	14	28.9	7.5	7.5
Completed graduation (10+2+3)	2	12.8	3.8	7.1
Completed Post Graduation	0	2.4	1.9	2.2
Completed Vocational training.	0	0.9	0.5	0
Diploma 1 year or higher	0	0	0	0

Sanitary napkin vending machine installed at a public school in Kamrup Rural, Assam.(June 2024)



One in every four women interviewed at the overall level never went to a school. Among the states, Rajasthan (36.3%) and UP (35.4%) had a higher proportion of respondents who never attend any school.

Figure 7: Educational profile of FLWs and Teachers (overall)

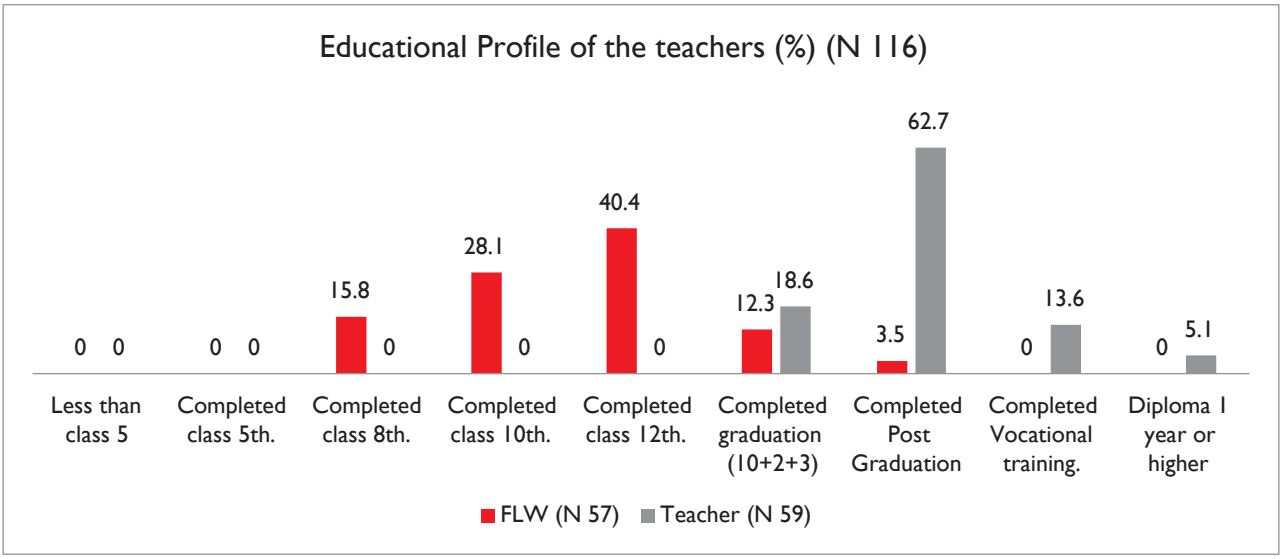


Table 17: State wise distribution of educational profile of FLWs & Teachers (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	FLW	Teacher	FLW	Teacher	FLW	Teacher	FLW	Teacher
N	*8*	*8*	*13*	*1*	*16*	*0*	*27*	*27*
Completed class 8th.	12.5	0	23.1	0	18.8	0	3.7	0
Completed class 10th.	50	0	30.8	0	18.8	0	14.8	0
Completed class 12th.	37.5	0	46.2	0	31.3	0	44.4	0
Completed graduation (10+2+3)	0	62.5	0	0	25	0	25.9	3.7
Completed Post Graduation	0	37.5	0	100	6.3	0	11.1	51.9
Completed Vocational training.	0	0	0	0	0	0	0	18.5
Diploma 1 year or higher	0	0	0	0	0	0	0	25.9

At the overall level, 40.4% of the FLWs interviewed have completed class 12th while 62.7% of the teachers completed post-graduation.

3.1.2. Social Category of Respondents

The respondents were asked voluntarily to identify their social identity (caste) and at the overall level 38% of AGs and 39% of AWs reported belonging to Other Backwards Castes (OBCs). Schedule Tribe representation at the overall level was 28% for AGs and 29% for AWs, while the Schedule Caste (SCs) representation was 19% and 18% for AGs and AWs respectively. Only 16% of AGs and 13% of AWs reported belonging to the General social category.

Among the states, Assam had 55% of AGs and 57% of AWs belonging to scheduled tribes, while their representation in Maharashtra was 46% each. In Uttar Pradesh, 58% of AGs and 57% of AWs reported belonging to Other Backwards Castes, the highest among the states. Rajasthan had more scattered representation across various social groups with 39% each of AGs and AWs belonging to Other Backwards Castes, while close to one-fourth of them belonging to Scheduled Castes and Scheduled Tribes each.

Figure 8: Social category of the respondents (overall)

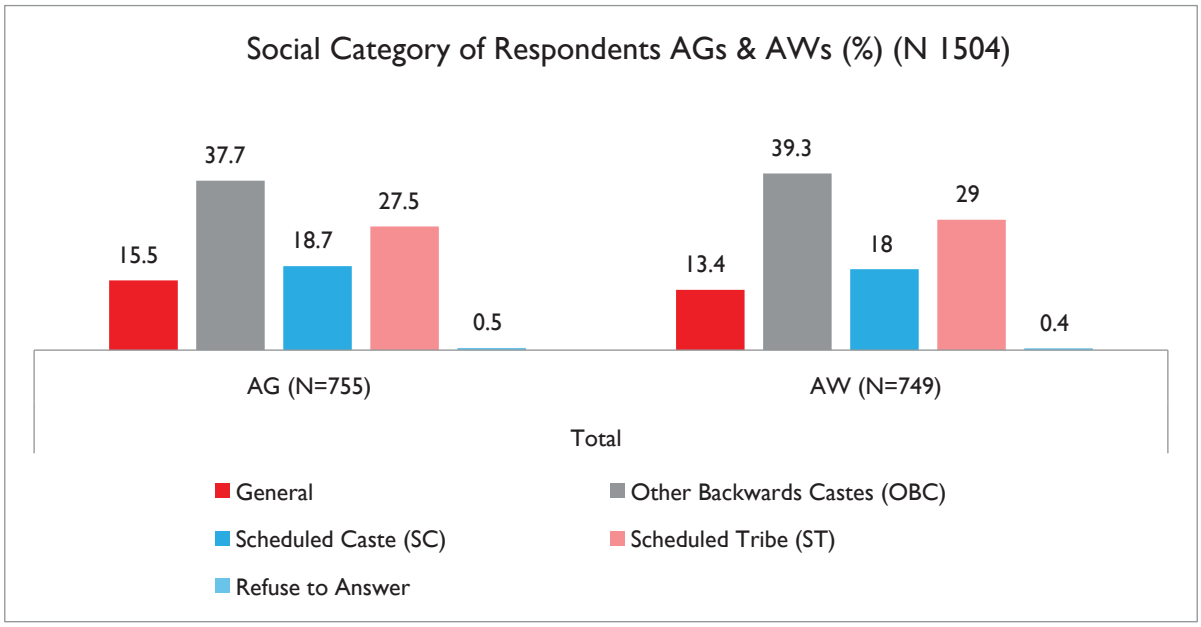


Table 18: State wise distribution of social categories of AGs and AWs (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	AG (101)	AW (100)	AG (212)	AW (211)	AG (211)	AW (212)	AG (231)	AW (226)
General	21.8	23	10.8	6.6	23.2	23.6	10	5.8
Other Backwards Castes (OBC)	7.9	8	30.2	37	57.8	57.1	39.4	38.5
Scheduled Caste (SC)	15.8	12	12.7	9.5	18.5	18.9	25.5	27.9
Scheduled Tribe (ST)	54.5	57	45.8	46.4	0.5	0.5	23.8	27
Refuse to Answer	0	0	0.5	0.5	0	0	1.3	0.9
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

3.1.3. Religious Profile of Respondents

The respondents were asked voluntarily to identify their religious affiliation. At the overall level, 90% of AGs and AWs reported belonging to Hindu religion. Around 6% of both the respondent groups belong to Islam, while 6% from the groups associated themselves to other religions.

Figure 9: Overall religious profile of AGs and AWs (overall)

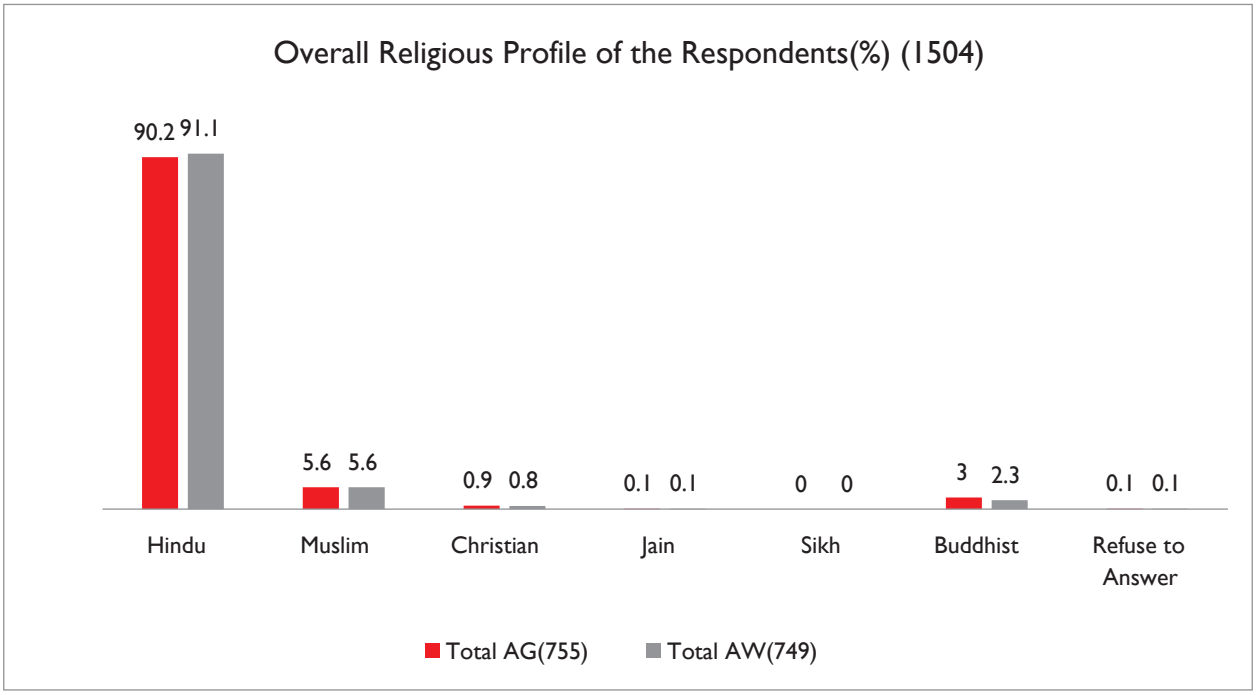


Table 19: State wise distribution of religious profile of AGs and AWs) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	AG (101)	AW (100)	AG (212)	AG (211)	AW (211)	AG (212)	AW (231)	AG (226)
Hindu	69.3	70	88.7	91.5	91.9	91.5	99.1	99.6
Muslim	23.8	24	0	0	8.1	8.5	0.4	0
Christian	6.9	6	0	0	0	0	0	0
Jain	0	0	0	0	0	0	0.4	0.4
Sikh	0	0	0	0	0	0	0	0
Buddhist	0	0	10.8	8.1	0	0	0	0
Refuse to Answer	0	0	0.5	0.5	0	0	0	0

The religious composition data underscores the significant Hindu majority among both adolescent girls and adult women across most states, particularly in Uttar Pradesh and Rajasthan. Assam and Maharashtra exhibit more religious diversity, reflecting the cultural and religious plurality in these regions. These insights are to be considered for designing culturally sensitive educational and health interventions that address the diverse religious backgrounds of the target populations.

3.1.4. Primary Wage Earner of the Household

The respondents were asked about the primary wage earner of their household. At the overall level, 84% of the AWs reported that their husband was the main wage earner, while 91% of the AGs reported their father being the main wage earner. This trend remained the same across the four states. It is pertinent to note, only 3 % of the AWs reported themselves being the main wage earner, and a similar proportion of AGs reported their mothers being the main wage earner. This shows the limited financial ability of the women in the household and their dependence on the patriarchs. The distribution of the main wage earners in households, categorized by Adolescent Girls (AG) and Adult Women (AW) across the four states are presented in the table below.

Figure 10: Primary wage earners of the family (overall)

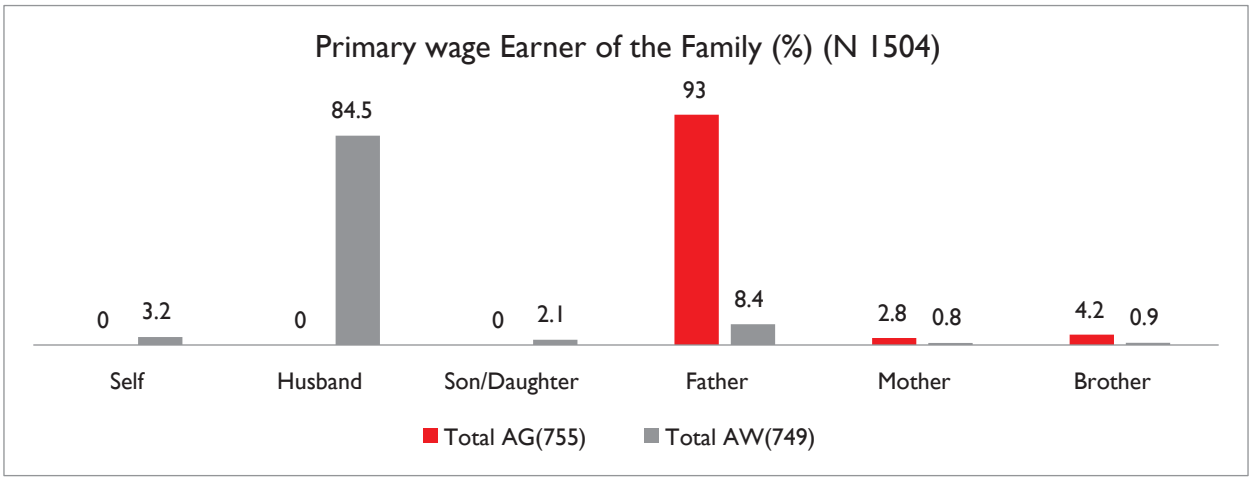


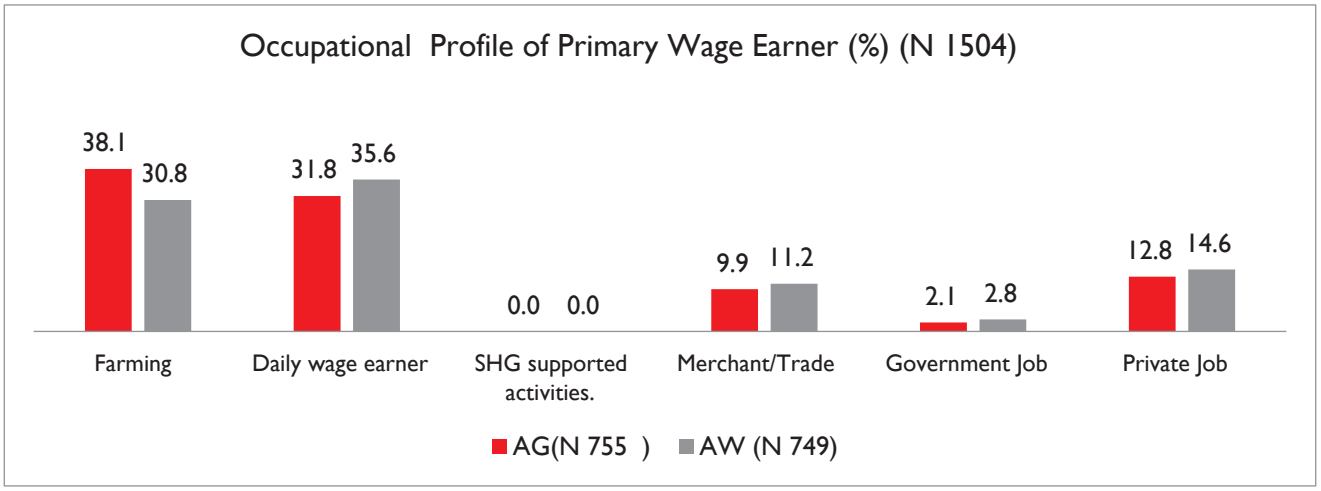
Table 20: Primary wage earners of the family (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	**AG (101)**	**AW (100)**	**AG (212)**	**AW (211)**	**AG (211)**	**AW (212)**	**AG (231)**	**AW (226)**
N	***101***	***100***	***212***	***211***	***211***	***212***	***231***	***226***
Self	0	4	0	3.3	0	3.3	0	2.7
Husband	0	89	0	81	0	92	0	78.8
Son/Daughter	0	1	0	1.9	0	3.8	0	1.3
Father	95	4	96.2	10.4	89.6	0.9	92.2	15.5
Mother	3	1	2.8	1.4	2.8	0	2.6	0.9
Brother	2	1	0.9	1.9	7.6	0	5.2	0.9

3.1.5. Occupation of Primary Wage Earner

When probed on the occupation of the primary wage earner, 38% of AGs and 31% of AWs reported farming as the occupation followed by daily wage warner (32% of AGs and 36% of AWs).

Figure 11: Occupation of primary wage earner (%) (overall)



State-wise analysis reveal that nearly one-third of the AGs and AWs in Assam reported their primary wage earner being involved in merchant/ trade, while in Maharashtra more that 50% of both the respondent group reported farming as the occupation of the primary wage earner. In Rajasthan, nearly one-fourth of both the respondent groups reported their primary wage earner being involved in private job.

Table 21: Occupational profile of the respondents by state (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
Respondent Group	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**
N	***101***	***100***	***212***	***211***	***211***	***212***	***231***	***226***
Farming	25.7	11.0	56.6	58.3	29.4	18.9	34.6	25.2
Daily wage earner	22.8	35.0	39.2	36.0	37.9	41.5	23.4	30.1
SHG supported activities.	0	0	0.0	0.0	0.0	0.0	0.0	0.0
Merchant/Trade	33.7	38.0	1.4	1.4	7.6	11.3	9.5	8.4
Government Job	2.0	2.0	0.9	0.9	4.3	2.8	1.3	4.9
Private Job	13.9	10.0	0.5	1.9	11.4	19.3	25.1	23.9

3.1.6. Household Composition

The table outlines the average household composition across the states for adolescent girls (AG) and adult women (AW). The data shows that the overall household size for both AGs and AWs is around six members. This consistency is observed across different states with slight variations.

Figure 12: Household composition (Mean) (overall)

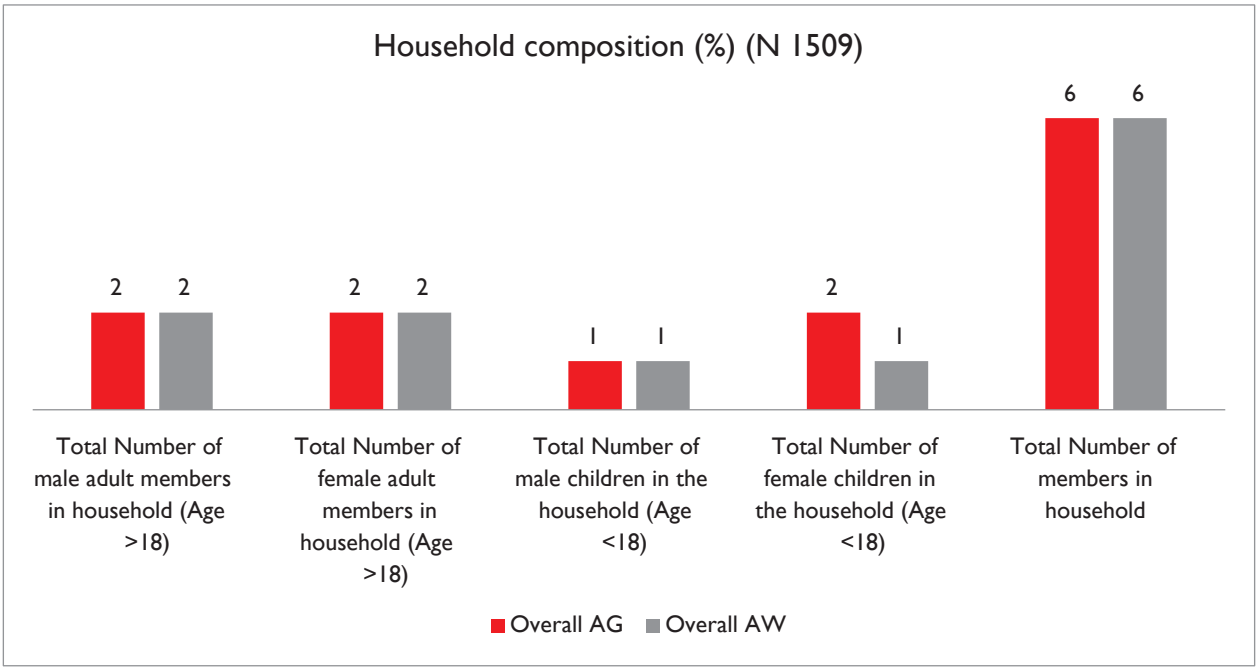


Table 22: Household composition of Interviewed AGs and AWs (Mean) by state

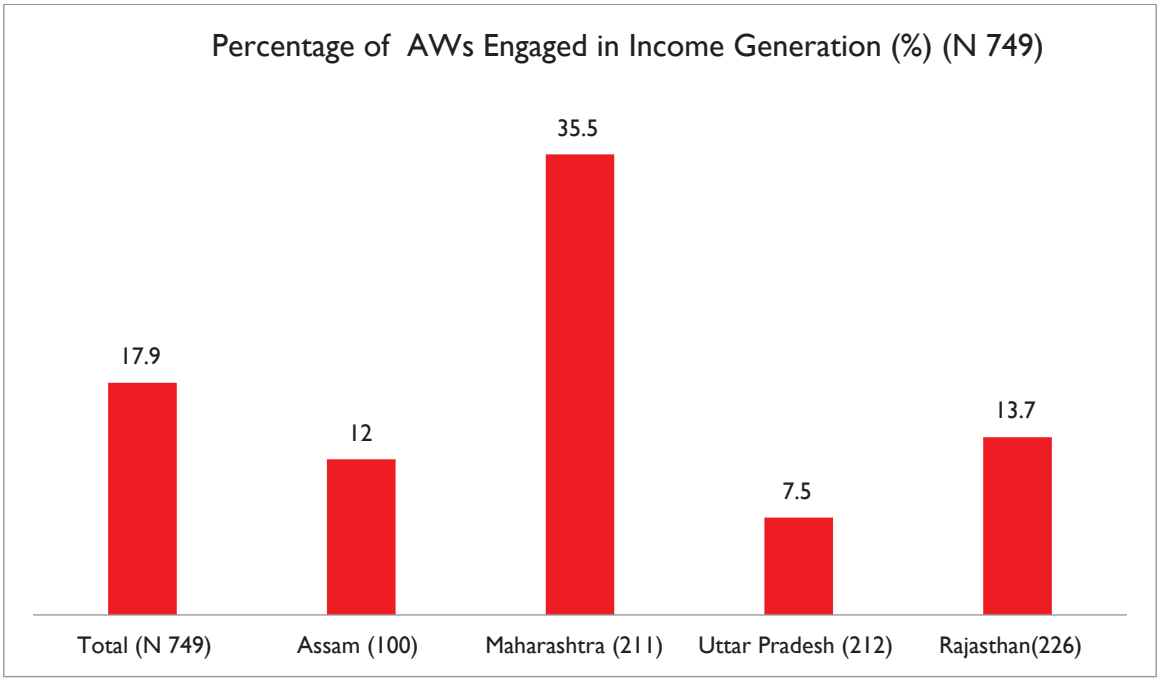
State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**
Total Number of male adult members in household (Age >18)	2	2	2	2	2	1	2	2
Total Number of female adult members in household (Age >18)	1	2	2	2	2	2	2	2
Total Number of male children in the household (Age <18)	1	1	1	1	1	1	1	1
Total Number of female children in the household (Age <18)	1	1	1	1	2	1	2	1
Total Number of members in household	**5**	**5**	**5**	**6**	**6**	**6**	**7**	**6**

While the overall household size remains relatively constant across the states, there are some minor regional variations present with Assam having lower average members in the household.

3.1.7. Involvement in Income Generation Activities

The AWs were probed about their engagement in any income generation activities and only 17.9% of adult women (AW) respondents reported involvement in income generation at overall level. There are notable variations across different states. In Maharashtra, a substantial 35.5% of AWs are engaged in income generation, contrasting sharply with Uttar Pradesh, where only 7.5% of AWs are involved. Assam and Rajasthan also show lower participation rates in income-generating activities, with 12.0% and 13.7% respectively. These figures highlight significant regional disparities in the involvement of adult women in economic activities, with Maharashtra showing higher engagement compared to other states.

Figure 13: AWs involvement in Income Generation Activities (by state) (%)



3.1.7.1 Occupation of Respondent

Overall, 50% of respondents who reported to have been involved in income generation activity are daily wage earners, followed by 25% involved in farming. Notably, only 1.5% are engaged in SHG-supported activities, 10% in merchant/trade, and 8% in private jobs.

Figure 14: Occupational profile of working AWs (overall)

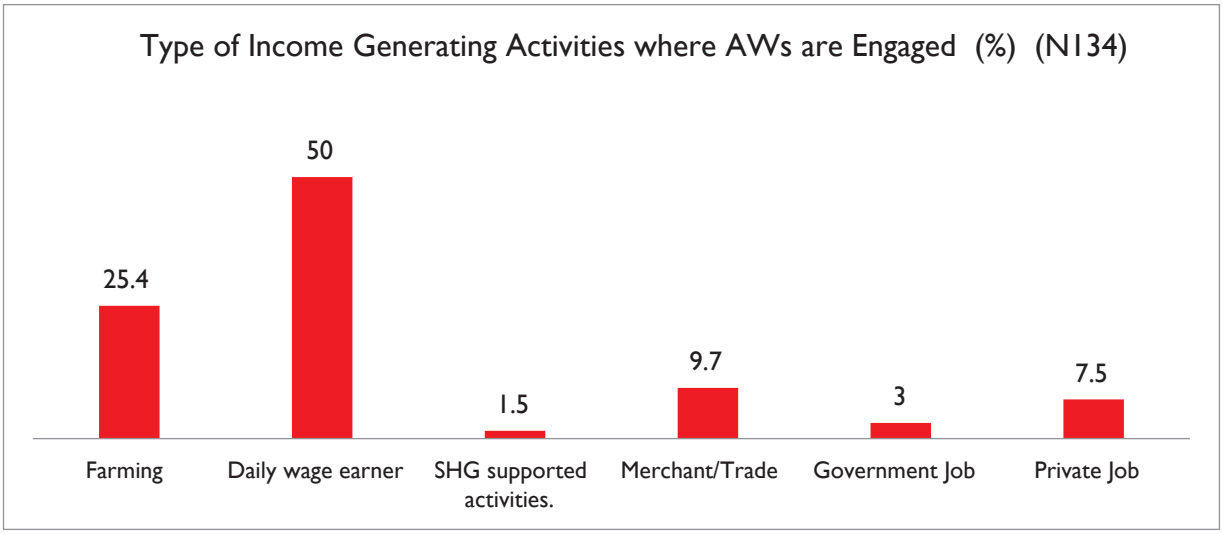


Table 23: Occupational profile of working AWs (by state) (%)

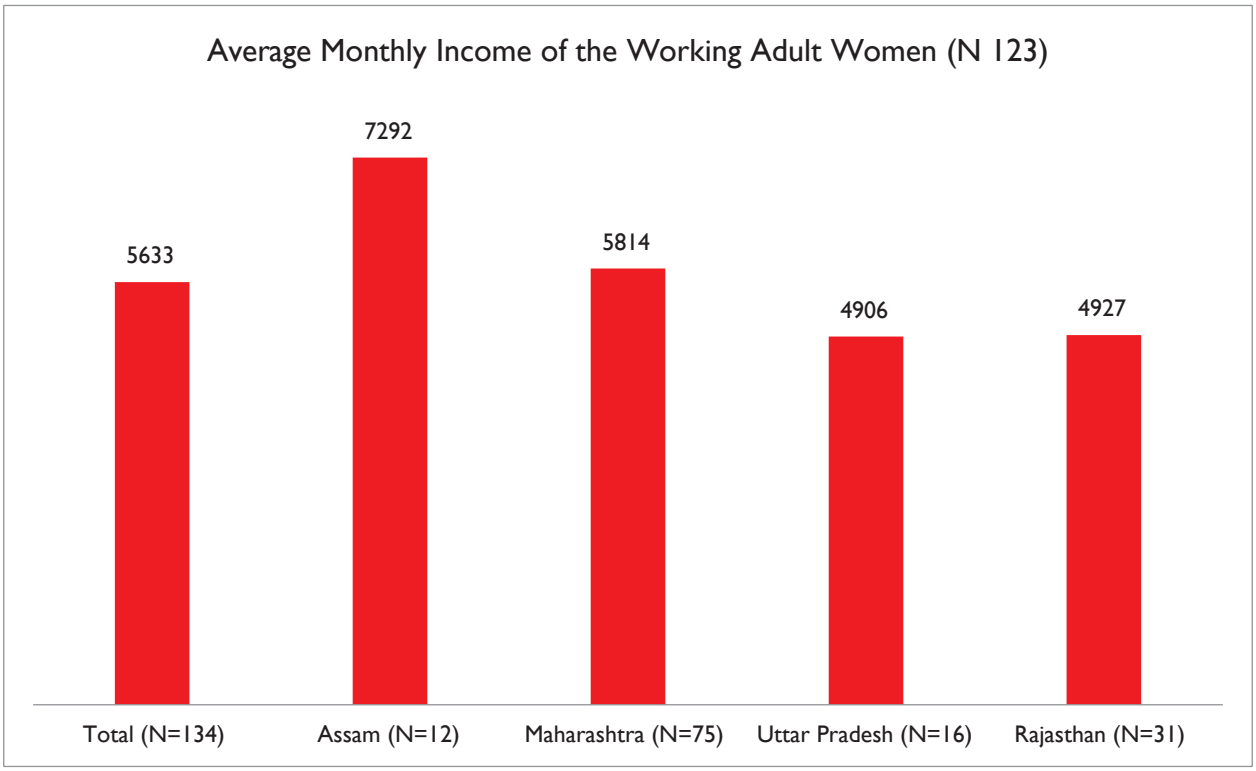
State	Assam	Maharashtra	Uttar Pradesh	Rajasthan
N	***12***	***75***	***16***	***31***
Farming	8.3	30.7	18.8	22.6
Daily wage earner	25.0	61.3	18.8	48.4
SHG supported activities.	8.3	0.0	0.0	3.2
Merchant/Trade	25.0	1.3	50.0	3.2
Government Job	8.3	0.0	6.3	6.5
Private Job	25.0	4.0	6.3	9.7

In Assam, the respondents have a more diverse occupational distribution with 25.0% each in daily wage earning and merchant/trade. Interestingly, 25.0% also work in private jobs, and 8.3% are involved in government jobs and SHG-supported activities respectively. Maharashtra has the highest percentage of daily wage earners at 61.3%, with 30.7% in farming. Uttar Pradesh has a unique profile with a significant portion in trade activities (50%).

3.1.7.2 Average Monthly Income of the Respondent

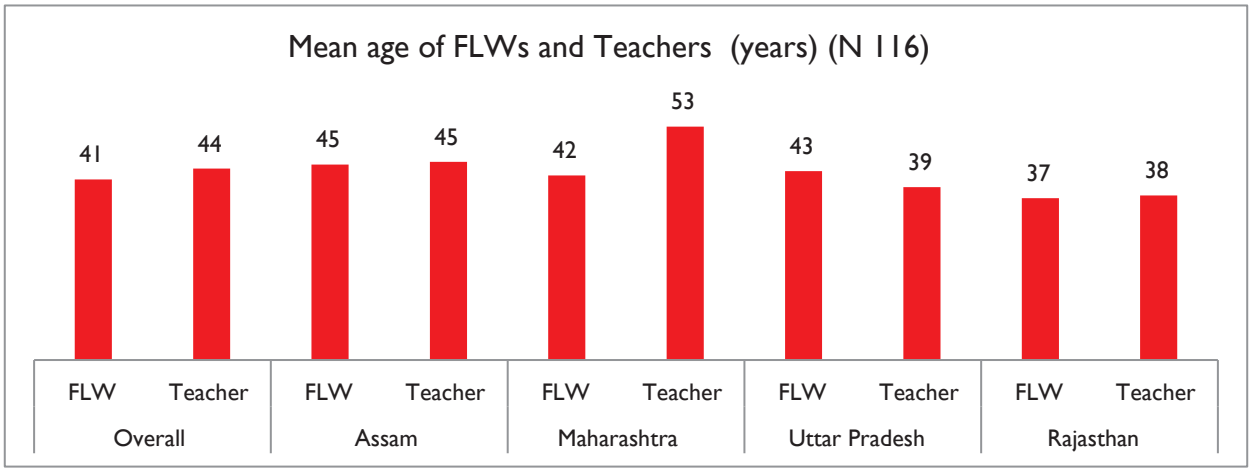
The table below illustrates the average monthly income of respondents across different states. On an overall level, the average monthly income among the respondents is ₹5633. There are, however, significant state-wise variations. Assam reports the highest average monthly income at ₹7292, followed by Maharashtra with ₹5814. In contrast, respondents from Uttar Pradesh and Rajasthan report lower average monthly incomes of ₹4906 and ₹4927, respectively. These differences in income levels may reflect varying economic conditions, employment opportunities, and participation in income-generating activities across the states.

Figure 15: Average monthly income of AWs (overall)



3.1.7.3. Mean Age of FLWs and Teachers

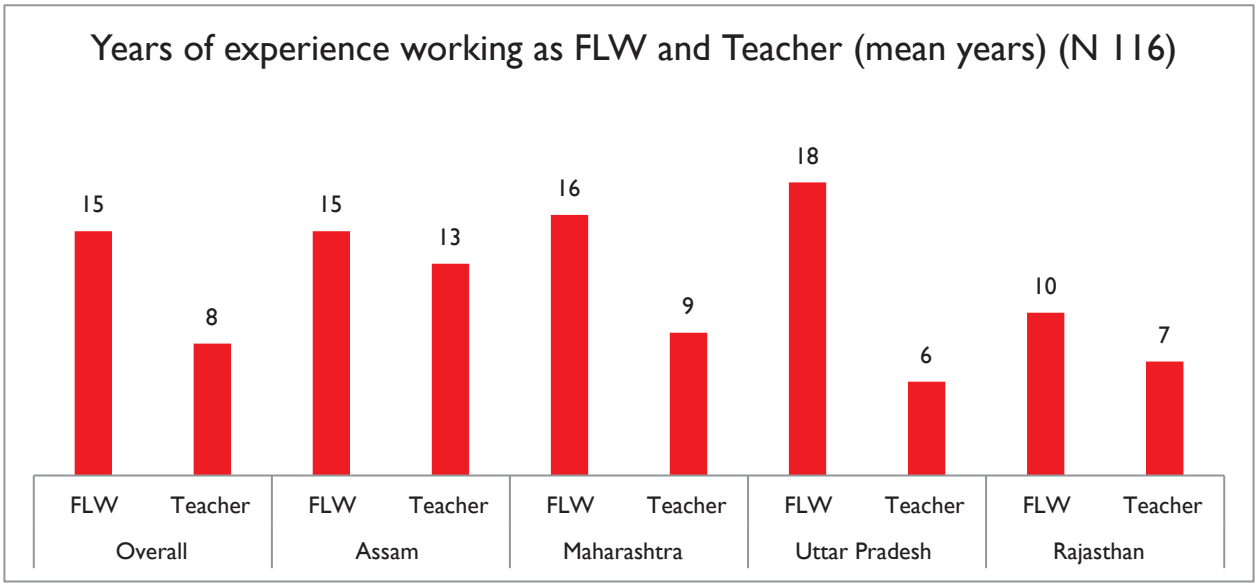
Figure 16: Mean age of FLWs and Teachers



At the overall level, the mean age of the FLWs was 41 years and Teacher 44 years

3.1.7.4. Years of Experience FLWs and Teachers

Figure 17: Working experience of FLWs and Teachers in years by state



Overall, the FLWs possess 15 years of experience on an average while the teachers have an average experience of 8 years. FLWs in Uttar Pradesh reported to have the highest years of experience i.e.18 years. Assam has the teacher with highest experience of 13 years.

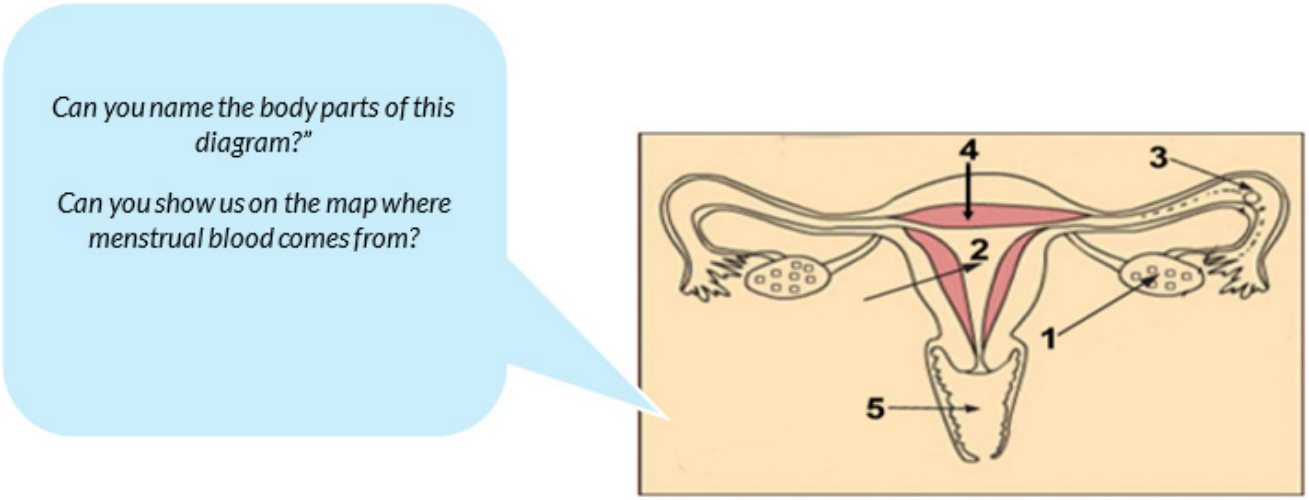
3.2 Knowledge on Menstruation

This section delves into the awareness levels and gender norms surrounding menstruation. It explores the prevalence of misconceptions and taboos related to menstruation, shedding light on societal perceptions and attitudes. Additionally, it examines health-seeking behaviors, for reproductive tract infection (RTI) symptoms, highlighting access to MHM products and services and the impact of capacity-building efforts on improving awareness and access.

3.2.1. Self-Awareness

To assess the current knowledge of reproductive health amongst the target group, the survey protocol included showing a picture cue card and asking the respondents to name the reproductive parts, followed by identifying the body part associated with the release of menstrual blood. The following tables report on the proportion of respondents who could name the reproductive organs correctly.

Figure 18: Anatomical Showcard



3.2.1.1 Knowledge about Reproductive Organs

The awareness and knowledge of reproductive body parts among Adolescent Girls (AG) and Adult Women (AW) across the four states reveal significant regional variations and highlight gaps in reproductive health education.

Figure 19: Correctly identified the reproductive organs (overall)

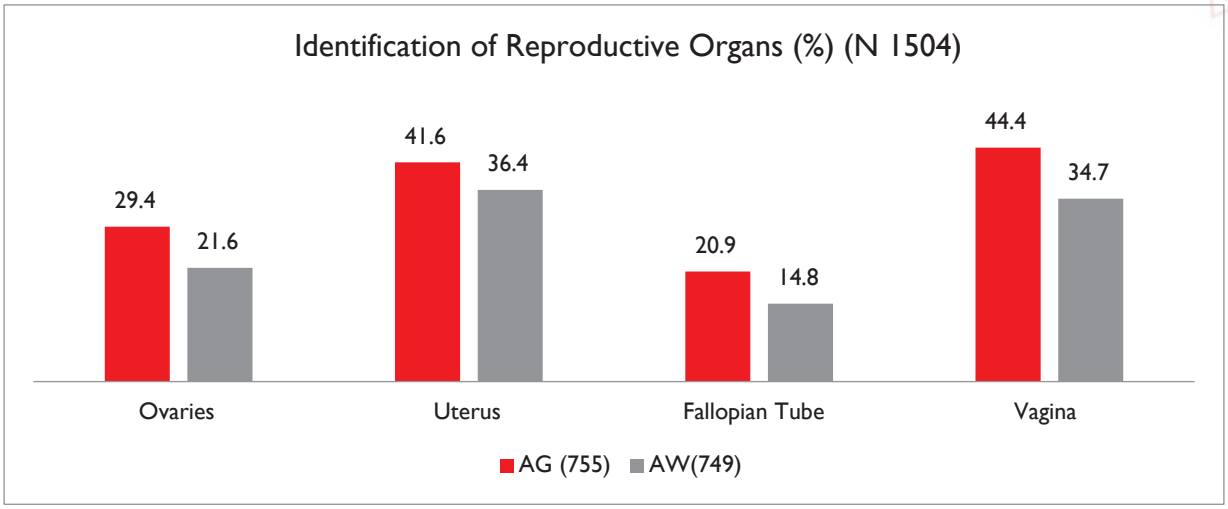


Table 24: Correctly identified the reproductive organs (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	AG	AW	AG	AW	AG	AW	AG	AW
N	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Ovaries	12.9	13.0	24.1	18.5	33.2	25.9	38.1	24.3
Uterus	42.6	43.0	25.9	22.3	46.9	45.8	50.6	38.1
Fallopian Tube	3.0	5.0	17.5	14.2	27.0	17.5	26.4	17.3
Vagina	52.5	43.0	25.0	19.9	53.1	40.6	50.6	39.4

Overall, the awareness of the uterus and vagina is relatively high, with 42% and 44% respectively as compared to the correct identification of Ovaries (29.4%) and Fallopian Tube (20.9%). Knowledge about reproductive body parts among adolescent girls shows considerable variation across states. Notably, in Rajasthan, awareness of the uterus (51%) and vagina (50%) is the highest. Assam has lower awareness levels, especially for the ovaries (13%) and fallopian tube (3%), highlighting a significant gap in reproductive health knowledge.

Adult women's knowledge of reproductive body parts also varies across states, and more importantly their knowledge tend to be lower than that of adolescent girls at the overall level as well as at states. On an overall level, the highest awareness is of the uterus (36.4%) and vagina (34.7%). Rajasthan shows relatively better awareness of the uterus (38.1%) and ovaries (24.3%). However, Assam and Uttar Pradesh display notably lower knowledge levels, particularly about the fallopian tube, where awareness is only 5% and 14% respectively.

These findings underscore the need for enhanced reproductive health education from the basics across all states, with a particular focus on regions like Assam and Uttar Pradesh, where knowledge gaps are more pronounced. Effective educational interventions can play a crucial role in improving awareness and understanding of reproductive

health among both adolescent girls and adult women. These findings are further supported by the qualitative discussions with the principals of the schools who reported that there are a lot of challenges in integrating MHM into the school curriculum, as it is not only a new thing forthem, but girls also do not come to know what is happening with them. Additionally, since girls can only openly discuss with female teachers, more women staff are needed to share knowledge among children.

Both AGs and AWs requires more education and learning around identification of reproductive organs. Proper identification not only help them in addressing the concerns in a timely manner but it will help them better explain the problems pertaining to it when they visit healthcare specialist.

3.2.1.2 Knowledge about the Source of Menstrual Blood

The ability of respondents to identify the origin of menstrual blood on a diagram highlights varying levels of knowledge and confidence across regions and respondent groups.

On an overall level, the data indicates that nearly half of the adolescent girls (47.4%) could correctly identify the source of menstrual blood while 22% of AGs hesitated to answer, and 31% did not know the answer, reflecting a mix of uncertainty, aversion to discuss reproductive health, and lack of knowledge about menstrual health. Among adult women at the overall level, even lesser proportion of them were able to identify the source of menstrual

Figure 20: Responses on source of menstrual blood (overall)

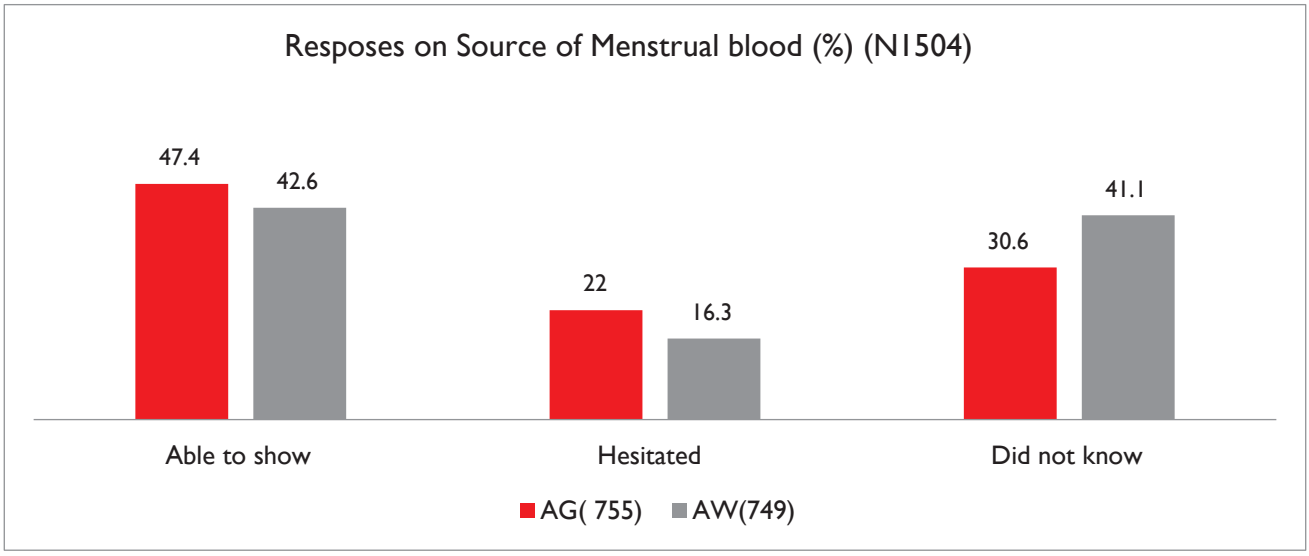


Table 25: Responses on source of menstrual blood (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	AG	AW	AG	AW	AG	AW	AG	AW
N	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Able to show	28.7	31.0	48.1	43.1	43.6	40.6	58.4	49.1
Hesitated	27.7	19.0	20.3	21.3	27.5	15.6	16.0	11.1
Did not know	43.6	50.0	31.6	35.5	28.9	43.9	25.5	39.8

blood correctly (42.6%). A significant portion of AWs (41.1%) did not know the source, indicating substantial gaps in menstrual health education among adults. The hesitation rate was lower in adults (16.3%) compared to AGs, suggesting slightly more confidence in discussing menstrual health, though knowledge gaps remain evident.

The data highlights that despite higher percentage of respondents across target groups being able to show the source of menstrual blood, there was a significant portion of respondents who hesitated. This mix of responses can also be validated with the help of qualitative discussions with adolescent girls, which highlight that although the girls were informed about menstruation from teachers in the school, they still felt hesitant about discussing menstruation with their fathers, brothers and male teachers, but at the same time felt that there should be no hesitation to discuss about menstruation with anyone irrespective of gender, which is a natural part of life.

However, there is significant regional variation. In Rajasthan, a higher percentage (58.4%) of AGs could accurately identify the source. In contrast, only 28.7% of AGs in Assam could do the same, highlighting a gap in awareness. Rajasthan again shows relatively better awareness with 49.1% of AWs able to identify the source, whereas Assam has the lowest percentage at 31% for AWs.

These findings underscore the need for targeted educational programs to improve menstrual health literacy, especially in regions like Assam and Uttar Pradesh where knowledge gaps are most pronounced.

3.2.2. First Reactions Towards Menstruation

Overall, an overwhelming majority of the of the AGs and AWs couldn't identify or hesitated to show the source of blood. This reflects the deeply ingrained taboo around mestruation that exist in our society. The intervention must focus on instilling confidence among the target groups around MHM.

The reactions of respondents towards the onset of menstruation highlight the emotional and psychological responses that can vary significantly based on regional and cultural contexts.

Figure 21: Respondents first reaction of menstruation (overall)

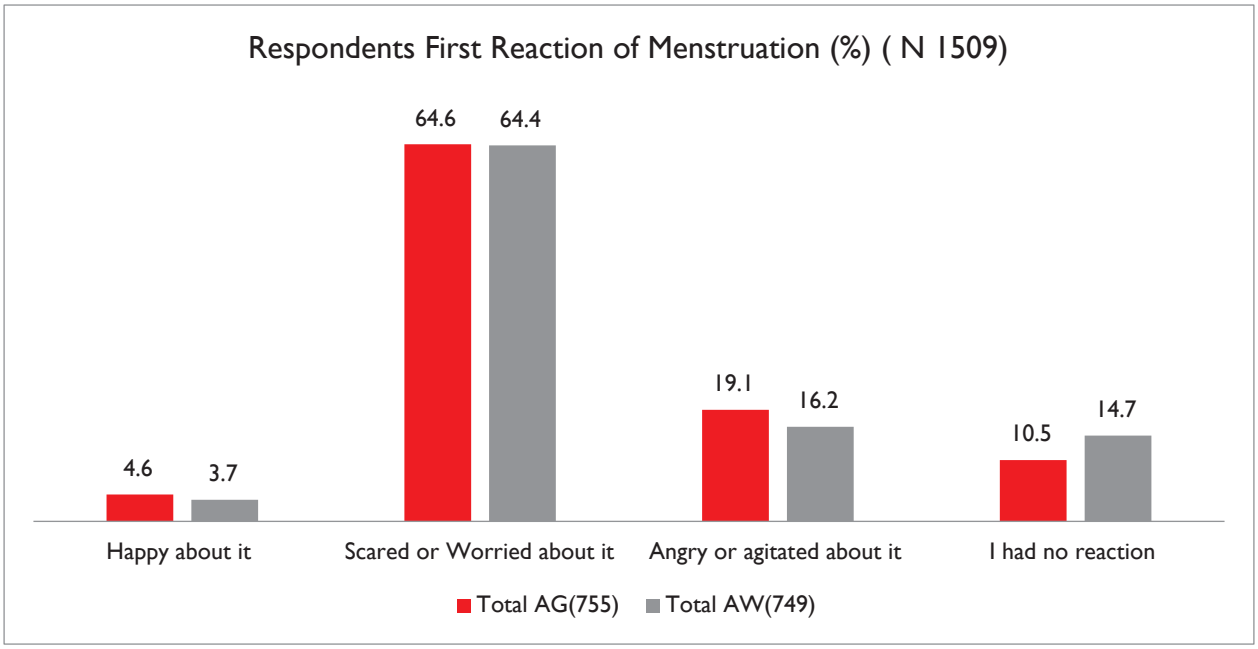


Table 26: Respondents' first reaction to menstruation (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
Respondent Group	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**
N	***101***	***100***	***212***	***211***	***211***	***212***	***231***	***226***
Happy about it	15.8	13.0	4.7	2.8	2.4	1.4	1.7	2.7
Scared or Worried about it	65.3	68.0	51.4	55.5	72	69.3	69.7	66.4
Angry or agitated about it	7.9	9.0	31.6	25.1	15.2	17.5	16.0	9.7
I had no reaction	10.9	10.0	12.3	15.6	6.6	9.4	12.1	20.8

At the overall level, the predominant reaction among both adolescent girls (64.6%) and adult women (64.4%) was one of fear or worry upon first experiencing menstruation. This indicates widespread anxiety and possibly a lack of preparatory education regarding menstruation. A smaller proportion of respondents expressed happiness, with only 5% of AGs and 4% of AWs feeling positive about the onset of menstruation. Anger or agitation was reported by 19% of AGs and 16% of AWs, reflecting frustration or discomfort with this new bodily change.

> *"The adolescent girls were shocked to see menstrual blood for the first time and were scared because they thought they had a serious disease. There was no information provided to them about menstruation ever, and the misinformation is rampant in the area, which leads to such panic and shock among them"* ***– Partner NGO Focal Person***

In terms of regional differences, Assam stood out with a higher percentage of respondents feeling happy about menstruation (16% of AGs and 13% of AWs), suggesting a more positive cultural framing or better preparatory education in this region. Conversely, Uttar Pradesh had the highest proportion of respondents feeling scared or worried, with 72% of AGs and 69% of AWs reporting this reaction, indicating a need for improved menstrual education and support in this state.

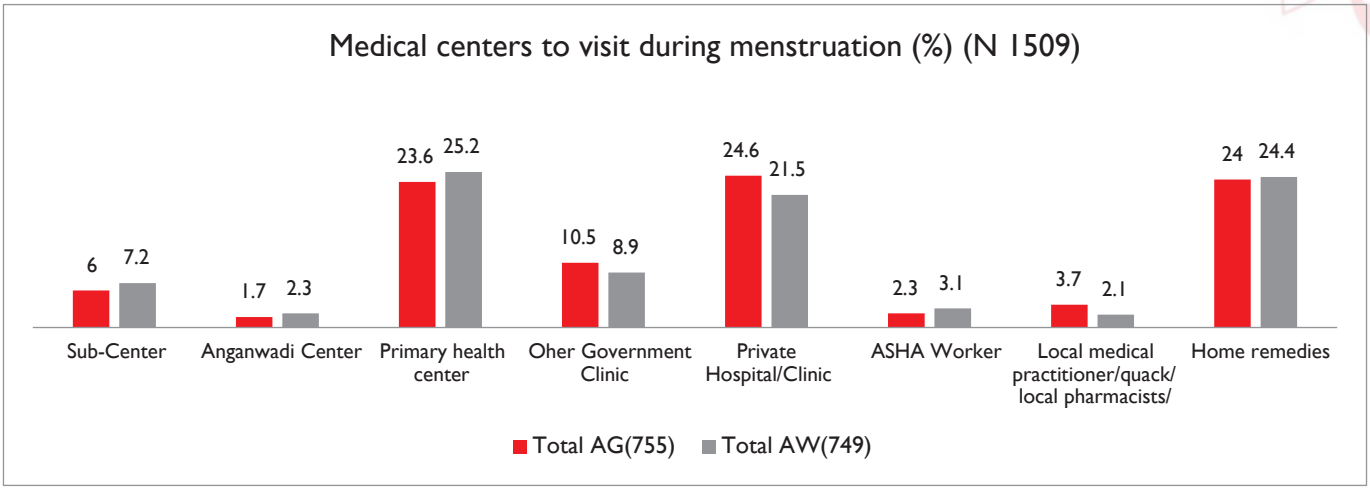
The findings underscore the importance of educational programs that prepare young girls for menstruation, fostering a more positive and informed attitude towards this natural biological process.

Due to lack of information and awareness majority of the target groups reported to have been worried or scared during the onset of menstruation. The situation underlines the need for a more intensive counselling around the MHM for the targeted group.

3.2.4. Health Seeking Behavior during Menstrual Discomfort

The table outlines the various healthcare facilities, and options women and girls generally turn to if they faced significant menstrual discomfort. On an overall level, the data shows that a considerable proportion of respondents would seek help from primary health centers, with 23.6% of adolescent girls (AGs) and 25.2% of adult women (AWs) choosing this option. Private hospitals and clinics are also a preferred choice for many, particularly among AGs (24.6%) and AWs (21.5%). Notably, a significant number of respondents still rely on home remedies, with 24.0% of AGs and 24.4% of AWs indicating this as their preferred option.

Figure 22: Medical Centers to Visit when Feeling Menstrual Discomfort (AG and AW) (overall)



Regional variations are evident as seen in Maharashtra, where a high percentage (47.5%) of AGs would go to a primary health center, while in Uttar Pradesh, 36% prefer private hospitals or clinics. Assam shows a diverse pattern, with responses using sub-centers (8.9%) and other government clinics (19.8%). The reliance on home remedies is notably high in Maharashtra (42.9%). Similar trends are observed among adult women - In Maharashtra, over half (54%) would seek help from primary health centers, while in Uttar Pradesh, a significant number (30.2%) prefer private hospitals or clinics. Assam and Rajasthan show a higher reliance on government facilities, with Rajasthan also having a notable percentage (41.7%) using home remedies.

Table 27: Medical centers to visit when feeling menstrual discomfort (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
Respondent Group	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**
N	***101***	***100***	***212***	***211***	***211***	***212***	***231***	***226***
Sub-Center	8.9	14.0	0.5	1.4	7.1	7.5	8.7	9.3
Anganwadi Center	0.0	0.0	0.0	0.9	0.9	0.5	4.8	6.2
Primary health center	47.5	54.0	9.0	8.1	19.9	27.4	29.9	26.5
Oher Government Clinic	19.8	11.0	14.6	12.3	0.5	0.9	11.7	12.4
Private Hospital/Clinic	4.0	3.0	24.5	22.3	36.0	30.2	23.4	20.8
ASHA Worker	2.0	2.0	3.8	5.2	1.4	4.2	1.7	0.4
Local medical practitioner/quack/ local pharmacists/	7.9	5.0	0.0	0.9	8.1	4.2	1.3	0.0
Home remedies	7.9	11.0	42.9	41.7	23.7	21.2	13.9	17.3

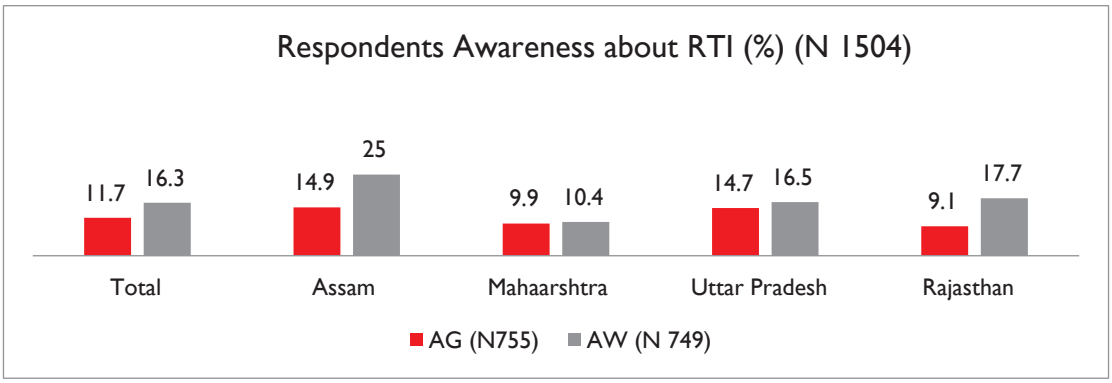
These findings highlight the diverse health-seeking behaviors and preferences across regions, emphasizing the importance of strengthening both formal healthcare systems and community-based support mechanisms. Targeted interventions to improve access to quality healthcare and educate about effective treatment options are crucial, particularly in regions where reliance on home remedies is high.

These findings highlight the diverse health-seeking behaviors and preferences across regions, emphasizing the importance of strengthening both formal healthcare systems and community-based support mechanisms. Targeted interventions to improve access to quality healthcare and educate about effective treatment options are crucial, particularly in regions where reliance on home remedies is high.

3.2.5. Awareness on Reproductive Tract Infections (RTIs)

The table presents data on the awareness of Reproductive Tract Infections (RTIs) among adolescent girls (AG) and adult women (AW). Understanding the level of knowledge about RTIs is crucial for designing effective health education and intervention programs. At the overall level, awareness of RTIs is relatively low among both adolescent girls (11.7%) and adult women (16.3%). This indicates a substantial gap in reproductive health knowledge that needs to be addressed through targeted educational programs.

Figure 23: Respondents Awareness of Reproductive Tract Infection by state



Among adolescent girls, Assam shows slightly higher awareness (14.9%), while Maharashtra has the lowest awareness (9.9%). In contrast, awareness among adult women is relatively higher in Assam (25.0%), indicating a better understanding of RTIs among older women in this region. Maharashtra again shows low awareness among adult women (10.4%). In Uttar Pradesh and Rajasthan, awareness levels are consistent across both AGs and AWs, with slight variations. For instance, in Uttar Pradesh, 14.7% of AGs and 16.5% of AWs are aware of RTIs, while in Rajasthan, the awareness is 9.1% for AGs and 17.7% for AWs. These figures highlight the need for increased educational efforts to bridge the knowledge gap in these regions.

These findings underscore the need for enhancing reproductive health education across all states, particularly focusing on regions with the lowest awareness levels. Tailored educational interventions can significantly improve understanding and management of RTIs among both adolescent girls and adult women.

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3.3 Practice on Menstruation

3.3.1. Open Discussions on MHM

Open discussions on menstrual health management are crucial for breaking taboos and improving menstrual hygiene practices. This subsection examines the confidence levels of frontline workers (FLWs) and teachers when discussing MHM topics with women and girls. It also explores the comfort levels of adolescent girls (AGs) and adult women (AWs) in discussing MHM with people outside their families, including FLWs and teachers. Understanding these dynamics can help in designing interventions that foster open communication and support around menstrual health.

Overall, a significant proportion of frontline workers (FLWs) and teachers feel confident discussing menstrual health and hygiene-related topics. Among FLWs, 63.2% feel very confident, and 17.5% feel moderately confident. Teachers exhibit slightly lower confidence levels, with 61% feeling very confident and 15.3% feeling moderately confident. Interestingly, FLWs in Maharashtra exhibit the highest confidence levels (87.5% very confident).

Figure 24: Confidence of FLWs and Teachers to discuss MHM in community/schools (overall)

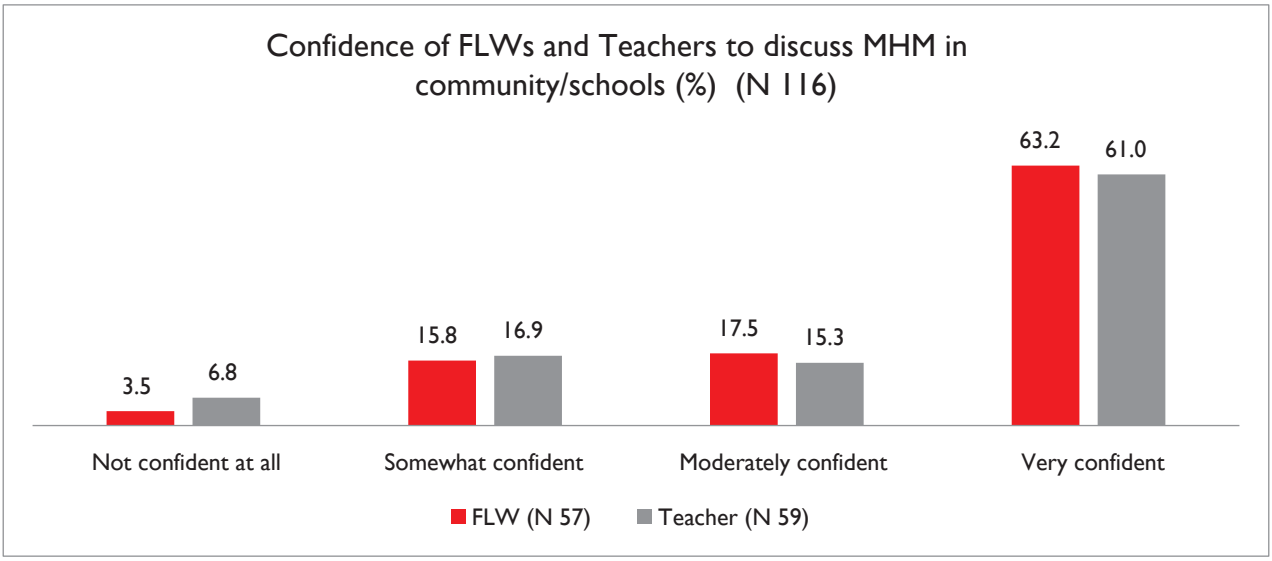


Table 28: Confidence of FLWs and Teachers to Discuss MHM in Community/Schools (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
Respondent Group	**FLW**	**Teacher**	**FLW**	**Teacher**	**FLW**	**Teacher**	**FLW**	**Teacher**
N	***8***	***8***	***13***	***17***	***16***	***17***	***17***	***27***
Not confident at all	0.0	0.0	0.0	0.0	6.3	11.8	5.9	11.8
Somewhat confident	37.5	37.5	6.3	23.5	25.0	11.8	5.9	5.9
Moderately confident	0.0	25.0	6.3	29.4	31.3	11.8	23.5	0
Very confident	62.5	37.5	87.5	47.1	37.5	64.7	64.7	82.4

The comfort levels of adolescent girls (AGs) and adult women (AWs) discussing menstrual health and hygiene vary significantly. Overall, 38% of AGs and 36% of AWs feel somewhat comfortable discussing MHM. Additionally, 16% of AGs and 20% of AWs feel very comfortable discussion MHM. A notable proportion of respondents still feel uncomfortable, with 15% of AGs and 10% of AWs feeling very uncomfortable. Regional variations are evident, with Assam exhibiting higher discomfort levels among AGs (25.7% feel very uncomfortable and 37.6% feel somewhat uncomfortable) and Uttar Pradesh showing significant comfort levels among AWs (41.5% feel very comfortable).

Figure 25: Level of Comfort among AGs and AWs to Discuss MHM (Overall)

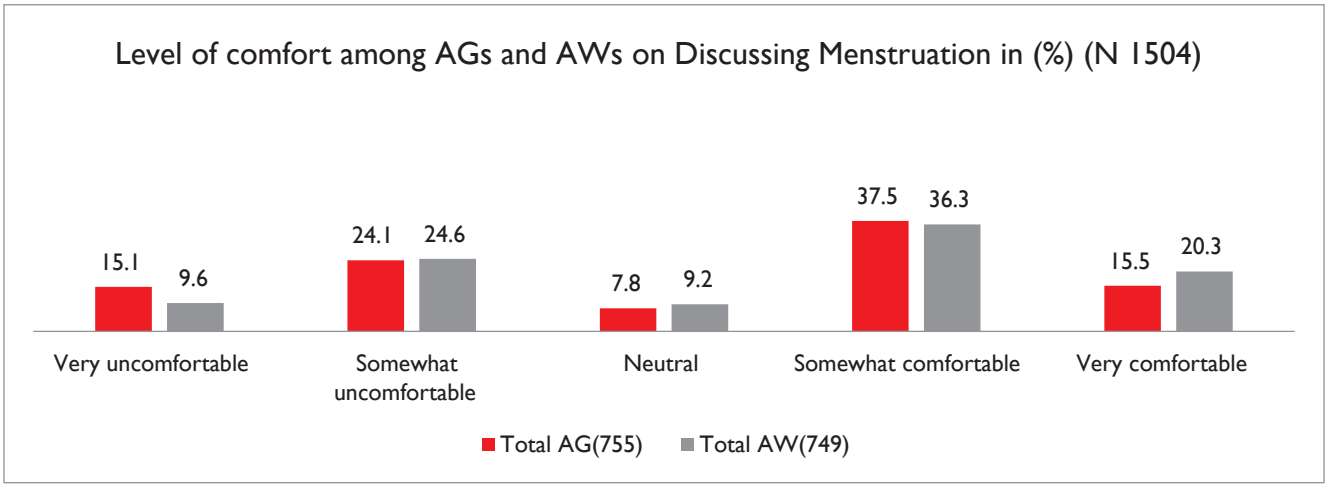


Table 29: Level of comfort among AGs and AWs to discuss MHM (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	AG	AW	AG	AW	AG	AW	AG	AW
N	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Very uncomfortable	25.7	8.0	22.6	14.2	9.0	7.1	9.1	8.4
Somewhat uncomfortable	37.6	39.0	20.3	25.1	14.2	10.4	30.7	31.0
Neutral	8.9	13.0	8.5	10.0	10.9	13.7	3.9	2.7
Somewhat comfortable	24.8	25.0	41.0	43.1	31.8	27.4	45.0	43.4
Very comfortable	3.0	15.0	7.5	7.6	34.1	41.5	11.3	14.6

The data reveals that while there is a general comfort among caregivers (FLWs and teachers) in discussing menstrual health, there are still roadblocks among adolescent girls and adult women. Enhancing the comfort levels for open discussions about MHM can be achieved through targeted educational programs and supportive community environments. Special focus is required in regions like Assam and Uttar Pradesh, where discomfort levels are higher, to create a more open and supportive atmosphere for discussing menstrual health as discussion about the subject without any hesitation is the first step towards taking decisive decisions.

The qualitative insights with teachers and FLWs, particularly around sensitive topics such as menstrual health, reveals significant societal and cultural influences that affect how these subjects

are discussed. Teachers play a crucial role in giving knowledge about these topics, often using indirect methods to avoid discomfort. In many families, discussing topics related to menstrual health remains a delicate issue, particularly in the presence of male family members. This thing can lead to a sense of shame and reluctance among girls to talk openly about these important subjects. Survey conducted among Adolescent girls revealed that a majority feel uncomfortable discussing menstrual health with male relatives. Despite the discomfort, there is a growing recognition of the importance of these discussions for the well-being and education of young girls.

We explain to them the process through examples and indirectly through other ways as well ***- Teacher Rajasthan***

If they (teachers) are male we do not discuss with them. If there are teachers (females) we discuss with them ***- AG, FGD, Rajasthan***

There is a need to break stereotype and taboos around MHM in the society as the baseline insights reveals that only two third of the AGs and AWs fell confident discussing it.

3.3.2. MHM Product Storage Practices

This section explains how respondents store their menstrual absorbent materials, highlighting practices that reflect cultural, social, and personal preferences and constraints.

The data reveals diverse storage practices among adolescent girls (AGs) and adult women (AWs) across the four states. On the overall level, almost half of both AGs and AWs store their products in a hidden and concealed place which could reflect cultural taboos and privacy concerns. A significant percentage of AGs (35.6%) and AWs (32.2%) store their absorbents in a safe and clean place, indicating awareness of proper hygiene practices.

Figure 26: Storage of MHM products by AGs and AWs (overall)

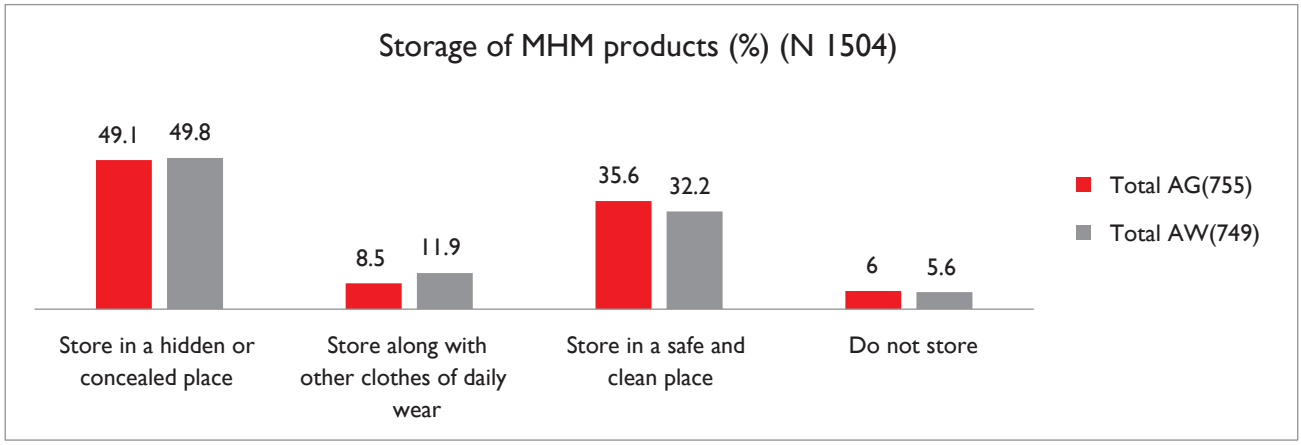


Table 30: Storage of MHM products by AGs and AWs (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
Respondent Group	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**
N	***101***	***100***	***212***	***211***	***211***	***212***	***231***	***226***
Store in a hidden or concealed place	20.8	13	36.4	39.8	62.6	63.7	61	62.4
Store along with other clothes of daily wear	4.0	19.0	0.9	2.8	9.0	9.0	16.9	19.9
Store in a safe and clean place	75.2	68.0	52.8	48.3	15.2	17.9	21.2	14.6
Do not store	0.0	0.0	8.5	7.6	12.3	9.4	0.4	2.7

In Assam, the majority of AGs (75.2%) and AWs (68.0%) store their absorbents in a safe and clean place, demonstrating strong adherence to hygienic practices. However, a substantial number also hide their absorbents, indicating ongoing stigma around menstruation. In Maharashtra, 53% of AGs and 48% of AWs store their absorbents safely, but a notable portion store them in hidden places or with other daily wear clothes, showing mixed adherence to best practices. Uttar Pradesh showed a significant tendency to hide absorbents, with 63% of AGs and 64% of AWs storing them in concealed places, highlighting the impact of cultural stigmas. The findings emphasize the need for targeted educational programs to address cultural taboos and promote proper storage practices for menstrual absorbents. While there is evidence of good hygiene practices in some regions, significant gaps remain, particularly in Uttar Pradesh and Rajasthan. Educational efforts should focus on encouraging the safe and clean storage of menstrual products to maintain hygiene and prevent infections.

Since around half of the targeted group prefers storing the MHM product in a hidden or concealed place. Therefore, if other household members are sensitized around MHM. There won't be any need to keep the MHM product in a concealed place and it would become more accessible to the user group.

Figure 27: Frequency of buying or collecting absorbent (%) (overall)

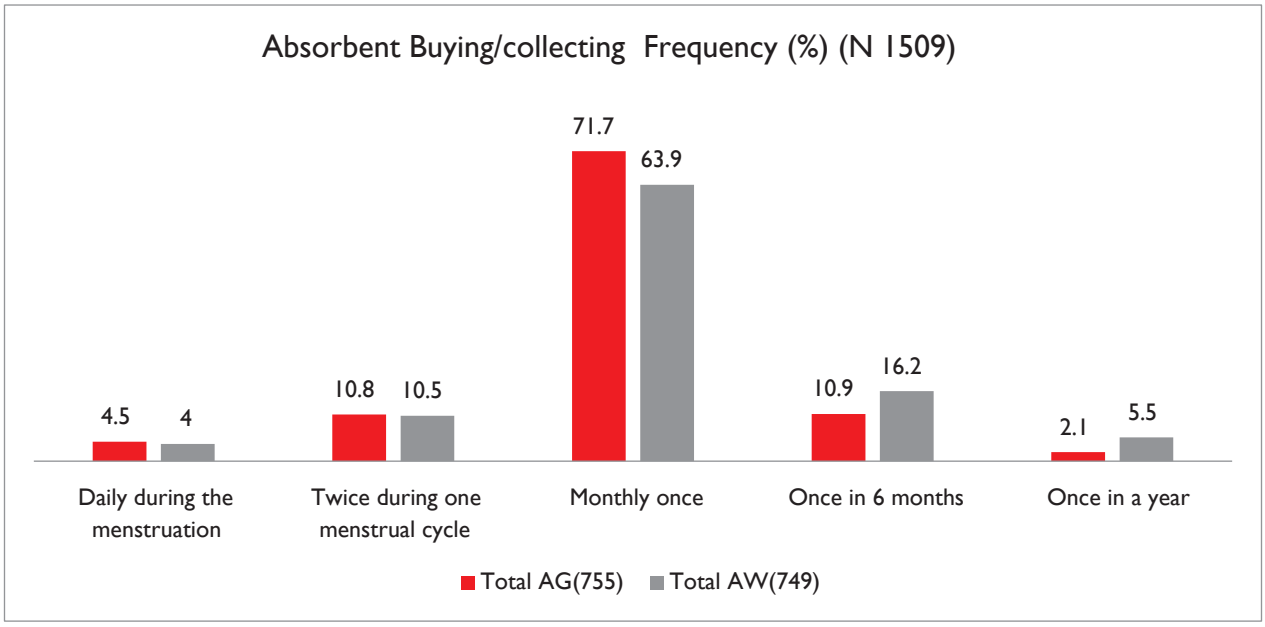


Table 31: Frequency of buying or collecting menstrual absorbent material (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**
N	***101***	***100***	***212***	***211***	***211***	***212***	***231***	***226***
Daily during the menstruation	4.1	8.5	7.5	5.3	4.9	3.4	1.8	1.5
Twice during one menstrual cycle	18.6	16.9	14.1	11.8	7.6	11.4	6.6	6.6
Monthly once	76.3	60.6	74.9	74.1	70.1	65.9	67.8	55.3
Once in 6 months	1.0	5.6	3.5	7.1	17.4	19.3	17.6	26.4
Once in a year	0.0	8.5	0.0	1.8	0.0	0.0	6.2	10.2

3.3.3. Absorbent Usage Frequency

This section explores the frequency with which respondents buy or collect menstrual absorbent materials. The data provides insights into menstrual hygiene practices and access across different regions.

Overall, only 4.5% AGs and 4% AWs reported buying absorbent 'daily' during menstruation, while majority 72% Ags and 64% AWs reported to be buying the absorbent 'once in a month' followed by 11% Ags and 16% AWs buying it 'once in six months'. Also, another 2.1% Ags and 5.5% AWs reported buying absorbent 'once in a year' which is quite startling given the need during menstruation. Across the study states, in Maharashtra 7.5% Ags and in Assam 8.5 % AWs had the highest proportion of respondents affirmed to buying absorbent 'daily during menstruation'. While Assam had the highest proportion of respondents buying absorbent 'twice a month' during menstruation. It is astounding that 6.2% of Ags and 10.2% AWs in Rajasthan bought absorbent 'once in a year. Understanding these purchasing behaviors helps to identify gaps in access to menstrual hygiene products and can inform interventions aimed at improving menstrual health management. Regional disparities suggest the need for targeted strategies to ensure that all women and girls have timely and affordable access to necessary menstrual products.

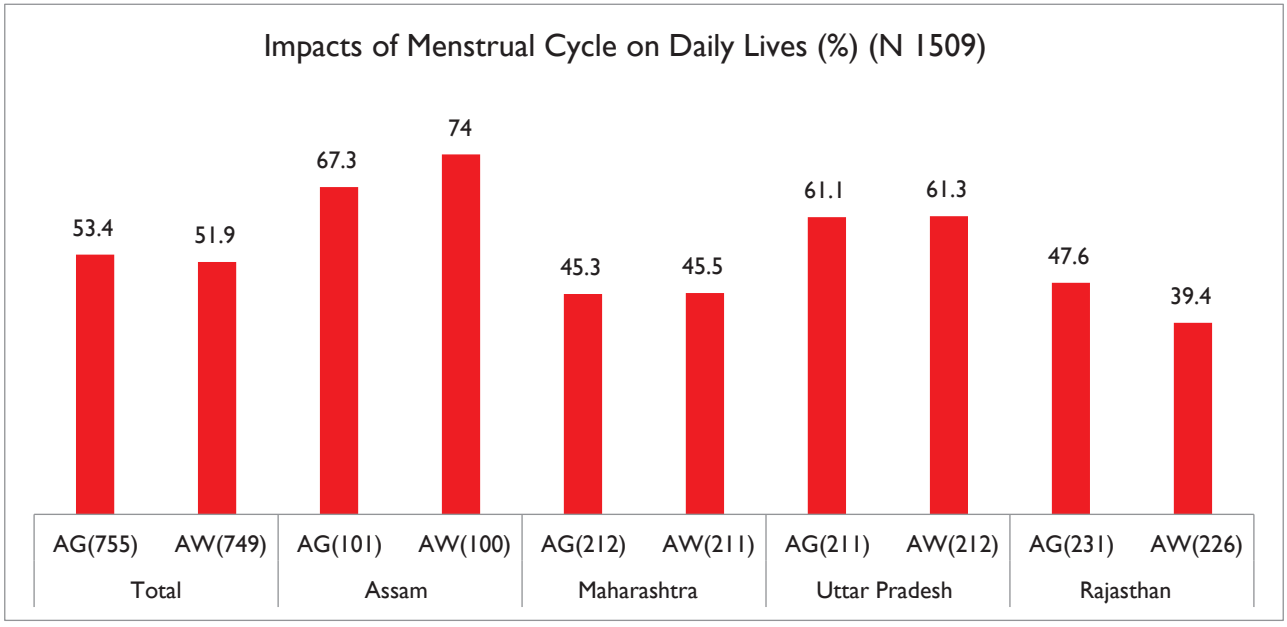
3.3.4. Impact of Menstruation on Everyday Activities

This section explores the impact of menstruation on the daily lives of respondents, focusing on everyday activities, the number of days affected during each menstrual cycle, and absenteeism from school due to menstruation. The analysis aims to understand how menstruation affects routine activities and the extent of its impact on education for adolescent girls.

3.3.4.1. Impact on Everyday Activities

The table below presents data on whether menstruation affects the everyday activities of adolescent girls (AG) and adult women (AW) across the four states.

Figure 28: Menstruation cycle has impact on daily lives of AGs and AWs by state



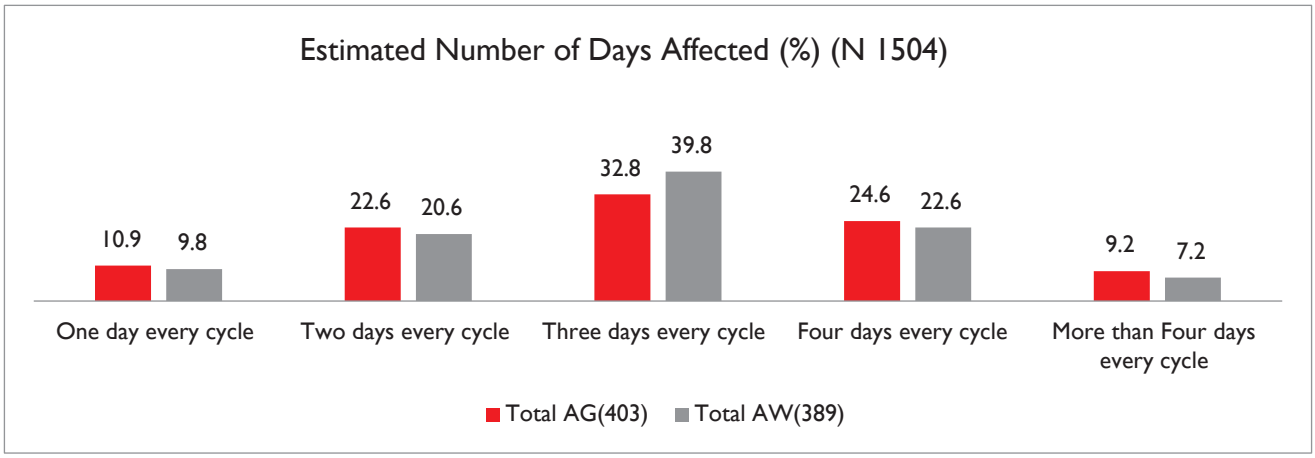
At the overall level, more than half proportion of respondents reported that menstruation affects their everyday activities, with 53% of AGs and 52% of AWs indicating an impact. The effect is notably higher in Assam, where 67% of AGs and 74% of AWs reported disruptions to their daily routine. In contrast, Maharashtra has the lowest reported impact among AGs (45.3%) and AWs (45.5%), suggesting regional variations in how menstruation is managed and perceived.

Qualitative analysis of discussions with girls and women shows that many women experience pain during their menstrual periods. This pain often affects their ability to work and perform daily tasks. They feel so much pain in their lower back area that they can't concentrate on their work. For girls, menstrual pain can be especially challenging. Many girls miss school during their periods because the pain makes it difficult to focus and participate in class. Menstrual pain can disrupt normal daily activities. Every state reported the same thing but comparatively girls from Maharashtra reported less impact on the school attendance than other states.

3.3.4.2. Number of Days Affected During Menstrual Cycle

The following table provides data on the estimated number of days during each menstrual cycle that respondents' daily lives are affected.

Figure 29: Estimated number of days where lives of AGs and AWs are affected (overall)



At the overall level, most respondents reported that menstruation affects their daily lives for two to three days every cycle, with 33% of AGs and 40% of AWs indicating three days of impact. Assam shows the highest percentage of respondents reporting three days of disruption (59% of AGs and 54% of AWs), whereas Uttar Pradesh has a significant proportion experiencing one day of impact per cycle (23.3% AGs and 20.8% AWs).

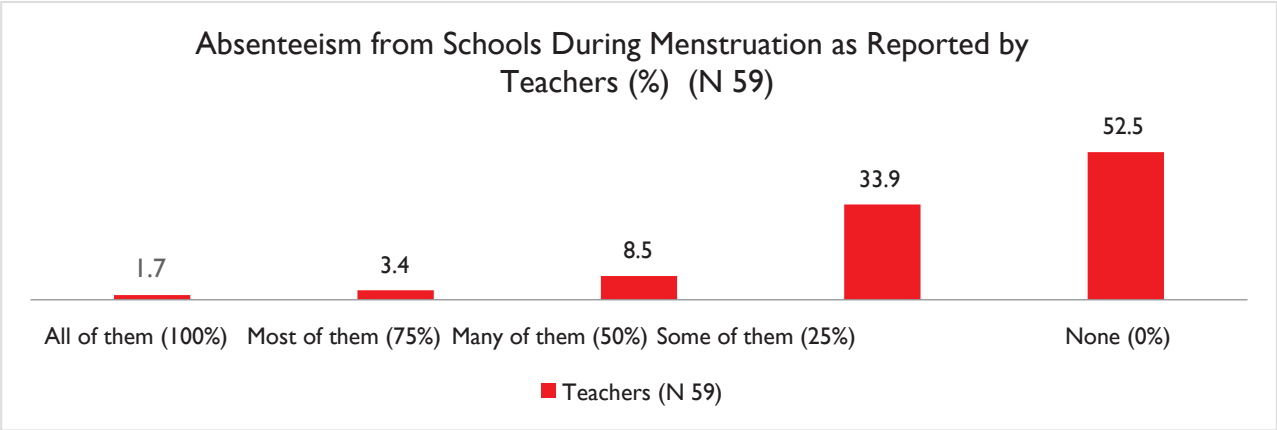
Table 32: Estimated number of days where daily Lives of AGs and AWs are affected (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**
N	***68***	***74***	***96***	***96***	***129***	***130***	***110***	***89***
One day every cycle	1.5	2.7	4.2	3.1	23.3	20.8	8.2	6.7
Two days every cycle	5.9	14.9	21.9	20.8	31.8	28.5	22.7	13.5
Three days every cycle	58.8	54.1	35.4	49.0	22.5	33.8	26.4	27.0
Four days every cycle	23.5	20.3	27.1	22.9	15.5	11.5	33.6	40.4
More than Four days every cycle	10.3	8.1	11.5	4.2	7.0	5.4	9.1	12.4

3.3.4.3 Absenteeism from School during Menstruation

The table below shows the extent to which teachers report that girls miss school due to menstruation.

Figure 30: Teachers on girls missing their school during menstruation (Overall)



The data indicates that absenteeism due to menstruation is a significant issue.At an overall level, 33.9% of teachers report that some girls (25% of students) miss school during their menstrual cycle.

Table 33:Teachers on girls missing school during menstruation (% by state)

State	Assam	Maharashtra	Uttar Pradesh	Rajasthan
N	**8**	**17**	**17**	**17**
All of them (100%)	0	100.0	5.9	0
Most of them (75%)	0	0	11.8	0
Many of them (50%)	12.5	0	11.8	11.8
Some of them (25%)	50.0	11.8	52.9	29.4
None (0%)	37.5	88.2	17.6	58.8

In Assam, Uttar Pradesh Rajasthan, a notable proportion of teachers (12.5%), (11.8%) and (11.8%) reported that many girls (50% of students) miss school due to menstruation. The high percentage of absenteeism underscores the need for improved menstrual health management and supportive school environments to ensure that girls do not miss out on their education due to menstruation.

Across the state Maharashtra stood out to be the state where teachers reported that All of the grils remain absent from school during menstruation. It highlights the need to dig deeper and understand the perspective of this mass absenteeism from the school.

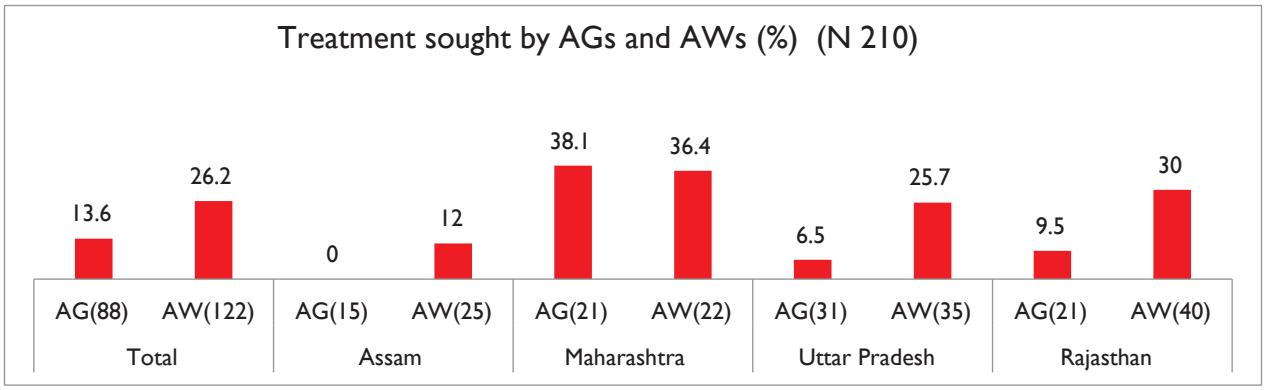
3.3.5. Heath Seeking Practices on RTI

3.3.5.1. Treatment of RTIs

This section examines the percentage of adolescent girls (AG) and adult women (AW) who sought treatment for Reproductive Tract Infections (RTIs). Understanding treatment-seeking behaviors is crucial for developing effective healthcare interventions and improving reproductive health outcomes.

At the overall level, 14% of AGs and 26% of AWs reported seeking treatment for RTIs. This indicates a higher rate of treatment-seeking behavior among adult women compared to adolescent girls. A significant proportion of respondents did not seek treatment, highlighting potential gaps in accessing healthcare services for RTIs.

Figure 31: AGs and AWs sought treatment for RTI (by state) (%)



3.3.5.2 Health Center Visited for RTI Treatment

This section examines the preferences of adolescent girls (AG) and adult women (AW) for different types of health centers when seeking treatment for Reproductive Tract Infections (RTIs). Understanding these preferences can help in tailoring healthcare services to better meet the needs of these groups.

At the overall level, primary health centers are the most preferred choice for both AGs (33.3%) and AWs (31.3%), followed closely by private hospitals/ clinics (33.3% of AGs and 31.3% of AWs). This indicates a reliance on both public and private healthcare facilities for treating RTIs.

Figure 32: Medical centers visited by AGs and AWs for RTI treatment (Overall)

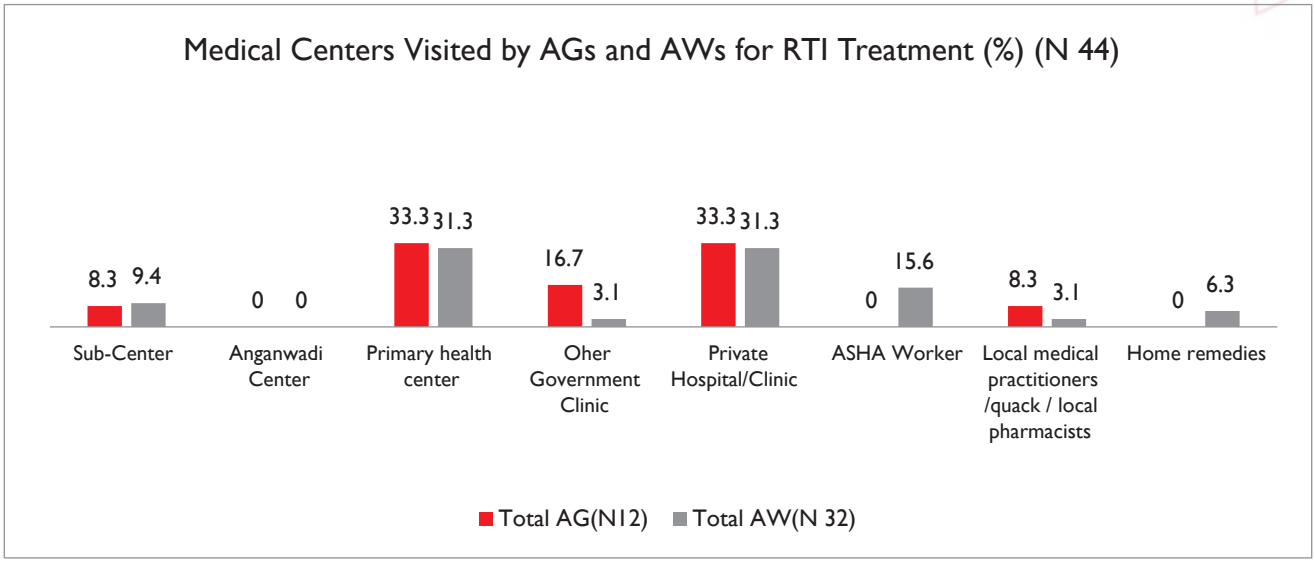


Table 34: Medical centers visited by AGs and AWs for RTI treatment (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	AG	AW	AG	AW	AG	AW	AG	AW
N	*0*	*3*	*8*	*8*	*2*	*9*	*2*	*12*
Sub-Center	0	0	0	0	0	22.2	50.0	8.3
Anganwadi Center	0	0	0	0	0	0	0	0
Primary health center	0	100.0	25.0	25.0	50.0	11.1	50.0	33.3
Oher Government Clinic	0	0	25.0	12.5	0	0	0	0
Private Hospital/Clinic	0	0	50.0	50.0	0	22.2	0	3.3
ASHA Worker	0	0	0	0	0	33.3	0	16.7
Local medical practitioners /quack / local pharmacists	0	0	0	0	50.0	11.1	0	0
Home remedies	0	0	0	12.5	0	0	0.0	8.3

In Assam, all AGs and AWs preferred primary health centers for treatment, reflecting strong trust and accessibility to these centers. However, in Maharashtra, preferences are split between primary health centers and private hospitals/clinics, each being selected by 50% of AGs and AWs. This suggests that while public healthcare facilities are trusted, private options are also significantly utilized. Uttar Pradesh shows a unique trend where AGs have a preference for local medical practitioners/ quacks (50%), while AWs primarily prefer primary health centers (11.1%) and ASHA workers (33.3%). This highlights a potential issue of accessibility or trust in formal healthcare facilities among AGs.

Rajasthan displays a high preference for sub-centers among AGs (50%), while AWs predominantly prefer primary health centers (33.3%) and private hospitals/clinics (33.3%). This indicates a varied approach to healthcare access and the potential

effectiveness of decentralized healthcare services in this region. These findings underscore the importance of enhancing both public and private healthcare infrastructure and services to cater to the needs of AGs and AWs. There is also a need for targeted interventions to improve trust and accessibility to formal healthcare facilities, particularly in regions where reliance on informal practitioners is high.

3.3.5.3 Barriers in Seeking Treatment for RTI

This section explores the reasons why adolescent girls (AG) and adult women (AW) who experienced symptoms of Reproductive Tract Infections (RTIs) did not seek medical treatment. Understanding these barriers is crucial for addressing gaps in healthcare access and improving reproductive health outcomes. At the overall level, a significant proportion of AGs (77.6%) and AWs (71.1%) reported never having RTI symptoms, which explains why they did not seek treatment. Among those who did not seek treatment despite having symptoms, the reasons include family members suggesting the issue will pass (11.8% of AGs and 12.2% of AWs) and feeling too shy to seek help (7.9% of AGs and 11.1% of AWs).

Figure 33: Reasons for not seeking RTI treatment by AGs and AWs (overall)

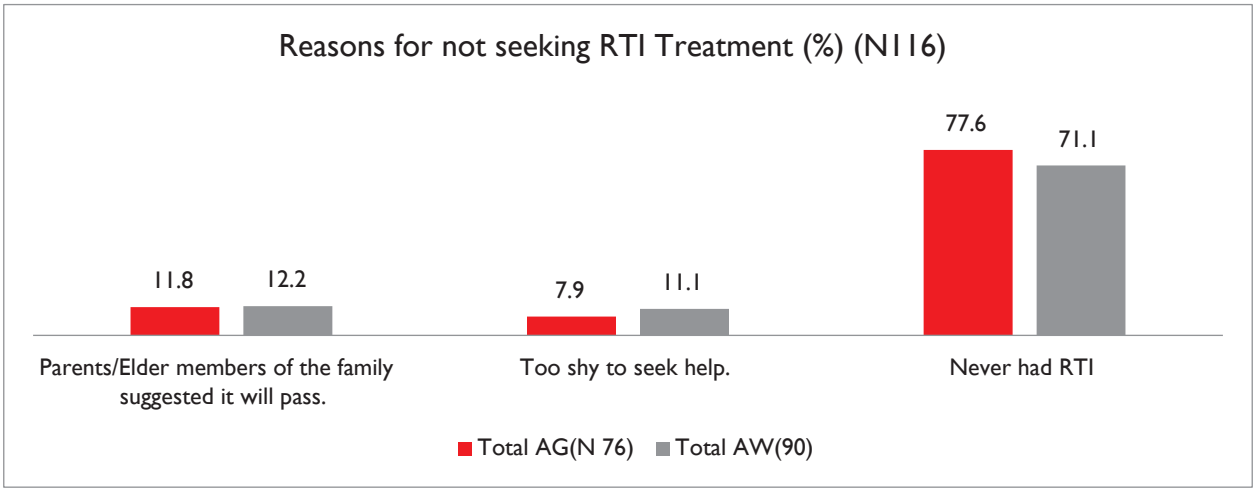


Table 35: Reasons for not seeking RTI treatment by AGs and AWs (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**
N	***15***	***22***	***13***	***14***	***29***	***26***	***19***	***28***
Parents/Elder members of the family suggested it will pass.	6.7	13.6	7.7	0.0	3.4	11.5	31.6	17.9
Too shy to seek help.	20.0	9.1	0.0	21.4	3.4	0.0	10.5	17.9
Never had RTI	73.3	77.3	84.6	50.0	93.1	84.6	52.6	64.3

In Assam, a substantial number of AGs (20.0%) felt too shy to seek help, while the main reason for AWs (13.6%) was family members suggesting it will pass. In Maharashtra, the most common reason for AWs not seeking treatment was feeling too shy (21.4%), whereas no AGs reported this issue, indicating a potential generational or cultural difference in health-seeking behavior. In Rajasthan, a significant number of AGs (31.6%) did not seek treatment because family members suggested it would pass, while 17.9% of AWs cited shyness as the main barrier. These findings highlight the importance of addressing social and cultural barriers that prevent individuals from seeking medical treatment for RTIs. Educational campaigns aimed at reducing stigma and increasing awareness about RTIs and their treatment options are essential to improve health outcomes for AGs and AWs. Additionally, engaging family members in health education could help alleviate misconceptions and encourage timely medical intervention.

The baseline data reveals low level of awareness on RTI. This can be improved further by educating and informing the target groups.

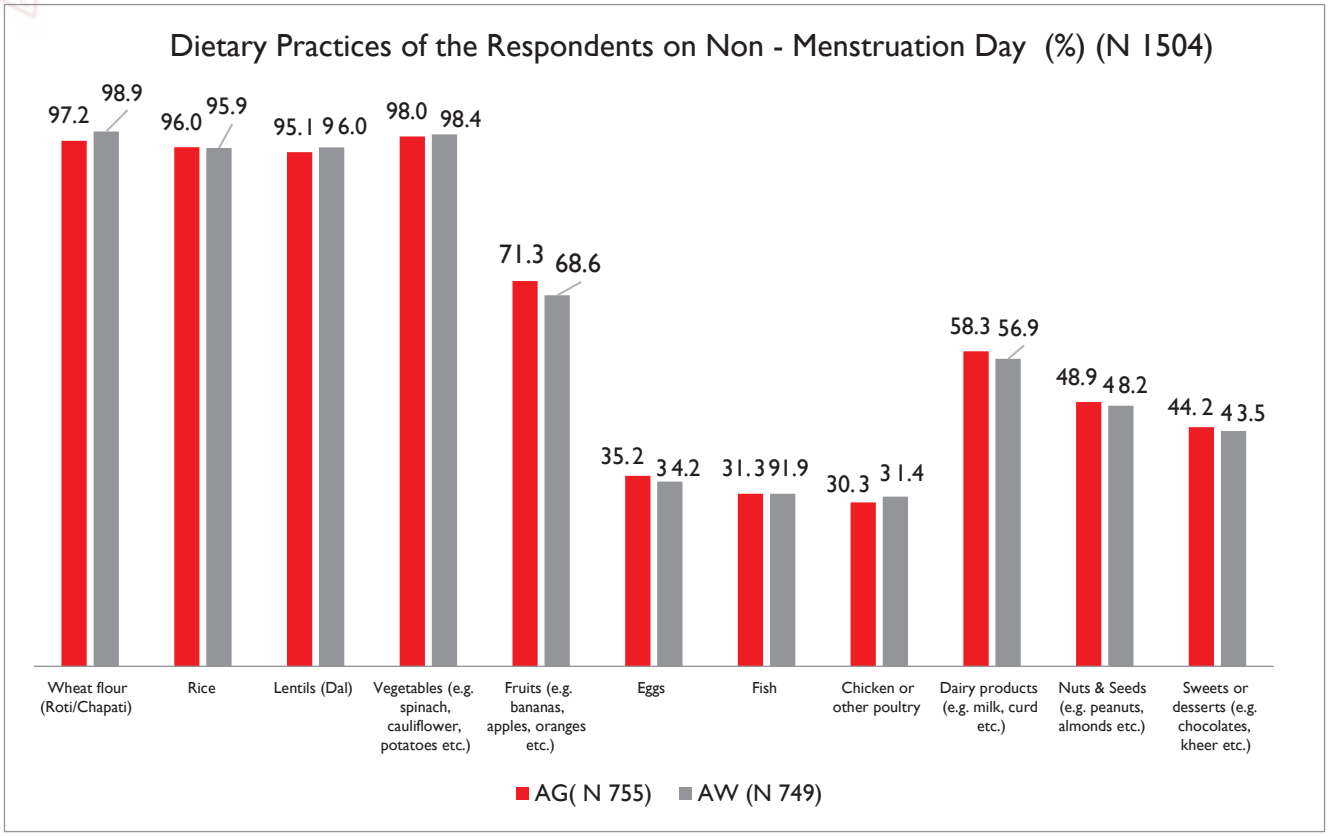
Similarly, once the target groups are made aware about the symptoms and reasons of RTI they will proactively seek treatment of the disease.

3.3.6. Dietary Practices of the Respondents

This section explores the dietary practices and restrictions that adolescent girls (AG) and adult women (AW) follow during their menstrual cycles, providing insights into cultural norms and nutritional habits.

Overall, most respondents consume a variety of staple foods such as wheat flour (Roti/Chapati) and rice, with nearly universal consumption among AGs (97.2% and 96.0% respectively) and AWs (98.9% and 95.9% respectively). Lentils and vegetables are also widely consumed, with 95.1% of AGs and 96.0% of AWs eating lentils, and 98.0% of AGs and 98.4% of AWs consuming vegetables. Fruits are less commonly consumed, with 71.3% of AGs and 68.6% of AWs including them in their diet. Protein sources like eggs, fish, and chicken show regional variations; for instance, a high consumption of eggs is seen in Assam (96.0% for AGs and 97.0% for AWs), while Uttar Pradesh shows lower consumption of eggs (24.2% for AGs and 27.8% for AWs). Dairy products are consumed by 58.3% of AGs and 56.9% of AWs, with significant regional variation, such as higher consumption in Assam and lower in Rajasthan. Nuts and seeds, and sweets or desserts, also show varying levels of consumption, with sweets being more popular in Assam and Maharashtra.

Figure 34: Dietary practices during non- menstruation day (Overall)



FGD with adult women in progress at Sadarbadi, Amravati, Maharashtra (June 2024)

Figure 35: Food items avoided AGs and AWs during menstruation (Overall)

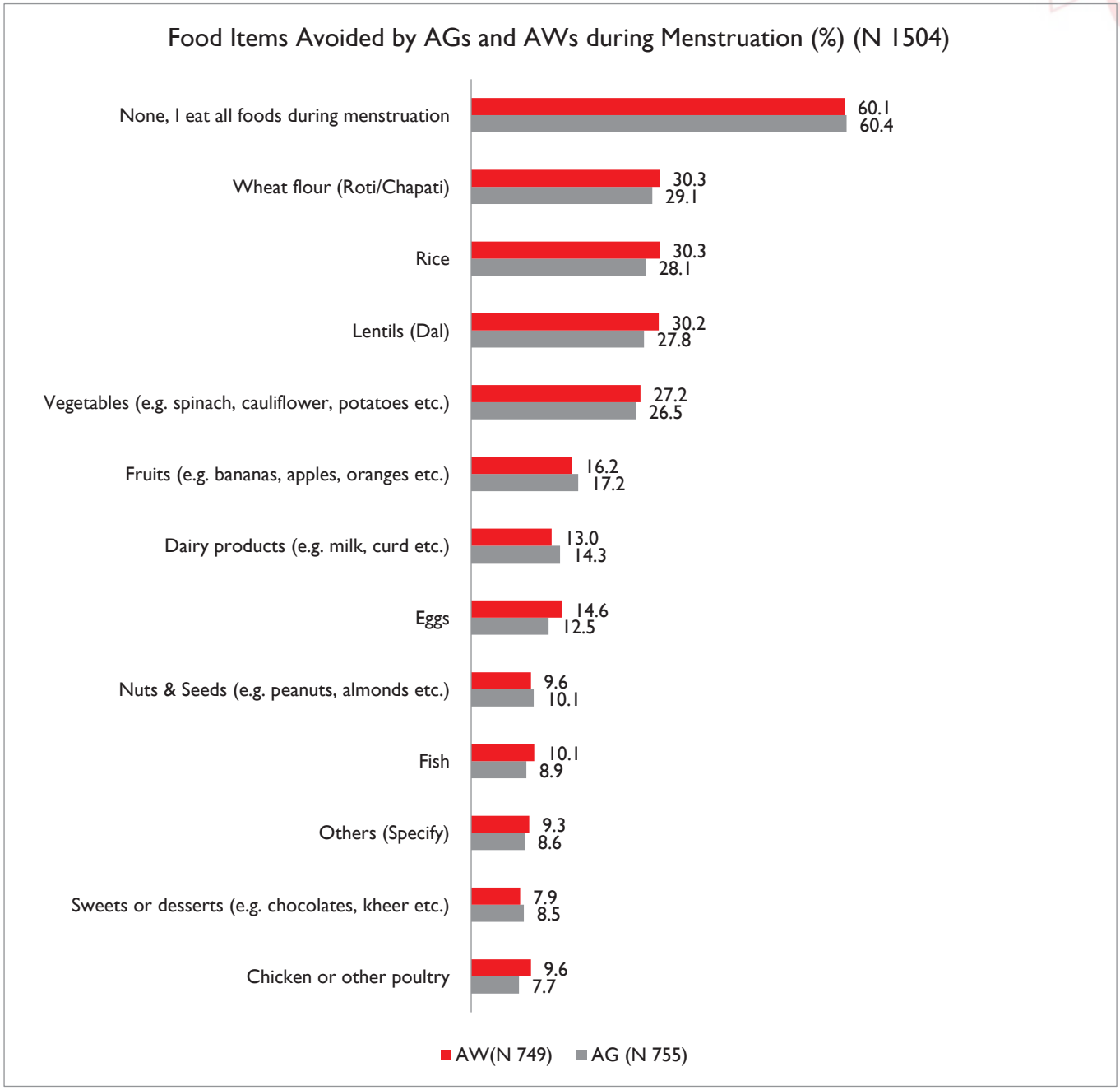


Table 36: Food items avoided by AGs and AWs during menstruation (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	AG	AW	AG	AW	AG	AW	AG	AW
N	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Wheat flour (Roti/Chapati)	20.8%	20.0%	33.0%	36.5%	53.1%	56.6%	7.4%	4.4%
Rice	30.7%	28.0%	31.6%	35.5%	51.2%	54.7%	2.6%	3.5%
Lentils (Dal)	31.7%	28.0%	28.8%	32.7%	49.8%	55.2%	5.2%	5.3%
Vegetables (e.g. spinach, cauliflower, potatoes etc.)	31.7%	29.0%	30.2%	31.3%	41.7%	47.2%	6.9%	4.0%
Fruits (e.g. bananas, apples, oranges etc.)	30.7%	26.0%	26.9%	31.3%	16.6%	12.3%	3.0%	1.3%
Eggs	58.4%	72.0%	9.0%	8.1%	7.1%	8.5%	0.4%	0.9%
Fish	36.6%	35.0%	8.5%	11.4%	5.2%	7.5%	0.4%	0.4%
Chicken or other poultry	28.7%	33.0%	8.5%	11.4%	4.3%	6.6%	0.9%	0.4%
Dairy products (e.g. milk, curd etc.)	18.8%	22.0%	19.3%	18.0%	19.0%	16.5%	3.5%	0.9%
Nuts & Seeds (e.g. peanuts, almonds etc.)	13.9%	13.0%	18.9%	18.0%	9.5%	9.9%	0.9%	0.0%
Sweets or desserts (e.g. chocolates, kheer etc.)	16.8%	19.0%	18.9%	17.1%	1.9%	1.9%	1.3%	0.0%
None, I eat all foods during menstruation	27.7%	22.0%	63.2%	61.6%	46.0%	42.9%	85.3%	91.6%

Regarding dietary restrictions during menstruation, a significant portion of respondents reported avoiding certain foods. Around 29.1% of AGs and 30.3% of AWs avoid wheat flour (Roti/Chapati) during menstruation, with the highest avoidance seen in Uttar Pradesh (53.1% for AGs and 56.6% for AWs). Similarly, 28.1% of AGs and 30.3% of AWs avoid rice, particularly in Uttar Pradesh (51.2% for AGs and 54.7% for AWs). Avoidance of lentils is reported by 27.8% of AGs and 30.2% of AWs, with the highest rates in Uttar Pradesh. Vegetables are avoided by 26.5% of AGs and 27.2% of AWs, with significant avoidance in Uttar Pradesh and Maharashtra. Fruits are avoided by a smaller portion, with 17.2% of AGs and 16.2% of AWs reporting avoidance. Protein sources like eggs, fish, and chicken are also avoided by a notable percentage, with eggs being most commonly avoided in Assam. A substantial number of respondents (60.4% of AGs and 60.1% of AWs) do not restrict any foods during menstruation, particularly in Rajasthan, where 85.3% of AGs and 91.6% of AWs report no dietary restrictions.

When asked if they find it reasonable to avoid certain food items during menstruation, 42.1% of AGs and 48.2% of AWs agreed, indicating a significant portion of respondents believe in the practice of dietary restrictions during menstruation. This belief is most prevalent in Assam, where 51% of AGs and 57% of AWs find it reasonable. In contrast, Maharashtra has the lowest agreement, with only 33% of AGs and 35% of AWs considering it reasonable to avoid certain foods. The rest of the states show a more balanced perspective, with nearly half of the respondents agreeing with the practice. These findings highlight There is a need for educational interventions to address and potentially mitigate unnecessary dietary restrictions, ensuring balanced nutrition during menstruation for adolescent girls and adult women across different regions.

3.3.7. Restrictions and Activities During Menstruation

This section delves into various restrictions faced by adolescent girls (AG) and adult women (AW) during menstruation, encompassing clothing choices, dietary habits, and participation in activities. The data reveals diverse restrictions imposed by societal norms, personal choices, and environmental factors across different regions. Respondents were asked about their ability and willingness to perform these activities, categorized into "Cannot do," "Will not do," "Should not do," "Can do," and "N/A." "Cannot do" means incapable of doing it due to environmental/ external factors. "Will not do" means self-imposed restrictions. "Should not do" means socially imposed restrictions.

3.3.7.1 Clothing Restriction

Table 37: Clothing Restrictions Faced by AGs and AWs during Menstruation (%)

Activity	State	Total		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
Wearing White/light clothes during menstruation	*N*	*755*	*749*	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	26.6	29.9	5.0	2.0	36.8	35.5	14.2	20.3	38.1	46.0
	Will not do	17.9	23.4	26.7	45.0	25.9	32.2	6.6	9.9	16.9	18.1
	Should not do	29.8	28.2	18.8	12.0	12.7	12.3	53.1	56.6	29.0	23.5
	Can do	25.7	18.6	49.5	41.0	24.5	19.9	26.1	13.2	16.0	12.4
	Not Applicable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Wearing new clothes	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	18.1	21.5	3.0	5.0	17.5	20.9	10.4	16.5	32.5	34.1
	Will not do	16.7	18.0	26.7	35.0	20.3	17.1	6.2	9.4	18.6	19.5
	Should not do	19.5	22.4	10.9	12.0	5.2	6.6	39.8	47.6	17.7	18.1
	Can do	45.7	38.1	59.4	48.0	57.1	55.5	43.6	26.4	31.2	28.3
	Not Applicable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Activity	State	Total		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
Wearing Jeans/tight clothes	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	20.4	28.2	3.0	16.0	25.5	33.6	8.1	18.4	34.6	37.6
	Will not do	16.7	18.7	23.8	37.0	17.0	18.0	11.4	11.8	18.2	17.7
	Should not do	24.2	30.0	32.7	35.0	5.7	15.6	44.1	46.2	19.5	26.1
	Can do	37.9	19.8	40.6	12.0	51.9	32.2	36.5	23.6	25.1	8.0
	Not Applicable	0.8	3.3	0.0	0.0	0.0	0.5	0.0	0.0	2.6	10.6
Wearing synthetic/nylon/ polyester/terry	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	19.3	20.8	11.9	10.0	13.2	13.7	9.5	14.2	37.2	38.5
	Will not do	18.0	18.4	39.6	47.0	8.5	6.6	13.7	13.2	21.2	21.7
	Should not do	25.4	24.2	34.7	40.0	8.0	6.6	40.3	38.7	23.8	19.9
	Can do	37.2	36.6	13.9	3.0	70.3	73.0	36.5	34.0	17.7	19.9
	Not Applicable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Wearing White/Light Clothes

A significant proportion of respondents face restrictions on wearing white or light-colored clothes during menstruation. 26.6% of AGs and 29.9% of AWs reported they cannot wear such clothes, while 17.9% of AGs and 23.4% of AWs choose not to wear them. Social restrictions were reported by 29.8% of AGs and 28.2% of AWs. Maharashtra shows the highest restriction with 36.8% of AGs and 35.5% of AWs reporting they cannot wear white or light clothes, whereas Assam has the lowest at 5.0% for AGs and 2.0% for AWs.

Wearing New Clothes

Restrictions on wearing new clothes during menstruation are also prominent. 18.1% of AGs and 21.5% of AWs reported they cannot wear new clothes, while 16.7% of AGs and 18.0% of AWs will not wear them. Social restrictions were noted by 19.5% of AGs and 22.4% of AWs. Rajasthan shows higher restrictions with 32.5% of AGs and 34.1% of AWs reporting they cannot wear new clothes, while Assam has the lowest restrictions for AGs (3.0%) and AWs (5.0%).

Wearing Jeans/Tight Clothes

Wearing jeans or tight clothes during menstruation faces significant restrictions. 20.4% of AGs and 28.2% of AWs reported they cannot wear them, while 16.7% of AGs and 18.7% of AWs will not wear them. Social restrictions were reported by 24.2% of AGs and 30.0% of AWs. Maharashtra reports higher restrictions with 25.5% of AGs and 33.6% of AWs unable to wear jeans or tight clothes, compared to Assam which shows lower restrictions.

Wearing Synthetic/Nylon/Polyester/Terry

Restrictions on synthetic fabrics are noted, with 19.3% of AGs and 20.8% of AWs reporting they cannot wear these fabrics, while 18.0% of AGs and 18.4% of AWs will not wear them. Social restrictions were reported by 25.4% of AGs and 24.2% of AWs. Rajasthan reports higher restrictions with 37.2% of AGs and 38.5% of AWs unable to wear synthetic fabrics, while Assam shows lower restrictions.

3.3.7.2 Food Restrictions

Table 38: Food restrictions faced by AGs and AWs during menstruation (by state) (%)

Activity	State	Total		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
	N	*755*	*749*	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Eating Sour Food	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	22.4	23.5	4.0	0.0	23.1	22.7	15.2	23.1	36.4	35.0
	Will not do	15.1	15.9	22.8	31.0	19.8	16.1	6.2	6.1	15.6	18.1
	Should not do	28.2	27.0	26.7	27.0	7.5	9.5	49.3	52.8	28.6	19.0
	Can do	34.3	33.6	46.5	42.0	49.5	51.7	29.4	17.9	19.5	27.9
	Not Applicable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Activity	State	Total		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
Eating Pickle/ Touching pickle	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	29.8	33.9	23.8	18.0	32.1	39.8	16.1	22.6	42.9	46.0
	Will not do	14.3	14.6	11.9	12.0	23.1	18.5	5.2	6.1	15.6	19.9
	Should not do	29.7	27.8	19.8	23.0	5.2	8.1	59.2	54.7	29.4	23.0
	Can do	26.2	23.8	44.6	47.0	39.6	33.6	19.4	16.5	12.1	11.1
	Not Applicable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Eating Spicy Food	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	16.7	19.8	0.0	0.0	21.7	26.1	8.1	13.7	27.3	28.3
	Will not do	10.2	11.1	8.9	14.0	15.1	14.7	2.4	2.4	13.4	14.6
	Should not do	17.7	16.8	17.8	13.0	5.2	10.0	28.4	24.5	19.5	17.7
	Can do	55.4	52.3	73.3	73.0	58.0	49.3	61.1	59.4	39.8	39.4
	Not Applicable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Eating Non-Veg Food	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	21.3	22.6	0.0	2.0	32.5	29.4	8.5	11.8	32.0	35.4
	Will not do	9.5	10.8	2.0	2.0	10.4	12.3	5.2	5.2	16.0	18.6
	Should not do	20.5	17.9	6.9	6.0	8.0	5.7	40.8	39.6	19.5	14.2
	Can do	38.1	38.9	91.1	90.0	44.3	46.9	35.5	34.4	11.7	12.8
	Not Applicable	10.5	9.9	0.0	0.0	4.7	5.7	10.0	9.0	20.8	19.0

Eating Sour Food

Restrictions on eating sour food during menstruation are evident. 22.4% of AGs and 23.5% of AWs reported they cannot eat sour food, while 15.1% of AGs and 15.9% of AWs will not eat them. Social restrictions were reported by 28.2% of AGs and 27.0% of AWs. Rajasthan shows higher restrictions with 36.4% of AGs and 35.0% of AWs unable to eat sour food, while Assam has lower restrictions. The qualitative discussion with AGs also reveals that women are not allowed to eat sour food during menstruation. Though it is seen more in Rajasthan the same has been reported in other states as well.

Mothers tell us that we will start menstruating early if we eat sour food. Also, mothers tell us that it (menstruation) will be painful if we eat sour food during menstruation. ***- AG, FGD, UP***

Eating Pickle/Touching Pickle

Restrictions on eating or touching pickle are notable. 29.8% of AGs and 33.9% of AWs reported they cannot do so, while 14.3% of AGs and 14.6% of AWs will not do it. Social restrictions were reported by 29.7% of AGs and 27.8% of AWs. Rajasthan again shows higher restrictions with 42.9% of AGs and 46.0% of AWs unable to eat or touch pickle, whereas Assam shows lower restrictions

Eating Spicy Food

Restrictions on eating spicy food during menstruation are observed. 16.7% of AGs and 19.8% of AWs reported they cannot eat spicy food, while 10.2% of AGs and 11.1% of AWs will not eat it. Social restrictions were reported by 17.7% of AGs and 16.8% of AWs. Maharashtra shows higher restrictions with 21.7% of AGs and 26.1% of AWs unable to eat spicy food, while Assam has lower restrictions.

As per the qualitative discussions with the AGs and AWs, there are restrictions on eating spicy food during menstruation. The respondents were informed about not eating spicy food from their schools as well.

During that time (during menstruation), we must not consume spicy food, if possible. we must also avoid roti, consuming roti instead of rice and consume boiled food. Also, consuming fruits is good. ***- AG, FGD, Assam***

Eating Non-Veg Food

Restrictions on eating non-vegetarian food during menstruation are significant. 21.3% of AGs and 22.6% of AWs reported they cannot eat non-veg food, while 9.5% of AGs and 10.8% of AWs will not eat it. Social restrictions were reported by 20.5% of AGs and 17.9% of AWs. Maharashtra reports higher restrictions with 32.5% of AGs and 29.4% of AWs unable to eat non-veg food, while Assam shows lower restrictions.

3.3.7.3 Activity Restrictions

Table 39: Activity restrictions faced by AGs and AWs during menstruation (by state) (%)

Activity	State	Total		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
	N	*755*	*749*	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Vising places of worship (for e.g. temple or mosque, etc.)/ Religious events	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	40.8	44.2	42.6	33.0	56.6	57.8	18.0	25.9	46.3	53.5
	Will not do	13.4	14.8	11.9	10.0	16.5	19.9	14.2	12.7	10.4	14.2
	Should not do	35.8	33.5	30.7	42.0	14.6	10.4	59.7	56.1	35.5	30.1
	Can do	9.8	7.3	14.9	15.0	12.3	11.8	8.1	5.2	6.9	1.8
	Not Applicable	0.3	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.9	0.4
Going to School	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	5.4	9.5	2.0	2.0	4.2	3.3	4.7	11.3	8.7	16.8
	Will not do	2.8	3.6	1.0	2.0	4.7	6.6	0.9	0.5	3.5	4.4
	Should not do	7.0	7.3	2.0	1.0	1.9	4.7	14.7	15.1	6.9	5.3
	Can do	84.8	79.6	95.0	95.0	89.2	85.3	79.6	73.1	81.0	73.5
	Not Applicable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Activity	State	Total		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
Attending Entertainment/Recreational gatherings	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	10.2	14.4	8.9	5.0	8.0	13.3	5.7	11.3	16.9	22.6
	Will not do	6.9	9.3	16.8	21.0	7.1	8.5	1.4	0.5	7.4	13.3
	Should not do	12.8	11.1	8.9	6.0	2.8	2.8	28.0	23.6	10.0	9.3
	Can do	70.1	65.2	65.3	68.0	82.1	75.4	64.9	64.6	65.8	54.9
	Not Applicable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Entering the Kitchen	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	19.9	22.2	18.8	15.0	34.0	36.5	14.2	17.9	12.6	15.9
	Will not do	7.5	8.1	5.0	9.0	13.2	14.7	1.4	3.3	9.1	6.2
	Should not do	13.2	15.5	9.9	11.0	3.8	4.7	29.4	34.0	8.7	10.2
	Can do	59.3	54.2	66.3	65.0	49.1	44.1	55.0	44.8	69.7	67.7
	Not Applicable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Visiting Places of Worship/Religious Events

Restrictions on visiting places of worship or participating in religious events during menstruation are prominent. 40.8% of AGs and 44.2% of AWs reported they cannot do so, while 13.4% of AGs and 14.8% of AWs will not do it. Social restrictions were reported by 35.8% of AGs and 33.5% of AWs. Maharashtra shows higher restrictions with 56.6% of AGs and 57.8% of AWs unable to visit places of worship, while Assam has lower restrictions. The qualitative discussions with the AWs and AGs reveals that women and girls are not allowed to go to temples or attend religious events during their periods. They also cannot worship God during this time of the month. After conducting the survey, it was found that every state has restrictions. These restrictions can make women and girls feel isolated and left out. They cannot touch their god and chant the prayers which make them frustrated. People should understand that it is a natural and normal process can help reduce these restrictions and allow women and girls to participate fully in religious and social activities.

"At home, we are told that we should not go to temple, kitchen. We should not consume sour things. We should not lift heavy items"***- Adolescent Girls, Rajasthan***

Going to School

Restrictions on going to school during menstruation are less severe. 5.4% of AGs and 9.5% of AWs reported they cannot go to school, while 2.8% of AGs and 3.6% of AWs will not go. Social restrictions were reported by 7.0% of AGs and 7.3% of AWs. Rajasthan shows higher restrictions with 8.7% of AGs and 16.8% of AWs unable to go to school, while Assam has the lowest restrictions. The qualitative discussions reveal that girls are allowed to go to school during their periods. There are no rules stopping them from attending classes. However, many girls face severe pain during their periods, which can make it hard for them to go to school. Because of this pain, some girls may be absent from school during their menstrual cycle. Qualitative analysis indicates that there is no formal restriction on school attendance, but if girls are facing any discomfort or pain then they can skip school on these days.

Attending Entertainment/Recreational Gatherings

Restrictions on attending entertainment or recreational gatherings during menstruation are evident. 10.2% of AGs and 14.4% of AWs reported they cannot attend, while 6.9% of AGs and 9.3% of AWs will not attend. Social restrictions were reported by 12.8% of AGs and 11.1% of AWs. Rajasthan shows higher restrictions with 16.9% of AGs and 22.6% of AWs unable to attend gatherings, while Assam has lower restrictions. The qualitative interaction with the AGs reveals that sometimes, women and girls choose not to attend social gatherings during their periods. They may feel uncomfortable or prefer to stay home. In the past, some women were not allowed to attend social gatherings during their periods. They needed permission but often did not get it. But now this issue is not that serious, but qualitative report says that states like Rajasthan have higher restrictions.

Entering the Kitchen

Restrictions on entering the kitchen during menstruation are notable. 19.9% of AGs and 22.2% of AWs reported they cannot enter the kitchen, while 7.5% of AGs and 8.1% of AWs will not enter. Social restrictions were reported by 13.2% of AGs and 15.5% of AWs. Maharashtra shows higher restrictions with 34.0% of AGs and 36.5% of AWs unable to enter the kitchen, while Assam has lower restrictions. Qualitative discussions says that most of the women especially in Rajasthan do not do any kitchen related chores during this time. Their husbands and family members restrict them from doing all the kitchen related chores this time. Mainly female members of the family used to help or do the chores.

"We can do all the work except enter the kitchen and we are also not allowed to go near the home temple." ***- AW, Rajasthan***

"They should not cook because during menstruation they feel uncomfortable and also they experience abdominal pain." ***- Adolescent Boy, Assam.***

3.3.7.4 Social Interactions

Table 40: Social restrictions faced by AGs and AWs during menstruation (by state) (%)

Activity	State	Total		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
	N	***755***	***749***	***101***	***100***	***212***	***211***	***211***	***212***	***231***	***226***
Touching other family members	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	11.9	15.9	10.9	12.0	28.8	28.9	4.3	11.8	3.9	9.3
	Will not do	5.6	5.6	9.9	4.0	8.0	11.8	0.0	0.9	6.5	4.9
	Should not do	7.4	9.6	11.9	7.0	2.4	4.7	11.4	17.9	6.5	7.5
	Can do	75.1	68.9	67.3	77.0	60.8	54.5	84.4	69.3	83.1	78.3
	Not Applicable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Activity	State	Total		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
Sleeping in Usual Bed	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	10.5	14.4	10.9	13.0	23.6	26.1	1.9	10.8	6.1	7.5
	Will not do	2.8	3.9	0.0	2.0	6.6	10.0	0.0	0.0	3.0	2.7
	Should not do	6.6	8.5	8.9	6.0	2.4	4.7	12.3	14.2	4.3	8.0
	Can do	80.1	73.2	80.2	79.0	67.5	59.2	85.8	75.0	86.6	81.9
	Not Applicable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Using Usual Washroom	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	1.6	1.9	0.0	0.0	2.8	1.4	0.9	2.4	1.7	2.7
	Will not do	0.7	0.0	3.0	0.0	0.0	0.0	0.0	0.0	0.9	0.0
	Should not do	3.3	3.5	2.0	0.0	0.5	0.5	6.2	6.1	3.9	5.3
	Can do	77.7	72.9	95.0	96.0	82.5	80.1	64.5	51.4	77.9	76.1
	Not Applicable	16.7	21.8	0.0	4.0	14.2	18.0	28.4	40.1	15.6	15.9
Doing Worship (Puja/Namaz) at home	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	41.9	42.5	36.6	34.0	60.4	62.6	18.0	24.1	48.9	44.7
	Will not do	13.4	11.7	13.9	9.0	17.0	15.2	12.8	10.4	10.4	11.1
	Should not do	31.5	32.7	36.6	41.0	12.7	11.4	51.7	50.9	28.1	31.9
	Can do	13.0	13.0	12.9	16.0	9.9	10.9	17.5	14.6	11.7	11.9
	Not Applicable	0.3	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.9	0.4

Touching Other Family Members

Restrictions on touching other family members during menstruation are evident. 11.9% of AGs and 15.9% of AWs reported they cannot do so, while 5.6% of AGs and 5.6% of AWs will not do it. Social restrictions were reported by 7.4% of AGs and 9.6% of AWs. Rajasthan shows higher restrictions with 42.9% of AGs and 46.0% of AWs unable to touch family members, while Assam has lower restrictions. Qualitative discussions also indicate that during their periods, many women and girls are not allowed to touch other family members. They are often required to sit separately. This makes them feel isolated during menstruation.

Sleeping in Usual Bed

Restrictions on sleeping in the usual bed during menstruation are noted. 10.5% of AGs and 14.4% of AWs reported they cannot sleep in their usual bed, while 2.8% of AGs and 3.9% of AWs will not do it. Social restrictions were reported by 6.6% of AGs and 8.5% of AWs. Maharashtra shows higher restrictions with 23.6% of AGs and 26.1% of AWs unable to sleep in their usual bed, while Assam has lower restrictions.

Using Usual Washroom

Restrictions on using the usual washroom during menstruation are minimal. 1.6% of AGs and 1.9% of AWs reported they cannot use the usual washroom, while 0.7% of AGs and 0.0% of AWs will not do it. Social restrictions were reported by 3.3% of AGs and 3.5% of AWs. Maharashtra shows higher restrictions with 2.8% of AGs and 1.4% of AWs unable to use the usual washroom, while Assam has lower restrictions.

Doing Worship (Puja/Namaz) at Home

Restrictions on doing worship at home during menstruation are significant. 41.9% of AGs and 42.5% of AWs reported they cannot do worship at home, while 13.4% of AGs and 11.7% of AWs will not do it. Social restrictions were reported by 31.5% of AGs and 32.7% of AWs. Maharashtra shows higher restrictions with 60.4% of AGs and 62.6% of AWs unable to do worship at home, while Assam has lower restrictions. Qualitative interactions reveal that most girls are not allowed to worship or touch God during their periods. This is a common practice in many families. Menstruation is still considered a taboo by many people. Because of this, girls are excluded from religious activities during this time.

"We are not allowed to worship God." ***- AG, FGD, UP***

"Their stomach hurts and they cannot enter the kitchen. they cannot enter temples and mosques" ***- Adolscent Boy, FGD, Assam***

3.3.7.5 Economic Activities

Table 41: Economic restrictions faced by AGs and AWs during menstruation (by state) (%)

Activity	State	Total		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
	N	*755*	*749*	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Women going out for work	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Cannot Do	5.2	0.5	5.0	0.0	6.1	0.9	5.7	0.0	3.9	0.9
	Will not do	3.3	2.0	4.0	1.0	6.6	6.6	0.5	0.0	2.6	0.0
	Should not do	7.2	0.7	6.9	0.0	0.5	0.5	12.3	0.9	8.7	0.9
	Can do	84.4	15.2	84.2	15.0	86.8	27.5	81.5	6.6	84.8	11.9
	Not Applicable	0.0	81.6	0.0	84.0	0.0	64.5	0.0	92.5	0.0	86.3

Women Going Out for Work

Restrictions on women going out for work during menstruation are minimal. 5.2% of AGs and 0.5% of AWs reported they cannot go out for work, while 3.3% of AGs and 2.0% of AWs will not go. Social restrictions were reported by 7.2% of AGs and 0.7% of AWs. Maharashtra shows higher restrictions with 6.1% of AGs and 0.9% of AWs unable to go out for work, while Assam has lower restrictions. Qualitative discussions with women reveal that women have the freedom to decide whether to go out to work during their periods based on their comfort level. There are minimal restrictions on their ability to attend work. Maharashtra faces a little higher restriction but now a days this restriction become minimal. If women feel comfortable and capable, they can go to work as usual. However, if they experience discomfort or pain, they may choose to stay home.

3.3.8. Social Norms (Approval/Disapproval of Everyday Practices)

In this section, respondents were asked about their personal and perceived family approval or disapproval of various activities during menstruation. This analysis helps understand the cultural norms and personal beliefs surrounding menstrual practices. Social norms were examined as a function of personal approval and perceptions about approval from others in the communities and reports on personal behaviors contrasted with perceptions about behaviors by others in the community. For individually, respondents were categorized into groups corresponding to their personal approval/behavior and their perception. The respondents could be in one of the four groups below:

1. Approve of the behavior themselves and think others in their communities also approve of the behavior.
2. Do not approve of the behavior themselves and do not think others in their communities also approve of the behavior
3. Approve of the behavior themselves but think others in their communities do not approve of the behavior.
4. Do not approve of the behavior themselves but think others in their communities approve of the behavior.

3.3.8.1 Cooking Food During Menstruation

Table 42: Menstrual social norms reported by AGs and AWs: cooking food (by state) (%)

Statement	State	Total		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
	N	*755*	*749*	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Girls attending school during menstruation.	Self-Approve + Family Approve	49.3	48.5	52.5	56.0	29.7	30.3	46.4	36.8	68.4	73.0
	Self Not approve + Family does not approve	38.5	43.8	22.8	30.0	50.0	58.3	49.8	60.8	24.7	20.4
	Self-approve + Family does not approve	9.7	6.1	22.8	14.0	18.4	7.6	1.9	1.9	3.0	5.3
	Self does not approve + Family approves	2.5	1.6	2.0	0.0	1.9	3.8	1.9	0.5	3.9	1.3

A significant portion of both adolescent girls (49.3%) and adult women (48.5%) self-approve and believe their family also approves of cooking food during menstruation. This trend is particularly strong in Rajasthan (68.4% AG, 73.0% AW). However, in Maharashtra, a large percentage of AGs (50.0%) and AWs (58.3%) do not approve of this activity, aligning with their family's disapproval. Interestingly, 22.8% of AGs in Assam approve of cooking during menstruation even if their family does not. As per the qualitative discussions it is common for women to refrain from using kitchen utensils and cooking during their menstrual periods. This practice is rooted in cultural beliefs and traditions. During their menstruation, women often seek help from their Mother-in-Law or Sister-in-Law for cooking and household chores. While this practice may not be common in all states, it is prevalent in rural areas of Rajasthan and Uttar Pradesh.

"We are not allowed to enter the kitchen, we cannot serve or touch the food and in marriages as well we are not allowed to touch anything. We cannot go to the temple as well" ***- AW, Assam***

3.3.8.2 Attending Social Functions or Gatherings

Table 43: Menstrual social norms reported by AGs and AWs: social gathering (by state) (%)

Activity	State	Overall		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
	N	*755*	*749*	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Girls 'attending a social function or gathering during menstruation'	Self-Approve + Family Approve	50.6	49.4	55.4	55.0	43.4	43.6	52.6	49.1	53.2	52.7
	Self Not approve + Family does not approve	37.7	40.2	18.8	20.0	39.2	42.7	44.1	47.6	39.0	39.8
	Self-approve + Family does not approve	9.4	7.9	22.8	23.0	14.6	8.1	1.9	2.8	5.6	5.8
	Self does not approve + Family approves	2.3	2.5	3.0	2.0	2.8	5.7	1.4	0.5	2.2	1.8

Approval for attending social functions during menstruation is moderately high, with 50.6% of AGs and 49.4% of AWs approving and perceiving family approval. Assam shows a higher approval (55.4% AG, 55.0% AW), while disapproval aligns between personal and family views in Uttar Pradesh (44.1% AG, 47.6% AW). In Maharashtra, a notable 22.8% of AGs approve despite family disapproval.The data is complimented by the qualitative findings as the girls and women try to attend the family function, but in UP and Rajasthan still people believes that they should not attend these functions. But earlier, this practice was approved by everyone but now they are trying to modify their customs and allow girls to attend social gatherings during menstruation. The discussions with AGs and AWs reveal that these practices now changes and people reconsider their beliefs and allow girls to attend social gatherings. Allowing girls to attend family functions during menstruation promotes social inclusion and respects their participation in important family events.

3.3.8.3 Attending School During Menstruation

Table 44: Menstrual social norms reported by AGs and AWs: attending school (by state) (%)

Statement	State	Overall		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
	N	*755*	*749*	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Girls 'attending a social function or gathering during menstruation'	Self-Approve + Family Approve	85.4	80.9	98.0	96.0	84.0	81.0	79.1	74.5	87.0	80.1
	Self Not approve + Family does not approve	11.3	12.8	0.0	1.0	11.8	10.0	17.5	21.7	10.0	12.4
	Self-approve + Family does not approve	2.1	5.3	2.0	3.0	2.4	8.5	2.8	3.3	1.3	5.3
	Self does not approve + Family approves	1.2	0.9	0.0	0.0	1.9	0.5	0.5	0.5	1.7	2.2

A substantial majority of respondents approve of attending school during menstruation, with 85.4% of AGs and 80.9% of AWs indicating self and family approval. This is especially pronounced in Assam (98.0% AG, 96.0% AW). Contrarily, in Uttar Pradesh, there is a higher rate of disapproval (17.5% AG, 21.7% AW) compared to other states. The qualitative findings further inform that many girls now attend school regularly. However, if they experience any discomfort, they do not attend school that day. If their menstruation begins while they are at school, they seek help from the Anganwadi workers or female teachers. These staff members provide support and guidance, ensuring the girls have the necessary resources and assistance to manage their menstruation comfortably.

"We are not allowed to enter the kitchen, we cannot serve or touch the food and in marriages as well we are not allowed to touch anything. We cannot go to the temple as well" ***- AW, Assam***

3.3.8.4 Visiting Religious Places During Menstruation

Table 45: Menstrual social norms reported by AGs and AWs: visiting religious places (by state) (%)

Statement	State	Overall		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
	N	*755*	*749*	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Females visiting religious places during menstruation	Self-Approve + Family Approve	10.3%	7.7%	11.9%	11.0%	12.3%	11.8%	12.3%	7.1%	6.1%	3.1%
	Self Not approve + Family does not approve	84.1%	90.4%	85.1%	88.0%	79.7%	85.3%	85.3%	92.9%	86.6%	93.8%
	Self-approve + Family does not approve	5.3%	1.7%	3.0%	1.0%	7.5%	2.4%	2.4%	0.0%	6.9%	3.1%
	Self does not approve + Family approves	0.3%	0.1%	0.0%	0.0%	0.5%	0.5%	0.0%	0.0%	0.4%	0.0%

Approval for visiting religious places during menstruation is low, with only 10.3% of AGs and 7.7% of AWs approving and perceiving family approval. The disapproval is overwhelmingly high, with 84.1% of AGs and 90.4% of AWs expressing disapproval. This trend is consistent across all states, reflecting strong cultural norms against this practice. Qualitative insights also reveal that visiting religious places during menstruation is not common. Many women and girls avoid going to temples or other religious sites during this time.

"We are not allowed to touch the things that are used in the temple" ***- AW, FGD, Assam***

"We cannot go to the temple." ***- AG, FGD, Maharashtra***

3.3.8.5 Washing Menstrual Cloth with Soap and Water

Table 46: Menstrual social norms reported by AGs and AWs: washing menstrual cloth (by state) (%)

Statement	State	Overall		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
	N	*755*	*749*	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Washing Menstrual Cloth with Soap and Water	Self-Approve + Family Approve	78.5	84.4	98.0	100.0	84.9	89.1	57.8	69.3	83.1	87.2
	Self Not approve + Family does not approve	18.8	14.2	1.0	0.0	11.3	9.0	39.8	29.2	14.3	11.1
	Self-approve + Family does not approve	0.9	0.8	1.0	0.0	0.9	1.4	0.9	0.0	0.9	1.3
	Self does not approve + Family approves	1.7	0.7	0.0	0.0	2.8	0.5	1.4	1.4	1.7	0.4

A majority approve of washing menstrual cloth with soap and water, with 78.5% of AGs and 84.4% of AWs aligning with family approval. Assam shows near-universal approval (98.0% AG, 100.0% AW). Disapproval is highest in Uttar Pradesh (39.8% AG, 29.2% AW).

3.3.8.6 Drying Menstrual Cloth in the Sun

Table 47: Menstrual social norms reported by AGs and AWs: drying menstrual cloth (by state) (%)

Statement	State	Overall		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
	N	*755*	*749*	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Drying menstrual cloth in the sun after washing with soap	Self-Approve + Family Approve	73.1	80.8	92.1	89.0	75.5	80.6	55.5	74.1	78.8	83.6
	Self Not approve + Family does not approve	23.2	16.8	3.0	3.0	18.9	16.6	42.2	25.9	18.6	14.6
	Self-approve + Family does not approve	2.0	1.9	5.0	7.0	1.9	2.4	1.4	0.0	1.3	0.9
	Self does not approve + Family approves	1.7	0.5	0.0	1.0	3.8	0.5	0.9	0.0	1.3	0.9

FGD with adolescent girls in progress at Zilpi, Amravati, Maharashtra (June 2024)

Approval for drying menstrual cloth in the sun after washing is high, with 73.1% of AGs and 80.8% of AWs approving and perceiving family approval. This practice is most accepted in Assam (92.1% AG, 89.0% AW). Uttar Pradesh shows the highest disapproval (42.2% AG, 25.9% AW). The qualitative discussion with adolescent girls reveals that girls prefer to dry their menstrual cloths in sunlight after washing them with soap. This practice is common and helps in keeping the clothes clean and hygienic. However, some women feel shy about drying their menstrual cloths, especially during the day. So, they choose to dry them at night when there are fewer people around. This shyness is more reported in UP.

3.3.8.7 Disposing of Used Cloth or Sanitary Napkins

Table 48: Menstrual social norms reported by AGs and AWs: disposal of MHM products (by state) (%)

Statement	State	Overall		Assam		Maharashtra		Uttar Pradesh		Rajasthan	
	TG	AG	AW	AG	AW	AG	AW	AG	AW	AG	AW
	N	*755*	*749*	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Disposing of used cloth or sanitary napkins by burning or burying them	Self-Approve + Family Approve	79.7	79.7	82.2	85.0	87.3	83.4	77.7	80.7	73.6	73.0
	Self Not approve + Family does not approve	16.7	17.1	11.9	9.0	9.9	14.2	19.9	15.1	22.1	25.2
	Self-approve + Family does not approve	3.2	2.7	5.9	5.0	2.8	1.4	1.9	3.8	3.5	1.8
	Self does not approve + Family approves	0.4	0.5	0.0	1.0	0.0	0.9	0.5	0.5	0.9	0.0

Approval for disposing of used cloth or sanitary napkins by burning or burying is very high, with 79.7% of AGs and 79.7% of AWs approving and perceiving family approval. This is particularly prevalent in Maharashtra (87.3% AG, 83.4% AW). Disapproval is highest in Rajasthan (22.1% AG, 25.2% AW). Insights from the qualitative discussion reveal that the disposal of sanitary pads is very high among girls. They are aware of the need to dispose of them properly to maintain hygiene. Girls understand that improper disposal of sanitary pads can lead to several issues. They know that if not disposed of correctly, cows might eat them, which can be harmful to the animals. Additionally, they are aware that germs can spread from used sanitary pads, so they are encouraged to wrap used pads in paper and dispose of them in designated bins to prevent health hazards.

"They should spread awareness that pads should not be thrown anywhere, it should be burnt after use." ***- AG, FGD, UP***

3.4 Menstrual Waste Management

3.4.1. Hygiene Practices: Washing MHM Products

This section explores the cleaning methods used by respondents for their menstrual hygiene products, shedding light on hygiene practices and preferences. It juxtaposes the practices recommended by frontline workers (FLWs) and teachers within the same geographies. The primary method endorsed for cleaning reusable menstrual hygiene products is using soap and water, which aligns with recommended hygiene practices.

The data indicates that most respondents across all regions and age groups use soap and water to clean their menstrual hygiene products. This is a positive indicator of good hygiene practices, suggesting that the recommended method of using soap and water is widely adopted. Qualitative findings reveal that teachers and FLWs teach girls to wash their hands with soap and water. School keeps soap in their washroom and tries to keep it clean. The discussion with AGs also reveals that most girls practice good hygiene by washing their hands with soap and water. They follow this routine both at home and at school. According to the AGS they have learned the importance of handwashing from school.

Figure 36: Recommended practice by FLWs and Teachers to wash reusable MHM products (overall)

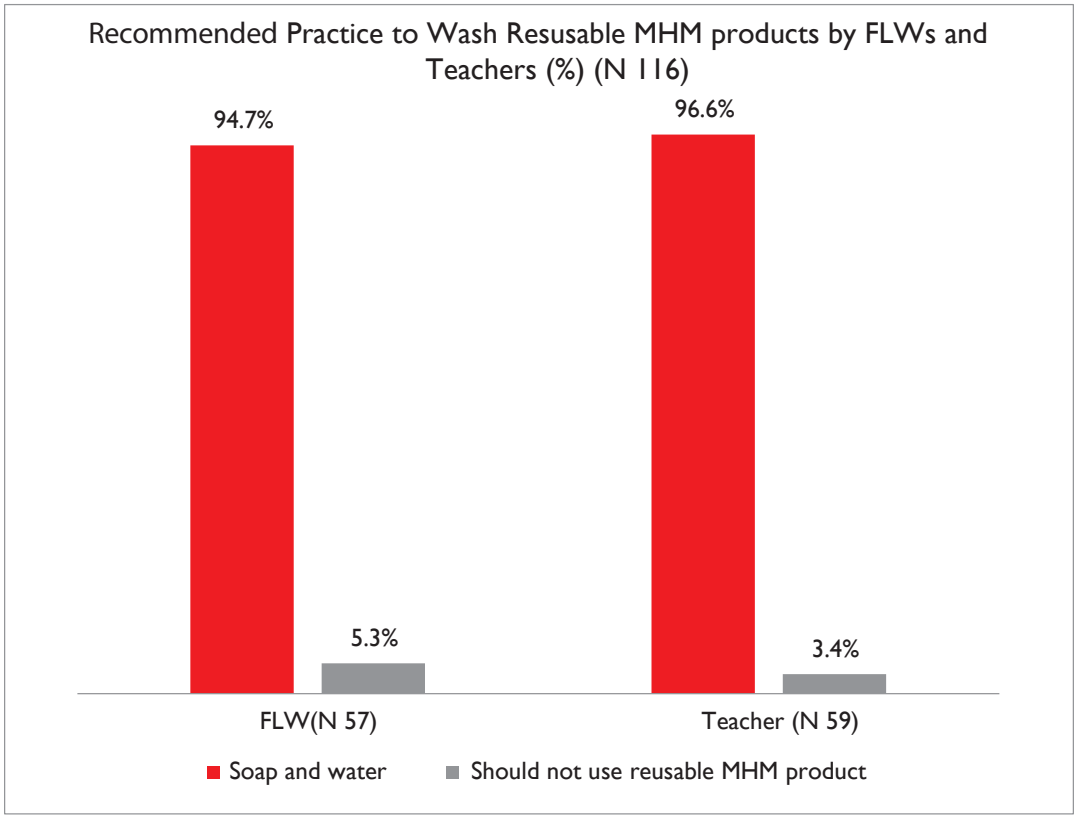


Table 49: Recommended practice by FLWs and Teachers to wash reusable MHM products (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	FLW	Teacher	FLW	Teacher	FLW	Teacher	FLW	Teacher
N	*8*	*8*	*16*	*17*	*16*	*17*	*17*	*17*
Soap and water	100.0	100.0	100.0	100.0	81.3	100.0	100.0	88.2

Among frontline workers and teachers, the use of soap and water is nearly universal, with 94.7% of FLWs and 96.6% of teachers advocating for this method. In Assam and Maharashtra, all FLWs and teachers recommend using soap and water, reflecting strong adherence to hygiene guidelines. Only a handful of FLWs (5.3%) and Teachers (3.4%) recommended not to use reusable MHM products. Uttar Pradesh shows some variation, with 18.8% of FLWs indicating other methods, while Rajasthan aligns closely with the overall trend.

Figure 37: Practices followed by AGs and AWs to clean Reusable MHM Products (Overall)

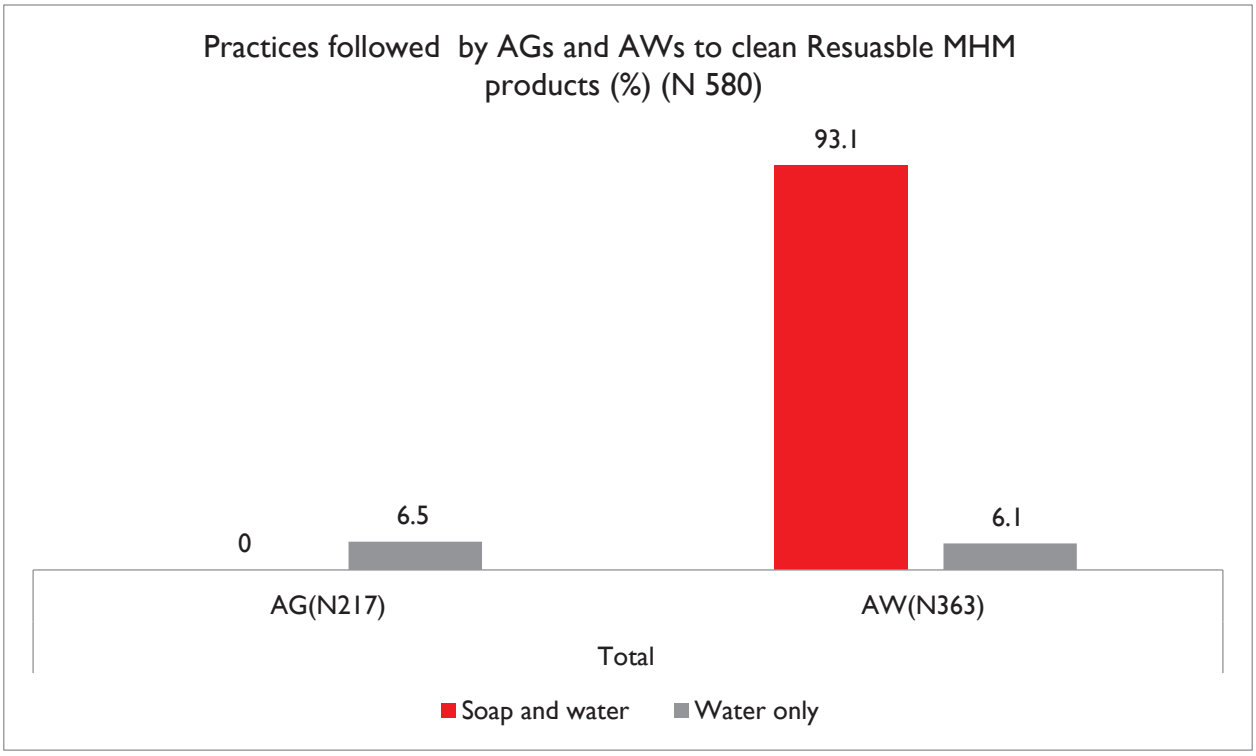


Table 50: Practices followed by AGs and AWs to clean reusable MHM products (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
Respondent Group	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**
N	***41***	***62***	***45***	***80***	***86***	***133***	***45***	***88***
Soap and water	100	100	80	77.5	95.39	96.2	97.8	97.7
Water only	0	0	20	22.5	4.7	3.8	2.2	2.3

For adolescent girls and adult women, similar patterns emerge. A vast majority of AGs (93.5%) and AWs (93.1%) use soap and water at an overall level, reinforcing the widespread acceptance of this hygienic practice. Regional differences are minimal, though Assam shows a perfect adherence (100%) among both AGs and AWs, whereas Maharashtra has a slightly higher reliance on water only, especially among AGs (20%).

3.4.2. Hygienic Practices: Safely Drying MHM Products

This section examines the methods used by respondents to dry cloth used during menstruation, revealing insights into hygiene practices and cultural considerations by juxtaposing them against preferential methods suggested by the care givers (FLWs, teachers) in the geography. The responses are categorized into four methods: drying directly under sunlight, drying under sunlight but covered under another cloth, drying inside the house, and other specified methods.

Figure 38: Recommended method for drying reusable MH products by FLWs and Teachers(overall)

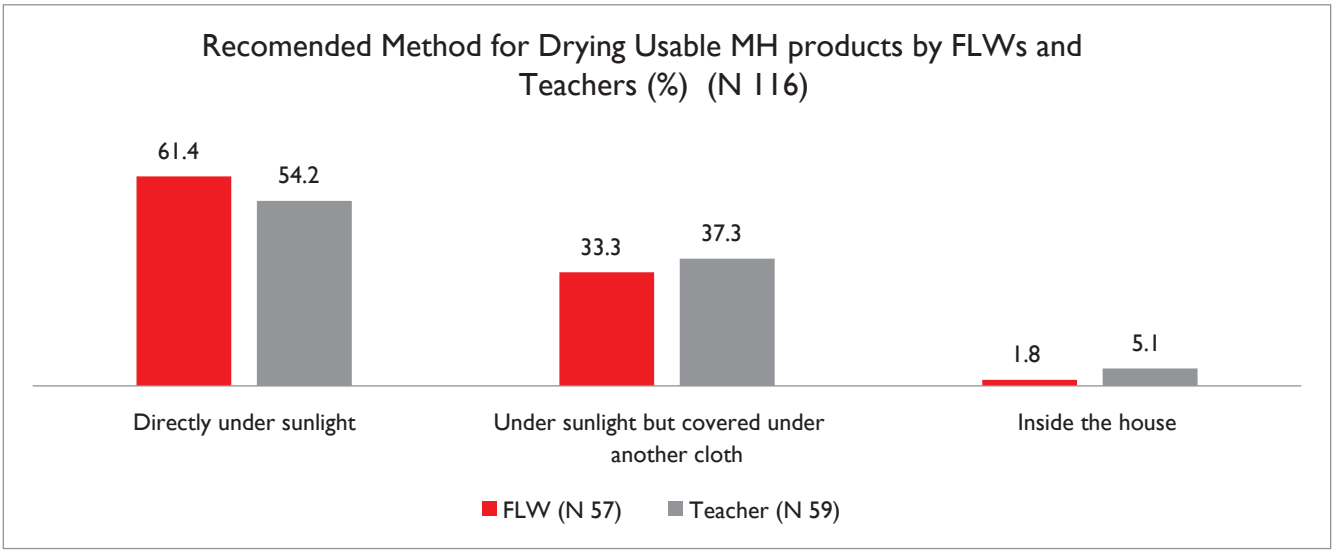


Table 51: Recommended method for drying reusable MH products by FLWs and Teachers (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
Respondent Group	**FLW**	**Teacher**	**FLW**	**Teacher**	**FLW**	**Teacher**	**FLW**	**Teacher**
N	***8***	***8***	***16***	***17***	***16***	***17***	***17***	***17***
Directly under sunlight	87.5	87.5	81.3	76.5	35.3	35.3	58.8	35.3
Under sunlight but covered under another cloth	12.5	12.5	12.5	11.8	56.3	64.7	41.2.	47.1
Inside the house	0.0	0.0	6.3	11.8	0.0	0.0	0.0	5.9

The data shows a preference for drying menstrual hygiene products directly under sunlight, considered an effective method for maintaining hygiene. Among frontline workers and teachers, 61% and 50% respectively recommend this method on an overall level. In Assam and Maharashtra, a significant proportion of FLWs (87.5%) and teachers (87.5% in Assam, 100.0% in Maharashtra) endorse this practice, indicating strong adherence to hygienic drying methods. In Uttar Pradesh, however, only 31.3% of FLWs recommend direct sunlight, with a notable percentage suggesting drying under sunlight but covered with another cloth (56.3%).

Figure 39: Methods for drying MH products by AGs and AWs (Overall)

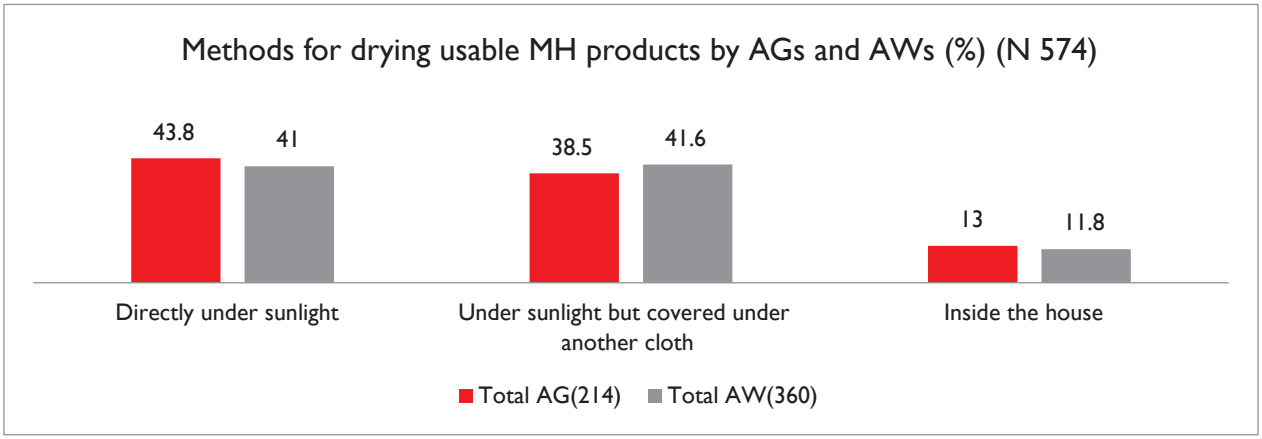


Table 52: Method for drying reusable MH products by AGs and AWs (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**
N	***39***	***62***	***45***	***79***	***86***	***133***	***44***	***86***
Directly under sunlight	82.5	74.2	42.3	27.3	25.6	22.5	43.2	51.7
Under sunlight but covered under another cloth	12.5	21.0	34.6	40.9	46.3	49.6	50.0	44.8
Inside the house	5.0	4.8	23.1	31.8	18.3	15.5	4.5	1.1

For adolescent girls and adult women, the preference for drying directly under sunlight is also prevalent. In Assam, 82.5% of AGs and 74.2% of AWs use this method, indicating a high level of awareness about the importance of drying menstrual products properly. However, in Uttar Pradesh, a lower percentage (25.6% of AGs and 22.5% of AWs) prefer this method, with many opting to dry the products under sunlight but covered with another cloth (46.3% of AGs and 49.6% of AWs). The practice of drying menstrual products inside the house is less common but still notable. In Maharashtra, 23% of AGs and 32% of AWs dry their products inside the house, reflecting possible cultural taboos or privacy concerns. This method is less preferred in other states, with very few respondents choosing this option.

The findings indicate a general awareness and adherence to hygienic practices for drying menstrual products, with a strong preference for using sunlight. However, the variation in methods across regions highlights the influence of cultural norms and privacy concerns. Targeted educational efforts can further promote the benefits of proper drying techniques, especially in regions where indoor drying is more prevalent.

3.4.3. MHM Product Disposal

This section delves into the various methods used by adolescent girls (AG) and adult women (AW) for disposing of menstrual absorbents along with their knowledge on the adverse environmental effects of improper MHM waste disposal. The combined analysis aims to shed light on the knowledge and practices of the respondents on MHM product disposal.

Majority of the target group use water and soap both to clean the reusable MHM product which is good as in terms of baseline. Once the intervention is done the gaps will eventually be plugged in.

The following table explores the respondents' awareness and practices concerning the environmental impacts of improper disposal of menstrual absorbents. It sheds light on the understanding of pollution types and health risks, highlighting the gaps in knowledge that need to be addressed through education and policy interventions.

Figure 40: AGs and AWs knowledge on the impact of improper waste management (Overall)

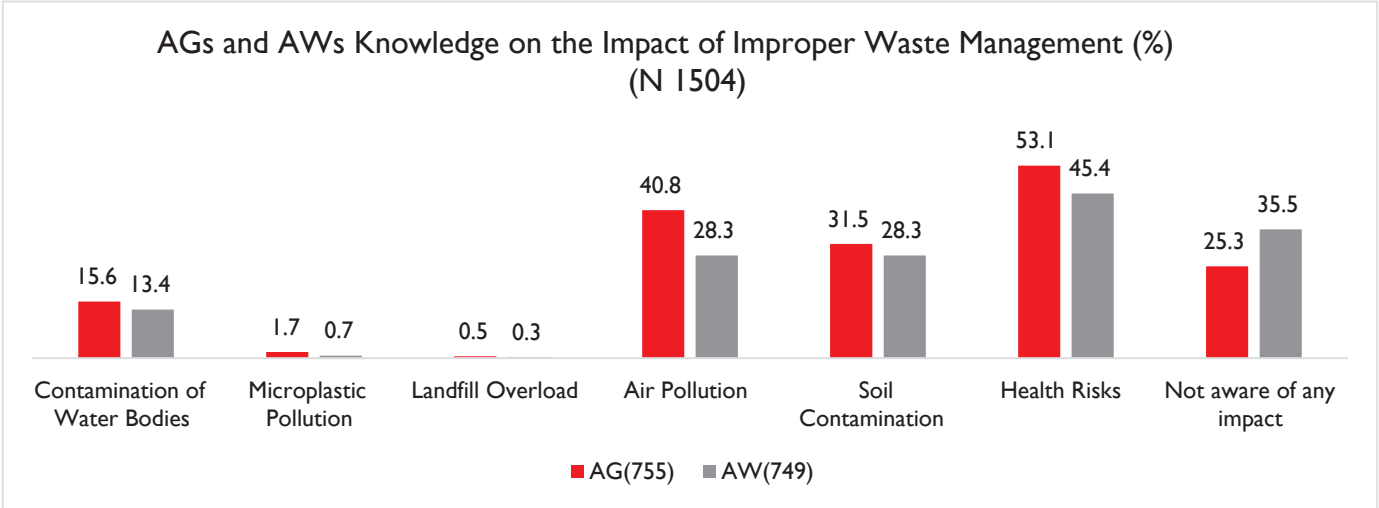


Table 53: AGs and AWs knowledge on the impact of improper waste management (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**
N	***101***	***100***	***212***	***211***	***211***	***212***	***231***	***226***
Contamination of Water Bodies	21.8	16.0	24.5	25.1	10.4	5.7	9.5	8.4
Microplastic Pollution	0.0	0.0	2.8	0.9	1.4	0.0	1.7	1.3
Landfill Overload	3.0	1.0	0.5	0.5	0.0	0.0	0.0	0.0
Air Pollution	50.5	36.0	44.8	37.9	30.8	18.4	42.0	25.2
Soil Contamination	62.4	62.0	32.5	30.3	27.0	19.8	21.2	19.5
Health Risks	38.6	40.0	67.9	64.9	40.8	28.8	57.1	45.1
Not aware of any impact	10.9	19.0	17.9	22.3	34.1	48.1	30.3	43.4

Overall, 53.1% of adolescent girls (AG) and 45.4% of adult women (AW) are aware of the health risks associated with improper disposal. Awareness of air pollution is significant among AGs (40.8%) and AWs (28.3%). Additionally, awareness of soil contamination is notable, with 31.5% of AGs and 28.3% of AWs recognizing it as a concern. However, the awareness of microplastic pollution and landfill overload is relatively low, indicating gaps in knowledge about these specific impacts. A considerable portion of respondents, particularly among AWs, reported not being aware of any environmental impact (35.5%).

Around half of the AGs and AWs are aware of the ill effects of improper MHM waste disposal but still half of the remaining AGS and AWs needs counselling around harmful effects improper disposal.

Figure 41: AGs and AWs practices on MHM product disposal

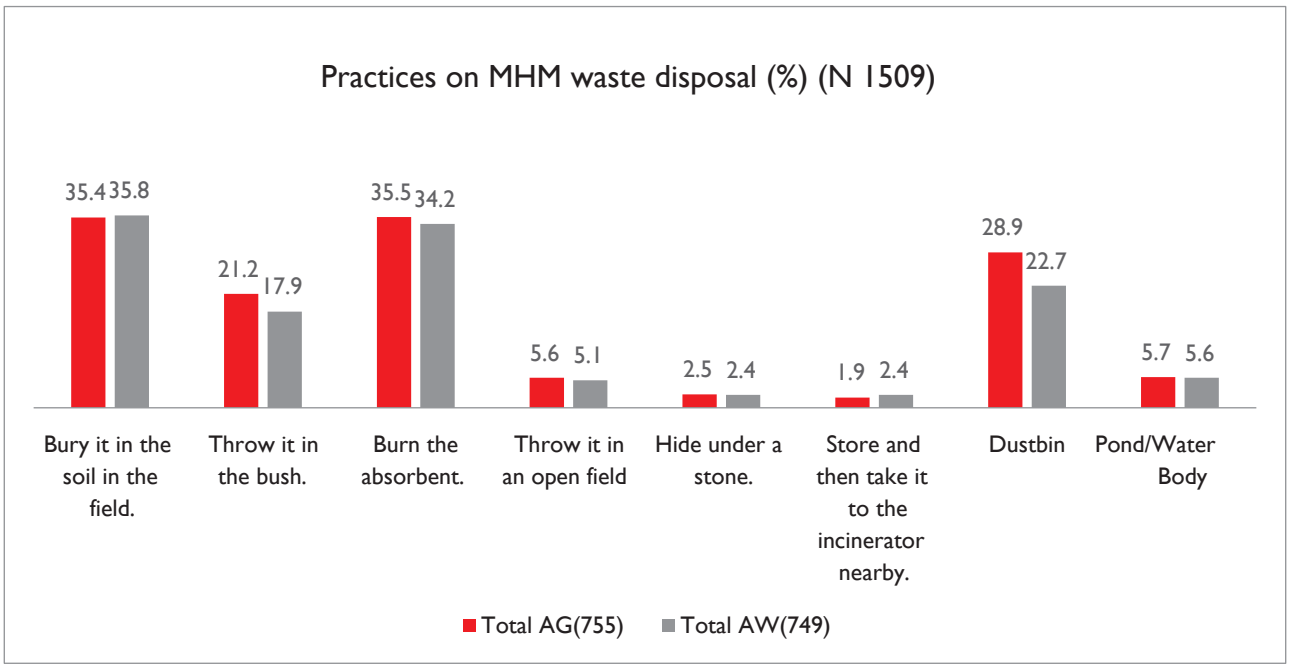


Table 54: AGs and AWs Practices on MHM Product Disposal (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**
N	***101***	***100***	***212***	***211***	***211***	***212***	***231***	***226***
Bury it in the soil in the field.	50.5	48.0	20.3	22.7	47.9	45.3	31.2	33.6
Throw it in the bush.	21.8	16.0	0.9	0.9	40.3	33.0	22.1	20.4
Burn the absorbent.	30.7	25.0	79.2	73.5	19.0	25.5	12.6	9.7
Throw it in an open field	5.0	4.0	1.4	3.3	4.7	8.0	10.4	4.4
Hide under a stone.	0.0	0.0	1.4	1.9	2.8	2.8	4.3	3.5
Store and then take it to the incinerator nearby.	0.0	0.0	2.4	1.9	0.0	0.9	3.9	5.3
Dustbin	12.9	17.0	8.0	5.2	15.2	7.5	67.5	55.8
Pond/Water Body	3.0	5.0	1.4	0.5	15.6	14.6	1.7	2.2

The data on disposal methods highlights diverse ways for menstrual absorbents among AGs and AWs across the states. The overall preference is to burn the absorbent (35.5% AG, 34.2% AW) or bury it in the soil (35.4% AG, 35.8% AW). The combined analysis of knowledge and practices reveals critical insights into menstrual absorbent disposal and its environmental impact. While a significant number of respondents are aware of the health risks and pollution types, there are still substantial gaps in knowledge, especially concerning microplastic pollution and landfill overload. These gaps are more pronounced among adult women than adolescent girls, suggesting the need for targeted educational programs.

The disposal practices further illustrate the environmental implications. Burning absorbents, although common (35.5% AG, 34.2% AW), contribute to air pollution, which is acknowledged by a significant portion of respondents. Burying absorbents in soil (35.4% AG, 35.8% AW) and throwing them in bushes (21.2% AG, 17.9% AW) also reflect practices that can lead to soil contamination and water pollution. The use of dustbins is notably higher in Rajasthan (67.5% AG, 55.8% AW), indicating better waste management practices in this region compared to others.

As per the qualitative discussion with AGs and AWs, many girls and women dispose of their sanitary pads properly to maintain hygiene. They understand the importance of safe disposal methods. Mainly they burn the pads or throw them in dustbins or bush. Teachers and FLW workers teach them not to dispose these used pads anywhere as cows might eat them or it will cause health risk. This will increase environmental pollution

"When we use pads, we don't have to use our hand, we don't have to use water to clean it. We can wrap it in paper and then we can bury or burn it." ***- FLW, Maharashtra***

"We should not throw the pads here and there, as it can lead to the spread of germs."
- AG, FGD, Maharashtra

3.5 Access to MHM Products & Services

In this segment, attention is given to the accessibility of MHM products and services, including the availability and utilization of retail points. It examines the impact of capacity-building efforts on improving access to MHM products and services, aiming to identify barriers and opportunities for enhancing accessibility.

3.5.1. Type of Absorbent used during Menstruation

The respondents were inquired about the type of absorbent they use during menstruation. In order to understand their current practice pertaining to hygiene during menstruation. As per the baseline data overall, 86% AGs reported using 'Use and throw sanitary pads' followed by 'New cloth washed and reused' (16%) and 'Old Cloth' (12.2%). While among the AWs 59% of them reported using 'Use and throw sanitary pads' while almost equal proportion of AWs state using "New cloth used washed and reused' and 'Old Cloth'. The data reveals that AGs are more inclined towards using 'use and throw sanitary pads' and it is their preferred absorbent as compared to AWs.

Figure 42: Type of absorbent used (Overall)

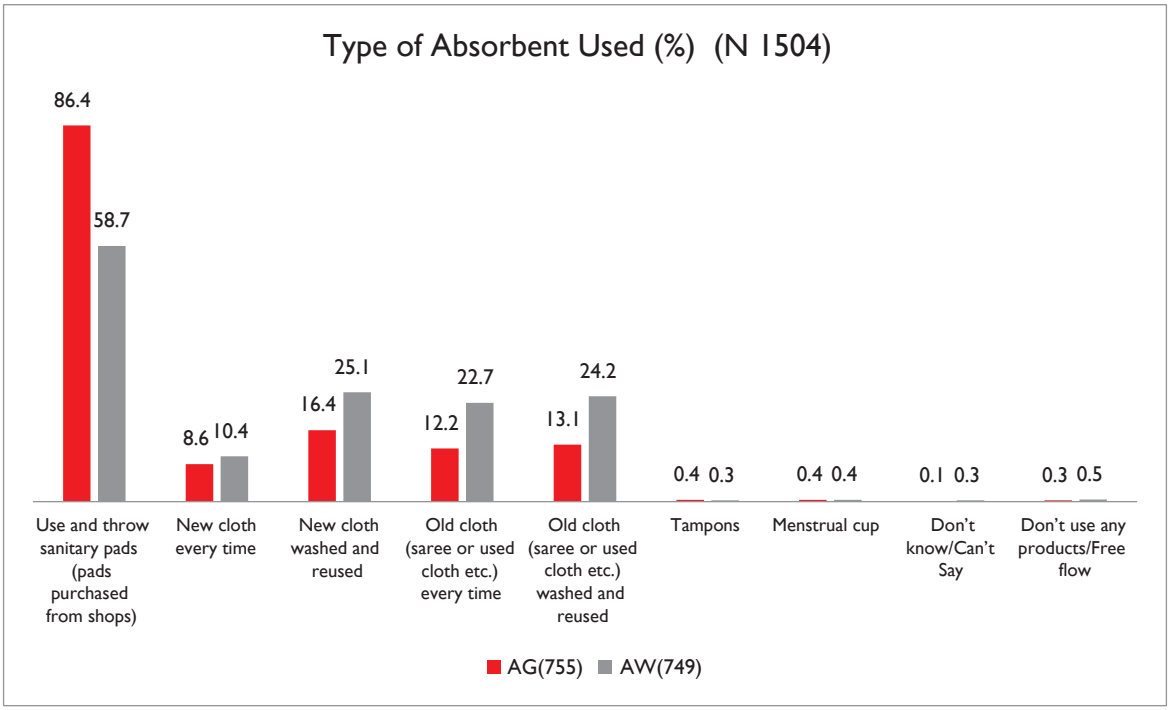


Table 55:Type of absorbent used (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	AG	AW	AG	AW	AG	AW	AG	AW
N	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*236*
Use and throw sanitary pads (pads purchased from shops)	93.1	58.0	89.2	69.7	71.6	40.1	94.4	66.4
New cloth every time	0.0	0.0	16.0	16.6	6.2	8.0	7.8	11.5
New cloth washed and reused	35.6	41.0	18.9	28.4	6.2	8.5	15.2	30.5
Old cloth (saree or used cloth etc.) every time	6.9	23.0	11.3	18.5	19.4	27.8	8.7	21.7
Old cloth (saree or used cloth etc.) washed and reused	5.9	25.0	7.1	12.8	30.3	47.2	6.1	12.8
Tampons	0.0	0.0	0.5	0.5	0.0	0.	0.9	0.4
Menstrual cup	2.0	0.0	0.0	0.5	0.0	0.0	0.4	0.9
Don't know/Can't Say	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.9
Don't use any products/Free flow	0.0	0.0	0.0	0.0	0.5	0.5	0.4	1.3

Sanitary pad was reported to be the first preference 'among the AWs in Assam with 93%, followed by Rajasthan 94% and Maharashtra 89%. 'Sanitary Padwas the most widely used absorbent by the AWs in Maharashtra 69.7% and Rajasthan 66.4%. 'New cloth washed and reused' was the second most used absorbent across the study states. Qualitative discussions with the women shows that many women use pads and throw it after use. Some women cannot have the access, use cloth and after using it they clean it with soap and water. After that they dried it in sunlight. They try to maintain hygiene. Anganwadi workers guide them and encourage them to use pads.

3.5.2. Procurement of Absorbent by Respondents

The respondents who responded to using absorbent during menstruation were asked further questions about the procurement of absorbent. Overall, two thirds of AGs and 60% AWs reported procuring absorbent from shop. Similarly, one fourth of AGs and nearly 42 % AWs arrange the absorbent in house itself. While only 17% AGs reported procuring absorbent from school, and the proportion of AWs procuring absorbent from school stood around 1.6%, an indication that AWs might be getting the absorbents through their family members attending school.

Figure 43: Source of Absorbent for AGs and AWs (Overall)

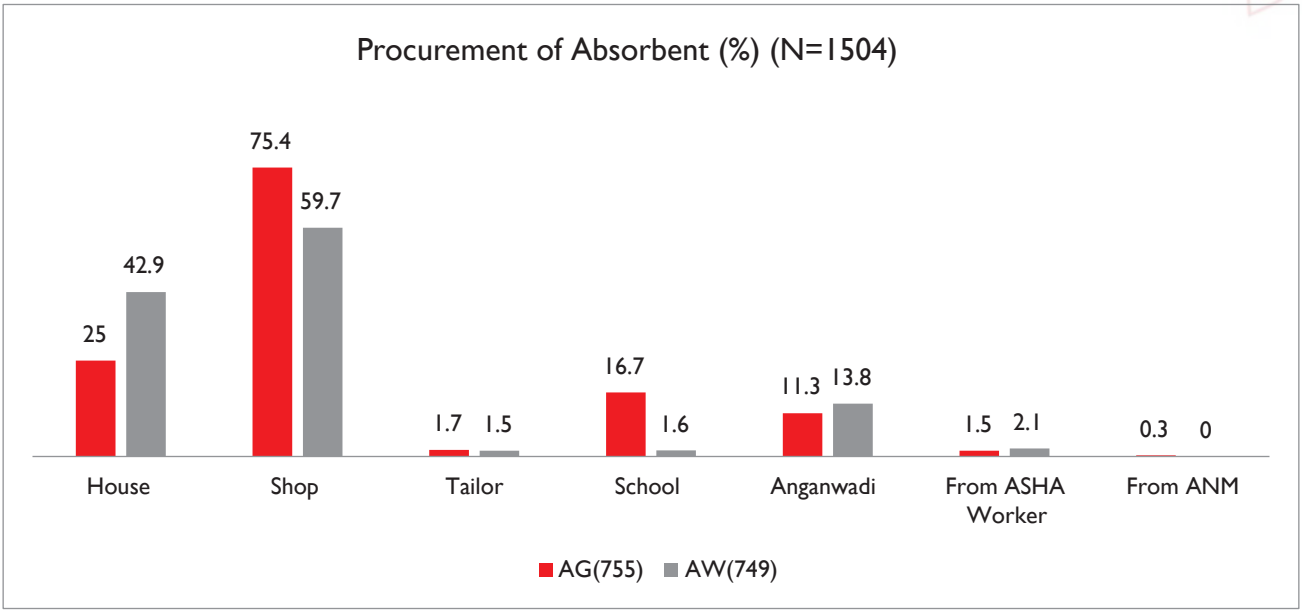


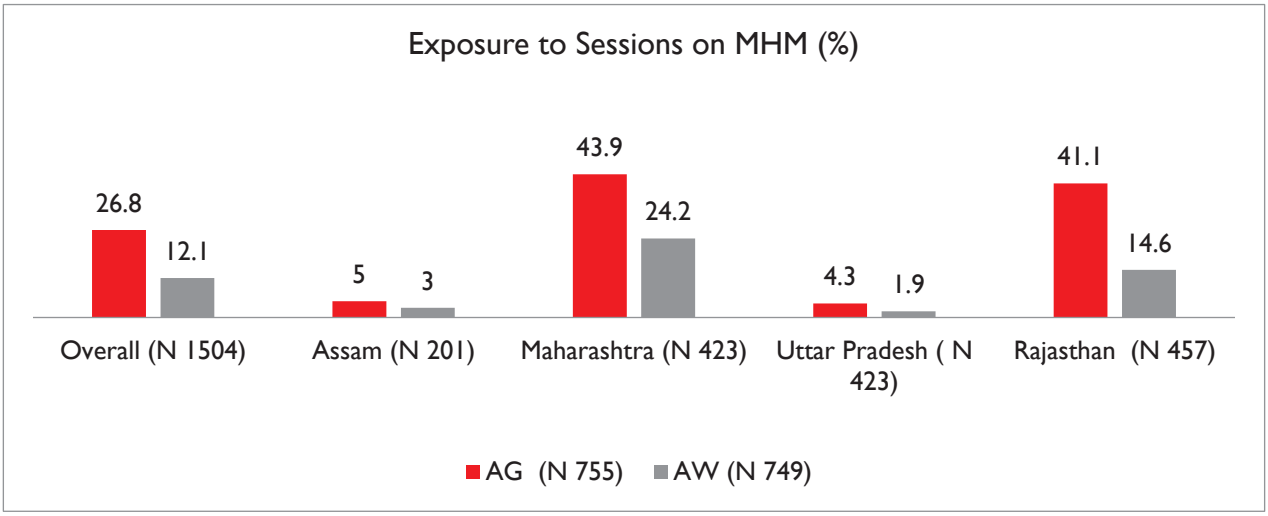
Table 56: Source of absorbent for AGs and AWs (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**	**AG**	**AW**
N	***101***	***100***	***212***	***211***	***211***	***212***	***231***	***226***
House	22.8	59.0	11.3	25.1	49.8	68.9	16.0	27.9
Shop	96.0	69.0	89.6	74.9	65.9	39.6	61.9	60.2
Tailor	0.0	0.0	4.2	2.4	1.4	1.4	0.4	1.3
School	1.0	0.0	0.5	0.0	0.5	0.5	53.2	4.9
Anganwadi	0.0	0.0	1.4	0.5	0.5	0.5	35.1	44.7
From ASHA Worker	0.0	0.0	3.3	3.3	0.0	0.5	1.7	3.5
From ANM	0.0	0.0	0.0	0.0	0.5	0.0	0.4	0.0

3.5.3. Exposure to MHM related classes/sessions by AGs and AWs

The AGs and AWs were inquired about their exposure to classes or sessions on MHM. Overall, only 27% of AGs and 12% of AWs reported exposure to sessions on MHM. The proportion of AGs was doble in comparison to the AWs in terms of attending sessions on MHM. State wise analysis reveals that around 44% of AGs in Maharashtra and 41% in Rajasthan had the exposure while 24% of AWs in Maharashtra and 15% of them in Rajasthan had similar exposure. Among both the target groups the level of exposure was least in Assam and Uttar Pradesh.

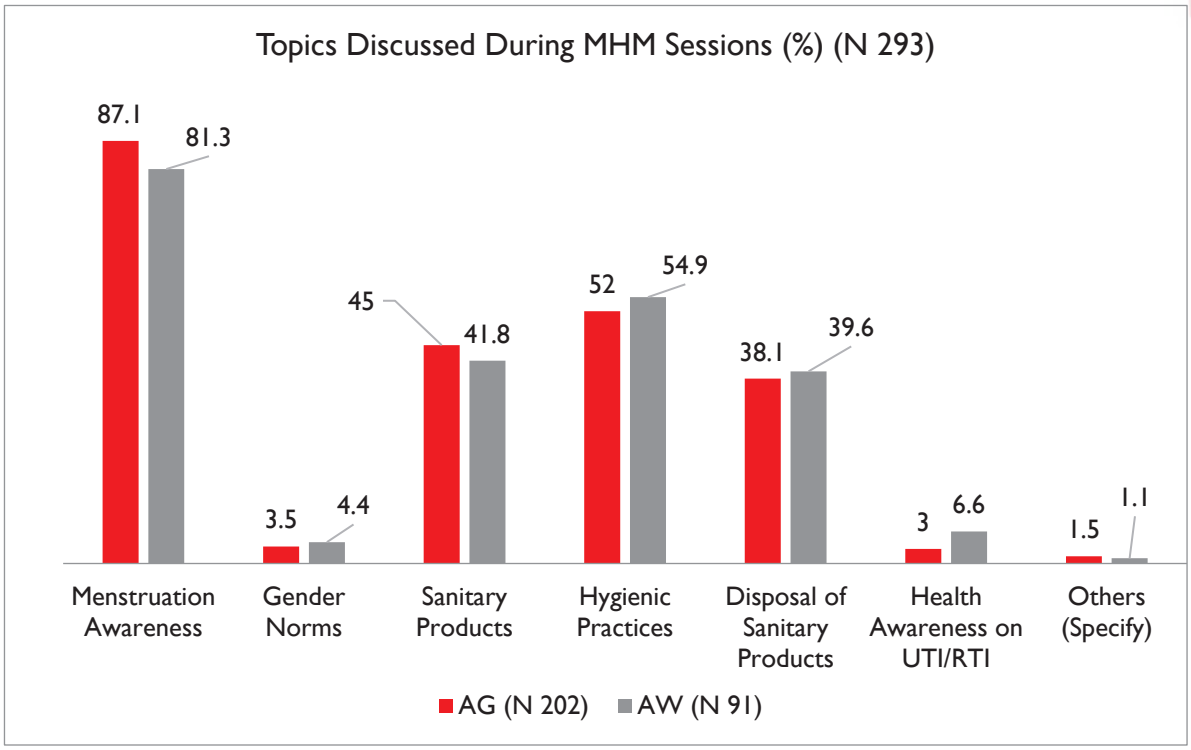
Figure 44: Exposure to sessions on MHM by AGs and AWs (by state) (%)



3.5.4. Topics Covered in the MHM related sessions

The respondents who claimed to have attended sessions were further inquired around the topics discussed during the sessions. The respondents who reported attending sessions on MHM were asked to recall about the topics covered in such sessions. As per the baseline data majority of the sessions were held on 'Menstruation Awareness' as per 87% AGs and 81% AWs, the second highest discussed topic was 'Hygienic Practices' followed by 'Sanitary Products'.

Figure 45: Topics discussed during MHM sessions reported by AGs and AWs (Overall Level) (%)



FGD with adult men in progress at Zilpi, Dharani, Maharashtra (June 2024)

Overall, 87% of AGs and 81%9 AWs reported the topic 'Menstruation Awareness during the sessions at school and at the community'. The topics varies from state to state in similar proportions but largely the sessions were held around 'Menstrual Awareness' followed by 'Hygienic Practices' and 'Sanitary Products'.

As per the qualitative discussions with the AGs and AWs, most adolescent girls (AG) attend menstrual hygiene sessions in their schools, while women attend similar sessions in Anganwadi centres. During these sessions, girls and women are taught how to use sanitary pads correctly. They learn about the importance of changing pads regularly to maintain hygiene and prevent infections. They teach how to dispose sanitary pads. They highlight the risks associated with improper disposal, such as the spread of germs and the danger of cows eating the pads. Women are instructed to wrap used pads in paper and dispose of them in designated bins or burn them if necessary. They advices women who still use cloths, to dry them under sunlight and wash them properly. Women and girls should consult Anganwadi if they face any discomfort and pain and took tablets with doctor concern. Additionally, FLWs also suggest that girls/women can be shown videos wherein they can be further be educated about sanitary napkin use. .

"We can show them videos on how to use sanitary napkins, its benefits, and the chances of infection if not used" ***- FLW, Rajasthan***

Table 57: Topics discussed during MHM reported by AGs and AWs (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	AG	AW	AG	AW	AG	AW	AG	AW
N	*5*	*3*	*93*	*51*	*9*	*4*	*95*	*33*
Menstruation Awareness	80.0	100.0	83.9	82.4	100.0	75.0	89.5	78.8
Gender Norms	40.0	0.0	4.3	2.0	0.0	0.0	1.1	9.1
Sanitary Products	20.0	33.3	55.9	52.9	11.1	25.0	38.9	27.3
Hygienic Practices	100.0	100.0	67.7	62.7	11.1	25.0	37.9	42.4
Disposal of Sanitary Products	0.0	33.3	48.4	43.1	0.0	25.0	33.7	36.4
Health Awareness on UTI/RTI	0.0	0.0	5.4	5.9	0.0	25.0	1.1	6.1

The baseline data highlights that majority of the training has taken place around "Menstruation Awareness" but Ideally it would bring more clarity to the target groups if these topics are diversified further to cover an holistic prospective of MHM by including gender norms, sanitary awareness, hygienic practices, disposal of sanitary products, health awareness on UTI/RTI.

3.5.5. Organizers of MHM related sessions

The respondents who reported attending sessions on MHM were further probed about organizers of such sessions. Overall, 76% of AGs reported 'Schools' while 70% of AWs reported 'Anganwadi' as the organizer. Only 10.9% AGs sessions conducted by 'Community Members'. Across the study schools lead the way in conducting MHM session as in Assam 100%, Rajasthan 79% and Maharashtra 75.3% AGs reporting the same.

As per AWs overall, 70% of the sessions were conducted through 'Anganwadi' (AWCs) followed by 'Schools' with 27.5%. Across the study states Uttar Pradesh 75% had the highest proportion of 'Anganwadi' conducting sessions, closely followed by Rajasthan with 72.7% and Maharashtra 68.6%. There are more or less similar int

Qualitative discussions with adolescent girls and adult women reveal that most of the girls who reported attending sessions on MHM had these sessions arranged by their schools. In contrast, the women who attended sessions had them organized by the Anganwadi centers in their respective localities. erstate variations in terms of organizing MHM sessions.

"We organize a meeting with the adolescent girls' group once a month. We discuss about tablets and how we should use these tablets. We also discuss about hygiene management during menstruation." ***– FLW, Maharashtra***

"We conduct community meetings or (spread awareness) through contact numbers (by contacting them) or we create awareness when they visit for vaccination, we ask them to sit for 10-15 minutes." ***– FLW, Rajasthan***

"Anganwadi workers can provide training or sessions on menstrual hygiene in the school. We also motivate girl students to support other girls during menstruation." ***– Teacher, Maharashtra***

Figure 46: Organizers of sessions on MHM (Overall)

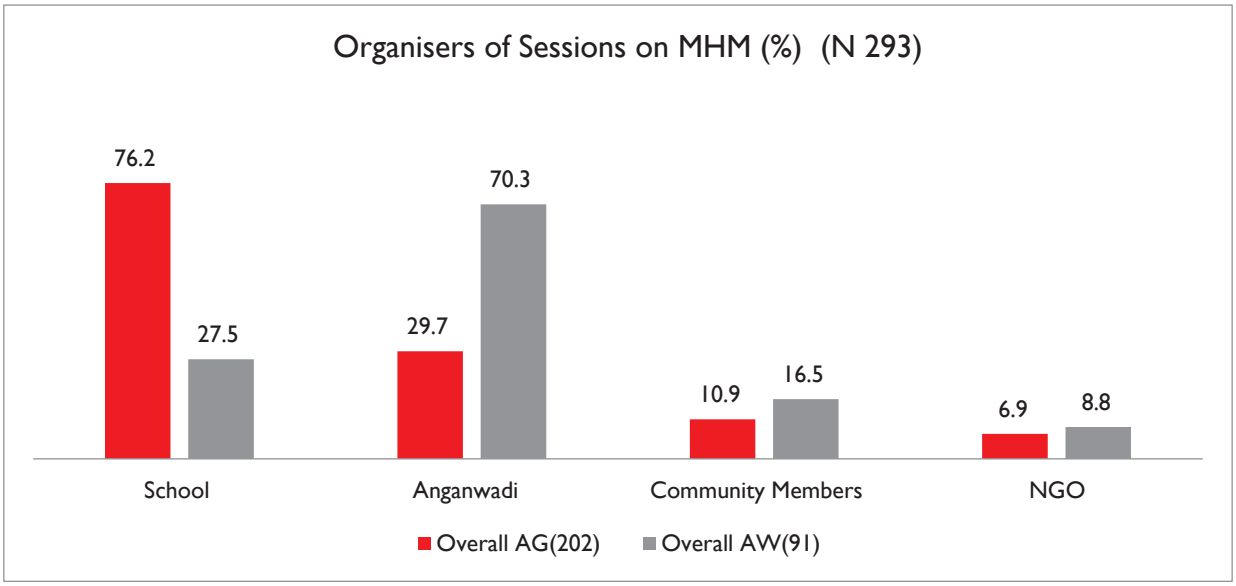


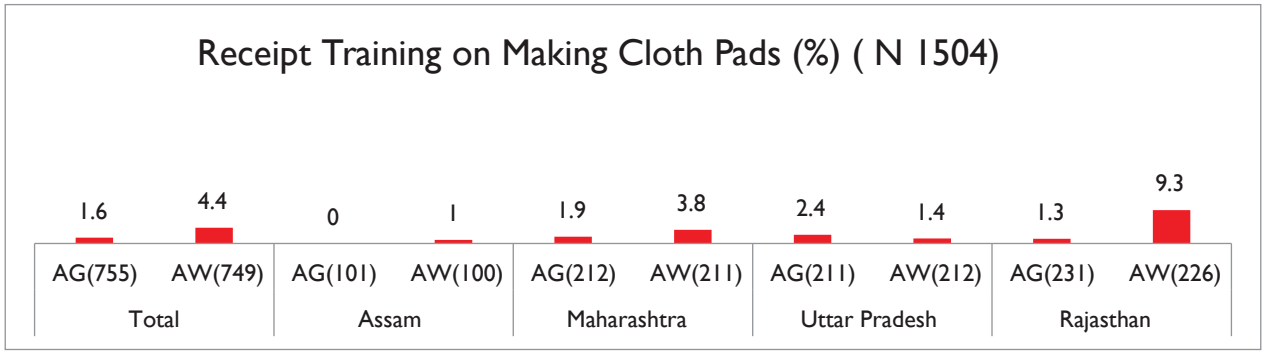
Table 58: Organizer of sessions on MHM (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	AG	AW	AG	AW	AG	AW	AG	AW
N	*5*	*3*	*93*	*51*	*9*	*4*	*95*	*33*
School	100.0	33.3	75.3	29.4	44.4	0.0	78.9	27.3
Anganwadi	40.0	66.7	32.3	68.6	22.2	75.0	27.4	72.7
Community Members	0.0	33.3	11.8	11.8	11.1	25.0	10.5	21.2
NGO	0.0	0.0	9.7	9.8	22.2	0.0	3.2	9.1

3.5.6. Training/Skill Development

The section delineates the respondents training for making cloth-based pads, which is essential for sustainable menstrual hygiene management. Especially with reference to affordability and economic feasibility it is poignant to have discussion on training around cloth-based pads. Overall, only a miniscule 1.6% of adolescent girls reported to have received training on making cloth-based pads. Across the states Maharashtra had the highest number of adolescent girls who got trained in making cloth-based pads. Similarly, only 4.4% of AWs reported receiving training on making cloth-based pads. Among the AWs Rajasthan with 9.3% reported the highest proportion of women trained on making cloth- based pad

Figure 47: Receipt of training on making cloth-based pads



A very miniscule proportion of both AGs and AWs have receipt training on making cloth based pads. Which plays a very critical role in communities and geographies which do not have access to market are thow who cannot afford to buy MHM products. Therefore, there is a need to increase training sessions on making cloth pads.

3.5.7. Affordability of Menstrual Hygiene Products

The respondents were also inquired about the affordability of Menstrual Hygiene Products. The baseline data provides insights into the perceived affordability of menstrual hygiene products among different respondent groups across various regions. This aspect is crucial as it directly affects menstrual health management and overall well-being.

Figure 48: Affordability of MHM products for respondents by state

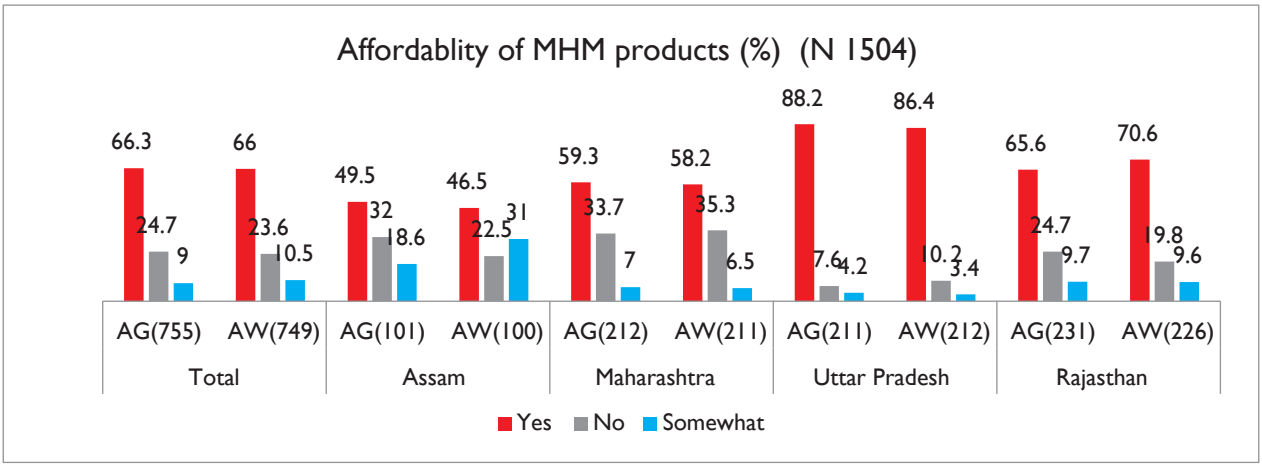


Table 59: Affordability of MHM products for respondents (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	AG	AW	AG	AW	AG	AW	AG	AW
N	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Yes	49.5	46.5	59.3	58.2	88.2	86.4	65.6	70.6
No	32.0	22.5	33.7	35.3	7.6	10.2	24.7	19.8
Somewhat	18.6	31.0	7.0	6.5	4.2	3.4	9.7	9.6

Overall, an equal proportion (two-third) of the respondents affirmed the affordability of the MHM products across the two target groups. Across the study states AGs 88.2% in Uttar Pradesh had the highest proportion affirming the affordability of the Menstrual Hygiene Products. While Assam only 49.5% AGs affirmed the affordability. Similarly, to the AGs the AWs across the study states shared the same views regarding the affordability of the Menstrual Hygiene Products. This suggests that while some may manage to afford these products, the cost might still pose occasional challenges. Understanding the affordability of menstrual hygiene products is vital for policymaking and implementing subsidy programs to ensure better menstrual health management, particularly in regions like Assam and Maharashtra, where affordability is a more significant issue.

As per the qualitative analysis with the AGs and AWs, most of them have access to pads and they can afford it. But in some states like Assam, many women still face problem to afford these products. The government should try to increase the supply of these products, so that they can easily get them or do some campaigns where they can get these for free.

"Sometimes we do not get this in the shop and have to travel far (to purchase it). Since it is a large village, everyone needs them monthly, so eventually when everyone buys it, sometimes it is not easily available, and at other times we cannot afford it due to lack of money. So, we are unable to get it every month." ***- AW, Assam***

3.5.8. MHM Facilities at Schools

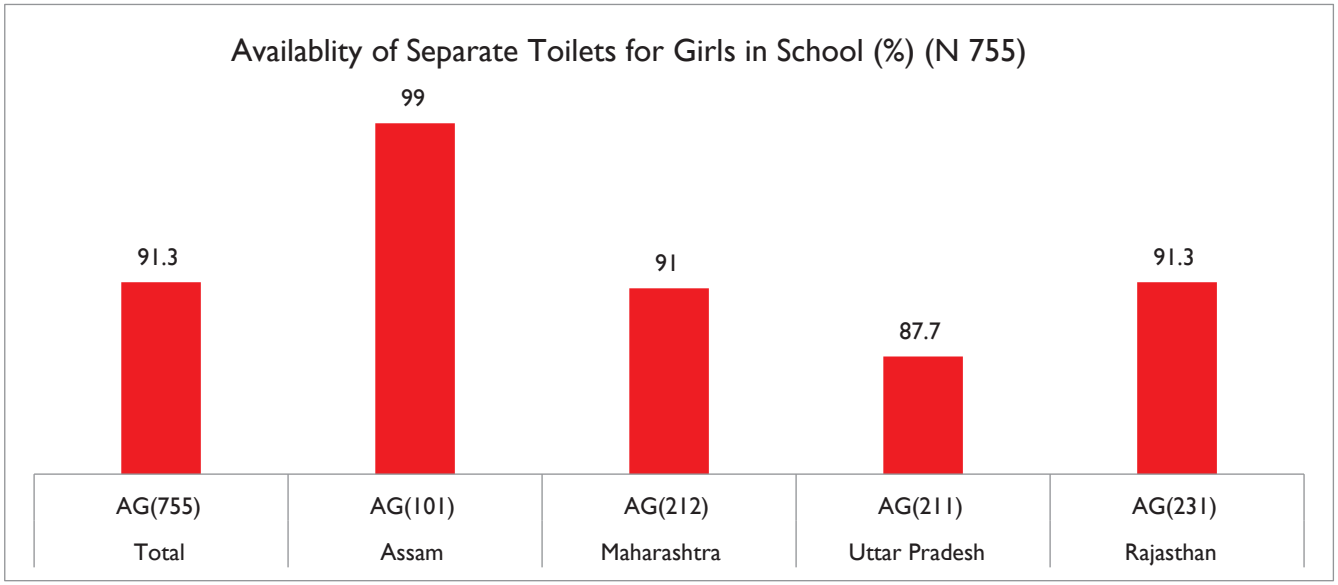
The following section analyze and presents a comprehensive overview of the Menstrual Hygiene Management (MHM) facilities available in schools across four Indian states: Assam, Maharashtra, Uttar Pradesh, and Rajasthan. The data collected from adolescent girls highlights the availability and adequacy of critical infrastructure elements such as separate toilets, the provision of soap, and appropriate facilities like latches, hooks, and shelves within school toilets. This assessment is crucial for understanding how well schools are equipped to support girls during their menstrual cycles, ensuring they can manage their hygiene needs with dignity and privacy, and identifying areas where improvements are necessary to promote better health and educational outcomes.

Toilets with appropriate facilities in school at Gilaula, Shravasti, Uttar Pradesh (June 2024)

3.5.8.1 Separate Toilets for Girls at School

The table below provides information on the availability of separate toilets for girls at schools as reported by adolescent girls (AG) and adolescent women across the study states. Overall, 91.3% of AGs affirmed to have separate toilets for girls exist at their school. As per the baseline data. Uttar Pradesh has the highest proportion of schools with no separate toilets for girls.

Figure 49: Availability of separate toilets for girls in school (Overall)



While Assam was reported to be the state with the highest percentage of schools 99.0% with separate toilets for girls. Despite the overall high availability, there are still notable gaps (Uttar Pradesh, Maharashtra and Rajasthan) in some regions that need to be addressed to ensure all girls have access to adequate sanitation facilities at school.

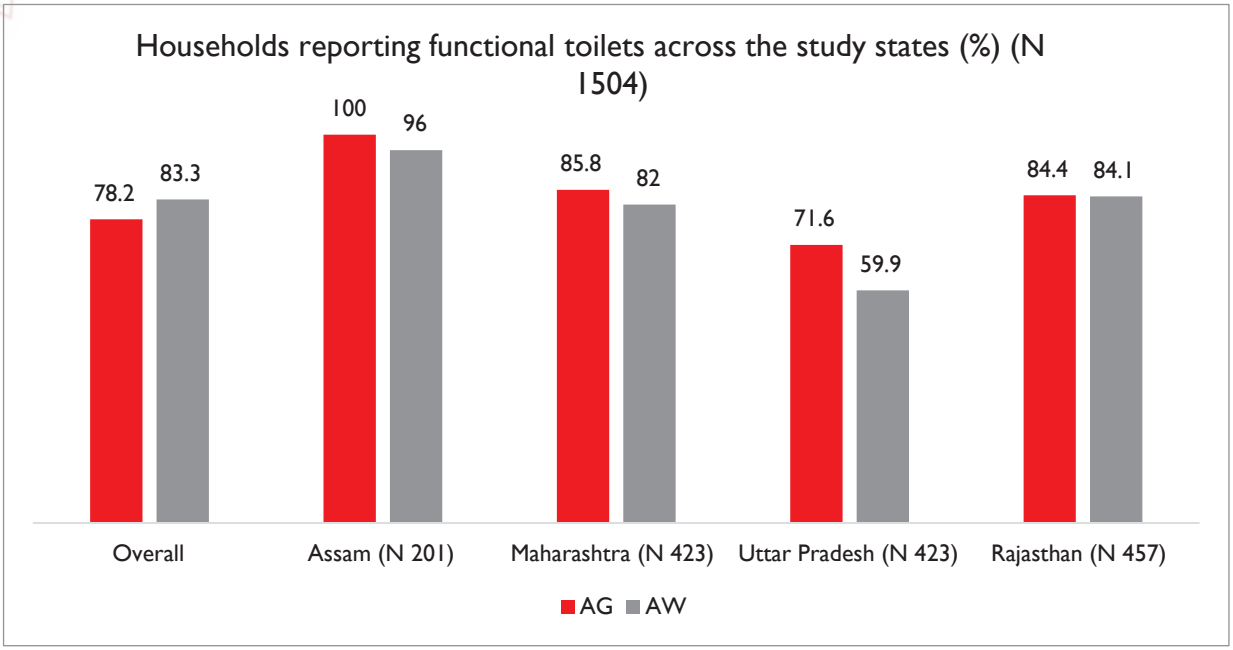
At the overall level a gap of 8.7% is high and the respective states like Uttar Pradesh and Rajasthan must take cognizance of the fact that they are at the bottom in terms of schools with separate toilet for girls.

3.5.8.2 Availability of Facilities in School Toilet

Respondents were further inquired about the presence of soap in toilets at school. As soap is critical for maintaining hygiene after using toilet.

The table provides information on the availability of soap for cleansing hands in school toilets as reported by adolescent girls across four study states. Overall, 82.3% of adolescent girls reported that their school toilets contain soap for cleansing. The availability of soap in school toilets is essential for maintaining hygiene during menstruation Interstate variation can be

Figure 50: Availability of Water, Soap and Appropriate Facilities in Toilets at School (overall)



Across the study states Uttar Pradesh leads with 93.0% of schools providing soap in toilet, ensuring that a vast majority of girls can maintain hygiene. Followed by Rajasthan with 89.6% availability, followed by Maharashtra 76.2%. On the contrary, Assam reports the lowest availability of soap, with only 59.0% of girls affirming its presence in school toilets. The absence of soap by 41% of as reported by 41% AG in Assam underscores a significant gap in basic hygiene provisions that need to be addressed urgently.

Table 60: Availability of water, soap and appropriate facilities in toilets at school (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	AG	AG	AG	AG	AG	AW	AG	AW
N	*100*	*193*	*185*	*211*	*211*	*212*	*231*	*226*
Availability of Water	94	90.2	96.8	96.2	88.2	86.4	65.6	70.6
Availability of Soap	59	76.2	93	89.6	7.6	10.2	24.7	19.8
Availability of appropriate latches, hooks and shelves	15	90.7	91.9	80.6	4.2	3.4	9.7	9.6

The adolescent girls were further enquired about appropriate toilet facility at the schools. Availability of appropriate toilets means the provision of latches, hooks, and shelves in school toilets that facilitate changing and cleansing of absorbents. It's very important to have the same installed for privacy as well as convenience of the users.

Overall, only a little more than two-thirds 76.9% of the AGs reported having appropriate toilet facilities in school. Appropriate facilities within school toilets, such as latches, hooks, and shelves, are critical for enabling girls to change and cleanse absorbents discreetly and hygienically. Uttar Pradesh again shows strong performance in terms of sanitation facilities in schools, with 91.9% AGs affirming the same. Maharashtra also scores high, with 90.7% of schools equipped adequately. Rajasthan has 80.6% of schools with appropriate facilities in toilets, reflecting relatively good provision but still leaving room for improvement. Assam, however, reports a concerning figure, with only 15% of girls indicating the presence of appropriate facilities in school toilets. This means that a staggering 85% of schools in Assam lack the necessary infrastructure to support menstrual hygiene, pointing to a critical area for intervention.

The provision of MHM facilities at schools shows significant variation across the study states. While Uttar Pradesh and Maharashtra generally provide adequate facilities, Assam lags considerably, particularly in the availability of soap and appropriate toilet facilities. Rajasthan shows mixed results, with the good provision of separate toilets and soap but room for improvement in other facilities. These insights underline the need for targeted infrastructure improvements, especially in states like Assam, to ensure all adolescent girls have the necessary support for managing their menstrual hygiene effectively. Ensuring these facilities are in place is crucial for promoting health, attendance, and overall well-being of adolescent girls in schools.

Qualitative insights show that most girls use soap and water in the washroom during their periods. But in some places like Assam and Maharashtra it is seen that washrooms are not cleaned enough. They have to arrange their own things to managing their menstrual hygiene. Schools and communities play a crucial role in ensuring that washrooms are clean and well-maintained. Providing access to soap and water, as well as keeping the facilities clean, supports girls in practicing good hygiene during their periods. The girls also reported that there should be some improvements made in the school.

"In my school, there is a machine wherein if we insert a coin, we get a pad from it."
- AGs-FGD, Rajasthan

"It is not clean, but I manage to change."
- AGs- FGD, Maharashtra

The school WASH infrastructure needs and urgent attention as around one-fourth of school lacks appropriate toilet infrastructure which is pivotal for addressing the concerns privacy and convenience.

3.5.9. MHM Facilities at the Household Level

The following section provides a detailed examination of Menstrual Hygiene Management (MHM) facilities available within households across four Indian states: Assam, Maharashtra, Uttar Pradesh, and Rajasthan. The data, collected from respondents (AGs and AWs) offers insights into the availability and functionality of household toilets, the presence of adequate water and soap for cleansing, and the existence of appropriate facilities such as latches, hooks, and shelves. This evaluation is essential to understanding the level of support adult women receive in managing their menstrual hygiene needs within their homes, which directly impacts their health, dignity, and quality of life. Identifying gaps in these facilities is crucial for developing targeted interventions to improve MHM practices in these communities.

3.5.9.1 Availability of Functional Toilet

This section assesses whether households have functional toilets as reported by adult women.

Figure 51: Availability of Functional Toilets at Home (overall)

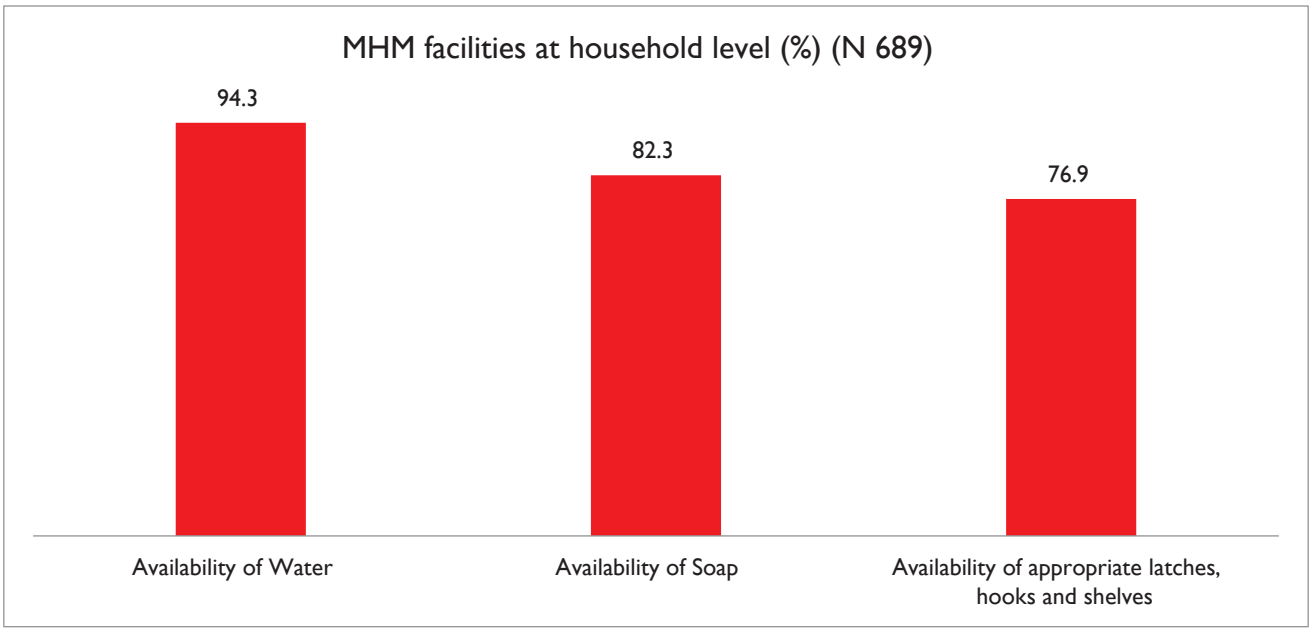


Table 61: Availability of functional toilets at home (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	AG	AW	AG	AW	AG	AW	AG	AW
N	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Yes	100.0	96.0	85.8	82.0	71.6	59.9	84.4	84.1

Overall, 78.2% of AWs and 83.3% AGs reported having a functional toilet in their household, indicating that a significant portion of households are equipped with basic sanitation facilities. As per the data in Assam 100% AGs and 96% AWs reported that their households are equipped with functional toilets. While in Uttar Pradesh only 72% AGs and 60% AWs reported having functional toilets, least across the study states. Uttar Pradesh lags despite the implementation of national level mission on sanitation i.e. Swachh Bharat Mission. Having functional toilets is critical to the health and wellbeing of individuals.

3.5.9.2 Availability of Facilities in Household Toilet

The respondents were also inquired about the availability of soaps in their household toilet. This section evaluates whether household toilets contain adequate water and soap for cleansing.

Overall, an equal proportion 97% of AWs and AGs reported that their household toilets have adequate water and soap for cleansing, indicating a high level of basic hygiene provision. Across the study states in Rajasthan almost all the surveyed households had soap and water facility in toilets highest across the study states. In Assam 94% AGs and 92% AWs reported the least household equipped with toilets with soap and water facility.

Figure 52: Availability of appropriate WASH facility at household level (overall)

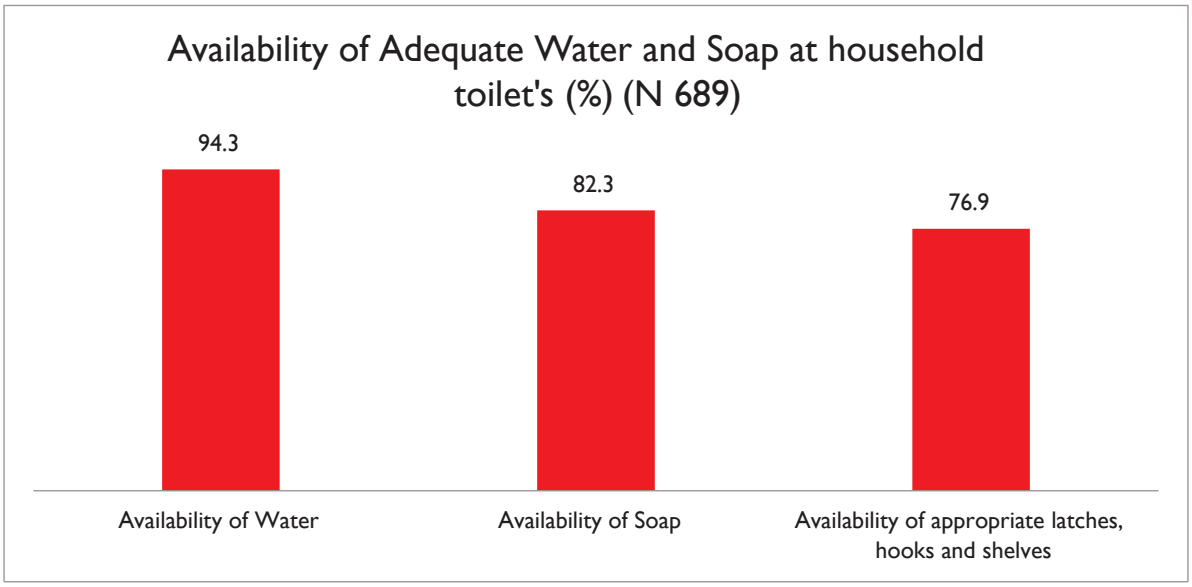


Table 62: Availability of adequate water and soap at household toilets (by state) (%)

State	Assam		Maharashtra		Uttar Pradesh		Rajasthan	
TG	AG	AW	AG	AW	AG	AW	AG	AW
N	*101*	*100*	*212*	*211*	*211*	*212*	*231*	*226*
Availability of Water and Soap	94.1	91.7	96.2	96.0	94.0	96.9	100.0	98.9
Availability of appropriate latches, hooks and shelves	30.7	20.8	90.7	90.8	99.3	98.4	88.7	83.7

Overall, 78.7% of AWs and 82.5% AGs reported that their household toilets have appropriate facilities for managing menstrual hygiene. In Assam only 30.7% AGs and 20.8% AW reported having appropriate toilet facilities, the least across the state highlighting a significant need for infrastructure improvement. The state of Uttar Pradesh reported an impressive 98.4% of households reported having appropriate facilities, indicating excellent support for menstrual hygiene management. The data reveals that while a majority of households across Maharashtra, Uttar Pradesh, and Rajasthan are well-equipped with functional toilets, water, soap, and appropriate facilities, as per the baseline data there are significant gaps in Assam, particularly in the availability of appropriate facilities for managing menstrual hygiene. Addressing these disparities is essential to ensure that all women have the necessary infrastructure to manage their menstrual hygiene effectively, promoting better health outcomes and enhancing their quality of life.

As per the qualitative Analysis with AWs and AGs, they have soap and water in their home, and they use it for cleaning their hands and clothes. They support menstrual hygiene and try to follow it. They understand that proper cleaning is essential to prevent infections and maintain health.

"When we cook and touch utensils, we should use Dettol and wash our hands with handwash! Because small children live in the house, it can affect them too." ***– AW, FGD, Maharashtra***

The toilets at household level are also marred with lack of water, soap and appropriate toilet infrastructure. All these components are essential to maintain proper sanitation and hygiene at household level. By sensitising the community the program team can nudge the households in improving their toilet infrastructure.

3.6 Benchmarking

Conducts a SWOT analysis and establishes baseline indicators and benchmarks for monitoring progress.

3.6.1 Strengths, weaknesses, opportunities, and threats (SWOT analysis)

A SWOT analysis was conducted to provide a strategic framework to identify the internal and external factors that can influence the success of the MHM program. This will help in understanding the strengths to build upon, the weaknesses to address, the opportunities to exploit, and the threats to mitigate.

3.6.1.1 Strengths

- **High Awareness of Cleaning Practices:** There is a strong consensus among Frontline Workers (FLWs) and Teachers on using soap and water to clean reusable menstrual hygiene products. This indicates high awareness and adherence to proper cleaning practices across states.
- **Confidence in Discussing Menstrual Health:** A significant proportion of FLWs and Teachers feel very confident discussing menstrual health and hygiene topics with women and girls, especially in Maharashtra and Assam.
- **Supportive Educational Institutions:** Teachers, particularly in Rajasthan and Maharashtra, exhibit high levels of educational attainment, which aligns with the professional requirements for teaching and enhances the potential for effective MHM education.

3.6.1.2 Weaknesses

- **Low Awareness of RTIs:** Awareness of Reproductive Tract Infections (RTIs) is generally low among adolescent girls and adult women, with significant regional variations. This lack of knowledge poses a barrier to effective health management.
- **Cultural Barriers and Stigma:** A notable proportion of respondents feel uncomfortable discussing menstruation outside their family, reflecting societal stigma and cultural barriers that hinder open conversations about menstrual health. The level of confidence among AGs and AWs to discuss MHM was low in many states.
- **Impact on Daily Activities:** Menstrual cycles significantly affect the daily routines of adolescent girls and adult women, particularly in Assam and Uttar Pradesh, disrupting their ability to perform household chores, work, and attend school.

3.6.1.3 Opportunities

- **Targeted Educational Programs:** Targeted educational interventions are needed to improve knowledge about reproductive health, particularly in regions with higher rates of uncertainty and lack of knowledge.
- **Enhanced Healthcare Access:** Improving access to healthcare facilities and increasing awareness about RTIs can encourage more women and girls to seek timely treatment and reduce the prevalence of untreated infections.
- **Community Engagement:** Leveraging the confidence and educational qualifications of FLWs and Teachers can enhance community engagement and promote better MHM practices.

3.6.1.4 Threats

- **Continued Stigma and Taboos:** Persistent cultural stigma and taboos around menstruation can undermine efforts to improve MHM practices and hinder open discussions about menstrual health.
- **Barriers to Healthcare:** Social and cultural barriers, such as shyness and reliance on traditional advice to let RTIs "pass," can prevent women and girls from seeking necessary medical treatment.
- **Regional Disparities:** Significant regional variations in knowledge, practices, and impact of menstruation on daily activities highlight the need for region-specific strategies to address unique challenges and ensure effective MHM interventions.

3.6.2 Baseline Indicators and Benchmarks

Establishing baseline indicators and benchmarks is crucial for monitoring the progress and impact of the MHM program. These indicators will provide a starting point against which future improvements can be measured. The following baseline indicators have been identified based on the survey data:

1. **Awareness and Knowledge Indicators:**
   a. **RTI Awareness:** Percentage of respondents aware of Reproductive Tract Infections.
      i. Baseline: 11.7 of adolescent girls, 16.3 of adult women.
      ii. Benchmark: Increase awareness to at least 50 within two years.
      iii. Rationale: This indicator is critical as awareness about Reproductive Tract Infections (RTIs) can significantly influence health-seeking behavior and preventive practices. Given the baseline awareness levels of 11.7% among adolescent girls and 16.3% among adult women, there is a substantial need for increased education. Government campaigns and health initiatives across India emphasize improving knowledge about RTIs as part of broader reproductive health education to enhance public health outcomes. Increasing awareness to at least 50% aligns with national health objectives to improve reproductive health awareness.[53]

   b. **Knowledge of Menstrual Hygiene Practices:** Percentage of respondents who correctly identify and practice recommended menstrual hygiene behaviors (e.g., cleaning reusable products with soap and water).
      i. Baseline: 94 overall recommendations for using soap and water.
      ii. Benchmark: Ensure at least 90 adherences to proper cleaning practices across all states within two years.
      iii. Rationale: The high baseline adherence to recommended practices indicates existing awareness, attributed to ongoing educational programs and national health policies. Maintaining high compliance with hygiene practices is essential for preventing infections and promoting safe menstrual management.[54]

2. **Behavioral Indicators:**
   a. **Treatment-Seeking Behavior for RTIs:** Percentage of respondents who have sought treatment for RTIs.
      i. Baseline: 13.6 of adolescent girls and 26.2 of adult women.
      ii. Benchmark: Increase treatment-seeking behavior to at least 50 within two years.
      iii. Rationale: Increasing the treatment-seeking behavior is vital for early diagnosis and treatment, reducing complications associated with RTIs. The baseline figures suggest a gap in health service utilization, which could be mitigated through enhanced health services and awareness programs.[55]

53. https://sdgs.un.org/
54. https://main.mohfw.gov.in/
55. https://sdgs.un.org/

b. **Comfort in Discussing Menstrual Health:** Percentage of respondents comfortable discussing menstrual health outside their family.
   i. Baseline: 15.5 of adolescent girls, 20.3 of adult women very comfortable.
   ii. Benchmark: Increase comfort levels to at least 40 within two years.
   iii. Rationale: Comfort in discussing menstrual health supports a more informed and supportive community environment. The current comfort levels are relatively low, reflecting societal stigmas and cultural barriers that need addressing through targeted community engagement and education.

3. **Impact Indicators:**
   a. **Impact on Daily Activities:** Percentage of respondents reporting that menstruation affects their daily activities.
      i. Baseline: 53.4 of adolescent girls, 51.9 of adult women.
      ii. Benchmark: Reduce the impact on daily activities to less than 30 within two years.
      iii. Rationale: Menstruation significantly impacting daily activities can contribute to broader socio-economic consequences, including education and employment. Reducing this impact is essential for promoting gender equality and women's empowerment.[56]

   b. **School Attendance During Menstruation:** Proportion of female students missing school during menstruation.
      i. Baseline: 100% of teachers report some level of absenteeism, with varying degrees.
      ii. Benchmark: Reduce absenteeism due to menstruation by 50 within two years.
      iii. Rationale: Absenteeism during menstruation is a critical barrier to education for girls, impacting their academic performance and leading to higher dropout rates. Addressing this through better facilities and supportive school environments is a priority under various educational and health initiatives.

4. **Waste Management Indicators:**
   a. **Proper Disposal of Menstrual Waste:** Percentage of respondents using recommended practices for menstrual waste management.
      i. Baseline: To be included.
      ii. Benchmark: Achieve at least 80 adherences to proper disposal practices within two years.
      iii. Rationale: Effective menstrual waste management is essential for environmental health and hygiene. Establishing robust disposal practices aligns with national sanitation initiatives like the Swachh Bharat Mission, which includes a focus on safe menstrual waste disposal.[57]

56. https://www.unicef.org/india/reports/menstrual-hygiene-management-schools-south-asia
57. https://www.ircwash.org/resources/menstrual-hygiene-management-national-guidelines

3.7 Program Level Insights

Based on discussions with the program team and relevant government stakeholders, several key insights have emerged regarding the implementation and impact of the Menstrual Hygiene Management (MHM) program, highlighting the necessity for collective action, current challenges, and opportunities for improving the program's effectiveness and sustainability.

One of the most critical insights is the **necessity for a collective effort** among all stakeholders involved in MHM initiatives. Currently, there is a noticeable lack of synergy among NGOs, government bodies, community, schools, and other relevant parties, which hampers the effectiveness of the work in the sector. A unified strategy and coordinated efforts are essential to create a sustainable impact. This could be achieved through the development of state-level policies that clearly delineate the roles and responsibilities of each stakeholder. Such policies should involve comprehensive guidelines for NGOs, government entities, community schools, and other local organizations to work collaboratively towards a common goal.

Awareness creation as well as **mediums for waste disposal** have been identified as immediate addressable issues within the program. Environmental efforts focused on these areas can be implemented at both school and community levels to enhance the overall effectiveness of the program. Creating awareness about menstrual hygiene and proper waste disposal methods can significantly improve health outcomes and environmental conditions in these communities. Particularly in Assam, where weather conditions and frequent flooding pose significant challenges, targeted strategies to address these environmental factors are crucial. Uttar Pradesh displaced initiative with the provision of portable earthen pots for safely burning the absorbents, which could be a valid way forward.

"In Assam, weather and floods are major barriers. We need targeted strategies to overcome these challenges." ***– Government Official***

Training is a vital component of the MHM program. The team involved in the program have shown significant capacity for providing training, offering subject-level expertise and extensive educational materials. The government can leverage these intellectual properties and support from the program to enhance the training programs for other local stakeholders. This collaboration can ensure that the training provided is comprehensive and impactful, leading to better implementation of MHM practices at the grassroots level.

The current deployment of CRPs presents several challenges. CRPs typically engage with women in the community up to four times before moving to the next village to meet their targets. This limited interaction is insufficient for creating lasting behavioural change and ensuring proper adoption of MHM practices. To address this, a more **rigorous follow-up system is required**. One effective approach could be the training of community leaders who can then take on the role of trainers within their communities. This **"Training of Trainers"** (TOT) model can ensure ongoing support and reinforcement of MHM practices, thereby fostering sustained change without leadining to the workload of CRPs.

Infrastructure in schools, particularly the availability of **adequate toilets and waste disposal facilities**, poses a significant barrier to the adoption of MHM practices. Many schools lack the necessary infrastructure to support proper menstrual hygiene management, which discourages girls from attending school during their menstrual periods. Addressing these infrastructural deficiencies is crucial for the success of the MHM program. Investments in building and maintaining proper toilets and waste disposal systems in schools can significantly

enhance the adoption of MHM practices and improve educational outcomes for girls.

Reusable cloth pads were mentioned as a viable alternative for menstrual management, but **behaviour change strategies around their use need to be more robust**. Additionally, local songs and community-based interventions were suggested as effective ways to engage the community and create a supportive environment for behaviour change. The importance of livelihood adaptations in the community was also noted, suggesting that integrating MHM with livelihood programs could enhance program sustainability.

"Integrating local songs and cultural practices can make a significant difference in how the community perceives and adopts MHM practices." – ***Partner NGO***

A core theme emerging from discussions with the program team is the **emphasis on sustainability**. The program's long-term success hinges on creating a self-sustaining model where the knowledge and practices of menstrual health are deeply embedded within the community. Government bodies are now ready to adopt and print training booklets on menstrual health, a significant step towards institutionalizing these practices. By training stakeholders, the program ensures that expertise is passed on effectively, empowering local leaders to continue the initiatives independently. As one team member noted, "We are planning to make it sustainable by training master trainers on menstruation, ensuring they can carry forward the initiative." Increasing the efforts towards sustainability would be vital to not only secure the progress made but also foster a culture of continuous improvement and resilience in menstrual hygiene management.

04

Conclusion and Recommendations

4 CONCLUSION AND RECOMMENDATIONS

4.1 Summary of Key Findings

The baseline data provides a comprehensive view of the state of menstrual hygiene management (MHM) and related health facilities across households in Assam, Maharashtra, Uttar Pradesh, and Rajasthan. The findings highlight both strengths and gaps in the existing infrastructure and health-seeking behaviors, which are critical for designing targeted interventions.

1. **Awareness and Knowledge of RTIs:**
   - There is a notable lack of awareness about Reproductive Tract Infections (RTIs) among both adolescent girls and adult women. Only 11.7 of adolescent girls and 16.3 of adult women are aware of RTIs, indicating a critical gap in reproductive health knowledge.

2. **Menstrual Hygiene Practices:**
   - A majority of respondents across states understand the importance of using soap and water to clean reusable menstrual hygiene products. This indicates a high level of awareness regarding proper hygiene practices, with 94 overall adherences to using soap and water.

3. **Confidence in Discussing Menstrual Health:**
   - Frontline Workers (FLWs) and Teachers display varying levels of confidence in discussing menstrual health topics. While a significant proportion of FLWs (57.8) and Teachers (66.7) feel very confident, there is a notable absence of responses from Teachers in some states, indicating potential gaps in their engagement.

4. **Impact on Daily Activities:**
   - Menstrual cycles significantly affect the daily routines of women and girls, particularly in Assam and Uttar Pradesh. More than half of the respondents in these states reported that menstruation disrupts their ability to perform household chores, attend school, and engage in income-generating activities.

5. **School Attendance:**
   - Teachers report that menstruation has a significant impact on school attendance. In Rajasthan and Assam, many female students miss or skip school during their menstrual periods, highlighting the need for targeted interventions to ensure that menstruation does not hinder educational attainment.

6. **Cultural Barriers and Stigma:**
   - Deep-rooted cultural beliefs and societal stigma around menstruation continue to pose significant challenges. A substantial number of respondents feel uncomfortable discussing menstrual health outside their family, which limits open conversations and access to accurate information.

7. **Healthcare-Seeking Behavior:**
   - A significant number of women and girls do not seek treatment for RTIs due to cultural barriers, shyness, and reliance on traditional advice. This is particularly evident in states like Maharashtra and Uttar Pradesh, where many respondents believe RTIs will pass on their own.

4.2 Recommendations

The study findings underscore the critical areas that require attention and intervention to improve menstrual hygiene and health outcomes.This section presents the evidence-based recommendations with details on the partnerships, priority, rationale and action points.

Recommendation 1: Enhance Awareness and Education on Menstrual Health and RTIs	
Responsible Organizations: Government (National and State), NGOs focused on gender and social issues, School Authorities, SMCs, Community Leaders, SHGs	**Priority:** High
Rationale	The data shows that menstruation significantly impacts school attendance for many girls, particularly in states like Assam and Rajasthan. School-based interventions can play a crucial role in ensuring that menstruation does not hinder educational attainment.
Action Points	• Develop and implement comprehensive educational programs targeting both adolescent girls and adult women. • Include RTI awareness and menstrual hygiene management in school curricula and community health programs. • Conduct regular workshops and training sessions for FLWs and Teachers to ensure they have the latest information and skills to educate their communities.

Recommendation 2: Strengthen School-Based Interventions for Menstrual Hygiene Management	
Responsible Organizations: Government (National and State), NGOs focused on education, gender and social issues, School Authorities, SMCs, Community Leaders	**Priority:** High
Rationale	The data shows that menstruation significantly impacts school attendance for many girls, particularly in states like Assam and Rajasthan. School-based interventions can play a crucial role in ensuring that menstruation does not hinder educational attainment.
Action Points	• Provide adequate sanitary facilities in schools, including clean toilets, water, soap, latches, hooks, and shelves. • Implement school health programs that include menstrual hygiene education and support systems. • Train Teachers and school staff to create a supportive environment for girls during their menstrual periods..

Recommendation 3: Promote Access to Healthcare for Menstrual Health Issues	
Responsible Organizations: Government (National and State), School Authorities, Community Leaders, Local Governments, NGOs focused on reproductive health, Community Health Centers	**Priority:** Medium
Rationale	Many women and girls do not seek treatment for RTIs due to cultural barriers and a lack of awareness. Seeking treatment during unusual discomfort during menstrual cycle is also not very high among the AGs and AWs. Improving access to healthcare services and increasing awareness about the importance of seeking treatment can reduce the prevalence of untreated infections.
Action Points	• Establish accessible healthcare facilities where women and girls can seek treatment for menstrual health issues without fear of stigma. • Train healthcare providers to offer sensitive and non-judgmental care for menstrual health issues. • Conduct community health campaigns to raise awareness about the importance of seeking treatment for RTIs.

Recommendation 4: Address Cultural Barriers and Stigma Around Menstruation	
Responsible Organizations: Government (National and State), NGOs focused on gender and social issues, School Authorities, SMCs, Community Leaders, Local Governments	**Priority:** High
Rationale	Cultural stigma and taboos around menstruation continue to pose significant challenges. Addressing these barriers is essential to create an environment where women and girls can discuss and manage their menstrual health without fear or shame.
Action Points	• Conduct community engagement programs to challenge and change cultural beliefs and societal stigma around menstruation. • Involve community leaders, parents, and other key influencers in promoting open discussions about menstrual health. • Use behaviour change campaigns to normalize menstruation and reduce stigma.

Recommendation 5: Support and Train FLWs and Teachers	
Responsible Organizations: Government (National and State), NGOs focused on gender and social issues, Local Governments	**Priority:** Medium
Rationale	FLWs and Teachers are crucial in educating and supporting women and girls on menstrual health. Providing ongoing training and support to these key influencers can enhance their confidence and effectiveness in their roles.
Action Points	• Develop and provide comprehensive training programs for FLWs and Teachers on menstrual health and hygiene. • Equip FLWs and Teachers with educational materials and resources to support their community outreach efforts. • Establish peer support networks for FLWs and Teachers to share experiences and best practices.

Recommendation 6: Improve Menstrual Hygiene Infrastructure	
Responsible Organizations: Government (National and State), NGOs focused on gender and social issues, School Authorities, SMCs, Community Leaders, Local Governments	**Priority:** High
Rationale	Adequate infrastructure is essential for proper menstrual hygiene management. Investing in and maintaining sanitary facilities in schools and communities can significantly improve the ability of women and girls to manage their menstrual health.
Action Points	• Invest in upgrading and maintaining sanitary facilities in schools and communities. • Ensure that toilets are equipped with essential amenities such as water, soap, latches, hooks, and shelves. • Regularly monitor and evaluate the condition of sanitary facilities to ensure they meet the required standards.

Recommendation 7: Monitor and Evaluate Progress	
Responsible Organizations: Government (National and State), NGOs focused on gender and social issues, Research Organizations	**Priority:** Medium
Rationale	Establishing robust monitoring and evaluation frameworks is essential to track the progress of MHM interventions and ensure they are achieving the desired outcomes.
Action Points	• Develop and implement a comprehensive monitoring and evaluation framework for MHM interventions. • Set clear benchmarks and indicators to measure improvements in awareness, practices, healthcare-seeking behavior, and impact on daily activities and school attendance. • Conduct regular evaluations to assess the effectiveness of interventions and make necessary adjustments.

Recommendation 8: Foster Collaboration and Partnerships	
Responsible Organizations: Government (National and State), NGOs focused on gender and social issues, School Authorities, International Agencies	**Priority:** Medium
Rationale	Collaboration between various stakeholders can enhance the impact of MHM interventions. Leveraging resources, expertise, and community networks can lead to more comprehensive and sustainable solutions.
Action Points	• Establish partnerships between government agencies, NGOs, and community organizations to implement MHM programs. • Encourage international agencies to provide technical and financial support for MHM initiatives. • Facilitate regular stakeholder meetings to share progress, challenges, and best practices.

Annexure 1 - List of selected villages

Annexure 1- List of selected villages

State	District	Block	Village Type	Village	Name of Panchayat
Uttar Pradesh	Bahraich	Tejwapur	Main Village	Kaudha	Kaudha
			Main Village	Sarai Mehrabad	Sarai Mehrabad
			Main Village	Adilpur	Adilpur
			Main Village	Raipura	Raipura
			Buffer Village	Bhogiyapur	Bhogiyapur
			Buffer Village	Tamachpur	Tamachpur
		Phakarpur	Main Village	Parashurampur	Parashurampur
			Main Village	Bamiyari	Dihwa Kala
			Main Village	Rajapur Khurd	Rajapur Khurd
			Main Village	Sangwa	Sangwa
			Buffer Village	Bhauri	Bhauri
	Shrawasti	Gilaula	Main Village	Manasukha	Manasukha
			Main Village	Nagaraura	Nagaraura
			Main Village	Parevpur	Parevpur
			Main Village	Vijaypur Siswan	Vijaypur Siswan
			Main Village	Keshavapur Pajav	Keshavapur Pajav
			Main Village	Bhauswa	Bhauswa
			Main Village	Ekadgawa	Ekadgawa
			Main Village	Baghwani	Baghwani
			Buffer Village	Asawa	Shahpur Bara
			Buffer Village	Bhadaura	Bhadaura
			Buffer Village	Kurweni	Kurweni

State	District	Block	Village Type	Village	Name of Panchayat
Maharashtra	Amaravati	Teosa Dharni	Main Village	Malegaon	Malegaon
			Main Village	Mardi	Mardi
			Main Village	Anakwadi	Anakwadi
			Main Village	Maldhur	Anakwadi
			Main Village	Dhotra	Dhotra
			Main Village	Shivangaon	Shivangaon
			Main Village	Satargaon	Satargaon
			Main Village	Wathoda kh	Wathoda kh
			Buffer Village	Raghunathpur	Anakwadi
			Buffer Village	Fattepur	Shivangoan
			Main Village	Khaparkheda	Khaparkheda
			Main Village	Mogarda	Mogarda
			Main Village	Kalamkhar	Kalamkhar
			Main Village	Sadrabadi	Sadrabadi
			Main Village	Dabida	Dabida
			Main Village	Chatwabod	Chatwabod
			Main Village	Lawada	Duni
			Main Village	Zilpi	Zilpi
			Buffer Village	Kekadabod	Chatwabod
			Buffer Village	Nagudhana	Dabida

State	District	Block	Village Type	Village	Name of Panchayat
Assam	Kamrup rural	Chaygaon	Main Village	Aggumi	Gumi Bankakata
			Main Village	Majgumi	Gumi Bankakata
			Main Village	Patgaon Khar Bakhar	Dakhin Pantan
			Main Village	Tari Gaon	Gumi Bankakata
			Buffer Village	Bherbheri	Dakhin Pantan
			Buffer Village	Mohghar	Gumi Bankakata
		Boko	Main Village	Da-gaon	No 75 Dakhin Luki
			Main Village	Gangra Para	No 75 Dakhin Luki
			Main Village	Jarpara (jarapara)	No 69 Dakhin Pachim Boko
			Main Village	Medhipara	No 69 Dakhin Pachim Boko
			Buffer Village	Gameri Mura	No 75 Dakhin Luki
Rajasthan	Sirohi	Sirohi	Main Village	Aamli	Velangari
			Main Village	Siyakara	Velangari
			Main Village	Valdara	Saratara
			Main Village	Mamawali	Saratara
			Buffer Village	Utha kheda	Velangari
			Buffer Village	Saratara	Saratara
		Sheoganj	Main Village	Kaldari	Kaldari
			Main Village	Paldi M	Paldi M
			Main Village	Posaliya	Posaliya
			Main Village	Arathwara	Arathwara
			Buffer Village	Baravera	Kaldari
			Buffer Village	Devon Ka Bera	Kaldari
	Pali	Sumerpur	Main Village	Dhola Jageer	Dhola
			Main Village	Sanderao	Sanderao
			Main Village	Dujana	Dujana
			Main Village	Netra	Netra
			Main Village	Paldi	Paldi Jod
			Main Village	Korta	Korta
			Main Village	Balana	Balana

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