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Menstrual Health and Hygiene Management among School-Going Girls in Aurai, District Bhadohi, Uttar Pradesh: A Cross-Sectional Study

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Abstract
Menstruation is a natural physiological process, yet in many rural parts of India it remains surrounded by silence, stigma, and restrictive cultural norms. This paper examines how deeply rooted beliefs and taboos influence menstrual hygiene practices among adolescent girls and women in rural communities. Drawing on socio-cultural perspectives and existing empirical evidence, the study highlights how notions of impurity, religious restrictions, lack of open communication, and limited access to sanitary resources contribute to unhygienic practices and adverse health outcomes. The paper argues that menstrual hygiene management is not merely a health issue but a social and cultural one, requiring community-based, culturally sensitive interventions.

Keywords: Menstruation, Taboos, Cultural Beliefs, Menstrual Hygiene, Rural India, Women's awareness

1. Introduction

Menstruation marks a crucial aspect of female reproductive health, yet it continues to be perceived as impure or polluting in many traditional societies. In majority of rural India and even in some parts of urban India, menstruation is often shrouded in secrecy, reinforced by intergenerational transmission of myths and prohibitions. Girls are taught to conceal their menstrual status, avoid religious spaces, sleep separately, and refrain from household activities. Such restrictions shape not only social participation but also personal hygiene behaviors.

Limited awareness, poverty, and inadequate sanitation infrastructure further compound the problem. Many rural women rely on reusable cloths, often washed without soap and dried in hidden, damp places due to shame. These practices increase vulnerability to infections and discomfort. Understanding the cultural context is therefore essential to address menstrual hygiene challenges effectively.

Moreover, the intersection of gender norms, educational limitations, and lack of open communication further perpetuates menstrual stigma in rural communities. Menstruation is rarely discussed in schools or within families in a scientific manner, leaving young girls unprepared at the onset of menarche and

dependent on informal sources of information that may reinforce fear and misconceptions in them. This silence not only affects physical hygiene practices but also shapes emotional responses, leading to anxiety, embarrassment, and reduced self-confidence. In many cases, the burden of managing menstruation falls solely on women, while men and boys remain excluded from awareness, thereby sustaining a cycle of ignorance and discrimination. Addressing menstrual health in rural India therefore requires a holistic approach that challenges harmful beliefs and taboos, promotes accurate knowledge, and ensures supportive social and infrastructural environments for women and girls.

2. Review of Literature

Existing literature on menstruation in rural India highlights that menstrual practices are deeply embedded within socio-cultural, religious, and gendered frameworks. Scholars widely agree that menstruation is not merely a biological phenomenon but a socially constructed experience shaped by beliefs about purity, pollution, and womanhood. Anthropological studies have documented that in many traditional communities; menstruating women are perceived as ritually impure, leading to restrictions on cooking, entering places of worship, sleeping arrangements, and participation in social activities. These practices reinforce gender hierarchies and contribute to the marginalization of women during their menstrual cycle.

Research also indicates that knowledge about menstruation among rural girls is often limited and acquired only after menarche. Mothers, elder sisters, and female relatives are the primary sources of information, yet their guidance frequently reflects inherited myths rather than scientific facts. Studies have shown that many girls experience fear, shame, and confusion at the onset of menstruation due to a lack of prior awareness. School-based education on reproductive health remains inadequate in several rural regions, further perpetuating misinformation and silence around the subject.

Several public health studies have examined menstrual hygiene practices and found that the use of sanitary napkins in rural India is significantly lower compared to urban areas. Economic constraints, lack of availability, and embarrassment in purchasing sanitary products from male shopkeepers contribute to the continued use of reusable cloth and other improvised absorbents. While cloth itself can be hygienic if properly washed and dried, research shows that many women dry it indoors or in hidden spaces due to shame, preventing exposure to sunlight that would help eliminate bacteria. Such practices increase susceptibility to reproductive tract infections, urinary tract infections, and skin irritations.

Educational outcomes are also closely linked to menstrual hygiene management. Numerous studies report that adolescent girls often miss school during menstruation due to inadequate sanitation facilities, absence of disposal mechanisms, and fear of staining or teasing. In some cases, girls drop out of school altogether after reaching puberty. This demonstrates how menstrual stigma intersects with broader issues of gender inequality, limiting girls' opportunities for education and social participation.

Government programs and non-governmental organizations have attempted to address menstrual hygiene challenges through the distribution of low-cost sanitary pads, awareness campaigns, and improvements in school sanitation infrastructure. However, literature suggests that the mere provision of products is insufficient to bring about sustained behavioral change. Cultural acceptance, family support, and community engagement are critical determinants of whether such interventions succeed. Studies

emphasize that without addressing entrenched beliefs and taboos, many women may hesitate to adopt modern hygiene products or practices.

Recent scholars increasingly advocate for a holistic approach to menstrual health that integrates education, infrastructure, and social transformation. Researchers highlight the importance of involving men and boys in awareness efforts, promoting open dialogue, and empowering women through accurate knowledge. Overall, the literature underscores that menstrual hygiene management in rural India is shaped by a complex interplay of culture, poverty, education, and gender norms. Understanding these interconnected factors it is essential for designing effective policies and interventions that safeguard the health, dignity, and rights of women and adolescent girls.

3. Methodology

This study adopts a descriptive research design to examine cultural beliefs and taboos related to menstruation and their impact on menstrual hygiene practices in rural India. Primary data is collected from adolescent girls in Aurai tehshil of district Bhadohi in eastern Uttar Pradesh through structured interviews and questionnaires. Secondary data will be obtained from government reports and scholarly sources. The primary data was analysed using simple statistical methods of mean, median, frequency and percentage analysis, weighted descriptive statistics for age, comparison of dominant responses, item non-response analysis and integrated interpretation of knowledge, attitudes and service expectations.

4. Data and Scope

Dataset: 110 girls from the study area aged 14–20 years and enrolled in Classes 10–12 are interviewed and have filled the questionnaire of 20 questions from Q1-Q20.

Percentages totaling 99.99%, 100.01% or 100.02% are treated as normal rounding effects, not substantive errors.

Average item non-response across Q1–Q20 was approximately 2.91%. Most questions had less than 4% missing data, which is manageable for a small descriptive study. However, Q17 had 8.18% missing responses, while Q15 and Q20 each had 6.36%.

This study analyses the frequency and percentage tables supplied for 110 adolescent girls. It examines the demographic profile, menstrual knowledge, preparedness before menarche, family communication, stigma, perceived symptoms, product access and institutional support. The analysis is descriptive based on the response filled in the questionnaire by the randomly selected sample.

The main aim of the this study is to find out the awareness level of adolescent girls about menstrual hygiene management in rural parts of India, with special reference to Aurai tehshil, district Bhadohi , Eastern Uttar Pradesh.

5. Observation

Headline finding	Analytical interpretation
Demographic concentration	Mean age was 16.41 years; 69.09% were aged

	16–17 and 44.55% were in Class 12.
Severe knowledge gap	73.64% described menstruation as the removal of "dirty blood"; only 13.64% selected the hormonal/glandular explanation.
Insufficient preparation	49.09% were not aware of menstruation before it began, compared with 47.27% who were aware.
Communication gap	A provisional 57.27% reported that their mother had discussed menstruation, yet prior awareness remained below half—suggesting that discussion may be late, incomplete or not scientifically accurate.
Stigma–support paradox	A provisional 69.09% viewed menstruation as a private matter that should not be discussed, but 79.09% wanted regular school discussion and a support committee.
Strong demand for affordability	A provisional 87.27% supported subsidised pads in institutions and 92.73% supported provision at subsidised rates with ration.

Demographic Profile. This section discusses the data collected on age group and educational level.

Age profile. The average age was 16.41 years (median 16, mode 16, standard deviation 1.12). Girls aged 16 formed the largest group (40.00%), followed by age 17 (29.09%). Together, ages 16–17 accounted for 69.09% of the sample and 57.27% were aged 16 years or younger (Fig. 1).

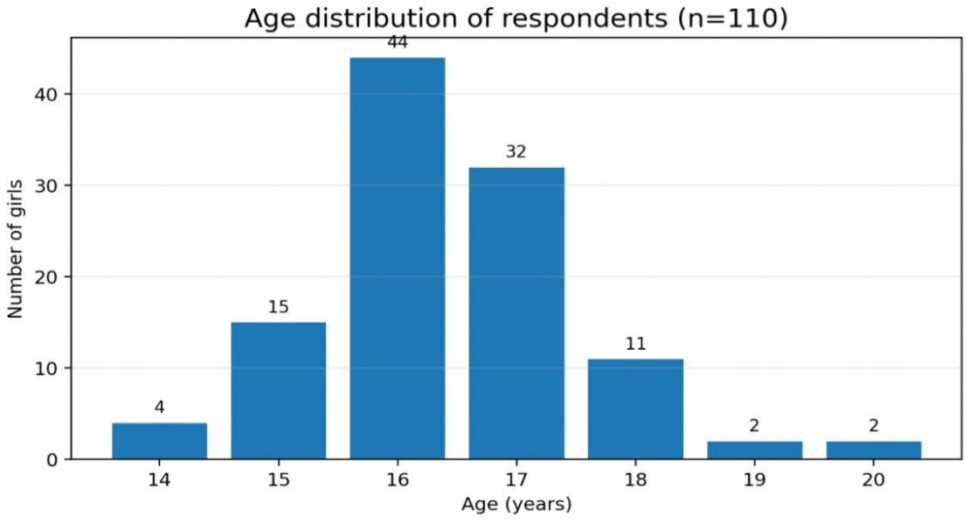

Figure 1. Age distribution of the study sample.

6. Educational profile

According to classwise analysis, class 12 students constituted 44.55% of respondents, class 11 students 30.91% and Class 10 students 24.55%. Thus, three-fourths of the sample (75.46%) was in Classes 11–12. The findings thus primarily represent late-adolescent, upper-secondary students (Fig. 2).

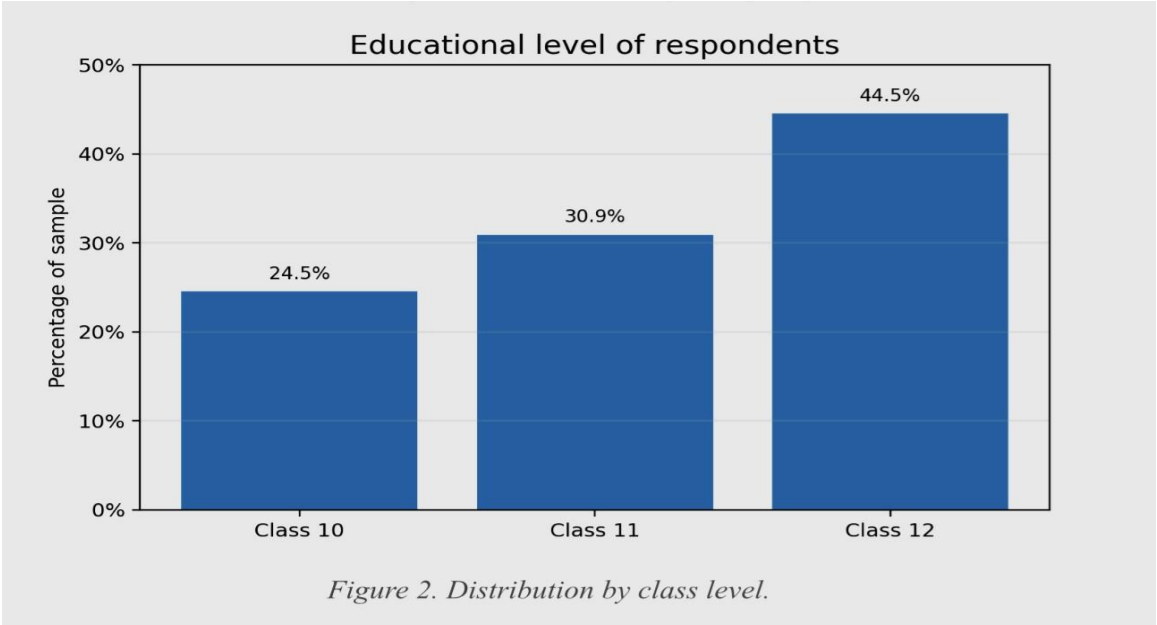

Figure 2. Distribution by class level.

7. Knowledge and Preparedness before Menarche

In understanding of menstruation the most serious finding is the dominance of the "dirty blood" explanation: 81 girls (73.64%) selected it. Only 15 girls (13.64%) selected the hormonal or glandular explanation, which is the closest scientifically valid option in the questionnaire. A further 10.01% selected other incorrect explanations or said they did not know, while 2.73% did not respond. This data is graphically represented below (Fig. 3). In the graph Q1 stands for question number 1 of questionnaire.

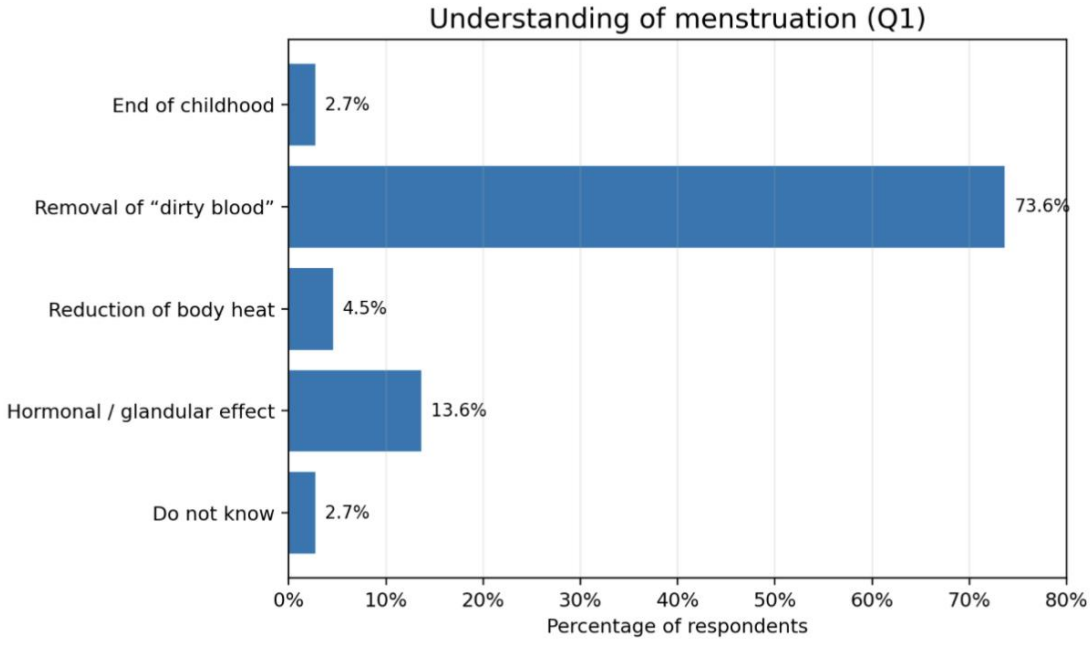

Figure 3. Reported understanding of menstruation (Q1).

Interpretation: This finding needs a separate presentation as it is an important outcome of their awareness. The data indicate that menstruation is understood mainly through a culturally negative "dirty blood" frame rather than as a normal biological process. This can reinforce shame, secrecy, poor hygiene decisions and delayed help seeking. Knowledge correction should therefore be the first intervention priority.

8. Awareness before the first period

Only 52 respondents (47.27%) knew about menstruation before it started, while 54 (49.09%) did not. Excluding four missing responses, 50.94% of valid respondents were unprepared. The sample therefore divides almost equally, with a slight majority entering menarche without prior knowledge.

Response	Number	Percentage
Aware before menarche	52	47.27%
Not aware	54	49.09%
Missing	4	3.64%

The gap between mother–daughter discussion (provisionally 57.27%) and pre-menarche awareness (47.27%) suggests that family conversations may occur only after the first period, may be limited to practical instructions, or may not convey an accurate biological explanation. This is an inference and should be tested with raw data or follow-up qualitative interviews.

9. Communication, Stigma and Institutional Expectations

Family communication exists but is insufficient: A provisional 57.27% said their mother had discussed menstruation. This is encouraging, but it has not produced adequate prior awareness or correct scientific understanding (Fig. 4).

Privacy and stigma remain strong: A provisional 69.09% agreed that menstruation is a personal matter that should not be discussed with others. The finding reflects social discomfort and fear of disclosure.

Girls still want safe institutional discussion: Despite the privacy belief, 79.09% wanted regular discussion in school and a support committee. This is not a contradiction: girls may reject casual or public discussion while supporting structured, confidential and trusted channels.

Demand for affordability is overwhelming: Support for subsidised sanitary products was 87.27% in educational institutions and 92.73% through the ration system. Affordability and predictable availability are clear policy concerns.

Physical and psychological effects are common: A provisional 87.27% reported experiencing physical or mental changes after menarche.

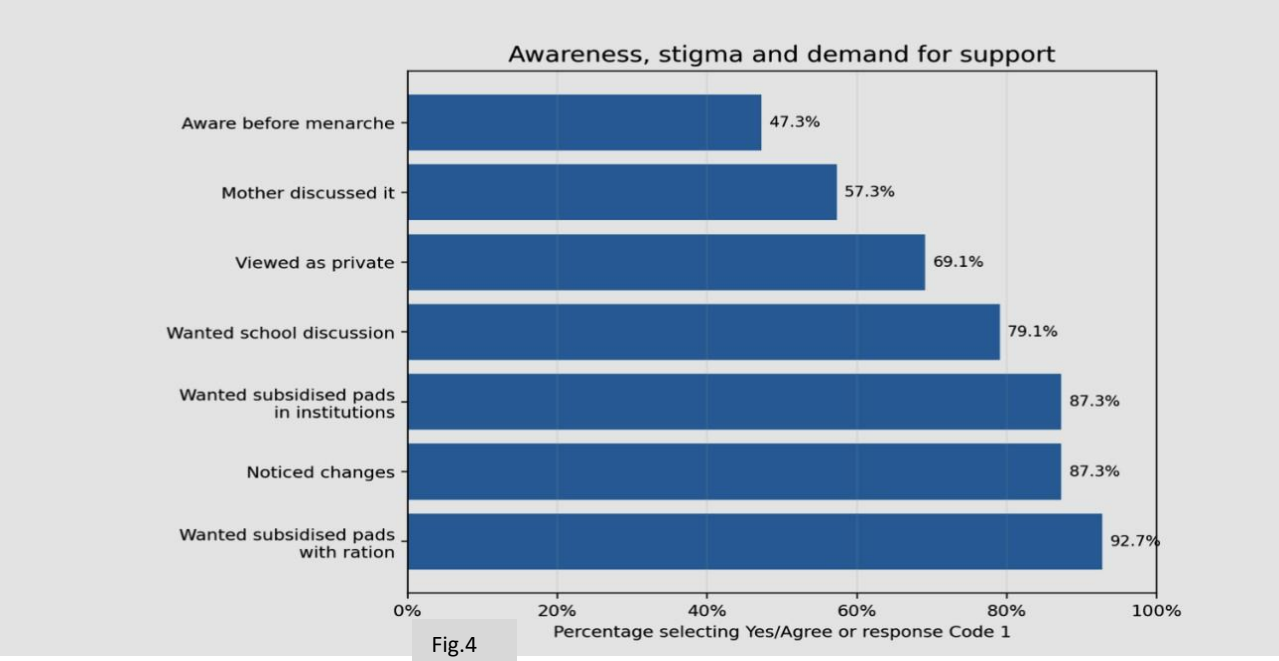

Fig.4

10. Conclusion and Recommendations

The observation obtained shows that there are integrated trends which could be made out from the current study that still prevails in rural India when talking of Menstruation and related problems.

1. Upper-secondary concentration. The sample is dominated by 16–17-year-old girls and Class 12 students. Interventions should be useful for this group, but preventive education must begin earlier than the ages represented in the sample.
2. Knowledge is weaker than experience. Most girls have experienced menstruation, yet correct biological understanding is very low.
3. Preparation occurs too late. Prior awareness is below half. Family discussion, where present, may be reactive after menarche rather than anticipatory.
4. Stigma coexists with help-seeking. Girls may regard menstruation as private while simultaneously demanding school-based education, support committees and subsidized products.
5. Affordability and access are policy-level concerns. The strongest responses in the survey concern subsidized products. Product access should be treated as a basic health and educational support measure, not merely a personal purchase decision.
6. Management practices are not standardized. There is high dependency on market pads for period management, about 79.09% go for it. For buying pads there is no single barrier, where money, shopkeeper being male and something else are almost same in frequency. Almost 50% changes pad twice a day. The dispersion in storage, barriers and disposal questions suggests inconsistent practices.
7. Apart from the above mentioned trends there some major outcomes. The sample has a major menstrual health literacy deficit. The “dirty blood” belief is not a marginal misconception; it is the dominant understanding. Preparation before menarche is inadequate: approximately half of respondents did not know about menstruation before its onset. When coming to Mother–daughter communication alone is not sufficient in its present form. It must begin earlier and include scientifically correct, practical and reassuring information. Stigma remains substantial, but girls

clearly support confidential school-based discussion and assistance. Institutional support is likely to be acceptable when privacy is protected. There is exceptionally strong support for subsidized sanitary products, both in educational institutions and through public distribution channels. Physical and psychological changes are widely reported, indicating the need for pain management information, counseling and referral pathways.

Declaration of Interests

We declare no competing interest**.**

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