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TOWARDS GENDER EQUALITY THROUGH MENSTRUAL HYGIENE MANAGEMENT PRACTICES: FINDINGS FROM INDIA

Supervisor: Prof. PAOLA DEGANI

Candidate: CELESTE IUS

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LIST OF ACRONYMS

AIDS: Acquired Immune Deficiency Syndrome

ARSH: Adolescent Reproductive and Sexual Health

ASHA: Accredited Social Health Activists

BIS: Bureau of Indian Standards

CEDAW: Convention on the Elimination of All Forms of Discrimination against Women

CRC: Convention on the Rights of the Child

CRM: Common Review Mission

DP: Development Partners

FP/RH: Family Planning/Reproductive Health

GoI: Government of India

GTA: Gender Transformative Approaches

HIV: Human Immunodeficiency Virus

ICPD: International Conference on Population and Development

ICT: Information and Communication Technology

IEC: Information Education Communication

JMP: Joint Monitoring Programme for Drinking Water, Sanitation and Hygiene

JRM: Joint Review Mission

KPIs: Key Performance Indicators

LMICs: Low- and Middle-income Countries

MH: Menstrual Health

MHH: Menstrual Health and Hygiene

MHM: Menstrual Hygiene Management

MHS: Menstrual Hygiene Scheme

MoDWS: Ministry of Drinking Water and Sanitation

MoHFW: Ministry of Health and Family Welfare

MoHRD: Ministry of Human Resource Development

MoUD: Ministry of Urban Development

MoWCD: Ministry of Women and Child Development

NBA: Nirmal Bharat Abhiyan

NFHS-5: 2019-21 National Family Health Survey

NGOs: Non-Governmental Organizations

NHM: National Health Mission

NRHM: National Rural Health Mission

ODF: Open-defecation free

PRI: Principles for Responsible Investment

RGSEAG: Rajiv Gandhi Scheme for Empowerment of Adolescent Girls

RKSK: Rashtriya Kishor Swasthya Karyakram

RMSA: Rashtriya Madhyamik Shiksha Abhiyan

SBM: Swachh Bharat Mission

SBM-G: Swachh Bharat Mission-Gramin

SDGs: Sustainable Development Goals

SEM: Socio-ecological Model

SRH: Sexual and Reproductive Health

SRHR: Sexual and Reproductive Health and Rights

SSA: Sarva Shiksha Abhiyn

SSG: Swachh Survekshan Grameen

TOC: Theory of Change

TOR: Terms of Reference

TSC: Total Sanitation Campaign

UDISE: Unified District Information System for Education

UN: United Nations

UNESCO: United Nations Educational, Scientific and Cultural Organization

UNICEF: United Nations International Children's Emergency Fund

UTs: Union Territories

VYA: Very Young Adolescent

WASH: Water, Sanitation and Hygiene

WHO: World Health Organization

INTRODUCTION

The topic of menstrual hygiene management and period poverty started receiving international attention early this century, by virtue of a powerful mobilization carried out by multinational feminine hygiene companies, donors, academics, United Nations agencies, social entrepreneurs, grassroots women's organizations and feminist researchers. Over the past decade, the discourse around menstrual cycle has seen tremendous expansion for a number of different reasons and according to diverse approaches. The worldwide resonance that the issue has had can be attributed first and foremost to the role of advocates in the field of education, who pioneered the identification of menstrual challenges and framed them as a public problem. With the effort of closing the gender gap in education in LMICs, a small number of NGOs began to support small-scale informative programmes, promote social science and technological research, as well as influence the policy agenda. Afterwards, private companies engaged in a range of menstrual management-related activities too, originating an innovative platform for gender equality and empowerment. Big consumer companies started to donate millions of funds to local, national and international entities destined to the distribution of products and the expansion of menstrual health education, while small corporations became proving ground for innovation and inclusion in the context of period-positive advertising and new delivery and supply services.

Based on these advances, new insights have influenced the cultural and structural dimensions of menstrual management and alternative frames have brought to light essential elements always relegated to the shadows. Moreover, the conceptualization of menstruation has been subjected to changes in terms of shifting its perception from an individual-based experience to a political problem reputable of government-level awareness. Besides biological and physiological considerations, the attention of different relevant actors has focused, over the years, on the recognition of menstruation according to existing cognitive beliefs and moral judgements. Recent international concern has been spearheaded through work to

investigate the impact of misconceptions and malpractices in women and girls[1]' enjoyment of human rights. In this case, menstruators result disproportionately affected by stigmatization and prejudices around the topic, raising issues for an individual's right to privacy, gender equality, human dignity and non-discrimination, predominantly. Cultural and religious traditions reinforce patriarchal norms, creating a condition of vulnerability and inducing negative consequences for women and girls' education, livelihood and productive opportunities.

Indeed, not everyone encounters menstrual cycle in the same way. This means that menstrual experience is strictly intertwined with global patterns of poverty, inequality and vulnerability. In actual fact, hygiene-related practices are still clouded by socio-cultural restrictions and menstrual management strongly depends on the availability of adequate infrastructure. To all intents and purposes, it is understandable that women and girls living in low- and middle-income countries face greater difficulties in managing menstruation in safety and dignity. This statement is supported by a number of recent studies, which confirm that the lack of access to menstrual products, inadequate existing sanitary facilities, social restrictions and cultural taboos lead to teasing, shaming and exclusion of menstruators from daily activities. Therefore, it is of the utmost importance to adopt an intersectional and holistic approach to the matter, meaning that all different factors, such as gender, cultural and religious belonging, geographic affiliation and socioeconomic status, which account for one's experience of menstruation, are taken into account.

Given these premises, the choice of India as the subject of the present research is justified by the fact that in this particular context, more than a natural process of the reproductive cycle, menstruation has significant economic, social, psychological and religious implications. Gender inequality corresponds to one of the most pressing issues in Indian society and gender-based discrimination intersects women and girls' experiences with menstrual hygiene management, strengthening and

[1] Throughout the present thesis, the term "women and girls" is frequently used to incorporate all menstruators, regardless of gender identity.

perpetuating discriminatory practices in the name of tradition and societal norms. This condition is exacerbated by the pervasive problem of sanitation insecurity, which reinforces preexisting structural inequalities and results in gender-based violence, risks for mental health, psychosocial stress, infections and diseases. Moreover, the common perception of menstruation is permeated with taboos and stigma, which worsen menstruating individuals' already precarious conditions and seriously jeopardize the enjoyment of women and girls' human rights. As expected, the so-called "culture of silence" contributes to preserving the patriarchal feature of Indian society, exacerbates the complex phenomenon of gender-based violence and reinforces discriminatory stereotypes and gender roles, preventing menstruating individuals from having access to decision-making arenas and sabotaging their political recognition.

With respect to the discourse on menstrual cycle, the media coverage that has recently poured into the country addresses the issue on multiple sides, from the lack of awareness about menses to lack of access to sanitary products, from the presence of inadequate water, sanitation and hygiene facilities to the case of school absenteeism and market-based solutions. In particular, two events have catalyzed attention toward India over the past five years.

On August 31, 2017, BBC News ran an article under the headline "*India girl kills herself over 'menstruation shaming*'", divulging the story of a twelve-year-old schoolgirl who committed suicide after a teacher presumably humiliated her over a menstrual bloodstain. The event was picked up by media around the world, accompanied by a mobilization and advocacy campaign of educators, government officials, health and women's rights activists, who called for better access to period products, improved education and the end of the legacy of shame[2]. In the fullness of time, "the twelve-year-old became symbol of menstrual injustice, her life virtually erased by her death"[3].

[2] Anita Diamant, *Period. End of sentence. A New Chapter in the Fight for Menstrual Justice* (New York: Scribner, 2021), 24

[3] Ivi

The debate around menstrual-related challenges continued to gain momentum across the country under the aegis of the film *Period. End of Sentence.*[4], whose plot is inspired by the life of Arunachalam Muruganantham, an Indian social activist in the menstrual firmament. The short documentary explains the efforts of Muruganantham, who, after years and years of trial and error, managed to create a low-cost alternative to non-affordable disposable pads. Considering that the vast majority of women and girls in India do not have access to menstrual products, the inventor produced an easy-to-operate machine to manufacture low-cost and biodegradable sanitary pads. His project engaged a group of rural women in utilizing the apparatus and creating pads with the intent of selling them to other women, creating a source of income and self-esteem, as well as empowering menstruating individuals in that community.

In 2019 the film was credited with the Academy Award for Best Documentary (Short Subject), the announcement of which was followed by more than 25 million viewers from 225 countries. Starting from this moment and thanks to the large audience formed after the recognition of the Oscar, The Pad Project witnessed an impressive media response, receiving several thousand messages from around the world. "Some inquired about getting a pad-making machine for their village, some offered to volunteer or donate money, others wanted to know if they could show the film at their school and to church groups to raise awareness and funds"[5]. Just as importantly, the great merit of this documentary was to reveal to the whole world the obstacles impeding proper menstrual hygiene management in India, and in low-income contexts generally. By investigating the consequences women face from living without access to hygienic products and examining the positive impacts of working for the sanitary pad company, "the film also exposes the profound silence and misinformation that surrounds menstruation and shows how talking and teaching about periods can change lives"[6].

[4] The documentary was released in 2018. It is directed by Rayka Zehtabchi and produced by Rayka Zehtabchi, Guneet Monga, Melissa Berton, Garrett Schiff and Lisa Taback.
[5] Ibid., 3
[6] Ibid., 2

Outline of the chapters

The present thesis will be divided into four main chapters – each one focusing on a different thematic area indispensable to answer the research question.

The first chapter of the dissertation will explain the research question incorporated into context of the analysis, theoretical framework considering menstrual experience, methodologies which were used in the course of the research, state of current art and the expansion in the literature on the topic. Most importantly, it will provide an overview surrounding the issue of sanitation insecurity in India, which disproportionately affects women and girls living in the country.

In the second chapter, the historical and legal framework concerning the discourse of menstrual health will be revealed. The aim of this part is to understand the process through which menstrual health has been framed as a public health issue and how menstrual cycle can be approached through the lens of human rights. For the purpose of comprehending the actual debate around menstrual hygiene management with its legal and political evolution, the second section of the chapter will try to seek synergies between menstrual health, non-discrimination and gender equality in the framework of CEDAW general recommendations and WASH sector.

The third chapter will dig deeper into women and girls' gendered experiences of menstruation in India, assessing the major impediments in the realization of good menstrual hygiene management practices. Next, Government of India's programmes and initiatives aimed at supporting menstrual hygiene management in the current legal framework will be investigated. For this purpose, efforts from the Ministry of Health and Family Welfare, Ministry of Drinking Water and Sanitation, Ministry of Women and Child Development and Ministry of Human Resource Development will be considered.

Finally, the fourth chapter will center on the monitoring systems supporting Government of India's programmes and initiatives by tracking progresses and impediments. Then, the contribution of grey literature and shadow reports will be taken into account, for the reason that the above-mentioned systems suffer from diverse shortcomings. Since it results difficult to assess competent Ministries'

interventions with the scarce sources available online, additional information from other entities is needed. In conclusion, the research will highlight possible future perspectives on the matter and some suggestions and recommendations will be given on this topic.

CHAPTER I: Background of the ongoing debate around Menstrual Health and Menstrual Hygiene Management

1.1 Research question

Menstruation can be defined as the periodic discharge of blood and mucosal tissue from the uterus, which occurs roughly every month from puberty to menopause in non-pregnant women[7]. As a matter of fact, it occurs regularly throughout the child bearing years, with the exception of pregnancy and lactation. The menstrual cycle consists in various stages, including menstrual, pre-ovulatory (follicular), ovulation and luteal phases and starts between the ages of 11 and 15. The first menstruation is called "menarche" and defines that the sexual maturation of the young female has occurred, with her body able of supporting pregnancy[8]. Even if the onset of menstruation represents the biological and natural capacity for women to reproduce, menarche is strictly connected with societal implications. As a result, adolescent girls all over the world experience menarche and menstruation dissimilarly, according to their socio-economic, environmental, nutritional, geographical, religious and cultural contexts of belonging.

While searching for materials for the present thesis, I found that nearly 26% of the world's population are females of reproductive age and are consequently menstruating. In general, adolescents are the major and most developing component of the world's population and more than half of them live in Asia[9]. In absolute numbers, globally "around 1.2 billion people are adolescents, aged 10-19 years with about 90% of them living in low and middle-income countries (LMICs); of these,

[7] Katrin Dauenhauer et al., "Menstrual Hygiene Management (MHM) in Schools – A neglected issue", Sustainable Sanitation Alliance, 1, accessed 17 June 2022, retrieved from https://www.susana.org/en/knowledge-hub/resources-and-publications/susana-publications/details/2876#

[8] K. Logeswari, "The effect of school based health education regarding menstrual hygiene – an intervention study among adolescent girls of Perambalur district" (master's thesis, Tamil Nadu Dr. M.G.R Medical University, 2018), 10

[9] Ibid., 5

500 million are adolescent girls living in developing countries"[10]. When considering the World Health Organization's definition of adolescents, it is possible to understand how the phase of life between childhood and adulthood represents a "unique stage of human development and an important time for laying the foundations of good health"[11]. The experiences of psychosocial, cognitive and physical growth necessarily impact young adults' future stages of life in terms of illness, injury, alcohol use, poor diet, unsafe sex, low physical activity and even mortality and morbidity. However, establishing the basis of good health among adolescents diverge in terms of sex, age and by geographic region. In this sense, young boys and girls living in LMICs suffer averagely from serious risks for health, linked with water, sanitation and hygiene (WASH). Since this tendency remains nowadays one of the world's most urgent problem, the commitment to ensure the accessibility and sustainable management of WASH results in six Sustainable Development Goals' (SDGs) targets. The proposed improvements aim at combating water-related diseases, achieving universal access to safe and drinking water, reaching solutions for equitable sanitation and hygiene in light of women and girls' needs, reducing the number of disorders related to water contamination and expanding international cooperation and capacity-building assistance to developing countries in water and sanitation attached projects and programmes[12].
In the context of WASH, according to the Special Rapporteur on the human rights to safe drinking water and sanitation "accommodating the menstrual needs is a key issue for the human rights to safe drinking water and sanitation"[13], given that it intersects women and girls' possibility to manage in dignity their menstrual cycle.

[10] Anjana Verma et al., "Breaking the silence around menstruation: experiences from urban and rural India", *International Journal of Community Medicine and Public Health* 8, n. 3 (2021): 1538, accessed 17 June 2022, retrieved from https://www.researchgate.net/publication/349596354_Breaking_the_silence_around_menstruation_experiences_from_urban_and_rural_India
[11] World Health Organization, "Adolescent health", accessed 17 June 2022, retrieved from https://www.who.int/health-topics/adolescent-health#tab=tab_1
[12] UN-Water Decade Programme on Advocacy and Communication, "Implementing Water, Sanitation and Hygiene (WASH)", Information brief, accessed 20 June 2022, retrieved from https://www.un.org/waterforlifedecade/waterandsustainabledevelopment2015/images/wash_eng.pdf
[13] Special Rapporteur on the human rights to safe drinking water and sanitation, "Menstrual Hygiene Day", United Nations Human Rights, accessed 20 June 2022, retrieved from https://www.ohchr.org/en/special-procedures/sr-water-and-sanitation/menstrual-hygiene-day

However, challenges related to menstruation extend beyond its factual management, affecting mostly young girls living in LMICs and their actual role in society. This statement finds its concretization in the 2016 *Report of the Special Rapporteur on the human rights to safe drinking water and sanitation*, in which he "seeks to underscore the importance of placing a strong focus on the needs of women and girls at all times, throughout their whole lifecycle, and of not overlooking the needs of women and girls with disabilities, living in poverty or suffering other disadvantages"[14]. From this document, it is possible to understand how menstrual management strongly impacts the enjoyment of women's human rights, producing dramatic gender inequalities in the access to education, food, adequate housing and sanitation. In addition, this trend is reinforced by social practices and beliefs, which consider menstruation as an impure and shameful part of the lives of women and girls. As a matter of fact, adolescent girls all over the world interiorize the idea that menstruation is an embarrassing event, which has to be kept secret because extremely shameful. In some cases, cultural norms evolve into gender stereotypes, limiting women's capacity to improve their personal abilities, perform their careers and make choices with respect to their lives[15] .

The document further outlines that stigmas and gender-assigned roles connected with menstruation may be unjustified whenever they lead to human rights violations and limit fundamental freedoms. For these reasons States cannot ignore the power of stereotypes and stigmas as social phenomenon over which they have no influence; instead, States must firmly combat those practices that result in wrongful stereotypes of men and women, in particular in the private sphere[16]. The attempt to raise awareness among States is justified by the fact that without concrete actions to break the taboo around menstrual health (MH), stigmas on this topic would be reinforced and poor menstruation management would cause large scale repercussions for the society as a whole. In this way, the international community is appealed to prioritize the question, including women and young girls in decision-making processes, since "in many cases, they are not consulted about the placement

[14] Special Rapporteur on the human rights to safe drinking water and sanitation, "Report of the Special Rapporteur on the human rights to safe drinking water and sanitation", (Report presented to the 33rd session of the Human Rights Council, Geneva, 27 July 2016), 3
[15] Ibid., 7
[16] Ivi

of water point and sanitation facilities, nor do they participate in designing the type of facility best suited to their needs or easiest for them to use"[17]. Women's participation is essential in order for them to see their rights completely fulfilled but the inability to participate in the formulation and implementation of policies has been motivated by cultural gender hierarchies and power relations, which limit women's contributions at all stages of planning, decision-making, monitoring and evaluation. In this regard a transformative approach is required to overcoming gender inequalities in respect of the rights to water and sanitation, focusing on the implementation of women's material needs and menstrual hygiene facilities[18]. In addition, with the aim of challenging discriminatory mindsets, intra-household patterns and social norms around menses, women's consultations must integrate a component of empowerment. In fact, "gender equality in respect of the human rights to water and sanitation will not only empower women individually but will also help women overcome poverty and empower their children, families and communities"[19].

Introducing the 2016 *Report of the Special Rapporteur on the human rights to safe drinking water and sanitation* is useful to initiate the discourse of menstrual hygiene management (MHM), since it represents one of the starting points to include the issue of menstrual health in the context of women's human rights. The next pages will be devoted to explicate the definition of MHM and its relation to the research question of the present thesis.

Menstrual hygiene management refers to the way in which women and girls handle their monthly menses, with a special attention to the health care needs, requirements and practical strategies for coping their menstrual cycle. Moreover, it refers as well to methods women themselves keep clean during menstruation and how they achieve, use and dispose of blood-absorbing materials[20]. In 2012 the WHO/UNICEF Joint Monitoring Programme for Drinking Water, Sanitation and Hygiene (JMP) defined MHM as: "*Women and adolescent girls are using a clean*

[17] Ibid., 16
[18] Ibid., 20
[19] Ivi
[20] Logeswari, "The effect of school based health education regarding menstrual hygiene – an intervention study among adolescent girls of Perambalur district", 10

menstrual management material to absorb or collect menstrual blood, that can be changed in privacy as often as necessary for the duration of a menstrual period, using soap and water for washing the body as required, and having access to facilities to dispose of used menstrual management materials"[21].

In the present instance, the prerequisites that have to be met for the definition are: "*access to accurate and pragmatic information (for females and males) about menstruation and menstrual hygiene; access to menstrual hygiene materials to absorb or collect menstrual blood; access to facilities that provide privacy for changing materials and for washing body with soap and water; access to water and soap within a place that provides an adequate level of privacy for washing stains from clothes and drying re-usable menstrual materials; access to disposable facilities for used menstrual materials (from collection point to final disposal)*"[22].

Bearing in mind all these considerations, it is possible to affirm that the term embraces the environmental, socio-political and psychological elements connected with menstrual health. Moreover, the feeble attempt to contextualize MHM in the human rights framework, requiring a holistic approach focused on women's and girls' human rights, becomes observable. In this case, the natural fact of menstruation, the necessity of managing menses and society's response find a connection with women and adolescent girls' human rights and gender equality[23]. From this point of view, when an appropriate environment to manage menstruation is absent, menstruating individuals run into difficulties to do so. Correspondingly, when women and girls encounter obstacles for the enjoyment of their rights to water, sanitation and education, they will experience impediments in managing their menstrual cycle. As a consequence, whenever menstruators cannot manage their menstrual hygiene, it can negatively affect their rights, including the rights to health, education and work[24]. Even if the definition of MHM originated in the

[21] WHO, UNICEF, "WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply and Sanitation", Consultation on Draft Long List of Goal, Target and Indicator Options for Future Global Monitoring of Water, Sanitation and Hygiene, 2012, 16
[22] Ivi
[23] UNICEF, "Guidance on menstrual health and hygiene", 14, accessed 22 June 2022, retrieved from https://www.unicef.org/media/91341/file/UNICEF-Guidance-menstrual-health-hygiene-2019.pdf
[24] Ivi

WASH sector, literature shows that, after decade of use, the understanding and acknowledgement of the term has been expanded. In fact, the institutionalization of the term in the field of WASH demonstrates that MHM programmes, which approach menstrual challenges and reduce their negative repercussions to women and girls, were solely incorporated in the developmental agenda. Considering that MHM programmes concentrated initially only on proper sanitation facilities and poor health practices, recent scientific researches have paid more attention to the issue, focusing on a variety of fundamental factors that have to be included and considered. In such circumstances, "taboos, grounded in cultural and religious beliefs, have to be addressed as much as questions of how to provide appropriate facilities and sanitation materials as well as how to establish a functioning monitoring system on MHM in order to reliably track progress, and shortcoming, respectively"[25]. Therefore, with the object of adequately addressing the issue, the topic has to be tackled on the basis of multiple angles, creating a window of opportunity for gender-transformative projects, such as sexual and reproductive health education and life skills improvement.

Having clarified the term menstrual hygiene management, it is necessary to specify that not all women and girls undergo menses in the same way. A growing body of qualitative researches has highlighted that menstrual experiences are complex and multifaceted, due to an increasing recognition that this natural process creates obstacles to health and gender equality especially in low-and middle-income contexts[26]. In fact, in those societies menstrual cycle is generally stigmatized, with stereotypes, prejudices and misconceptions making it a taboo. Around 200 million women and girls from developmental regions suffer from consequences of the disregarded importance of appropriate menstrual hygiene[27]. Many of them lack

[25] Katrin Dauenhauer et al., "Menstrual Hygiene Management (MHM) in Schools – A neglected issue", 2

[26] Julie Hennegan et al., "Women's and girl's experiences of menstruation in low- and middle-income countries: A systematic review and qualitative metasynthesis*", PLoS Med* 16(5), 2019: 3, accessed 22 June 2022, retrieved from https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002803

[27] Steffi Rönitzsch, "Dropping out of school because of menstruation? An analysis of factors of success for Menstrual Hygiene Management-projects in low and lower-middle income countries" (master's thesis, University of Marburg, 2015), 3

sanitary items because they cannot afford or access them, some demand adequate sanitary facilities in schools or in work places, other face social restrictions or even exclusion because of religious and cultural norms and others fail to receive, due to the taboo, appropriate counselling or pain relief[28]. In the context of LMICs, menstruation truly represents a monthly challenge for a huge number of women and girls, with hundreds of millions of them facing impediments to dignified menstrual health. In practice, 33% of girls in school living in South Asia had never heard of menstruation prior to experiencing menarche, and 98% of adolescent girls were unaware that menstrual blood came from the uterus[29]. In addition, more than half of menstruating individuals living in LMICs utilize handmade products as principal manner to approach and manage menstrual cycle. But in those countries, menstrual health goes beyond practical management and hygiene. Since the onset of menstruation often signifies an abrupt change for girls as they transition from childhood to adulthood, with expectations about sexual purity and social submissiveness, MHM in LMICs must include all the broader systemic factors that link menstruation with health, well-being, gender, education, equity, empowerment and rights[30]. Thus, one can realize how menstrual health constitutes an unexplored problem in LMICs, due to the fact that communities, decision-makers and systems players have ordinarily neglected the topic. In fact, "the filed is just beginning to understand the complex sociobiological dynamics at puberty and how these can set girls on a path to healthy development"[31].

In recent years, attempts to develop MHM programmes have gathered importance in this area, with the aim of providing a possibility for adolescent girls to combat discriminatory social norms around menstrual health in order to achieve broader development outcomes. Among others, the South Asia region has been at the leading position of innovation in policies, programmes and practices to safeguard

[28] Ivi
[29] Alexandra Geertz et al., "An Opportunity to Address Menstrual Health and Gender Equity", Reimagining Social Change, 5, accessed 23 June 2022, retrieved from https://www.fsg.org/resource/opportunity-address-menstrual-health-and-gender-equity/
[30] Ivi
[31] Ivi

the needs of menstruating women and girls in the framework of WASH services[32]. In this context, the discourse on menstrual hygiene has become pervasive in the women's human rights agenda, with an increasing recognition among government bodies that the issue is multi-sectoral and thus necessitates combined efforts from several sectors. As the body of research on the importance of MH develops, there exists a growing concern in addressing it: state bodies, academic institutions, civil society organizations, development agencies and social enterprises have all been active in producing analysis and pioneering methods for MHM[33]. More specifically, those services seek to address practical needs for a huge number of young girls, for the reason that more than half of all adolescents in the world live in Asia.

In absolute terms, South Asia is home to more adolescents – around 340 million – than any other region and India hosts the world's highest number of 10-24-year-olds, with an estimated 356 million[34]. Also, this latter comprises 20% of the world's 1.2 billion adolescents, with more than 1 in 10 children in India are teenagers or presently experiencing puberty and more than a quarter of all children living in the state is going to transition to adolescence within the next decade[35]. However, Indian menstruators face several challenges in managing their menses, due to a deeply rooted culture of silence around the topic. The lack of knowledge regarding menstrual cycle creates feelings of guilt, shame and fear among young girls, whose physiological process is often described as "bad blood". Evidence also suggests that the majority of the girls living in both rural and urban areas experience cultural restrictions when menstruating. In particular, they face impediments in socializing with peers, cooking, playing, moving in and out of the house, sports and religious participation, school attendance, academic performance and touching people or special food[36]. Thus, the issue is particularly relevant in the country, not only

[32] Tracey Keatman et al., "Menstrual hygiene management in schools in South Asia – Synthesis report", WaterAid, 4, accessed 23 June 2022, retrieved from https://washmatters.wateraid.org/sites/g/files/jkxoof256/files/menstrual-hygiene-management-in-schools-in-south-asia---synthesis-report.pdf
[33] Ivi
[34] Ibid., 7
[35] K. Logeswari, "The effect of school based health education regarding menstrual hygiene – an intervention study among adolescent girls of Perambalur district", 6
[36] Anjana Verma et al., "Breaking the silence around menstruation: experiences from urban and rural India", 1539

because it is linked with social and religious practices, but also because, according to Indian National Family Health Survey 4, less than 50 percent of rural women uses hygienic methods during their menstrual period[37]. Due to the lack of accessibility and availability of hygienic products, menstruating individuals are commonly subject to reproductive health problems. Moreover, most health care workers are not adequately trained and the health care system is replaced by accredited social health activists (ASHA), who represent the very first contact of Indian women and girls in the light of community awareness. Even so, due to the great diversity in sociodemographic features of the population in India, the menstrual experience of the 120 million adolescent girls is not the same, where substantial variations subsist between different states, districts, urban and rural areas, and between the rich and poor[38]. Furthermore, India represents a country of contrasts, with extreme wealth, poverty and gender-related disparities, leading to critical differences in health and social indicators among women and girls[39]. These are precisely the reasons why I decided to choose India as my case study.

Taking this into account, the present thesis will pose its focus on the array of programmes and policies of menstrual health implemented at the state and local level by the Government of India (GoI). In concrete, this study will analyze the four GoI Ministries contributions towards supporting WASH facilities and MHM schemes for women and, in particular, adolescent girls. The choice falls specifically on schoolgirls since they face most of all inadequate supply of disposal facilities, water and privacy issues in schools, as well as insufficient social support and scarce knowledge about menstruation and social taboos. All these practices have the potential to restrict girls' right to education, hence it is rather evident that the lack of awareness challenges them and in consequence impede their school attendance[40], limiting their ability to succeed academically and impacting their long-term

[37] Ibid., 1538
[38] Ibid., 1539
[39] Anna Maria van Eijk et al., "Menstrual hygiene management among adolescent girls in India: a systematic review and meta-analysis", BMJ Open, 2, accessed 26 June 2022, retrieved from https://bmjopen.bmj.com/content/bmjopen/6/3/e010290.full.pdf
[40] Steffi Rönitzsch, "Dropping out of school because of menstruation? An analysis of factors of success for Menstrual Hygiene Management-projects in low and lower-middle income countries", 4

economic potential. It must also be noted that adolescent girls face mutually reinforcing impediments, human rights violations and limitations of fundamental freedoms in the face of MH, mainly when attending school. In fact, poor MHM can exacerbate discrimination towards menstruators, but it can be also considered as an opportunity to break the culture of silence and promote gender equality, while dismantling prejudices and stereotypes belonging to the patriarchal society.
In concrete, this work aims to make a contribution to the management of menstrual cycle and human rights discourse, by investigating in which way poor MHM undermines women's human rights. Thus, in concrete, I will analyse the efforts to address MHM and the government initiatives in the current Indian legal framework, taking into account the effective outcomes, articulating possible gaps and future perspectives. In this thesis, an answer is sough to the question: are Indian menstrual hygiene management policies an effective tool to promote gender equality?

1.2 Theoretical framework

The discourse on the relationship between menstrual hygiene management and gender equality needs to be formulated within a theoretical framework, with the purpose of providing the research with a specific theory-driven basis and approach. In this regard, there exists two current theoretical debates surrounding the issue, that is the Socio-ecological framework for MHM and the contemporary argumentation around the integration of MH in the Sexual and Reproductive Health and Rights (SRHR) discourse.

1.2.1 The socio-ecological framework for Menstrual Hygiene Management

This paragraph introduces the first theoretical embedding of menstrual hygiene, which is used to frame the research into a scientific setting. In order to understand the features of the so-called socio-ecological model, the ecological framework for human development will be firstly explained.

The socio-ecological model (SEM) was developed in the late 1960s by the US-American psychologist Urie Bronfenbrenner as a conceptual model for

understanding human development, and subsequently formalized as a theory in 1980s. Most importantly, ecological models of health promotion, like the SEM, originated in the field of earlier behavioral and social sciences theories, but later have been promoted by national and international health organizations as pivotal to designing successful health interventions[41].

According to Bronfenbrenner, a person's development greatly depends on his or her environment, and the interaction of both as well has impact on both, one another[42]. The SEM conceptualizes five levels which affect a person's development, with many factors impacting health behaviors in a matter of a complex system constituted of multiple elements. The subject is placed at the center of the system, surrounded by a fixed number of circles. The first one is called microsystem and is the closest to the individual, containing the strongest influences and incorporating the interrelation with the nearest surrounding. The second is represented by the mesosystem, which encompasses the immediate relationships of the person, taking into account his/her direct interactions. The third corresponds to the exosystem, that does not directly impact the individual, but exercise both positive and negative interactive constraints, including community contexts and social networks[43]. The fourth, that is the macrosystem, embraces cultural, religious and societal norms and values. Finally, the chronosystem includes both internal and external elements of time and historical content and, only in some adjusted models, also the influence of policy[44].

As it has been pointed out, the present theory-based framework can be useful to understand the complex interactions of personal and environmental factors, with the aim of examining the multi-level, multi-determined and multi-structured societal systems. Therefore, any time an issue occurs and a change for the individual

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[41] Ellen McCammon et al., "Exploring young women's menstruation-related challenges in Uttar Pradesh, India, using the socio-ecological framework", *Sexual and Reproductive Health Matters* 28, n. 1 (2020): 292, accessed 27 June 2022, retrieved from https://www.tandfonline.com/doi/full/10.1080/26410397.2020.1749342?scroll=top&needAccess=true

[42] Steffi Rönitzsch, "Dropping out of school because of menstruation? An analysis of factors of success for Menstrual Hygiene Management-projects in low and lower-middle income countries", 8

[43] Jill F. Kilanowski, "Breadth of the Socio-Ecological Model", *Journal of Agromedicine* 22, n.4 (2017): 295, accessed 27 June 2022, retrieved from https://www.tandfonline.com/doi/pdf/10.1080/1059924X.2017.1358971?needAccess=true

[44] Ibid.

or the whole community is expected, the model can be employed to determine influencing aspects and phenomena on which interventions can be programmed[45].

This theoretical model constitutes the basis of the socio-ecological framework for menstrual hygiene management. In this case, the issue is framed within the context of public health, in an effort to consider the plurality of factors that affect menstruating women and girls. The 2019 UNICEF *Guidance on Menstrual Health and Hygiene* utilizes the present model as a way to develop programmes related to menstrual health and hygiene (MHH), focusing on all those individual, social and systemic challenges linked to menstruation. Indeed, the above-mentioned document defines five categories: biological factors, personal factors, interpersonal factors, environmental factors and societal factors.

In this model, the first classification equates Bronfenbrenner's individual level, which consists of the age of the menstruator, the timing of the menarche and the duration and intensity of the menstrual cycle. Other aspects that can be taken into considerations are: severity of pain (including cramps, headaches, abdominal pain), intensity of flow, influence on behavior, ability to manage menstruation and psychological changes (such as ability to concentrate, fatigue, mood swings)[46].

The personal factors correspond to the microsystem, which include personal knowledge, practical skills and beliefs. This second category comprises in particular the biological knowledge about menstruation, practical knowledge to handle menses, behavioral adaptations and coping mechanisms, needs and approaches about menstrual cycle and self-efficacy[47].

The relationships with peers, family and teachers represent menstruators' interpersonal factors. The mesosystem incorporates perceptions of changes in gender roles post-menarche, role of family, peers and teachers in supporting girls, changing in interaction with others, access to information, supplies and practical guidance[48].

[45] Steffi Rönitzsch, "Dropping out of school because of menstruation? An analysis of factors of success for Menstrual Hygiene Management-projects in low and lower-middle income countries", 9

[46] UNICEF, "Guidance on menstrual health and hygiene", 33

[47] Ivi

[48] Ivi

The fourth classification equates Bronfenbrenner's exosystem and represents the environmental factors, namely resource availability, water and sanitation. These last foster women and girls' ability to practice hygiene, since the accessibility of sanitary system and the existence of gender separated sanitation facilities assure privacy and dignity in managing menstruation. The category precisely comprises WASH conditions, cost of HMH supplies and provision of resources for WASH facilities[49].

The environmental factors rely upon the support from the macrosystem, that comprehend national resources, policies, traditions, values of cultures, beliefs and ideologies. The societal factors reflect the role of religion, solicitation of norms and local knowledge from teachers, mothers, girls and boys, school/gender WASH policies, teacher training standards, national and community-level government officials[50] as important factors in the context of menstrual health, considering that they have far reaching influences on all the other factors.

In summary, the socio-ecological framework is helpful to guide the programming of MHM activities, select the type of information to solicit, identify key stakeholders to engage and, most importantly, ensure that women and girls' experiences are explored according to their physical and social environment[51].

1.2.2 Integrating Menstrual Health in the Sexual and Reproductive Health and Rights discourse

These pages will introduce current trends and theories regarding the integration of MH in the SRHR discourse. In order to do so, contemporary feminist approaches and contributions are going to be explored. To illustrate this point, I will firstly clarify the discourse around the definition of Sexual and Reproductive Health and Rights, then identify possible linkages around MH and SRHR and lastly discover the potential inclusion of MH in existing SRHR programmes.

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[49] Ivi

[50] Ivi

[51] UNICEF, "WASH in Schools Empowers Girls' Education: Tools for Assessing Menstrual Hygiene Management in Schools", 3, accessed 28 June 2022, retrieved from https://www.researchgate.net/publication/270880911_WASH_in_Schools_Empowers_Girls'_Education_Tools_for_Assessing_Menstrual_Hygiene_Management_in_Schools

The human rights and global health communities have been active for decades with the purpose of defining and promoting SRHR, with both improvements and setbacks[52]. The very first attempt to create a common language around the issue can be found in the 1994 *International Conference on Population and Development (ICPD) Programme of Action*, which defines reproductive health and classifies the elements of reproductive health care, such as maternal health care, family planning, prevention and appropriate treatment of reproductive tract infection, etcetera. The document describes reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes"[53]. Therefore, it implies that "people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so"[54]. ICPD describes reproductive rights as resting on "the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have information and means to do so, and the right to attain the highest standard of sexual and reproductive health"[55].

Apparently, even if the document does not define the term sexual right, it led the way by connecting reproductive rights to human rights. In this scenario, women's human rights activists and feminist movements played a fundamental role in integrating the definition of reproductive rights by stressing the importance of gender equality and women's empowerment as part of the reproductive health care system.

Over the past 20-25 years, the vocabulary around SRHR has advanced remarkably. Although sexual rights have been considered as a challenging element, over the decades the SRHR community has widely recognized that each component of

[52] Ann M Starrs et al., "Accelerate progress - sexual and reproductive health and rights for all: report of the Guttmacher-*Lancet* Commission", The Lancet, 2644, accessed 28 June 2022, retrieved from https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30293-9/fulltext

[53] International Conference on Population and Development, "Programme of Action" (Cairo: 5-13 September 1994), 59

[54] Ivi

[55] Ibid., 60

SRHR is linked to other elements, and that their implementation is essential to attain sexual and reproductive health[56]. When considering various United Nations and regionally negotiated documents, WHO technical publications, as well as international human rights treaties and principles, an extensive and holistic definition of SRHR is starting gradually to emerge. The recent contributions of the Guttmacher-*Lancet* Commission[57] and the World Health Organization to include menstrual health within the framework of sexual and reproductive health and rights do not disclose a clear intersection between the two. A strong attempt to describe evidence linking MH and SRHR originates from contemporary feminist movements, whose approach finds conformity with the right-based paradigm. According to different sources, efforts to improve MH and SRHR are radically intertwined and share similar overarching goals for enhancing health and well-being and increasing gender equality[58]. Current debates around the topic demonstrate that, in the past, the two fields have operated independently and, for this reason, the potential synergies between them have not been comprehensively investigated.

The reasons behind the emergence of a new feminist advocacy around the topic reflect the necessity to consider MH in the broad system of SRHR, according to biological and sociocultural perspectives. In such circumstances, menstrual health constitutes an essential indicator of women's sexual and reproductive health, whose importance have often been ignored. Accordingly, women and girls do not obtain appropriate knowledge in relation to their fertility and menstrual cycle, contributing to a lack of self-confidence and ownership of their own bodies, which represent

[56] Ann M Starrs et al., "Accelerate progress - sexual and reproductive health and rights for all: report of the Guttmacher-*Lancet* Commission", 2646

[57] The Guttmacher-*Lancet* Commission comprises of 16 experts from North and South America, Africa, Asia, the Middle East and Europe, with expertise in a wide variety of SRHR matters. It represents a research and policy organization, whose mission is to develop a practical agenda for SRHR issues on a global scale. For more information see: https://www.guttmacher.org/guttmacher-lancet-commission/commission-resources

[58] Lucy C Wilson et al., "Seeking synergies: understanding the evidence that links menstrual health and sexual and reproductive health and rights", *Sexual and Reproductive Health Matters* 29, n.1 (2021): 44, accessed 29 June 2022, retrieved from https://www.tandfonline.com/doi/full/10.1080/26410397.2021.1882791

crucial factors to make informed decisions throughout their sexual and reproductive health journeys[59].

In principle, menstruation is central to human reproduction, representing the natural indicator that pregnancy has not occurred. The biological linkages between MH and SRHR can be read through the lens of genital tract infections; menstrual disorders (and the role of contraception in alleviating it); contraceptive-induced menstrual changes and menopause. Evidence from LMICs points out that when women and girls cannot afford and/or otherwise access menstrual products, they often employ improvised materials, including improperly cleaned cloth or tissue paper[60]. This tendency generates genital tract infections, such as bacterial vaginosis and vulvovaginal candidiasis, which negatively impact fertility and increase the predisposition to HIV infection. Challenges related to 'period poverty'[61] affect reproductive health in many ways, limiting menstruators' ability to engage in daily activities. In such a case, missing work and dropping out of school are common trends among those suffering from abnormal bleeding and dysmenorrhea, with serious impacts on productivity, sleep quality, stress level and psychological health[62]. However, recent studies demonstrate that hormonal contraceptives play an important role in alleviating menstrual disorders, given that they can be useful to improve reproductive health and well-being. In fact, contraceptives may constitute the preferred treatment for some menstrual disorders, particularly dysmenorrhea, menorrhagia and endometriosis, since they preserve future fertility and may be more cost-effective[63].

Further connections between MH and SRHR should be seen in the context of perimenopause and menopause. In fact, several studies reveal that hormonal changes typical of this period can result in diverse undesirable effects relevant to MH and SRHR, especially less frequent and less predictable menstrual bleeding,

[59] Maria Carmen Punzi et al., "Technical brief for the Integration of Menstrual Health in SRHR", PSI-Europe, 1, accessed 30 June 2022, retrieved from https://www.psi.org/wp-content/uploads/2019/06/PSI_MHSRH_TechnicalBrief_English-1.pdf

[60] Lucy C Wilson et al., "Seeking synergies: understanding the evidence that links menstrual health and sexual and reproductive health and rights", 46

[61] Period poverty is defined as the lack of access to menstrual products, hygiene facilities, waste management, education, or a combination of these elements.

[62] Ibid., 47

[63] Ivi

discomfort during sexual intercourse and vaginal dryness[64]. However, the issue of SRHR addressed to older people is commonly neglected in academic discourse, leaving many challenges and opportunity to study the subject often overlooked. Nonetheless, researches have brought to light some trends connected with sexual vulnerability and sexual dysfunction among post-menopausal individuals. In this case, older women are exposed to an increased risk of being victims of gender-based violence and sexually transmitted infections, since they continue to experience sexual relations but suffer from socioeconomic dependency and gender-based inequities[65]. Moreover, individuals in this age group may face risks of engaging in unsafe sexual behaviors and of being exposed, as well as exposing others, to the risk of venereal diseases, especially in LMICs where people over a certain age are excluded by HIV screening programmes and safe sex interventions target merely younger people[66].

Sociocultural connections between MH and SRHR can be analyzed according to various aspects of women and girls' experience of menstrual cycle, for example knowledge about puberty and menarche; challenges related to education and school drop-out; gender norms and equity and gender-based violence. As regards the first case, young girls' experiences of puberty and menarche deeply affect their future reproductive health and well-being. The inadequacy of knowledge around the start of menstruation perpetuates negative feelings in managing menses, which can be associated with embarrassment, fear and segregation, but also unhygienic and damaging practices. This lack of body literacy generates a feeling of lack bodily control and shame, mainly in respect to reproduction and sexuality, and may also influence women's future ability to request safe sex and negotiate other reproductive health matters[67].

[64] Ibid., 48
[65] Manjula Lusti-Narasimhan et al., "Sexual health in older women", *Bulletin of the World Health Organization* 91, n.9 (2013): 708, accessed 3 July 2022, retrieved from https://apps.who.int/iris/bitstream/handle/10665/271375/PMC3790224.pdf?sequence=1&isAllowed=y
[66] Ivi
[67] Lucy C Wilson et al., "Seeking synergies: understanding the evidence that links menstrual health and sexual and reproductive health and rights", 49

Similarly, MH issues potentially affect SRHR outcomes related to gender norms and equity. Evidence demonstrates that cultural expectations and harmful gender norms experienced during puberty and girls' sexual maturation restrict menstruators' ability to manage menstruation in dignity with serious repercussions on physical and psychological health, along with education and social engagement. In practice, multiple MH and SRHR programmes aimed at changing social norms and several strategies to empower women and girls in LMICs have generally been associated with favorable reproductive health-related outcomes, with gender-transformative results for men too[68]. At the same time, "efforts to promote reproductive rights within a human rights framework and allow women to control their fertility will only have limited success unless women's individual resources and skill sets are expanded and the broader context in which they are operating is taken into account"[69].

Education represents another area in which efforts of the MH and SRHR fields overlap. In actual fact, most studies on education in low-income settings have found a connection between school absenteeism, poor academic performance and menstrual-related challenges. The aforementioned obstacles incorporate a lack of adequate menstrual materials, absence of appropriate sanitary facilities in school, minimal toilet breaks permitted during lessons, menstrual pain and the connected difficulty to manage menstrual blood, the long distances that menstruating individuals have to walk to reach school and fear of being bullied by boys[70]. Although empirical data with reference to the impact of menstrual cycle upon girls' non-attendance is scarce, recent literature demonstrates a series of harmful consequences because of poor MHM, whose most pervasive effect is the growth of gender gap in education, both at primary and secondary school levels. Since

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[69] Ndola Prata et al., "Women's empowerment and family planning: a review of the literature", *Journal of Biosocial Science* 49, n.6 (2017), 738, accessed 4 July 2022, retrieved from https://www.cambridge.org/core/services/aop-cambridge-core/content/view/DB0C0FC1BB23407AC9C256556DAE435B/S0021932016000663a.pdf/womens-empowerment-and-family-planning-a-review-of-the-literature.pdf

[70] Robyn Boosey et al., "The Menstrual Hygiene Management and the International Human Rights System: A Vicious Cycle of Silence", World Bank, 4-5, accessed 4 July 2022, retrieved from https://consultations.worldbank.org/sites/default/files/consultation-template/update-world-bank-group-gender-strategy-consultations/submissions/a_vicious_cycle_of_silence_final_version_of_paper_0.pdf

education is a human right and educating young women results in evident benefits for a country's economic development, MH and SRHR fields share similar objectives in this framework. Evidence suggests that the longer a girl attends school, the more likely she is to employ contraception, delay marriage, postpone first birth and have healthier babies, with significant repercussions in influencing gender norms and fostering empowerment[71].

Finally, a few studies have found connections between MH and SRHR in the field of gender-based violence, considering that the distance of WASH facilities from residences, especially in LMICs, forces menstruators to reach sanitary arrangements at night. This tendency is justified by the fact that women and girls search for a certain level of privacy during darkness, but this fact places them at risk of harassment and sexual assault[72].

In recent times, policy makers, researches and donors have been debating the incorporation of MH into SRHR interventions, but movement toward this purpose is slow. In such a scenario, global feminist advocacy emphasizes the necessity to understand menstrual health in its complexity and strengthen the implementation of a comprehensive sexuality education, without missing the opportunity to reach common goals in improving health and well-being while, at the same time, increasing gender equality. Recommendations for integrating MH and SRHR programming arise from feminist researchers, whose intentions fall under the scope of supporting the SRHR work in-country and providing technical briefs for global health practitioners.

Punzi and Hekster's *Technical brief for the Integration of Menstrual Health in SRHR* identifies several aspects that investigate mechanisms to include MH in existing SRHR programs. Within the framework of service provision, the authors underline the necessity to include discussions on the menstrual cycle in all family planning/reproductive health (FP/RH) counseling, as a means to support women and girls in determining the FP method suited for them, while addressing

[71] Lucy C Wilson et al., "Seeking synergies: understanding the evidence that links menstrual health and sexual and reproductive health and rights", 49-50

[72] Ivi

contraceptive discontinuation[73]. In such circumstances, health care workers should play a key role in defining the causes of variations in menstrual cycle and bleeding, assessing whether they are induced by sexually transmitted infections, menstrual disorders or abortion (induced and spontaneous). In contrast, Punzi and Hekster underscore that the interference of health care workers should only be encouraged in case of possible complications, since awareness and knowledge of menstrual health represent an opportunity to practice self-care. Whenever women take control over their own health and bodies, even sexual and reproductive health issues can be addressed. To illustrate this point, the authors suggest the introduction of apps for tracking the menstrual cycle in SRHR programs, due to the fact that such tool can help both track periods but also visualize fertility windows, considering the likelihood of conceiving at the desired time or avoiding an unintended pregnancy[74]. In other words, the integration of menstrual cycle in SRHR discourse could be indispensable, in the sense that MH practices impact women and girls' self-confidence and influence their possibility to manage safe sexual relationships. As programmes incorporate menstruation in all its SRHR elements, they strive for substantial gender-transformative goals, challenging destructive norms that prevent women and girls from making informed and autonomous decisions concerning their health and body[75]. Therefore, a feminist and multi-sectoral approach to menstrual health is crucial and robustly needed with the intention of investigating the reasons behind all the consequences of poor MHM and its repercussions to women's sexual and reproductive rights.

1.3 Context background: sanitation insecurity in India

Prior to focusing on the specific findings regarding the current situation of menstrual hygiene management in India, I will present a general overview surrounding the issue of sanitation insecurity, which disproportionately affects women and girls living in the country.

[73] Maria Carmen Punzi et al., "Technical brief for the Integration of Menstrual Health in SRHR", 5
[74] Ibid., 7
[75] Ibid., 2

India represents the second most populated country on earth, with almost 18% of the world's total population living in this area. According to recent estimations, India is expected to surpass China as the world's most populous country by 2024. The rapid decline of fertility rate in India (from an average of 6 children down to 2.4 children per woman) indicates that the population growth rate has decelerated in recent decades[76]. On these facts, the country is projected to reach a "population peak" in the late 2050s, at around 1.7 billion people, before tapering off in the second half of the century[77]. Currently, the 50% of the total population in India is below the age of 25 and about 65% below the age of 35. However, this demographic trend, if not properly monitored, can provoke the collapse of public services and state facilities, among others the health care system. In this scenario, the major problem of sanitation insecurity may worsen, as several other people could face serious difficulties in the access of toilets. Even though the estimations pertaining to the future of India can be associated with a potential degree of uncertainty, it is evident that the country is currently representing a crucial sanitation challenge.

Nowadays, India continues to have the highest number of people defecating in the open (59% of the world's open defecators), with only 32.7 percent of rural population who has access to toilets[78]. In order to ensure sustainability of sanitation services, a series of government programmes has addressed over the years the problem of open defecation, by principally building toilets. The five-year Swachh Bharat Mission (SBM) constitutes the very last attempt to provide sanitation to all households and cease the above-mentioned practice by October 2019. However, evaluations of the previous campaign reveal that a lot was remained to be accomplished. And even if the plan underlines the need for women to be an active part in every single stage of the programme, from planning to post-implementation management, gender inequalities associated with sanitation insecurity have not

[76] Hannah Ritchie, "India will soon overtake China to become the most populous country in the world", Our World in Data, accessed 8 July 2022, retrieved from https://ourworldindata.org/india-will-soon-overtake-china-to-become-the-most-populous-country-in-the-world

[77] Ivi

[78] Kathleen O'Reilly, "Safe sanitation for women", United Nations Office for the Coordination of Humanitarian Affairs, accessed 8 July 2022, retrieved from https://reliefweb.int/report/india/safe-sanitation-women

been prioritized. In such circumstances, investigating how sanitation policies approach or do not approach women's specific needs could be useful to delineate a comprehensive strategy for addressing menstrual hygiene management too. In order to do so, I will provide a definition of sanitation insecurity, focusing on how poor or non-existent sanitation facilities disproportionately affect women and girls during menstrual cycle.

A small but growing line of research suggests that toilet insecurity does not only refer to the multiple risks a woman subjects herself to while defecating in the open, but it also pertains to the presence of unusable or unsafe public toilet[79]. In this case, inadequate sanitation includes: inconsistent number of toilets; poor quality toilets; lack of cleanliness and maintenance; insufficient lightning and defective infrastructural elements[80]. The phenomenon can be further described according to multiple dimensions (sociocultural context; physical environment; social environment and personal constraints), considering that it has little to do with a woman's biology but deeply connected with gender inequalities and different power relations present in contemporary society.

As reported by *Understanding and defining sanitation insecurity: women's gendered experiences of urination, defecation and menstruation in rural Odisha, India*, the term sanitation insecurity can be defined as: "*insufficient and uncertain access to a socio-cultural and social environments that respect and respond to the sanitation needs of individuals, and to adequate physical spaces and resources for independently, comfortably, safely, hygienically, and privately urinating, defecating, and managing menses with dignity at any time of the day or year as needs arise in a manner that prevents fecal contamination of the environment and promotes health*"[81].

Data collected from this study emphasize that inadequate sanitation facilities extremely impact women's ability to manage their menstrual cycle in privacy and dignity. Moreover, nearly all participants revealed major concerns with respect to

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[81] Bethany A Caruso et al., "Understanding and defining sanitation insecurity: women's gendered experiences of urination, defecation and menstruation in rural Odisha, India", *BMJ Global Health* 2, n. 4 (2017): 9, accessed 9 July 2022, retrieved from https://pubmed.ncbi.nlm.nih.gov/29071131/

all aspects related to the management of menses, with little lower percentage of concern for urination and defecation. Taking the sociocultural context as example, several of the urination, defecation and menstruation problems participants described revolved around upholding their gendered roles within the family and community, since urination, defecation and menstruation could not interfere with responsibilities women were expected to fulfil[82]. By comparison, the physical environment underlines menstruators' compromised privacy when manage their needs, with important repercussions on the possibility of changing and washing menstrual cloths. In fact, many participants expressed their concerns for the lack of toilets, for their effective status (without doors or roofs) and for their locations (too distant from home). In addition, seasonal conditions and nightfall can aggravate menstruation concerns: women bother managing menses during winter months or monsoon due to wet or cold weather, being also unable to wash and dry menstrual cloth during the rains[83]. In this connection, the analysis reveals a lack of social support around the urination, defecation and menstruation concerns. Women perceived the absence of privacy when defecating, entering or leaving toilets, urinating, bathing at menstrual onset or washing, drying and disposing of materials, feeling humiliated and worried about their reputations if seen[84]. Most importantly, sanitation insecurity can result in gender-based violence, psychosocial stress and risks for mental health, adverse pregnancy outcomes, urinary and faecal incontinence, irregular menstruation and infectious diseases.

On the one hand, the sociocultural context, physical environment, social environment and personal constraint mutually exacerbate women's sanitation experience, rendering them more vulnerable in the absence of sanitation facilities. But on the other hand, the above-mentioned constituents inevitably include gender as crucial element for change. In fact, these findings demonstrate that the issue of sanitation insecurity has to be addressed according to a multidimensional and transformative approach, formulating the right to sanitation within the human rights framework and requiring explicitly gendered solutions. With a view to properly address the issue of MHM in India, I will critically consider the multitude of

[82] Ibid., 6
[83] Ibid., 8
[84] Ivi

unaddressed menstruation concerns, as well as the possibility to create gender-responsive facilities that meet menstruators' needs and requests. Therefore, it would be useful for the GoI to respond to such public health issue with a specific focus on achieving women's empowerment and gender equality through the implementation of sanitation access in all country.

1.4 Methodology

In order to properly address the topic of menstrual hygiene management in India and its relation to women's empowerment, the present thesis will be based on a variety of different sources.

Following from these premises, it is important to underline that menstrual hygiene management represents an area of work that has been recently developed. In fact, literature and evidence on this specific research question are difficult to find and studies on the matter are rare, but not inconsistent.

With the purpose of collecting the information, I have used qualitative research methods, since a quantitative approach appeared to be impossible to implement. In reality, the original idea was to conduct field research, which could have helped me in the evaluation of first-hand experiences, gathering data directly from the source. Unfortunately, the situation of Covid-19 pandemic and the impediments concerning the possibility of being assisted by local experts and community leaders has prevented me to do so. In fact, field research carried out by individuals without the support of any local NGOs could have been problematic to organize, due to the vastity and heterogeneity of Indian territory. For these reasons, qualitative research methods appear to be more appropriate, since "the strength of qualitative research is its ability to provide complex textual descriptions of how people experience a given research issue"[85]. The choice is further justified by the fact that this type of investigation seems suitable in order to understand the complex reality of a given scenario, but it is also "effective in identifying intangible factors, such as social

[85] Family Health International, "Qualitative Research Methods: A Data Collector's Field Guide", 1, accessed 10 July 2022, retrieved from https://course.ccs.neu.edu/is4800sp12/resources/qualmethods.pdf

norms, socioeconomic status, gender roles, ethnicity, and religion, whose role in the research issue may not be readily apparent"[86].

Predominantly, I have appeal to literature review, making use of data from primary and secondary sources. To define the framework of menstrual hygiene management in India and the connected challenges experienced by women and girls, a review of the existing literature regarding the legal and policy system of menstrual health in the country will be done. These literatures include government publications, ministerial documents, national guidelines, reports published by the Special Rapporteur on the human rights to safe drinking water and sanitation, CEDAW general recommendations, CEDAW/CRC joint general recommendations and UNICEF contributions.
However, in an effort to adequately address the issue of gender equality and menstrual hygiene management, a mere legal approach is not sufficient. Apart from international standards and legal sources, the analysis will benefit from the contribution of significant secondary sources and academic papers from distinguished scholars. Therefore, the present thesis aims at answering the research question through the use of newspaper articles, surveys, press releases, discussion papers and reports published by various local, national and international NGOs working in the field. As just mentioned, a fundamental role will be played by the information retrieved from NGOs, agencies and associations, operating at the international, regional, national and local level in the field of menstrual health and menstrual hygiene management. These include, inter alia, WASH in Schools for Girls, WaterAid, United States Agency for International Development, Bill and Melinda Gates Foundation and FSG Reimagining Social Change.

1.5 State of the Art

In recent years, the emergence of menstruation as a public health issue has seen a growing interest among the international community, reflected also by an expansion in the literature on the topic. As a matter of fact, MHM represents an

[86] Ibid., 1-2

object of study that is quite recent in the areas of practical development assistance and scientific research, since it has historically been relegated to the shadows.

The pivotal moment in this context corresponds to the years 2004-2005, when a small number of researchers started to consider a potential connection between gender gap in education and menstrual challenges. As part of their focus on girls in school, a limited group of NGOs began to tackle the issue of menstrual cycle in their girls' education programming, by providing improved latrines and comfort kits with sanitary materials and underwear[87]. Similarly, various companies coming from the private sector took action in raising awareness around menstrual health and supporting trainings for schoolgirls, especially in LMICs, with the help of local institutions. In this scenario, one of the leading global sanitary material producers Proctor & Gamble advocated to remove the value-added tax for importing sanitary materials and engaged in a series of menstrual management-connected activities for girls, which contemplated both instrumental and principled objectives: expanding their trading, developing their brand and complying with social responsibility ethic dedicated to educating girls about their bodies[88]. However, in the immediate years following this first mobilization, the issue of menstrual cycle as an obstacle to schoolgirls still missed the opportunity to gain momentum globally.

An attempt to achieve global recognition around the topic was supported by UNICEF and other NGOs working in the WASH sector in the context of the 2005 Oxford Roundtable. Within this framework, public acknowledgement shifted to the linkages between Millennium Development Goals (MDGs) and water, sanitation and hygiene priorities. In this case, the promotion of gender equality and the empowerment of women started to be intended according to the health and security risks associated with the lack of private sanitation facilities, as well as the inclusion of women in decision-making powers in the management of community water and

[87] Marni Sommer et al., "Comfortably, Safely, and Without Shame: Defining Menstrual Hygiene Management as a Public Health Issue", *American Journal of Public Health* 105, n. 7 (2015): 1303, accessed 11 July 2022, retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4463372/
[88] Ivi

sanitation systems to improve their status in the community[89]. During the meeting, the director of JunctionSocial Archana Patkar exposed her concern around the small number of professionals that have undertook actions regarding the issue. According to her "the literature on gender mainstreaming in the water and sanitation sector is silent on menstrual management"[90], moreover "initiatives in this area are restricted to very small pilot projects (Bangladesh, India, Kenya, South Africa and Uganda) and monitoring is poor"[91].

From this moment on, the cultural and structural dimensions of attributions of responsibility for MHM changed. In particular, the existing perceptions of schoolgirls living in LMICs and their actual experiences of menstrual management played a fundamental role for those trying to place emphasis on the matter. The publication in the peer-reviewed scientific literature of new data was seen from 2006 onward, with much of those studies reflecting the increased commitment in MHM researches of scholars and experts from the educational and public health sectors[92]. Since then, many academics and feminist activists took advantage of this window of opportunity to investigate the issue and eventually publish papers and contributions, emphasizing challenges related to the lack of sanitary facilities and common stigmas.

To illustrate this point, it is crucial to mention the contribution released by WaterAid in collaboration with sixteen practitioners and researches in the field of WASH, health, education and gender. The 2012 *Menstrual hygiene matters; A resource for improving menstrual hygiene around the world* represents the most comprehensive publication available on MHM, as well as a groundbreaking resource for improving MH globally. The document is divided in nine modules and toolkits, which consider menstrual cycle according to different related perspectives, such as sanitary protection materials and disposal, menstrual hygiene in

[89] UNICEF/IRC, "Roundtable Proceedings and Framework for Action", Water, Sanitation and Hygiene Education for Schools, 11, accessed 11 July 2022, retrieved from https://www.ircwash.org/sites/default/files/Goodman-2005-Water.pdf
[90] Ibid., 51
[91] Ivi
[92] Marni Sommer et al., "Comfortably, Safely, and Without Shame: Defining Menstrual Hygiene Management as a Public Health Issue", 1305

emergencies and in the workplace, practical interventions at community level and in schools, challenges of women and girls in vulnerable, marginalized or special circumstances and research, monitoring and advocacy. Other than offering a pragmatic guidance for the improvement of good menstrual hygiene practices for women and girls in LMICs, it also describes the cycle of neglect surrounding menstruation. The authors acknowledge the exclusion of menstruating individuals from decision-making and management in development and emergency relief programmes, the lack of information and awareness and the scarcity of sanitary protection products and facilities (such as private spaces with a safe disposal method for pads or used cloths and water supply)[93]. All these elements strongly impact women and girls' rights to education and health and have also negative effects on sustainability. As for the first challenge, the study reveals that inadequate water and sanitation facilities in schools make managing menstruation very difficult, that can result in bloodstained clothes, causing stress and embarrassment as well as reducing educational opportunities or even drop out completely[94]. Considering the impacts on health, evidence suggests that poor MHM generates serious reproductive and urinary tract infections, psychological stress and sometimes depression. Moreover, neglecting menstrual hygiene in WASH programmes can result in harmful consequences on sustainability and solid waste problems, with latrines turning blocked and pits filling rapidly[95]. In conclusion, the authors call for additional research and information on the matter "to fully understand women's menstruation-related needs, appropriate responses and their impacts"[96]. Evidently, further case studies are still needed on the impact of improved menstrual hygiene on educational retention, aspects of social marketing of pads, material disposal and hygiene practices, involvement of boys and men in menstrual hygiene, challenges of women and girls in vulnerable situations and practical experiences in order to respond to MHM in emergencies from the field[97].

[93] Sarah House et al., "Menstrual hygiene matters; A resource for improving menstrual hygiene around the world", 22, accessed 12 July 2022, retrieved from https://washmatters.wateraid.org/sites/g/files/jkxoof256/files/Menstrual%20hygiene%20matters%20low%20resolution.pdf
[94] Ivi
[95] Ibid., 23
[96] Ibid., 180
[97] Ivi

Other worthwhile literature regarding the effects of improved MHM and connected challenges dates back again to the year 2012. Sumpter and Torondel's *Systematic Review of the Health and Social Effects of Menstrual Hygiene Management* identifies several published articles on MHM and associated health or psycho-social outcomes in lower income setting. For the purpose of investigating, the authors systematically combine, synthesize and evaluate the available evidence in order to appraise MHM interventions and related effects in LMICs. On the one hand, the authors recognize the effectiveness of educational interventions for the purpose of improving menstrual health practices and reducing social restrictions. In fact, "the quality of evidence indicating that providing targeted education can improve MHM practices such as the use of disposable absorbents, changing and washing of pads was consistent and persuasive"[98]. On the other hand, the quantitative evidence of the reduction of school absenteeism was impossible to examine, since "there is a gap in the evidence for high quality randomized intervention studies which combine hardware and software interventions, in particular for better understanding the nuanced effect improving MHM may have on girls' attendance at school"[99].

Analyzing other similar or related published researches, it is possible to examine a series of context-specific studies on menstruation and menstrual hygiene. For the purpose of this thesis, three core investigations focused on menstrual hygiene management in India will be presented.

Dasgupta *et al*. conducted a descriptive, cross-sectional study among 160 adolescent girls of a secondary school situated in West Bengal, with the aim of discovering beliefs, conceptions and source of information about menstrual cycle. With the help of pre-designed and pre-tested questionnaires, collected data were statistically analyzed by simple proportions. Among 160 respondents, 108 (67.5%) girls know about menstruation prior to attainment of menarche and mothers were considered as the first informants regarding menstruation in the case of 60 (37.5%)

[98] Colin Sumpter et al., "A Systematic Review of the Health and Social Effects of Menstrual Hygiene Management", *PLoS ONE* 8, n.4 (2012): 11, accessed 12 July 2022, retrieved from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0062004

[99] Ibid., 1

participants[100]. Half of the girls were aware about the use of sanitary pads, but only 18 out of 160 used them regularly. Moreover, 97.5% used both soap and water for cleaning purposes and 85% practiced different restrictions during menstruation[101].

A cross-sectional and questionnaire-based study to assess the knowledge and practices of menstrual hygiene among rural and urban adolescent girls in Sharda Vidyalaya, Hyderabad was conducted in 2015 by Channawar Kanchan and Prasad VSV. Among the two hundred and sixty-three menstruators of age 13-16 involved in the study, the 85.9% of them were not aware of the cause of the bleeding. In addition, only 154 of the participants know about menstruation before menarche, with grandmothers as the most important source of information[102].

Lastly, *A study on knowledge and practices regarding menstrual hygiene among urban adolescent girls* carried out by Kartik Ramachandra *et al*. assess the level of knowledge regarding menstrual hygiene among adolescent girls in Bangalore, India. In this case, an epidemiologic study among 550 school-going girls aged 13-16 years was undertaken. Results show that "around 34% of the participants were aware about menstruation prior to menarche, and mothers were the main source of information"[103]. It is also observed that "69% of adolescent girls were using sanitary napkins as menstrual absorbent, while 6% were using both cloth and sanitary napkins"[104]. The authors further outline the importance to equip young menstruators with consciousness and awareness concerning hygienic practices to manage their menstrual cycle, in order to assure a safe and healthy reproductive life.

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[100] A Dasgupta et al., "Menstrual hygiene: How hygienic is the adolescent girl?", *Indian Journal of Community Medicine* 33, n.2 (2008), accessed 13 July 2022, retrieved from https://www.ijcm.org.in/article.asp?issn=0970-0218;year=2008;volume=33;issue=2;spage=77;epage=80;aulast=Dasgupta

[101] Ivi

[102] Channawar Kanchan et al., "Menstrual Hygiene: Knowledge and Practice among Adolescent School Girls", *Panacea Journal of Medical Sciences* 6, n. 1 (2016): 31, accessed 4 October 2022, retrieved from https://www.ipinnovative.com/journal-article-file/1827

[103] Kartik Ramachandra et al., "A study on knowledge and practices regarding menstrual hygiene among urban adolescent girls", *International Journal of Contemporary Pediatrics* 3, n. 1 (2016): 142, accessed 13 July 2022, retrieved from https://www.ijpediatrics.com/index.php/ijcp/article/viewFile/350/339

[104] Ivi

In conclusion, this overview of literature demonstrates that a great number of studies investigate menstruation-related challenges with a focus exclusively on LMICs. Even if there exist more researches on menstrual hygiene with different regional foci available, their relevance is limited and further investigation concentrated in Central and South America is still needed. As a result, it is possible to affirm that literature on menstrual hygiene management and its impact on gender equality is not extensive. Furthermore, what is missing is a comprehensive understanding of the outcomes regarding MHM programmes and strategies. Furter research needs to be done concerning the impact of possible solutions in the education field, in particular of those addressing the problem of school absenteeism and drop-out. As a consequence, this thesis is intended to analyze whether MHM policies in India represent an effective tool to promote gender equality and enhance women's empowerment, a country with extensive literature on and active NGOs working in the field for this purpose.

CHAPTER II: Approaching menstruation: interventions, strategies and objectives in CEDAW general recommendations and WASH programmes

2.1 The discourse of Menstrual Health under the human rights framework from a historical to a legal point of view

2.1.1 From personal to political: Menstrual Hygiene Management as public health issue

After providing a theoretical framework and context background about the ongoing debate around menstrual health and menstrual hygiene management, it is now possible to concentrate on other principal topics that lay at the basis of the present research question. The aim of this paragraph is to understand the process through which menstrual health has been framed as a public health issue and how menstruation can be approached through the lens of human rights.
In order to do so, the first subparagraph will provide an overview of the historical dimensions of the MHM agenda, while the second subparagraph will focus on the risks and opportunities related to the recognition of menstrual health according to a human rights perspective.

As to understand how a particular problem achieves a certain political recognition, it is necessary to investigate the cultural dimensions attached to that issue. In fact, the way a phenomenon is perceived within the society may change in the course of time and the political responsibility over that question can be differently attributed. Across diverse social contexts, the topic of menstruation has often been relegated to the individual level, due to a vicious cycle of silence. For decades, MHM has been neglected, while the population health community has given prominence to questions linked to adolescent girls' sexual and reproductive health, for example contraceptive use, risks from HIV and other sexually transmitted infections and family planning[105]. Moreover, a review of the scholarly and grey literature over the

[105] Marni Sommer et al., "Overcoming the Taboo: Advancing the Global Agenda for Menstrual Hygiene Management for Schoolgirls", *American Journal of Public Health* 203, n.9 (2013): 1557, accessed 19 July 2022, retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3780686/

past 10-15 years reveals a number of many other factors which contributed to assign the responsibility for menstruation and menstrual health outside the realm of a public problem. In this case, the perception of menarche as a rite of passage, the history of education in some LMICs and the lack of women in leadership positions relegated, until recently, menstrual cycle as a socially stigmatized issue in most contexts.

As already mentioned in the previous chapter, recent grassroots activism has been engaging in research on MHM, with a specific focus on its impact in poor income settings. The growing body of documentation on the topic highlights girls' experiences and the potential to solve their challenges with existing tools, assuming the notion of primary prevention in public health: intervene in advance in order to prevent public health problems from developing (such as school dropout and negative sexual or reproductive health outcomes)[106]. Once recognized the multifaceted characteristics of the matter, it is possible to affirm that "the interdisciplinarity of this work, which crossed both topical and methodological boundaries, with public health academics using innovative methodological approaches and publishing in education and WASH-focused journals, helped stimulate greater awareness of the menstrual challenges facing girls across various sectors"[107]. In this context, private-sector sanitary pad companies, NGOs and researchers played a key role in publishing findings on MHM and its impact on women and girls. Since the beginning of the millennium, various actors established partnerships in order to serve multiple interests concerning the management of menstrual cycle. All of them "wanted to bring attention and resources to menstruating girls' needs around the world and thereby improve girls' lives"[108], leading to the acceptance and conceptualization of the acronym "MHM" itself. However, reframing this long-neglected issue resulted in important gaps in research methodology and content. The growing focus on menstrual hygiene management has been initially translated into qualitative and participatory researches, with

[106] Marni Sommer et al., "Comfortably, Safely, and Without Shame: Defining Menstrual Hygiene Management as a Public Health Issue", 1305
[107] Ivi
[108] Ivi

important obstacles to overcome. In fact, even if these approaches seem adequate due to the sensitive nature of this health issue, the data and information provided are not satisfactory, taking into account the limited availability of government and donor resources[109]. On the contrary, quantitative evidence of interventions employed new feminist methodologies, which strongly contributed to bring MHM into focus as a public problem. For these reasons, creative and mixed approaches should be incorporated into future research conducted on MHM, due to the fact that more comprehensive analysis will be crucial to define the most cost-effective and efficient means of addressing menstrual cycle in the global agenda.

Significant developments in the past years signal a shift toward a structural and political response about the issue. By 2010s, a growing number of United Nations agencies started increasingly to consider the societal ownership of the problem, calling attention to the inadequacy of the existing responses to menstruation and suggesting the need for government accountability of the question. As a matter of fact, the structural responsibility of menstrual health and menstrual hygiene management switched from the individual level to the political level, with the involvement of international institutions and state authorities. On this occasion, it is crucial to specify that the structural dimensions of a public problem refer to "the successful attribution of responsibility onto institutions or personnel who may then see the designation as an obligation to society they are responsible to address or, alternatively, as an opportunity to solve a public problem"[110]. However, the attention around it remained in these years closely connected to the WASH sector, in particular to the field of education in lower income countries.

By 2011, the United Nations International Children's Emergency Fund began to push NGOs working in the WASH sector in order to undertake concrete actions in the context of MHM in schools. The agency, in partnership with educational institutions such as Emory University, has supported researches and studies in several countries with the aim of broadening the qualitatively-based exploration

[109] Marni Sommer et al., "Overcoming the Taboo: Advancing the Global Agenda for Menstrual Hygiene Management for Schoolgirls", 1558

[110] Marni Sommer et al., "Comfortably, Safely, and Without Shame: Defining Menstrual Hygiene Management as a Public Health Issue", 1304

and creating an evidence-base for programs in schools. Soon thereafter, alternative framings on the menstrual issue began to emerge, and simultaneously new actors started to turn their attention on the topic. Among them, an increasing number of social entrepreneurs contemplated new approaches to address MHM by using engineering and industrial design for articulating solutions in LMICs[111]. These new players joining the menstruation scene "may have been motivated to identify – from an entrepreneurial perspective – market-based solutions to what other might perceive as a more complex cultural and structural issue"[112]. Apart from them, local and global feminist grassroots activists, as well as women's movement, started to advocate for health and education by giving an emphasis to the connection between the universality of menarche and menstruation and the experience of gender equality and discrimination. With the early 2010s, MHM advocacy was strengthened also by the role of charismatic individuals, major news agencies, social media and sustainable health enterprises. Thanks to the activity of awareness-raising and strong commitment to the cause, the cognitive beliefs and moral judgement around menstruation began to transform. In particular, the 2014 *Handbook on realizing the human rights to water and sanitation* framed, for the first time, women and girls' challenges related to the inadequate water, sanitation and materials as human rights violations. In there, the stigmatization attached to menstruating women is defined as a mechanism deeply entrenched sociocultural phenomenon, which lies at the heart of discrimination[113].

In that same year, two other attempts to globally recognize the problems surrounded menstrual cycle surfaced. In this respect, it is fundamental to mention the document published by the United Nations Educational, Scientific and Cultural Organization (UNESCO) named *Good policy and practice in health education*, which focuses on puberty education and menstrual hygiene management. The volume outlines good policies and practices regarding menstrual hygiene management, based upon

[111] Ibid., 1306
[112] Ivi
[113] Special Rapporteur on the human right to safe drinking water and sanitation, "Handbook on realizing the human rights to water and sanitation", United Nations Human Rights, 30, accessed 22 July 2022, retrieved from https://www.ohchr.org/en/special-procedures/sr-water-and-sanitation/handbook-realizing-human-rights-water-and-sanitation

international technical consultations, peer reviews, key informant interviews and literature revise. In the present instance, the consultation conducted by UNESCO in July 2013 gathered together a great number of actors coming from the international arena, such as academia, civil society, private sector and other UN agencies.

In order to assist the education sector in addressing puberty education and menstrual health systematically and successfully, the above-mentioned document designates an entire section dedicated to the factors impacting MHM. Those elements "lay out the specific needs that must be tackled for girls and women to manage their menstruation in a dignified and hygienic manner"[114] and comprise accurate and timely knowledge; informed and comfortable professionals; sanitation and washing facilities; safe and hygienic disposal; available, safe and affordable menstrual materials; referral and access to health services; positive social norms and advocacy and policy.

As for the first aspect, the importance of timely information and right-informed components in education programmes is highlighted. To illustrate and support this statement, "an analysis of rigorously-evaluated sexuality/HIV education programmes strongly suggests that curricula encouraging critical thinking about gender norms and power in intimate relationships are more likely to show positive health outcomes than 'gender-neutral' curricula"[115]. With the aim of providing accurate and reliable knowledge, teachers, health workers and other actors working in the education field must be properly trained, being able to interact and communicate in an informed and inclusive way. Moreover, sanitation and water planners are called to apprehend all the questions embracing affective menstrual hygiene management, for the purpose of incorporating special provisions in the planning and building[116].

With reference to sanitation and washing facilities, the present booklet accentuates the need for private and safe spaces in order to change menstrual hygiene materials. In this case, menstrual hygiene-friendly infrastructures in schools have to guarantee

[114] United Nations Educational, Scientific and Cultural Organization, "Good policy and practice in health education" (Booklet 9), Puberty education and menstrual hygiene management, 30, accessed 23 July 2022, retrieved from https://unesdoc.unesco.org/ark:/48223/pf0000226792
[115] Ibid., 31
[116] Ibid., 32

separate, secure and hygienic latrines, hand-washing facilities, a method to collect sanitary protection materials and safe water. Also, menstrual waste (such as menstrual absorbents, cloth, disposable sanitary napkins, tampons and other materials) has to be properly addressed with mechanisms of safe disposal of sanitary wastes. In the final analysis, satisfactory strategies on MHM must conjointly tackle myths and misconceptions surrounding the matter because "as long as menstruation remains a taboo and shameful issue poorly understood by both men and women, it will be very difficult to develop good public policy and practice around it"[117].

The other instance refers to the 2014 *MHM in Ten* meeting in New York City, organized by UNICEF and Columbia University, with the aim of formulating a ten-year agenda for MHM in schools. During this period, efforts from academia and development sector started to focus on the challenges facing menstruating individuals during school years in LMICs. Despite that, key actions both from the international and national level intending to address the issue have not been comprehensively identified. Regardless of the increasing evidence and commitment in making progress to enhance school conditions for girls, there has not been a coordinated mapping of MHM priorities or a joint effort from relevant branches and disciplines to catalyze change, with a need to develop country-level expertise[118].

In that respect, the meeting brought together a wide range of actors and stakeholders, for example donors, NGOs, advocacy organizations, academics, UN agencies and national governments from various sectors, who defined a joint objective for the ten-year agenda. In this framework, *MHM in Ten* participants shared a common vision: "girls in 2024 around the world are knowledgeable about and comfortable with their menstruation and able to manage their menses in school in a comfortable, safe and dignified way"[119]. In order to help dramatically improve MHM by 2024, five key priorities were also identified. Precisely, these last are not

[117] Ivi
[118] Marni Sommer et al., "A Time for Global Action: Addressing Girls' Menstrual Hygiene Management Needs in Schools", *PLoS Med* 13, n.3 (2016): 1, accessed 24 July 2022, retrieved from https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001962
[119] Ibid., 4

intended to be in sequence, as some may develop simultaneously. "Build a strong cross-sectional evidence base for MHM in schools for prioritization of policies, resource allocation and programming at scale"[120] represents the first point. Within this framework, it would be essential to accurately evaluate the impact of school interventions and promote national-level researches on the matter.

The second pays attention to "develop and disseminate global guidelines for MHM in schools with minimum standards, indicators and illustrative strategies for adaptation, adoption and implementation at national and sub-national levels"[121], while the third emphasizes to "advance MHM in schools activities through a comprehensive evidence-based advocacy platform that generates policies, funding and actions across sectors and at all levels of government"[122].

With the aim of improving an effective change in the education systems, States should dedicate resources for the provision of MHM in schools, by working also with their own constituents to break the silence on menstrual cycle within their corresponding institutions and populations[123]. In this field, national governments are as well called to "integrate MHM and the capacity and resources to deliver inclusive MHM into the education system"[124] in order to guarantee beneficial actions and appropriate monitoring systems of MHM interventions in schools.

Even if significant momentum was generated at the meeting, the advancement of the MHM agenda for schoolgirls around the world still needs to be properly defined and much work remains to be done. Although the WASH sector led the effort, evidence shows that it cannot advance its activities alone. In fact, to ensure multisector involvement, it must be supported by different actors globally and within countries (i.e., Ministries of Health, Women and Children's Affairs, Finance), in conjunction with any other government specific entities at the state

[120] UNICEF et al., "MHM in Ten: Advancing the MHM Agenda in WASH in Schools", 3, accessed 29 July 2022, retrieved from https://static1.squarespace.com/static/5988738af9a61e3bd699b5e4/t/5988f0f4e6f2e1fa708fedc1/1502146981926/2014+MHM+in+Ten+Meeting+Report.pdf

[121] Ivi

[122] Ivi

[123] Marni Sommer et al., "A Time for Global Action: Addressing Girls' Menstrual Hygiene Management Needs in Schools", 5

[124] UNICEF et al., "MHM in Ten: Advancing the MHM Agenda in WASH in Schools", 3

level holding responsibility on account of the legal and competence frame of each country[125]. At the same time, significant public health lessons have been learned from the emergence of MHM agenda thus far, and the global first-ever Menstrual Hygiene Day[126] established by WASH United with its different partners presupposes that social activism will perpetuate for some time to come[127]. In the present circumstances, there exists a window of opportunity to contemplate menstruation from a personal to a political point of view, producing this way public sector responsibility. Framing menstrual health according to a human rights perspective clearly defines the ownership of the problem, addressing the capacity and responsibility to approach the problem to public institutions. And since framing is part of structural intervention, "it would not have been possible to get governments to talk about MHM or to place MHM on the global agenda without it being turned into a social problem"[128].

2.1.2 Menstrual Health in the international human rights system

As previously mentioned, before 2010s the subject of menstrual health has been rarely considered by UN bodies and agencies as a human rights issue. The year 2014 represents the very first time in which the UN Human Rights Council referred to menstrual hygiene management in the context of the *Resolution 27/7* on the human right to safe drinking water and sanitation during its twenty-seventh session. From this perspective, "the lack of access to adequate water and sanitation services, including menstrual hygiene management, and the widespread stigma associated with menstruation have a negative impact on gender equality and the human rights

[125] Marni Sommer et al., "A Time for Global Action: Addressing Girls' Menstrual Hygiene Management Needs in Schools", 6
[126] Menstrual Hygiene Day takes place on 28 May every year and represents a global chance to catalyze awareness about menstrual health and highlight the challenges that face women and girls when do not have access to sanitary products.
[127] Marni Sommer et al., "Comfortably, Safely, and Without Shame: Defining Menstrual Hygiene Management as a Public Health Issue", 1309
[128] Ivi

of women and girls"[129]. As a matter of fact, framing the discourse of menstrual health and hygiene under the human rights framework requires a holistic approach to women and girl's human rights, which could be able to identify the multidimensional challenges menstruators experience and explore possible solutions and strategies to confine those challenges. The issue of menstrual health and poor menstrual hygiene management certainly compromises a series of other interrelated human rights, such as the right to health, the right to water and sanitation, the right to education, the right to work, non-discrimination and gender equality.

Realizing the human right to health transcends the right for health care and medicine, since it represents one of the most important preconditions to provide the means to practice effective menstrual hygiene management for women and girls. Indeed, according to the Committee on Economic, Social and Cultural Rights, it has to include "the underlying determinants of health, such as access to safe and potable water and adequate sanitation, and adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health"[130]. Further, it has been antecedently accentuated in article 12 of the 1979 *Convention on the Elimination of all Forms of Discrimination against Women* that "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning"[131]. The connection between the right to health and the principle of non-discrimination and gender equality has been widely expanded in the realm of

[129] Human Rights Council, "Resolution adopted by the Human Rights Council 27/7. The human right to safe drinking water and sanitation", Agenda item 3: Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development, UN Doc. A/HRC/RES/27/7, 3, accessed 30 July 2022, retrieved from https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/177/87/PDF/G1417787.pdf?OpenElement

[130] UN Committee on Economic, Social and Cultural Rights, "General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)", 11 August 2000, E/C.12/2000/4, 3, accessed 30 July 2022, retrieved from https://www.refworld.org/docid/4538838d0.html

[131] General Assembly, "Convention on the Elimination of All Forms of Discrimination against Women", 5, accessed 30 July 2022, retrieved from https://www.ohchr.org/sites/default/files/cedaw.pdf

CEDAW general recommendations, according to article 21 of the above-mentioned international agreement. Introducing menstrual cycle in the frame of women's human rights demands duty bearers to ensure that menstruators can enjoy their right to health to the fullest extent possible, in conformity with their legal obligations. Owing to the fact that the general recommendations on the specific provisions of the Convention will be later better explained, a conclusive statement could be additionally provided. The importance of understanding menstrual cycle and menarche as a completely normal biological process (including how they works, how to manage them, symptoms, and pre-menstrual syndrome) is linked with the possibility of empowering women and girls to manage their menstruation adequately, safely and with dignity, and to consequently guarantee that they can feel and be as healthy as possible[132]. In fact, stigma and stereotypes associated with menstruation generally cause negative health repercussions, preventing women and girls to seek for treatments and affecting their right to achieve the highest attainable standard of health and well-being.

The human right to water and sanitation was explicitly recognized by the UN General Assembly through *Resolution 64/292* on 28 July 2010, with a clear appeal to States and international organizations "to provide financial resources, capacity-building and technology transfer, through international assistance and cooperation, in particular in developing countries, in order to scale up efforts to provide safe, clean, accessible and affordable drinking water and sanitation for all"[133]. In an effort to draw a correlation between water, sanitation and menstrual health, it is fundamental to understand how safe and affordable water, as well as accessible and private sanitation facilities, represent the principal preconditions for enabling good MHM. Since the WASH sector has initially played a leading role in bringing menstrual cycle onto the international development agenda, the earliest

[132] Hannah Neumeyer et al., "Menstrual hygiene management and human rights: What's it all about?!", menstrualhygieneday.org, 9, accessed 30 July 2022, retrieved from https://menstrualhygieneday.org/menstrual-hygiene-management-human-rights-whats/

[133] General Assembly, "Resolution adopted by the General Assembly on 28 July 2010. 64/292. The human right to water and sanitation", A/RES/64/292, 3, accessed 31 July 2022, retrieved from https://documents-dds-ny.un.org/doc/UNDOC/GEN/N09/479/35/PDF/N0947935.pdf?OpenElement

interventions were predominantly focused on technical solutions, within the realm of access to sanitation, provision of pads and availability of sufficient water. At the same time, the lack of accessibility and adequacy of those elements affects differently women and girls as compared to men and boys. Actually, when sanitation facilities do not allow menstruators to wash or change menstrual materials, women and girls will suffer a discrimination based on their gender, as it has been pointed out by the UN Human Rights Council *Resolution 27/7* and the General Assembly *Resolution 79/169*[134].

The right to education is incorporated in several human rights treaties, for example article 13 of 1966 *International Covenant on Economic, Social and Cultural Right*s and article 10 of the 1979 *Convention on the Elimination of all Forms of Discrimination against Women*. On the one hand, the first document outlines that States Parties observe the right of everyone to education, agreeing that it "shall be directed to the full development of the human personality and the sense of its dignity, and shall strengthen the respect for human rights and fundamental freedoms"[135]. On the other hand, the second agreement delineates that "States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education"[136]. From this point of view, it is clear that access to education should be granted regardless of gender, race, religion or background, but concretely the impact of menstruation on girls' education remains a crucial area of concern. For this reason, the inability to manage menstrual cycle in a safe and dignified manner can culminate in poor educational outcomes, high female school dropout rate and school absenteeism. In this field, education institutes, either public or private, should play an important role in addressing women and girl's needs connected with menstrual management and hygiene. In fact, menstrual health practices in relation to the right to education are not only targeted at advancing girls' opportunities to

[134] Hannah Neumeyer et al., "Menstrual hygiene management and human rights: What's it all about?!", 8
[135] General Assembly, "International Covenant on Economic, Social and Cultural Rights", 4, accessed 31 July 2022, retrieved from https://www.ohchr.org/sites/default/files/cescr.pdf
[136] General Assembly, "Convention on the Elimination of All Forms of Discrimination against Women", 4

do their best at school, but they also challenge school itself in terms of providing an efficient education on menstrual cycle in forms of guidelines or an extra course[137]. In actual fact, empirical data focused on low-income settings have found evidence of common trends regarding dropping out of school by girls when they reach puberty. Moreover, literature on education often notes evidence of menstruation-related absenteeism and poor school performance, with harmful effect on girls' education when they miss class and cannot impart information or knowledge because of inadequate academic support. In spite of that, policy makers and international institutions have been recently considering the issue of gender gap in education according to a gender perspective. Thanks to this tendency, education could undoubtedly constitute an effective tool to empower girls, considering all those menstrual-related concerns as contributing factors to discrimination and obstacles to the fulfilment of the human right to education.

Furthermore, menstrual health is intrinsically connected with the right to work and strongly related to safe and healthy working conditions. According to articles 6 and 7 of the *International Covenant on Economic, Social and Cultural Rights*, two are the basic elements incorporated in the right to work: accepting and choosing work opportunities without being entailed by fear or intimidation and the right to secure working environment, as well as adequate water and sanitation facilities in workplaces. In the 2016 *General comment No. 23*, the Committee on Economic, Social and Cultural Rights has precisely clarified that "access to safe drinking water, adequate sanitation facilities that also meet women's specific hygiene needs, and materials and information to promote good hygiene are essential elements of safe and healthy working environment"[138], meaning that employers and States Parties must provide all those elements in order to assure the enjoyment of just and favorable working conditions. In the section named *Special topics of broad*

[137] Khansadhia Afifah Wardana, "Human Rights Framework on Menstrual Health and Hygiene", International Conference on Law, Economics and Health (ICLEH 2020), Advances in Economics, Business and Management Research, volume 140, 142, accessed 31 July 2022, retrieved from https://www.atlantis-press.com/proceedings/icleh-20/125940493

[138] UN Committee on Economic, Social and Cultural Rights, "General Comment No. 23 (2016) on the right to just and favorable conditions of work (article 7 of the International Covenant on Economic, Social and Cultural Rights)", 27 April 2016, E/C.12/GC/23, 8, accessed 3 August 2022, retrieved from https://www.refworld.org/docid/5550a0b14.html

application, paragraph 47, the Committee recognizes that "intersectional discrimination and the absence of a life-cycle approach regarding the needs of women lead to accumulated disadvantages that have a negative impact on the right to just and favorable conditions of work and other rights"[139]. For these reasons, duty bearers are called to update, examine and implement adequate standards in workspaces, with the aim of ensuring that employers do not limit job opportunities for women and girls and provide healthy working conditions that could meet menstruators' needs. On the contrary, when women struggle to find a safe washroom to change their menstrual materials, they face workplace discrimination and encounter unequal working conditions. In these circumstances, the fact of changing menstrual materials in inappropriate locations or not changing them when desired could lead to serious health consequences, such as vaginal infections. Moreover, in the case of poor healthy working conditions, women are more likely to stay at home, with repercussions on their ability to earn an income, affecting their right to work itself as well as the right to health and human dignity more broadly[140].

The principle of non-discrimination represents the foundation all human rights law, with gender equality as the vital element in circumscribing menstrual health and hygiene according to human rights lenses. In this sense, all major human rights documents contemplate that human rights should be enjoyed on an equal footing by everyone, with the identification and removal of any existing inequalities or indirect discriminations causing obstacles and violations in their application[141]. On the ground of this, States have the obligation to eradicate discrimination in the realization of human rights and should take, as stated in article 3 of CEDAW, "all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men"[142]. Although menarche and menstrual cycle are natural and biological facts,

[139] Ibid., 11
[140] Hannah Neumeyer et al., "Menstrual hygiene management and human rights: What's it all about?!", 11
[141] Ivi
[142] General Assembly, "Convention on the Elimination of All Forms of Discrimination against Women", 2

the real discriminatory factor attached to them is reflected by stigmas and cultural norms surrounding menstruation. Indeed, the topic of menstrual health is frequently followed by embarrassment and prejudice, where the purpose in fighting for substantive equality corresponds with the elimination of those predicaments[143]. As a matter of fact, taboos, societal, cultural and religious beliefs prevent women and girls to manage their menstruation safely, creating a vicious cycle of discriminatory practices, which hamper gender equality and impact menstruators' dignity. As to banish policies and practices that cause direct and indirect discrimination in the field of MHM, article 5(a) of CEDAW requires States Parties to take all appropriate measures "to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women"[144]. In the final analysis, approaching menstrual health through the human rights framework means not only recognizing the distinctive biological characteristics between women and men, but also interpreting the issue in the range of a transformative setting, with the possibility of menstruating individuals to claim their rights and demand accountability.

As previously stated, period poverty and poor menstrual hygiene management compromise a wide array of human rights, in view of the fact that menstrual health is "an important determinant of the realization of all human rights of women and girls in all their diversity, the achievement of gender equality and the Sustainable Development Goals"[145]. In this interpretation, understanding menstrual health and hygiene though the lens of human rights could create opportunities for responsible actors and policy-makers to identify a favorable framework to effectively address the issue and advancing further researches and studies on the topic. The definitive

[143] Khansadhia Afifah Wardana, "Human Rights Framework on Menstrual Health and Hygiene", 142

[144] General Assembly, "Convention on the Elimination of All Forms of Discrimination against Women", 3

[145] High Commissioner for Human Rights, "Panel discussion on menstrual hygiene management, human rights and gender equality", Human Rights Council 50th Session (21 June 2022), accessed 3 August 2022, retrieved from https://www.ohchr.org/en/statements/2022/06/high-commissioner-human-rights-statement-menstrual-health

key for Sates is to approach menstruation by implementing existing international human rights obligations, such as addressing gender-based discriminatory social norms and patterns that impact the menstrual experience of women and girls; building an enabling context in which menstruators in all their diversity are empowered to exercise control over their lives and bodies and guaranteeing them access to justice and effective remedies in case of sexual and reproductive health and rights violations[146].

By reasonable assumption, considering menstrual cycle through the lens of human rights can expose the question at risk of instrumentalization, tokenism and reductionism. In fact, current efforts to address menstruation at the global level tend to promote technical solutions in spite of taking into consideration the impact of stigmatization and stereotypes regarding menstruation on women's human rights. Menstrual products and hygiene interventions are certainly an excellent opportunity for addressing menstruation, but "the barriers many people face are far more complex and cannot be overcome by a piece of cotton or even medical-grade silicone in menstrual cups alone"[147].

In addition, the discourse around menstruation and human right inclines towards tokenism. The practice of making token efforts or symbolic gestures is particularly common in the context of humanitarian emergencies, with the distribution of the so called "dignity kits" composed of toothbrush, toothpaste, comb, reusable menstrual pad set, flashlight, washing powder, sanitary napkins and bath soap. In this case, menstruators are expected to manage, keep clean and exercise proper hygiene secretly, creating expectations and responsibilities which reinforce the idea that menstruation has to be kept hidden[148].

Finally, the use of human rights framing tends also to be reductionist. In the case in which the focal point of policies and interventions regarding menstrual cycle is on the human right to water and sanitation, other connected human rights are

[146] Ivi

[147] Inga T. Winkler, "Menstruation and Human Rights: Can We Move Beyond Instrumentalization, Tokenism, and Reductionism?", *Columbia Journal of Gender and Law* 41, n.1 (2021): 246, accessed 4 August 2022, retrieved from https://journals.library.columbia.edu/index.php/cjgl/article/view/8842/4544

[148] Ivi

considered in a reductionist way. Actually, "some texts address the socio-cultural dimension of menstruation, but consistently present culture as restriction and barrier to the realization of human rights rather than also discussing cultural rights in a positive way"[149].

2.2 Framing Menstrual Health in the context of non-discrimination and gender equality: an overview of CEDAW general recommendations

The following section of this chapter will try to seek synergies between menstrual health, non-discrimination and gender equality in the framework of CEDAW general recommendations. Correspondingly, this analysis is necessary for the purpose of comprehending the actual debate around menstrual hygiene management and its legal and political evolution, contemplating the updating interpretation of norms included in one of the most comprehensive documents on women's human rights, that is the *Convention on the Elimination of All Forms of Discrimination against Women*.

In order to do so, the first part will provide a brief summary of the above-mentioned document, the second passage will focus on the methodology that has been used to identify references to menstruation in CEDAW general recommendations, while the last section will explicitly reveal the encountered allusions.

2.2.1 How CEDAW frames the linkages between the principle of non-discrimination, gender equality and menstrual health

The *Convention on the Elimination of All Forms of Discrimination against Women* was adopted by the United Nations General Assembly on 18 December 1979 and entered into force on 3 September 1981, in accordance with article 27(1) of the treaty. Before the adoption of this international document, several United Nations bodies elaborated many *ad hoc* binding acts according to different specifications on diverse matters, with a main idea represented by a general approach aimed at protecting women rather than empowering them. Under these circumstances, the United Nations Commission on the Status of Women tried to overcome this

[149] Ibid., 247

approach and comprehensively bring to light all the fields in which women suffer from discrimination and are denied equality with men. And even if several statements contained in the document find space also in general treaties on human rights, the need to enclose the rights of women within a new juridical instrument was justified by the pervasive dimension of discrimination against women during the time of its the adoption and the need to reaffirm the principle of equality with men. For these reasons, "the Convention establishes not only an international bill of rights for women, but also an agenda for action by countries to guarantee the enjoyment of those rights"[150]. In its direction, the present document highlights the specificity of women's experience of discrimination, as well as advances a strong form of substantive equality, recalling issues of great importance in the past global political agenda.

The structure of the Convention is based on different parts: Section I focuses on the advancement of women; Section II is concerned with women's rights in political and public life; Section III moves towards the elimination of discrimination against women in education, employment, health, economic and social rights; while Section IV revolves around women's equality before the law, in marriage and in family law. The very last part of the international treaty is devoted to rule the mechanism and the mandate of the Committee on the Elimination of Discrimination against Women, defined in the articles 17 to 30. For the purpose of the present thesis, it is fundamental to mention article 21, which specifies that the Committee "may make suggestions and general recommendations based on the examinations of reports and information received from the States Parties"[151]. To be specific, general recommendations represents authoritative statements that can be employed to elucidate States' report obligations or to remark specific approaches to implement treaty provisions[152]. Under such circumstances, the Committee

[150] Office of the High Commissioner for Human Rights, "Convention on the Elimination of All Forms of Discrimination against Women. New York, 18 December 1979", Human Rights Instruments, Introduction, accessed 4 August 2022, retrieved from https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women

[151] General Assembly, "Convention on the Elimination of All Forms of Discrimination against Women", 8

[152] Centre for Women, Peace and Security, "General Recommendations", Progressing human rights – Accessing justice – Transforming equality, accessed 5 August 2022, retrieved from https://blogs.lse.ac.uk/vaw/int/cedaw/general-recommendations/

continues to play an influential role in updating women's human rights, by interpreting single articles and issues coherent on the contents of the Convention, in parallel with global transformations, such as menstrual hygiene management.

2.2.2 Addressing menstrual issues and updating the interpretation of the Convention through the contribution of CEDAW Committee

With the aim of seeking linkages between menstrual health, non-discrimination and gender equality, a document analysis based on CEDAW general recommendations will be presented. Although these last are not legally binding, but merely address contemporary issues expanding the scope of the present treaty, they carry fundamental legal weight and transmit significant political meanings on human rights matters which require remarkable consideration.

In this case, an electronic search of key words in all CEDAW general recommendations available on the website of the Office of the High Commissioner for Human Rights was conducted. Moreover, the language of the mentions or allusions was subsequently analyzed, in order to explore the extent to which menstrual health and menstrual hygiene management are addressed and considered by the Committee. Key words used in the electronic search were: menstruation, menstrual, menstruating, menses, period, cycle, menopause, reproductive health and sexual health. Next pages will chronologically expose the references to menstruation present in the official documents, and the related articles of the Convention.

General recommendation No. 24 on article 12 of the Convention (women and health) was elaborated in 1999 by the Committee on the Elimination of Discrimination against Women. The above-mentioned instrument tries to enlarge the scope of CEDAW articles related to women and girls' health, by affirming that "it is discriminatory for States party to refuse to provide legally for performance of

certain reproductive health services for women"[153]. From this perspective, member States are called to recognize women's needs and interests in the framework of policies and measures on health care, with a view to properly designate those elements and characteristics that draw a distinction between men and women. Menstrual cycle, sexually transmitted diseases, menopause and women's reproductive function are quoted as biological factors that may negatively affect women or certain groups of women in a different manner from men. Therefore, the section devoted to recommendations for government action exhorts, *inter alia*, States parties to "place a gender perspective at the centre of all policies and programmes affecting women's health and should involve women in the planning, implementation and monitoring of such policies and programmes and in the provision of health services to women"[154], as well as, "require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice"[155].

Nine years later, the 2008 *general recommendation No. 26 on women migrant workers* emphasizes the need to respect, protect and fulfil the human rights of this particular group of women, since they are "entitled to the protection from discrimination on the basis of the Convention, which requires States parties to take all appropriate measures without delay to eliminate all forms of discrimination against women and ensure that they will be able to exercise and enjoy de jure and de factor rights on an equal basis with men in all the fields"[156]. Even though there are no explicit references to menstrual cycle, the section devoted to *Responsibilities specific to countries of origin* recalls to prioritize gender- and right-based information on reproductive health for women migrant workers. At the same time,

[153] Committee on the Elimination of Discrimination against Women, "General recommendation No. 24: Article 12 of the Convention (women and health)", A/54/38/Rev.1, twentieth session (1999), 3, accessed 6 August 2022, retrieved from https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=3&DocTypeID=11

[154] Ibid., 7

[155] Ivi

[156] Committee on the Elimination of Discrimination against Women, "General recommendation No. 26 on women migrant workers", CEDAW/C/2009/WP.1/R, 5 December 2008, 4, accessed 6 August 2022, retrieved from https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=3&DocTypeID=11

article 26(i) on *Responsibilities specific to countries of destination* urges States parties to guarantee "linguistically and culturally appropriate gender-sensitive services for women migrant women"[157] even in the field of health care.

The Committee on the Elimination of Discrimination against women, alarmed by the experiences of multiple forms of discrimination faced by older women, adopted in its forty-second session the 2010 *general recommendation No. 27 on older women and protection of their human rights*. Within this frame of reference, a specific area of concern is represented by access to health care, social services, long-term care and private health insurance. In this case, "post-menopausal, post-reproductive and other age-related and gender-specific physical and mental health conditions and diseases tend to be overlooked by research, academic studies, public policy and service provision"[158], and "information on sexual health and HIV/AIDS is rarely provided in a form that is acceptable, accessible and appropriate for older women"[159]. Recommendations centred around accessible health care systems for older women encourage States parties to adopt comprehensive health-care policies that contemplate women's physical, sexual, post-menopausal, mental and sanitation needs. As reported by the Committee, such programmes should focus particular attention on "women belonging to minorities and women with disabilities, as well as women tasked with caring for grandchildren and other young family dependants due to the migration of young adults, and women caring for family members living with or affected by HIV/AIDS"[160].

Both the 2013 *general recommendation No. 30 on women in conflict prevention, conflict and post-conflict situation* and the 2014 *joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general*

[157] Ibid., 12
[158] Committee on the Elimination of Discrimination against Women, "General recommendation No. 27 on older women and protection of their human rights", CEDAW/C/GC/27, forty-second session (2010), 4, accessed 6 August 2022, retrieved from https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=3&DocTypeID=11
[159] Ivi
[160] Ibid., 8

comment No. 18 of the Committee on the Rights of the Child on harmful practices tackle the issue of sexual reproductive health and rights information.

As for the first, the section dedicated to access to education, employment and health and rural women underscores the inclusion of "psychological support; family planning services, including emergency contraception; maternal health services, including antenatal care, skilled delivery services, prevention of vertical transmission and emergency obstetric care; safe abortion services; post abortion care; prevention and treatment of HIV/AIDS"[161], among others in the context of sexual and reproductive health care.

As for the second, the Committee recognizes that women and girls who have been, or are at risk of being, subjected to harmful practices are remarkably exposed to endangerment of their sexual and reproductive health. Under such circumstances, teachers and health-care providers play a leading role in imparting information and recognizing those practices that can put at risk women and girl's well-being. Moreover, States parties to the Convention are recommended to provide age-appropriate education based on accurate and reliable information on sexual and reproductive health, since it "contributes to empowering girls and women to make informed decisions and claim their rights"[162].

General recommendation No. 34 (2016) on the rights of rural women explicitly mentions the words "menstruating girls" and "menstrual hygiene". The problem of school drop-out and poor school attendance is experienced by a large number of rural adolescent girls worldwide, often affected by "domestic and care work, including cooking, farm work and fetching water and firewood, the long distances

[161] Committee on the Elimination of Discrimination against Women, "General recommendation No. 30 on women in conflict prevention, conflict and post-conflict situation", CEDAW/C/GC730, forty-seventh session (2013), 14, accessed 6 August 2022, retrieved from https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=3&DocTypeID=11

[162] Committee on the Elimination of Discrimination against Women, "Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices", CEDAW/C/GC/31-CRC/C/GC/18, 14 November 2014, 18, accessed 6 August 2022, retrieved from https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=3&DocTypeID=11

to travel to school and the lack of adequate water, toilet facilities and sanitation in schools, which fail to meet the needs of menstruating girls"[163].

In order to expand the scope of article 14 of the Convention, the Committee delineates authoritative interpretations on the content of legal duties assumed by States parties in the field of water, sanitation and energy. In this case, member States are called to ensure that rural women and girls enjoy decent living conditions and have access to fundamental services and public goods, including "adequate sanitation and hygiene, enabling women and girls to manage their menstrual hygiene and have access to sanitary pads"[164].

In year 2017, *general recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19* and *general recommendation No. 36 (2017) on the right of girls and women to education* were adopted.

The first specifies that violations of women's sexual and reproductive health and rights represent forms of gender-based violence. Those infringements may include "forced sterilization, forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and/or post-abortion care, forced continuation of pregnancy and abuse and mistreatment of women and girls seeking sexual and reproductive health information"[165] and can develop into cruel, inhuman or degrading treatment, as well as torture.

The second seeks to address gender-based discrimination in education, alluding to article 10 of the Convention. The Committee recognizes that the right of access to education is threatened by the availability of adequate school infrastructure, mentioning that the onset of menarche can hinder girls' school careers. In addition, "lack of enabling school environment including: inadequate gender segregated

[163] Committee on the Elimination of Discrimination against Women, "General recommendation No. 34 (2016) on the rights of rural women", CEDAW/C/GC/34, 7 March 2016, 12-13, accessed 6 August 2022, retrieved from https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=3&DocTypeID=11

[164] Ibid., 23

[165] Committee on the Elimination of Discrimination against Women, "General recommendation No. 35 on gender-based violence against women, updating general recommendation No. 19", CEDAW/C/GC/35, 26 July 2017, 7, accessed 6 August 2022, retrieved from https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=3&DocTypeID=11

water, sanitation and hygiene (WASH) facilities, untrained or unsupportive staff, lack of appropriate sanitary protection materials and lack of information on puberty and menstrual issues, contribute to social exclusion, reduced participation in and focus on learning, and decreased school attendance"[166].

According to the *general recommendation No. 37 (2018) on the gender-related dimensions of disaster risk reduction in the context of climate change*, the term "menstrual hygiene management" falls within the scope of article 12 of the Convention on the Elimination of All Forms of Discrimination against Women. It is recognized that climate change disproportionately affects women and girls, in view of the fact that they are more likely to be exposed to disaster-induced risks. As a matter of fact, gender inequalities are denoted as one of the main determinants accounting for the distinguished impacts of climate change. The obligations of States parties to successfully mitigate the effects of climate change are associated with various CEDAW cross-cutting and right-based general principles, such as equality and non-discrimination, participation and empowerment, accountability and access to justice. In particular, for the purpose of providing health-care services, as well sexual and reproductive health services and mental and psychological health services, States parties are recommended to abolish discriminatory practices and advance a strong form of women's substantive equality. Based on these premises, the Committee requests member States to "invest in climate- and disaster-resilient health systems and services and allocate the maximum of their available resources to the underlying determinants of health, such as clean water, adequate nutrition and sanitation facilities and menstrual hygiene management"[167]. This commitment should be intended for "transforming health systems so that they are responsive to

[166] Committee on the Elimination of Discrimination against Women, "General recommendation No. 36 (2017) on the right of girls and women to education", CEDAW/C/GC/36, 16 November 2017, 7, accessed 6 August 2022, retrieved from https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=3&DocTypeID=11

[167] Committee on the Elimination of Discrimination against Women, "General recommendation No. 37 (2018) on the gender-related dimensions of disaster risk reduction in the context of climate change", CEDAW/C/GC/37, 13 March 2018, 20, accessed 7 August 2022, retrieved from https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=3&DocTypeID=11

the changing health-care needs arising from climate change and disasters and sufficiently resilient to cope with those new demands"[168].

In the final analysis, the *joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the rights of the Child (2019) on harmful practices* is examined. Despite the fact that there are no clear references to menstruation, the section focused on the empowerment of women and girls replicates objectives and scope of the joint general recommendation/general comment on harmful practices that was initially adopted in 2014. As already mentioned, women and girls that experience or are at risk of being subjected to harmful practices meet several negative consequences to their sexual and reproductive health, "in particular in a context where they already encounter barriers to decision-making on such issues arising from lack of adequate information and services, including adolescent-friendly services"[169]. Women and adolescent girls should be granted accessibility to accurate and reliable information about sexual and reproductive health and rights, along with availability of satisfactory and confidential services. As a consequence, the Committee on the Elimination of Discrimination against women and the Committee on the Rights of the Child recommend States parties to the Conventions to "ensure that schools provide age-appropriate information on sexual and reproductive health and rights, including in relation to gender relations and responsible sexual behavior, HIV prevention, nutrition and protection from violence and harmful practices"[170].

To conclude, a final consideration regarding the work of the independent experts that monitor the implementation of the Convention can be made. From this

[168] Ivi
[169] Committee on the Elimination of Discrimination against Women, "Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the rights of the Child (2019) on harmful practices", CEDAW/C/GC/31/Rev.1-CRC/C/GC/18/Rev.1, 8 May 2019, 15, accessed 7 August 2022, retrieved from https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=3&DocTypeID=11
[170] Ibid., 16

perspective, the Committee's approach towards menstruation has developed over the years following two main directions. On the one hand, several analyzed general recommendations show a clear reference to menstrual issues in the context of articles 12 (right to health), 10 (right to education) and 14 (right of rural women) of the international treaty. On the other hand, the topic is mentioned from the viewpoint of sexual and reproductive health and rights, when referring to women migrant workers, conflict prevention and post-conflict situation, elimination of harmful practices and gender-based violence against women.

The document analysis demonstrates that menstrual cycle is quoted in a limited way. Moreover, it is crucial to consider that all the above-mentioned documents come within the ambit of CEDAW's main objective, that is the elimination of discrimination against women. With the aim of broadening the scope of application of menstrual health and extending it beyond the context of non-discrimination, it would be critical to explore other strategies and different alternatives to mainstream the question.

2.3 Framing Menstrual Health in the context of Water, Sanitation and Hygiene

As previously described, WASH is an acronym that corresponds to the interdepended areas of Water, Sanitation and Hygiene. With respect to the first element, access to adequate water supply and availability of safe drinking water represent the two core components. Sanitation comprises, instead, "clean toilets; access and practice of basic latrines and techniques to distinct human waste from interaction with people; management of water and waste material; clean household/environment"[171], in an effort to eradicate the exercise of open defecation. While the term hygiene includes personal health, washing with soap, food security and, just as importantly, menstrual hygiene. To be specific, challenges for providing WASH services can negatively impact women and girls, especially when there is a lack of adequate sanitation facilities and they cannot meet their hygiene and privacy needs connected with pregnancy and menstruation. Under these conditions,

[171] Kusum Wagle, "What is WASH (Water, Sanitation and Hygiene)?", Public Health Notes, accessed 8 August 2022, retrieved from https://www.publichealthnotes.com/what-is-wash-water-sanitation-and-hygiene/

international human rights law requires States to engage in achieving universal access to water and sanitation for all, being guided by five main principles: availability, accessibility, affordability, quality and safety, and acceptability. On these facts, water and sanitation facilities must be sufficient and continuous to cover personal and domestic use, physically accessible, affordable to all, hygienically safe, culturally acceptable, appropriate and sensitive to gender, life-cycle and privacy requirements[172].

The most comprehensive response to the issue of menstrual health and menstrual hygiene management based on WASH standards is incorporated into the 2019 *Guidance on Menstrual Health and Hygiene*. The document was formulated with the joint effort of UNICEF WASH, Education, Health and Gender specialists, being guided by the priorities disclosed in other UNICEF's publications, such as *Strategy for WASH 2016-2030*, *Strategic Plan 2018-2021* and *Gender Action Plan 2018-2021*. It predominantly emphasizes the process to support government in designing MHH programmes and developing a theory of change, with the objective to strengthen national systems. Moreover, the Guidance is divided into five sections, named *A global opportunity*; *Programme design*; *Core package of interventions*; *MHH for girls and women in vulnerable situations*; *Learning, monitoring, reporting and evaluation*.

For the purpose of this research, UNICEF's guiding principles aimed at achieving safe and dignified menstruation for all women and girls are examined. According to the document, MHH programmes are required to be gender-equal, government-led, evidence-based, evidence-generating, at scale, inclusive and collaborative, developing technical capacity. At this time, two are the major focal points: identifying a situation analysis and elaborating a theory of change. The first step consists in determining the problem that the intervention aspires to address, the causes and the consequences of the matter, opportunities and synergies with other initiatives, in an effort to develop a shared understanding of the issue with decision-

[172] Office of the High Commissioner for Human Rights, "About water and sanitation", OHCHR and the right to water and sanitation, accessed 8 August 2022, retrieved from https://www.ohchr.org/en/water-and-sanitation/about-water-and-sanitation

makers and actors who can affect women and girls' lives[173]. The second step is devoted to establish a theory of change (TOC), which explains "how activities are understood to produce a series of results that contribute to achieving the final intended impacts"[174]. In general terms, the TOC should begin with an appropriate situation analysis and then proceed with the individuation of the problem and associated outputs, outcomes and impacts. Specifically, UNICEF has produced a TOC for MHH programmes, based on five grades: inputs/activities; short-term changes; medium-term changes and ultimate goals. The very first phase encompasses "coordination, advocacy and awareness raising; knowledge generation and learning; integration of MHH into strategies, guidelines, standards; training and technical assistance to develop capacity; social mobilization and community dialogue; teaching and learning on MHH in formal and non-formal education and health programmes; provision and operation/maintenance of MHH-responsive WASH facilities; facilitation of access to menstrual materials and pain relief, directly or via market"[175]. Short- and medium-term transformations involve various areas of intervention, such as the education and health systems, public discourse and political arena. According to the Guidance, it is crucial to strengthen an improved enabling environment nationally and globally, guarantee political commitment, resources and knowledge to invest in MHH, include boys and men in supporting women and girls and empower them to manage their menstruation in dignity at home and away from the household[176]. The final results correspond to the fulfillment of gender equality, accompanied by "objectively verifiable indicators of achievement, sources and means of verification and assumptions"[177].

2.3.1 Limitations and barriers: an opportunity for scaling up

Although the above-mentioned Guidance represents one of the most exhaustive responses to poor MHM globally, evidence shows that, on average, WASH

[173] UNICEF, "Guidance on menstrual health and hygiene", 25
[174] Patricia Rogers, "Theory of Change", Methodological Briefs – Impact evaluation No. 2, 1, accessed 9 August 2022, retrieved from https://www.unicef-irc.org/publications/pdf/brief_2_theoryofchange_eng.pdf
[175] UNICEF, "Guidance on menstrual health and hygiene", 30
[176] Ivi
[177] Ibid., 31

schemes address mainly short-term interventions. This tendency prioritizes the implementation of practical solution and limits the possibility for cultural change. In actual facts, only few examples have demonstrated a successful implementation of WASH strategies towards MHM, owing to the fact that they accomplish a mere sanitation mission and do not guarantee transformational outcomes. Moreover, findings indicate that lack of awareness among policymakers and development practitioners about the issue has signified that menstrual health and menstrual hygiene management are not prioritized in either the supply of or the demand for WASH services[178]. To be effective, WASH programmes have to tackle gender inequalities through female empowerment and challenge the existent gendered perceptions regarding roles and responsibilities held by both women and men in the field of water, sanitation and hygiene, integrating these approaches into mainstream effective policies and programmes[179].

Based on these assumptions, it should be noted that there exist practical opportunities for joint action to holistically address menstrual health by intersecting WASH programmes with the framework of SRHR. In exploring the convergence between the two sectors, grey literature on menstrual health reveals common challenges and similar outcomes that create a window of opportunity for integrated programming. In this sense, shared goals incorporate educating young people on taboo topics; ensure access to essential services; support girls' school attendance; and enhance health outcomes[180]. While shared obstacles comprehend challenges in shifting gender and social norms and attitudes; difficulties in involving men and boys on specific topic following a gender-sensitive approach; and a necessity to contact girls out of school, along with those with disabilities and other marginalized and vulnerable groups[181].

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[178] Thérèse Mahon et al., "Menstrual hygiene in South Asia: a neglected issue for WASH (water, sanitation and hygiene) programmes", *Gender and Development* 18, n. 1 (2010): 111, accessed 9 August 2022, retrieved from https://www.tandfonline.com/doi/full/10.1080/13552071003600083

[179] Ivi

[180] WaterAid et al., "Integrating Menstrual Health, Water, Sanitation and Hygiene, and Sexual and Reproductive Health in Asia and the Pacific Region", A Discussion Paper – WaterAid and Marie Stopes International Australia, 14, accessed 9 August 2022, retrieved from https://washmatters.wateraid.org/publications/integrated-approaches-to-menstrual-health-in-asia-and-the-pacific

[181] Ivi

WASH and SRHR actors can jointly play a leading role in creating opportunities for cross-sectional and integrated solutions, whose point of convergence resides in age-appropriate education and community awareness of menstrual health. By normalizing taboo topics and informing adolescent boys and girls, as well as women and men on menstrual health and sexual and reproductive rights, the debate around menstruation could be promoted beyond a simple public health issue, revising social and religious norms, gender attitudes and overcoming stereotypes. From this perspective, "identifying cross-sectional opportunities to provide intergenerational, gender transformative MHM and SRH education should therefore be a key strategy in future efforts to improve menstrual health"[182].

[182] Ibid., 15

CHAPTER III: Towards possible solutions. Existing menstrual-related concerns and current schemes to manage them

The aim of this third chapter is to define women and girls' gendered experiences of menstruation in India and assess the major impediments in the realization of good menstrual hygiene management practices. The identified obstacles will be circumscribed according to three main sections, namely lack of awareness; lack of menstrual products and lack of sanitary facilities. To do so, various studies and research articles on the matter will be analyzed and taken into account, such as *Women's and girls' experiences of menstruation in low- and middle-income countries: A systematic review and qualitative metasynthesis*; *Menstrual Health in India | Landscape Analysis* sponsored by the Bill and Melinda Gates Foundation; *Perceptions of Indian women regarding menstruation* from the International Journal of Gynecology and Obstetrics and *Exploring young women's menstruation-related challenges in Uttar Pradesh, India, using the socio-ecological framework*. The second part of the chapter enters into the merits of the Government of India's programmes and initiatives aimed at supporting menstrual hygiene management in the current legal framework. For this purpose, efforts from the Ministry of Health and Family Welfare (MoHFW), Ministry of Drinking Water and Sanitation (MoDWS), Ministry of Women and Child Development (MoWCD) and Ministry of Human Resource Development (MoHRD) will be considered. This review will predominantly cover GoI's contributions, whose beneficiary group is represented by adolescent schoolgirls.

3.1 Discrimination against women and girls in India: challenges and customary beliefs as regards menstrual cycle

Gender inequality can be regarded as one of the most pressing issues in Indian society, impacting women and girls' education, health, workforce and political participation. In the concrete, according to the World Economic Forum's Global Gender Gap Report 2022, India ranks 135 among a total of 146 examined countries, with the lowest position in the world as per the sub-index named "health and

survival" (sex ratio at birth and health life expectancy). The Global Gender Gap Index examinates as well three other dimensions, including "political empowerment" (percentage of women in parliament and ministerial positions); "economic participation and opportunity" (percentage of women in labour force, wage equality for equivalent work, earned income) and "educational attainment" (literacy rate, enrolment rates in primary, secondary and tertiary education). With respect to the first sub-index, the country ranks 48 out of 146, as for the second it is classified 143 even though its score has improved over 2021 from 0.326 to 0.350 and concerning the third, India ranks 107 with its point marginally worsened since last year[183]. Even if the condition of gender inequality diverges across states, regions and districts, evidence shows that discriminatory gendered social norms are deeply rooted among Indian society, impacting women and girls' human rights and fundamental freedoms. Gender-based discrimination across the country creates a chain reaction in which women and girls accept persistent discriminatory practices in the name of tradition and societal norms, facing this way significant obstacles to a comfortable and dignified experiences with menstrual hygiene management. In order to address the barriers of safely managing menstruation in India, this thesis aspires to better understand young women's experiences with menstrual cycle and connected challenges by distinguishing three main areas of concern. Accordingly, the following pages will concentrate on education and awareness, menstrual products and sanitary materials and sanitation and disposal infrastructure.

3.1.1 Women and girls' awareness about menstruation. How religious restrictions, cultural taboos and traditional customs affect Menstrual Hygiene Management practices

Exploring young women's menstruation-related challenges in Uttar Pradesh, India, using the socio-ecological framework exemplifies an appropriate starting point with the aim of approaching problems associated with menarche and menstrual cycle among adolescent girls living in the slums of Lucknow, Uttar Pradesh. This example focuses on individual, social and systemic challenges

[183] Social Justice, "Global Gender Gap Index 2022", accessed 12 August 2022, retrieved from https://www.drishtiias.com/daily-updates/daily-news-analysis/global-gender-gap-index-2022

experienced by young women in a highly-inequitable Indian state. Uttar Pradesh is home to 19.3% of all Indian adolescents from 10 to 19 years, representing the lowest quintile of all country's states as to girls' enrolment in secondary school, with only the 16% of women accounting for the working population, again close to the lowest percentages of all Indian states[184]. Since the above-mentioned research article incorporates results that are congruous with findings from other areas of India, it can be employed as valuable model for the purpose of the present thesis.

Life course interviews reveal important gaps regarding knowledge and awareness about menstruation. In fact, a small number of participants gave an account on learning or hearing anything about menstrual cycle prior to menarche, while most of them reported no knowledge of the matter before they started menstruating[185]. Potential types of information, guidance and suggestions following the onset of menstruation originates from teachers and female relatives. Once it occurred, a large number of young women encountered misinformation and misconception about the issue. The most common described misjudgment was that eating particular foods would increase menstrual pain or flow, whereas others focused on touching certain objects, washing and grooming and being at risk of harming others or themselves while menstruating[186].

Moreover, participants disclosed limited discussions of menstruation among mother, friends and female teacher, as well as limitations on mobility and interaction during menstrual cycle. In this case, "participants did not typically report knowing the reason for prohibitions against speaking about menstruation to certain groups of people, although a few participants were advised that speaking to a socially inappropriate person might be source of embarrassment and shame for both parties"[187]. The institutional-level challenges concern instead shame and embarrassment attached to a lack of normalization of menstruation in schools. Indeed, teachers' unawareness, inappropriate sanitary infrastructures and unhygienic toilets are key elements that perpetuate the stigmatization of menstruation.

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[184] Ellen McCammon et al., "Exploring young women's menstruation-related challenges in Uttar Pradesh, India, using the socio-ecological framework", 292
[185] Ibid., 293
[186] Ibid., 294
[187] Ibid., 295

With that being said, it should be pointed out that more than a natural process of the reproductive cycle, menstruation has economic, psychological, social and religious implications. In fact, women and girls' perceptions of menstrual cycle may vary from culture to culture, country to country, religion to religion, according to age, social class, education and professional status[188]. This reality obfuscates education on puberty and menstruation, as well as knowledge about the physiology of menstrual cycle.

It is common that in both in-school and out-of-school programming, interventions focus more on MHM in practical terms (e.g., product use), rather than biological aspects or psycho-social changes, since the issue is closely associated to reproductive health and consequently considered a taboo subject in India, in conjunction with sex education[189]. Being unaware of menstruation until the day of menarche or uniformed about what is normal and abnormal during the menstrual cycle means tolerating dysfunctions and infections as an ordinary feature of the monthly period. Several studies notify that delayed menarche, excessive bleeding and irregular periods, along with other serious menstrual problems are rarely reported. In practical terms, "under-reporting leads to under-diagnosis of serious conditions, which if untreated may have significant effects on both the reproductive health and productivity of women"[190].

As already indicated, adolescent girls across India have limited knowledge and awareness about menstruation prior to reaching menarche. Perceiving the topic as something dirty and impure does not only mean accepting health disorders, but also making it difficult to obtain accurate information and seek support. As a matter of facts, qualitative studies of women and girls' experiences of menstrual cycle in low

[188] R. Bhatt et al., "Perceptions of Indian women regarding menstruation", *International Journal of Gynecology and Obstetrics* 88, n. 2 (2005): 164, accessed 13 August 2022, retrieved from https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1016/j.ijgo.2004.10.008

[189] FSG Reimagining Social Change, "Menstrual Health in India | Country Landscape Analysis", 8, accessed 13 August 2022, retrieved from https://menstrualhygieneday.org/wp-content/uploads/2016/04/FSG-Menstrual-Health-Landscape_India.pdf

[190] United States Agency for International Development et al., "Spot On! Improving Menstrual Health and Hygiene in India", 14, accessed 13 August 2022, retrieved from https://www.dasra.org/resource/improving-menstrual-health-and-hygiene

and middle-income countries reveal great deficits in knowledge and coexisting requirements for practical information in managing menses and handling pain. According to *Women's and girls' experiences of menstruation in low- and middle-income countries: A systematic review and qualitative metasynthesis*, pragmatic understanding about the topic can influence practices undertaken as well as menstruators' perceptions of their practices, without a clear recognition of what is required for "hygiene" causing concern[191]. In these settings, mothers are identified as the most frequent information source and first contact to learn about how to manage menstrual hygiene. Manifestation of mother-daughter communication is context dependent, with individuals' access to support sources diverging more in compliance with personal circumstances than country[192]. Other female family members and female peers are cited as source of advice, but several studies reported that they are usually uninformed and not necessarily well-appointed to fill gaps in menstruators' education and knowledge. In fact, ill-informed sources of information at home move towards reinforcing stigma, misconceptions and negative beliefs. But the lack of awareness transcends family members and pertains also teachers and frontline health workers. As for the first category, evidence shows that schoolgirls from low- and middle-income contexts encounter difficulties to discuss the topic of menstruation in classroom settings, feeling more comfortable with female than male teachers. Adolescent menstruators reveal that teachers generally provide mixed support during menstruation, with some of them being sensitive to girls' needs in providing information or assistance (such as emergency supplies), while others appearing uncomfortable or punitive if girls soiled themselves at school[193]. As for the second category, several studies demonstrate that healthcare providers represent only a small percentage of providers of menstrual information. In fact, according to Chandra-Mouli and Patel's review, less than 1.0% of girls in rural areas of India reported having acquired knowledge

[191] Julie Hennegan et al., "Women's and girl's experiences of menstruation in low- and middle-income countries: A systematic review and qualitative metasynthesis*",* 20
[192] Ibid., 21
[193] Ivi

regarding menstrual cycle from health professionals[194]. The information provided to women and girls by nurses or community health workers results not always timely nor adequate, and does not properly respond to menstruators' needs.
In a few instances, mass media, such as television, magazines, book, radio, newspaper and the Internet constitute the only source available to girls or supplements to other sources of information[195].

In the final analysis, lack of awareness about menarche and menstruation reinforces and perpetuates cultural restrictions within the country, in accordance with social, religious and also family expectations. This tendency directly impacts women and girls' social participation, restricting their possibilities to interact with others, take part to religious functions and even touch or cook food. Social limitations frequently reported in India regard the complete abstinence of religious activities, missing school and avoiding sports. Daily activities are also limited within the household: menstruating girls in India are occasionally not allowed to enter kitchens or bedrooms to ensure that menstrual blood does not contaminate food or others; cooking is sometimes forbidden and female students from rural and urban settings reported restrictions on who they could touch while menstruating[196].

The above-mentioned behavioral expectations disproportionately affect menstruators' health and management practices. Such beliefs can be translated also into negative reactions to girls' first period. On this account, menarche is often conceived as a traumatic and shocking event for young girls in most parts of India and many of them cry upon seeing their blood[197]. These patterns affecting Indian adolescent girls are stronger in rural areas and influence women's behavior in the future. However, the psychological dimension of menstrual-related experiences

[194] Venkatraman Chandra-Mouli et al., "Mapping the knowledge and understanding of menarche, menstrual hygiene and menstrual health among adolescent girls in low- and middle-income countries", *Reproductive Health* 14, n. 30 (2017): 4, accessed 17 August 2022, retrieved from https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0293-6
[195] Ivi
[196] Ibid., 9
[197] K.A. Narayan, "Puberty Rituals, Reproductive Knowledge and Health of Adolescent Schoolgirls in South India", *Asia-Pacific Population Journal* 16, n.2 (2001): 230, accessed 18 August 2022, retrieved from https://www.un-ilibrary.org/content/journals/15644278/16/2/27/read

remains to be exhaustively investigated, in view of the fact that mental repercussions (such as anxiety, depression and feelings of powerlessness) extend beyond the immediate menstrual phenomenon, affecting women's lives in a broad sense. The internalization of menstrual stigma and restrictions is directly connected with internally and externally enforced behavioral expectations and strongly constrained by unawareness of menstrual hygiene and associated healthcare practices. This reality impacts confidence to engage in other activities during menses and implement experiences of shame since a failure to hide menstruation is perceived as a personal defeat to maintain feminine standards or menstrual etiquette[198].

3.1.2 Lack of access to menstrual products: disposal and alterative use of sanitary materials in urban and rural India

As to understand the lack of regular access to safe menstrual materials by Indian women and girls, it is firstly appropriate to provide an overview of the options used to catch menstrual blood.

UNICEF *Guidance on Menstrual Health and Hygiene* delineates five types of sanitary materials, including menstrual cloth; reusable pad; disposable pad; menstrual cup and tampon. The first relies on privacy, clean water, soap and time to wash and dry but is reusable and affordable; the second can be home-made or produced locally; the third depends on disposable systems and access to market but is widely available and recommended by many menstruators; while the fourth and the fifth are both hindered by cultural taboos surrounding insertion and virginity and only available in some countries[199]. Undoubtedly, the availability of menstrual materials may change on the basis of geographic areas or income levels, in conjunction with individual preferences which are extremely personal. As a general rule, menstruating individuals from LMICs use cloths to absorb menstrual flow but these are "usually not purchased specifically for menstrual hygiene purposes, but rather cut from old pieces of clothing or other materials in the household"[200]. This

[198] Julie Hennegan et al., "Women's and girl's experiences of menstruation in low- and middle-income countries: A systematic review and qualitative metasynthesis*",* 22
[199] UNICEF, "Guidance on menstrual health and hygiene", 59
[200] Ivi

tendency is sustained by the fact that reusable pads or tampons are mostly supplied though the market and, as a consequence, are less extensively accessible for purchase in those countries. Furthermore, "other, less common materials usually confined to high-income countries include absorbent underwear and sponges"[201]. Given these premises, it is possible to notice that women and girls from LMICs adapt to the lack of regular access to safe menstrual materials and experience inadequate standards for sanitary options. Additionally, "this lack of access is due to a series of systematic barriers that prevent them from having control of resources at the household and community levels, and from having a voice in the allocation of state resources"[202].

The issue of unaffordability of menstrual materials differs in India from rural to urban areas. For women and girls living in villages it is common practice to make use of homemade, unsanitary and unsterilized menstrual materials. In some cases, rural menstruators do not even use sanitary products and end up bleeding on clothes they are wearing. When not using underwear, women and girls in rural India resort to makeshift methods to hold the material in place: in poorest regions menstruators fill old socks with sand and tie them around their waists to absorb the blood[203]. Limited knowledge of hygienic alternatives to menstrual cloth results in sharing the same product among female family members, using unclean pieces of cloth and utilizing them for a long period of time, usually for over a year. This tendency increases the possibility to contract menstruation-related diseases, since unhygienic period practices can have serious consequences on the health of women and girls, causing for instance hepatitis B infection, urinary tract infection, cervical cancer and reproductive tract infection. Indeed, menstruating individuals from low- and middle-income countries experience "genital discomfort, irritation, rashes, and bruising during menses stemming from the properties of menstrual materials or inadequate frequency of change"[204], taking actions to assure that other people

[201] Ivi
[202] Ivi
[203] United States Agency for International Development et al., "Spot On! Improving Menstrual Health and Hygiene in India", 16
[204] Julie Hennegan et al., "Women's and girl's experiences of menstruation in low- and middle-income countries: A systematic review and qualitative metasynthesis", 28

cannot "see or access their disposed menstrual blood such as washing materials prior to disposal, eschewing single-use disposable sanitary pads, or wrapping used absorbents to prevent detection"[205].

With the aim of providing a numerical assessment regarding the use of hygienic methods of protection during menstrual period among Indian menstruators, it is fundamental to explore the *2019-21 National Family Health Survey (NFHS-5)* released by GoI Ministry of Health and Family Welfare.

The document examines what kind of methods are used by women aged 15-24 during menses, defining menstrual protection as "women who use locally prepared napkins, sanitary napkins, menstrual cups, or tampons during their menstrual period"[206]. The survey reveals that, as years go by, the percentage of women in the above-mentioned age group using hygienic method of menstrual protection is increasing. In the country, 78 percent of adolescents utilize menstrual materials: 64 percent use sanitary napkins, 50 percent use cloth and 15 percent use locally prepared napkins[207]. As it is possible to observe from the data, the increasing education level corresponds with the considerably growing number of menstruators that use menstrual materials. In fact, "women with 12 or more years of schooling are more than twice as likely to be using a hygienic method as women with no schooling (90% versus 44%)"[208]. In addition, there exists a noticeable variation between girls living in different income levels, as well as menstruators residing in rural or urban India. Actually, evidence shows that "women in the highest wealth quintile are almost twice as likely to use a hygienic method as women in the lowest wealth quintile (95% versus 54%)"[209] and "seventy-three percent of rural women use a hygienic method of menstrual protection, compared with 90 percent of urban women"[210]. The poor socio-economic conditions of rural families represent an

[205] Ibid., 21
[206] Government of India Ministry of Health and Family Welfare, "National Family Health Survey (NFHS-5), 2019-21", India Report, International Institute for Population Sciences Deonar, Mumbai-400088, 115, accessed 22 August 2022, retrieved from https://dhsprogram.com/pubs/pdf/FR375/FR375.pdf
[207] Ivi
[208] Ivi
[209] Ivi
[210] Ivi

influencing factor about the choice of sanitary protection methods used by women aged 15-24. Cloth remains the cheapest material employed for protection during menstruation by women living in slums. Moreover, all kinds of ragged, old and rejected clothes are used by the majority of women that reside in poorest areas, as long as the main reasons for using homemade materials are the inability to buy readymade sanitary napkins and the lack of their availability in those regions[211].

Recent investigations disclose an increasing awareness about menstrual hygiene among Indian women, which is supported by a demand for sanitary napkins. Thanks to the impact of awareness campaigns organized by NGOs, multinational companies and central government, low-cost disposable sanitary pads are slowly entering the market space. Over the past few years, small-scale private enterprises have been engaging in implementing a decentralized model to develop low-cost manufacturing machines and distributing them to Self-Help Groups or NGOs in order to produce and sell menstrual products locally and offer livelihood opportunities for women[212]. In particular, the inclusion of underprivileged and rural women in workforce is directly proportional to an expanding usage of disposable sanitary pads, growing purchasing power and increasing roles in decision-making positions.

At present, disposable pads represent the most popular product type in India, while insertable products (such as tampons and menstrual cups) are contemplated as a high barrier product, mainly due to societal misconceptions and lack of acceptability. In practical terms, community norms constitute a critical factor that hamper a regular use of preferred MHM products. Similarly, scarce knowledge of products and their use (understand the pros and cons of different products, including how to hygienically use them); high prices (access to funds regularly to purchase preferred products) and poor access (freedom of mobility to travel to markets where

[211] Harshad Thakur et al., "Knowledge, practices, and restrictions related to menstruation among young women from low socioeconomic community in Mumbai, India", *Frontiers in Public Health* 2, n. 72 (2014): 5, accessed 22 August 2022, retrieved from https://www.frontiersin.org/articles/10.3389/fpubh.2014.00072/full

[212] FSG Reimagining Social Change, "Menstrual Health in India | Country Landscape Analysis", 11

products are sold) are the most significant challenges facing Indian women and girls in the context of appropriate and consistent use of MHM products[213].

In recent times, the environmental impact about the increasing share of disposable sanitary pads is as well taken into consideration. Since the growing demand and supply of disposable sanitary materials advance environmental concerns, recent debates around appropriate and sustainable MHM solutions are emerging. Even though there have been some early attempts to promote innovative menstrual products (for example bio-degradable pads made out of locally grown material and re-usable cloth pads), these goods present a high up-front cost and are not available at scale[214]. Despite innovative methods to address the question of last mile distribution of sanitary pads and endeavors to limit ecological consequences, these efforts have been largely unsuccessful. There emerges a need to better explore the work of Self-Help Groups in manufacturing affordable pads and evaluate other possible interventions that can holistically provide access to preferred products at scale[215].

3.1.3 Inadequate water, sanitation and hygiene facilities as a barrier for appropriate Menstrual Hygiene Management practices

The lack of sanitary facilities corresponds as well to one of the major impediments in the realization of good menstrual hygiene management practices. In actual fact, the absence or presence of inadequate facilities disproportionately affects women and girls in case of urination, defecation and menstruation. According to UN Women, sanitation needs are gendered, requiring an explicitly gendered solution, since the lack of access to dignified sanitation impacts women differently than men, due to different requirements for personal security, modesty and incommensurate burden of unpaid labour[216]. In this framework, social and cultural variables culminate in experiences of humiliation faced by menstruators when defecating,

[213] Ibid., 12
[214] Ibid., 13
[215] Ivi
[216] UN Women, "Towards gender equality through sanitation access", Discussion Paper, 24, accessed 23 August 2022, retrieved from https://www.unwomen.org/en/digital-library/publications/2016/3/towards-gender-equality-through-sanitation-access

urinating or managing menstrual cycle in public. This reality strongly affects women and girls' safety, because they are often forced to reach toilets and sanitary infrastructures outside their community, leaving them exposed to verbal and physical assaults, sexual harassment, rape and other forms of violence. For these reasons, safe sanitation constitutes an opportunity to advance human dignity, human health and gender equality. In fact, "meeting public health goals and human rights goals are not competitive pursuits: they are synergistic efforts and vital parts of any well-functioning sanitation system"[217].

The issue of sanitation insecurity in India is marginally associated with women's biology, but robustly related to gender inequality. Even though the availability and characteristics of infrastructures vary across regions, households, schools, work places and public areas, there exist some common features regarding the limited access to functioning toilets within the country. The absence of sanitation facilities and safe spaces outside the home impedes women and girls in undertaking a range of menstrual tasks, for instance changing menstrual materials, washing and drying menstrual materials and cleaning their hands and bodies[218]. Moreover, menstrual practices and associated disposal choices are affected by additional elements, such as availability of soap and water, presence of locks on doors and gender-separate latrines, accessibility of bins, incinerators and community waste disposals. This set of circumstances is exacerbated by cultural practices, hygiene routines and community attitudes about toilet access and MHM methods. In fact, social norms and misconceptions associated with menstrual cycle inhibit women and girls from using toilets and disposal mechanisms appropriately, often preventing them from discarding menstrual products in dustbins due to the fear of being noticed having menstruation[219]. Sanitary waste disposal has become an expanding problem in India, leading to negative health and environmental consequences. Common practices for collecting and removal of menstrual waste may vary from burying

[217] Ivi
[218] Julie Hennegan et al., "Women's and girl's experiences of menstruation in low- and middle-income countries: A systematic review and qualitative metasynthesis*",* 22
[219] FSG Reimagining Social Change, "Menstrual Health in India | Country Landscape Analysis", 15

sanitary pads in the ground or burning them one after another or altogether after a menstrual cycle and throwing them into fields and on rooftops[220].

This issue immediately raises the question of sustainable waste management of menstrual products because small scale incineration in India do not appeal to effective emission control measures and solid waste interventions for sanitary waste are only implemented in urban settings. In addition, "there are instances where incinerators do not reach the appropriate 900 degrees and thus do not process menstrual waste properly, or incinerators are too large and it is not efficient to burn the pads until the incinerator is full"[221]. Within this framework, current system level efforts to address the problem and forward-looking environmental legislations have achieved scarce outcomes. Recent actions do not consider the health of waste management workers nor menstruators' needs and the gendered differences between sanitation infrastructures available for men and women. Indeed, "interventions to improve community attitudes and practices around access to sanitation as it relates to menstruation needs to be addressed in a more targeted way"[222]. The design of infrastructures and the planning of projects must be women- and girls-friendly, explicitly incorporating biological and social needs of menstruating individuals, as well as contemplating the question of convenience, privacy and safety.

In terms of bathing practices during menstrual period, some positive trends become visible. Increasing the access to private household latrines can undoubtedly culminate in better MHM practices, as confirmed by governmental investigations. According to the *2019-21 National Family Health Survey (NFHS-5)*, bathing practices during menstrual period coincide with "percentage of women who take a bath during their menstrual period, and take a bath in the same bathroom used by other household members"[223]. For the purpose of this research, menstrual conducts of women and adolescents aged 15-49 who had a menstrual period in the six months

[220] Ivi
[221] Ivi
[222] Ibid., 16
[223] Government of India Ministry of Health and Family Welfare, "National Family Health Survey (NFHS-5), 2019-21", 116

before the analysis are taken into consideration. In general terms, "96 percent of women in urban areas and 91 percent of women in rural areas take a bath during their menstrual period in the same bathroom where other household members take a bath". In a similar fashion, this study demonstrates that increasing education level corresponds with the considerably growing number of menstruators that perform bathing practices. In fact, "women with 12 or more years of schooling are more likely (97%) to take a bath during their menstrual period than women with no schooling (94%)"[224]. As demonstrated in the previous paragraph, there still exists an evident divergence between girls living in different income levels, as well as menstruators residing in rural or urban India. In this case, "ninety-seven percent of women from the highest wealth quintile take a bath during their menstrual period in the same bathroom where other household members take a bath, compared with 85 percent of women in the lowest wealth quintile"[225].

Despite these encouraging tendencies, 355 million menstruators lack access to toilets and 63 million young women live in households without sanitary facilities among the country. In the absence of household toilets, recent studies report that women and girls from rural areas tend to manage their menstrual cycle for the most part in open fields and bathe in ponds. Likewise, when the access to water is limited both in rural zones and urban slums, menstruators experience complications in washing reusable sanitary products. The situation is aggravated in some communities since women and girls are not allowed to use water sources during menstrual cycle and have to stay away from flowing water[226]. Challenges related to sanitation and menstrual health extend beyond private access to facilities, impacting the school context as well. As such, "in 2012, 40% of all government schools lacked a functioning common toilet, and another 40% lacked a separate toilet for girls"[227]. In this regard, girls avoid changing menstrual products at school in view of the fact that they feel embarrassed to share common spaces with boys and are afraid of being identified as menstruators. Moreover, "while 60% of schools have a separate

[224] Ivi
[225] Ivi
[226] United States Agency for International Development et al., "Spot On! Improving Menstrual Health and Hygiene in India", 17
[227] FSG Reimagining Social Change, "Menstrual Health in India | Country Landscape Analysis", 15

toilet for girls, menstrual hygiene is largely ignored in toilet design and construction – an ideal facility would provide adequate privacy, space, light, and disposal mechanisms to change, wash and discard sanitary material discreetly"[228].

3.2 Combating gender-based discrimination by addressing Menstrual Hygiene Management in the current Indian legal framework

After analyzing the complex and multifaceted challenges experienced by Indian women and girls in managing menstrual cycle, it is now possible to define the legal and political responses to the issue. In this connection, current state of the Government's initiatives will be analyzed and an overview of MHM-related policies and programmes led by multiple Ministries in India will be provided.
The decision to examine GoI's interventions is justified by the fact that "national governments are key to improving MHH given their responsibility for programming in schools, product access programs, and tax and product policy"[229].
In the past few years, several Ministries have brought their own unique approach to target the issue of poor menstrual hygiene management with strategies, guidelines and programs. However, successful examples remain few and only a small number of national programs addressing MHM provide holistic solutions.

3.2.1 Ministry of Health and Family Welfare: recent development on the matter

Two are the initiatives launched by the Ministry of Health and Family Welfare that mention menstrual hygiene management as key area of intervention.
The first programme was introduced in 2010 under the National Rural Health Mission (NRHM) as part of the Adolescent Reproductive Sexual Health (ARSH) component. The so-called *Scheme for Promotion of Menstrual Hygiene among Adolescent Girls in Rural India* (MHS) targets menstruating individuals from 10 to 19 years living in 112 selected districts. Initially, the scheme was implemented only

[228] United States Agency for International Development et al., "Spot On! Improving Menstrual Health and Hygiene in India", 17
[229] FSG Reimagining Social Change, "Advancing Gender Equity by Improving Menstrual Health", Opportunities in menstrual health and hygiene, 30, accessed 25 August 2022, retrieved from https://www.fsg.org/resource/advancing-gender-equity-improving-menstrual-health/

in 17 States wherein a pack of 6 sanitary napkins were provided to adolescent girls in rural areas under the NHM's brand 'Freedays'"[230]. Subsequently, from 2015-2016 the procurement of sanitary materials as well as Information Education Communication (IEC) and Behavior Change Communication projects started to be provided under proposal of engaged States. Under MHS, menstrual materials are sold to adolescent girls within a pack of 6 napkins at six Rupees by Accredited Social Health Activists through door-to-door sale or via platforms of school and *Anganwadi* Centres. For the purpose of the present strategy, diverse IEC materials have been promoted according to a comprehensive approach, in order to create awareness among the target group about safe and hygienic menstrual health practices, including audio, reading materials and videos directed to young menstruators and ASHA[231]. In this case, increasing the awareness among young women on menstrual hygiene and enlarging the access of high-quality sanitary materials in rural and underprivileged areas represent the two missions of the scheme.

According to the *Operational Guidelines*, the GoI will be engaged in monitoring and supervising three components: quality of sanitary napkins, uninterrupted supplies and distribution and sale. As for the first constituent, it is fundamental to ensure that the characteristics of the products conform to the National Standards Body of India, namely Bureau of Indian Standards. The supervision "will be done through issue and updates of guidelines for manufacture and quality control, and periodic checks of random samples across the states"[232] and also "through the quality assurance cell in the states and in collaboration with quality testing labs set up in selected technology institutions"[233]. In terms of uninterrupted supplies, monthly stocks and supply chain will be monitored. With respect to the third element, the distribution and sale of sanitary napkins will be regulated at village

[230] National Health Mission Department of Health & Family Welfare, "Menstrual Hygiene Scheme (MHS)", National Health Mission, accessed 26 August 2022, retrieved from http://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1021&lid=391

[231] Ivi

[232] Government of India Ministry of Health & Family Welfare, "Operational Guidelines", Promotion of Menstrual Hygiene among Adolescent Girls (10-19) in Rural Areas, 21, accessed 26 August 2022, retrieved from https://nhm.assam.gov.in/schemes/detail/rashtriya-kishore-swasthya-karyakram-rksk

[233] Ivi

(such as random verification of beneficiaries); sub-centre (for example estimation of sanitary napkins requirements, ensuring transport to ASHA village); block (i.e., monthly meetings to review programme implementation and progress); district (for instance monthly financial review of funds flow and fund recouped into the District Health Society) and state levels (such as conducting quarterly meetings to review programme implementation and progress)[234].

The second programme was launched in January 2014 under the name of *Rashtriya Kishor Swasthya Karyakram* (RKSK) in order to promote the adolescent health segment under NRHM. With the aim of ensuring holistic development of adolescent population, the program's strategy focuses on a target group composed by male and female adolescents within 10-19 years of age. The RKSK differentiates younger adolescents (10-14 years) to older adolescents (15-19) but brings round to the idea of universal coverage, including boys and girls living both in urban and rural areas, in school and out of school, vulnerable and under-served, married and unmarried.

The objectives that have been identified in the document are: improving nutrition and reducing malnutrition; enabling sexual and reproductive health towards knowledge, attitudes and behaviors; enhancing mental health; preventing injuries and violence (including gender-based violence); preventing substance misuse by supporting adolescents' awareness about possible effects and consequences and addressing noncommunicable diseases[235]. Furthermore, RKSK's approach concentrates on a customized programme and service delivery, operationalized by the so-called seven Cs framework, including communication; counselling; clinics; content; community; coverage and convergence.

MoHFW's efforts concerning menstrual hygiene management fall under the scope of the sexual and reproductive health section. Within this framework, menstrual hygiene is contemplated as a strategic priority, whose plan of action directs

[234] Ibid., 22-23

[235] Government of India Ministry of Health & Family Welfare, "Strategy Handbook Rashtriya Kishor Swasthya Karyakram", 57, accessed 27 August 2022, retrieved from https://nhm.assam.gov.in/schemes/detail/rashtriya-kishore-swasthya-karyakram-rksk

attention to promotion and prevention. In the first case, the document explicitly refers to "provide knowledge about menarche, healthy menstrual practices and associated health benefits (with focus on the 10-14 age group)"[236] and also "promoting menstrual hygiene through access to menstrual aids such as sanitary pads and clean cloth"[237]. In the second case, RSKS mentions commodity provision and the dissemination of information regarding management of common menstrual problems[238]. The implementation of software and hardware interventions is conducted through the counselors of clinic-based services, as well as health and frontline workers and ASHA. However, budgetary allocations illustrate a greater hardware concentration and only recently, with the proposed 2014-2015 budget format, activities under the MHS as a line item started to be included, while the budget for the acquisition of sanitary napkins has been slotted under procurement[239]. In the past few years, the programme has been expanded in several areas within the country, enlarging the scope of the activities beyond the originally identified 9 high priority districts. Lately, RKSK has been extended to 10 more districts in the State and 4093 villages have been covered by the agenda so far[240].

3.2.2 Ministry of Drinking Water and Sanitation: strategies to overcome the problem

The Ministry of Drinking Water and Sanitation manages two schemes which affect women and girls in the context of menstrual hygiene and individual health. The first one is called *Nirmal Bharat Abhiyan* (NBA), formerly Total Sanitation Campaign, and concentrates on improving sanitation practices, as well as ending open defecation by 2022 through the adoption of a community-led and people-centered approach. The NBA guiding principles are applicable from 2012 onwards and

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[236] Ibid., 88
[237] Ivi
[238] Ivi
[239] Arundati Muralidharan et al., "Unpacking the policy landscape for menstrual hygiene management: implications for school WASH programmes in India", *Waterlines* 34, n.1 (2015): 83-84, accessed 28 August 2022, retrieved from https://practicalactionpublishing.com/article/2742/unpacking-the-policy-landscape-for-menstrual-hygiene-management-implications-for-school-wash-programmes-in-india
[240] Department of Health & Family Welfare Govt. of Tamil Nadu, India, "Rashtriya Kishor Swasthya Karyakram (RKSK)", accessed 28 August 2022, retrieved from https://www.nhm.tn.gov.in/en/nhm-programsrmncha/rashtriya-kishor-swasthya-karyakram-rksk

consist of encouraging local self-governments and communities to develop sustainable sanitation solutions; promoting health and hygiene education in schools; supporting cost-effective sanitation technologies and constructing toilets in all types of government schools[241]. For the purpose of the present thesis, it is fundamental to underline that the present programme precisely prioritizes the need for separate toilet blocks for girls in co-educational schools. Not surprisingly, the MoDWS directs attention to children attending schools when designing interventions aimed at using lavatories and toilets instead of practicing open defecation. Owing to the fact that young boys and girls are more receptive to new ideas, school environments are considered as appropriate institutions for modifying habits, behaviors and mindsets of the target group. In this case, educational institutions are encouraged to install toilets to match the exact number of students attending the school, providing also access opportunity to children with special needs[242].

Until December 2013, menstrual hygiene management was not explicitly tackled under the NBA strategy. In order to accelerate progress towards WASH and MHM in schools, a government amendment modified in 2014 the above-mentioned document. This included the establishment of water supplies, provision of funds in IEC activities to enhance awareness, toilet construction (ensuring separate spaces for girls), critical hand-washing and napkin incinerators for disposal menstrual waste. Within this framework, "an online monitoring system exists to track both physical and financial progress under NBA in each state nothing the proportion of toilets and related infrastructure constructed as per project aims"[243], although "the latest MHM amendments are not explicitly addressed nor reflected in monitoring indicators for 2014-2015"[244].

[241] Arundati Muralidharan et al., "Unpacking the policy landscape for menstrual hygiene management: implications for school WASH programmes in India", 84
[242] Government of India Ministry of Drinking Water & Sanitation, "Guidelines Nirmal Bharat Abhiyan", 7, accessed 28 August 2022, retrieved from https://pmposhan.education.gov.in/Files/WASH/Final%20Guidelines%20(English).pdf
[243] Arundati Muralidharan et al., "Unpacking the policy landscape for menstrual hygiene management: implications for school WASH programmes in India", 85
[244] Ivi

The nationwide launch of the *Swachh Bharat Mission* (SBM) by the Government of India on 2nd October 2014 is of considerable significance for a number of reasons. From this perspective, two are the most important: "one, elimination of open defecation is stated to be one of the key objectives of the national rural sanitation program for the first time; two, menstrual hygiene management (MHM) is included as part of the 'equity and inclusion' component of *Swachh Bharat Mission-Gramin* (SBM-G)"[245]. In addition, India's national cleanliness strategy is managed in rural areas by the MoDWS, while run in urban areas by the Ministry of Urban Development.

The so-called *Clean India Mission* is formulated according to two distinct phases: phase one lasted until October 2019, while phase two is being implemented between 2020-21 and 2024-25. Both of them aim at achieving an open-defecation free (ODF) country through the construction of toilets as main purpose, but differ in terms of subordinate objectives. As for the first, the programme introduced a statutory framework concerning sanitation that was gender neutral in its approach. The policy framework governing the first phase focused on eradication of manual scavenging, constructing sanitary toilets for households below the poverty line and implementation of awareness-raising campaigns to spread knowledge and health education. Consequently, it imposes an approximate responsibility on local institutions and other relevant agencies to maintain sanitation, without a clear priority on addressing sanitation-related needs and concerns of women[246]. Differently, the second phase directs attention to strengthen the management of solid and liquid waste, reinforce ODF behaviors and improve the lives of sanitation workers, having regard to target 6.2 of the 2030 Agenda for Sustainable Development. The objectives of SBM-G phase II cover the sustainment of ODF conducts, implementation of cost-effective technologies in the field of ecologically safe and sustainable sanitation and promotion of social inclusion, with a specific focus on marginalized communities and gender inequality.

[245] Water Supply & Sanitation Collaborative Council, "Menstrual Hygiene Management (MHM) Guidelines and implementation Framework", Bihar State, 2, accessed 29 August 2022, retrieved from https://www.wsscc.org/sites/default/files/migrated/2019/11/Bihar-MHM-guidelines-2019.pdf

[246] Sujith Koonan, "Sanitation Interventions in India: Gender Myopia and Implications for Gender Equality", *Indian Journal of Gender Studies* 26, n. 1&2 (2019): 46, accessed 29 August 2022, retrieved from https://journals.sagepub.com/doi/full/10.1177/0971521518812114

The year 2015 represents a breakthrough in the policy landscape regarding menstruators' rights and sanitation in India. In fact, the Ministry of Drinking Water and Sanitation (with support from UNICEF India) allocated a dedicated funding for MHM in order to improve menstrual health as part of the Swachh Bharat Mission, delegating states and districts to formulate context-specific guidelines. The *Menstrual Hygiene Management National Guidelines* advocates states to prepare their own guiding principles to achieve the following: "convergence and coordination with different ministries, departments and schemes; state specific MHM operational guidelines/policies/district level plans; definition and monitoring of KPIs; awareness creation around MHM through well targeted communication and media plans; training and capacity building across all levels; sharing of good practices with central ministry as well among districts"[247].

From a broader perspective, the document is divided into three parts, namely *Main Guideline*, *Action Guides* and *Technical Guides*, which encompass a specific MHM framework. According to the strategy, the expected results contemplate two outcomes, such as guaranteeing dignity for menstruators and ensuring the capacity for adolescent girls to attend school while bleeding. These last manifest an interconnection with other elements, which are essential in order to develop an effective MHM programme according to specific sanitation and hygiene requirements of Indian women and girls. The above-mentioned framework highlights seven components that should be integrated in to other government schemes, including "access to knowledge and information; access to safe menstrual absorbents; water, sanitation and hygiene infrastructure; access to safe disposal of used menstrual absorbents; societal, community, family and individual awareness; informed and trained support for girls and women; supportive policies, guidelines and behaviors"[248]. In this case, MHM interventions have to be framed on the basis of actors' different skills and capacities. A general list of who should be orientated and/or trained across the state is actually provided in the *Guidelines*. It is therefore

[247] Water Supply & Sanitation Collaborative Council, "Menstrual Hygiene Management (MHM) Guidelines and implementation Framework", Bihar State, 2

[248] Government of India Ministry of Drinking Water and Sanitation, "Menstrual Hygiene Management National Guidelines", 2, accessed 4 September 2022, retrieved from https://www.susana.org/en/knowledge-hub/resources-and-publications/library/details/3861#

the responsibility of those with influence – including state level officials, community frontline workers, health staff and doctors, district collectors, public health engineers, community leaders, teachers and civil society to consider appropriate solutions to raise awareness about the issue and take necessary actions to implement an effective MHM framework[249].

The involvement of public actors, communities and families is explained by the fact that MHM is a social issue and, as such, it has to be addressed according to different perspectives. With the aim of breaking the silence around menstruation and challenging menstrual taboo, it is crucial that everyone in society is in possession of a basic understanding of it. Moreover, in order to create the conditions whereby women and girls can articulate their needs and problems, family and community norms have to be changed. According to the document, the lack of information on the process of menstruation and inappropriate support and facilities jeopardize menstruators' health, education and dignity. Because of these aspects, adolescent girls must be equipped with adequate information and skills on MHM, as long as this process helps in empowering them with knowledge and education, enhancing their self-esteem and positively impacting their academic performance[250].

Another platform aimed at enabling the empowerment of women and girls and promoting human dignity is represented by the 2017 *Guidelines on Gender issues in sanitation*, issued by the MoDWS. The legal paper deals with the role of women in sanitation, IEC/BCC messaging, maintenance of toilets, inclusivity and MHM. For the purpose of the present thesis, few points connecting menstrual health to the implementation of SBM-G may be taken into consideration. First of all, the participation of women as active promoters of sanitation programmes needs to be further consolidated. According to the document, state government and local government bodies must increase women's leadership in local governance, by involving them in leading positions of SBM-G committees and other institutions such as WASH committees, Village Water and Sanitation Committees and Village

[249] Ibid., 5-7
[250] Ivi

Water Sanitation and Health Committees[251]. Furthermore, women's experiences in the field of open defecation must be approached in an inclusive way. Along with focusing on women and girls, as well as boys and men, the *Guidelines* recognizes the specificity of the so-called third-gender. It has been enlightened that transgender people must be recognized as equal citizens and users of toilets, being "allowed to use the facility of their choice (men or women) in community or public toilets"[252]. In the same way, particular needs of elderly and pregnant women are taken into consideration. Following this approach, designing toilets according to SBM-G perspective means adopting inclusive design. Community/public toilets have to be barrier-free and accessible by children, senior citizens and people with disabilities: "they should be well-ventilated and well-lit to avoid stumbling, the floor should have a gentle slope towards the drain to keep the floor dry and to prevent slipping"[253].

Public toilet design is strictly connected to menstruators' needs too. The *Guidelines*, in fact, dedicate an entire section to the implementation of adequate MHM facilities, requiring a participatory process based on the feedbacks of users. Safety, privacy, ample lighting, sanitary pad disposal mechanism, adequate ventilation, and water availability are mentioned as key elements in the realm of community/public toilet design. Expanding the scope of SBM-G by focusing on gender issues is a way also to approach taboos and superstitions associated with menstruation. As reported by the document, efforts must be made through the IEC activities, counseling sessions, special educational sessions organized by qualified professionals as part of school education of girls of appropriate age and menstrual health and hygiene awareness camps[254].

3.2.3 Ministry of Human Resource Development: latest efforts in the school context

[251] Government of India Ministry of Drinking Water and Sanitation, "Guidelines on Gender issues in sanitation", 2, accessed 4 September 2022, retrieved from https://jalshakti-ddws.gov.in/sites/default/files/Guidelines%20on%20Gender%20issues%20in%20Sanitation.pdf
[252] Ibid., 3
[253] Ibid., 4
[254] Ibid., 4-5

MoHRD's main objective resides in the development of school system and literacy in the country. Important schemes and initiatives under its realm consist of expanding access and improving quality of educational institution and recognizing the universalization of education. As already noted, poor menstrual hygiene practices affect girls' school attendance in various ways: the lack of privacy or inadequate toilets pose challenges to Indian adolescents during their periods, while discomfort, menstrual pain and fear of bullying comprise their concentration.

Sarva Shiksha Abhiyn (SSA) programme has been launched in 2001-2002 in order to attain universal elementary education to all children in the 6 to 14 age group by 2010. However, the intervention program's time limit has been pushed forward indefinitely. In general terms, SSA is designed to strengthen existing school infrastructure, build new schools, construct additional classrooms, promote equal education opportunity, provide academic resource support and overcome the shortage of teachers. Specifically, the strategy incorporates a gender concern component that aims at promoting girls' education, in an effort of changing the status of women. Removing gender gap in elementary schools and supporting an inclusive education for girls is part of the *Kasturba Ghandi Balika Vidyalaya* agenda. Despite that, MoHRD's mandate does not cover software interventions for education regarding menstrual health, but mainly prioritizes the construction of gender specific toilets in order to provide safe spaces for MHM practices. As reported by *SSA Manual for planning and appraisal*, problems of poor enrollment, retention and learning achievement should be arranged according to specific strategies based on available data, gender indicators and research studies aimed at mainstreaming gender concerns in all programme activities[255].

Focusing on sanitation infrastructures in secondary schools as a way to improve school retention represents the pivotal objective of the 2009 *Rashtriya Madhyamik Shiksha Abhiyan* (RMSA) scheme.

[255] Ministry of Human Resource Development Department of Elementary Education & Literacy, "Sarva Shiksha Abhiyan. A Programme for Universal Elementary Education. Manual for planning and appraisal", accessed 5 September 2022, retrieved from https://dsel.education.gov.in/sites/default/files/2019-05/Manual_Planning_and_Apprisal.pdf

The above-mentioned document's mission includes "improving quality of education imparted at secondary level through making all secondary schools conform to prescribed norms, removing gender, socio-economic and disability barriers, providing universal access to secondary level education by 2017, i.e., by the end of 12th Five Year Plan and achieving universal retention by 2020"[256]. The implementation of the scheme imposes the established state government societies to provide for crucial physical facilities, such as additional class rooms, residential hostels for teachers in remote areas, laboratories, drinking water provisions, libraries, art and crafts rooms and most importantly toilet blocks. As for this last, RMSA emphasizes the need to build separate toilet blocks for girls, based on the idea of removing the existing gender disparities and granting the right of education in those areas where it is denied. One of the four major heads called *Access and Equity* is devoted to manage the strategy bearing in mind special groups' needs, including those of vulnerable and disadvantaged groups. The programme commonly refers to this category inclusive of scheduled tribe and scheduled caste groups, children with special needs and disabilities and minority girls. In this case, multi-dimensional strategies to provide free access towards secondary education are implemented and several steps, comprising of identification of disadvantaged groups, need assessment, strategizing for the addressing gaps and project-based proposal, must be followed. The scheme is put into action by MoHRD as principal guiding force, whereas several other entities, institutions and support systems assist RMSA execution. In the present case, the National Resource Group advances tactics to enact changes in teaching-learning materials, ICT education and monitoring and evaluation systems and the Technical Support Group provides specialized and operational support and expertise at the federal, state and local level[257].

[256] Ministry of Human Resource Development Department of School Education & Literacy, "Rashtriya Madhyamik Shiksha Abhiyan (RMSA)", accessed 5 September 2022, retrieved from https://www.education.gov.in/en/rmsa

[257] Teachmint, "Rashtriya Madhyamik Shiksha Abhiyan", Education, accessed 5 August 2022, retrieved from https://blog.teachmint.com/rashtriya-madhyamik-shiksha-abhiyan/

3.2.4 Ministry of Women and Child Development: empowering adolescent girls through information disclosure

The Ministry of Women and Child Development originated as a separate Ministry in 2006, originally under the Ministry of Human Resources Development, whose mission concentrates on "promoting social and economic empowerment of women through cross-cutting policies and programmes, mainstreaming gender concerns, creating awareness about their rights and facilitation institutional and legislative support for enabling them realize their human rights and develop their full potential"[258]. In congruence with *Menstrual Hygiene Management National Guidelines*, the MoWCD is required, among others, to train *Anganwadi* supervisors and workers, carry out MHM promotional activities, provide for supply of sanitary napkins and set up Self Help Groups. Against this background, it launched a national flagship programme, designed to address the educational, sanitary and nutritional needs of adolescent girls, which will be illustrated in the following pages.

The 2010-2011 *Rajiv Gandhi Scheme for Empowerment of Adolescent Girls* (RGSEAG) is mandated to provide an integrated package of services to girls aged 10 to 18 years, both school-going and out-of-school, under the *Integrated Child Development Scheme*. Even if the strategy is tasked to converge with MHS, its goals range beyond menstrual health and menstrual hygiene.

RGSEAG's combined effort directed toward empowerment, education and nutrition is highlighted by its objectives: advancing empowerment and self-development; enhancing health and nutrition status; disseminating knowledge about ARSH, hygiene, family and child care; upgrading home-based, life and vocational skills; integrating out-of-school girls into formal or non-formal education and advising them about existing public services[259]. The choice of addressing adolescent girls' needs is justified by the fact that the period between 10 to 18 years represents a window of opportunity, in which mental, emotional

[258] Ministry of Women & Child Development, "About the Ministry", accessed 5 August 2022, retrieved from https://wcd.nic.in/about-us/about-ministry

[259] Arundati Muralidharan et al., "Unpacking the policy landscape for menstrual hygiene management: implications for school WASH programmes in India", 84

physical and psychological development is consolidated and can be partially corrected. In India, adolescent girls suffer disproportionately from undernourishment, low literacy rates, iron deficiency anaemia and sexually transmitted diseases, mainly "due to the lack of targeted health services for adolescents and widespread gender discrimination that prevail and limit their access to health services as well as the practice of early marriage and child-bearing that persists and puts adolescent girls and their children at increased risk of adverse outcomes"[260].

In this case, no funding is specified for school activities and menstrual hygiene is not supported by a separate budget allocation. Under RGSEAG, information on MHH, reproductive system and menstrual practices is primarily imparted by *Anganwadi* centers, NGOs, Medical Officers, Community Based Organizations (CBOs) and village-level female health workers. Correspondingly, the initiative to empower adolescent girls takes shape in age-appropriate guidance, according to a distinction between two groups: one that comprises girls from 11 to 15 years, and the other from 15 to 18 years. Menstruation and menstrual hygiene are mentioned under the *ARSH* component, incorporating, among others, age-specific modules for onset of puberty, planned parenthood, reproductive and sexual health, sexually transmitted infections and contraception. As specified in the document, the Ministry of Women and Child Development is required to collaborate with resource persons from NGOs and CBOs with the aim of providing counselling and assistance with respect to three additional matters. For example, the area on *Family Welfare* covers family planning, safe motherhood and reproductive cycle; the section called *Child care practices* considers benefits of exclusive breastfeeding, common ailments and health child feeding practices; while the part on *Home management* incorporates saving, budgeting, gender sensitivity, home maintenance and running household[261].

As can be deduced from the strategy, the distribution of sanitary napkins and treatment of menstrual disorders are not included under RGSEAG, for this reason

[260] Government of India Ministry of Women and Child Development, "Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) - 'SABLA' - The scheme", 1, accessed 6 September 2022, retrieved from https://wcd.nic.in/sites/default/files/1-SABLAscheme_0.pdf

[261] Ibid., 14

adolescent girls may be referred to health facilities if required during the established adolescent health days[262].

[262] Arundati Muralidharan et al., "Unpacking the policy landscape for menstrual hygiene management: implications for school WASH programmes in India", 84

CHAPTER IV: Tracking progresses and impediments of Menstrual Hygiene Management schemes: on program effectiveness, goal attainment and gender impact assessment

As it was explored in the previous subheadings, menstruating individuals in India are at serious risk of gender-based discrimination in different levels and dimensions. The relevance of appropriate MHM practices has been recently recognized by the Government of India as important determinant, which can cause profound effect on women and girls' education, health and well-being. In this framework, the involvement of multiple ministries in improving MHM policies denotes a clear attempt to bring unique and diversified approach with the aim of addressing this intersecting topic. In fact, some have focused on improving adolescent knowledge, constructing incinerators, placing napkin vending machines in schools, while others have given attention to the production and marketing of low-cost sanitary napkins, improving water access, installing gender separated toilet facilities and promoting ARSH education.

Given these premises, the fourth and last chapter will at first identify the monitoring systems which support GoI's programmes and strategies by tracking progresses and impediments. Afterwards, it will consider challenges and barriers to successful provision of MHM activities and then outline opportunities and future practices that respond to the field's most pressing needs.

4.1 Monitoring and evaluation of Government of India's Menstrual Hygiene Management programmes: expected results and factual outcomes

Before exploring Government of India's monitoring systems regarding menstrual hygiene management, it would be useful to impart an alternative point of view in the matter of methodologies that can be used for researching, obtaining feedbacks and supervising. In this respect, *Menstrual hygiene matters; A resource for improving menstrual hygiene around the world* produced by Sarah House, Thérèse Mahon and Sue Cavill exemplifies a different source and valuable synthesis of good practices in terms of ensuring opportunities for menstruators to provide feedbacks

and voice options. According to the authors, obtaining regular responses on menstrual hygiene interventions and ongoing monitoring of programmes could potentially induce a critical contribution to learning over the next few years, on the condition that information is appropriately documented and shared[263].

In general terms, the document distinguishes two different ways for evaluation, research and monitoring. The first comprises qualitative (or participatory) methodologies such as observations, focus groups, distributing questionaries with open-ended questions, collecting existing data in the form of video recordings, audio, images and texts, key informant interviews and semi-structured interviews. On the one hand, these practices could be functional in order to investigate myths, cultural beliefs and taboos surrounding menstruation, since the person concerned should be given the chance to freely communicate and give opinions. On the other hand, owing to the fact that menstrual cycle is often perceived as an unspeakable topic, "it can be difficult to obtain opinions from women and girls on proposed interventions and get their feedback once a programme is underway"[264]. To overcome the above-mentioned difficulty and aspire to successful interventions, it is fundamental to guarantee appropriate, effective and inclusive programmes. For these reasons, social mapping, body mapping, use of diaries, storytelling, cartoons, drama/role play, drawings, asking for recommendations, anonymously provided questions on menstrual hygiene and anonymous one page 'menstrual stories' explaining women and girls' own experience of menarche[265] have to be included in this specific approach. From this perspective, the advantages of qualitative research are numerous, owing to the fact that it seeks to preserve the voice and the viewpoint of the participants. Qualitative data analysis relies on flexibility (data collection can be adapted as new ideas or patterns emerge); natural settings; meaningful insights (comprehensive narratives of people's experiences, perceptions and feelings can be employed in testing, designing or improving systems or products) and generation of new ideas[266].

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[263] Sarah House et al., "Menstrual hygiene matters; A resource for improving menstrual hygiene around the world", 180

[264] Ibid., 181

[265] Ibid., 182

[266] Pritha Bhandari, "What is Qualitative Research? | Methods & Examples", Scribbr, accessed 8 September 2022, retrieved from https://www.scribbr.com/methodology/qualitative-research/

The second comprises, instead, quantitative methodologies, that refer to a set of strategies based on the exploration of numeric patterns and consolidation of empirical data. Quantitative research underscores objective measurements and mathematical and numerical examination by means of structured observations, closed questions, questionaries, surveys, polls and manipulation of pre-existing statistical documentation. According to the above-mentioned paperwork, it can also include pre- and post-assessment questionnaires to evaluate outcomes, intervention and control situations and alternative methods to triangulate data[267]. Despite the fact that this technique does not explore the rationale for behaviors and practices connected to MHM, its results are considerably reliable and representative of the involved population. Moreover, the research study can generally be replicated and monitoring projects based on this procedure can be exercised to generalize concepts or investigate causal relationships.

All things considered, "the methodologies used will vary depending on the objective of the information gathering, the scale of the information collection planned, and the stage at which the information is to be collected"[268]. As regards outcomes of MHM policies, evidence shows that improved confidence or empowerment constitute difficult elements to measure and record.

For the purpose of evaluating GoI's policies and strategies addressing menstrual hygiene management in the current legal framework, it is fundamental to investigate each ministry's monitoring systems and affiliated procedures to collect information. With the intention of doing so, factual details concerning control mechanisms will be provided, in order of appearance as stated in the previous chapter.

Making allowance for Ministry of Health and Family Welfare's schemes, the National Rural Health Mission is monitored by the Common Review Mission (CRM), which "was set up as a part of the Mission Steering Group's mandate of

[267] Sarah House et al., "Menstrual hygiene matters; A resource for improving menstrual hygiene around the world", 183
[268] Ibid., 181

review and concurrent evaluation"[269]. The working group consists of GoI Officials, Public Health Experts, Civil Society Members and Representatives of Development Partners[270], whose principal task involves the investigation of initiatives and programmes for recommendations. Every year the team undertakes an assessment for each state of the functional status of various health programmes running under NHM, documenting key drivers, best practices and challenges impacting their implementation and enabling also mid-course corrections[271]. During the course of field visits, the CRM collects information in many different areas concerning public health care system's performance of family planning programmes, child health and maternal health, according to the citizens perspective. After having analyzed secondary data collected at the national level and relevant findings from past evaluations, the review culminates with a final report. At the end of the process, the documentation is disseminated through workshops, covering 24 parameters related to the NRHM's core strategies.

The first CRM was conducted in November 2007 and until 2010 no specific mention about menstrual health and menstrual hygiene management is possible to observe.

In the fifth Common Review Mission (2011), the issue of menstrual hygiene is cited several times. The document outlines that menstrual hygiene programme training for ASHA operates in all states, with the exception of Assam and Bihar. This last "has ten districts under Menstrual Hygiene scheme but the state has not yet undertaken training of ASHA"[272], while others reveal different phases of implementation. For example, in Uttarakhand the project has been launched in five

[269] National Health System Resource Centre, "Common Review Mission (CRM) Reports", Technical Support Institute with National Health Mission, accessed 8 September 2022, retrieved from https://nhsrcindia.org/practice-areas/kmd/common-review-mission-crm-reports

[270] To give an instance, the CRM team can be composed, among others, of Officials of the MoHFW; Regional Directors of Health & Family Welfare; Non-official members of Mission Steering Group of NHM; Consultants from various divisions of the Ministry and Representatives of National ASHA Mentoring Group

[271] Ivi

[272] Government of India Ministry of Health and Family Welfare, "Fifth Common Review Mission Report 2011", National Rural Health Mission, 130, accessed 9 September 2022, retrieved from https://nhm.gov.in/images/pdf/monitoring/crm/5th-crm/report/main-report-5th-crm.pdf

districts, in Haryana in seven districts, in Karnataka in nine, while in Goa it is not yet operationalized[273].

The following CRM (2012) recognizes strong commitment in MH programmes from Rajasthan, Tamil Nadu, Assam, Odisha and Punjab, but notices critical concerns regarding the quality of distributed sanitary napkins. To illustrate this point, in the section dedicated to Kerala's *Planning of Facilities, Health services and Human resource*, the document delineates that "under the Menstrual Hygiene scheme the uptake of sanitary napkins shows decreasing trend because of issues of poor quantity and quality"[274].

The 2013 *Report & Recommendations of the Seventh Common Review Mission* mentions a stabilized implementation of the MHS across the country and an increasing acceptance and usage of menstrual materials among adolescent girls. In this case, "the initial challenge of inappropriate selection of storage sites, ad hoc distribution mechanisms and inadequate stock management have not been reported from any state"[275].

According to the subsequent CRM, the implementation of *Rashtriya Kishor Swasthya Karyakram* suffers a setback in various areas. Of the four components of RKSK, menstrual hygiene initiatives are operational only in few districts. In this context, "field interactions indicate poor quality of sanitary napkins in the states of Kerala, Odisha and Rajasthan affecting community demand for these napkins"[276]. Moreover, in various districts the level of availability and adequateness of several services included in RKSK strategy is low.

Both the nineth and tenth Common Review Missions report irregular supply of sanitary napkins and poor quality of menstrual products, while the eleventh

[273] Ibid., 101-135

[274] Government of India Ministry of Health and Family Welfare, "Sixth Common Review Mission Report 2012", National Rural Health Mission, 97, accessed 9 September, retrieved from https://nhm.gov.in/images/pdf/monitoring/crm/6th-crm/report/6th_CRM_Main_Report.pdf

[275] Government of India Ministry of Health and Family Welfare, "Report & Recommendations of the Seventh Common Review Mission", National Rural Health Mission, 48, accessed 9 September 2022, retrieved from https://nhm.gov.in/images/pdf/monitoring/crm/7th-crm/report/7th_CRM_Main_Report.pdf

[276] Government of India Ministry of Health and Family Welfare, "Eighth Common Review Mission Report 2014", National Rural Health Mission, 53-54, accessed 9 September 2022, retrieved from https://nhm.gov.in/images/pdf/monitoring/crm/8th-crm/Report/8th_CRM_Main_Report.pdf

demonstrates that "Menstrual Hygiene Scheme and the provision of Sanitary Napkins is not well operationalized in visited CRM states"[277].

In the 2018 document, the issue of menstrual hygiene is cited many times and in diverse sections. In the framework of national overview with reference to adolescent health, the working group recommends that "intensive IEC campaign including digital campaigns in social media, to educate adolescents on menstrual hygiene and nutrition should be organized in the schools"[278], as long as awareness amongst adolescent girls regarding menstrual problems is unsatisfactory in most areas.

The 2019 CRM is the last document available in the MoHFW's website. According to the findings, Menstrual Hygiene Scheme is implemented dissimilarly across the country. In some states the program has taken a back seat, in others the topic is still connected with stigma and misconceptions, while only in a small number of cases "adolescent girls and boys are aware about the importance of nutrition, physical exercise and menstrual health issues"[279]. Based on the information retrieved from the field visits, poor quality of sanitary napkins and its partial distribution remain one of the most crucial issues in several visited states.

As for the monitoring systems supervising the Ministry of Drinking Water and Sanitation's schemes, it is fundamental to notice that data regarding the above-described *Nirmal Bharat Abhiyan* intervention are difficult to encounter. This flagship sanitation programme is monitored according to a multi-level approach, from the village to the state. The review is initially undertaken by the *Gram Panchayat*, then it is examined on a monthly basis by the Secretary of the District Water and Sanitation Committee and on a quarterly basis by the Secretary in-charge of the rural sanitation in the concerned state; finally, the district level NBA/TSC

[277] Government of India Ministry of Health and Family Welfare, "Eleventh Common Review Mission Report 2017", National Rural Health Mission, 62, accessed 10 September, retrieved from https://nhm.gov.in/New_Updates_2018/Monitoring/CRM/11th_CRM_Report_Web.pdf

[278] Government of India Ministry of Health and Family Welfare, "Twelfth Common Review Mission Report 2018", National Rural Health Mission, 101, accessed 10 September 2022, retrieved from https://nhm.gov.in/New_Updates_2018/Monitoring/CRM/12th/12th-CRM_Report.pdf

[279] Government of India Ministry of Health and Family Welfare, "Thirteenth Common Review Mission Report 2019", National Rural Health Mission, 73, accessed 10 September 2022, retrieved from https://nhm.gov.in/New_Updates_2018/Monitoring/CRM/13th/13th-CRM_Report.pdf

cell and the Department of Water Sanitation Management evaluate the entire project in the district[280]. The MoDWS has launched considerable measures in order to develop an online monitoring system and abandon, this way, the manual offline arrangement. The benefits of the previously mentioned apparat enable easy data access and increase the efficiency and transparency of the scheme. Since it represents a comprehensive web-based information system, the new system helps in monitoring financial aspects and the progress of the coverage of toilets for individual households, *Anganwadi*, schools at the centre, state, district, block and panchayat level[281]. Despite that, the website page's latest update dates back to March 2017 and no findings about NBA's outcomes or gaps are available.

With respect to the *Swachh Bharat Mission*, the Ministry of Drinking Water and Sanitation has recently implemented a comprehensive monitoring system to track progress towards this goal. The so-called Management Information Systems aggregates data from the household level concerning the construction of toilets and the presence of sanitation facilities of all *Gram Panchayats*. Moreover, it has been upgraded to facilitate the reporting of creation of ODF communities and develop a reviewing system based on the generation of SMS texts once the construction of toilets has been accounted[282]. Another salient feature of the newest practice is the introduction of the mobile application under the name of SwachhApp. On the basis of this provision, it is possible to track real time sanitation coverage in percentage, sanitation status up to household level, number of ODF villages and list of beneficiaries in each village, with the option of uploading geo-tagged photographs of toilets constructed after 2nd October 2014.

In general terms, the implementation and impact of the mission is supervised through Vigilance and Monitoring Committees at the State/District Level,

[280] Swaniti Initiative, "Nirmal Bharat Abhiyan", accessed 10 September 2022, retrieved from http://www.swaniti.com/wp-content/uploads/2014/03/Nirmal-Bharat-Abhiyaan_Web-Final1.pdf

[281] Junaid Ahmed Usmani, "ICT Enabled Monitoring for Enhancing Effectiveness of Nirmal Bharat Abhiyan in India", *South Asian Journal of Evaluation in Practice* 1, n.1 (2013): 65, accessed 10 September 2022, retrieved from https://sajep.org/wp-content/uploads/2013/04/4.-ICT-Enabled-Monitoring-for-Enhancing-Effectiveness-of-Nirmal-Bharat-Abhiyan-in-India-Junaid.pdf

[282] UN Global Compact, "Swachh Bharat (Clean India) Mission: Management Information System (MIS) and Mobile App", Collective Action, accessed 11 September 2022, retrieved from https://ceowatermandate.org/resources/swachh-bharat-clean-india-mission-managment-information-system-mis-mobile-app/

Periodical Progress Reports, District Level Monitoring, Performance Review Committee meetings and Area Officer's Scheme. Each state is responsible for the adoption of "a five-pronged strategy consisting of (i) creation of awareness about the schemes, (ii) transparency, (iii) people's participation, (iv) accountability/social audit and (v) strict vigilance and monitoring at all levels"[283]. As for this last, states are regularly controlled by periodic review meetings, field visits and Rapid Action and Learning Units, which address implementation challenges and dispense advices on corrective actions, effective solutions and good practices.

Giving consideration to the latest *Swachh Survekshan Grameen*[284] (2019), no mention regarding menstrual cycle is observable. Even if the survey design allows for citizen feedbacks involving group meetings, face to face interviews with teachers, observations, key informant interviews, telephonic calls to influencers and PRI members, the results predominantly bring into focus the percentage of public spaces with access to toilet and waste disposal arrangements in the villages. This clearly represents a missed opportunity for the Ministry of Drinking Water and Sanitation in the role of monitoring SMB on the basis of a gender perspective. Besides, the mixed-method approach composed of secondary data, direct observation and citizen feedback does not take steps towards the disaggregation of statistical data nor the involvement of women in collecting information and data-processing. Notwithstanding the above-cited gaps, "the national score for awareness among the citizens regarding their district's participation in SSG-19 was found to be 97.5%"[285]. As compared to the SSG-18 outcomes, a considerable change in terms of arrangement of solid and liquid waste in villages was observed in 2019. In this case, "84.1% of the citizens reported that their village had sufficient arrangement for solid waste management and only 8% of the citizens reported

[283] Government of India, "M & E (Monitoring & Evaluation)", Committed to building a Swachh and Swasth Bharat, accessed 11 September 2022, retrieved from https://swachhbharatmission.gov.in/SBMCMS/monitoring-evaluation.htm

[284] The SSG is an annual national survey undertaken by the Department of Drinking Water and Sanitation, Ministry of Jal Shakti. It classifies all districts and states of India, according to qualitative and quantitative sanitation parameters, which include, among others, self-reporting by districts; village-level surveys of public spaces and citizen's perception.

[285] Department of Drinking Water and Sanitation Ministry of Jal Shakti, Government of India, "Swachh Survekshan Grameen 2019", 34, accessed 15 September 2022, retrieved from https://swachhbharatmission.gov.in/SBMCMS/writereaddata/Portal/Images/pdf/SSG-2019-report_Updated-18Nov.pdf

insufficient arrangements"[286], while "83% citizens reported sufficient arrangements in their village to manage liquid waste"[287]. The document further outlines an increasing percentage of public places with access to toilets (with nineteen states above the national average for this parameter) and a decreasing rate of public places with water logging (with seventeen states upon the national average for this parameter). In general terms, the impact of SBM can be estimated in terms of construction of toilets. As stated by the official MoDWS website, 7,26,514 is the number of toilets built in 2021-22; 711 the ODF districts, 6,00,894 the ODF villages and 2,62,789 the ODF Gram Panchayats across the country and 61.24 the percentage of households with toilets since 2nd October 2014[288].

In point of fact, accurate information concerning gender specific needs is missing, "preventing the use of the girls' toilets to pupil ratio being calculated as an indicator of progress"[289]. Even supposing MoDWS monitoring systems are advancing new technologies and modern techniques of up-to-date information gathered, the absence of any reporting quality is noticeable.

The implementation of existing policies remains therefore a challenge, due to limited capacity on the ground and inadequate methods of evaluation, which fail to catch different perspectives, excluding women's voices. In addition, both the *Menstrual Hygiene Management National Guidelines* and the *Guidelines on Gender issues in sanitation* do not make progress towards monitoring and policy assessment. Measurement of impact of these schemes is generally limited to outputs, ignoring the information about the quality of the processes. At the present time, SBM reports focus only on progress of physical infrastructures and indicators of *Menstrual Hygiene Management National Guidelines* are limited, among others, to percentages of separate functional toilet blocks for adolescent girls, schools with

[286] Ibid., 35
[287] Ivi
[288] Department of Drinking Water and Sanitation Ministry of Jal Shakti, "Swachh Bharat Mission - Gramin (All India)", SBM-G at a Glance, accessed 15 September 2022, retrieved from https://sbm.gov.in/sbmreport/home.aspx
[289] Department of Clinical Sciences Liverpool School of Tropical Medicine (LSTM) et al., "Review of Menstrual Hygiene Management in Schools in India RFP/2014/058/9112095 FINAL REPORT", WASH in Schools for Girls, 58, accessed 15 September 2022, retrieved from http://www.wins4girls.org/resources/2017%20India%20MHM%20Final%20Report.pdf

incinerators and facilities for disposal of menstrual waste and educational institutions that stock or have provisions for sanitary napkins. Although the MHM *Guidelines* make reference to the fact that "effective MHM will ultimately result in an improved ability for adolescent girls to stay in school, there is little to no data collected to build this evidence"[290]. In the final analysis, no current data is obtainable for monitoring or evaluation of the two *Guidelines*, an overall evaluation of India regarding the realization of SBM cannot be found and links to specific programmes and key indicators do not operate properly.

As formerly anticipated, the Ministry of Human Resource Development is accountable for the implementation of two schemes, namely *Sarva Shiksha Abhiyn* and *Rashtriya Madhyamik Shiksha Abhiyan*.

Relating to the first, SSA programme is scrutinized twice every year by a Joint Review Mission composed of members of external funding agencies and independent experts. The monitoring structure to oversee the strategy's execution is based on a multi-layered set up from national to school level[291]. At the state level State Project Director, State Advisory Council and Governing Body & State Execution Committee examine academic and administrative aspects of the plan; at block and cluster level Local Authorities and Functionaries supervise infrastructure and organizational features of schools, while at district level District Project Coordinator and Local/Public Representatives monitor the allocations of funds. Educational data on outcomes are placed in the public domain in the National Portal for SSA, where states, districts, villages and citizens can access information on the examination of the strategy.

After various online searches, it can be asserted that the only report available is the one of June 2010. As attested by the document, the issue of menstrual hygiene management is not cited. However, the question of infrastructural deficiencies and lack of separate toilets for girls are significant element to take into consideration with the aim of advancing equal opportunities in the school environment. Although

[290] FSG Reimagining Social Change, "Menstrual Health in India | Country Landscape Analysis", 17
[291] Ministry of Human Resource Development, "Sarva Shiksha Abhiyan Manual for District-Level Functionaries 2017", 13, accessed 15 September 2022, retrieved from https://darpg.gov.in/sites/default/files/Sarva%20Siksha%20Abhiyan.pdf

a vast improvement in addressing infrastructural deficits is reported, "some states continue to face shortages in terms of adequate number of classrooms, separate toilet facilities for girls, blackboards, drinking water and electricity in most schools"[292]. In addition to the above, one of the scheme's main objectives contemplates the responsiveness of the educational system in the direction of girls' needs. The attempt to bring about an improvement in gender equality has been operationalized "through targeted interventions which serve as a pull factor to enhance access and retention of girls in schools and on the other hand to generate a community demand for girls' education through training and mobilization"[293]. In order to achieve this point, the programme provides for three different types of incentives, such as recruitment of female teacher as to reach 50% of female teacher ratio; free of charge uniforms, scholarships, textbooks and separate toilets for girls in schools. As a result of these measures, the 2010 report divulges that common toilets are available in 82% of the selected schools and separate toilets for girls in 51% of cases[294]. Infrastructural deficits are present in particular areas of the country, for example Tamil Nadu, Assam, Andhra Pradesh, Bihar and Madhya Pradesh, while the highest percentages of separate toilets for girls appear in Uttar Pradesh, Haryana and Union Territory of Chandigarh. Moreover, none of the examined schools in West Bengal is in possession of toilets for girls, sanitation facilities in schools of urban slums are in neglect and financial resources for their maintenance are in short supply[295]. Considering the overall trend, during the very first years of its implementation the SSA scheme caused an increase of the rate of girls' enrolment and an improvement of gender parity ratio across almost all states.

Relating to the second, it is fundamental to observe that *Rashtriya Madhyamik Shiksha Abhiyan* is financed both by domestic resources and external fundings. As

[292] Programme Evaluation Organization, "Evaluation Report on Sarva Shiksha Abhiyan", PEO Report No. 203, 12, accessed 15 September 2022, retrieved from https://dmeo.gov.in/sites/default/files/2019-10/Evaluation%20Report%20on%20Sarva%20Shiksha%20Abhiyan%20%28English%29.pdf
[293] Ibid., 20
[294] Ibid., 25
[295] Ibid., 60

for these last, the RMSA Development Partners[296] (DP) play a key role in sponsoring the programme and review progress of its implementation. As per the respective Agreements, the Ministry of Human Resource Development in conjunction with Development Partners bring into completion a Joint Review Mission twice a year.

The main purpose of the monitoring system is to evaluate the realization of the scheme according to RMSA's targets, "with a particular emphasis on a small number of issues, and to discuss follow-up actions in the light of the Terms of Reference (TOR) agreed upon for each JRM"[297]. Five reports have been published so far, and each of them relates to different mission objectives. The first JRM places emphasis on exploring the topics of planning and appraisal process and civil works; the second provides guidance on teacher training, learning outcomes and teacher management and deployment; the third puts special focus on teacher recruitment and assessment of the nature of government aided schools at secondary level; the fourth pays attention to establishment of the learning assessment systems and evaluation of procurement procedures following the post procurement review, while the fifth revolves around vocational/skills education in schools and UDISE implementation structure. Analyzing the documents available on the Ministry website, it is possible to state that in none of the five JRM is the issue of menstruation mentioned. On the contrary, only in the case of the first review is the question of separate toilets for girls discussed. The Mission assumes that the presence of adequate toilets in school environments is of paramount importance to ensure boys and girls' attendance, since "poor sanitary provision increases the disease burden on students and teachers reducing attendance and thereby the opportunity to learn"[298]. In many of the schools visited, the number of toilets is inadequate, the design is not effective, a relation to the number of toilets and the total of students who are likely to use them is missing and no flushing arrangements is present. In this case, important insights emerge from the monitoring, which

[296] World Bank's International Development Association and United Kingdom's Department for International Development

[297] Government of India et al., "Rashtriya Madhyamik Shiksha Abhiyan (RMSA) First Joint Review Mission January 14-28, 2013", 1, accessed 17 September 2022, retrieved from https://www.education.gov.in/en/sites/upload_files/mhrd/files/upload_document/JRM1.pdf

[298] Ibid., 14

translate into recommendations for the examined states. According to the official paper, educational institutions stand in the need of more acceptable sanitary infrastructures, "especially for girls at the secondary level who are adolescent going through a challenging phase requiring clean and hygienic toilet facilities"[299]. Moreover, "in girls' toilets, provision for disposing of sanitary napkins is necessary"[300].

Since the issue of menstrual cycle and its relation with educational outcomes is not mentioned in the second, third and fourth reports, it is not indispensable to dwell on these documents given the purposes of the present thesis. Instead, mention should be made of the section dedicated to social and gender gaps in JRM number five. In such circumstances, DP call states to "move beyond use of averages and undertake a more detailed disaggregated analysis of their gender related indicators and develop strategies accordingly"[301]. On average, India has achieved an optimal level (equal to one or greater than one) in terms of Gender Equity Index at Secondary Level[302], but the adverse sex ratio plays an important part in the measurement of progress. To illustrate this point, states like Haryana and Gujarat are taken as example. These two maintain highly adverse sex ratios and keep unsatisfactory performance with reference to parity and equity indicators. The foregoing reality indicates that adolescent girls are "doubly disadvantaged in these states: their number is low in the elementary school population, but it becomes even lower than that in secondary education"[303].

The monitoring mechanism directed to analyze performances under the *Rajiv Gandhi Scheme for Empowerment of Adolescent Girls* pertains to the supervision strategy set up under the *Integrated Child Development Scheme*. In order to examine successful outcomes and possible gaps, monitoring committees are set up

[299] Ibid., 5 (State Report: Punjab)
[300] Ibid., 14
[301] Government of India et al., "Rashtriya Madhyamik Shiksha Abhiyan (RMSA) Fifth Joint Review Mission 27 January to 9 February, 2015", 14, accessed 17 September 2022, retrieved from https://www.education.gov.in/sites/upload_files/mhrd/files/upload_document/JRM_5.pdf
[302] Gender Equity Index at Secondary Level in year t is equal to the share of girls in enrolment to total enrolment in grades IX-X in year t / share for girls in the age group 14-15 in the total 14-15 age group population in year t
[303] Ivi

at the state, union territory and community levels. At the state level, State Monitoring and Supervision Committees are guided by a Chief Secretary and incorporates, among others, representatives from Planning Department, Finance, Rural Development, Youth Affairs, Labour, Education and members of Parliament. At the district level, District Collector, Deputy Commissioner and District Magistrate are in charge of the monitoring committee. Finally, at the village level, the responsibility for supervising the programme falls on members of Sakhi and Youth members, *Anganwadi* workers and Panchayat members. The supervision mechanism follows a specific procedure: field visits to ensure effective implementation of the scheme; communication of identified gaps to states and union territories for taking corrective measures and coordination and convergence between concerned departments to check progress of the scheme[304]. Besides, "baseline surveys and situational analysis will be made up by the States/UTs for identification of beneficiaries so that the impact evaluation later may indicate the outcomes"[305]. Aside from these specifications, no current information is available for monitoring or evaluation of MoWCD strategies and official webpages contain only general information regarding the interventions.

4.2 Barriers and obstacles to successful provision of Menstrual Hygiene Management practices: the contribution of grey literature and shadow reports in filling the gaps

As it was possible to ascertain from the last paragraph, GoI monitoring systems regarding MHM interventions suffer from diverse shortcomings. Unequivocally, in some cases they are provided for by the programs but are not totally implemented, in other cases they do not exist at all, and sometimes the review reports exist but are not available to be accessed.

Given this background, it is difficult to evaluate the efforts and the contributions of competent Ministries solely with the sources that are available online and additional

[304] Government of India Ministry of Women and Child Development, "SABLA Scheme to benefit nearly 100 lakh adolescent girls per annum", Press Information Bureau, accessed 17 September 2022, retrieved from https://pib.gov.in/newsite/PrintRelease.aspx?relid=133064

[305] Government of India Ministry of Women and Child Development, "Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) - 'SABLA' - The scheme", 8

information from other entities is needed to properly assess results and gaps. In this case, the contributions of UN Women, WaterAid, researchers, experts, nonprofit foundations and NGOs are crucial with the aim of enabling an organic assessment of the situation in India.

The reasons why it is important to make use of such studies, discussion papers, synthesis and shadows reports are many. First of all, the absence of proper review mechanisms damages the intervention itself, since it is not possible to determine whether the programme has achieved its objectives. Secondly, monitoring results in better transparency and accountability and helps ensure resources are used efficiently, preventing their waste and determining priority areas[306]. Thirdly, it improves decision-making processes, supports innovation, helps institutions replicate best practices and catch problems early[307].

That being said, this section will examine challenges and barriers to provision of MHM interventions, considering access to menstruation-related information, provision of menstrual supplies, existence of WASH facilities in schools and public places and involvement of boys and male teachers into the menstrual discourse.

According to government interventions, health education is a highlight on which various Ministries in different manner have contributed through guidelines, missions and strategies. However, evidence shows that activities have not been operationalized into substantial improvements in the direction of girls' knowledge and awareness. Actually, "there has been no tangible impact on religious restrictions and cultural taboos which strongly affect girls' lives across different settings"[308]. Systems for providing information to schoolgirls appears inefficient and counselling by ASHA seems minimally effective, while mothers continue to play a key role in imparting information but "have minimal knowledge and propagate myths and traditions around menstruation"[309]. Women and girls'

[306] Emmaline Soken-Huberty, "10 Reasons Why Monitoring and Evaluation is Important", EVALCAREERS Opportunities in Monitoring and Evaluation, accessed 18 September 2022, retrieved from https://evalcareers.com/magazine/why-monitoring-and-evaluation-is-important/

[307] Ivi

[308] Department of Clinical Sciences Liverpool School of Tropical Medicine (LSTM) et al., "Review of Menstrual Hygiene Management in Schools in India RFP/2014/058/9112095 FINAL REPORT", 61

[309] Ivi

perceptions of menstrual practices represent a critical question connecting other impacts, such as school absenteeism, where confidence to manage menstrual bleeding corresponds to salient contributors to educational, social and psychological outcomes[310]. Limited information and resources for menstrual hygiene management clearly culminate in significant educational consequences, asserted also by observed academic performances and grade repetition. In spite of government efforts to provide instruction in school settings focusing on the biological aspects of menstrual health and product usage, only few education and awareness program target out-of-school girls[311]. Furthermore, research has shown that menstrual health education and awareness programming hardly target vulnerable women and girls, including those HIV-positive and with disabilities. The quality of these software interventions is low, "with several studies providing insufficient detail on study design, intervention, evaluation, and results, thus hindering efforts to draw firm conclusions and replicate the interventions"[312].

In this context, another important element to take into consideration is the role of teachers in imparting information. The Government of India has allocated several funds with the intent of ensuring that menstrual health is included in educational programmes, with special emphasis on building teachers' capacity in MHM awareness-raising, training and skills building. This is connected with "efforts to improve the quality and availability of age-appropriate, replicable and user-friendly information and education materials on MHM and getting them into the school curriculum for teachers to use (including visual and other tools to enable access for differently-able or less literate girls)"[313]. Despite the fact that significant expectations are placed on teachers in this regard, an evaluation of government measures found that resources to support them are limited and the quality of training

[310] Julie Hennegan et al., "Women's and girl's experiences of menstruation in low- and middle-income countries: A systematic review and qualitative metasynthesis*",* 31
[311] Alexandra Geertz et al., "An Opportunity to Address Menstrual Health and Gender Equity", 27-28
[312] Ernestina Coast et al., "Puberty and menstruation knowledge among young adolescents in low- and middle-income countries: a scoping review", *International Journal of Public Health* 64, n. 2 (2019): 302-303, accessed 18 September 2022, retrieved from https://pubmed.ncbi.nlm.nih.gov/30740629/
[313] Tracey Keatman et al., "Menstrual hygiene management in schools in South Asia – Synthesis report", 32

programs is inconsistent. In order to improve menstrual health, educators need to be trained in both the psychosocial and biological aspects of puberty education, as well as appropriate hygiene behavior and practices[314]. Moreover, "values clarification training may also be required to ensure that teachers feel comfortable teaching all topics, and additional training may be required for male teachers who have been found to be less sensitized to girls' menstrual needs"[315]. Thus, the implementation of these measures turns out to be restricted by a limited human resource capacity. On the one hand, it is still difficult for adolescent girls to consider health workers as a source for their information and, on the other hand, ASHA and counselors themselves do not feel comfortable discussing such topics.

A number of actions are operating to provide girls with sanitary napkins, in view of the fact that low-income consumers lack regular access to affordable commercial MHM products. Free pad programs have been promoted in the Indian government agenda and, at the same time, small and medium-sized social enterprises have advanced strategies in LMICs in an effort to furnish high-quality and low-cost menstrual products for women and girls in need. In this framework, the inclusion of women's voices in the financial planning and pricing negotiation represents a critical tool for them to save and invest in strategic goods and control over household resources. But most of the times the priorities of women and girls are deprioritized and their voices concerning the planning of projects and creation of financial plans are not taken into account.

The opportunities to facilitate the supply of sanitary products in India has been done through "supporting tax cuts on MH products; influencing BIS standards especially for lower-cost/bio-degradable options; encouraging disposable pad providers to promote better disposal options and linking that to their social responsibility activities; and linking to other solid waste programmes"[316]. However, experts convey concerns about the impact of these programs and the connected long-term sustainability of providing menstrual materials to women and girls in need. In

[314] Alexandra Geertz et al., "An Opportunity to Address Menstrual Health and Gender Equity", 28
[315] Ivi
[316] Tracey Keatman et al., "Menstrual hygiene management in schools in South Asia – Synthesis report", 33

factual reality, the consequences of such measures depend on several elements. First of all, the proliferation of free or subsidized schemes culminates in filling short-term gaps but creates market distortions in the long term[317]. Secondly, the presence of luxury taxes on period products is instrumental to high costs for commercial MHM materials, as long as the impost increases significantly the overall price to menstruators. To overcome this trend, "affordable commercial product lines with broad distribution channels from multi-national corporations or social enterprises may be a more sustainable solution"[318], in conjunction with a reduction of taxes in order to increase the overall affordability of menstrual materials.

The systematic review of recent shadow reports across India reveals further challenges and barriers to the access and use of hygienic absorbents. One of these concerns logistical complications for product distribution, especially at the community level, as well as the discontinuity in the supply chain. Provision to women and girls is additionally compromised by scarce support for delivery of supply to individual first line workers (such as ASHA) and low-quality napkins manufactured by local brands[319]. Informant interviews illustrate that most girls from poor communities and rural areas face serious restrictions in procuring packs of 6 napkins at six Rupees, owing to the fact that the cost is too high and not affordable. For these reasons, menstruators in India continue to use cloth, because of their availability, or stack of "multiple napkins to prevent leakage, increasing cost, causing discomfort"[320].

In this scenario, there exists an immediate opportunity for the field to enhance the effectiveness of existing efforts in the direction of supporting market-based solutions and implementing innovative low-cost distributions. According to *Menstrual Health in India | Landscape Analysis*, three are the immediate priorities to overcome inappropriate MHM practices related to improper products usage. The

[317] Alexandra Geertz et al., "An Opportunity to Address Menstrual Health and Gender Equity", 29
[318] Ivi
[319] Department of Clinical Sciences Liverpool School of Tropical Medicine (LSTM) et al., "Review of Menstrual Hygiene Management in Schools in India RFP/2014/058/9112095 FINAL REPORT", 61
[320] Ivi

first resorts to a decentralized model of producing low-cost pads through low-cost machines. In this case, market-based strategies aimed at increasing the capacity of moderately priced apparatus are fundamental to expand scale, quality and capacity of products produced as part of the decentralized model[321]. The second examines the role of centralized manufacturing systems and the cross-sectional and multi-stakeholder collaboration in reaching menstruators from remote rural areas. On this account "additional research is needed to understand the underlying distribution challenges in specific regions, the price points that women and girls are willing to pay for the product, and user product preference"[322]. Ultimately, the third considers the debate around sustainable menstruation supporting the "innovation of products which are environmentally friendly, culturally appropriate, and affordable given the environmental concern with disposable pads"[323].

As highlighted in the previous subchapter, progress has been made on securing separate toilets for girls and boys both in schools and public spaces. However, gaps remain on the topics of services (i.e., uncleaned toilets), infrastructure (i.e., no doors, locks and light) and products (i.e., lacking toilet paper and soap). The fact that such limitations still exist in the Indian context is not just a matter of infrastructure, as it is not only with the correct and satisfactory facilities that adequate MHM practices are guaranteed. It is true that poorly supportive physical infrastructures undermine menstruators in undertaking their preferred menstrual practices in dignity, but the underlying problem concerns the lack of inclusion of women and girls in engineering and logistical choices with reference to toilet construction. With the aim of addressing social environment concerns, "women should decide where to place toilets to optimize accessibility and safety; low-cost lights could be installed for safer, independent use and locks could enable privacy"[324]. At the same time, "to address personal constraints, water could be available within toilets to eliminate fetching, walkways could be constructed to

[321] FSG Reimagining Social Change, "Menstrual Health in India | Country Landscape Analysis", 19
[322] Ivi
[323] Ivi
[324] Bethany A Caruso et al., "Understanding and defining sanitation insecurity: women's gendered experiences of urination, defecation and menstruation in rural Odisha, India", 10

prevent falling and elevated seats or rails could aid the elderly, infirm and pregnant"[325].

The voices of menstruating individuals should be heard in the design of gender-responsive infrastructures, having regard to the fact that "gender equality means that toilet programmes and design cannot stop at defecation and disease; they have to take equally seriously the requirements of hygiene and dignity for daytime urination and menstruation management"[326].

If such factors are lacking, then government programs have failed in their intent to tackle gender inequalities and empower women and girls. As a confirmation of this, data accrued from recent study surveys and group discussions reveal that WASH arrangements in schools specific for menstruating adolescent girls remains an unfulfilled component of the GoI programme, and many stakeholders disclose difficulty in water provision, especially in arid areas[327]. In addition, the current trend shows that the exact number of male and female students is constantly being tracked by monitoring systems, but "it appears these data are not used to calculate how many gender-specific toilets are needed to satisfy the government target of 80:1 girl per toilet"[328].

Given this background, it is evident that the recognition of women and girls' sanitation and hygiene needs within the Indian legal and political framework remains on paper. Despite the fact that it represents a first step toward eliminating gender discrimination, sanitation interventions have rarely been translated into successful actions. The clearly expressed recognition of MHM as a sanitation matter in policy documents is for sure a progressive step, but the actual fulfilment of the right to sanitation depends on how menstrual concerns are reflected in the implementation of schemes and strategies[329]. Thus, there exists a gap between political recognition of menstrual hygiene management and its actual practice.

[325] Ivi
[326] UN Women, "Towards gender equality through sanitation access", 25
[327] Department of Clinical Sciences Liverpool School of Tropical Medicine (LSTM) et al., "Review of Menstrual Hygiene Management in Schools in India RFP/2014/058/9112095 FINAL REPORT", 61
[328] Ivi
[329] Sujith Koonan, "Sanitation Interventions in India: Gender Myopia and Implications for Gender Equality", 49

When considering fieldworks and studies from rural areas, it can be observed that implementing agencies in charge of administering SBM focus almost exclusively on the construction of toilets. The elimination of open defecation remains the key priority, while MHM and other hygiene practices have been downgraded to a subsequent phase after ODF status has been attained[330]. Efforts coming from state governments are insufficient and pilot projects promoted by districts refer only to the availability of toilet facilities and sanitary products, leaving out the possibility of breaking the taboo around menstrual cycle. In this context, "programmes conducted to bring about behavioural change and 'trigger' people to build and use toilets often use patriarchal social and cultural norms that perpetuate or reinforce the inferior status of women"[331], where "many of these norms are in fact root causes of the sanitation burden on women"[332]. Available data indicate that in some areas implementing agencies and monitoring committees have employed intimidating and discriminatory methods in order to eliminate harmful practices, justifying their use given their effectiveness. By means of such strategies, the efficacy "takes priority over the objectification and humiliation of women"[333], reinforcing this way "men's control over women instead of challenging patriarchal norms"[334].

It is worth considering another issue, brought to light by few NGOs, regarding the inclusion of boys and men within the discourse around menstrual cycle. Since the unequal distribution of power among men and women corresponds to the exclusion of these last in the utilization of water and sanitation facilities, as well as the inability to fully participate in social life, "addressing both the practical and strategic needs of women and girls related to menstruation and menstrual hygiene requires comprehensive programmes that target women and girls and men and boys"[335]. As can be determined from the literature reviewed, Indian society is

[330] Ivi
[331] Ibid., 50
[332] Ivi
[333] Ibid., 51
[334] Ivi
[335] Thérèse Mahon et al., "Putting the men into menstruation: the role of men and boys in community menstrual hygiene management", *Waterline* 34, n. 1 (2015): 8, accessed 21 September 2022, retrieved from https://menstrualhygieneday.org/wp-content/uploads/2017/07/Putting-the-men-into-menstruation.pdf

extremely patriarchal and menstrual hygiene challenges are rooted in gender inequalities. Despite this, the role of men and boys in supporting women and girls to manage menstruation is totally absent within the policy framework already examined. In this case, those who do not experience menstruation influence those who do "through many roles, including as husbands, fathers, brothers, students, peers, teachers, community leaders, entrepreneurs, employers, development and humanitarian practitioners, and policymakers"[336].

Thanks to the intervention of WaterAid and Vatsalya, it was possible to study and further investigate this phenomenon through a study conducted in 2011 in the state of Uttar Pradesh, India. The project consisted of a community-based menstrual hygiene and WASH programme, implemented in 66 rural villages in Lucknow District, whose objective was to empower women and adolescent girls by addressing MHM, build self-esteem, provide access to sanitary materials, water and sanitation[337]. The innovative element of the program is to have recognized the importance of men and boys in this context and to have adapted the connected approach to that finding.

After two and a half years of implementation, the scheme was revised through observations, interviews and focus groups discussions using inclusive methods and experimental strategies. Experts report that in an initial monitoring phase it was difficult to establish a dialogue with men on MHM issues, due to myths, misconceptions, reluctance and prejudices revolving around the question[338]. Subsequently, by means of training meetings, interpersonal communications and awareness raising sessions, interesting results have emerged in terms of transformed perception with respect to the issue, reduction of gender inequality and infrastructure support.

The lessons that have been learned through this study relate first and foremost to the importance of developing systems and policies regarding MHM that take into account the gender component as pervasive element in Indian social system. It is therefore recommended to establish inclusive programs and sensitize all stakeholders for successful outcomes. In fact, "an inclusive approach where men

[336] Ivi
[337] Ibid., 11
[338] Ivi

are equal partners ensures greater support and leads to successful empowerment of the whole community especially women and girls"[339]. As a result of the initiative, "the involvement of men and boys through creating spaces for open dialogue has enabled men and boys to realize the importance of MHM as well as issues of reproductive health, women's self-esteem, and empowerment"[340]. Given the significant results, it is desirable that agencies responsible for designing MHM policies engage that segment of population who do not experience menstruation but can play a decisive role in challenging related cultural norms resulting in gender discrimination.

4.3 The way forward. Future practice and research

Having established which are the gaps, barriers and obstacles as regards provision of MHM interventions in India, it is now possible to bring into focus future perspectives and policy recommendations, in particular pointing at favoring gender transformative approaches. GTA constitute a functional opportunity both for men and women to question gender norms and create suitable conditions directed to gender transformation. Accordingly, GTA address power inequities and multi-leveled authority hierarchies in communities which impede the individual's capacity to make decision about his/her health too[341]. These kinds of approaches can be effectively contextualized in the menstrual framework, improving health access for women and shifting responsibility about resource management to menstruators. The scale of intervention of these methodologies varies according to different factors and distinct priority areas, from the individual to the state level. Despite their heterogeneity, the goal is common: promoting "changes in gender relations, opportunities and resources by women and men, and girls and boys by challenging the root causes of gender discrimination, including the constraining gender norms, discriminatory attitudes and behaviors, unequal power relations and

[339] Ibid., 13
[340] Ivi
[341] Health Communication Capacity Collaborative, "Gender Transformative Approaches. An HC3 Research Primer", 1, accessed 22 September 2022, retrieved from https://www.healthcommcapacity.org/wp-content/uploads/2014/08/Gender-Transformative-Approaches-An-HC3-Research-Primer.pdf

social, economic and political structures (laws, policies and rules) that create and reinforce gender inequalities"[342]. To be effective, gender transformative approaches have to be at first included in MHM strategies, and then constantly monitored through appropriate mechanisms. However, from what has emerged in the past few pages, in the Indian policy framework both of these elements are missing. In confirmation of this, numerous studies from NGOs, nonprofit foundations, researches and experts have helped to fill those gaps left unconcluded by governmental entities and design new perspectives with the premises just mentioned.

As a matter of fact, the aim of this conclusive paragraph is to outline a new kind of social change, which transcends infrastructure building and products distribution. The goal is therefore to offer a different standpoint as for MHM policies, the foundation of which is based on human rights and gender equality.

To begin with, according to a study conducted by Susan M. Igras *et al.* it can be found that gender norms disproportionately impact adolescents' sexual and reproductive health, especially in LMICs. Misinformation due to gender bias can influence the physical, cognitive, social and emotional development of younger adolescents, accompanied by important repercussions even in adulthood.

In the early nineties, the international community has witnessed a mobilization, through studies and conferences, with respect to SRH issues. As of this time and with poor results, some developing countries have begun to invest in very young adolescents' sexual and reproductive health by strengthening the role of educational institutions and implementing prevention programmes. However, the authors argue that, in more recent times, international human rights laws are beginning to be applied to VYAs and, as the documentation of holistic programmes increases, the bottom-up advocacy may potentially influence critical macro-level barriers to VYA

[342] Food and Agriculture Organization of the United Nations, "Joint Programme on Gender Transformative Approaches for Food Security and Nutrition", Gender transformative methodologies, accessed 22 September 2022, retrieved from https://www.fao.org/joint-programme-gender-transformative-approaches/overview/gender-transformative-approaches/en

plans of action[343]. Clearly, the discourse around menstrual health falls within the scope of these schemes, since menarche marks a transition from childhood to adulthood, setting the stage for sexual and reproductive health behaviors and gendered attitudes. The key to implement better policies with reference to the specific needs of adolescents, whether male or female, corresponds to better evidence and fact-finding. As attested by the article, research is needed to explicate the developmental trajectories of VYAs, as well as identify social determinants and developmental assets of strategies[344]. At the same time, experts advocate for better programme monitoring and collection of age and sex-disaggregated data to build evidence on adolescents' participation and determine verifiable outcomes. Based on this, "as more experiences occur and are documented, moving from grey to published literature, the complex theoretical and practical issues and tensions surrounding SRH-related programmes, policies and research for and about younger adolescents will allow practical refinement in all domains"[345].

The above-mentioned investigation opens the way for other possible considerations in the research sphere. Recommendations for future practice and examination are based on overcoming the lack of research capturing MHM practices and related psychosocial, education and health consequences.

Although there have been several initiatives by central and state governments, one of the fundamental elements missing from the menstrual discourse in India is the lack of data on the hypothesized causes and consequences of poor MHM. On the authority of a recent systematic review, there emerges insufficient evidence to determine the effectiveness of MHM strategies, although some encouraging indicators are emerging[346]. The authors highlight improvements for future work, suggesting the enforcement of larger and randomized trials. In such assessments, a

[343] Susan M. Igras et al., "Investing in very young adolescents' sexual and reproductive health", *Global Public Health* 9, n. 5 (2014): 565, accessed 22 September 2022, retrieved from https://www.tandfonline.com/doi/full/10.1080/17441692.2014.908230

[344] Ivi

[345] Ibid., 567

[346] Julie Hennegan et al., "Do Menstrual Hygiene Management Interventions Improve Education and Psychosocial Outcomes for Women and Girls in Low and Middle Income Countries? A Systematic Review", *PLoS ONE* 11, n.2 (2016): 17, accessed 22 September 2022, retrieved from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0146985

comparison between various strategies has to be addressed, for the reason that "this would improve comparability across studies, enabling researchers to grasp the severity of distress caused by menstrual poverty, and the influence of interventions"[347].

Further study or more rigorous evaluation is also needed regarding the broader environment that shape women and girls' menstrual experience. With the intention of advancing the coordination of existing policies and increasing financial and human capital resources, it is necessary to develop and propagate evidence and metrics on MHH[348]. Opportunities for action identified by Laura Amaya, Jaclyn Marcatili and Neeraja Bhavaraju cover three aspects regarding building data and evidence base. The first aims at "aligning on a priority set of metrics that captures the experiences of women and men with menstruation, and including them in national and global datasets"[349]. The second focuses attention on "consolidating the existing evidence on MHH and conducting new research, including longitudinal studies and randomized control trials to fill salient gaps"[350]. As a final point, the last relies on "translating the evidence base into practical guidance by evaluating MHH interventions and disseminating best practices for implementers"[351].
One of the most critical points with respect to MHM policies in India concerns the failure to contextualize these measures within a human rights framework, covering the rights to water and sanitation, privacy, education, health and work. In the event that women and girls are not enabled to properly and adequately manage menstrual cycle in educational institutions and workplaces, then violations of their human rights and threats to gender equality may occur. In order to guarantee the human rights of menstruating individual, it is necessary to create a supportive context for menstrual management. This prerequisite evolves from building a robust evidence base in MHM, which requires considerable investment of resources in menstrual research in order to quantify the scope of associated challenges and evaluate related

[347] Ivi
[348] FSG Reimagining Social Change, "Advancing Gender Equity by Improving Menstrual Health", 33
[349] Ivi
[350] Ivi
[351] Ivi

interventions[352]. Based on a study conducted in Uttar Pradesh using the socio-ecological framework, the importance of considering participatory research and intervention approaches emerges. The aforementioned tools aspire to engage women and girls as experts in intervention design, in order to avoid involuntarily reinforcing stigma and preconceptions[353]. Accordingly, the identification of community facilitators and existing resources for dignified and safe menstruation corresponds to an additional avenue for research and evidence base for effective MHM solutions[354].

Furthermore, reframing the discourse around menstruation as a question of rights can open a new window of opportunity, in which women and girls are undoubtedly the rights-bearing agents. The right set of circumstances may upgrade human rights as the primary driver for investment in menstrual health, reconsidering the concept of menstrual hygiene management currently present in the international development discourse. On the one hand, the access of a new window of opportunity would permit to specifically target vulnerable women and girls and set them on a path to a healthy, fulfilling and empowered life, with positive outcomes and cross-cutting effects on different levels[355]. On the other hand, reassessing in general terms the definition of MHM centered on rights as opposed to hygiene would help to shed the stigma around menstruation and bring new voices into the global movement for better menstrual practices[356].

This consideration is functional for a re-examination of the measures designed and implemented by Indian Ministries, since the area of intervention remains largely dominated by the WASH sector. Framing the issue within the boundaries of sanitation and hygiene excludes women and girls' understanding of menstruation in the context of reproductive and sexual health. Therefore, to the question "What's

[352] Ellen McCammon et al., "Exploring young women's menstruation-related challenges in Uttar Pradesh, India, using the socio-ecological framework", 298
[353] Ivi
[354] Ivi
[355] Alexandra Geertz et al., "An Opportunity to Address Menstrual Health and Gender Equity", 35
[356] Jennifer Thomson et al., "What's missing in MHM? Moving beyond hygiene in menstrual hygiene management", *Sexual and Reproductive Health Matters* 27, n.1 (2019): 12,14, accessed 23 September 2022, retrieved from https://www.tandfonline.com/doi/full/10.1080/26410397.2019.1684231

missing in MHM?", Jennifer Thomson *et al*. answer a holistic and right-based understanding of menstrual cycle. In this case, "framing the issue as being about the right to safe, healthy and dignified menstruation moves it from being a negative problem to be solved, and instead an affirmative principle through which the facts of women and girls' lives are acknowledged and validated"[357].

As pointed out above, situating menstrual hygiene in the human rights framework helps to designate elements required to manage menstruation in dignity. As a consequence, the identification of appropriate strategies based on human rights obligations requires States to protect individuals from abuses of their human rights by others and reach into menstruators' private sphere, contributing to their full realization. To be specific, States are in charge of progressively creating an enabling environment for women and girls to manage menstruation adequately to the maximum of their available resources. The contribution of the human rights foundation lies, in fact, in "drawing attention to the plight of women and girls who are not able to manage their menstruation adequately by highlighting States' and other actors' obligations and responsibilities with respect to menstrual hygiene"[358]. On account of the fact that equality and non-discrimination represent keystones of human rights law, "any practice that prevents gender equality or that allows for stigma, prejudice, and discrimination against women and girls must be eliminated and replaced with a practice that promotes human rights"[359].

It is clear that the recognition of biological differences between men and women is decisive in achieving substantive equality, but the question of menstrual hygiene management necessitates an all-embracing consideration of stereotypes and stigma surrounding the issue. For these reasons, future research needs to capture the complexity of women and girls' experiences with the intent of normalizing menstruation and menstrual management as pivotal steps to securing interventions and strategies in line with human rights standards. To do so, the commitment of

[357] Ibid., 14
[358] Inga T. Winkler et al., "Taking the bloody linen out of the closet: menstrual hygiene as a priority for achieving gender equality", *Cardozo Journal of Law and Gender* 21, n.1 (2014): 37, accessed 24 September 2022, retrieved from https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2575250
[359] Ivi

multiple actors and the consideration of the matter according to a multi-level perspective is indispensable. Funders, academics, experts and fieldworkers could potentially catalyze change by build the data in order to understand the inherent attributes of the challenge and the connected links to other life outcomes[360]. While policymakers, program implementers, practitioners and monitoring specialists may possibly "maximize their impact by bridging across siloes to integrate different aspects critical to MHH: knowledge and awareness of menstruation, access to menstrual products, improved WASH infrastructure, and changes in social and gender norms"[361].

[360] FSG Reimagining Social Change, "Advancing Gender Equity by Improving Menstrual Health", 36
[361] Ivi

CONCLUSIONS

Overall, this thesis aims at examining menstrual challenges and related solutions in the Indian context, by taking women and girls' experiences and subjectivities into account. The factors which escalate the vulnerability of menstruating individuals, contemporary schemes to tackle gender-based discrimination in menstrual hygiene management policies in the current legal framework, connected program effectiveness and gender impact assessment are illustrated with multidimensional perspectives through the lens of human rights and feminist theory. The adoption of a right-based approach to menstrual cycle, thus, appears fundamental in order to broaden the definition of menstrual hygiene management and reframe the concept according to a more holistic frame of reference. Such viewpoint permits the adoption of an intersectional approach, which takes into consideration interrelated elements of menstruators' life, such as gender, cultural and religious belonging, socioeconomic status and geographic affiliation that shape the experience of such natural and biological process. This expression of views comes to be particularly pertinent in circumstances where high level of gender inequality, gender-based discrimination and pervasive patriarchal norms are present. Precisely for these reasons, India represents an ideal background for the research.

The purpose of chapter two is to illustrate the dimension of menstrual hygiene management agenda, underlying potential risks and opportunities linked to the recognition of menstrual health according to a human rights perspective. The reason for tackling menstruation as a public health issue is to pave the way toward the identification of favorable frameworks to address the question, contemplating a series of measures that go beyond short-term interventions. This study demonstrates that prioritizing the implementation of practical solutions, such as having access to facilities to dispose of used menstrual materials, limits substantially the possibility for cultural change. Mere sanitation missions do not guarantee desirable transformational outcomes, owing to the fact that WASH-based programmes lose sight of the objective to normalize menstrual cycle and, eventually eradicate gender discrimination. Based on the elaboration of available literature, it is possible to

affirm that the key strategy to overcome stereotypes, cultural norms, religious preconceptions and stigma attached to menstrual cycle is to determine cross-sectional opportunities resulting in gender-sensitive solutions.

Given these premises, the present dissertation aspires to answer the question of whether Government of India's menstrual hygiene management policies could be an effective tool to promote gender equality. Before proceeding with the analysis of such interventions, it is necessary to investigate challenges and impediments that Indian women and girls face in managing menses. Coherently with this purpose, examining the multi-dimensional nature of menstrual experience proves that the combination of several factors provokes gender inequalities and discrimination, impacting menstruators' enjoyment of human rights and limiting their fundamental freedoms. As a matter of fact, the first part of the third chapter reveals that the lack of education, awareness and information with respect to the topic reinforces stigma, misconceptions and negative beliefs. To continue, these patterns are stronger in rural areas, affecting social participation and the possibility to interact with others. The most obvious finding emerging from this study in the above-mentioned chapter is that the majority of Indian women and girls face a lack of regular access to safe menstrual materials and experience inadequate standards for sanitary options. This tendency is closely related to the previously analyzed condition, since limited comprehensive knowledge of menstruation leads to limited knowledge of hygienic alternatives to menstrual cloths and unappropriated period practices. Even if low-cost disposable sanitary pads are gradually entering the market space, the actual concern is that women and girls have no voice in the management and allocation of resources within the household. Similarly, menstruating individuals are not included in designing sanitary facilities which meet gendered needs, missing this way the opportunity to promote safe sanitation and advancing synchronically human dignity, human health and gender equality.

Thus, it can be deduced that the three mentioned factors are interlinked and mutually reinforcing. Moreover, existing menstrual-related concerns create a vicious cycle, at the basis of which the asymmetrical gender system of power is maintained.

The second part of chapter three enters into the merits of the legal and political responses to the issue, clarifying the current state of Government of India's initiatives and distinguishing competent Ministries' different approaches to target poor menstrual hygiene management practices. With the attempt to define program effectiveness, goal attainment and gender impact assessment, governmental monitoring reports and evaluation strategies are taken into consideration. As to compensate for scarce resources available online, grey literature and shadow reports concurrently contribute to shape a comprehensive, organic and inclusive groundwork with respect to objectives and limitations of such plans.

The evidence from this study suggests that Indian legal and policy framework concerning menstrual hygiene management policies timidly recognizes the gender dimension of sanitation. Despite some circumscribed attempts to address challenges related to the rights to privacy, education, water and sanitation, health, safe and healthy working conditions and the principle of non-discrimination, there is still a long way to go in view of ensuring that menstruating individuals' needs are successfully met. There are essentially four main reasons to support this statement.

First, the analyzed interventions may possibly contribute to the realization of several women and girls' human rights, but the principle of gender equality misses the opportunity to be appreciated as driving factor and transformative principle. Instead of being recognized as rights-bearing agents, menstruating individuals are defined as objects and targets of such policies, rendering it arduous to bring about behavioral changes and ensure long-term effects.

Second, Government of India's programs tend to relegate menstruators' challenges to infrastructural solutions. This approach excludes the possibility to tackle the structural factors of menstrual-related concerns and address the root causes of gender-based discrimination, as well as patriarchal norms that govern Indian society.

Third, the role of men and boys in supporting menstrual hygiene is totally absent within the policy framework already examined. Recent investigations strongly demonstrate that inclusion of those who do not encounter period in the menstrual

discourse could create spaces for open dialogue with the aim of challenging cultural norms and taboos resulting in gender discrimination. In this scenario, the implementation of a community-based menstrual hygiene and WASH programme by WaterAid and *Vatsalya* in Uttar Pradesh, India confirms that establishing inclusive strategies and sensitizing different stakeholders brings about successful outcomes. According to current findings, a change of perception of men and boys towards menstruation helps in reducing gender inequity and exclusion, along with minimizing shame and embarrassment and restoring women and girls' dignity and self-esteem[362]. Moreover, "the involvement of males has generated a more positive environment for establishing counselling centers where affordable and hygienic materials and counselling on safe MHM practices are available"[363].

Last but not least, the exclusion of menstruating individuals in all stages of planning, decision-making, monitoring and evaluation in menstrual hygiene management policies limits the adoption of gender-sensitive measures. In effect, the inadequate participation of women and girls does not secure schemes and resources aimed at supporting the human rights of menstruating individuals. In order to create a sustainable supportive environment for challenge-free menstruation, it is required to eradicate existing male bias inherent in sanitation interventions and extirpate male domination in decision-making and implementation processes. On account of this, it should be noted that a true menstrual revolution is only possible when women and girls are recognized as agents of change, meaning that their necessities and experiences are contemplated in multilevel and culturally appropriate interventions.

Regardless of these reflections, there exist several satisfactory representative cases in India which can offer lessons to other states. To give an instance, the *Kudumbashree Mission* in Kerala incorporates women in solid waste management products and production of sanitary napkins; in Jharkhand menstruators are trained in the construction of toilets in rural areas, some of them are appointed as treasures

[362] Thérèse Mahon et al., "Putting the men into menstruation: the role of men and boys in community menstrual hygiene management", 12
[363] Ibid., 11-12

of the village water and sanitation committees and others sign for the SBM Fund[364]. These local-based actions include women "in the implementation of sanitation programmes while promoting their agency and autonomy, as well as providing them livelihood opportunities"[365].

Truth of the matter, such above-mentioned examples represent singularities within the Indian policy and legal setting. On the one hand, menstrual hygiene management policies constitute a giant step forward in recognizing challenges, barriers, limitations and discriminations from which women and girls suffer and continue to suffer. But on the other hand, the way these initiatives are designed suggests that a rights-based understanding of menstruation is missing and an evident focus on women's human rights is lacking. In conclusion, more complete and accurate documentation on how MHM plans are realized will facilitate potential adjustments and improvements. Once we have a clearer understanding of benefits and positive implications associated with achieving gender equality through these policies, then policymakers can take further steps to reframe menstruation as a question of rights, reorientate the ownership of the issue, acting "as a catalyst to bring new voices into the global movement for better menstrual practices"[366]. In any case, for the purpose of observing and analyzing the future reality of Indian menstruators and empirical progress regarding better menstrual hygiene management practices, further research is needed.

[364] Sujith Koonan, "Sanitation Interventions in India: Gender Myopia and Implications for Gender Equality", 54
[365] Ivi
[366] Jennifer Thomson et al., "What's missing in MHM? Moving beyond hygiene in menstrual hygiene management", 14

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