



Social and Market Research: Menstrual and Reproductive Health Beliefs, Practices, Products and Markets in Barmer, Rajasthan

Final Report



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ABBREVIATIONS

ANM	:Auxiliary Nurse Midwife
ASHA	: Accredited social health activist
AWW	:AnganWadi Worker
CHC	: Community Health Center
FGD	: Focus Group Discussion
FLW	: Frontline Workers
ICDS	: Integrated Child Development Scheme
KPI	: Key Person Interview
MH	: Menstrual Health
OBC	: Other Backward Class
OCP	: Oral Contraceptive Pill
PHC	: Primary Health Center
RH	: Reproductive Health
RTI	: Reproductive Tract Infection
SC	: Scheduled Caste
SN	: Sanitary Napkin
ST	: Scheduled Tribe

GLOSSARY

ADOLESCENT GIRLS¹ (AG): The girls in the age group between 11 to 18 years are generally considered in the category of adolescent girls. It is a significant phase of transition from childhood to adulthood. Since our study is probing menstruating AGs and adult women, the age bracket used is 14- 18 years.

ADOLESCENT BOYS²: Similar to Girls, the boys in the age group between 11 to 18 years are generally considered in the category of adolescent boys, however, in this study we used the age bracket 14-18 years.

MENARCHE³: Menarche is another name for the beginning of menstruation. Menarche is the first menstrual cycle, or first menstrual bleeding, in females.

MENOPAUSE⁴: It is permanent cessation of menstruation resulting from the loss of ovarian follicular activity.

MENSTRUATION⁵: Menstruation is a woman's monthly bleeding. It is also called menses, menstrual period, or period. When a woman has her period, she is menstruating. The menstrual blood is partly blood and partly tissue from the inside of the uterus (womb). Most menstrual periods last from three to five days.

MENSTRUAL CYCLE⁶: Menstruation is part of the menstrual cycle, which helps a woman's body prepare for the possibility of pregnancy each month. A cycle starts on the first day of a period. The average menstrual cycle is 28 days long. However, a cycle can range anywhere from 23 days to 35 days. In human females, the menstrual cycle occurs repeatedly between the ages of menarche, when cycling begins, until menopause, when it ends.

MENSTRUAL HEALTH⁷: Menstrual health and hygiene holistically includes the i) articulation, awareness, information and confidence to manage menstruation with safety and dignity using safe hygienic materials together with ii) adequate water and agents and spaces for washing and bathing and iii) disposal with privacy and dignity.

Menstrual hygiene management is not the production and distribution of sanitary pads or hygiene education on its own. The combination of all three dimensions is essential for ensuring that girls and women are able to break taboos and demand adequate facilities for MHM that suit their needs.

¹ RAJIV GANDHI SCHEME FOR EMPOWERMENT OF ADOLESCENT GIRLS (RGSEAG)—'SABLA' - The scheme. URL: <http://wcd.nic.in/SchemeSabla/SABLAscheme.pdf>

² ibid

³ Menstruation and the Menstrual Cycle. November 2002. Archived from the original on 2 Mar 2007. URL: <http://web.archive.org/web/20070302205256/http://www.4woman.gov/faq/menstru.htm>

⁴ World Health Organization. Research on the menopause in the 1990's. Report of a WHO Scientific Group. World Health Organ Tech Rep Ser. 1996;866,12–14 URL: <http://consensus.nih.gov/2005/menopauseabstracts.pdf>

⁵ Menstruation and the Menstrual Cycle. November 2002. Archived from the original on 2 Mar 2007. URL: <http://web.archive.org/web/20070302205256/http://www.4woman.gov/faq/menstru.htm>

⁶ ibid

⁷ http://www.wssinfo.org/fileadmin/user_upload/resources/MENSTRUAL-HYGIENE-MANAGEMENT-Paper-for-END-group-1.pdf

REPRODUCTIVE HEALTH⁸: Reproductive health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

MHRH INFRASTRUCTURE: The MHRH infrastructure in this study includes facilities and infrastructure for urination, defecation, hand-wash, SN disposal, etc.

MHRH Products: MH product primarily is sanitary napkin. The RH products include Oral Contraceptive Pills (OCP), Male Condoms, Female Condoms, IUD and Pregnancy Testing Kit.

SCHEDULED CASTE: Scheduled Castes means such castes, races or tribes or parts of or groups within such castes, races or tribes as are deemed under article 341 to be Scheduled Castes for the purposes of this Constitution⁹.

SCHEDULED TRIBE: Article 366 (25) of the Constitution of India refers to Scheduled Tribes as those communities, who are scheduled in accordance with Article 342 of the Constitution. This Article says that only those communities who have been declared as such by the President through an initial public notification or through a subsequent amending Act of Parliament will be considered to be Scheduled Tribes¹⁰.

SERVICE PROVIDER: The study is based in rural India, therefore the service providers considered are those based at village, Panchayat, and block levels: public (Anganwadi, Health Sub-Centre, PHC, CHC); private (dispensary, clinics, medical shops) and community-based initiatives.

FRONTLINE WORKERS (FLWs): Frontline functionaries are the interface of service system with community on crucial behaviours related to health, nutrition, water and sanitation. FLWs act as important and sometimes last mile delivery points of services to people. The ANM, ASHA and anganwadi worker (AWW) along with a range of community volunteers, reach out directly to families as part of government implementation mechanisms providing advice, referrals, linkages, diagnosis and information.

⁸ http://www.who.int/topics/reproductive_health/en/

⁹ <http://socialjustice.nic.in/constprov2.php?pageid=1#a1>

¹⁰ <http://tribal.nic.in/Content/IntroductionScheduledTribes.aspx>

EXECUTIVE SUMMARY

Maternal and child health are major development issues of global concern. They are central to the achievement of the Millennium Development Goals 4 (reduce child mortality) and 5 (improve maternal health) and will certainly remain in focus in the United Nations Post-2015 Development Agenda. They are also the priority areas within India's national and regional health goals and objectives. Within this domain falls menstrual hygiene (MH), which for practical reasons is often associated with reproductive health (RH).

CARE India in partnership with CAIRN India Limited works towards improving menstrual and reproductive health and hygiene in Barmer District, Rajasthan wherein the goal is to improve access of girls and women in rural areas to high-quality sanitary napkins (SN) and other MH&RH products and services. In this context, Kaarak Enterprise Development Services Pvt. Ltd. was assigned to conduct a study which would help guide their future interventions in the improvement of menstrual and reproductive health status of women and adolescent girls while establishing a sustainable/commercial market for MH&RH products and services aimed at low-income households. The core objectives of the study were to:

- Identify the prevailing MH&RH awareness, beliefs, practices and behaviour among members (both male and female) and the key factors (or determinants) that influence these in rural households in Baytu and Dhorimanna block.
- Assess the main benefits sought by adolescent girls and women in the form of MH&RH products, facilities and services.
- Understand the current local market for MH&RH products and services.
- Identify the barriers to adopting improved MH&RH.
- Gauge target households' ability and willingness to contribute and/or pay for MH&RH products, facilities and services.

The primary research was conducted in January 2015 in two blocks Baytu and Dhorimanna of Barmer district. Both primary and secondary methods of data collection were used including desk review, key person interviews, focus group discussions and quantitative surveys. The respondents included: men, women, adolescent girls, adolescent boys, front-line workers (FLWs), service providers, NRHM/DWSM officials and relevant officials at block and district levels (ICDS). Qualitative data collection was based on around 20 FGDs and 30 KPIs with the stakeholders. Quantitative data collection took place in 21 villages in both blocks covering 308 females (127 adolescent girls and 181 adult women) and 220 males (60 adolescent boys and 160 adult men). In terms of communities, the sample included Meghwals (SC), Bhils (ST), Jats (OBC), Sansi (SC), Muslim (OBC) and general castes.

KEY FINDINGS

A summary of the key findings can be seen below.

a. Norm and Beliefs

- **Awareness of MH is low:** Menstruation remains a taboo subject that is not frequently discussed in public or in private spaces. Over half of the women surveyed (55.5%) knew nothing of menstruation before it started for them. Only 3.9% affirmed that they were completely aware. Even after they begin experiencing it, awareness is relatively low (only 53.9% recognize it as a biological process while 35.1% believe it is a work of god and 11% do not know at all).
- **Communication on MH is poor:** Information about the menstruation, (whether pre or post menarche) comes from four primary sources: mother/sisters/ relatives, female friends, female friends and FLWs (AWWs, ASHA, ANMs). Most of the information girls receive about menstruation comes from the first three categories (families in particular), and it mostly concerns restrictions and things that females are not allowed to do during their periods. Overall, cross-generational communication on the subject is relatively low. During focus group discussions, women and girls shared that they know about the norms and practices from their mothers since they witness them practice it. But they don't talk to mothers about it. At menarche or after, they confide only in 'joking relations' as sisters, sister-in-law, *chachi*, *bu* et cetera. In addition, discussion on the topic between males and females is non-existent.

Again education seems to be an important factor in determining where girls and women learn about MH. The source of information about menstruation changes dramatically depending on the level of education. Mother/sister/relative was cited as a main source of information by 90% of females who were uneducated, but only by 55.2% of women who had attended to secondary levels. Again, this could be attributed to the instruction girls receive at school, as well as the increased mobility and social interactions of school-going girls.

As social groups, girls and women from Bishnoi and Brahmin communities face stricter restrictions as opposed to other communities where restrictions are less stringently enforced. However, praying, visiting temples and fasting are universally restricted among all communities.

- **Male's awareness of menstruation is moderate:** 69.1% of men claimed they knew about menstruation and 55.9% described it as a biological process (28.2% said a work of god and 15.9% did not know). 52.2% of men said that women in their families faced menstruation-related restrictions. 36.8% said women in their family did not face restrictions, and 10% were not aware. Of those who knew of these restrictions, 65% said that following restriction was necessary because it was a tradition and 20% believed that restrictions are necessary because women are 'impure' during menstruation.
- **Males learn about menstruation and MH products in different ways than women:** Males said that they know of menstruation and sanitary napkins primarily from telecommunications/ radio (72%) followed by FLWs/ health workers (39.6%), friends (36%) and school teacher (19.8%).

b. Awareness of MH

- **Women and MH products:** Three important factors that were found to significantly affect MH were 1.) age 2.) level of education and 3.) community (or caste).

- **Use of sanitary napkins is low:** The present use of products is divided into cloth (63%), sanitary napkin (40%) and nothing (9%) and scattered use of sand bags and ash bags.
- **Distribution of use of products:** Use of SN is directly correlated to education and inversely correlated to use of cloth. School going girls have physical and social mobility, and this increased mobility has played a vital role in increased accessibility of SN among school going girls. At present, use of SN is 96% for those currently studying in senior secondary and 75% of those in secondary level (grade 6 to 10). On the contrary, only 12% of uneducated girls were using SN and 76% reported using cloth.
- **Stayfree is the market leader in sanitary napkins:** As for the SN brands the market research revealed that price, strong distribution channel and effective advertisement campaigns have played an important role. Stayfree (pack of 8) is the market leader since it excels in all three, followed by a more institutional sale of Butterfly and Care. 40% of current SN users are using Stayfree while 40% are not aware of the brand they use and around 7% of them also mentioned buying the brand 'Rehsam' –which is manufactured by SHGs under a pilot women health initiative (RACHNA) supported by CARE India and CAIRN India. This is especially true for villages close to SN units and also the locations where CARE India conducted special programmes and also sold the SNs.
- **Price of product does not seem to be a major barrier to SN use:** Of female respondents who use menstrual hygiene products (either always or sometimes), the vast majority (82.3%) spent between 11-50 rupees per month. Specifically 46.9% spent Rs. 11-20 and 35.4% spent Rs. 21-50. The education level of respondents was directly related to the amount of expenditure with more educated women spending more per month.
- When women were asked if they would be willing to use 'a more convenient and easier to use product', over half (166/308) said yes. Of those who said yes, respondents were asked how much they would be willing to spend every month, answers ranged from Rs 5-10 (2.4%), Rs 11-20 (38%) Rs 21-50 (38%) and over Rs 50 (21.7%). Similarly, education seems important as higher educated respondents claimed to be willing to spend more per month than lesser educated ones.
- **Male awareness of MH products is moderate:** Around 51% of men know about sanitary napkins, and 50% were at least somewhat aware of the price of such products. Almost all men said they would be willing to spend money on sanitary napkins for the women in their families and the amount they could spend ranged from Rs 5-Rs 100 per month.
- **Women's knowledge of contraceptives is low:** Of married women surveyed, only 31% were aware of some sort of contraceptive. Those who were aware, largely named four types—oral pills, male condoms, female condoms, copper T and pregnancy test kit. The awareness levels are directly correlated with education levels as 77% of the uneducated women are unaware of contraceptive products.

- **Use of contraceptives is low:** Only 25 % of the currently married women surveyed reported regular use of contraception (condoms, IUDs, OCP) in the last three months preceding the survey while 40% reporting not using any method at all. Women acquire these products from: medical shop in town (43%) and FLWs (9%) although over one-third of the women using these products were not aware of the source of the products. 91% of those who have used contraceptive in last three months have used male condoms. FGDs further reveal a trend that many women are aware of and opting for terminal method of contraception: '*nasbandi*' or sterilization.
- **Men are more aware of RH Products but use is the same as women:** 55% of men are aware of the contraceptive products. They mostly know (and use) male condoms, but some mentioned other products as well. 25% of men said that they had used contraceptives in the past 3 months which was the same answer as women. 27% mentioned obtaining contraceptive from FLWs (i.e. ASHA, AWW or ANM), 23% from local level RMP or dispensary stores, 20% from local medicine stores and 20% from other private doctors.

C. Infrastructure and service providers

- **Village level infrastructure related to MH/RH is relatively low and in some cases inexistent.** The study area is rural, impoverished and overall levels of development are low. No special structures related to MH/RH exist. For instance vending machines were mentioned as a future possibility, but up until now, none exist. Also, there is currently no organized system for disposal of MH/RH products. This is a major obstacle that has been observed in other studies as well.
- **Schools have toilets, but they are not satisfactory.** Although all schools in the study area have toilets, they are generally unsanitary and not convenient places for girls to change sanitary napkins during menstruation. This can affect girl's participation and performance rates in schools. Most girls avoid using the toilets and if they need to change their pads, some return home during breaks. Although the majority of girls did not miss school because of menstruation issues, some did.
- **FLWs are not the primary source of sanitary napkin distribution.** However, there is scope for their role to increase. Some women said that they were uncomfortable purchasing products from male shop keepers, but would buy from Anganwadi centres or ASHA worker if they carried MH products. SN sold by Rachna units currently occupy 5% of the market with a wide range of potential consumers.

D. MHRH Market

- **Sanitary napkin market structure follows a similar market structure as any Fast Moving Consumer Good (FMCG),** however, it is interspersed with certain players who deal exclusively with it as part of their medical products profile (such as the Butterfly brand supplying SN to clinics and hospitals) while other major brands take it as a FMCG product for mass consumption.
- **The market for RH related products especially male condoms is similar to that of sanitary napkins.** The major difference being that government also distributes products including condoms and oral pills through its network of health workers. There is no such government led

effort for MH products in the district of Barmer (although there may be in other parts of the country).

- **The total immediate market potential is estimated around 2 lakhs females.** As per the current sales data provided by the leading stockists and wholesalers, around 20,000 packets of sanitary napkins are being sold which is only 3% of the total universe and 10% of the total customers who can be immediately targeted.

CONCLUSION:

- a. Caste/community plays an important role in the MH related knowledge, beliefs, behaviors and practices of women and girls in the study area. Interestingly, women and girls from the higher castes faced more restrictions than lower castes.
- b. Age emerged as a very important determinant on all issues. The awareness and practices of younger girls are significantly different than for older generations. This is related by multiple factors amongst the most significant is education.
- c. Education is a crucial aspect in the MH/RH scenario of the study area. On practically every issue, the awareness and practices of school-going females was better than those of uneducated females. This is a result of a.) instruction that girls receive in schools b.) increased mobility outside of the home c.) increased social interaction (with peers, teachers, etc.)
- d. Communication on MH and RH issues is very poor between generations (e.g. adolescent girls and older women) and non-existent between sexes (male to female), except in spousal relation.
- e. There is no MH/RH specific infrastructure in the general community or within homes. Of particular importance is the absence of any regularized disposal system for products. This must be addressed for significant improvement.
- f. All schools have toilets, but they are largely unsanitary and inconvenient for adolescent girls.
- g. Media (telecommunications/ posters/ radio) is an important source of knowledge, particularly for men.
- h. Presence and effectiveness of FLWs is mixed. Some are relatively active and provide information and support related to MH/RH. These include AWWs, ANMs, ASHAs. However, Jan Mangal couples and Saathins are hardly noticeable and have very low impact on the ground.

RECOMMENDATIONS TO DEVELOP LOCAL MARKETS

The key recommendations to develop the local markets for SN are as follows. These recommendations have been detailed out in the relevant section in the main report.

- Finalise the enterprise design and strategy
- Set the Goal and the Sales Targets
- Specify the target consumer
- Improve the packaging of the SN product
- Keep the price of the product in line with other competitive products
- Key Message or advertising campaign should focus on the SN as a wellness product with positive imageries
- Experiment with both conventional and unconventional sales channels

- **Conduct educational and supporting activities for market development**

I. Introduction

CARE, CAIRN and RACHNA

In a strategic effort to reduce maternal and infant mortality and improve menstrual hygiene and reproductive health in Barmer District, Rajasthan, CARE India has partnered with CAIRN India Limited. This partnership is part of a programme called RACHNA and represents a serious commitment to improving the health of local communities. One of the essential elements of RACHNA is a component on menstrual and reproductive health and hygiene wherein the goal is to improve access of girls and women in rural areas to high-quality sanitary napkins (SN) and other MH&RH products and services.

Before intervening or implementing a programme, however, the two organizations seek to fully understand the local contexts including the needs and resources that are available within the target area. A Health Needs Assessment Study conducted in 2012¹¹ indicated multiple factors and constraints related to access to basic health products and services in rural areas. However, the study did not focus specifically on MH/RH, and behavioural, socio-economic and market characteristics were not part of the study framework. Therefore, further investigation on these specific issues was required.

About the study

In this context, CARE India contracted Kaarak Enterprise Development Services Pvt. Ltd. to conduct a study which would help guide their future interventions in the local area. As per the original terms of reference of the assignment, that the study would assist CARE India in developing an evidence-based MHRH component within RACHNA which would improve the menstrual and reproductive health status of women and adolescent girls while establishing a sustainable/commercial market for MHRH products and services aimed at low-income households. The specific objectives were to:

- Identify the prevailing MH&RH awareness, beliefs, practices and behaviours among members (both male and female) in rural households in Baytu and Dhorimanna.
- Identify the key factors (or determinants) that influence these beliefs, practices and behaviours.
- Assess the main benefits sought by adolescent girls and women in the form of MH&RH products, facilities and services.
- Understand the current local market for MH&RH products and services.
- Identify the barriers to adopting improved MH&RH.
- Gauge target households' ability and willingness to contribute and/or pay for MH&RH products, facilities and services.
- Provide evidence based recommendations that can assist in developing local MH&RH markets.

Scope of Work and Study Design

¹¹ Kaarak Enterprise Development Services Pvt. Ltd. was the research partner for this study as well.

The thematic scope of work (SoW) included study of prevailing MHRH awareness, beliefs, practices and behaviours and the factors/determinants that influence them. The scope of execution included:

- a) Design of the research protocol which included sampling design, methodology, and analytical framework.
- b) Execution of study which included pre-testing and finalization of research instruments, data collection, quality assurance and data analysis.
- c) Reporting of results and recommendations in the form of a report and presentation.

The study made use of both qualitative and quantitative data sources. These included primary as well as secondary sources of information.

Methodology

Secondary Research

Extensive literature review was conducted in order to understand the, context as well as the appropriate factors to be considered within the framework and tools. Many studies on these issues focus on either MH/RH beliefs, awareness, and practice OR market research. However, because this study included both of these elements, secondary research on both was conducted. In addition to articles and documents available in the public domain, the research team also made use of materials that were provided by CARE India and local stakeholders as they were made available.

Primary Research

Primary research involved collecting data from adolescent girls, men and women, village level service providers (ASHA, ANM, AWW [AnganWadi Workers], Saathin and school teachers) and vendors/suppliers of MH&RH products. In addition, key stakeholders involved in MH&RH service delivery were approached to get an overview of achievements and challenges in executing programmes meant for improved awareness and access to MH&RH, and related factors.

- **Sample and Coverage for qualitative data collection**

Focus group discussions with community members (adolescent and adult women and men) and key person interviews (KPIs) with suppliers and retailers of MH&RH products and MH&RH service providers were the key methods for collecting qualitative data. At the community level, the discussions focused on awareness, beliefs & practices as well as facilitating and inhibiting factors in adopting improved MH products. Service providers at village, as well as block and district levels were interviewed for their perceptions and experiences on of MH/RH, provisions under state and national government schemes, and their implementation.

Actual coverage during data collection exceeded the original targets. The tables below provide details of the proposed and actual coverage through FGD and KPIs.

Table 1: Proposed and actual coverage through FGDs

	FGDs- Proposed Coverage	FGDs- Actual Coverage
Coverage	16 (8 FGDs spread over 4 villages)	20 (Ten FGDs in each block spread across 6

	in each block)	villages of Baytu and 7 in Dhorimanna)
Respondent/participants	Adolescent girls and adult women, adolescent boys and adult men (separate FGDs for each group)	Adolescent Girls: 5 Adult Females:7 Adolescent Boys:4 Adult Males: 4

The village wise coverage is provided as **Annexure II**.

Table 2: Proposed and actual coverage through KPIs

	KPIs- Proposed Coverage	KPIs- Actual Coverage
Coverage	20-25 (estimated)	>30
Respondent /participants	ASHA, AWW, ANMs, PHC/CHC/AYUSH doctors, School Teachers– (approx. 6) Chemists/Retailers/wholesalers of MH&RH products – (approx. 10) Care India team members – (approx 3) NRHM/DWSM officials – (approx. 2) Relevant officials at block and district levels (ICDS/education) – (approx. 2)	ASHA, AWW, ANMs, PHC/CHC/AYUSH doctors– 15 Chemists/Retailers/wholesalers of MH&RH products –10 School teachers- 3 Care India team members –3 NRHM/DWSM officials – 1 Relevant officials at block and district levels (ICDS/education) – 2

- **Coverage for quantitative data collection**

The quantitative data was collected through close-ended individual survey. This survey was administered to according to sample plan that was created and agreed upon in consultation with CARE officials. Potential villages for individual survey were identified keeping in mind the distance (from market/urban centre) and presence of disadvantaged communities.

The original sample plan and actual coverage is as below:

Table 3: Sampling plan and actual coverage

Levels of sampling	Proposed Coverage	Sampling Logic	Actual Coverage
Blocks covered	Dhorimanna(GudaMalani Sector) and Baytu blocks of Barmer district	Both the blocks are part of RACHNA's MH&RH interventions	2 Blocks- Dhorimanna/GudaMalani and Baytu of Barmer district
No. of villages to be covered	20 (10 each in the two blocks. Of these 5 villages will be relatively close to urban areas/health facility and	Proximity and connectivity to urban areas and/or public health service is a key determinant to awareness, access and health seeking behavior.	Baytu: 10 Dhorimanna: 11 Total:21

	the other 5 will be distant or remote ¹²)		
Respondents to be covered	500 in total (300 females and 200 males) 250 (150 female and 100 male) in each block 15 females (8 adolescent girls and 7 adult women in reproductive age group) and 10 males in each village	The 3:2 proportion of female and male respondents was decided with the assumption that while females would be a key source of information on awareness, beliefs, practices and facilitating/inhibiting factors in adopting MH&RH products, male views and perspectives would be important on issues relating to their awareness regarding hygiene-health connect, awareness about MH&RH products and willingness and ability to pay. Apart from the female-male ratio, the final sampling also considered caste/religion factors.	Female: 308 (127 adolescent girls and 181 adult women) Male: 220 (60 adolescents boys and 160 adult men) Total:528

• Implementation Steps

Step I: Inception phase

The initial phase of the assignment was used for literature review and development of draft tools. The tools were eventually finalised after the exploratory (scoping) visit and feedback from CARE India. The scoping visit began on the 7th January 2015 and was used to:

- Familiarize with the local context and engage with key stakeholders
- Conduct 4 FGDs in 2 different villages to get an overview of the local context and potential inputs towards finalizing tools
- Test the survey tool for males and females
- Visit the SN production groups
- Finalize selection of villages to be covered during primary data collection in consultation with the project team at Barmer
- Develop sampling strategy that included all members of society (especially vulnerable marginalized groups including Dalits, Adivasis (ST) and Muslims)
- Finalize list of stakeholders to be interviewed during primary data collection

Training and Orientation of Enumerator: Agenda

- A general orientation on the background and rationale for conducting the study;
- Brief profile of the study sites;
- Review of terms of reference, expectations and coverage targets
- Detailed discussion on the tools, followed by mock interviews
- Session on quality control parameters to be followed by staff during the survey.

STEP II: Data Collection

¹²Following common practice in public health studies, distance can be determined by geographical distance or by connectivity/estimated time travel between locations. A decision can be determined upon the scoping visit in consultation with project officials.

The scoping visit was followed by collection of both quantitative and qualitative data. Quantitative data collection involved orientation and supervision of enumerators towards conducting the individual HH survey. The enumerators' team was 16 members (plus two supervisors). The team was gender-balanced and trained by Kaarak. The qualitative data was collected directly by the Kaarak team members, with the help of interpreters wherever required.

Data collection took place between January 10th and 18th, 2015.

STEP III: Data Collation and analysis

The quantitative and qualitative data were then analyzed for drafting the final report. The analytical framework was referred to for analysis of quantitative and qualitative findings. For quantitative data analysis, the web-based platform Survey Monkey, was used.

Step IV: Report writing and submission of deliverables

This phase entailed coming together of the team once data collection and dissemination were completed. The core team had the final responsibility of developing the comprehensive draft and final reports. In accordance with the ToR this final report includes:

- ✓ Detailed results from data analysis (including overall and block specific data)
- ✓ Key recommendations to inform the design of MH&RH component of RACHNA (especially market development and behavioral change interventions).

Limitations

Presence of Muslims and scheduled tribes (STs) is quite low in the study area. In order to ensure their representation, villages with Muslim and ST populations were included purposively in the sample. Muslim men were reluctant to participate in the survey. This gap was filled by conducting an exclusive FGD with Muslim men with support from active men in the village.

Finding eligible surveyors, particularly female surveyors, was a challenge in Dhorimanna as young females are now allowed to move out on their own. During quality monitoring, we found that the survey team for Dhorimanna was not up to the mark. The survey team for Baytu was therefore used to cover Dhorimanna as well.

II. Context Analysis

Maternal and child health are major development issues of global concern. They are central to the achievement of the Millennium Development Goals 4 (reduce child mortality) and 5 (improve maternal health) and will certainly remain in focus in the United Nations Post-2015 Development Agenda. They are also the priority areas within India's national and regional health goals and objectives. Within this domain falls menstrual hygiene (MH), which for practical reasons is often associated with reproductive health (RH).

Within India, numerous studies have shown that MH is an issue that is largely unaddressed¹³¹⁴¹⁵¹⁶. The associated needs and problems are highest amongst underprivileged and rural sections of the population. Many girls in India are partially or totally unaware of menstruation until their first experience because it is rarely discussed or explained in homes or in public places. In India, menstruation and menstrual practices are clouded with taboos and socio-cultural restrictions for women as well as adolescent girls. Limited access to products for sanitary hygiene and sanitary facilities (which includes sanitary napkins, toilets in schools, availability of water, privacy and safe disposal) can prove to be important barriers.

In fact, usage of sanitary napkins in rural areas has been observed as alarmingly low as two to three per cent¹⁷. Traditionally, in absence of sanitary napkins alternative materials such as old clothes, ash, straw or sand are used.

These unfortunate realities lead to negative consequences and outcomes for women and girls. The most significant impacts of the failure to address MH can be characterized as:

Health problems:

Physical-Menstrual hygiene is suspected to be linked with reproductive tract infections (RTI) as well as skin conditions such as rashes. Although concrete causal evidence of this link (especially in developing countries like India) is limited, the connection is reasonable and anecdotal evidence is abundant. Menstrual Hygiene Matters: A resource for improving menstrual hygiene around the world¹⁸ explains the potential risks associated with poor menstrual hygiene, and one recent report- Spot On! Improving Menstrual Health and Hygiene in India suggests that women who used unsanitary products to control menstrual bleeding were 70% more likely to contract RTIs¹⁹.

Mental- Although it is cited less frequently than the physical health effects, the mental and emotional aspects of menstruation are undeniably important. Menstruation is a time that naturally causes stress and

¹³ www.wateraid.org/~media/.../menstrual-hygiene-south-asia.pdf

¹⁴ <http://medind.nic.in/jav/t12/i2/javt12i2p69.pdf>

¹⁵ <http://www.krepublishers.com/02-Journals/S-EM/EM-06-0-000-12-Web/EM-06-2-000-12-Abst-PDF/S-EM-06-2-085-12-217-Dube-S/S-EM-06-2-085-12-217-Dube-S-Tt.pdf>

¹⁶ http://www.sswm.info/sites/default/files/reference_attachments/JOGDAND%20et%20al.%20A%20community%20based%20study%20on%20menstrual%20hygiene%20among%20adolescent%20girls.pdf

¹⁷ <http://www.thehindu.com/sci-tech/health/more-safe-from-now/article4952872.ece>

¹⁸ www.wateraid.org/~media/.../Menstrual-hygiene-matters-low-resolution.pdf

¹⁹ http://www.dasra.org/files/mh_spot_on_report.pdf

psychological difficulties to women and girls. However, when it is stigmatized, tabooed and generally viewed negatively (as is often the case in India), it becomes a heavy burden. Feelings of stress, fear, shame embarrassment and isolation are commonly reported by Indian women and girls.

Social aspects:

Poor understanding and address of MH affects women and girls not only in terms of health, but often affects the way she interacts with her family and the community. They are often restricted during menstruation because of factors that are explicit (such as those originating from religion) or tacit (such as not leaving the house to avoid embarrassing situations).

In some developing countries inadequate menstrual hygiene awareness and infrastructure becomes a serious obstacle to education with many girls leaving school after reaching menarche. These and other social aspects of menstruation are in reality more consequential than the health impacts.

Important factors:

Poor menstrual hygiene has been linked to a variety of factors and influences. Amongst the most important are 1.) Awareness and beliefs 2.) Insufficient support and infrastructure 3.) Insufficient market for MH products.

The current study sought to fully understand these important elements in the study areas so that CARE India, in partnership with CAIRN India can address them in an efficient, effective and sustainable way.

III. Respondent profile

As described in the methodology section, the study covered four primary cohorts-adolescent girls and boys and adult females and males. This section provides an account of the profile of respondents across key attributes-age, religion, caste, education and marital status.

Age: Overall the age distribution of the respondents shows that about 49 percent female respondents and 32 percent male respondents were below 20 years of age. Among females about 24 percent were in the age group 31-45 years while nearly 30 percent male respondents were in this age group.

Table 4: Age profile of respondents

Age Group	Female %	Male %
14 - 20 Year	46.8	31.8
21 - 25 Year	14.9	20.5
26 - 30 Year	14.3	18.6
31 - 40 Year	22.7	24.1
41 - 45 Year	1.3	5.0
Total	100	100

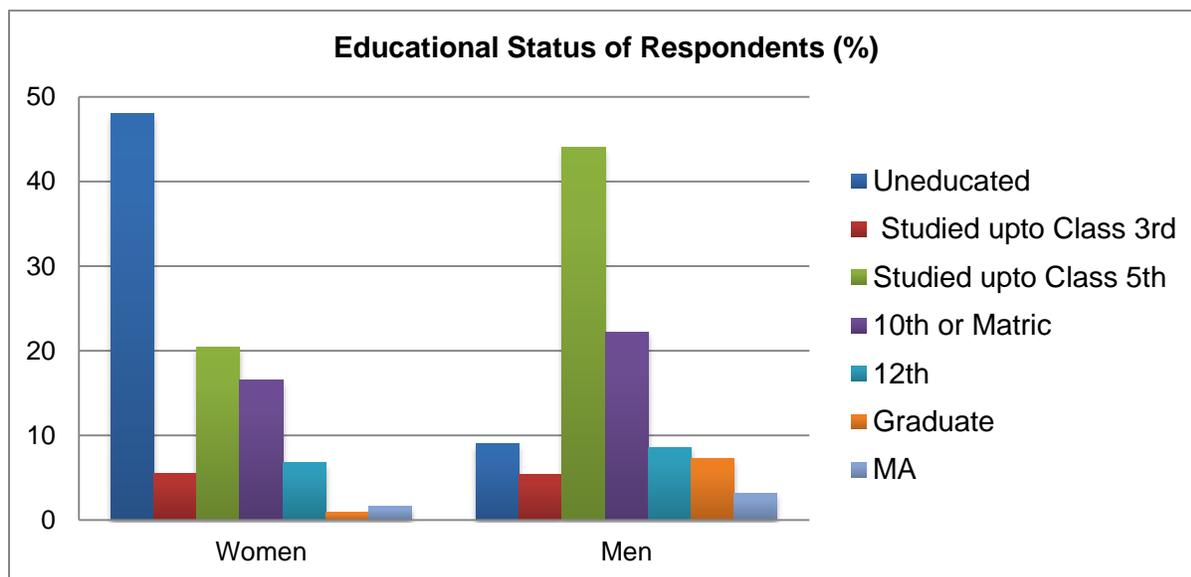
Religion and Caste: Nearly 87 percent of female respondents were Hindus and 13 percent were Muslims. Among males, all, except one respondent were Hindus.

Of all female respondents, a majority (55 percent) were from OBC, 21 percent were from general category and similar proportion from scheduled caste (SC) category. About 4 percent female respondents were from the ST category. Among male respondents, only 9 percent were from general category while 34 percent were from SC. The presence of OBC males in the sample is again high at 49 percent. This also corresponds the general prevalence of communities in the study villages.

Table 5: Caste wise distribution of respondents

Caste	Female %	Males%
General	20.8	9.1
OBC	54.9	49.1
SC	20.5	34.5
ST	3.9	7.3
Total	100	100

Education level: The educational profile of respondents shows that almost half of the female respondents were uneducated, 20 percent had primary level of schooling, 17 percent were educated upto class 10th (or matriculation) while just seven percent were educated upto 12th grade. Proportion of females educated upto graduation levels or above is negligible. Educational profile of males shows a sharp contrasting picture where only nine percent were found to be uneducated while 44 percent had studied upto primary level. Proportion of men educated upto higher classes is also proportionately high, as shown in the graph below. As clear from the study design, males and females currently attending school/college were also part of the study.

Figure 1: Educational status of respondents

Marital status: Nearly 41 percent of female and 29 percent of male respondents were unmarried while around 2 percent of both male and female respondents were married but had not initiated co-habitation. 56 percent females and about 69 percent males were married.

Table 6: Marital status of respondents

Marital Status	Female Number	Female (%)	Male Number	Male (%)
Unmarried	125	40.6	65	29.5
Married	173	56.2	151	68.6
Married but Gauna is yet to take place	8	2.6	4	1.8
Widow	2	0.6	-	-
Total	308	100	220	100

IV. Perceptions, beliefs, practices and behaviours

This chapter deals with all the important phases of women’s menstrual cycle. Over all this is a neglected topic, not open to discussion usually because onset of menstruation is directly related to the fertility of female. This phenomenon is also considered as impure period for women and affects their participation in the key activities including daily household chores and prayers. ‘Fertility’ of a woman is a heavy guarded concept in India not open for views in the public domain. There is a section later that elucidates further on the reproductive practices and products. The section has been dealt separately because firstly, MH and RH questions were addressed to different target respondents differentiated on the basis of marital status. While all the 528 respondents were posed with questions related to MH products only married women and men were surveyed about RH products. Secondly, familiarity to MH and RH product is inverted among males and females.

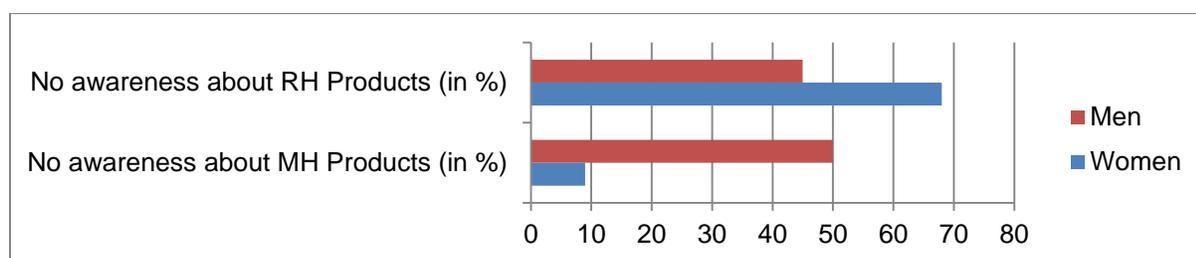


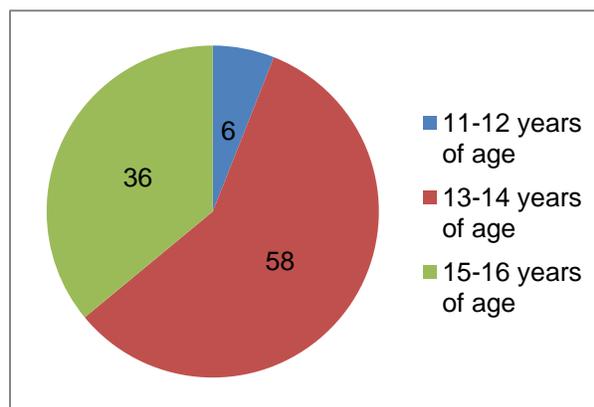
Figure 2: Awareness of MH and RH product between men and women

Awareness, Sharing and Solution Seeking

a. Menarche

We holistically probe into all the details of women and girls initiation into this cycle. The term ‘menarche’ is what describes this initiation. On an average a girl is in the bracket of 11 to 16 year of age when she had her menarche. Women and adolescent girls often find it difficult to recall their exact age.

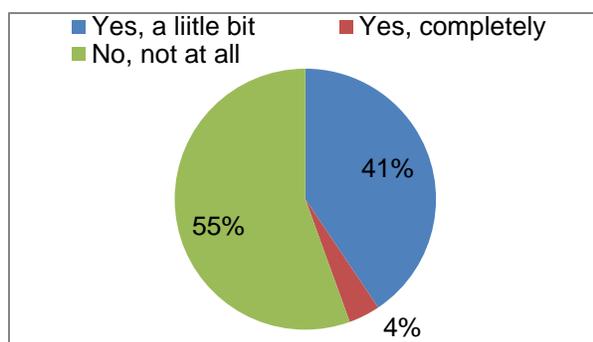
Figure 3: Women's age at menarche (in %)



b. Awareness at Menarche

Before menarche happens, most girls are vaguely acquainted with the concept. This pre-introduction happens because they help their mother out with the household chores during latter's menstruation. Yet the girls never discuss the full length of the phenomenon with their mothers. There is significant communication gap and most of the girls shy away from discussing with their mothers. On the occasion of their first menstruation girls share it with females, who fall under the 'joking relation'²⁰, in their family genealogy like bhabi, mami, bua; and peers (friends, neighbors). On the other hand, mother and other male members fall in the category of 'avoidance relations'²¹ give the high degree of formality and respect. Hence, the first product and explanation which they get is also given to them by these members.

Figure 4: Level of awareness about menstruation at menarche



c. Main Source of Information on MH

Immediate female relatives (mothers/sister/relatives) are pivotal in explaining the restrictions to be observed by the girls during menstruation. 80.5% sought knowledge from sisters/ mothers and relatives. 36.7% of those surveyed have learnt about the same from female friends, followed by service providers. The understanding of these girls is not so developed in terms of biology and sexuality. On the whole they know that it recurs every 28 days and are well versed with the community stigma, beliefs and restrictions, while one might find exceptions where girls are more educated by virtue of some training.

Table 7: Main source of information on MH

Main source of knowledge about menstruation, menstrual hygiene and health education (More than one source was mentioned by respondents)				
	Overall %	14 – 20 years	21- 30 years	31 – 45 years
From your mother/sister/relatives	80.5	68.8	91.1	90.5
From a female friend	36.7	48.6	31.1	20.3
From a teacher/	10.7	20.8	2.2	1.4
From school books	23.4	37.5	15.6	5.4
From Anganwadi worker	25.0	25.7	26.7	21.6
From ASHA	20.8	22.9	17.8	20.3
From ANM	19.5	22.2	23.3	9.5
Jan Mangal couple	0.6	1.4	0.0	0.0
From radio or television/From newspapers	6.5	8.3	7.8	1.4
From public hoardings	2.9	5.6	0.0	1.4
Training or information by any NGO	9.4	4.9	13.3	

²⁰ Anthropologically, joking relationships are defined as those which necessarily involve free, familiar discourse between individuals occupying specific kin categories in relation to one another.

²¹ Avoidance relationships are defined as those which similarly involve great formality by virtue of the respective kin categories to which those in the relationship belong. The notion of compulsion is important.

School as a source of information

A significant percentage of adolescent girls mentioned school (school books and teachers) as one of the main source of information as against the women. Please refer to table above. According to syllabus, girls and boys in school starting from class 8th to class 12th are supposed to receive information regarding MH & RH as a section in biology and physical education. The detail of reproductive system is gradually disaggregated class 8th onwards. Class 10th syllabus explains all the required details of the same. This is further taught in class 11th and 12th if the student opts for science with biology. This is the most credible source of their knowledge but has major roadblocks. One of the issues is the discomfort caused in co-education. There is a degree of discomfort on teacher's part to impart lessons, which are gender specific in presence of the opposite gender. The problem aggravates if the teacher is male. Teachers usually end up superficially teaching it or asking students to take the lesson home. Mostly students have learnt partially about menstruation from schoolbooks by reading it themselves. Due to this gap the students are not able to conceptually comprehend the biological reasons that lead to menstruation and its effect on the body. The other issue is that biology textbooks do not focus on aspects of hygiene or hygienic products.

d. Male students and their awareness

Male students on the other hand have accounted having access to third stage learning of menstrual health, much less of the other two channels. Discussions don't take place between two successive generations hence the communication gap is as prevalent amongst boys as for girls. The second stage is as vital for males as for women. Discussions happen among peers, among men and school going boys too. Female counterparts (especially at school) are exclusive of this peer group. Wives are a source of information among married men. The gender norms practised (that is, of avoidance and joking relation) at the level of family structure gets replicated at school in health lessons, such as no interaction with female counterparts or with teachers (notion of seniority and respect). Therefore, lessons are not imparted fearing socialization of this extremely muzzled topic. The general outline they have is that '*mahwari*' or '*MC*' comes every 28 days. But details like menarche, menopause, and use of products, restrictions or norms practiced by women in their houses or friends at school are not clear to them. But there were exceptions where one or two among a group of 15- 20 boys knew the topic in further details. This indicates that MH was not a topic of common discussion among boys.

Some of the most popular sources of information among men are television/radio/ newspaper, service providers (like ANMs, ASHA, AWWs) and male friends.

e. Supplementary roles of schools

Schools are important in terms of space they provide beyond delivery of classroom education. School aggregates students and eases any external effort in this direction. Schools provide a uniform space for any constructive intervention by government and non-government institutions. For example, in some of the schools where training on MH and RH were conducted by CARE the girls showed a better understanding of menstruation, necessity of hygiene, range of MH/RH product and how to put it to use. School students have also been provided with reading material from these external bodies. There is a visible degree of inquisitiveness amongst student that finds its way when they are introduced to an unrestrained environment of healthy discussion without compliance to any pressure to maintain 'proper

conduct' as with their teachers. The same applies to boys. They are far more vocal when their '*masterji*' is not in the same room.

Change in Lifestyle

a. Increase in socialization

School as an institution has begun to take girls away from their houses and hence improved their socialization and exposure vis-à-vis those who don't attend school. There is improved mobility and freedom now. This enables them to form their social circle and greater periphery of sharing in addition to kins at home. This collectivization helps them a great deal in being informed about various products and its use. Almost all the school going girls (grade 8th onwards) are definitely aware of 'pads' and specific brands including 'Stayfree', 'Kotex' and 'Whisper' and about 68% of those who have ever attended school (till grade 5th and above) responded positively to using it always or sometimes. Women participants in FGDs attested to this high use of pads among school going girls.

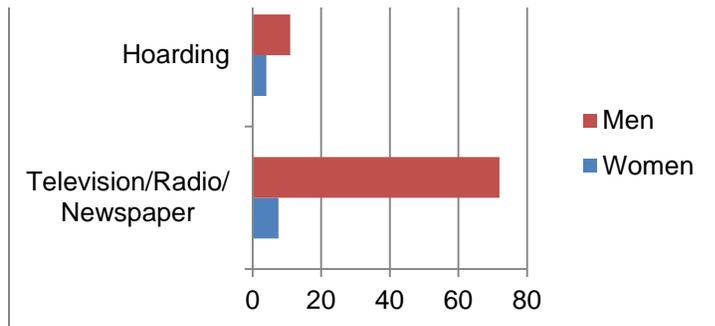
b. Mobility

School has increased girls mobility and they have access to some money as pocket money for either transportation or food. With increased mobility comes accessibility to marketplace and an urge to experiment with products. Out of all the women/ girls who have procured pads from any of the sources, 83% have been to school (upto grade 5 or more). Girls have named Stayfree and Whisper as brands of pads repeatedly and have purchased small packs worth INR 11-50. Affordability did not appear to pose as a barrier. All these girls are converts or partial converts from using clothes to pads. Conversion to pad is also a necessity to further their comfort levels.

Girls continue to attend school even during their menses. Sanitary pads have relived them of worrying about '*daag*' or stains. Few cases of absenteeism during menses were attributed to other determinants addressed later.

c. Telecommunication as a medium

Figure 5: Influence of telecommunication and advertisement of SN products



Penetration of telecommunication has been on a constant rise. Television in any society has been laterally and vertically spreading its reach. This uninhibited growth has impacted MH and RH products too. These products have a more pronounced presence in not only the television but also on the minds of people. Sharing common knowledge repeatedly aided by visuals creates an impact like no other. In the last 2-3

years, awareness campaigns and commercial marketing via advertisements using this medium has led to an increase in demand of these products. The popularity of brands such as ‘Stayfree’, ‘Kotex’, and ‘Whisper’ vis-à-vis the term ‘sanitary pad’ or ‘sanitary napkin’ shows the way in which these advertisements are decoded. Both males and females have quoted television as one of the sources of learning about these products. But there is difference:

While men consider TV and radio as the main source of information; for females it is the relatives, peer groups, friends and service providers (AWWs, ANMs, ASHA).

Practice

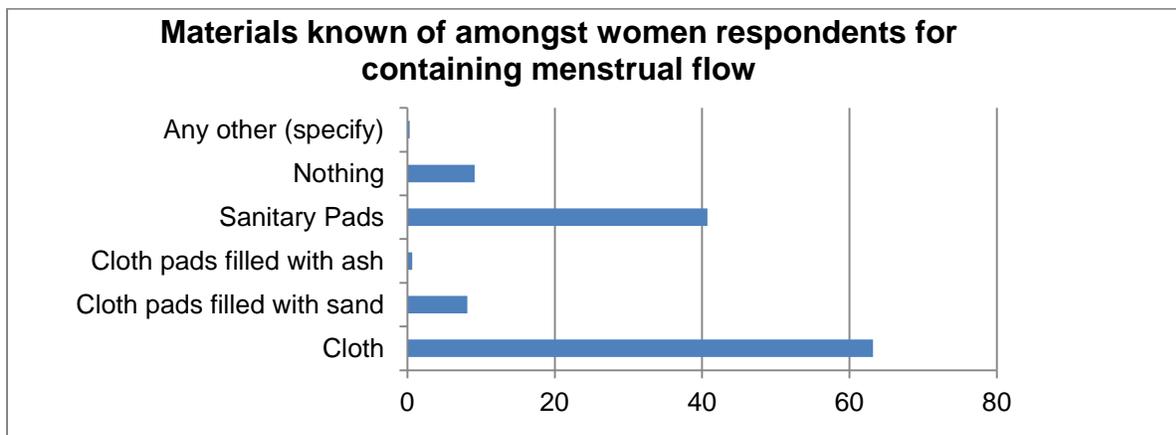


Figure 6: Materials known to women for MH

a. Products

SANDBAGS or ‘Ret/ rakhki Potli’: Discussions were carried about around sanitary pads, cloth (‘kapda’) and sand bags (‘ret ki potli’). The use of sand bags was quite prevalent till about 10- 15 years ago on an average. This was a tradition method of dealing with menstruation of yesteryear. However, the quantitative survey results suggest that now only 12 to 13% women and 3% adolescents are still use it to contain the menstrual flow. She explains it as:

‘Earlier people had hardly any spare cloth, hardly enough to wear, so they used sand-filled pads during menstruation but now everyone can afford to spare some cotton clothes’

-Participant, Female FGD, Bhilon ki Basti, Chitar ka Paar, Baytu

Sandbags were also used because the concept of ‘underwear’ or more colloquially, ‘*chaddi*’ was not prevalent amongst these women. In such cases cloth or adhesive based pads cannot be put to use sartorially.

CLOTH or ‘*kapda*’: Cloth is widely used by women because of its easy availability within home and also that it is traditional practice. Women use strips of cloth torn out from old ‘*ghagras*’ (skirt). Some women also reported using napkins/hand towel, which they buy from the market or from ‘*lakharu*²²’. A piece of cloth is used throughout the day or changed twice or thrice. The change is subject to individual preference. The cloth is then washed in water and detergent and dried in the sun. After using a piece for about a year, it is disposed.

Sanitary Napkins: Sanitary napkins, often known by the different brand names or simply called ‘pad’, is a recent product. It is popular amongst adolescent girls going to school or women going out to work. Overall, 28% of those surveyed are using sanitary pads with a much higher proportion (refer table 7 below) in younger age group use SNs. Current awareness of sanitary napkins stands at an optimistic rate 40%. Table 8 further reiterates this finding wherein use of SN is comparatively higher for younger females mostly in schools. Telecommunication, mobility, increased awareness, heightened role of service provider resulted in an increase in demand of sanitary napkins. Stayfree is the most commonly used product which is because of its competitive rate and packaging in all sizes. 37.5% of all the users listed Stayfree as the product which they have last used, followed by 13.9% of them using ‘Whisper’. 6.9% of the users purchased it from the ‘Resham’ unit. These are school girls from villages closed to the center in Mundon ki Dhani, Baytu. Stayfree, Kotex or Whisper on the other hand is bought by 35.4% at the village level shops, 30.8% of the users get it from Barmer while 13.8% from local medical shops.

Table 8: Current use of SNs among women of various age groups

		Currently use of Sanitary napkin or pad			
		14 - 20 Year	21 - 30 Year	31 - 45 Year	Overall
		%	%	%	%
Are you currently using Sanitary napkin or pad?	Always	40.3	24.4	8.1	28
	Yes, sometimes	18.1	7.8	4.1	11.7
	Yes only when I go out	2.8	3.3	1.4	2.6
	No, never	38.9	64.4	86.5	57.8

²² ‘Lakaharu’ is a local term used to address women who does door to door sale of women related products as bindi, bangles, make-up et cetera. We heard this term used at ‘dhanis’ close to GudaMalani.

While the above describes the usage of sanitary napkins among various AG and women demographic groups, the following segregates the use of various protective materials among girls (14- 20 years). This group has been further distinguished as those who are going to school while those who don't. As the study illustrates girls as a vehicle to spread the knowledge of MH products, it is important to see what the use of products is during menarche and present; and change in trend between two periods.

Table 9: Use of SN among adolescent girls and young women

		Currently use of Sanitary napkin or pad	
		14 - 20 Year (Currently in school), n=59	14 - 20 Year (Not in school), n=85
		%	%
Are you currently using Sanitary napkin or pad?	Always	76	15
	Yes, sometimes	14	21
	Yes only when I go out	5	1
	No, never	5	63

While school going girls show better numbers in term of use of SN and lower use of other products but the rate at which habits are changing is more or less similar among both groups. The group that uses 'Nothing' is a constant because of the beliefs in the community. These are girls from Muslim community where girls and women have admitted to using nothing because of reasons cited below.

'Nothing': This was a practice found only amongst Muslim women (through irrespective of age), education (limited till grade 5), and marital status. Using any such products was considered a religious taboo amongst the Muslim communities of the study. Non use of products was found by both quantitative and qualitative data collected. Amongst other communities such as Bhils and Meghwals, not using any products existed in the past (for example by current grandmothers or great grandmothers).

Men and their understanding of the product: On an average, 86% of men know what menstruation is while the remaining 14% do not know anything about it. To corroborate this with FGDs, married men are far more aware of menstruation as an occurrence amongst women vis-à-vis adolescent boys. '*Mahina*', '*kapdewali*', '*MC*' are colloquial ways of understanding it. While men have a fairly detailed understanding of the processes involved, adolescent boys are familiar with key words like 28 days, '*bimaar hoti hai*' and TV advertisements of Stayfree.

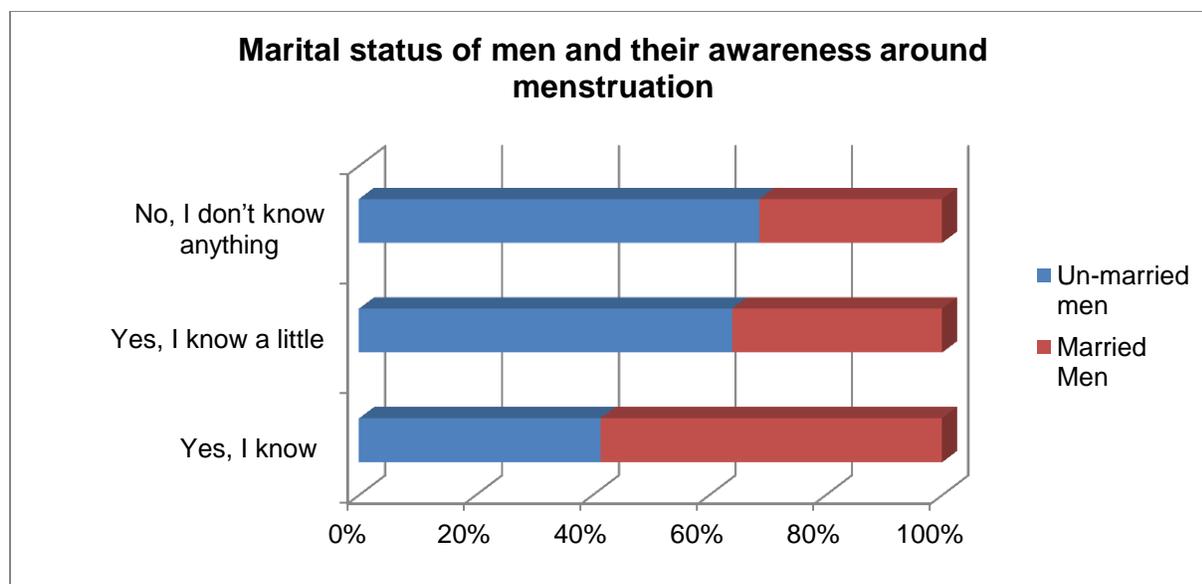


Figure 7: Marital status of men and their awareness around menstruation

The communication channel between husband and wives on this subject is not very open. While some women ‘talk’ to their husbands about it, for example newly-wed Bhils²³, some have denied confiding anything to their husbands and vice-a-versa, as among Muslim community. The ‘talk’ is restricted to informing husbands about the event of menses when women are going through it. This is done on the account of observing certain restrictions such as not cooking, or praying when the role of husbands in the household chores may be crucial. The ratio of men who know about the product used to contain menstrual flow and those who don't is 1:1. The sources of these 50% men, aware of the product includes in descending order: television/ radio/ newspaper (72%), health workers (40%), friends (36% while male relatives are 1%), school teachers (20%) and wives (11%). Out of those who have some knowledge roughly 55%- 60% know of women using SNs in their family. Other do not know or are unaware, the former exceed the latter in all scenarios. Cases of those knowing of menstruation from wives and knowing of usage of SNs in house was exceptionally as high as 83%.

b. Nature of Use of these Products

Women and adolescent girls at menarche are introduced to the products by their sisters, female friends and relatives. This is further corroborated by the quantitative data. 71.8% surveyed females were informed about these products from their mothers/ sisters/ relatives. The most popular product used when at menarche was homemade pad or cloth. 67% used it, followed by 14% using cloth pad filled with sand, and 10% using sanitary pads. Some also responded to have not used anything (8%).

²³ One possible explanation is that young couples have comparatively more liberty to talk to each other whereas caste-based communities have more purdah which leads to limited interaction with spouses in front of other family members.

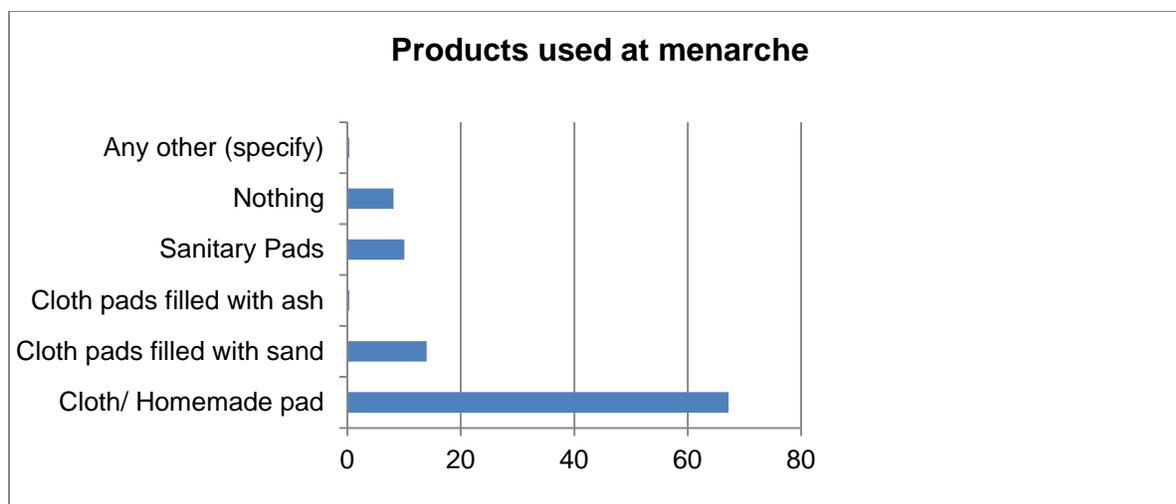


Figure 8: Products used at menarche

During the FGDs, some women who have been to hospital for delivery or have accompanied someone, reported having seen delivery pads filled with cotton that were given by the hospital post-delivery. Quantitative survey reveals that knowledge regarding the products comes primarily from the relatives/ sisters at home (71%), followed by various village level service providers like Anganwadi, ANMs and ASHA and 30% of them know it from female friends. Meeting and training is also another source which may include meetings with the service providers too. Teachers at school form a source for only 12%.

Overall there seems to be a generational shift in terms of products used for menstruation. While in some older women were found to use cloth pads filled with sand, a miniscule percentage, 2.8% of the 14-20 year old respondents used them. Adolescent girls during the FGDs attested to this departure from the traditional methods of using sand bags. Almost no respondents No one responded to have had used sand bags to begin with. Broadly the FGDs suggested that use of sandbags is an older practice that is becoming increasingly obsolete.

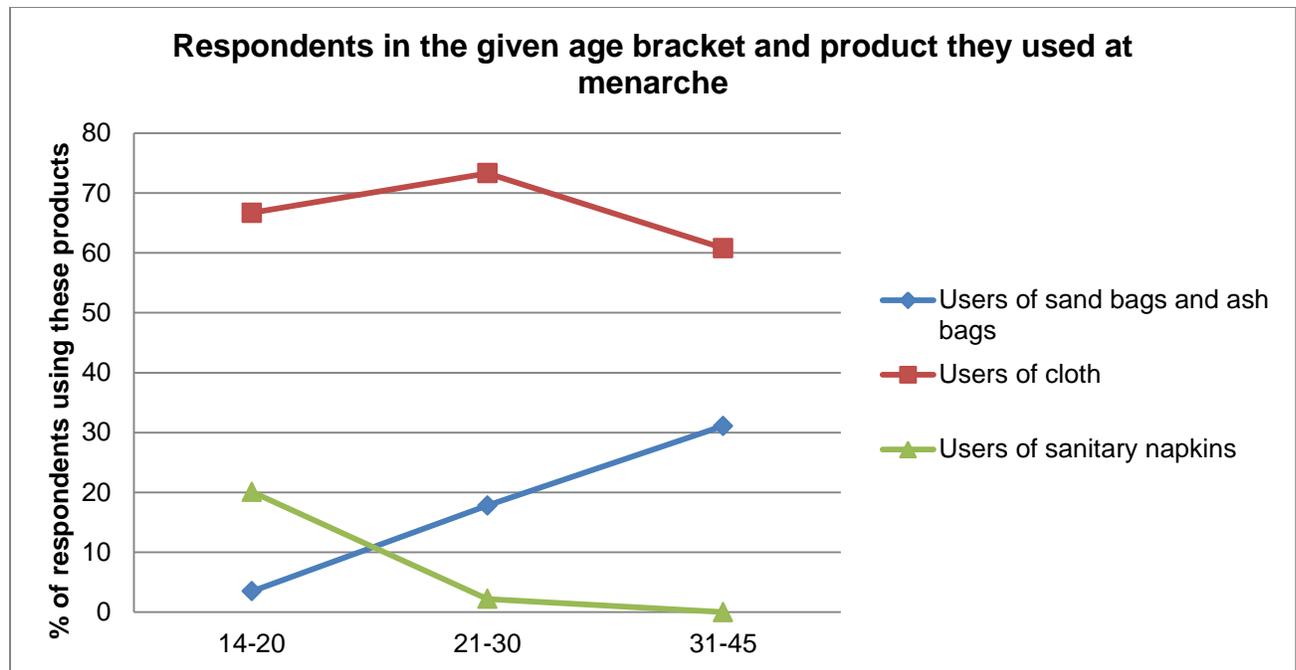


Figure 9: Respondents in the given age bracket and product they used as menarche

The trend of use of sanitary pad and sand bags/ ash bags is inverted. Given that the use of cloth has been constant and uniform across all age brackets; younger girls are beginning to use sanitary pads and abandoning sand bags. Hence it can safely be stated that there is an intergenerational difference in use of products and the change towards safer products has been stirred.

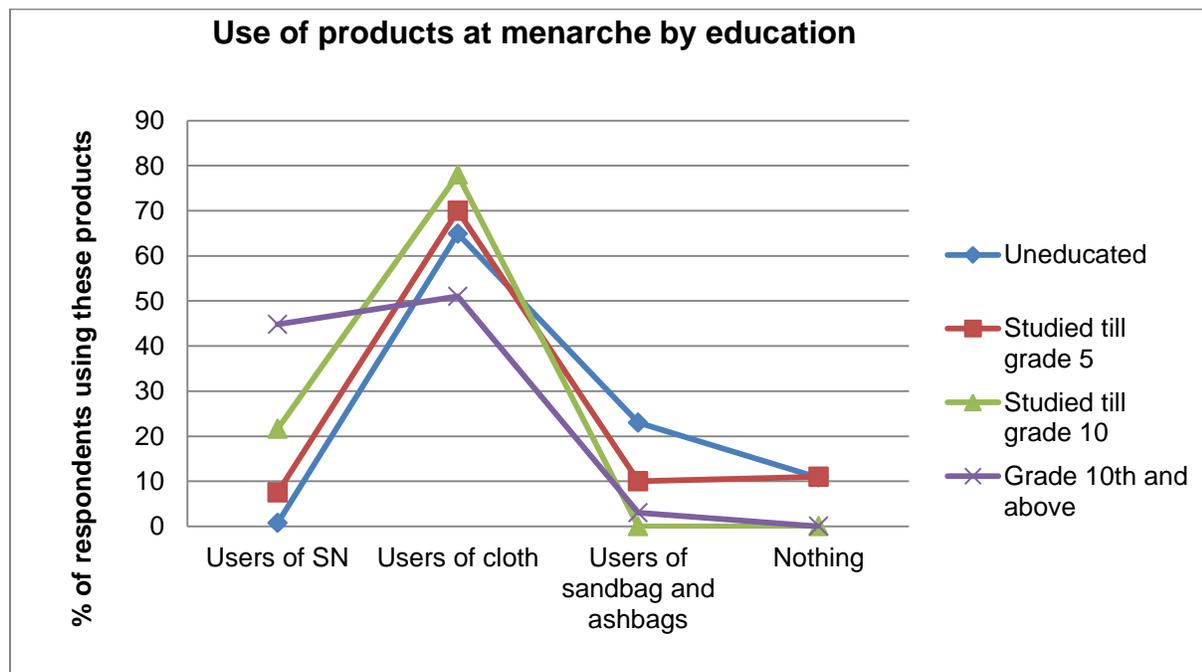


Figure 10: Influence of education on use of products at menarche

Education (no education) has direct impact of the high (low) use of SNs and low (high) use of cloth and sand bags. Use of cloth still remains high despite the range of education. To find out the other trends in use of cloth and ‘nothing’, which have been ambiguous so far, we look at community. Use of ‘nothing’ remains restricted to OBC (all Muslims). This can be collated with semi structured FGD with Muslim women and girls where levels of education are very low due to absence of schools and vacant seat of ‘*maulvis*’ in the ‘*madarssa*’. There are strong religious taboos attached to use of sanitary pads in this community.

Some women have also reported that confronting a male shop keeper can be a hurdle since they feel embarrassed and shy to ask for sanitary pads. Therefore they suggested they will be more comfortable if they had to ask for it from a female saleswomen or if such products are available with village level service providers as Anganwadi workers or AWWs.

The use of cloth at menarche is common amongst all communities, highest among general and SCs and lowest among OBCs.

The elder women (35 years and above) were less prone to change from using sand bags to cloth, or cloth to sanitary pads. Women in this age bracket are least influenced by any of the social factors. This was attributed more to habit than availability, accessibility or affordability. While they were not as willing to purchase and use products themselves, they were supportive of adolescent girls and younger women using pads. In terms of access to cash, interactions revealed that women of the family are frequently given ‘Haath-Kharcha’ (literally ‘out of hand expense’) every month from the earning male. They might also have some cash from selling products (agriculture, animal, etc.) from which they earn some profit. School-going girls are then given money (also referred to as Haath-Kharcha) by their mothers or sisters-in-law. Girls can also ask for money from men if they need it for a specific purpose.

Many women seemed supportive of their girls using MH products. They encouraged it on account of ‘no worries’, ‘no stain’ and endorsed it further by financially enabling girls to purchase it. They also observed that using cloth during menstruation is inconvenient as it is always wet and often causes irritation and rashes. Younger women seemed very interested in SN and requested that the AWW should keep some stock. On discussing the market price, women wanted to know the cost and felt that sparing Rs 20-30 per month is not a problem for any of them.

Table 10: Use of various protective materials among women of various age groups to contain menstrual flow at menarche and at present

		14 - 20 Years		21 - 30 Years		31 - 45 Years	
		% at menarche	% using currently	% at menarche	% using currently	% at menarche	% using currently
NAME OF THE PRODUCT USED	Cloth	67	56.6	73	63.3	61	75.7
	Cloth pads filled with sand	3	2.8	17	12.2	31	13.5
	Cloth pads filled with ash	0	0.7	1	1.1	0	0.0
	Sanitary Pads	20	60.1	2	33.3	0	12.2

	Nothing	10	9.8	6	7.8	8	9.5
	Any other (specify)	0	0.0	1	1.1	0	0.0

'It is better to use good things. Saving Rs 20 can lead to spending Rs 20,000 in treatment if any of us get some (health) problem'

- Bhiki Bai, MDM cook, Chak Guda, Guda Malini

The graph is a comparison to chart the movement of users of MH products between two phases: at the time of their menarche and at present. The sample shows a significant, if not satisfactory, increase of use sanitary napkins as compared to all other products. The current users of SNs are also broken down into those who use it regularly and others (sometimes/ when they go out). Education and age of respondents directly impact the regular/ irregular/ no use of the pads.

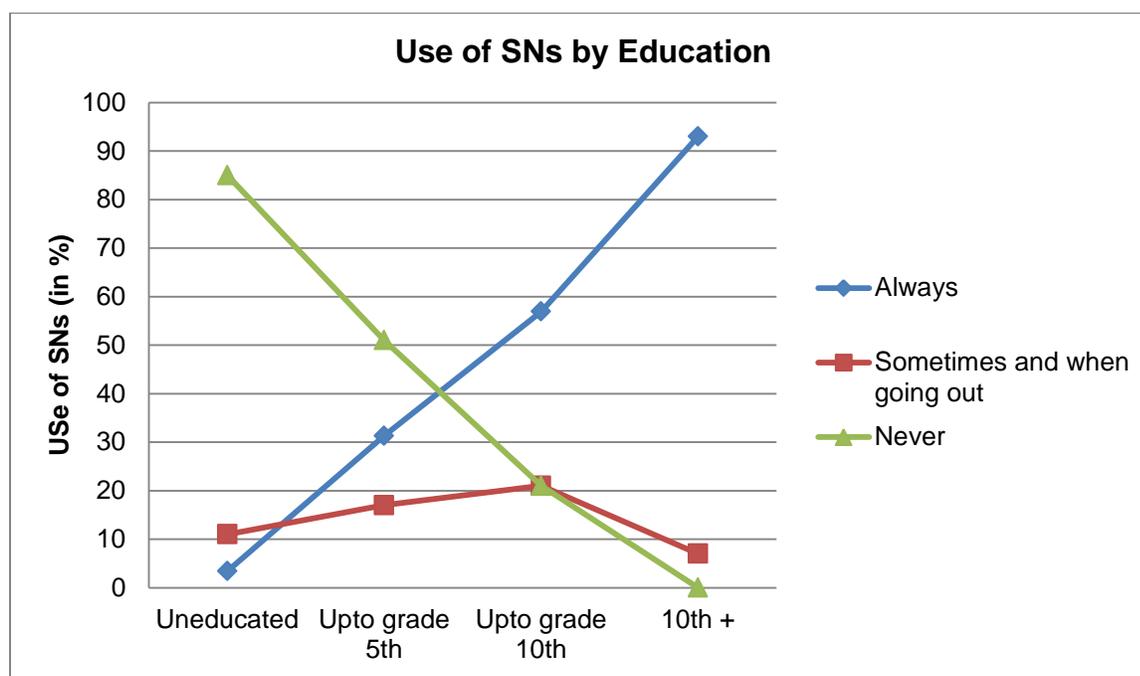


Figure 11: Use of SNs by education

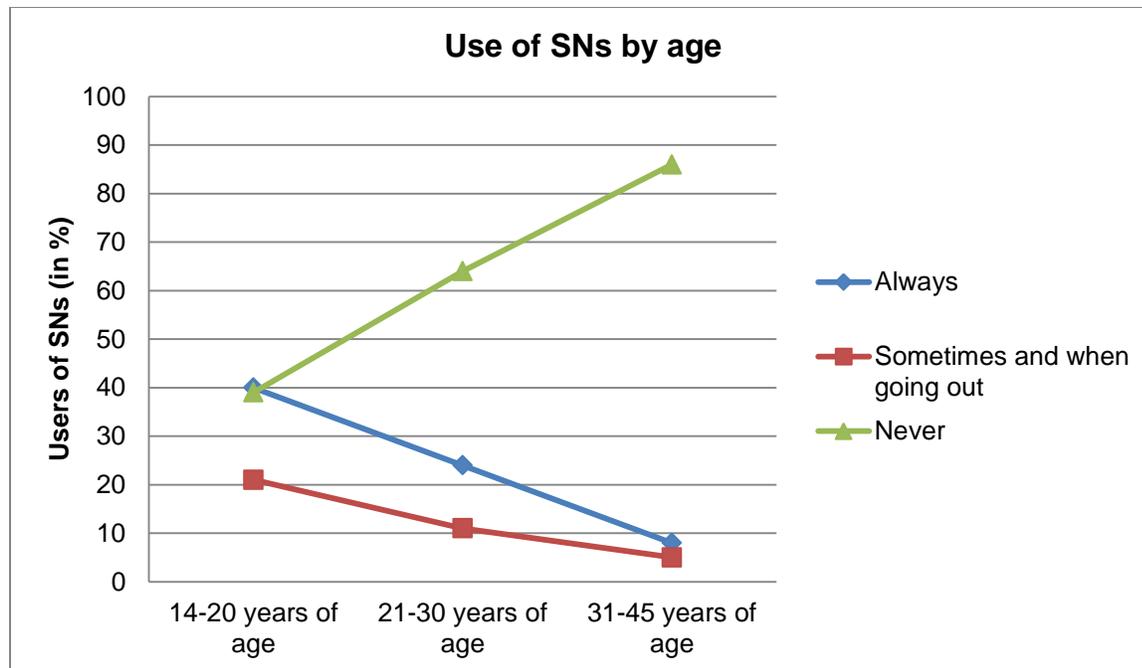


Figure 12: Use of SNs by age

Analysing trends in expenditure on SNs: We look at disaggregated data to map the trends of current expenditure on SN and ascertain further willingness to spend, if any. 42% of the respondents are using SNs and 54% of the respondents (irrespective of what they currently use) are willing to spend on a product which is hygienic and convenient.

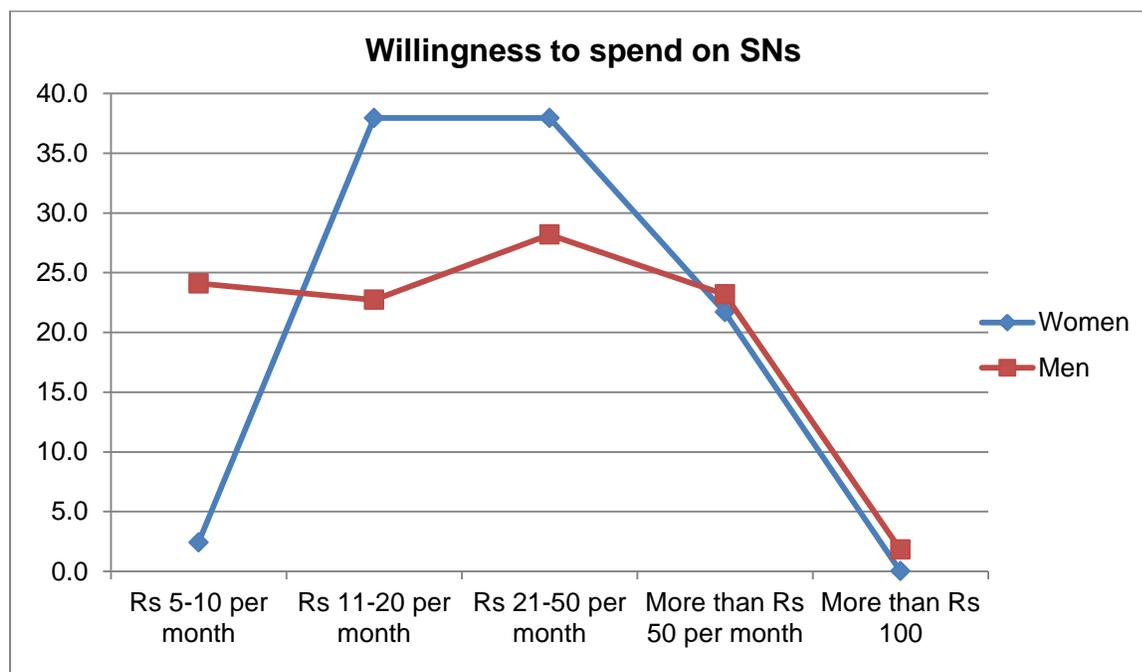


Figure 13: Willingness to spend on SNs

Men’s understanding of use of these products: As stated above 50% of surveyed men are aware of sanitary napkins and have stated various sources of such information. Married men have displayed a heightened sense of sensitivity to the issue and seriousness towards discussing the issue. As established before, communication between the two sexes on this subject is abysmally low due to the stigma attached to the menstruation. At best, such a communication gap is bridged between husband and wife, or female health workers (ASHA, ANM, AWW) and community male members. 83% of those who know from wives know about use of SNs in their family, it is 56% for those who know female health workers. The trend amongst men is as follows:

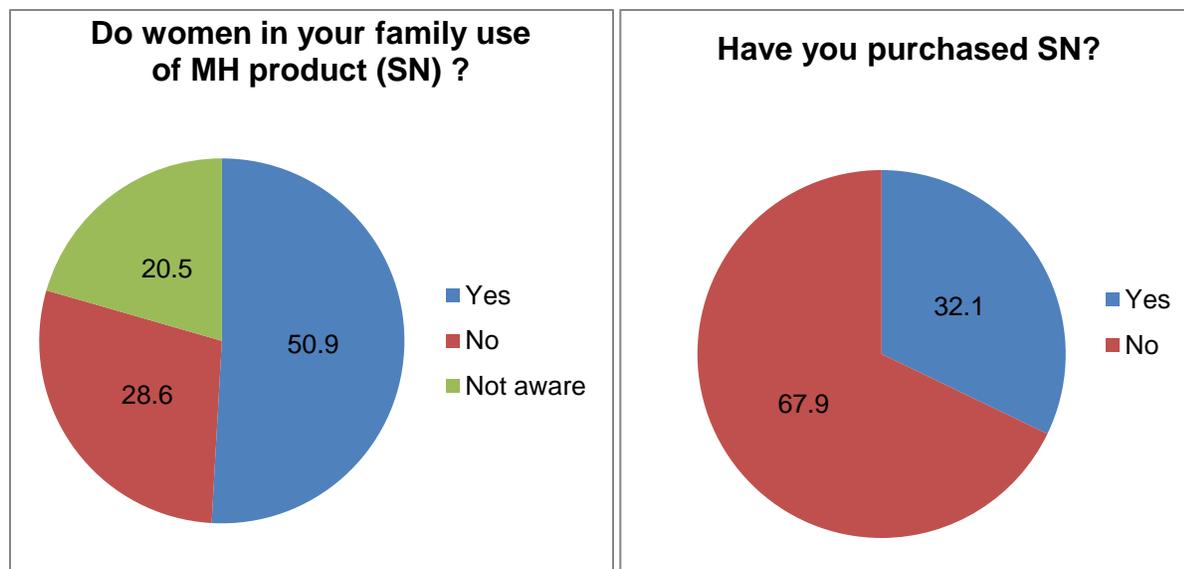


Figure 14: Do women in your family use of MH product (SN)? Figure 15: Have you purchased SN?

c. Cleanliness

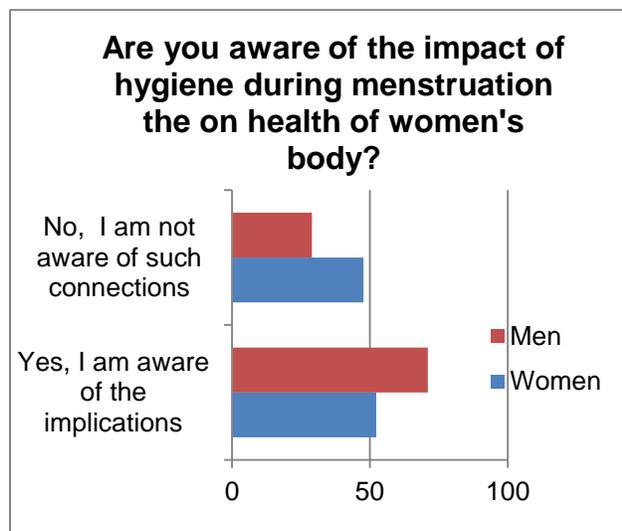


Figure 16: awareness of impact of hygiene during menstruation on

The FGDs revealed that cleanliness was of utmost importance both among girls and women. They were aware that keeping oneself clean is important during this menstruation. When asked about what leads to menstruation, 54% understand it as biological processes while 35% attribute it as work of God’s. But only a handful can explain the biological process. They have a vague understanding it. Some were also able to link menstruation (hygiene) with diseases, problems in uterus etc -although they were not describing as infection. Only 9% women reported problems like itching or infection in reproductive tract. Others (86%) complained of the generic problem of abdominal pain/ cramps and 45% of headache or feeling giddy. There has been no instance of

severe consequences due to menstruation. In the FGDs women frequently highlighted their high hygiene and cleanliness standards like changing cloth if need be, washing and drying it in the sun before reuse.

ANM followed by ASHA are the most sought of service provider in case there is any problem related to menstruation.

The figure depicts that the awareness of linkages between hygiene and healthy body exists among a little more than 50% of women, but this does implicate that the hygiene levels are low. The study reveals, hygiene is a valued concept among menstruating women even if they do not know the direct implication on body. Although, more training and regular meetings at Anganwadi Centre; and enhanced information by the service providers like ANMs, ASHA and Saarthen, can improve the statistics and lead the women to understand menstrual health better. The fact that younger women and adolescent girls displayed eagerness and are more receptive to such trainings was evident from the FGDs.

Men's understanding of cleanliness: High percentages of men who know of relation between hygiene during menstruation and its implication on women's body have responded positively to know of SNs as a safer and convenient MH product. Similarly, not knowing of this connection is related to high percentage (75%) ignorance about SNs as a MH product. But not knowing of SNs does not automatically imply that men are not aware of connection between hygiene and its implication on women's bodies. 55% of these men are aware of such connections. Education plays an important role in helping men connect hygiene and implication on women's body.

Restrictions and Norms

The restriction, norms and adoption of these norms by any woman or girl is directly dependent on the community she belongs to. The restrictions and norms are archaic and are followed as per the beliefs of the particular caste. FGDs with different communities and caste groups revealed that those which are at the bottom of the structure are imposed with fewer restrictions as opposed to those who are placed higher up the caste hierarchy. The restrictions are directly related to the impurity of women while she is menstruating. *'Hygiene is always invoked to justify the idea of impurity'* (Dumont 1988: 47). These restrictions and norms practiced in India are directly correlated to both hygiene and impurity of women. As per the Hindu code of religious law, Manu, there are 12 bodily secretions which are held as impure. Menstruation is one of them. According to general knowledge, as corroborated by field research- all menstruating women, including highest in the order (e.g. Brahmins, Rajputs etc.) cross the threshold of purity into temporary impurity. This temporary impurity last for 3-5 days, women are dictated with different prohibitions, different objects get polluted on contact and need to undergo the process of purification like washing. These rules are determined by the caste of the women.

a. Restrictions amongst different communities

Some of the caste groups in the research area and their restrictions/ norms are listed below. This information is based on primary qualitative data:

Table 11: Restriction on women during menstruation among some of the communities in Baytu and Gudamalani

ACTIVITI ES	Cooking	Drawing water from	Using common	Milking Cow/clean	Using common	Praying	Participati on in	Participati on in	Touching seeds/
----------------	---------	-----------------------	-----------------	----------------------	-----------------	---------	----------------------	----------------------	--------------------

COMMUNITIES		Tanka/well	utensil (by menstruating women)	ing cow-dung	bed		social function	religious function	grain/pickles
Meghwal	✓	✓	✓	✓	✓	✗	✓	✗	
Rebari	✓	✓	✓	✓	✓	✗		✗	
Prajapat	✗	✓	✓	✓	✓	✗		✗	
Bishnoi	✗	✗	✗	✗	✗	✗		✗	
Jat	✓	✓	✓	✓	✓	✗		✗	
Brahmin	✗	✗	✗		✗	✗		✗	
Khatri	✗	✓	✓	✓	✓	✗		✗	
Bhil	✓	✓	✓	✓	✓	✗	✓		
Saansi	✓	✓	✓	✓	✓	✗	✓		✗
Muslims (Sunni)	✗					✗	✗	✗	✗

✓ : Unrestricted activity

✗ : Restricted activity (Blanks are for topics that were not covered with particular population groups within the study)

The activities listed are those which are commonly prohibited among various communities based on FGD discussions and supported by secondary research. Women and girls from the same community, Bhil for instance, would adhere to same set of norms or practices. Going to school is not a restriction in any of the communities. Absenteeism of girls from school is attributed to other reasons like disposal, fear of stain et cetera. This is significant because mobility of girls is not being restricted due to menstruation.

Senior women of any household are the enforcers of these norms. While both set of females, girls (both school going and community) and women practice them, there is a difference of opinion about restriction between the two.

While women are of the view that these rules are as per religious scriptures and one must abide by them. Primarily, it's a matter of religiosity for them.

'How can puranas/Bhagwat be wrong (about restrictions during menstruation)' -A Brahmin AWW, Guda

'If we follow other rules of Bishnoi code of conduct, we have to follow this one too.' -A female FGD participant, Guda

On the other hand, while girls are in complete abidance of these norms, they reflected concerns. Girls feel that these norms are self proclaiming in nature and everyone gets to know that they are menstruating. This leads to further embarrassment and shame amongst young girls. Others who are newly married are concerned about how to stick by these rules like not cooking and not drawing water from the well/ tanka. When there is no one else in the household to help these women with household chores they are forced to do it themselves. A Khatri women and ASHA in Gudamalani raises a legitimate concern as, *'Yes cooking is not allowed but many are unable to follow. Husband and children have to go out and they need food on time.'*

In case of breach a FGD participant says, *'If we touch anything related to prayer/worship by mistake during menstruation, we ask God's forgiveness.'*

A few reactions to breaches of restrictions were discovered during FGDs. In one case a woman shared that her mother-in-law would go to another relative's house if she cooked while menstruating so she would not have to eat food prepared by a menstruating woman. Within the same house, though the husband and children did not mind. In other instances, husbands cooked while their wives were menstruating. In general it seems reactions depended on characteristics of the household (such as size and whether or not it was a joint family).

b. Men and their Understanding of Norm and Restriction:

The figure below depicts an overall understanding of menstruation between men and female. This should help us understand other data that follows. There is not much significant difference between the understanding of men and women even though 90% of men went to school as opposed to 52% of women.

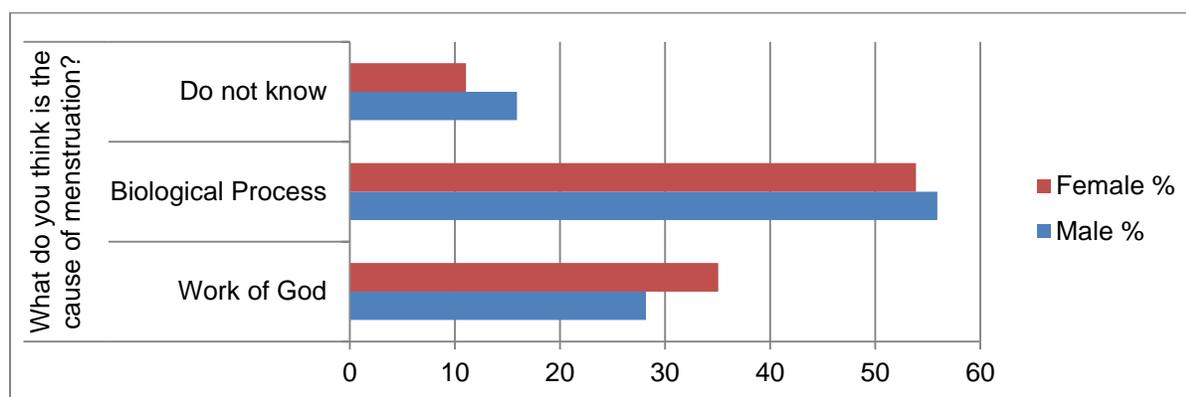


Figure 17: Overview of cause of menstruation among men and women

As mentioned above married men are more aware of MH processes, similarly married men (56%) are aware of restrictions imposed on women during menstruation. The caste distribution shows approximately 50%- 55% of OBC, ST and SC men know of these restrictions as opposed to 80% of general. The distribution along variables like education and age does not reveal anything concrete. Since restrictions and norms are rooted in community belief and practice and not in educational course books, education doesn't impact awareness about restrictions and norms. The study questions men's contribution in the household while women are menstruating. Men or boys have not contributed in household tasks like cooking, drawing water et cetera. Therefore restriction on a woman is a task shifted on another woman, like between neighbours or mother and daughter and so on.

Men who feel that menstruation related restrictions are 'necessary' held this view, largely based on 'tradition'. Education does not seem to affect men's opinions on the necessity of restricts because respondents who said that 'no, restrictions are not at all necessary' were very few for all education groups. 'Restriction' is a multivariate overburdened with community/ caste rules. To maintain the purity of caste these restrictions are not changed either by men or women.

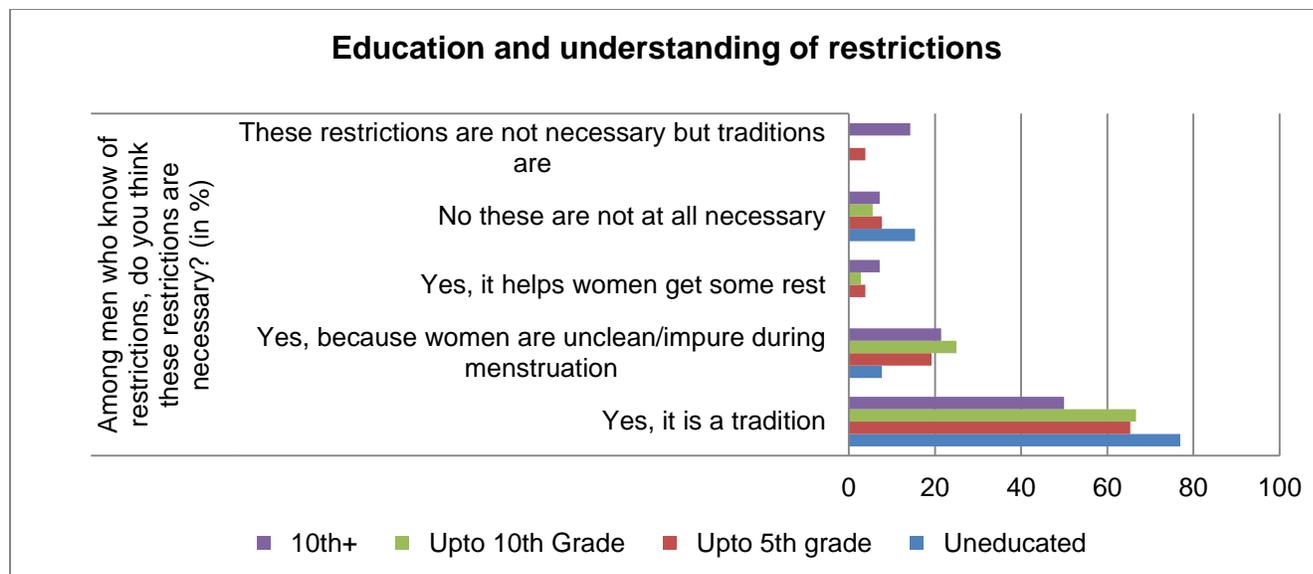


Figure 18: Education and understanding of restrictions

Similar to women’s responses, mobility is not restricted in term of going to school or work, 73% of men believe that menstruation cannot be a barrier for women to school or work.

RH PRODUCTS

Reproductive health and family planning have been woven neatly as a part of national agenda, although the same cannot be said for menstrual health. Population control, demographic study, demographic transition and so on are buzzwords that have garnered significant attention in independent India and so has reproductive health.

The following (figure 20 and 21) depict the role of National Rural Health Mission, the village level service providers and extensive promotion of contraceptives like ‘Nirodh’, ‘Nischay kit’, ‘Copper T’ and OCP (oral contraceptive pills).



Figure 19: Role of Nirodh in family planning and maintain interval between two kids. Figure 20: Different contraceptives like Nirodh, Mala D promoted by government through service providers like ASHAs.

AWARENESS

The study reveals a clear contrast in knowledge about contraceptives between men and women. The following figure shows that the majority of the women are unaware of these products. The FGDs revealed that sterilization among women is very common. As per popular opinion once a women has delivered desired number of children, in which a boy is essential, she gets sterilized. The government also provides incentives for women and men to get sterilized. The following table shows the incentives that the government offers to men and women (‘acceptor’) as well as the FLWs who convince individuals to undergo such operations (‘motivator’). Rajasthan is considered one of the ‘High Focus 18 States’.^{24,25}

²⁴ http://nrhm.gov.in/images/pdf/guidelines/nrhm-guidelines/family-planning/revised_compensation.pdf

²⁵ Other incentives including prizes such as vehicles and appliances in Rajasthan have been reported in the media- <http://www.dw.de/rajasthan-introduces-sterilization-incentive-scheme/a-6677425>

A. Public (Government) Facilities:

Category	Breakage of the Compensation package	Acceptor	Motivator	Drugs and dressings	Surgeon charges	Anesthetics	Staff nurse	OT technician/ helper	Refre shment	Cam p management	Total
*High focus 18 States	Vasectomy (ALL) Tubectomy (ALL)	1100 600	200 150	50 100	100 75	- 25	15 15	15 15	10 10	10 10	1500 1000
**Non High focus 17 States/UTs	Vasectomy (ALL) Tubectomy (BPL + SC/ST only)	1100 600	200 150	50 100	100 75	-- 25	15 15	15 15	10 10	10 10	1500 1000
**Non High focus 17 States/UTs	Tubectomy (NON BPL + NON SC/ST only) i.e. APL	250	150	100	75	25	15	15	10	10	650

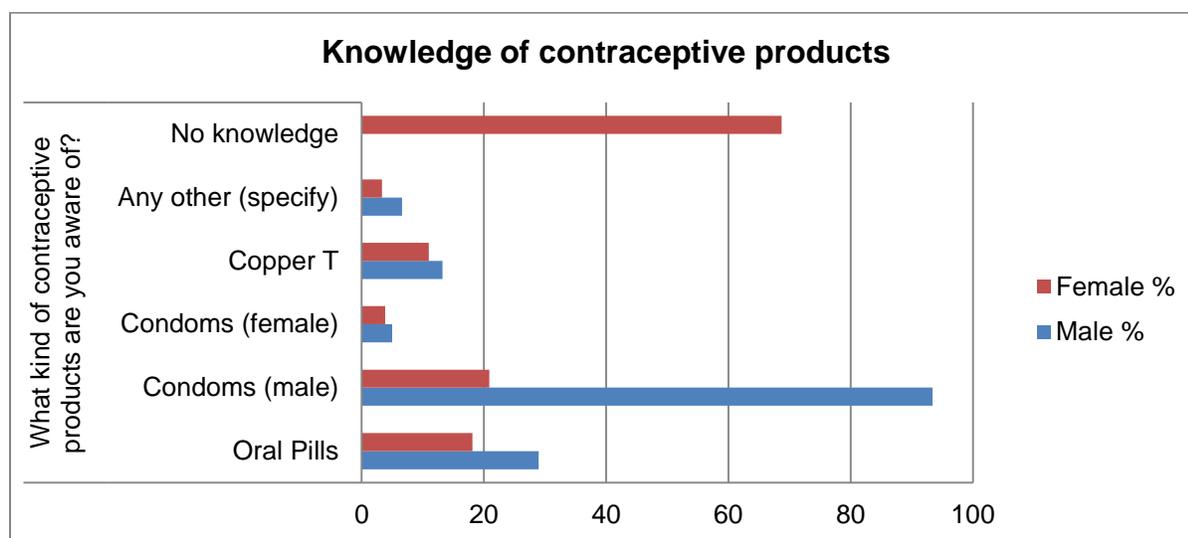


Figure 21: Knowledge of contraceptive products

Awareness among men: on an average, 93% of men are aware of condoms. This is true for men from different caste, age groups and education levels. Condoms are a matter of common knowledge followed by a handful of men who are aware of oral pills and copper T.

Emphasis on menstruation, various product and health are understood as standalone variables but the inter-linkages between these are missing. Secondly, there is a positive movement in acceptability of new products like SNs. This is directly linked to education and age of girls. This section is more susceptible to adopting and taking these new advances further to the community. Thirdly, availability and affordability is not as problematic as mind-blocks among middle aged or elder women.

V. Local infrastructure, health facilities and health programmes

It is unrealistic to expect that important changes to menstrual and reproductive health in rural Rajasthan will happen at the individual or community levels without significant support. A supportive environment is key to helping women and girls understand and practice good MH & RH. In order to fully understand these two issues in the local context of Barmer District, investigation of a.) local infrastructure, b.) Government health facilities, and c.) Government health programmes/schemes place was necessary. This understanding will help CARE India to maximize impact by working with and improving existing resources and avoid overlap or redundancy. In this section, the three aforementioned elements will be described and explained.

Local Infrastructure

It is important to understand the existing infrastructure in place related to MH and RH. Depending on the context and levels of development (physical and social), this can involve multiple components. The list in Barmer District, however is relatively short as there is very limited infrastructure related to MH and RH. A description of elements that have been identified as relevant by studies and experts follows:

- **Toilets at household level**

Barmer District, including the target blocks of the study (Baytu and Dhorimana) are rural, desert areas with low levels of development. Thus the prevalence of toilets within households is extremely low. This was observed at the field level, and can be supported by the Swachh Bharat Mission (Gramin) Baseline Survey-2012²⁶.

Table 12: Presence of toilets

Category	Baytu Block	Dhorimana Block	Barmer District
% of households with a toilet	29.07%	16.57%	19.37%
% of households with a functional toilet (of those with a toilet)	33.92%	57.74%	41.61%

With only a small fraction of the population having functional toilets, the grand majority of people practice open defecation. Menstruating women go outside of the house for their toilet needs, but change sanitary napkins (or other menstrual products) within the house.

- **Toilets in schools**

²⁶<http://tsc.nic.in/BLS2012/District.aspx>

In contrast, practically all schools in the study areas have toilets²⁷.

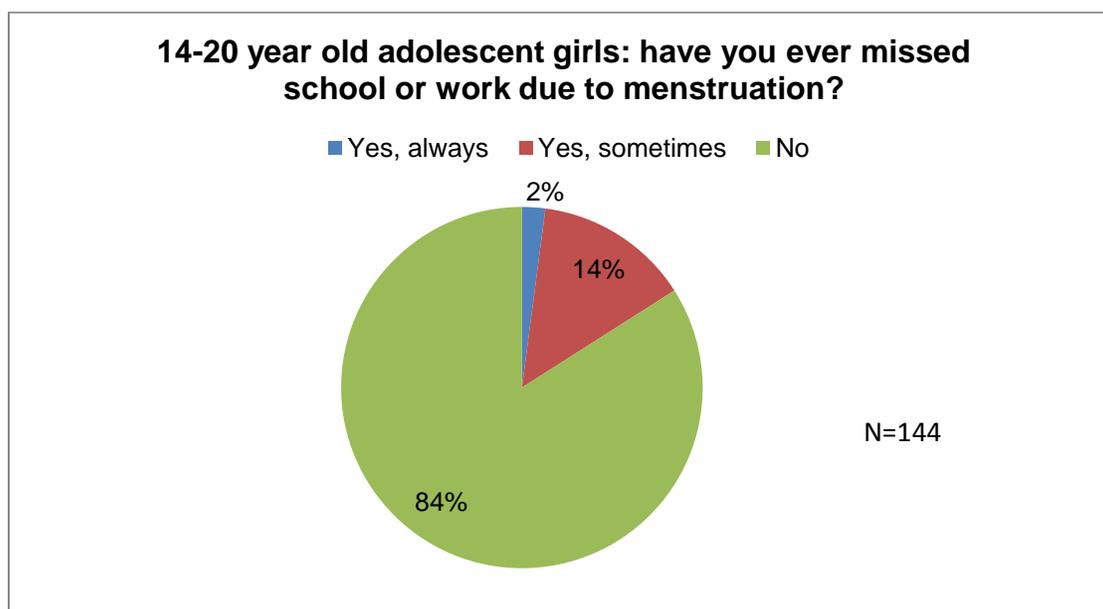
Table 13: Toilets in schools

Category	Baytu	Dhorimana	Barmer District
% of Gov't school with toilet	99%	99.44%	99.37%
% of Private school with toilet	100%	96.97%	98.06%

*Generally schools have separate toilets for boys and girls. However, the functionality of toilets in schools was not covered by the survey.

However, the high numbers of toilets in schools does not automatically result in effective solution for menstrual health and hygiene for girls. School toilets were observed and described as unclean and inconvenient places that girls avoid except for emergencies. Some adolescent girls participants said that they would stay home during their periods specifically so they could change their pads more conveniently. Others said that they would return home during their lunch break to change pads. Quantitative survey results for girls between 14 and 20 years of age when asked if they ever missed school or work because of menstruation were as follows:

Figure 22: Absence from Schools



The above graphic shows that while the majority of girls do not miss school due to menstruation, a significant portion does either always or sometimes. When asked about their reasons, the girls who admitted to missing school during menstruation cited issues similar to those found in FGDs which included: fear of leakage/stains, shame, lack of privacy for cleaning, lack of disposal system, pain and discomfort. Although the majority of girls did not report missing school during menstruation, it is likely

²⁷ http://tsc.nic.in/BLS2012/Report/Rpt_BaselineSurvey2012_Selection.aspx

that they are also affected by these same issues which can be highly detrimental to their educational experience.

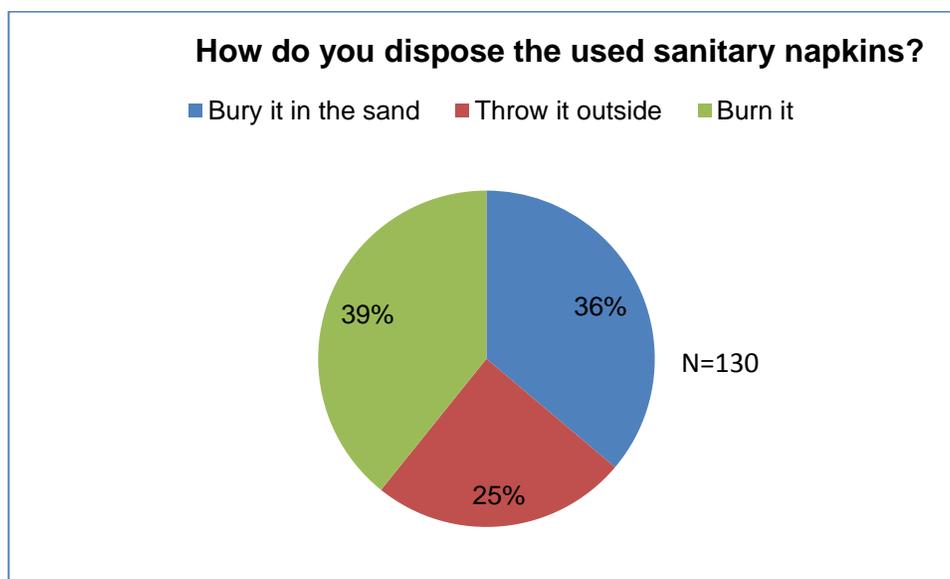
- **Vending Machines/dispensaries**

One option mentioned to the research team by CARE India to improve access to MH and RH products are automatic vending machines which could distribute sanitary napkins or condoms. However, this remains a possible solution, until now it has not been used. No such infrastructure currently exists. If it is to be implemented successfully, important considerations such as privacy, maintenance and disposal would be required.

- **Disposal**

Multiple studies and international programmes have shown that disposal is a crucial part of menstrual health interventions that must be addressed. Rural village life and culture are very different from urban regarding trash and waste management. Traditionally, consumer products such as those with plastic and paper packaging are much less common in villages, so the overall amount of waste produced is much less. Concepts such as dust-bins and door-to-door trash collection are essentially non-existent in these areas. Any trash or waste is simply discarded or thrown out at in an unorganized way. However, the study found that used products related to menstruation (sanitary napkins or otherwise) are usually treated differently. Most women asked in FGDs said that they buried them.

Figure 23: Of women who reported using sanitary napkins, what is the means of disposal?



Quantitative survey results varied on this issue. Survey results showed that over one third would bury used products. An even larger proportion burns them while the smallest percentage (24.6%) would throw them outside²⁸. Treating sanitary napkins differently than other trash is related to the taboos and stigma associated with menstruation, but also some notions of health and hygiene.

Government Health Facilities

This section will provide a description of the relevant formal Government health facilities and health programmes/schemes which should be in place and functional in the study areas.

Health service delivery in rural areas is organized into a multi-tiered system that includes:

- i. **Sub-Centres-** The most peripheral and first point of contact between the primary health care system and the community. Sub-centres are expected to provide promotive, preventive and some curative health care services. Many services are provided outside of the centre as part of outreach activities. Sub-centres are staffed by one or two auxiliary nurse-midwives (ANMs) and one male health worker²⁹.
- ii. **Primary Health Centres (PHCs)-** Are the cornerstone of rural health services, a first port of call to a qualified doctor. People can consult the PHC directly or be referred there by sub-centres for curative, preventive and promotive health care. PHCs are intended to cover populations of 20,000-30,000 people. They should provide : Medical care, maternal/child health care including family planning, medical termination of pregnancies, management of reproductive tract infections/STIs, Nutrition services in (coordination with ICDS), school health, adolescent health and other essential services³⁰.
- iii. **Community Health Centres (CHCs)-** Are designed to provide referral as well as specialist health care to rural populations. In addition to the ones mentioned above, services to be provided include routine and emergency care in surgery medicine, obstetrics and gynecology, pediatrics, dental and AYUSH.³¹
- iv. **Sub-District Hospitals-** Facilities offering a wide range of services ranging from simple interventions to highly specialized. They should have 31-100 beds³².
- v. **District Hospitals-** Hospitals at the secondary referral level responsible for a district of a defined geographical area containing a defined population. Their objective is to provide comprehensive secondary health care services to the people in the district at an acceptable level of quality and being responsive and sensitive to the needs of people and

²⁸Differences between qualitative and quantitative findings can be the result of embarrassment or reluctance of respondents to admit that they simply throw their sanitary napkins outside.

²⁹<http://nrhm.gov.in/images/pdf/guidelines/iphs/iphs-revised-guidelines-2012/sub-centers.pdf>

³⁰<http://nrhm.gov.in/images/pdf/guidelines/iphs/iphs-revised-guidelines-2012/primay-health-centres.pdf>

³¹<http://nrhm.gov.in/images/pdf/guidelines/iphs/iphs-revised-guidelines-2012/community-health-centres.pdf>

³²[http://health.bih.nic.in/Docs/Guidelines/Guidelines-SD-&-SDH-\(Revised\)-2012.pdf](http://health.bih.nic.in/Docs/Guidelines/Guidelines-SD-&-SDH-(Revised)-2012.pdf)

referring centres. Depending on the populations they serve, district hospitals may have between 75-500 beds³³.

The profile of the health facilities in the study areas, as per the National Health Mission: Medical, Health & Family Welfare Department of Rajasthan is³⁴:

Table 14: Health centers in study blocks

Health Facility	Baytu Block	Dhorimanna Block
Sub-Centre	87	77
PHC	9	14
CHC	3	2

In addition, it should be noted that there are some private health facilities existing in rural areas as well. The 2012 HNA Report of Barmer District showed that people preferred government health facilities for treatment of minor problems, while a substantial percentage would go to the private sector for major health issues.

Use of government health facilities for MH/RH

Overall, it seems that people are aware of, and access the government health facilities. However, on specific issues related to MH, they do not use them often. People rarely go to the aforementioned health centres or hospitals for MH related products or advice, and the doctors interviewed said they do not usually give advice or services on MH issues. However, household survey data indicated that in case of menstruation related problems, some females do access government health facilities particularly lower level facilities (e.g. Anganwadi centres), but also hospitals.

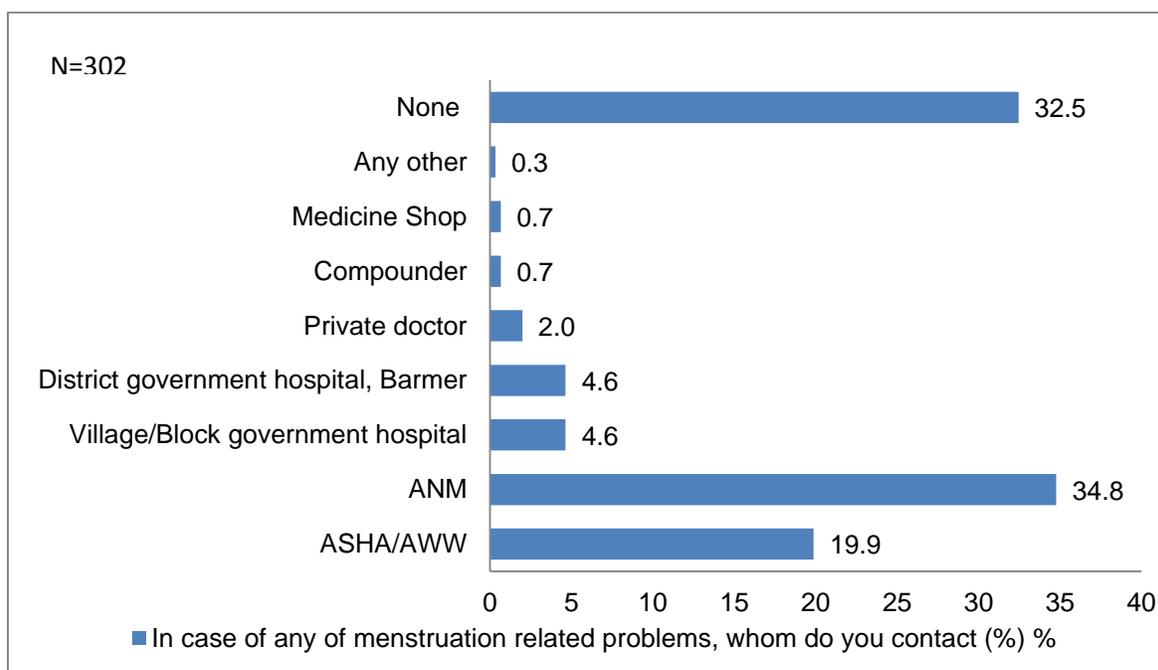
Access of government health facilities for RH is more common because RH includes a wider range of serious health issues such as child birth. However this too is an area of concern as some women still give birth at home. The use of government facilities for RH was not a primary focal point for this study, but evidence suggests that men and women are most likely to access basic facilities such for contraceptives or terminal methods while only using larger facilities in case of emergency or major health problem.

It should be noted that some private sector facilities providing products and services related to MHRH exist. These facilities are more likely to be accessed by families that are relatively well off and located in close proximity. Underprivileged and isolated families are unlikely to use them. However, the exact extent to which men and women access these facilities was not measured under the study.

³³<http://health.bih.nic.in/Rules/District-Hospital-2012-Revised.pdf>

³⁴<http://nrhmrajasthan.nic.in/District%20Map.htm>

Figure 24: Where do women go in case of menstruation related problems?



Multiple interpretations for low use of facilities for MH are possible.

- The General public and/or health professionals themselves are unaware of the MH support and services that government health facilities are intended to provide.
- Barriers to access such as transportation prevent people from accessing support and services.
- Needs and problems are sufficiently addressed at local levels.

Government Health Programmes and Frontline Workers

There are two large Government programmes which, among other issues, are meant to address MH and RH. They are interrelated and linked at numerous points, but have been separated below for clarity.

- **National Rural Health Mission (NRHM)**- an initiative launched by the Prime Minister of India in 2005 which seeks to ‘provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups’. The NRHM is designed to respond to the specific health problems and characteristics of rural populations and includes numerous sub-initiatives and components. One recent and highly relevant one is:

- **Scheme for Promotion of Menstrual Hygiene-** Launched to ensure that adolescent girls (Ages 10-19) have adequate knowledge and information about menstrual hygiene and the use of sanitary napkins, and also that high quality, safe products are made available to them. The scheme includes creation of a NHM brand product of sanitary napkins called ‘Freedays.’ These products are to be produced by SHGs and provided or sold at a fixed, low cost by ASHA workers³⁵. Schools also play an important role in the dissemination of information and products. This scheme is operational in seven out of the nine districts in Rajasthan, but not currently in Barmer District³⁶.
- **Integrated Child Development Services (ICDS) Scheme-** One of the world’s largest programmes for early childhood development which simultaneously seeks to provide pre-school education and break the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality³⁷. Within ICDS, multiple components related to MH and RH include:
 - **Kishori Shakti Yojana-** A programme that aims to improve the nutritional, health and development status of adolescent girls (aged 11-18), promote awareness of health, hygiene, nutrition and family care. This programme is implemented in numerous regions of the country and is the counterpart of RGSEAG³⁸.
 - **Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG)—SABLA** A centrally sponsored government scheme that amongst other objectives seeks to ‘promote awareness about health, hygiene, nutrition, adolescent reproductive and sexual health and family and child care’. The programme covers adolescent girls in the age groups of 11-18 years which are divided into two age brackets (11-15 years old and 15-18 years old). This programme is implemented in districts in which Kishori Shakti Yojana is not³⁹.

Frontline Workers

Given the sparse population density and multiple barriers to access in many parts of India, the effectiveness and reach of these schemes relies heavily on Frontline Workers (FLW). Those with significant roles to play on MH & RH include:

- **Auxiliary Nurse Midwife-**Heads sub-centres at the village level and works in coordination with other FLWs. Amongst other duties, ANMs play important roles in immunizations, health check-ups, referral services, nutrition and health education.

³⁵http://indiasanitationportal.org/sites/default/files/Menstrual%20Hygiene_Operational%20Guideline_Eng_25-08-10.pdf

³⁶<http://nrhm.gov.in/nrhm-components/rmnch-a/adolescent-health/menstrual-hygiene-scheme-mhs/schemes.html>

³⁷<http://wcd.nic.in/icds.htm>

³⁸<http://wcd.nic.in/schemes/sabla/sablaguidemar11.pdf>

³⁹ SABLA is implemented in 10 districts across Rajasthan, including Barmer. The rest are covered under Kishori Shakti Yojana.

- **Anganwadi and Anganwadi Workers-** Anganwadis are fundamental components of the Indian public health system. They provide basic health services in rural villages. Anganwadi workers are women (preferably aged 18-44 years of age) from the local village who have good rapport with the community. Their numerous tasks include facilitating health check-ups and providing supplementary nutrition, referral services, pre-school education and nutrition and health education⁴⁰.
- **Accredited Social Health Activists (ASHA)-** Women, preferably between the ages of 25-45 selected from the village itself that are trained to work as an interface between the community and public health system. Among other responsibilities, the ASHA worker is charged to a.) provide information to the community on determinants of health including sanitation and hygienic practices b.) counsel women and provide products related to reproductive health issues including contraception and prevention of common infections including Reproductive Tract Infections/Sexually Transmitted Infections (RTIs/STIs)⁴¹. Additionally, ASHA workers have an important role in the Scheme for Promotion of Menstrual Hygiene where they are the main sellers of sanitary napkins.
- **Saathin-** In each Gram Panchayat, one Saathin is trained to counsel and provide advice to adolescent girls by forming *kishorisamuh*'s (adolescent girls' groups) in each village. They are coordinated by ICDS offices and collaborate with other FLWs like Anganwadi Workers and ANMs. Their scope of work includes counseling and awareness on a variety of issues related to female health such as puberty and related biological changes.
- **Janmangal couples-** Are teams of unpaid volunteers (usually husband and wife) who are recruited by ANMs then trained to promote health of mothers and children through proper spacing between births. They do this through a.) supply of contraceptives b.) contraceptive counseling and referral c.) provision of information on the needs and benefits of spacing methods.

Implementation of Government Programmes

Despite a significant amount of resources and support intended to address issues of menstrual and reproductive health, their reach into the study areas is somewhat limited. The aforementioned schemes are being implemented by FLWs, however in some cases it seems that the reach of schemes and FLWs is more significant on the subject of RH than MH.

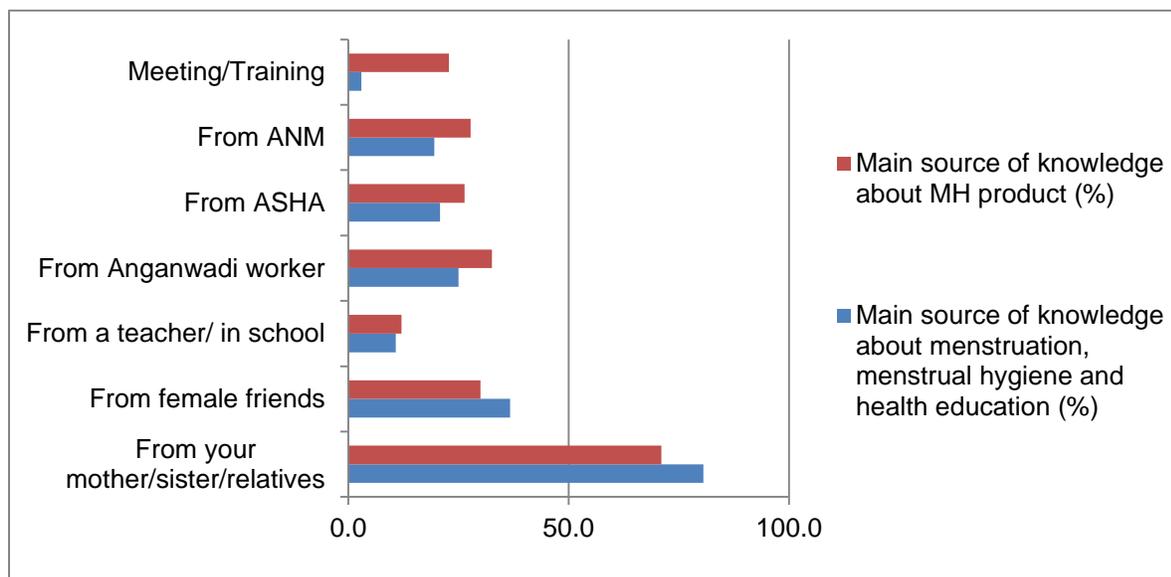
MH: Learning and provision of products

Learning

⁴⁰<http://wcd.nic.in/icds/icds.aspx>

⁴¹<http://nrhm.gov.in/communitisation/asha/about-asha.html>

Figure 25: Knowledge about MH and MH products amongst adolescent girls and women



While majority of women and girls surveyed said that mothers, sisters and female relatives were their main source of knowledge about MH and RH products, some did also say that they learned from FLWs including Anganwadis, ASHAs and ANMs. Alone, none of these responses were overwhelming, but when combined, the contribution of FLWs to female knowledge and understanding of MH is significant. The reach of FLWs was similar across both study blocks, among different castes and age groups with the exception of ANMs who have impact with women over 30. Out of the given options, Jan mangal couples, public hoardings, radio or television did not make a significant contribution in the spreading knowledge about the MH product or around its awareness. In reference to the table found in the earlier section, it does seem that in case of MH related problems, women and girls look to AWWs, ASHAs and ANMs for help.

Figure 26: Main source for knowledge about menstruation, menstrual hygiene, and health among Females as per age group

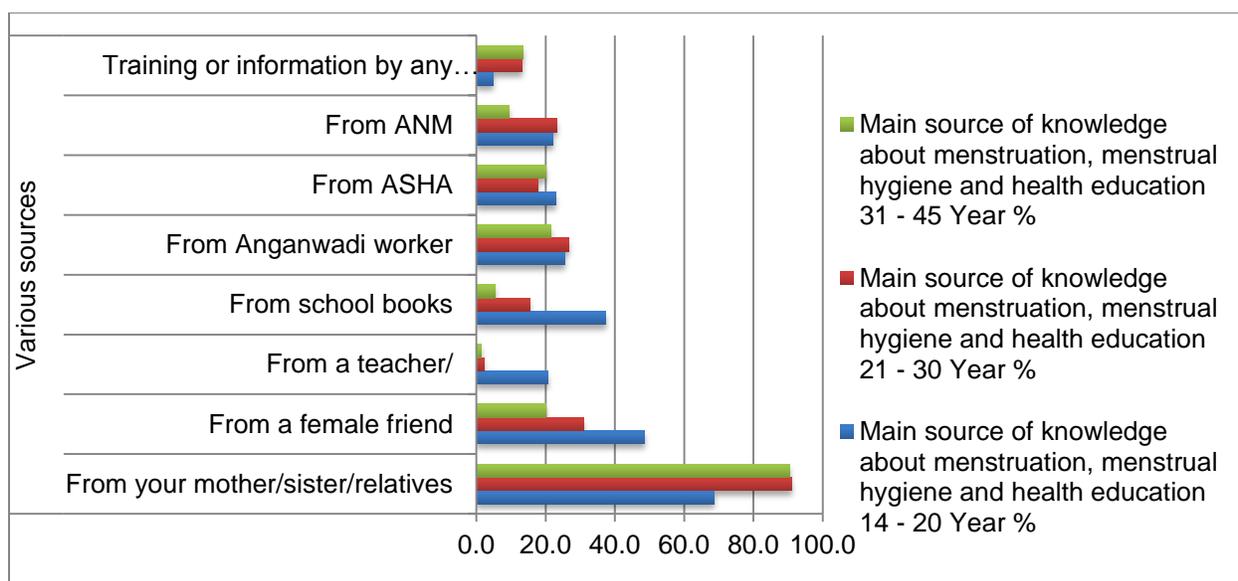
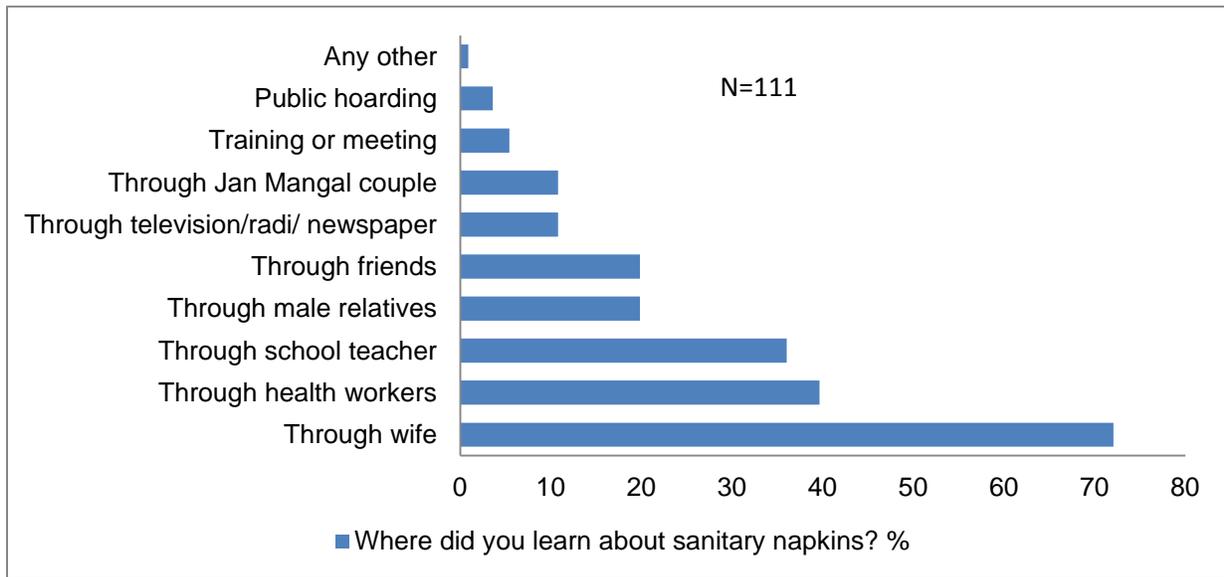


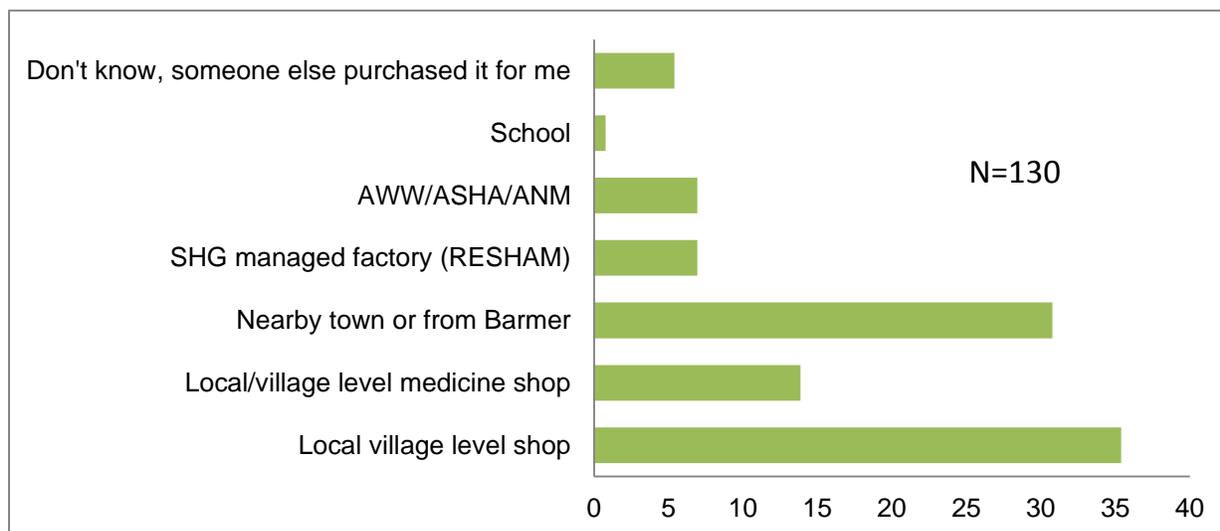
Figure 27: Source of learning about SN amongst Males



Frontline workers including health workers were found to be a significant source for male learning about MH products. Although, Jan Mangal couples and public hoarding were not so impactful.

Products

Figure 28: Mapping access of SN of women using SN

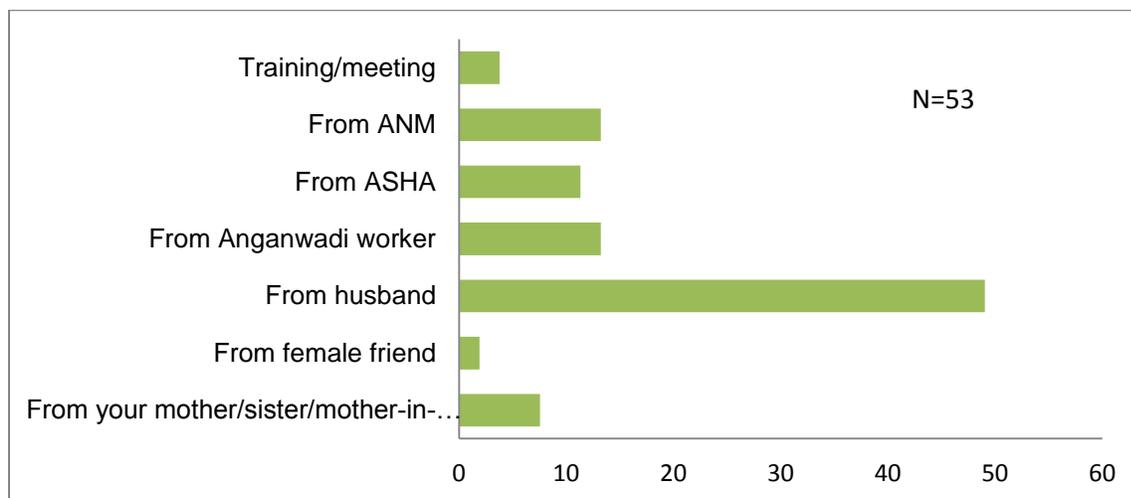


In terms of providing sanitary napkins, FLWs were a source, but found to be far less significant than other sources.

RH: Learning and provision of products

Learning

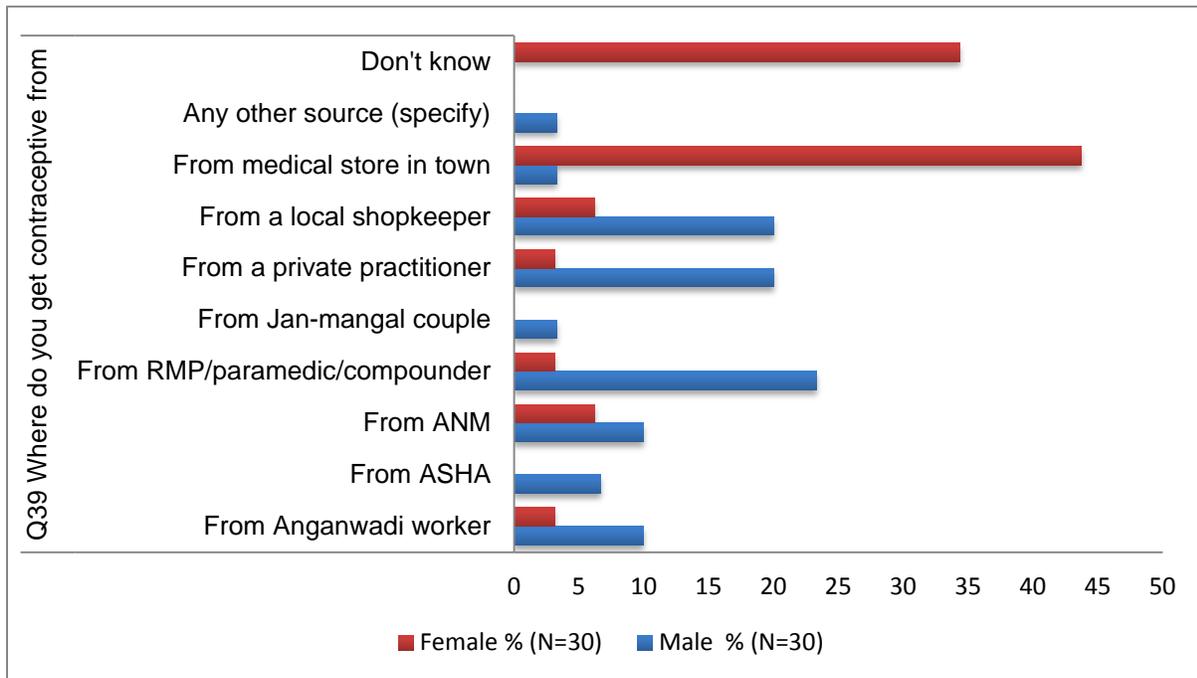
Figure 29: Women’s source of awareness about contraceptives



Again, FLWs are not the primary source of information on the subject of contraceptives. However, when combined, the contribution of ANMs, ASHAs and AWW is significant.

Products

Figure 30: Source of obtaining contraceptives amongst men and women



Although implementation on RH was generally higher than for MH, Jan Mangals were surprisingly absent from results.

Figure 31: Jan Mangal Couples services to women

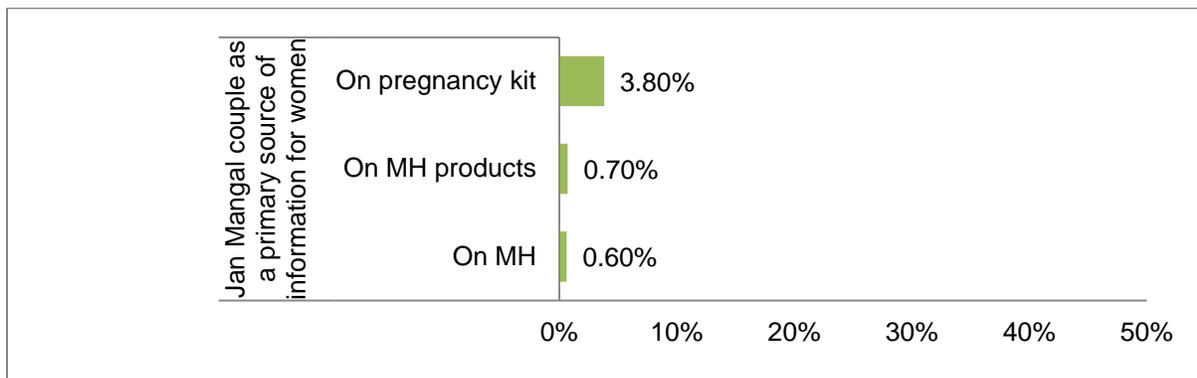
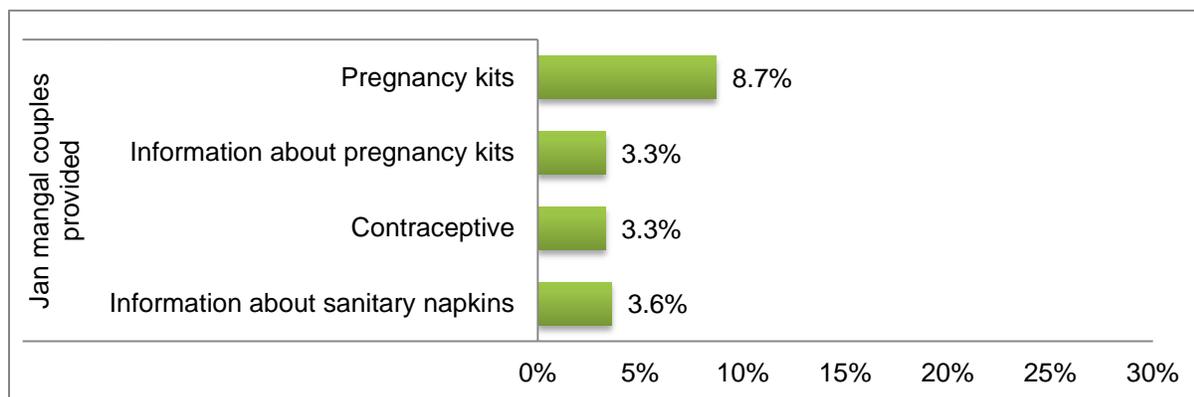


Figure 32: Jan Mangal services provided to men



Challenges to implementation

The factors identified during qualitative data as challenges to implementation include:

- Lack of awareness among service providers-** During interviews and FGDs, it was revealed that some FLWs did not even know the government schemes or related to MH/RH or that their responsibilities included activities related to MH/RH. For instance, one ASHA worker shared that these topics were outside of the purview of her work and so she did not discuss them with women or men in the village. In fact, lack of awareness and information among FLWs was suggested by the CPDO as an obstacle. During an interview, he said that because FLWs are largely uneducated or have low levels of education, awareness raising and knowledge dissemination is not very successful.
- FLWs own views and practices-** Even if FLWs have been adequately trained on MH/RH and recognize their roles and responsibilities, there may be other problematic factors. Most FLWs come from the local areas in which they work and have profiles not dissimilar to the general population. Therefore their own practices and beliefs can interfere or conflict with the work they are meant to do. For instance many of the FLWs interviewed do not themselves use sanitary napkins. The quality and sincerity of advice or guidance of an FLW that she herself does not follow are likely to be compromised. It is troubling, although not surprising that the FLWs often hold, share and propagate the general community's beliefs and taboos related to MH/RH. One FLW said that she herself believed that restrictions during menstruation were good and that she advised women about them. Regarding such restrictions, one Anganwadi worker said 'How can puranas/bhagwat be wrong?'
- Insufficient time-** During an interview, a CPDO claimed that because of the non-tangible nature of interventions such as counseling and awareness raising, impacts are not always immediately obvious. In the case of Saathin's for example, he suggested that the benefits would only be visible in the long term.
- Communication/connection with community-**In addition to these obstacles, another major dysfunction is the poor or in-existent communication on MH/RH between FLWs and members of the community. Frontline workers are intended to be the interface between the community and government schemes. However, in this case it seems as though some gaps are not being bridged. Two factors can explain the poor communication.

a.) Logistics- There is no reliable or commonly used platform for communication between FLWs and community members (especially young girls). For instance, Anganwadi workers pointed out that adolescent girls do not come to the Anganwadi Centres. One commonly provided service is distribution of supplementary nutrition for girls. However, the girls themselves do not come, and often other family members such as mothers and brothers come to collect it. Another testament to the low level of communication is that, according to one ASHA worker, out of 15 deliveries in her jurisdiction in the last year, 8-9 were at home and in other cases, families went to hospitals in Barmer without her knowledge.

b.) Sensitivity- The other major hindrance to communication is that both the FLWs and community have difficulty in speaking of MH/RH. In the community, reactions to discussion of MH/RH range from discomfort to strong opposition. Therefore, even FLWs have problems discussing these issues. Many said they simply do not attempt to discuss such things. One ASHA worker interviewed said ‘If someone is using condoms within their home, how will I know?’ Discussion on these issues is even more limited when it comes to adolescent girls. For instance, according to qualitative discussions with FLWs family planning is not discussed with girls for fear of adverse reactions by community members.

5. Result: Informal support

Due to the insufficiency (or absence) of formal support and infrastructure, women and girls in the study areas are forced to seek support elsewhere. This often means girls and women learn about and get support on MH/RH through family members and/or peers. For obtaining products, people in the study areas are more likely to go to other sources such as stores and shops. For a detailed description of these trends and behaviors refer to the other sections of this document on Practice and Markets.

Conclusions

- Village level infrastructure related to MH/RH is relatively low and in some cases inexistent.
- There is currently no reliable system for disposal of MH/RH products such as sanitary napkins. This is an issue that should be considered for any intervention.
- Although almost all schools have toilet facilities, they are not ideal (often unclean with no waste disposal), and menstruation does affect girls educational experience.
- Formal (Government) support and services related to RH seem to be more effective and visible in the study communities than those related to MH.
- Although frontline workers are not the primary source for distribution of sanitary napkins, they could potentially play an important role. Some women (especially younger women) said that they were uncomfortable purchasing MH related products from male shop keepers, but if they were available at Anganwadi centres or through ASHA workers, they would purchase them.

VI. Market Research

This section presents the market research findings of the key MHRH product, i.e. Sanitary Napkins. CARE India with support from CAIRN India is promoting sanitary napkin manufacturing units with the overall objectives of promoting MH/RH and sustainable livelihoods. Currently two units have been set up, one in Baytu and other in GudaMalini, while another four are planned to be set up in another two to three years. The market research findings shall guide the CARE India to inform the marketing strategy of the sanitary napkins, currently branded as ‘Resham’.

The market research also included studying the market of RH products to understand the structure and supply chain to assist us in understanding the possibilities with regard to MH products and specifically sanitary napkins.

This section accordingly presents the market research findings as per the product profile and by describing the supply and demand components.

Product Profile

Sanitary napkins - Profile

A sanitary napkin or pad is an absorbent item used by a female while she is menstruating or in any other situation where it is necessary to absorb a flow of blood. The napkins are applied inside an undergarment with a press-on adhesive fixing strip. The key elements of sanitary napkins are to absorb and retain menstrual fluid, isolate fluids from the body, ensure no leakage and no odour.⁴²

The standard design includes a top sheet – nonwoven or apertured film, transfer layer, absorbent layer, absorbent core and back sheet film. The pads are either flat or curved, with/ without wings to secure the pad in place and add additional leak protection.

As per international standards, there are three sizes in terms of length are regular, large and extra large sizes is 180mm to 220mm, 220mm to 260mm, and 260mm to 300mm, respectively. In terms of width, the napkins has to be in the range of 60mm–75mm depending upon the size as declared.

The pad thickness normally depends on the manufacturer and the category (from regular to extra large). There is lot of variety wherein it ranges from 30 mm to 120 mm.

Popular SN products in Barmer

The most popular brands and their current sales are as per the table below:

Brand	Company	Popular package	Estimated monthly sales
Stayfree	J&J	Pack of 8	10,000
Stayfree	J&J	Big pack 18	4,500
Butterfly	Jai Durga	Pack of 5	2,000
Whisper	P&G	Pack of 8	1500

⁴² <http://consumeraffairs.nic.in/consumer/writereaddata/Sanitary%20Napkins.pdf>

Care	Jackson Care Product	Pack of 5	500
Kotex	Kimberley Clark	Pack of 8	1000

As can be seen above, Stayfree is the market leader due to its price, strong distribution channel and effective advertisement campaigns. Medium brands like Butterfly and Care thrive on its strong distribution channel and institutional sales which they have managed to build in last so many years. These brands have also branded themselves as medical products. Whisper has a strong distribution channel (almost same that Stayfree), however with limited sales due to relatively high prices. Kotex on other hand neither has a very strong distribution network nor a strong advertisement campaign despite competing effectively in terms of pricing. The most popular packaging is the eight piece one in all the brands. This particular packaging is also the cheapest as a single product, but not necessarily in terms of unit cost (unit refers to the pack or packet and not a single pad).

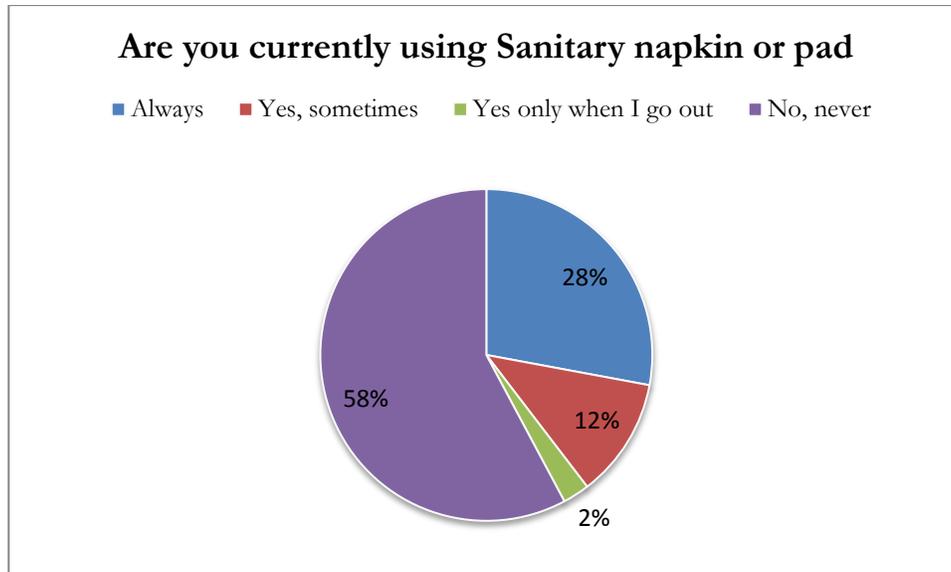


Consumer Profile and findings from Consumer Survey

According to the survey and FGDs, the females have their menarche starting from the age of 11 to 16. Accordingly, all the females in the age group of 15 years to 49 years are potential customers. The current

consumer behaviour as per the survey indicates the following profile of the sanitary napkin customers.

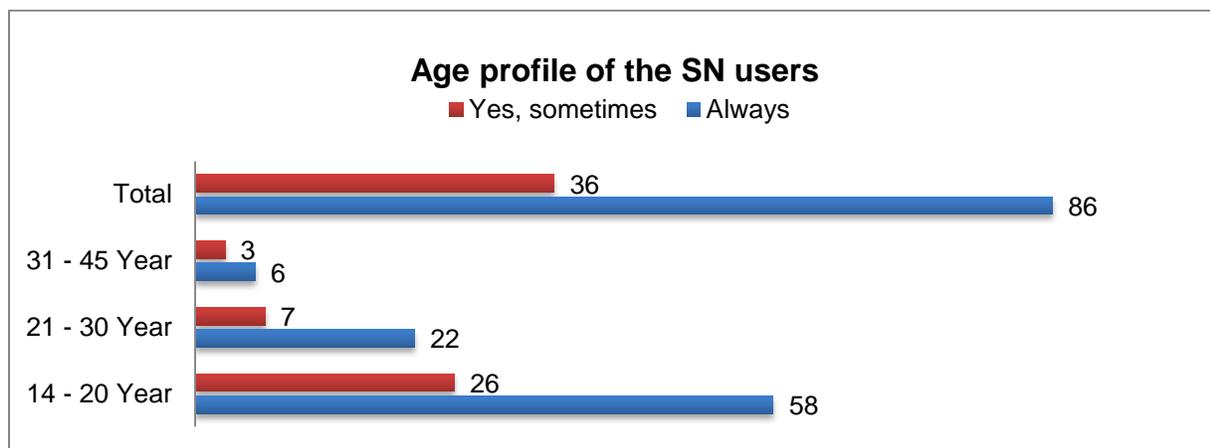
Figure 33: Use of SNs



As per the above chart, 58% of the females do not use sanitary napkins at all, while 28% are already using regularly. 14% of the females are using sanitary napkins infrequently.

Majority of the SN users are young, i.e. in the age group of 14 – 20 followed by the age group of 21 – 30 years.

Figure 34: Age profile of SN users



- 93% of the SN users are in the age group of 14 – 30 years, wherein 67% are in the age group of 14 – 20 years.
- Similarly 92% of the irregular users are also in the age group of 14 – 30 years.

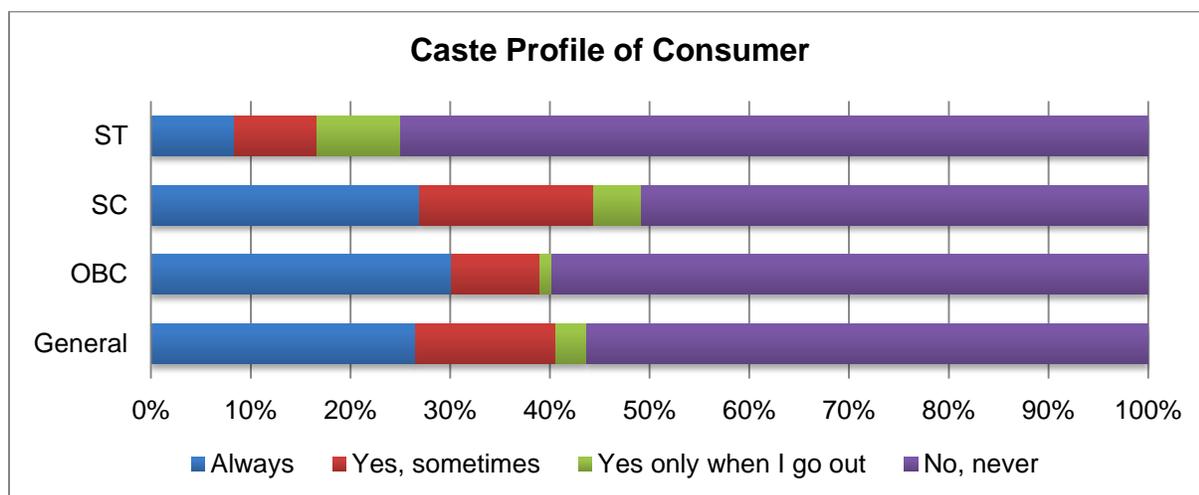
- It is also worth noting that almost 87% of the females in the age group of 31-45 have never used SNs at all.

Most of the SN users are educated while the non-users largely comprise of uneducated females (Refer to figure 13 in Section IV)

- Most of the regular SN users have studied upto 5th Standard and above while a very few uneducated females are using SNs.
- 96% of the respondents who have studied upto 12th and above are regular SN users. Similarly, 60% of the 10th pass respondents are regular SN users.
- It is also important to note that out of respondents who have never used SNs, 71% are uneducated. This goes to establish the direct relationship between the education levels and usage of SNs.

Caste or community is not a very important determinant in deciding usage of SNs except in case of SCs and Muslims whose numbers are very limited.

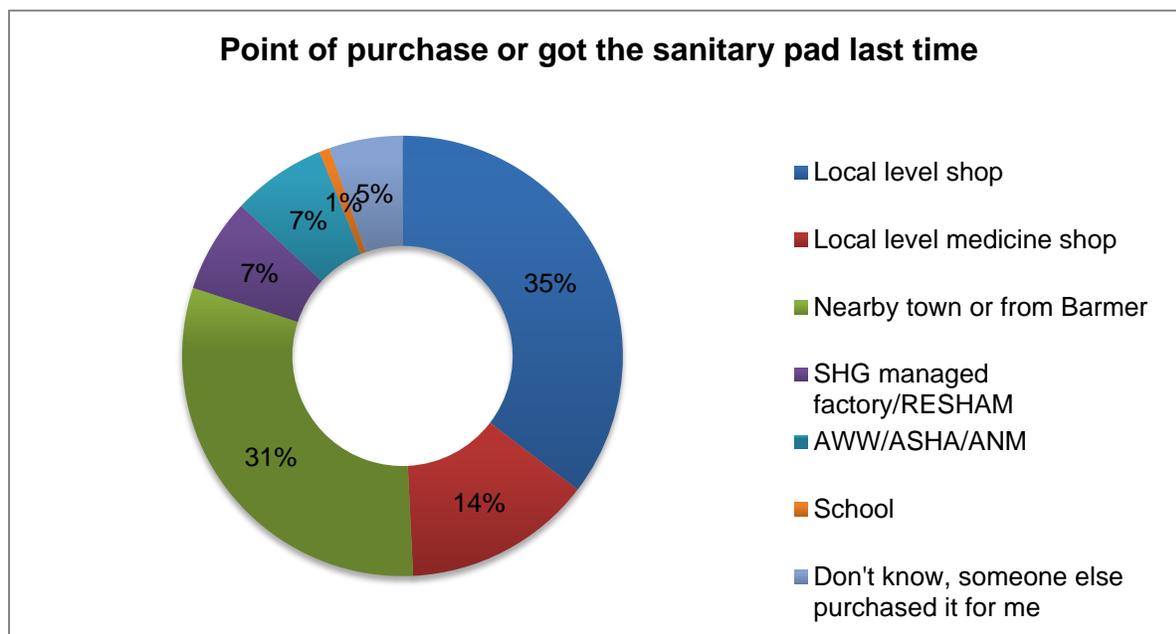
Figure 35: Caste profile of SN users



- Around 20% to 30% in each of the three categories of General, SC and OBC regularly use SNs, while it is significantly low in case of STs.
- It is significant to note that almost 50% of the respondents in each of the categories have never used SNs.

Majority of the consumers buy the SNs from the local level shops or medicine stores and from Barmer or nearby major town.

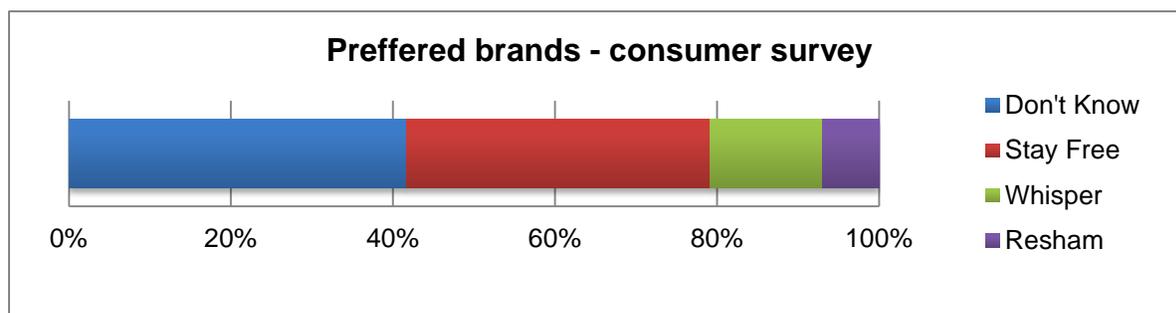
Figure 36: Point of purchase of SN



- Around 50% of the total users currently purchase the SNs from the local level shops or medicine stores. It is important to understand the local level stores include the ones located in nearest GP h.q.s.
- A significant proportion of females, i.e. 31% purchase the SNs from Barmer or any other major town like Dhorimanna or Baytu.
- Around 7% of the respondents also mentioned buying *Rehsam* –which is manufactured by SHGs under a pilot women health initiative (RACHNA) supported by CARE India and CAIRN India. This is especially true for villages close to SN units and also the locations where CARE India conducted special programmes and also sold the SNs.
- Around 50% of the respondents mentioned that they purchased the sanitary pads from 0 to 5 kms, another 15% from 6 to 10 kms, another 10% from 11 to 15 kms and rest of the 20% from more than 16 kms.

Stayfree, Whisper and Resham are the brands which the respondents prefer in that order.

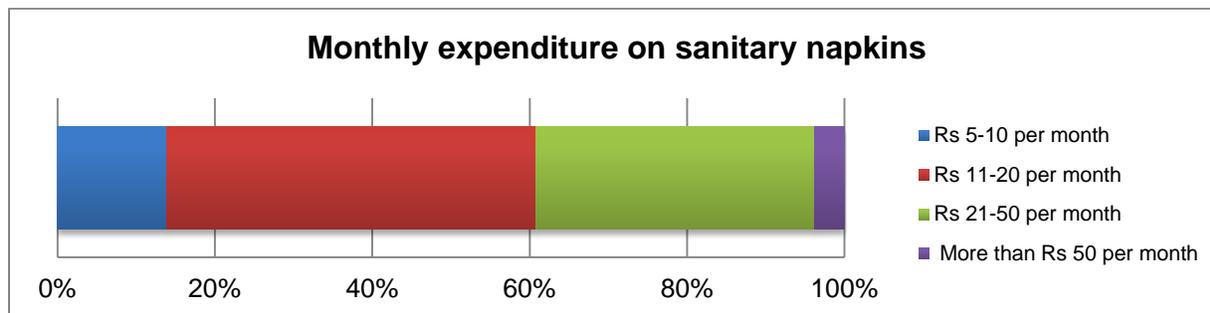
Figure 37: Preferred brands of SN



- As can be seen from the graph above, more than 40% are not aware of the brands which they use while another 40% use Stayfree which is the most popular brand.
- Whisper is the next popular brand while respondents also mentioned Resham as the brand which they have used.
- The data suggests that education levels or community/caste does not influence the brand selection decision.

Around 50% of the users spend Rs. 11 to 20 on sanitary napkins followed by 35% users who spend between Rs.21- 50 per month.

Figure 38: Expenditure on SN

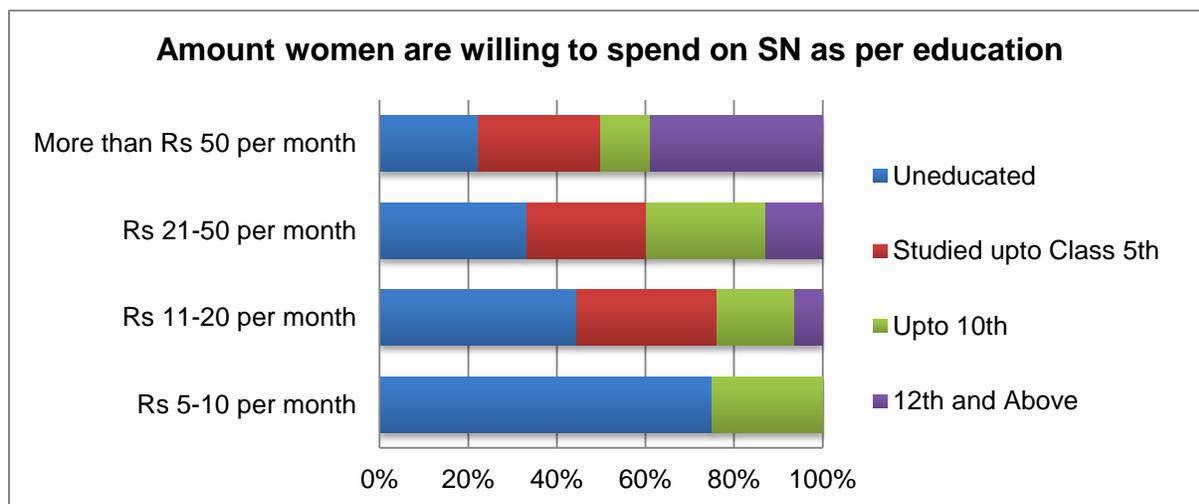


- As per the pricing of the different products available in the market, women are mostly spending about Rs. 11 to Rs 50 per month.
- The other factors which influence is also the amount of SNs required by a particular woman depending on the nature of bleeding.
- Education of the females has correlation with the amount being spent as 72% of the uneducated and 59% of the females studied upto 5th spend from Rs. 11 – 20 per month, while 52% of the females studied upto 10th and 42% of the females studied upto 12th and above spend between Rs. 21 – Rs. 50.
- It is also clear that the highly educated women prefer the premium ones, i.e. all women who spend more than Rs. 50 per month have studied upto 12th and above.

53% of the respondents are willing to spend on improved product for menstrual hygiene, i.e. better sanitary napkins, of which 38% are willing to spend Rs. 11 to Rs. 20 and another 38% Rs. 21 to Rs. 50 per month.

- **Refer to figure 15 (section IV)** to see the nature of willingness to spend on SN by women.
- As can be seen from the graph below, as the education levels are directly related to amount of expenditure.

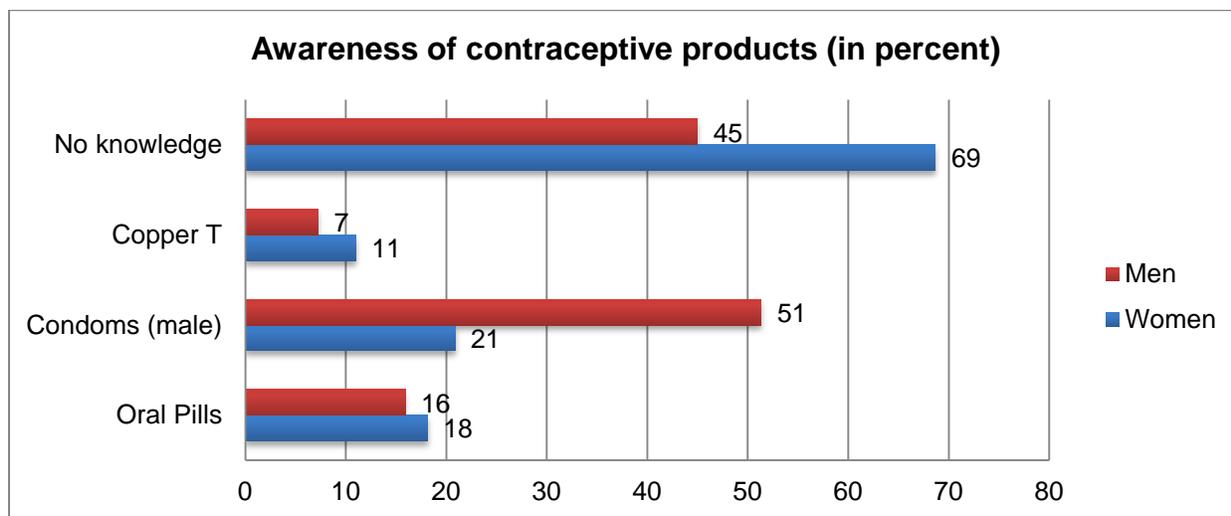
Figure 39: Amount women with different educational attainments are willing to spend on SN



- While female with all education levels are present in the different amount categories, their proportion is varied.
- Clearly, higher the education level, a female is willing to spend a larger amount.

Only 55% men and 31% women are aware of the contraceptive products

Figure 40: Awareness of contraceptive products



- The most popular contraceptive products amongst men are condoms as more than 50% are aware of it. In case of women, only 21% are aware of condoms while only 16% are aware of oral pills.
- The awareness levels are significantly low considering the government’s efforts towards promoting these products.
- Once again, the awareness levels are directly correlated with education levels as 77% of the uneducated women are unaware of contraceptive products. Similarly 63% of the women educated upto class 5th and 35% of the women educated upto class 10th are unaware of such products.
- The data analysis reveals that there is no significant difference in the awareness levels from the

women of different caste groups.

- 43% of the women mention that they get the contraceptives from local level medicine stores while 35% are awareness of the point of purchase.
- In case of men, 23% mentioned obtaining contraceptive from local level RMP or dispensary stores, 20% from local medicine stores, 20% from other private doctors, 27% from FLWs (i.e. ASHA, AWW or ANM).
- From the women who used contraceptives, 50% claimed to have spent Rs. 50 – 100, 28% from Rs. 21 – 50 and a significant 16% are not aware. Amongst males, 43% claimed to have spent Rs. 21 – 50 and 30% mentioned obtaining it free from government system.

Only 14% of women and 50% of men are aware of the pregnancy kits. Usage levels are extremely low.

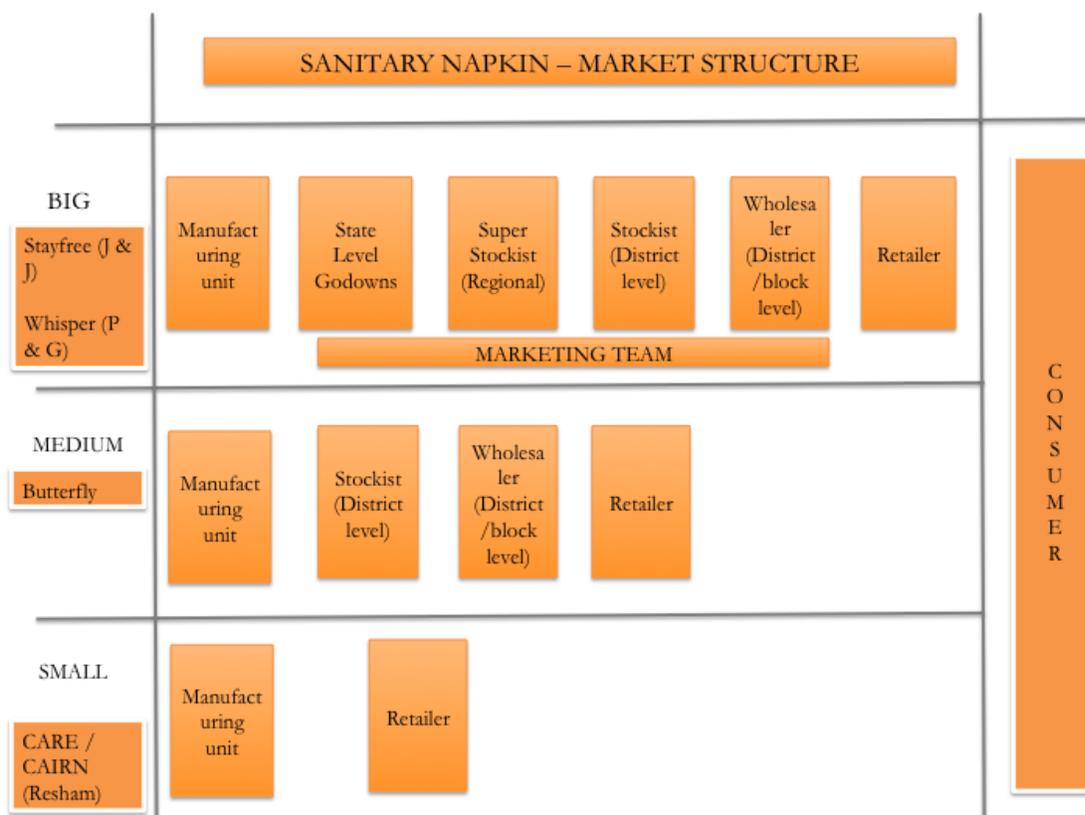
- Out of women who are aware, More than 50% of the women claimed to have got the information about the pregnancy kit from the FLWs especially ANMs and Anganwadi workers. 16% also mentioned husbands as the source of information while another 27% mentioned training or meetings.
- Only 18 women and 23 men claimed to have used the pregnancy kit. Most of them claimed to purchased it from local medicine shops while another few mentioned obtaining it from ANM.
- Only 9 women and 14 men were aware of the price of the kit which they mentioned it to be in the range of Rs. 50 to Rs. 70.

Market Structure

The market structure of the sanitary napkins or pads is like that of any other Fast Moving Consumer Good (FMCG) product. Since it's a sanitary product, the medical aspect is also attached. And so there are certain players who deal exclusively with it as part of their medical products profile (for instance, Butterfly brand depends on institutional sales to clinics) while the other major players take it as a FMCG product for mass consumption. The RH related products especially that of male condoms is similar to that of sanitary napkins. The only difference being that government through its network of health workers is also distributing RH products like oral pills and condoms while there is not such government led effort for MH products.

The market structure can be simply explained with the following diagram in the context of Barmer district.

Figure 41: SN - Market Structure



Overall, the market structure and its stakeholders are determined by the size of the manufacturers. The size of the supply or distribution channel is directly proportional to the brand size.

Manufacturers

Big: The market is dominated by the large manufacturers and their brands as already mentioned above. Johnson and Johnson, Procter and Gamble and Kimberley- Clark who all are multinationals. All of these manufacturers have their presence in Barmer. In all these cases, the manufacturing units are located outside the state, i.e. Rajasthan. In case of Johnson and Johnson, the company has a storehouse or a godown in Jaipur from which they supply the sanitary pads to north-western region.

Medium: In this category, there are two manufacturers, Butterfly by Jai Durga Enterprises and Care by Jackson Care Product. Both these brands pitch their products as medical products and depend largely on institutional sales. In both the cases, the manufacturing units are located within Rajasthan, i.e. Bikaner for Jai Durga Enterprises and Jaipur for Jackson Care Products.

Small: There are no manufacturers or local level entrepreneurs in Barmer district, except the two units promoted by CARE India/CAIRN India project.

Stockists and wholesalers

The stockists are the link between the company and the wholesalers of the product like any other FMCG

product. In many ways, they represent the company. The same entity often doubles up as stockists for one product while being wholesaler for another product. In Barmer, the main stockists with whom the research team met are as below. In few other cases, the stockists are based in Jodhpur and they deal directly with the wholesalers:

Table 15: Major Stockists/wholesalers of SN in Barmer

Stockist/Wholesaler (big)	Brand	Company
Shiv Enterprises	Stayfree Whisper	J&J P&G
Jeet Surgicals	Butterfly Care	Jai Durga Jackson Care Product

Often the companies have one stockist for the district or an area. For e.g. Shiv Enterprises largely cater to the Barmer town and the neighbouring villages and small towns while the far off ones are taken care of by the Jodhpur based super stockist or stockists based in other major town. Overall, the structure is based on the principle of achieving operational efficiency in the distribution channel. According to Shiv Enterprises, they supply to 8 wholesalers, 200 – 225 medical stores and 60 other retail stores. Similarly, JeetSurgicals supply to 100 to 150 medical stores and other hospitals. Jeet Surgicals claims to be sole wholesaler of Butterfly brand in Barmer.

It is estimated that a total of 12 to 15 wholesalers would be there of the sanitary napkins in Barmer city.

Retailers

The major categories of retailers are medicine shops, general stores (especially the ones which store beauty products) and beauty parlours.

An estimation of the number of three categories are as below:

1. **Medicine shops:** The best of estimates indicate that there would be around 200 medicine shops in Barmer city, around 10 in Guda, another 10 in Baytu, around 15 in Dhorimanna and around 5 to 7 in small semi-urban centers like Khawas, Nagar, etc. Many of the Panchayat Headquarters like GudaMalini also have medicine shops. Overall, it is estimated that there would be around 500 medicine shops in whole of Barmer district of which 70 to 80% potentially stock sanitary napkins. Random survey and meetings by the research team indicated that all the medicine shops did have sanitary napkins and availability did not seem to be any issue.

2. General stores: While it is difficult to estimate the total number of general stores due to variety in terms of size and the informal nature of operations, however, estimates suggest that almost 200 stores in this category would be selling sanitary napkins in Barmer city, Guda and Baytu, wherein more than 50% would be in and around Barmer city. In some of the cases, even small shops in small towns like Khawas were found to be selling sanitary napkins. In small towns, the general stores selling beauty products or fancy items targeting female customers were found to be selling sanitary napkins.
3. Beauty parlours: With the popularization of beauty care, it was found that some of the beauty parlours have started stocking sanitary napkins. Since privacy is ensured at these beauty parlours, female customers find purchases easier and convenient.

It was also found that most of the retailers, especially the smaller general stores sell only one brand.



Figure 42: A small retailer selling SNs in Khawas

Market Size

In Barmer district, the total female population in the reproductive age group is around 6.5 lakhs (based on the census 2011 data assuming that 55% are in the 15-49 age group), which can also be considered as the total potential market size. However, considering that many would not change their behaviour and around 30% are willing to purchase, the total immediate market potential is of around 2 lakhs females. As per the current sales data provided by the leading stockists and wholesalers, around 20,000 packets of sanitary napkins are being sold per month which is only 3% of the total universe and 10% of the total customers who can be immediately targeted.

According to the market players, their sales has significantly increased in last 2 to 3 years which they attribute to television advertisements and the new generation who are adopting the usage of sanitary napkins.

Key constraints to scaling up of MHRH products and services

The key constraints as mentioned by different stakeholders from government, private sector and others in scaling up of MHRH products and services are being described below:

- Low education and awareness levels: As already seen in the previous sections, education levels are directly related to awareness and usage of MHRH products. Since majority of the population is uneducated, the market penetration of MHRH is extremely limited.
- Dispersed population and difficult geography: Barmer is the district with one of the lowest population density. Additionally, since it is part of Thar desert, the terrain is quite difficult. This increases the transaction cost quite significantly which further leads to problems related to availability.
- Taboo attached with MHRH products: There is taboo attached with practices related to use of sanitary napkins and contraceptives. This leads to communication gaps between family members and the products are hardly discussed. The local (village or town) level shopkeepers belong to the same local society and so they also consider these products as taboo and do not like to sell them from their stores.
- Availability of MHRH products at the level of a woman: Due to local level taboo and low awareness levels, many of the shops do not store these items especially at the village. Overall, in comparison to other products and services, availability of SN is an issue. Most of the population living Panchayat H.Q. or any other major service center, the product is available while for the population living in the hamlets it is not, just like many any other items.

VII. Recommendations to develop local markets

As mentioned in the ToR, the following recommendations are aimed at developing the local markets for MHRH product and specifically Sanitary Napkin which the project is promoting by setting up manufacturing units. These recommendations are based on the findings of both the social and market components as well as on the learnings from other experiences.

Finalise the enterprise design and strategy

Firstly, it is important to design the social enterprise in a way that it competes with other commercial products, which would mean sorting out fundamental issues like ownership and stakeholdership of different actors including CARE and CAIRN and women. Since there will be multiple enterprises operating under the common brand, it is important to set common norms to decide the price, quality and sales. While doing that, the role of professionals for sales, finance and their engagement in the process will also need to be considered.

Set the Goal and the Sales Targets

It is important to set the goal and the time period required to achieve that goal. Considering the sales of competitive products and production capacities, the enterprise level goals and sales target can be well stated and defined.

Based on the discussions, it is understood that the current production capacity of each unit is around 1500 packs per month which can be taken up to 2000 packs per month. Considering that around four to six units are planned to be set up in next couple of years, it will be worthwhile to design the marketing strategy and distribution channel for 10,000 packs per month. Looking at the sales figures of big brands, this target definitely looks challenging, however, achievable as the market penetration of SN is really low and there is huge opportunity.

The sales targets can then be broken as per geographical areas and distribution channels. Overall, the sales targets will need to be expressed in terms number of customers, retailers and wholesalers.

Specify the target consumer

The findings of the primary survey clearly suggests that an ideal consumer of SN is an educated or school going female in the age group of 14 years to 30 years. Since behaviour change takes time, the marketing strategy should focus on school going girls who are going to experience menarche. The educated newly married women are also potential targets. It is also important to mention that the project should focus on rural women and girls as the urban women may already have strong brand preferences.

Improve the packaging of the SN product

It was common suggestion by many of the shop keepers that the quality of packaging is a strong determinant in establishing the quality of the product and accordingly it is important that Reshamdevelops

a unique and high quality packing for its product which will also help in product recall by consumers and establishing it as high quality product. It will also help in introducing the product in the traditional distribution and sales channels.

Keep the price of the product in line with other competitive products

The price of the current pack of Resham sanitary napkins is Rs. 20 which is less than the competitive products. According to market survey, the price is an important factor in making purchasing decision, however, only when it is significantly different or high. For e.g. Whisper is considered to be better quality product, however, sells less due to its high price. While Stayfree and Kotex are almost in the same price range, but Stayfree sells more. The field study indicates that affordability is not a major issue in the rural areas and there is a significant women population who are willing to spend on SNs. A significantly low price of the product also creates negative impression in the minds of the consumer with regard to its quality. As a sales strategy, discounts can be offered to first time users to develop dedicated clientele.

Key Message or advertising campaign should focus on the SN as a wellness product with positive imageries

Based on the studies from different parts of the world with regard to communication and branding strategies, it is suggested that the use of SN should be pitched as a product which enhances quality of life. Other positive images could be those of supportive, responsible males and older men and women who are portrayed as champions of the topic. In contraceptives, positive messages and imagery focusing on the enjoyment of sex (passion, desire, pleasure, etc.) are more successful than negative ones that focus on health aspects (HIV, STI's, unwanted pregnancy, etc.). Similarly with sanitary napkins- a positive message highlighting the convenience, freedom, empowerment, etc. could be more effective than a negative one focusing on uncleanliness of poor hygiene, infections etc.

Experiment with both conventional and unconventional sales channels

Considering the nature of product and the target market, it is recommended to experiment with both conventional and unconventional sales channels. Medicine stores and beauty stores for part of the conventional sales channels and should definitely be approached to be the sale points. If successful, this can be most cost effective and profitable sales channel.

Unconventional channels like SHG members, lakharus, beauty parlor, ANMs, Saathins, AWW can be tried to become part of the sales network. However, it is important to note that not everyone can engage in selling and so the FLWs with entrepreneurial attitude to be promoted.

Conduct educational and supporting activities for market development

The project is already conducting intensive awareness campaigns at the village and schools level which should be continued. Some of the additional activities, which can be included in the campaign, could be as below:

- Never having used a sanitary napkin can be a barrier. Giving out free samples along with instruction is a common and effective way to introduce young girls (even pre-menarche) to sanitary napkins. Girls can keep them in their purses or school bags and use them as necessary. This way they will not be caught unprepared.
- Similarly, never having purchased a sanitary napkin from a store can itself be a barrier. The first purchase is undoubtedly the most difficult. If females feel more comfortable, they are much more likely to buy. Different strategies could help familiarize girls with the buying process. For instance:
 - Taking groups of schoolgirls to local shops, introducing them to the salesperson, showing them exactly where products are located and how much they cost. Doing this in a group could help alleviate stress or discomfort.
 - Give school girls an assignment (or perhaps incentive) to go to a local store and purchase sanitary napkins. Girls could go in groups of 3-5, proof would be obtained by asking the shopkeeper to sign a slip of paper. Doing so under the pretext of an assignment, and in a group would help reduce embarrassment.
- Men and boys can play an important role and engaging with them, informing and encouraging them to be more supportive can be an effective strategy.
- Also, it was found that some FLWs were either unaware or unprepared to effectively carry out their duties related to MH/RH. Sensitization and capacity building for these actors could be conducted to improve delivery.
- Conduct Mother-daughter counseling sessions to break the myths around menstruation and to break the communication barrier.



ANNEXURE I: Probe Areas Considered under the Study

- Awareness, Beliefs, Practices, Support and Infrastructure

<u>Probe Area</u>	<u>Methods</u>	<u>Key Respondents</u>
<p>Awareness and Beliefs</p> <ul style="list-style-type: none"> ➤ Knowledge, understanding and perceptions related to MH&RH ➤ Knowledge about MH&RH product & service providers (public/ private/ community) in village/Panchayat. ➤ Norms surrounding MH&RH. <p>Practices</p> <ul style="list-style-type: none"> ➤ Preparedness and adoption of Menstrual and Reproductive Hygiene practices. ➤ Sharing and solution-seeking behaviour of adolescent girls and women, esp. pertaining of MH&RH problems ➤ Changes in their daily routine, lifestyle, mobility, etc. that girls and women make during menstruation / while facing a RH problem and reasons behind them (Which of these changes are voluntary?) ➤ Storage practices of girls and women for MH/RH product within the HH. ➤ Propounders, enforcers and followers of the norms surrounding MH&RH (at HH, community, service provider levels). <p>Problems and Inhibitions</p> <ul style="list-style-type: none"> ➤ Common MH&RH problems being faced by adolescent girls and women. ➤ Inhibitions and fears of adolescents and adults regarding MH&RH (both female and male). 	<p>FGDs</p> <p>HH Survey, female FGDs, KPIs.</p> <p>HH Survey, KPIs FGDs</p>	<p>Adolescent girls and boys⁴³ and Adult Males and Females</p> <p>Individuals (HH level), Adolescent and Adult Female FGDs, Village level service providers</p> <p>Individuals (HH level), Adolescent and Adult FGDs, Village level service providers</p>
<p>Availability and Preference</p> <ul style="list-style-type: none"> ➤ Support structures at HH, community and service provider levels for adolescent girls and women. ➤ Analysis of the MH/RH service providers at village, Panchayat, block and district levels : <ul style="list-style-type: none"> - Numbers and nature, - Product & service portfolio, - Location, distance from house & means of communication/ transport ➤ Analysis of MH/RH products and services used (e.g., SN/medicine/advice) <ul style="list-style-type: none"> - Preferred and frequently used products & services. 	<p>Market research (quantitative- surveys and qualitative- interviews and FGDs), HH survey, KPIs</p>	<p>Individuals (HH level), Female Adults and Adolescents, KPIs with public and private service providers in the locality (e.g., chemist and retailers of SN) and the ASHA worker.</p>

⁴³Definitions and practices can vary for the definition of adolescent females. Depending on the topic, the low end of this age group this could range from 10-15 years. However, as per the ToR and available academic studies, awareness of MH&RH is very low and many young girls are surprised by their first menstrual cycle. For the study purposes, adolescent males were defined as 14-18 years of age and adolescent females were defined as 11-18 yrs. However, after the initial scoping in the study area, it was decided to consider girls 14 -18 yrs as adolescent respondents as they were likely to have reached/about to reach menarchy. Adolescent boy respondents for the study were finally decided as those between 15-18 yrs.

<u>Probe Area</u>	<u>Methods</u>	<u>Key Respondents</u>
<ul style="list-style-type: none"> - Composition of the products & services (e.g., what is the SN made of? Ayurvedic/homeopathic/plant-based medicine, etc.); - Preferred sources of the products & services? (e.g., SN is homemade/ready-made; who makes it? Who sells it? Similarly for medicines) <p>Determinants</p> <ul style="list-style-type: none"> ➤ Perceived Factors determining user preference for or avoidance of different MH&RH products and services (e.g., product quality, price and access). ➤ Knowledge about MH&RH related schemes in village/Panchayat (e.g., Jan Mangal couples). ➤ Decision making and control related to women and girls' access to MH&RH products and services. ➤ Monthly expenditure on accessing various MH/RH products and services; source of money for making these expenses. ➤ User satisfaction with and feedback on service content & quality of various MH&RH product & service providers (public/ private/ community) in village/ Panchayat. ➤ User satisfaction with and feedback on benefit/content, access & quality of various MH&RH related schemes in village/Panchayat. 	FGDs, KPIs, HH survey	Women and adolescent girls; ASHA worker; Individuals (HH level)
<p>Characteristics of Sanitation and MH&RH infrastructure</p> <ul style="list-style-type: none"> ➤ Present characteristics of facilities and infrastructure for sanitation and menstrual hygiene- urination, defecation, hand-wash, SN disposal, etc. ➤ The nature, availability and quality of these facilities and infrastructure. ➤ Nature, availability and quality of MH&RH infrastructure and facilities at workplace ➤ Space and provision to store clean SNs and dispose used ones. ➤ Nature and Types of MH&RH service providers in village and in Panchayat – public, private, community-based. ➤ Are the women and adolescent girls benefitting from any schemes for MH&RH operational in their village? Which ones? Who is the person dispensing the scheme at point of contact? <p>Preference, Change and Determinants of the Facilities Used</p> <ul style="list-style-type: none"> ➤ Preferred characteristics of facilities and infrastructure for sanitation (urination, defecation, hand-wash) and menstrual hygiene (SN disposal) - e.g., user fee, security, cleanliness, distance from house, etc. ➤ Changes (if any) in nature and extent of use of facilities and infrastructure by girls and women used during menstrual cycle or when suffering from RH problems. If different, why? ➤ Reasons for benefitting or not benefitting from the existing MH&RH schemes. 	HH survey, KPIs.	Adult Males and Females and Adolescent boys and girls; FLWs
<p>Preference, Change and Determinants of the Facilities Used</p> <ul style="list-style-type: none"> ➤ Preferred characteristics of facilities and infrastructure for sanitation (urination, defecation, hand-wash) and menstrual hygiene (SN disposal) - e.g., user fee, security, cleanliness, distance from house, etc. ➤ Changes (if any) in nature and extent of use of facilities and infrastructure by girls and women used during menstrual cycle or when suffering from RH problems. If different, why? ➤ Reasons for benefitting or not benefitting from the existing MH&RH schemes. 	HH Survey, FGDs	Adult Males and Females and Adolescent boys and girls

Simultaneously, the study sought to understand and describe the market scenario by probing both the supply and demand for MH&RH products and services.

Supply	Demand
<ul style="list-style-type: none"> ▶ Options analysis of supply chain and distribution scenarios – who produces/provides required products and services, how they are distributed to female users, who are various players in the value chain and what roles they perform. ▶ Main suppliers and service providers of the MH&RH products/services in use. ▶ Key constraints to scaling up of existing outreach and depth of MH&RH products and services ▶ Gaps in current market and possible alternative local market – manufacturing and distribution. ▶ Key constraints identified by other local stakeholders to including MH&RH products and services in their existing programs. ▶ Identification of best practices and lessons learnt regarding working with men and women on MH&RH product/service design, production and distribution. ▶ Identification of successful campaigns, distribution chains and institutional models in any past MH&RH projects or in any other relevant sectors (e.g., sanitation, contraceptive marketing, etc.), especially in terms of design, distribution, and livelihood creation. 	<ul style="list-style-type: none"> ▶ Profile of female and male consumer behavioural patterns. ▶ The key drivers of the choices of consumers- like price points, sensitivity and accessibility. ▶ Identification of key issues related to MH&RH products and services, for different consumer segments. ▶ MH&RH products and services currently used, the commercial viability of MH&RH produce/service vendors and potential for livelihood creation in the value chain. ▶ Estimation of potential market size for MH&RH products and services and market segmentation. ▶ Evaluation of potential sources of financing for MH&RH product/service based business, for consumer financing and key constraints in accessing financing.

▶ **Market Research**

ANNEXURE II: Distribution of FGDs

VILLAGES	DHORIMANNA				
	Women	Adolescent Girls	Men	Adolescent Boys	Total
Dhandlawas		1		1	
Bheemtal	1		1	1	
Chakguda	1				
MandokiDhani	1				
Silo is Basti			1		
Guda	1	1			
Mangle Ki Beri		1			
TOTAL	4	3	2	2	11
VILLAGES	BAYTU				
	Women	Adolescent Girls	Men	Adolescent Boys	
Bheelonkibasti	1	1			
Nimbodiyonkidhani		1			
Lekhehtali			1		
MundokiDhani				1	
Meghwalonka was	1		1	1	
Sansiyon Ki Basti	1				
TOTAL	3	2	2	2	9

ANNEXURE III: List of villages for CARE Social and Market Study – MHRH

S.N	Sample Villages -GudaMalani	Sample Villages -Baytu
1	Dhandhalawas	Jatiyakawas(Kumhar)
2	MaliyonkiDhani	Lakhetali (Muslim)
3	BheelonkiBasti (Near MaliyonkiDhani)	PurohitonkiBasti
4	Mangle kiBeri	SarokiDhani (Jat)
5	Aalpura	NayaBhuritiya
6	GoliyaGarwa	Meghwalonka was
7	MeghwalonkiDhani (Ratanpura – G.P.)	Bheelonkibasti
8	Jurni Nagar (Nagar Parada)	KhanjikaTala
9	SilukiBasti	Sansiyonkibasti
10	Chakguda (Aalpura G.P.)	Siyogonkidhani
11	Bheemthal (G.P.)	

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