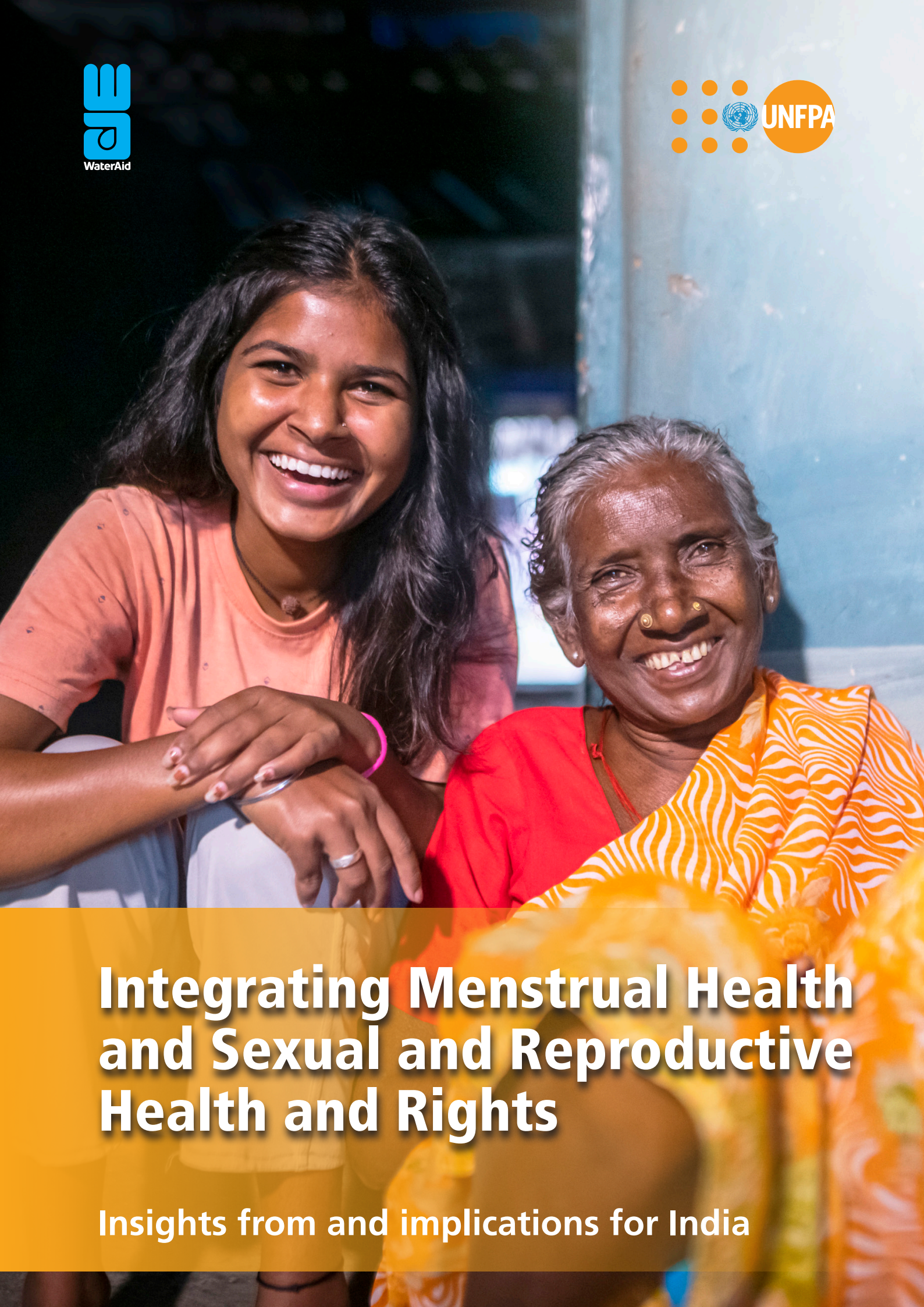

Integrating Menstrual Health and Sexual and Reproductive Health and Rights

Insights from and implications for India

This publication was developed by the United Nations Population Fund (UNFPA) in collaboration with WaterAid India.

The United Nations Population Fund (UNFPA) is the United Nations sexual and reproductive health agency. The organization is guided by the mission to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. UNFPA calls for the realization of reproductive rights for all and supports access to a wide range of sexual and reproductive health services – including voluntary family planning, maternal health care and comprehensive sexuality education.

WaterAid India (Jal Seva Charitable Foundation) is part of the global WaterAid network which seeks to improve access to clean water, decent toilets and good hygiene for everyone, everywhere.

This report was authored by Arundati Muralidharan (WaterAid India, MHAI) and Anjali Singhania (WaterAid India)

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Executive Summary

Introduction

Sexual and reproductive health (SRH) and menstrual health (MH) are fundamental to health, wellbeing, and gender equity. SRH and MH have deeply intertwined roots, biologically and socio-culturally; yet over the years, these integral components of health have not been addressed in conjunction, with joint programming or integration often overlooked in programs, policy and research, globally and in India. Recent conceptualizations of SRH and MH, such as the integrated definition of sexual and reproductive health and rights (SRHR) by the Guttmacher - Lancet Commission, and the comprehensive definition of menstrual health by Hennegan and colleagues (2021) allude to their interconnectedness, even though explicit references of these linkages are missing. These recent conceptualizations of both SRH and MH emphasize important constructs of bodily autonomy and control, decision making and communication, and the need to address discrimination, violence, and coercion. This represents an important shift in addressing SRH and MH as biological health events, to understanding and addressing them through multiple intersecting socio-cultural and economic determinants as well, with the implicit recognition that the achievement of SRH and MH is fundamental to human rights.

Existing insights on joint or integrated programming of MH and SRH suggests significant benefits in terms of health, wellbeing and gender equity (UNFPA, 2021; Wilson et al, 2021; Population Services International 2018). The need for integration is even more compelling following the COVID-19 pandemic that significantly compromised the health and wellbeing of girls, women and gender diverse identities, in the short term and in the long term.

Global reports have examined the intersectionality between MH and SRH; however, country focused synthesis and recommendations do not exist. Drawing on global insights and guidance, this white paper makes the case for integrated action on MH and SRH in India by:

1. Exploring the linkages between MH and SRH in the Indian context
2. Understanding how MH and SRH are integrated in India through programs and policy
3. Proposing recommendations for integrating MH and SRH

The case for integration

MH is a vital aspect of SRH; both have common biological underpinnings, social determinants of health, and share similarities in program design. The biological linkages between MH and SRH include: puberty, nutrition, menstrual problems and disorders, contraceptive induced menstrual changes and menstrual suppression, vaginal/uterine bleeding, reproductive tract infections, HIV/AIDS, hysterectomies, and peri-menopause and menopause. Social determinants that underlie both MH and SRH encompass gender, water, sanitation and hygiene, and socio-cultural vulnerabilities. Current MH and SRH interventions in India have similarities in programming and policy, with opportunities to strengthen integrated action. In the policy realm in India, the intersectionalities are articulated only to some extent. A stark gap in both policy and program interventions is the limited focus on individuals across the reproductive life span, often overlooking the MH needs of adult women, and on understanding and meeting the needs of PwD, those with gender diverse identities, and those facing crises and emergencies. These are important gaps to be addressed through integration.

Perspectives for integration

The inter-linkages between MH and SRH are strong, and programs and policies have operationalized this integration in different ways and to varying extents. The integration of MH and SRH lies along a continuum. At the very minimum, programs co-target the same population and/or the same geographical area. At the next level, SRH programs can incorporate elements of MHM (e.g., sanitary pad distribution, sessions on menstrual hygiene as a part of an adolescent health program). At the last level, joint or integrated programming critically examines the SRH and MH needs of the population it serves, identifies or defines the intersections, articulates how the intervention addresses SRH and MH through its objectives, and develops a plan to integrate the two in programming, as well as through programmatic evidence generation and monitoring efforts.

Drawing from discussions with SRH and MH experts in India and a review of the policy landscape of MH, adolescent health and SRH in the country, this paper presents two dominant programmatic approaches, within each of which several intervention modalities exist:

1. Health products and services approach (incorporates health awareness/promotion)
2. Approaches promoting gender equity

The above two approaches are not mutually exclusive; however, the two approaches have been identified and called out separately in this paper as they have emerged as two dominant pathways to integrate SRH and MH in India. Both approaches can and must incorporate an inclusion lens, implementing measures to ensure that no individual or community is left behind, irrespective of their gender, sexual orientation, disability, and socio-economic status. Several implementation modalities exist within each of the two approaches, as shown below.

Health products and services	Addressing and transforming gender norms, roles and power dynamics
1. Adolescent health interventions and adolescent friendly health clinics 2. MHM and MH interventions 3. Family planning and contraceptive services 4. Comprehensive abortion care, and post-partum care services 5. Integrated programs for people living with other health conditions 6. Integrated programs for marginalized and vulnerable groups 7. Addressing MH-SRH through allied services (WASH) 8. Addressing MH-SRH through digital health interventions	1. Social and behaviour change communication (SBCC) 2. Interventions that promote equitable relationships and decision making through rights-based life skills, comprehensive sexuality education or pleasure-based sex education 3. Interventions that empower youth through education and collective action

Recommendations

MH is a vital component of SRH, and is integral to the continuum of sexual and reproductive health across the life course. Both MH and SRH have strong common determinants and shared outcomes, providing fertile ground to support and strengthen integrated programming, policy and research. Given the current state of siloed policy and program interventions for MH and SRH in India (and across the world), the case for integration must be made and demonstrated across domains of policy, implementation and evidence generation, using insights and successes from each of these domains to inform and strengthen action in others.

India is well placed to support and champion MH-SRH integration, having a rich foundation of MH and SRH (including adolescent health) policy and programs, through public sector and NGO efforts. This paper presents five action areas to support integration of MH and SRH in the Indian context, relevant for Government and non-Government stakeholders:

1. Make the case for MH-SRH integration in policies, programs and research
2. Collate and generate evidence for and demonstrate MH-SRH integration
3. Build understanding and capacities for MH-SRH integration at all levels
4. Ensure a rights-based and inclusive approach to MH-SRH integration
5. Foster collaboration across organizations working on MH and SRH to support the above.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AFHC	Adolescent Friendly Health Clinic
ANC	Ante-natal care
aPRR	Adjusted proportional reporting ratio
ASHA	Accredited Social Health Activist
BCC	Behaviour change communication
BV	Bacterial vaginosis
CAC	Comprehensive Abortion Care
CEDAW	Convention on the Elimination of Discrimination Against Women
CIMBC	Contraceptive induced menstrual bleeding changes
CRC	Convention on the Rights of the Child
CSE	Comprehensive sexuality education
DLHS	District Level Household and Facility Survey
FPA India	Family Planning Association of India
GARIMA	Girls' Adolescent and Reproductive Rights: Information for Management and Action
GBV	Gender based violence
ICPD	International Conference for Population and Development
IEC	Information, education, communication
HIV	Human Immunodeficiency Virus
IPC	Interpersonal communication
LMIC	Low- and middle-income countries
MDG	Millennium Development Goals
MH	Menstrual health
MHM	Menstrual hygiene management

MPA	Medroxy Progesterone Acetate
MTP	Medical Termination of Pregnancy Act
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NYKS	Nehru Yuva Kendra Sangathan
PCOS	Polycystic ovarian syndrome
PID	Pelvic Inflammatory Disease
PPH	Post-partum haemorrhage
PSI	Population Services International
PwD	Persons with Disabilities
RKSK	Rashtriya Kishor Swasthya Karyakram
RMNCH+A	Reproductive, maternal, neonatal, child and adolescent health
RTI	Reproductive tract infection
SBCC	Social and behaviour change communication
SBM	Swachh Bharat Mission
SDG	Sustainable Development Goals
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TV	Trichomonas Vaginalis
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Definitions of key terms

Contraceptive induced menstrual bleeding changes	Contraceptive-induced menstrual bleeding changes (CIMBCs) may include bleeding patterns which are predictable but diverge from a "typical" menstrual pattern (such as amenorrhea (no bleeding) and scanty bleeding, commonly induced by methods such as progestin-only injectables, or heavy, prolonged bleeding often experienced by copper IUD users, or may cause unpredictable bleeding patterns (Polis, Hussain and Berry, 2018)
Comprehensive sexuality education	Comprehensive sexuality education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality. It equips children and young people with the knowledge, skills, attitudes and values that will empower them to realize their health, wellbeing and dignity, develop respectful social and sexual relationships, consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives (UNESCO et al 2018)
Gender diverse identities	Gender identity is a person's deeply-felt, inherent sense of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender (e.g., genderqueer, gender non-conforming) which may or may not correspond to a person's sex assigned at birth or to a person's primary or secondary sex characteristics Gender Diversity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex. This term is becoming more popular as a way to describe people without reference to a particular cultural norm, in a manner that is more affirming and potentially less stigmatizing than gender nonconformity (American Psychological Association)
Life skills	Life skills refer to the abilities for adaptive and positive behaviour that enables individuals to deal effectively with the demands and challenges of everyday life (WHO)
Menstrual health	Menstrual health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in relation to the menstrual cycle. This definition is applicable to all menstruators, including those with disabilities (Hennegan et al, 2022)
Person/people who menstruate	A person who menstruates refers to any individual who experiences a menstrual cycle and a menstrual period irrespective of their gender identity
Persons with disabilities (PwD)	A 'person with disability" as a person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others" (The RPwD Act, 2016)

Reproductive Health	Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people can have a 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 (WHO, 2006)
Sexual Health	According to the World Health Organization (2006), sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, and infirmity
Sexual and reproductive health	Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity (Starrs et al, 2018)
Reproductive life course	The reproductive life course extends from menarche (the first menstrual period) through menopause. A life course approach to reproductive and sexual health involves the investigation of factors across life and, also across generations, that influence the timing of menarche, fertility, pregnancy outcomes, gynaecological disorders, and age at menopause (Mishra, Cooper, Kuh, 2010)

A note on terminology used in the paper

Certain terminologies used in this paper are defined differently by various stakeholders. The authors of this white paper draw upon a rights-based and inclusive perspective while using these terminologies, and in using selected definitions (noted in the section on definition of key terms).

This paper acknowledges that people who menstruate may or may not identify as female. Given that a majority of people who experience menstruation identify as female, the terms girls and women are predominantly used in the paper, while taking care to ensure that the practice of menstruation is not linked to women and girls alone. The paper calls out actions to integrate MH and SRH for persons with gender diverse identities.

Lastly, the paper notes that some groups are socio-economically marginalized or are particularly vulnerable, and includes considerations for three such groups – persons with gender diverse identities, PwD and communities facing emergencies and humanitarian crises. Other marginalized and vulnerable groups do exist, for instance women engaged in manual scavenging and sex work, women migrants and those engaged in the informal labour economy. Their needs and rights are equally important, and can be addressed within the rubric of approaches and recommendations outlined in this paper.

Introduction: Laying the Foundation for integration of Menstrual Health and Sexual and Reproductive Health and Rights

1

Sexual and reproductive health (SRH) and menstrual health (MH) are fundamental to health, wellbeing, and gender equity (Wilson et al, 2021, Starrs et al 2018, Hennegan et al 2021). SRH and MH have deeply intertwined roots, biologically and socio-culturally; yet over the years, these integral components of health have not been addressed in conjunction, with joint programming or integration often overlooked in programs, policy and research, globally and in India (Wilson et al 2021; Population Services International, 2018).

Recent conceptualizations of SRH and MH allude to their interconnectedness, even though explicit references of these linkages are missing. The landmark report of the Guttmacher - Lancet Commission in 2018 proposed an integrated definition of SRH, highlighting the interlinkages between reproductive health and sexual health, as a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity (Starrs et al 2018). Box 1 presents further details of the revised definition. This seminal report delves into the various aspects of SRH, yet does not clearly call out MH as a critical aspect.

In 2021, a group of renowned academics and practitioners working on MH conceptualized menstrual health as "a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity, in relation to the menstrual cycle" (Hennegan et al 2021). The expanded definition of MH is shown in Box 2.

Box 1: The Guttmacher-Lancet Commission's Integrated definition of sexual and reproductive health and rights (Starrs et al, 2018)

Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity

Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right.

Essential sexual and reproductive health services must meet public health and human rights standards, including the "Availability, Accessibility, Acceptability, and Quality" framework of the right to health. The services should include:

1. Accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education
2. Information, counselling, and care related to sexual function and satisfaction
3. Prevention, detection, and management of sexual and gender-based violence and coercion
4. A choice of safe and effective contraceptive methods
5. Safe and effective antenatal, childbirth, and postnatal care
6. Safe and effective abortion services and care
7. Prevention, management, and treatment of infertility
8. Prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections
9. Prevention, detection, and treatment of reproductive cancers

Box 2: Definition of menstrual health (Hennegan et al, 2021)

Menstrual health is a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity, in relation to the menstrual cycle

Achieving menstrual health implies that women, girls, and all other people who experience a menstrual cycle, throughout their life-course, are able to:

- Access accurate, timely, age-appropriate information about the menstrual cycle, menstruation, and changes experienced throughout the life-course, as well as related self-care and hygiene practices.
- Care for their bodies during menstruation such that their preferences, hygiene, comfort, privacy, and safety are supported. This includes accessing and using effective and affordable menstrual materials and having supportive facilities and services, including water, sanitation and hygiene services, for washing the body and hands, changing menstrual materials, and cleaning and/or disposing of used materials.
- Access timely diagnosis, treatment and care for menstrual cycle-related discomforts and disorders, including access to appropriate health services and resources, pain relief, and strategies for self-care.
- Experience a positive and respectful environment in relation to the menstrual cycle, free from stigma and psychological distress, including the resources and support they need to confidently care for their bodies and make informed decisions about self-care throughout their menstrual cycle.
- Decide whether and how to participate in all spheres of life, including civil, cultural, economic, social, and political, during all phases of the menstrual cycle, free from menstrual-related exclusion, restriction, discrimination, coercion, and/or violence.

The foundation for both conceptualizations is the World Health Organization's (WHO) definition of health, going beyond illness and its treatment, to drawing attention to health promotion and wellbeing, vital perspectives to advance the health agenda, particularly for girls and women. Importantly, the above conceptualizations of both SRH and MH emphasize important constructs of bodily autonomy and control, decision making and communication, and the need to address discrimination, violence, and coercion. This represents an important shift in addressing SRH and MH as biological health events, to understanding and addressing them through multiple intersecting socio-cultural and economic determinants as well, with the implicit recognition that the achievement of SRH and MH is fundamental to human rights.

International human rights treaties, agreements and commitments have emphasized the criticality of sexual and reproductive health and rights (SRHR) in various ways; and while direct references to MH are lacking, the actualization of SRH requires action on aspects of MH (Box 3). The Sustainable Development Goals (SDGs) also do not mention MH directly, but the achievement of several SDGs needs to be supported by action on SRH and MH (Box 4). Further, MH has been an important component in operationalizing relevant SDGs, such as SDG 4 (Quality Education), 5 (Gender Equality) and 6 (Clean water and sanitation) in low- and middle-income countries (LMIC).

Box 3: International treaties, agreements and commitments related to SRHR, with relevance for MH

Convention on the Elimination of All Forms of Discrimination against Women (1979)

Convention on the Rights of the Child (1989)

Convention on the Rights of Persons with Disabilities (2007)

The Program of Action of the International Conference on Population and Development (1994)

The Beijing Declaration and Platform for Action (1995)

The Millennium Development Goals (2000-2015)

The Sustainable Development Goals (2015-2030)

Box 4: Relevance of SDGs for SRH and MH

SDG 3: Ensure healthy lives and promote wellbeing at all ages	**Target 3.7:** By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
SDG 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all	**Target 4.a:** Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive, and effective learning environments for all
SDG 5: Gender Equality Achieve gender equality and empower all women and girls	**Target 5.6:** Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

Box 4: Relevance of SDGs for SRH and MH	
SDG 6: Ensure availability and sustainable management of water and sanitation for all	**Target 6.2:** By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, **paying particular attention to the needs of women and girls and those in vulnerable situations**[1]
SDG 8 Promote sustained, inclusive, and sustainable economic growth, full and productive employment, and decent work for all	**Target 8.8: …**promote safe and secure working environments for all workers, including migrant workers, in particular women migrants…

Explicit acknowledgement of the importance of MH and its interlinkages with SRHR and gender equity are found in several international commitments and recommendations made since 2015. FSG's report in 2016 outlined the interlinkages between menstrual hygiene and health, wellbeing, empowerment, education, and noted that action on menstrual health is a pathway to gender equity (Amaya, Marcatili and Bhavaraju, 2020). In 2018, the Johannesburg Call to Action: Improving Menstrual Health Management, proposed a number of clearcut recommendations for advancing the MH agenda in the African region, including a comprehensive approach to menstrual health beyond hygiene, integration of MH and SRHR, and the establishment of the African Coalition for Menstrual Health Management (Republic of South Africa and UNFPA East and Southern Africa, 2018). The 2020 Resolution adopted by the Human Rights Council, clearly noted menstruation and menstrual hygiene as integral to the right to water and sanitation (The Human Rights Council, 2020). Most recently, in June 2022, a landmark statement by the WHO called for menstrual health to be recognized, framed and addressed as a health and human rights issue, not a hygiene issue, and further emphasizes menstrual health across the life course (World Health Organization, 2022) (Box 5).

Box 5: WHO Statement on menstrual health and rights (World Health Organization, 2022)

WHO calls for three actions:

Recognize and frame menstruation as a health issue, not a hygiene issue – a health issue with physical, psychological, and social dimensions, and one that needs to be addressed in the perspective of a life course – from before menarche to after menopause

Recognize that menstrual health means that women and girls and other people who menstruate, have access to information and education about it; to the menstrual products they need; water, sanitation, and disposal facilities; to competent and empathic care when needed; to live, study and work in an environment in which menstruation is seen as positive and healthy not something to be ashamed of; and to fully participate in work and social activities

Ensure that these activities are included in the relevant sectoral work plans and budgets, and their performance is measured

[1] *SDG 6 is often referred to for menstrual hygiene management, given the links with water, sanitation and hygiene services as well as behaviours. However, other SDGs are equally relevant for menstrual health and hygiene management*

MH is an integral part of SRH, as menstruation and the menstrual cycle shape the understanding and experience of critical sexual and reproductive events across the life course, both physically and socially (Wilson et al, 2021). The United Nations Population Fund (UNFPA) underscores MH as an important "determinant and outcome" of SRH (UNFPA 2021). Despite this, SRH programs do not always address aspects of MH or even menstrual hygiene management (MHM). Further, MH and MHM programs rarely link well to the wider arena of SRH.

Sector actors have been making the case for integrating MH into the larger SRH agenda, a case that has only intensified with the COVID-19 pandemic and the State of the World's Population 2022 Report (UNFPA, 2022). In 2018, Population Services International (PSI) developed the first technical brief for the integration of MH in SRHR, powerfully stating that "when programming integrates menstruation in all its SRHR aspects, it becomes even more gender transformative, challenging those harmful norms that inhibit girls and women to make informed and independent decisions about their health and body" (Population Services International, 2018). In addition to this document, two other reports have explained the intersection between MH and SRH, drawing attention to common goals, common areas of work, both biological and socio-cultural, as well as similarities in intervention approaches (Figure 1) (UNFPA, 2021; Wilson et al, 2021). Over the past few years, both SRH and MH/MHM interventions have been increasingly cognizant of reaching particularly vulnerable groups such as persons with disabilities (PwD), those with gender diverse identities and in humanitarian crises; the three global reports on MH-SRH integration include mention of these considerations. The reports conclude that integration of MH and SRH must be strengthened through evidence, programs and policies, and through capacity building of relevant stakeholders and informed investments (UNFPA, 2021; Wilson et al, 2021; Population Services International, 2018).

Table 1: Intersectionality between MH and SRHR (UNFPA 2021; Wilson et al, 2021; Population Services International 2018)

Common goals	Human rights Gender equity Sustainable Development Goals
Common underpinnings	*Physiological/biological* (Menstrual cycle and family planning/contraceptive use, menstrual irregularities, HIV, cancers, maternal health, nutrition) *Socio-cultural* (Stigma, inequitable gender norms and power dynamics, violence, knowledge and power, early marriage, school and workforce participation, poverty)
Focus groups & special interest groups	Adolescents Persons of reproductive age People in vulnerable situations and from marginalized backgrounds (PwD, persons with gender diverse identities, and persons facing humanitarian crises)
Common approaches	Comprehensive SRH education Products (expanding product choice) and services (quality services) Addressing social norms and gender dynamics Creating an enabling environment Working with community influencers (e.g., mothers, mothers-in-law, men and boys, religious leaders, community leaders)

Contd...

Table 1: Intersectionality between MH and SRHR (UNFPA 2021; Wilson et al, 2021; Population Services International 2018)	
Essential to human rights (Poor MH and SRH undermines human rights)	The right to health The right to education The right to work The right to non-discrimination and gender equality The right to water and sanitation

In spite of these shared goals and attributes, MH and SRH are addressed in silos in India, possibly resulting from several interlinked push and pull factors[2]:

- SRH is a sensitive issue in India, particularly for unmarried adolescents. MH has been largely addressed through the rubric of menstrual *hygiene management* (MHM), an issue that is perceived as relatively less controversial than SRH, owing to the focus on hygienic management of periods, and associated sanitary pad promotion. Introduction of comprehensive sexuality education (CSE) for young people has been a challenge; on the other hand, few states have recently begun investing in MHM programs through state specific schemes.
- A significant proportion of SRH programming focus in India for long focussed on increasing availability and accessibility of maternal health and family planning services. The introduction of the Reproductive, maternal, neonatal, child and adolescent health (RMNCH+A) strategy in 2013 marked a paradigm shift in the country's health planning as it recognised the SRH interlinkages across life-stages and focussed on adolescence as a distinct life-stage for health planning. MHM can potentially serve as an effective entry point to address relevant adolescent health issues, particularly relevant since the median age at marriage for girls has increased and more girls are in school than before[3]. The National Family Health Survey – 4 (NFHS- 4), conducted in 2015-16, found that 26.8% of young women reported marrying before they were 18 years, while NFHS-5 (2019-2020) reported that a lower proportion (23.3%) of young women married before the legal age for women. Further, the proportion of women with at least 10 years of schooling increased from 35.7% to 41.0% between the two rounds of NFHS (IIPS and ICF, 2017; IIPS and ICF, 2022).
- Perhaps the most striking development that has fuelled separate programming is a clear, acceptable, desirable service and product offering under MHM interventions, namely female friendly or gender responsive sanitation facilities in schools, and sanitary pad distribution (free of cost or at subsidized cost). Adolescent health and SRH interventions also provide products and services such as iron and folic acid supplements, contraceptives, family planning counselling, adolescent friendly health clinics (AFHC). Yet for unmarried adolescents, the services under MHM programs may be perceived by policy makers as more acceptable than those under adolescent health and SRH programs, given the focus on hygiene, and limited emphasis on sensitive issues such as SRH for unmarried youth.
- Early and persuasive positioning of MH as MHM (focus on hygiene) at the global level[4], the use of evidence highlighting widespread low levels of awareness on menstruation, menstrual cycle, and the widespread use of unhygienic materials (such as old rags, ash, sand, leaves) to manage periods made for a compelling case for separate and concerted MHM programming.

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[2] *These factors have been identified by the authors of this report, drawing on the discussions held with experts as well as their own work in this area*

[3] *The age at marriage and school enrolment of girls may have been affected as a result of the COVID-19 pandemic, however, data on this is currently unavailable*

[4] *Currently, the global discourse is focusing on menstrual health than on hygiene. However, in the early years of work, starting 2014, the focus was on MHM*

- The water, sanitation and hygiene (WASH) sector, and notably, the Swachh Bharat Mission (SBM) Grameen bolstered action on MHM in India, ensuring gender responsive WASH facilities in schools, addressing one of the factors supporting girls' continued education after puberty. Further, schools were an effective setting for MHM awareness interventions and sanitary pad distribution schemes by several State Governments (WaterAid India and UNICEF, 2022).
- Investments in MHM have been relatively straightforward, directed towards menstrual products distribution such as sanitary pads, infrastructure (e.g., gender responsive toilets, sanitary pad production units), as well as towards campaigns and awareness interventions, and have resulted in measurable change in terms of improved knowledge and increased access to safe products, namely sanitary pads, as seen in the latest NFHS - 5 findings (WaterAid India and UNICEF, 2022).

Existing insights on joint or integrated programming of MH and SRH suggests significant benefits in terms of health, wellbeing and gender equity (UNFPA, 2021; Wilson et al, 2021; Population Services International 2018). The need for integration is even more compelling following the COVID-19 pandemic that significantly compromised the health and wellbeing of girls, women and gender diverse identities, in the short term and in the long term (Asthana and Muralidharan, 2021). The State of the World's Population 2022 Report underscored the neglected crisis of unintended pregnancies. Unplanned and unintended pregnancies reveal serious gaps in knowledge, access to essential contraceptives and family planning services, bodily autonomy and decision-making capacities, and inequitable gender norms, roles and power dynamics (UNFPA, 2022). Unintended pregnancies, are an SRH issue, and intimately linked with menstrual health, particularly the understanding of the menstrual cycle and fertility awareness among unmarried and married adolescents and youth.

Rationale for this white paper

India's demographic profile highlights that youth (ages 15-29 years) comprise 27.2% of the Indian population (Ministry of Statistics and Programme Implementation, 2022) and one-fifth of the world's youth population. With concerted efforts from Government health programs, India has reached replacement level fertility, with adolescent fertility rates also indicating a decline in a majority of states (IIPS and ICF, 2022). At the same time, life expectancy has increased, with the average life expectancy for women now at 72.2 years. These important and positive trends have implications for the SRH of people across the reproductive life span. The SRH needs of adolescents and young people must be a focus to ensure good health and well-being during this phase and to sustain the benefits of replacement fertility rates. For older women, information and services to support the transition to menopause and ensure good health beyond this phase is critical for a healthy elderly population. Against this backdrop, integrated and comprehensive SRH programming, that incorporates all aspects of MH, across the life span is essential.

Global reports have examined the intersectionality between MH and SRH; however, country focused synthesis and recommendations do not exist. Drawing on global insights and guidance (PSI, 2018; UNFPA 2021; Wilson et al 2021), this white paper makes the case for integrated action on MH and SRH in India by:

1. Exploring the linkages between MH and SRH in the Indian context
2. Understanding how MH and SRH are integrated in India through programs and policy
3. Proposing recommendations for integrating MH and SRH

The following sections of the report address these objectives.

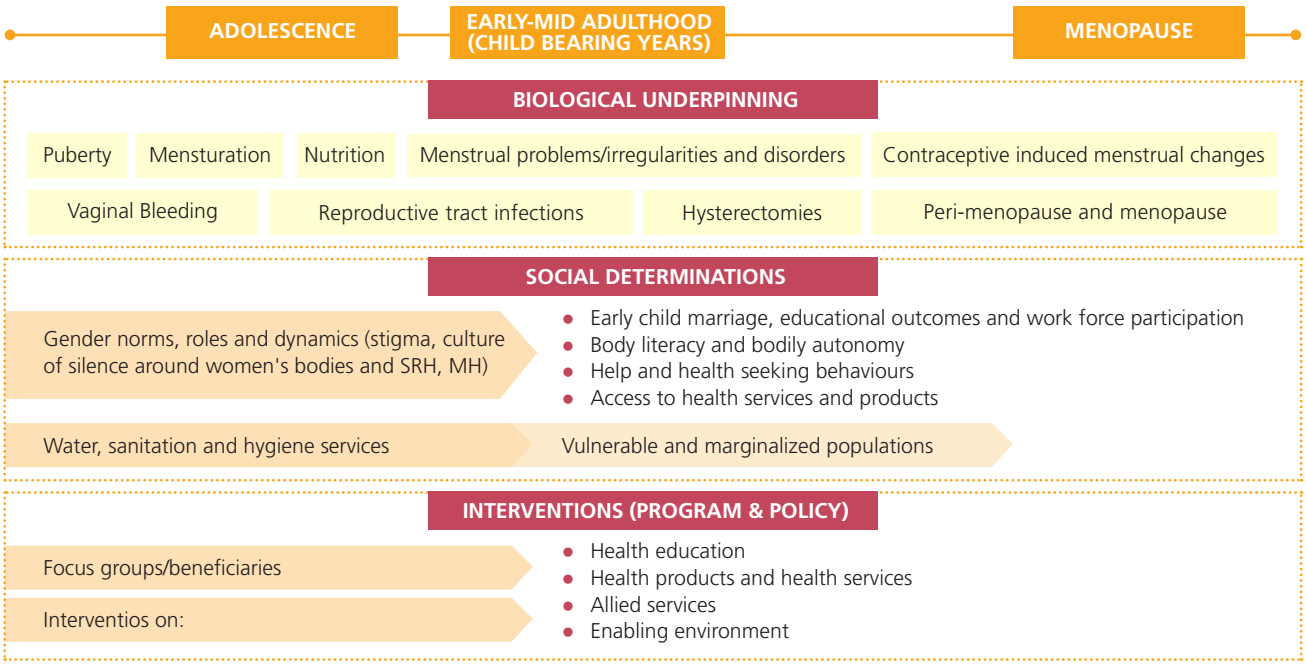
The development of this white paper has been informed by a review of literature on the integration of MH and SRH globally and in India, evidence on intersectionalities in India, and key informant interviews with 20 SRH and MH experts working in India.

The case for integration: The intimate linkage between SRH and MH

2

MH is a vital aspect of SRH - both have common biological underpinnings, social determinants of health, and share similarities in program design. These aspects affect SRH and MH across the lifespan, having direct and indirect implications for each other. Figure 1 visually depicts these intersectionalities, followed by more detailed examination of these aspects.

Figure 1: An overview of the linkages between SRH and MH across the reproductive lifespan



2.1 MH and SRH across the reproductive lifespan

MHM interventions primarily focus on adolescents, as menarche is an integral aspect of puberty, and heralds the start of many socio-cultural restrictions and enforcement of gender norms, roles and power dynamics. The basic premise of MHM interventions is that if menstrual hygiene is addressed during these formative years, the basic understanding, knowledge and practices related to menstruation and menstrual hygiene will persist into adulthood, and protect against avoidable adverse health outcomes. However, MH and MHM are relevant for adult women, as well. Girls and women in relationships (marital or otherwise) who are using contraception (traditional and/or modern methods) to prevent or time pregnancies, need to understand the menstrual cycle and links with fertility and pregnancy, and changes to the menstrual cycle as a result of the contraceptives they use or will use. Women who have recently given birth, experienced miscarriages or abortions, will have uterine bleeding that requires the use of safe and effective absorbents to soak the blood and other bodily discharge, maintain hygiene, and identify signs of irregularities or complications through bleeding patterns. Older adult women who are in the peri-menopause or menopausal phase of their lives may experience abnormal bleeding, and require understanding of how this phase can affect the menstrual cycle and bleeding. Menstrual discomfort and disorders, as well as conditions such as polycystic ovarian syndrome (PCOS), endometriosis, cancers, reproductive tract infections, and even HIV/AIDS affect the menstrual cycle and bleeding patterns across the life span, not just during the adolescent phase.

The emphasis on MHM in India has focused policy and program interventions on adolescents. Recent programmatic developments in India are expanding the scope to MH to address menstrual problems and disorders, with a focus on adolescents and young people (e.g., PCOS Club of India, Bleed Equal). Organizations promoting reusable products such as reusable/washable cloth pad and menstrual cups are working with adult (often married) women due to greater familiarity with cloth among this group, and greater acceptance of vaginal insertion products such as the menstrual cup.

Just as MH or more aptly, MHM, is perceived as relevant for adolescents, SRH is considered relevant for married women who are planning their families. SRH issues outside the realm of marriage and family planning are rarely addressed, including sex education and contraceptive use for unmarried adolescents. Reproductive tract infections (RTI) and sexually transmitted infections (STI), including HIV are tackled through treatment but not from a prevention lens, apart from HIV/AIDS programs with high-risk groups. Similarly, female reproductive health conditions and cancers also come under the purview of treatment, with the exception of ongoing efforts to screen for cervical and breast cancer. However, SRH is vital for all adolescents, irrespective of their marital status, for wellbeing during this transitional phase, as well as for their health and wellbeing in throughout adulthood.

2.2 The biological linkages between MH and SRH

MH and SRH share several biological commonalities. Further, specific MH and SRH events directly and indirectly impact each other. These are discussed below.

Puberty

The onset of menstruation or menarche is considered the most definitive sign of puberty in girls, and marks the start of a girl's SRH, including her MH, journey. The average age at puberty in India is 13.7 years, with variations by region, socio-economic factors, level of education, and lifestyle factors (Pathak et al, 2014; Ramraj et al, 2021). On attaining menarche, girls across India typically receive some though limited information and support on managing menstrual bleeding using menstrual products or materials, and are provided guidance on social norms and restrictions to be practiced during this time, with mothers often being the primary

source of information (van Eijk et al, 2016). Information on the reproductive system, the menstrual cycle and the process of menstruation, as well as links with SRH events such as pregnancy, are either not provided or are explained superficially. A systematic review and meta-analysis of MHM in India found that 52.0% of adolescents were unaware of menstruation before their first period, 77.0% did not know that the uterus was the source of menstrual blood, and 46.0% did not consider menstruation as normal (van Eijk et al, 2016). This limited understanding of the body, and negative or unfavourable norms towards fundamental aspects of SRH, affects girls and women's understanding of other SRH processes, as well as their access to information, safe products and services, and even social supports throughout the reproductive life course (Igras et al, 2014). This is reflected in other research - evidence suggests that only 17.05% of adult women were aware of the fertile period (during which they can get pregnant) during the menstrual cycle, affecting their ability to plan for a pregnancy or prevent an unintended pregnancy (Dev & Babbar, 2022).

Nutrition

Nutrition is an important determinant of health, and can affect MH and SRH positively and adversely. As per NFHS-5, 59.1% of adolescents and 57.0% of adult women of reproductive age have iron deficiency anaemia (IIPS and ICF, 2022). Menstrual conditions that cause heavy bleeding can exacerbate anaemia, with India focused studies finding that 5.0 - 10.0% of women with heavy bleeding have iron deficiency anaemia (Todd & Caroe, 2007). India has the highest prevalence of anaemia in pregnancy, a serious public health problem that affects healthy pregnancy, leading to maternal morbidity, maternal deaths, low birth weight infants, and high infant mortality (Kalaivani and Ramachandran, 2018; Figueiredo et al, 2018).

Menstrual problems and disorders

Studies on MHM among adolescent girls have alluded to menstrual discomfort, pain and other conditions experienced by respondents in the form of pre-menstrual symptoms and irregular menstrual cycles, as well as symptoms of dysmenorrhoea, amenorrhea (unrelated to pregnancy), menorrhagia and oligomenorrhoea (Bachloo et al., 2016; Gupta, 2019; Gupta et al., 2018; Kshirsagar et al., 2016; Priya et al., 2016; Parle & Khatoon, 2019; Sumedha & Singh, 2019). Existing community-based studies have found that 50.0 – 88.0% of adolescents complained of painful menses (or dysmenorrhea) (Omidvar et al, 2016) and 10.0 – 30.0% of adolescents had heavy bleeding (menorrhagia) (Wilson et al 2021). These studies are based on self-report, and not on clinical examination and diagnosis, and resultantly, these experiences cannot be classified as medical conditions. However, the experiences of pain, and discomfort, and disruption to daily routines are real, and need to be understood and adequately addressed.

Studies have found poor health seeking behaviour for menstrual problems. A village-based study in Uttar Pradesh noted that 52.5% of those who complained of painful menses took over-the-counter generic antipyretic and analgesic medicines to relieve pain (Sumedha & Singh, 2019). Another study from the state revealed that 71.0% of respondents who reported severe menstrual pain, weakness, and other symptoms did not seek any treatment (Gupta, 2019). Research in Rajasthan also found that only 11.4% of adolescent girls consulted a doctor for a menstrual health problem (Choudhary & Gupta, 2019). Reasons for self-medication and unwillingness/inability to seek professional medical support were unexplored in these studies.

Data on other medical conditions related to menstrual health, such as endometriosis and PCOS come from clinical studies. An estimated 10.0% of women of reproductive age have endometriosis, approximately 26 million women in India (Federation of Obstetrics & Gynecological Societies of India, 2019). While this condition is typically diagnosed in adulthood, symptoms begin in adolescence, but are often overlooked until the condition begins to affect fertility. Data on the prevalence of PCOS in India suggests that between 3.7% - 22.5% of girls and women have this condition (Ganie et al, 2019). These conditions are treated clinically, with a few interventions in India starting to create awareness, supporting health seeking practices, and addressing social norms and taboos related to these conditions for adolescent and adult women.

Contraceptive induced menstrual changes and menstrual suppression

Contraceptive induced menstrual bleeding changes (CIMBC) refers to changes in menstrual bleeding and the menstrual cycle resulting from the use of contraceptives. Certain types of contraceptives, particularly hormonal contraceptives, may bring changes in a women's menstrual cycle. Periods may change in terms of their duration, heaviness of menstrual flow, and may stop all together (Polis, Hussain and Berry, 2018). While some alterations in menstrual bleeding from the use of certain contraceptives is expected, fear of side effects and the implications of these side effects on future health (and fertility) may limit uptake of and adherence to contraceptives (Polis, Hussain and Berry, 2018). A systematic review on this issue found that up to 40 studies noted CIMBC as a leading or common reason for discontinuing contraceptives (Polis, Hussain and Berry, 2018).

Menstrual suppression is the use of certain types of hormonal contraceptives in specific ways to intentionally prevent a period or reduce a period (Polis, Hussain and Berry, 2018; Hillard, 2014). Menstrual suppression may be resorted to in the short term to prevent a period for specific events (e.g., wedding, religious events) (Polis, Hussain and Berry, 2018). Contraceptives may also be used to reduce or stop periods to address medical conditions such as endometriosis, dysmenorrhea, heavy bleeding and PCOS (Hillard, 2014). The use of menstrual suppression for medical reasons is monitored by medical professionals, and has health benefits for those with these gynaecological morbidities, that markedly affects their lives and wellbeing. However, preventing periods through hormonal means in response to social norms and taboos that preclude the participation of menstruating girls and women in social and religious festivals, is not advisable, particularly if done regularly[5].

Vaginal/Uterine bleeding

Girls and women experience other forms of uterine bleeding include post-partum and post abortion bleeding, bleeding associated with peri-menopause, uterine fibroids, STIs, and certain types of cancers. A seminal paper noted that girls and women experience different types of vaginal bleeding through the life course, and that all vaginal bleeding is associated with shame, discomfort, stigma, compounded by low awareness about what is happening to their body and the type of support and care they need (Sommer et al, 2017). Figure 3 highlights the types of bleeding cross the reproductive life course from menarche to menopause identified by research (Sommer et al, 2017). While the factors associated with different types of bleeding vary, similarities do exist in terms of the information, products and services that are required to manage the bleeding comfortably, safely, hygienically and privately. For instance, bleeding after childbirth and abortion calls for the use of absorptive materials that are hygienic and effective. People who experience all types of vaginal bleeding need accessible WASH facilities that allow them to change their absorbents, and wash their bodies and their reusable materials as required. Abnormal bleeding (in terms of frequency and quantity) requires access to health facilities for diagnosis and treatment. Another common thread across all types of bleeding is the anxiety, discomfort, shame and even discrimination resulting from deeply held conceptions of the impurity associated with vaginal bleeding (Sommer et al, 2017). Irrespective of the type of vaginal bleeding, girls and women are often unaware of whether the bleeding is normal or abnormal, and consequently do not seek timely support, diagnosis or treatment, which can be detrimental in the case of underlying infections and disorders (Sommer et al, 2017).

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[5] *While there are no published papers on the use of hormonal contraceptives to delay or prevent menses in response to social norms related to menstruation (e.g., not participating in religious functions during menstruation), two key informants who are medical professionals raised this as unadvisable*

Figure 2: Type of uterine and vaginal bleeding experienced across the life course (Sommer et al, 2017)				
Age range		**'Normal' amount of blood**	**'Normal' length of time**	**Definition/symptoms**
Cervical cancer	Any age, median age is 49	Menstrual can be heavy, irregular, painful or spotting	Continues until treated, bleeding likely to occur during MP; varies	Cancer is the cells of the cervix linked to the human papilloma virus; bleeding is often not related to menses
Endometriosis	Most cases diagnosed between 25 and 35 years of age	Menstruation can be heavy, irregular, painful or spotting	Continues until treated, bleeding likely to occur during MP; varies	A condition resulting from the appearance of endometrial tissue outside the uterus; heavy MP, irregular MP, painful MP or spotting, abdominal cramping, constipation or nausea
Menarche	Usually between 8 and 16 years	Can vary but usually lighter spotting	2–7 days is normal; cycles are often irregular for 1–2 years	First menstrual cycle, can be accompanied by cramps, irritability/heightened emotions, tender breasts
Menorrhagia	From age of menarche to menopause (ages ~8-60)	60–90 ml or more	Can be over 7 days	Abnormally heavy menstrual bleeding; MP lasts longer than 7 days or is too frequent (less than 21 days between periods), spotting or bleeding between MPs or during pregnancy
Menstrual bleeding	From age of menarche to menopause (ages ~8-60)	Average blood lost is 30–40 ml, with 90% of women <80 ml	2–7 days is normal	Process of discharging blood and other materials from uterine lining monthly, can be accompanied by cramps, irritability/heightened emotions, tender breasts
Miscarriage	From age of menarche to menopause (ages ~8-60)	Spotting can occur after miscarriage	Can spot for up to 2 weeks after miscarriage; can result in haemorrhage	Expulsion of a fetus from the womb before childbirth; irregular uterine bleeding, pain (abdomen, lower back, pelvis), vaginal discharge, uterine contractions, nausea
Perimenopause/ menopause	Usually mid–40s to early 60s; average age 51–52	Spotting or heavy	Average length is 4 years. Ends when 12 months without MP	Time before and during the end of menstruation in the life cycle; absence of MP, spotting, heavy or irregular MP, hot flashes/night seats, vaginal dryness
Postpartum haemorrhage	Menarche to menopause (ages ~8-60)	Excessive vaginal bleeding (<90ml)	Up to 6 weeks postpartum	Excessive bleeding after childbirth; vaginal bleeding, fast heart rate or low blood pressure
Sexually transmitted infections	Any age if sexually active	Heavy, spotting	Continues until treated	Diseases passed on through sexual contact (ie., chlamydia, gonorrhoea); pelvic inflammatory disease, menorrhagia, bleeding after intercourse, spotting between periods
Uterine fibroids	Can occur by age 20, usually between 35 and 54	Menstruation can be heavy, irregular, painful or spotting	Continues until treated, bleeding likely during MP, varies	Non-cancerous growths in uterus that can develop during childrearing years; heavy MP, pelvic pressure/pain, frequent/difficult urination
Uterine polyps	Rare before 20, can occur after menopause	Menstruation can be heavy or irregular	Continues until treated	Usually non-cancerous growths attached to inner wall of uterus; irregular or excessive bleeding and bleeding after menopause can occur

Reproductive Tract Infections

RTIs include STIs, endogenous infections (e.g., vulvovaginal candidiasis and bacterial vaginosis), and iatrogenic infections (associated with unsafe medical procedures such as unsafe abortions and birthing) (CDC, 2003). RTIs are associated with MH in two ways: first, evidence suggests that unhygienic menstrual management practices (such as use of dirty cloth or poor personal hygiene) can cause RTIs; second, some RTIs, especially STIs, are associated with heavy and irregular vaginal bleeding, or spotting and severe pain during menstruation in addition to other symptoms of STIs and RTIs.

In Odisha, hospital-based research conducted on non-pregnant women (18-45 years) collected data (survey questionnaire and vaginal swabs) to determine whether poor menstrual hygiene practices were associated with three common infections of the lower reproductive tract; Bacterial vaginosis (BV), Candida, and Trichomonas vaginalis (TV) (Torondel et al, 2018). The researchers found strong and consistent associations between hygienic product usage and menstrual hygiene practices such as personal washing (Candida--aPRR = 1.34, 95%CI 1.07–1.7; BV-- (aPRR = 1.25, 95%CI 1.0–1.5). Reusable cloths were found to be strongly associated with Candida infection (aPRR = 1.54, 95%CI 1.2–2.0), weakly associated with BV infection (aPRR =1.23, 95%CI 1.0–1.54) and not associated with TV infection. Further, among women reusing absorbent material, Candida but not BV or TV

infection was more frequent among those who dried their pads inside their houses and those who stored the cloth hidden in the toilet. Higher frequency of changing absorbents prevented infections (aPRR = 0.72, 95% CI 0.61–0.86) (Torondel et al., 2018). Besides this clinically evidenced study, other research reported health issues derived from lived experiences and self-reporting of the respondents. Findings from data analysis of District Level Household Survey- 3 (DLHS - 3) noted that women using unhygienic methods of menstrual protection, namely cloth, were significantly more likely to report symptoms of RTIs and abnormal vaginal discharge (Anand, Kumar, Unisa, and Singh, 2015). An analysis of the NFHS-4 found a strong association between the use of hygienic materials and RTI symptoms (genital sore/ulcer and had genital discharge) (Vishwakarma et al., 2021). In addition to the use of unsafe or unclean materials during periods, research further suggests that limited access to WASH facilities, particularly toilets, affects menstrual hygiene practices (like changing materials regularly, and washing genitals), thereby enhancing risk for infections (Das et al, 2015).

HIV and AIDS

HIV/AIDS can affect the menstrual cycle of people living with this condition. A global meta-analysis found that women living with HIV were at higher risk for menstrual disorder amenorrhea (missing three or more consecutive periods in the absence of a pregnancy) than women without HIV, though the pathways that explain this association were unclear. Some studies in the review found that the supressed immune system and low body mass index found in people living with HIV may cause amenorrhea, while other studies noted that the condition may have been a complication of the virus itself (King et al, 2018). People living with HIV who experience menstruation need support to manage menses safely to avoid infections associated with unhygienic practices, that can further compromise their immune system. This is particularly relevant for certain groups at high risk for HIV/AIDS such as persons engaged in sex work, who are highly susceptible to STIs.

Hysterectomies

A hysterectomy is the surgical removal of the uterus, and may include the removal of the cervix, ovaries, fallopian tubes as well. Hysterectomies are conducted in response to a medical problem such as gynaecological and breast cancers, as well as endometriosis, fibroids, and other menstrual disorders causing heavy/abnormal bleeding, and uterine prolapse. Hysterectomies in response to these medical conditions can therefore bring important benefits to those who are suffering from these conditions (Clarkson, 1997; Uzun et al, 2009; Kjerulff et al, 2000). This procedure however, does have some persistent negative side effects including urinary incontinence, backache, weakness, and earlier onset of menopause (Brown et al 2000; Singh and Arora, 2008; Farquhar et al, 2005). Data from India suggests some alarming insights, alluding to unnecessary hysterectomies among young and pre-menopausal women, particularly from low-income groups (McGivering, 2013; Radha et al, 2015). An analysis of the nationwide DLHS-4, conducted in 2012-2013, estimated a hysterectomy prevalence of 17 out of 1000 ever married women 15-49 years (Prusty, Choithani, Gupta, 2018). Notably, the study found a strong correlation between education status and hysterectomies; women with at least 10 years of schooling were 53.0% less likely to have a hysterectomy as compared to women with primary or no education (Prusty, Choithani, Gupta, 2018). Hysterectomies at a younger age (before peri-menopause), especially without compelling medical reasons, had adverse health effects, including early onset menopause, increased risk of osteoporosis, cardiovascular conditions, psychiatric conditions and even death (Shuster et al, 2010; Rivera et al, 2009).

Evidence highlights three concerning issues with hysterectomies in India: 1) younger age at hysterectomies; 2) hysterectomies among women engaged in certain types of seasonal agriculture; 3) hysterectomies among girls and women with disabilities. While the determinants of hysterectomies in these circumstances remain underexplored in India, existing evidence points to menstrual regulation as one potential reason. Prusty and colleagues (2018), in their analysis of DLHS-4 data, identified the median age of hysterectomies at 42 years, and estimated that 36.0% of women had the procedure before they were 40 years old, with a marked proportion of women from high hysterectomy prevalence states, Andhra Pradesh, Telangana and Karnataka, undergoing the procedures before they were 25 years old (Prusty, Choithani, Gupta, 2018). In Beed district of

Maharashtra, a prominent sugarcane growing district in India, more than 4600 hysterectomies were performed on female sugarcane cutters between 2016-2018, for varied reasons, one being to stop menstruation during the intensive cane cutting season (the assumption being that women will be more productive if they do not experience menstruation and related symptoms). However, among cane cutters who had the procedure, many complained of weakness, backache and other conditions that markedly reduced their quality of life, health, productivity and even income (Shukla and Kulkarni, 2019).

Menstruation is challenging for PwD as they lack the awareness, products, and support services to manage their menses in a healthy way (WaterAid India and UNFPA, 2022). Challenges are particularly marked for those with intellectual disabilities who have limited understanding of what is happening to them. For PwDs, hysterectomies may be considered as a way to permanently deal with the challenges of managing menstruation. A systematic review of ethical guidelines and research papers concluded that non-therapeutic hysterectomies among women with intellectual impairments "should not be recommended as a routine and appropriate method to cope with menstrual hygiene, even if it is technically safe" (Marquez-Gonzales, Valdez-Martinez, Bedolla, 2018).

Limited literature exists that links pelvic inflammatory disease (PID) resulting from poor menstrual hygiene practices, with hysterectomies. Studies estimate that PID accounts for approximately 5.0% of hysterectomies in India (Verma and Verma, 2016; Radha et al, 2015). This condition is associated with poor menstrual hygiene practices, however, the prevalence of this association in India is currently unknown. Unnecessary procedures conducted on girls and women without their consent, or with minimal or misleading information, or under false pretexts, is a violation of their human rights.

Peri-menopause and menopause

Perimenopause is the phase during which the body transitions into menopause, and is also referred to as the menopausal transition (Santoro, 2016). Due to hormonal changes during this phase, women may experience irregular bleeding, lighter or heavier bleeding, longer or shorter bleeding, and spotting. Perimenopause and menopause are rarely discussed in India, and are even more hidden than women's other SRH needs, and like menstruation, this phase is shrouded in silence, shame, and misinformation. Perimenopause is not a medical disorder, but a physiological transition. However, understanding of this phase of the reproductive life cycle, and the impact of hormonal changes on the body, including on menstruation, is critical to prepare for and manage symptoms. Understanding Indian women's experience of peri-menopause and menopause across socio-economic strata will help address these issues from a health promotion lens. This is particularly relevant given the increased life expectancy in India for women as per the latest data from the Sample Registration System (Government of India, Officer of the Registrar General & Census Commissioner).

2.3 Social determinants of MH and SRH

Social determinants of MH and SRH influence health, health behaviours and health seeking through the life course. Here we discuss selected social determinants that shape both MH and SRH, and their integration.

Gender

Gender, power and patriarchy are critical determinants of SRH, including MH. Gender, a social construct that shapes women and men's attitudes and perceptions, behaviours, roles, relationships, intersects and interacts with other social determinants such as socio-economic status, religion, disability, age, gender-identity and sexual orientation, geographic location, often resulting in greater vulnerabilities among certain populations (George et al, 2020; Malhotra et al, 2019; Pulerwitz et al, 2019; Sen et al, 2007). Gender inequalities deeply influence SRH and MH, shaping whether people have access to information, as well as the type and depth of information received; access to essential services (health, nutrition, education, psycho-social support); control over their

bodies, decisions, lives; as well as GBV and discrimination (Sen et al, 2007, Wilson et al, 2018). Early marriage, an important gender issue in India, is intimately related to MH and SRH– menarche is simultaneously considered a sign of readiness for marriage as well as a risk factor for pre-marital relationships (Santhya, 2011, Girls Not Brides, 2018; Raj et al, 2015,). Early marriage is associated with discontinuing education, early child bearing, which has adverse implications for the health and wellbeing of young women, at times with dire outcomes such as maternal mortality (Santhya, 2011, Girls Not Brides, 2018). Enhancing gender equity in health, and facilitating the right to health of girls, women and gender diverse identities is "one of the most direct and potent ways to reduce health inequities overall and ensure effective use of health resources" (Sen et al, 2007).

Water, sanitation and hygiene

WASH is another social determinant of health, MH and SRH, and affects the quality of SRH services in health facilities, menstrual hygiene practices, and the realization of the right to health. Health care facilities with inadequate WASH place women seeking abortions at risk for infections; inaccessible, unsafe, and dysfunctional WASH facilities in community toilet blocks make it difficult for girls and women to manage their periods and other forms of vaginal bleeding hygienically, and places them at risk for GBV. Responsive WASH facilities at home, in communities, at schools, worksites, and public spaces, can facilitate hygienic practices, prevent absenteeism in schools and at worksites, improve treatment outcomes in health care facilities, and contribute to reducing risk of GBV (WaterAid, PLAN International, Marie Stopes International and Simavi, 2019).

Vulnerable and marginalized groups and communities

Girls and women with disabilities, and those facing humanitarian crisis are particularly vulnerable to adverse MH and SRH outcomes, that are compounded by poor integration of the two essential intervention areas (WaterAid India and UNFPA, 2021; WaterAid India and UNFPA, 2022). The United Nations High Commission for Refugees (UNHCR) considers SRH to be a salient public health need in general, and one that is significantly compromised for girls and women during humanitarian crises (World Health Organization, 2012). MH is also affected as people who menstruate may abruptly find themselves without safe and sufficient menstrual products, safe and private places to change, wash themselves and discard their used materials (WaterAid and UNFPA, 2021). In humanitarian crises, pre-pubescent girls may also be at risk for GBV, and need age and context appropriate information and support on SRH and MH before puberty. The SRH and MH needs of PwD are starkly overlooked, despite provisions in India under the Rights of Persons with Disabilities (RPwD) Act, 2016 to support these rights and meet these basic needs[6].

2.4 Similarities between MH and SRH programming and policy

Current MH and SRH interventions in India have similarities in programming and policy, with opportunities to strengthen integrated action, as depicted in Table 2.

In the policy realm in India, the intersectionalities are articulated only to some extent. While the adolescent health interventions integrate MHM, MHM interventions rarely link to the larger SRH agenda. A stark gap in both policy and program interventions is the limited focus on individuals across the reproductive life span, often overlooking the MH needs of adult women, and on understanding and meeting the needs of PwD, those with gender diverse identities, and those facing crises and emergencies. These are important gaps to be addressed through integration.

[6] *The RPwD Act, 2016, recognizes reproductive rights, stipulating that, "Government shall ensure that persons with disabilities have access to appropriate information regarding reproductive and family planning" and that "no person with disability shall be subject to any medical procedure which leads to infertility without his or her free and informed consent" (Government of India, 2016)*

Table 2: Common ground for policies and programs			
Area of focus	**Mainstream SRH programs**	**Mainstream MH programs**	**Opportunities for integrated action on MH and SRH**
Beneficiaries/ focus group	• Adolescents • Women planning a pregnancy or seeking to prevent pregnancy • Pregnant and newly delivered women	• Adolescents • Individuals and communities from marginalized backgrounds and with particular vulnerabilities	• Reach people of reproductive age, including the most marginalized, vulnerable and hard to reach groups such as sex workers, incarcerated women, the homeless, seasonal migrants, as well as girls and women in humanitarian settings, PwD, and persons with gender diverse identities
Information and education	• Puberty and bodily changes • Menstruation and the menstrual cycle • Reproductive systems and processes • Family planning and contraceptives • Abortion and related post-abortion care • Ante-natal care (ANC) counselling to include care of bleeding during immediate postpartum period	• Puberty and bodily changes • Menstruation and the menstrual cycle • Menstrual hygiene and use of products • Disposal of menstrual products • Address stigma and taboos, and dispel myths related to menstruation	• Comprehensive information about puberty and menstruation, link between menstrual cycle and fertility and pregnancy, other forms of vaginal bleeding that are normal (e.g., post-partum and post abortion bleeding, contraceptive induced menstrual changes, and menopause related changes) • Comprehensive information about menstruation and its hygienic management, including product options, hygiene practices, and safe disposal • Basic information on normal and abnormal menstruation, and symptoms of menstrual problems and disorders • Information tailored to meet information and support needs across the lifespan, and for particularly vulnerable groups such as PwDs and persons with gender diverse identities

Contd...

Table 2: Common ground for policies and programs			
Area of focus	**Mainstream SRH programs**	**Mainstream MH programs**	**Opportunities for integrated action on MH and SRH**
Access to menstrual hygiene and SRH commodities	• Contraceptives (for married women) • Menstrual products (for adolescent girls) • Nutritional supplements (e.g., Iron and Folic acid tablets) • Hygiene commodities for women immediately after delivery and abortion	• Menstrual products	• Menstrual products access for all people who menstruate, adolescents and adults, girls in school and those out of school, along with information on the product basket and hygienic use • Contraceptive access to be accompanied by information on any potential changes to the menstrual cycle as a result of certain hormonal contraceptives • Information on the link between nutrition and SRH, MH, particularly iron deficiency anaemia • Information on medical drugs used to relieve menstrual pain, regulate menses, and the effects of medical abortion on uterine bleeding
Access to health services	• Family planning/ contraceptive counselling and services • Abortion services and post abortion care • Treatment for reproductive tract infections /urogenital infections • Postnatal care for bleeding during immediate postpartum period • Cancer screening	• Limited access to services apart from adolescent health camps under the School Health Program	• Menstrual problems and disorders • Responsive health services • Health services addressing SRH and MH for PwD, in humanitarian settings, and for persons with gender diverse identities

Contd...

Table 2: Common ground for policies and programs			
Area of focus	**Mainstream SRH programs**	**Mainstream MH programs**	**Opportunities for integrated action on MH and SRH**
Access to other allied services	• Quality WASH facilities in health centres, particularly in labour and delivery rooms	• Gender responsive and inclusive WASH services in schools	• Gender responsive and inclusive WASH services in educational institutions (schools and higher educational institutions), formal and informal worksites, health care facilities, public toilets and community toilets
Enabling environment to engender and sustain healthy behaviours	Addressing gender and social norms (including through transformational approaches) to promote: • Body literacy, bodily autonomy and care seeking • Contraceptive use and timing of first pregnancy • Decision making, including those relating to age at marriage and timing and spacing of children • Couple communication	Gender and social norms: • Body literacy, bodily autonomy and care seeking • Menstruation and menstrual blood • Taboos and restrictions related to menstruation • Continuing education after puberty	• Educational attainment and workforce participation • Links between SRH and MH with consent and mutual respect, communication, sexuality and sexual pleasure

Perspectives for integration of MH and SRH

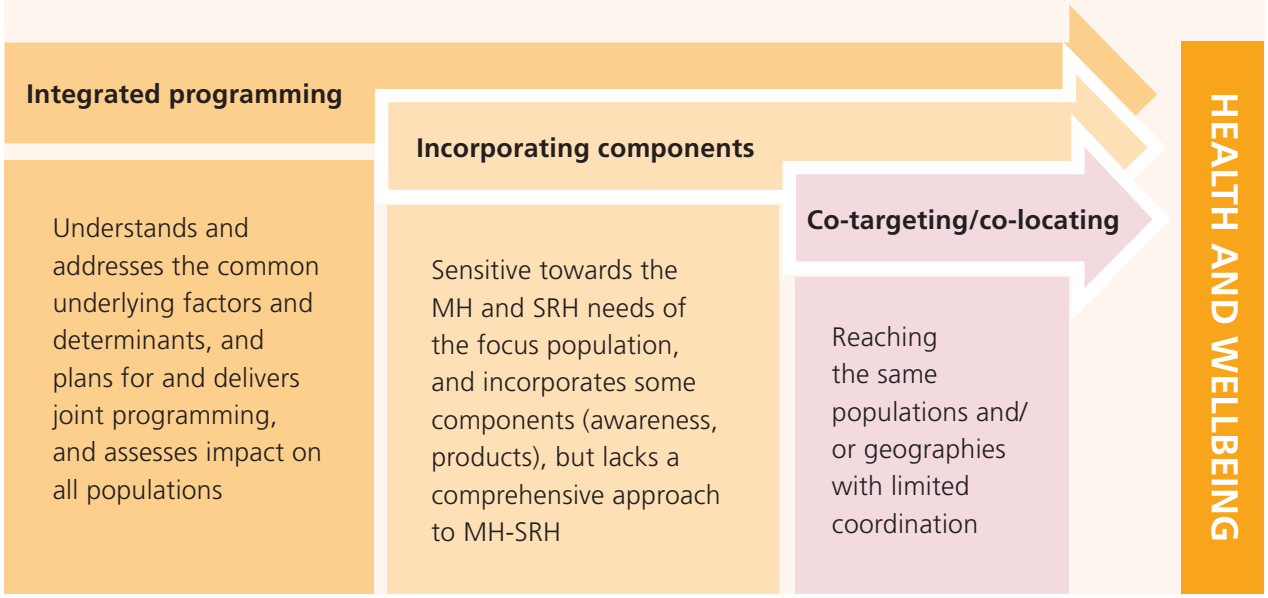
3

3.1 Integrating MH and SRH in program and policy

The inter-linkages between MH and SRH are strong, and programs and policies have operationalized this integration in different ways and to varying extents. Drawing from discussions with SRH and MH experts in India and a review of the policy landscape of MH, adolescent health and SRH in the country, this paper presents two dominant programmatic approaches, within each of which several intervention modalities exist.

The integration of MH and SRH lies along a continuum. At the very minimum, programs co-target the same population and/or the same geographical area, as is seen in Government interventions, such as the Weekly Iron and Folic Acid Supplementation Program and MHM, both of which reach adolescent girls, and often times in the same catchment areas and program delivery points (e.g., anganwadi centres, schools). At the next level, SRH programs can incorporate elements of MHM (e.g., sanitary pad distribution, sessions on menstrual hygiene as a part of an adolescent health program). For example, the Government's Rashtriya Kishor Swasthya Karyakram (RKSK) and the School Health and Wellness Program have sessions on menstrual hygiene. The Government's Family Planning initiatives provide information to women on possible changes to the menstrual cycle from the use of certain contraceptives. At the last level, joint or integrated programming critically examines the SRH and MH needs of the population it serves, identifies or defines the intersections, articulates how the intervention addresses SRH and MH through its objectives, and develops a plan to integrate the two in programming, as well as through programmatic evidence generation and monitoring efforts.

Figure 3: The continuum of joint programming



In addition to the continuum of integrated programming, integration of MH and SRH in India can facilitated through these two approaches, as identified through discussions with experts:

- Health products and services approach (incorporates health awareness/promotion)
- Approaches promoting gender equity

The above two approaches are not mutually exclusive; for instance, interventions on health products and services may incorporate a gender transformative lens, and a gender transformative intervention may enhance access to essential health products and services. However, the two approaches have been identified and called out separately in this paper as they have emerged as two dominant pathways to integrate SRH and MH in India. Both approaches can and must incorporate an inclusion lens, implementing measures to ensure that no individual or community is left behind, irrespective of their gender, sexual orientation, disability, and socio-economic status. Several implementation modalities exist within each of the two approaches, as shown below.

Health products and services	Addressing and transforming gender norms, roles and power dynamics
1. Adolescent health interventions and adolescent friendly health clinics 2. MHM and MH interventions 3. Family planning and contraceptive services 4. Comprehensive abortion care, and post-partum care services 5. Integrated programs for people living with other health conditions 6. Integrated programs for marginalized and vulnerable groups 7. Addressing MH-SRH through allied services (WASH) 8. Addressing MH-SRH through digital health interventions	1. Social and behaviour change communication (SBCC) 2. Interventions that promote equitable relationships and decision making through rights-based life skills, comprehensive sexuality education or pleasure-based sex education 3. Interventions that empower youth through education and collective action

3.2 Modalities for integrating MH and SRH through health products and services

Health products and health services have been and can continue to be leveraged to integrate MH and SRH. Additionally, allied products and services (e.g., nutrition, WASH, livelihoods interventions) can address common determinants of MH and SRH. Strategically using existing platforms providing health education, products and services in health and allied sectors can facilitate integrated MH-SRH interventions for people who menstruate across the reproductive life span, as well as reach vulnerable and overlooked groups in an efficient, more accessible and acceptable manner. An illustration of how integrated programming can benefit adult women are family planning services providing information on the menstrual cycle and menstrual hygiene in addition to contraceptive induced changes to the menstrual cycle. For adolescent girls, the RKSK program incorporates MH as a part of adolescent health. For marginalized groups such as women engaged in sex work, STI and HIV testing and counselling centres can provide essential information on MH and SRH (beyond STIs and HIV), and emphasize hygienic practices and provide consistent access to quality menstrual products. For vulnerable groups such as girls and women who are displaced due to conflict or natural disasters, essential MH and SRH can be offered in tandem during emergency preparedness, relief, and recovery efforts, with a wider array of MH-SRH interventions provided during the recovery phase. As programming evolves and strengthens, comprehensive SRH interventions should integrate MH through the various services and products required across the reproductive life span.

Box 6: Potential for integrating MH-SRH into comprehensive SRH education, products and services

SRH education	Products	Services
• Adolescent health • Menstruation, menstrual hygiene • Menstrual disorders and hysterectomies • Planning pregnancies • Abortion and post abortion care • Safe motherhood • Cancer screening • Menopause • Comprehensive SRH (include all the above components)	• Menstrual products • Contraceptives • Nutrition supplements (for adolescents, pregnant and lactating mothers) • Medication for menstrual conditions and disorders, cancer treatment, HIV/ AIDS, RTIs and STIs	• Adolescent health (adolescent friendly health services) • Family planning and contraceptives • Abortion • Ante-natal care, delivery and post-natal care • Diagnosis and treatment of RTIs, STIs and HIV • Diagnosis and treatment of menstrual conditions • Diagnosis and treatment of gynaecological and breast cancers • Nutrition services • Training/capacity building for livelihoods

3.2.1 Adolescent health and adolescent friendly health services

Adolescent health programs in India typically offer disease prevention, health promotion, and curative services (Barua et al, 2020). In the public health system, adolescent health is under the larger umbrella of the RMNCH+A program. RKSK, launched in 2014, established a comprehensive health program for adolescents, addressing but not limited to SRH and MH. Adolescent friendly health clinics (AHFC) provide a range of services for adolescents from nutrition, SRH, MH and even substance abuse.

Mainstream adolescent health programs and MHM programs in India reach adolescent girls and provide essential information on puberty and the reproductive system, menstruation and menstrual hygiene, and to some extent, on pregnancy. Information on contraceptives, family planning and safe sex are often limited in these programs, owing to the sensitive nature of these issues, and widely held notions that these topics are more appropriate for married youth, not unmarried adolescents. Further, the Protection of Children from Sexual Offences (POCSO) Act, 2012, the legal age of consent in India is 18 years. The Act criminalizes any form of sexual engagement even within consensual romantic relationships, calls for mandatory reporting of instances of any sexual offense involving a child under age 18 years, and proposes imprisonment, fine or both for those who do not report such offences (despite being aware of them). The mandatory reporting requirement, and associated punishments for non-reporting can place health care providers offering health services to adolescents in a precarious situation. It can affect the services provided to young people in terms of contraceptives and counselling. Further, since the Act criminalizes adolescent sexual activity, providers themselves may hold negative attitudes towards pre-marital sex among adolescents, affecting their ability to provide the requisite health services in a respectful manner.

Both adolescent health and MHM programs target school going girls in educational settings, with several initiatives reaching girls through health facilities, anganwadis, and in communities, as well. The School Health and Wellness Program launched in 2020 reaches school going children with a comprehensive package of services that include components of SRH and MH through health education, health screening and health services. Teachers, frontline health and community workers (ASHAs, anganwadi workers) and peer educators are trained to conduct sessions.

Adolescent friendly health clinics present a service delivery platform to integrate MH and SRH, through information and counselling on MHM, access to a basket of menstrual products (reusable and disposable) combined with information on their hygienic use, as well as screening, diagnostic and treatment services or referrals for menstrual problems. In a similar vein, anganwadi centres that deliver sessions to adolescent girls and provide them with essential nutritional supplements, can provide MHM education, distribute or sell menstrual products, train girls to make reusable cloth pads, and emphasize the linkage between nutrition and adolescent health and MH.

Box 7: Opportunity to integrate MH/MHM into adolescent health interventions and adolescent friendly health clinics

- Comprehensive SRH education on:
  - Linkage between menstruation, menstrual cycle and pregnancy, contraceptive use
  - The importance of nutrition for adolescent health and MH
  - Range of safe menstrual products, including sanitary pads, reusable cloth pads, and menstrual cups, and their hygienic use and disposal
  - Menstrual problems and disorders
- Expand the scope of adolescent friendly health services to:
  - Provide access to a range of menstrual products, and enable choice with support to select appropriate product(s) to meet needs
  - Provide information, screening, diagnosis and treatment of menstrual disorders, and referrals where needed
- Enhance capacities of teachers and frontline workers who implement adolescent health sessions to integrate MH/MHM and SRH

3.2.2 MHM and MH interventions

MHM programming in India was initiated by the Ministry of Health and Family Welfare under the erstwhile Menstrual Hygiene Scheme, launched in 2011, that was later subsumed under RKSK (Muralidharan, Patnaik and Patil, 2015). The National Guidelines on MHM in Schools by the Government of India (2015) catalysed action on MHM as a separate area of work from adolescent health, with several State Governments launching schemes to reach adolescent girls with MHM education and menstrual products, specifically sanitary pads (Government of India, Ministry of Jal Shakti, 2015). The combination of MHM education and product distribution was appealing, and resulted in significant budgetary allocations by State Governments (SPLASH, 2020; WaterAid India and UNICEF 2022). The past decade has seen tremendous action on MHM by the non-government sector and the private sector, resulting in a rich array of interventions and menstrual product offerings across the country (WaterAid India and UNICEF 2022; WaterAid India and UNFPA 2022). Mainstream MHM interventions, whether by Government or NGOs, are centred on menstruation and its safe management, and provide limited information on other aspects of adolescent health and SRH. To a large extent, MHM interventions are delivered in schools, though there are efforts to reach out of school girls in communities and through anganwadi centres (WaterAid India and UNICEF 2022). MHM interventions respond to components across the MHM value chain to varying degrees. A unique feature that sets MHM interventions apart from other adolescent health interventions are efforts to understand and tackle social norms and taboos related to menstruation (such as norms and taboos about food consumption, social interactions, mobility and religious worship during periods).

Mainstream Government and non-government MHM interventions do not provide much information on menstrual problems and disorders; a weak area that requires further development. Clinical interventions for menstrual conditions such as PCOS and endometriosis exist in select urban centres, with recent education focused interventions in India creating awareness about these conditions, countering stigma, and providing social support and counselling (e.g., PCOS Club of India, Bleed Equal). Both endometriosis and PCOS affect the menstrual cycle, as well as fertility, hence awareness sessions and counselling efforts address the condition, associated stigma and implications for pregnancy (PCOS Club of India). Discussions with experts suggested that efforts that address the clinical and non-clinical aspects of menstrual disorders do not delve into SRH, apart from counselling on how the condition may affect fertility. Further, such interventions are currently more available in select urban areas, and are not widely implemented with low-income urban populations and rural populations. Lastly, discussions suggest that interventions on menstrual disorders are led by the private health sector and NGOs, while Government interventions for this issue are non-existent.

Menstrual health programs in India rarely reach adult women of reproductive age, apart from seeking their engagement as mothers, through community wide campaigns, with menstrual products related interventions (e.g., menstrual cups), and through interventions on menstrual disorders in urban centres[7]. The menstrual needs of adult women in India are poorly understood due to limited research, and lie unaddressed.

[7] *Adult women are reached through interventions addressing PCOS and endometriosis as these conditions are often diagnosed in adulthood.*

Box 8: Opportunity to expand the scope of MH/MHM programs to integrate aspects of SRH:

- Provide information on:
  - Linkage between menstruation, menstrual cycle and pregnancy, contraceptive use
  - The importance of nutrition for adolescent health and MH
  - Menstrual problems and conditions, and timely health care seeking
- Link with SRH or adolescent health programs being implemented in the same geography and/or with the same population
- Support research on the menstrual health needs of adult women across the reproductive life span (from early adulthood to menopause) and explore linkages with SRH across the lifespan
- Expand the scope of clinical and non-clinical interventions on menstrual disorders to low-income urban areas, and rural areas, in collaboration with NGOs and Government initiatives
- Enhance capacities of teachers and frontline workers who implement adolescent health sessions to integrate MH/MHM

3.2.3 Family planning and contraceptive services

India's family planning program has a long history and has evolved from a program focused on population stabilization to a comprehensive set of initiatives to promote reproductive health, and reduce maternal morbidity and mortality. The Government run family planning program provides contraceptive methods for spacing of births (e.g., oral contraceptives, injectable contraceptive), limiting births (i.e., male and female sterilization), and emergency contraceptives.

Family planning and contraceptive services are a platform to reach adult women with information and support on MH, providing information on the links between the menstrual cycle and pregnancy, contraceptives, as well as addressing contraceptive induced changes to the menstrual cycle. Knowledge of the menstrual cycle and ovulation can be used to plan for or prevent pregnancy, using methods such as Standard Days Method, the Two Day Method, and the Lactational Amenorrhea Method, with research suggesting that these methods have effectiveness rates similar to other modern contraceptives, and expand the range of family planning methods available to women and couples who may not want to or cannot use modern contraceptives (Malarcher et al, 2016; Jennings et al, 2019)

Box 9: The Family Planning Association of India (FPA India): Integrating MH into the range of SRH services

FPA India offers a range of services related to family planning, maternal health, child health services, integrated services for STI/HIV and RTI management, prevention, early detection and management of reproductive tract cancers, screening for GBV, and age specific SRH services for young people and for the elderly. MH is not a separate service delivery vertical, and is integrated into all these services. For instance, women seeking contraceptives are counselled about possible changes to the menstrual cycle as a result of contraceptive methods, and are supported to continue using the method of choice through these changes. Fears and misconceptions about future fertility as a result of contraceptive included changes to the menstrual cycle are addressed to facilitate adherence and avoid unintended pregnancy.

Box 10: Ministry of Health and Family Welfare, Family Planning Program IEC resources

IEC material used for both health care providers and clients by the Ministry of Health and Family Welfare's Family Planning Program include information on changes to the menstrual cycle as a result of contraceptive methods. This clear communication prepares clients to anticipate changes, adhere to the contraceptive method, and seek health care if side effects are unusual. Resources for providers and clients are available here and here

Box 11: FHI 360's NORMAL toolkit

FHI 360 has been leading global efforts to create more awareness and action on contraceptive induced changes to the menstrual cycle. Their NORMAL toolkit presents simply and clear information on normal changes to expect when using contraceptives, and prepares providers and people considering contraceptives on the changes associated with different contraceptives, enabling them to make a choice and anticipate potential changes. The NORMAL toolkit is available here.

3.2.4 Comprehensive abortion care, and post-partum care services

To tackle unsafe and illegal abortions, the Government of India has legalized the medical termination of pregnancy[8], and enhanced availability of and access to comprehensive abortion care (CAC). CAC in India draws on a woman-centric approach emphasizing choice (of pregnancy termination methods and post abortion contraception), access, and quality services. SRH and MH (in the form of vaginal bleeding) are addressed, and must continue to be addressed as a part of CAC.

Women undergoing abortions need information on vaginal bleeding post medical and surgical abortion, the use of safe and appropriate menstrual materials, symptoms of abnormal bleeding and on changes to the menstrual cycle as a result of the procedure. The National Guidelines recommend that women undergoing the procedure be informed about bleeding, abnormal bleeding, and when to anticipate a normal menstrual period after the procedure. The guidelines further recommend that two packets of sanitary pads be provided to those having a surgical procedure (Ministry of Health and Family Welfare, 2018).

Given that some women seeking abortions may have had an unintended pregnancy, post abortion contraception counselling is important to prevent another unintended pregnancy. Further, women need to be informed of when they can get pregnant after an abortion, and when it is safe for them to plan a pregnancy. These details are provided as a part of CAC guidelines.

Post-partum care is a part of the continuum of maternal health care. Government of India guidance on post-partum care addresses post-partum bleeding, the use of safe absorbent materials, and hygiene practices, and recommends counselling on contraception. However, information is provided soon after birth, with little

[8] *The Medical Termination of Pregnancy (MTP) Act (1971) governs the provision of abortion in India, permitting termination of pregnancy up to 20 weeks gestation under set conditions. The MTP Act Amendments in 2021 expands access to safe and legal abortion in several ways: 1) unmarried women are now covered, in addition to married women; medical termination of pregnancy allowed up to 24 weeks to rape survivors, and beyond 24 weeks in cases where the foetus has substantial abnormalities; breach of the woman's confidentiality now carries a fine and/or imprisonment for one year. Details about the MTP Act 1971 can be accessed here and the 2021 Amendment can be accessed here.*

reinforcement of hygienic practices over the post-partum period. Women who have given birth should be provided with information on the safe management of post-partum bleeding with appropriate absorptive materials and hygiene practices, and signs of post-partum haemorrhage (PPH) and infection that will require immediate medical attention[9]. Such information should be reiterated during all post-partum health visits. Newly delivered mothers also need information on the association between breastfeeding and menstruation, and when menstruation resumes after childbirth.

Box 12: Opportunity to expand the scope of Family Planning/contraceptive services, abortion and post-partum services to incorporate MH:

- Provide information on:
  - Linkage between menstruation, menstrual cycle and pregnancy, family planning/contraceptive use, and breastfeeding
  - Changes to the menstrual cycle and bleeding patterns resulting from the use of contraceptives
  - Signs of abnormal bleeding as a result of abortion or after birth (PPH)
  - Use of safe and effective menstrual products to deal with post abortion and post-partum bleeding

3.2.5 Integrated programs for persons living with other health conditions (HIV/AIDS)

Interventions addressing other health issues affecting women in India can incorporate information on MH and SRH. Groups at high risk for HIV, such as sex workers, receive information and support on safe sex to prevent STIs, including HIV. Counselling sessions can include information on menstrual hygiene practices as well, as well as signs of abnormal vaginal bleeding. People living with HIV who experience menstruation need information on how the condition may change their menstrual cycle, how to manage their periods hygienically given their compromised immune system, and to address concerns about the effects of anti-retroviral therapy on the menstrual cycle.

3.2.6 Integrated programs for marginalized and vulnerable populations

Girls and women in humanitarian settings, including natural emergencies and conflict situations, are particularly vulnerable. SRH and MH needs are often overlooked in humanitarian and emergency response efforts, with the exception of providing sanitary pads. However, with the COVID pandemic, the range of SRH and MH needs came to the fore, resulting in greater acknowledgement that these essential needs have to be addressed across humanitarian and emergency situations. Integrating MH and SRH, and providing a common service delivery point and outreach support can enable girls, women, and people with gender diverse identities, to access these essential services amid other constraints (Columbia University and International Rescue Committee 2017; WaterAid India and UNFPA 2021). A report on menstrual health and hygiene during emergencies in India recommends that in addition to distribution of hygiene kits and sanitation pads, and the establishment of safe and accessible WASH facilities for girls and women facing emergencies, health services can be expanded to address other aspects of MH. For example, health workers providing contraceptives, maternal care (antenatal and post-natal care) in relief shelters can provide basic information on hygienic management of menses and post -partum bleeding, and identify those with menstrual problems or disorders who need immediate medical attention (WaterAid India and UNFPA, 2021). Responsive WASH services that meet the needs of girls and women in such settings can also meet common needs.

[9] *PPH is a serious condition that can occur immediately after birth and up to 12 weeks post birth*

Box 13: Dignity kits for girls and women in emergency settings

In 2000, UNFPA recommended that the response to reproductive health during emergencies should include 'dignity kits' with menstrual materials, and successfully advocated that such services are life-saving and therefore eligible for humanitarian funding. Dignity kits promote mobility and safety of women and girls and increases their psychosocial and physical well-being. Dignity kits typically comprise of:

- Menstrual materials (disposable sanitary pads and/or cloth pads)
- Underwear
- Soap
- Washing soap
- IEC materials with information on the usage of menstrual materials, and on other relevant information and services for girls and women
- Bag for storage

More information on dignity kits for emergencies and humanitarian contexts can be found here.

PwD and people with gender diverse identities who experience menstruation are often missed by routine programs, even though they require comprehensive information about the body, menstruation, menstrual hygiene, pregnancy and contraceptive use, as well as concepts such as bodily autonomy and consent (WaterAid India and UNFPA 2022). Integration of MH and SRH can support and enhance access to these services. Some organizations working with PwD, for example, provide them with basic information on menstruation and its hygienic management. Given that SRH is rarely discussed with this group, sessions on MHM are an entry point to provide essential information on pregnancy, contraception, consent, and other relevant SRH issues (WaterAid India and UNFPA 2022).

Box 14: MH-SRH education for PwDs

WSSCC, in collaboration with IIT Cell – the Centre for Excellence in Tactile Graphics, and Saksham Trust developed a tactile book in Hindi and English on menstrual hygiene management helping people with visual impairment to understand pubertal changes in their bodies.

The Red Talk App developed by Aaina provides information about puberty, adolescence and menstruation for girls and women with visual and hearing impairments using pictorial (visual) and storytelling(audio) formats that engage users in an interactive way. It was developed for adolescent girls, including girls with disabilities, their parents, caregivers, organizations working with PwDs who require support to understand and effectively communicate on menstruation, hygiene practices, use and disposal of absorbents, and facts and myths about menstruation. More resources can be found here.

Little is known about the experience of transgender men in India who continue to menstruate (before they have completed their physical transformation from female to male) in India. This invisible and marginalized group struggles to access health, WASH, and other services in general owing to their gender identity and the stigma attached to the transgender community (Saraff, Singh, Kaur, Biswal, 2022). For them as well, jointly addressing MH and SRH can be beneficial. If transgender men are undergoing medical treatment to support their transition from female to male, SRH and MH should be addressed during medical consultations and treatment, as the use of hormone therapy will result in changes to the menstrual cycle. For transgender men

who are seeking mental health support and counselling, they may need support to deal with menstruation and how it may contribute to their gender dysphoria (Rydstrom 2020).

3.2.7 Addressing MH-SRH through allied services – Water, Sanitation and Hygiene

Apart from health-related services and products, other allied services such as WASH can jointly addressed common aspects of SRH and MH. Gender responsive WASH facilities are accessible, safe, private and have essential features that enable girls, women and gender diverse people to use them as and when needed. Further, such facilities are required at home, in communities and public spaces, in educational institutions and worksites, in relief camps and settlements, and in other settings where girls and women engage. Such facilities can support hygienic practices, and evert preventable infections and adverse health outcomes (WaterAid, 2022). SBM-Grameen catalysed action on sanitation for all, and promoted sanitation facilities that were gender responsive and inclusive in various settings (households, communities, schools, health facilities, and public spaces).

A resource on female friendly public and community toilets provides guidance on making sanitation facilities accessible, acceptable and usable for girls, women and transgender people with these features (UNICEF, WaterAid, and WSUP 2018):

- Be safe and private
- Cater to menstrual hygiene management and other hygiene requirements
- Be accessible to all users
- Be affordable and available when needed
- Be well maintained and managed
- Meet the requirements of caregivers and parents

The guide further elucidates specific requirements for menstrual hygiene, such as:

- Access to water and soap
- Access to menstrual products
- Disposal of menstrual products
- Hooks and shelves
- Mirror
- Washing and bathing units

3.2.8 Addressing MH-SRH through digital health interventions

In addition to direct or in-person MH-SRH products and services, digital health platforms present another opportunity to integrate MH and SRH. The use of digital health interventions is growing in India, both within and outside of the Government systems. Digital health interventions (telemedicine, helplines and digital platforms) for SRH and MH already exist in India. Though not widely available, existing platforms provide information, counselling, and even health services and referrals. Some menstrual cup companies (e.g., Sirona Hygiene Private Limited) run helpline service to support girls and women with the use of the menstrual cup. Their counsellors are trained to address problems with the cup related to insertion, removal, and abnormal symptoms in the reproductive tract. Digital health platforms have limited availability and access in India, but where accessible, can provide a safe and private *space* to discuss sensitive issues. Digital health interventions that provide information on MH and SRH include Hello Saheli and Arogya Sathi by Uninhibited, and Kahi Ankahi Baatein by CREA and TARSHI.

Digital interventions for health have potential in India; however, efforts are required to ensure equitable, safe and confidential access to digital platforms for girls, women, and people from particularly marginalized and vulnerable communities.

3.2.9 Summary of integrating MH and SRH through health products and services

Leveraging health products and services to integrate MH and SRH can have several advantages:

- Provides several opportunities for engagement with girls, women and people with gender diverse identities across the reproductive lifespan from puberty to menopause, addressing a range of MH and SRH needs
- Is more acceptable to individuals and communities, and can facilitate greater outreach through frontline workers (ASHAs, anganwadi workers, SHG members)
- Links MH and SRH to a felt need (e.g., family planning, menstrual products)
- Creates demand for other MH-SRH products and services (e.g., girls receiving sanitary pads through an adolescent friendly health facility can be exposed to other adolescent health issues, and can access SRH information, counselling and support)
- Provides opportunity to expand health services to incorporate other aspects of MH and SRH (e.g., abortion and post abortion care can incorporate information on the use of safe materials to deal with vaginal bleeding, adolescent friendly health centres can provide services for screening, diagnosis and treatment of menstrual disorders)
- Potential to develop a health promotion lens for MH-SRH integration, moving beyond the disease or morbidity prevention focus for SRH
- Enhances access to MH and SRH information through digital means when physical access is limited or constrained, and even services where available, as they may afford greater privacy to discuss sensitive information

At the same time, there are important gaps to be addressed that can undermine integration, that need to be addressed. These include:

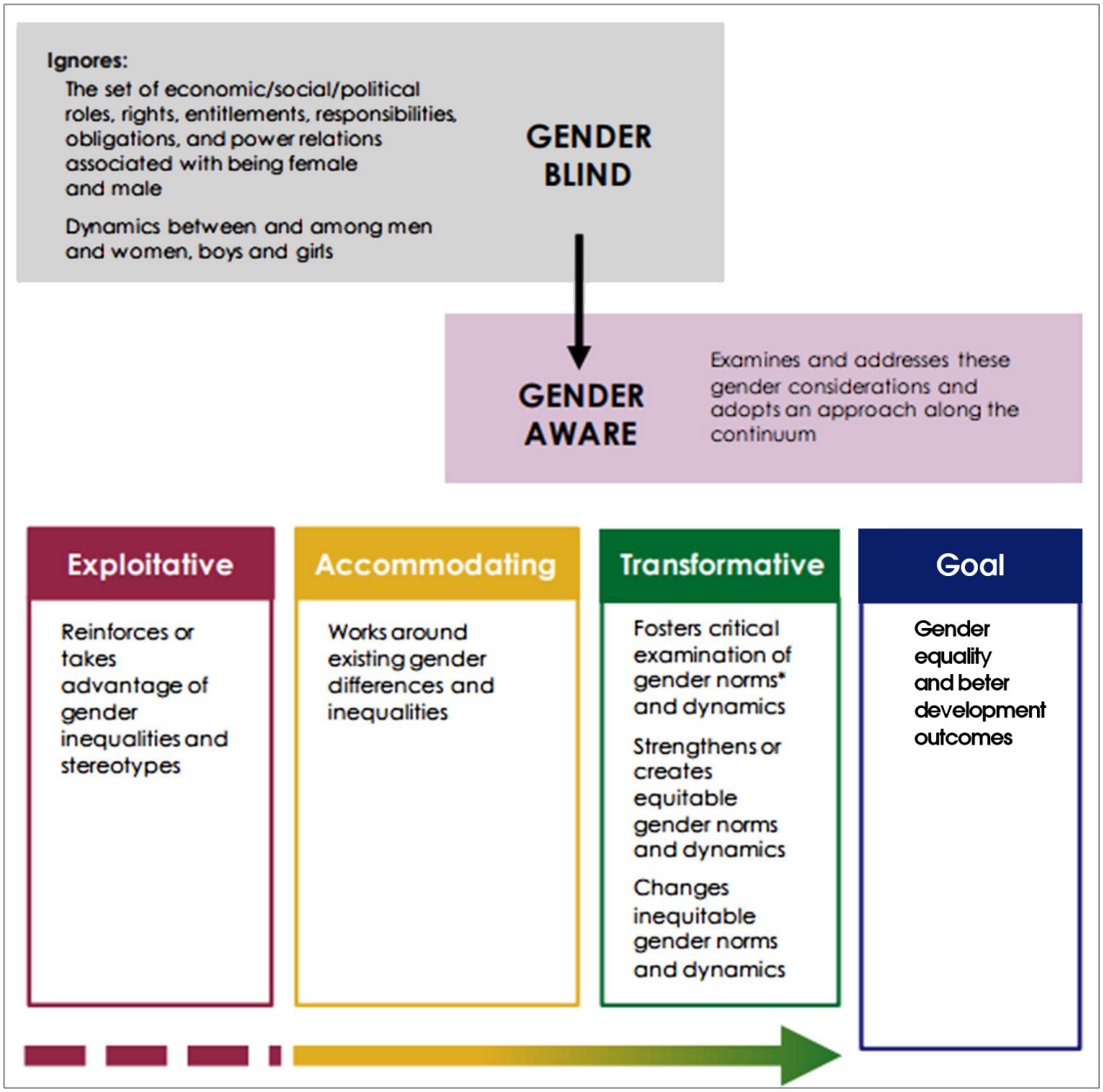
- Platforms distributing menstrual products or providing family planning services may lack the resource capacity and time to provide comprehensive information on SRH-MH
- Existing health services are clinical in nature and therefore limited in their abilities to provide information on health promotion and social support
- Girls, women and people from marginalized communities have limited digital access. Further, digital platforms operated by NGOs may focus more on education and online social support, and may not necessarily connect with off-line support services such as health facilities. Government supported digital platforms for SRH and MH may have to expand their scope to providing information and social support, beyond access to services and products, and tracking beneficiaries

3.3 Addressing and transforming gender norms, roles and power dynamics

The second dominant approach to MH and SRH integration, shared by experts, deployed a gender integration lens, specifically a gender transformative lens. This approach identifies and tackles the underlying inequitable gender norms, roles, and power relationships that adversely shape health outcomes. Interventions may lie along a continuum, differing in the extent to which they acknowledge, leverage and address gender and/or gendered barriers to achieve the desired health outcomes. At one end of the continuum are interventions that are gender blind, and completely ignore how gender intersects and shapes outcomes of interest (e.g., common or unisex toilets in schools, sanitary pad distribution by male teachers or volunteers). Some interventions are exploitative, and leverage and reinforce gender inequalities and stereotypes (e.g., MH and SRH interventions that highlight the role of male family members in making decisions with regard to health care or in accessing menstrual products or contraceptives). The continuum then moves towards interventions that are accommodating in nature, acknowledging and working around existing gender differences and inequalities, while not shifting the structural determinants of these inequalities. MH interventions that provide information on menstruation and hygiene in schools and anganwadis, and acknowledge social

norms and restrictions, yet do not engage relevant community influencers through awareness sessions and tackle their deep-set beliefs related to MH and SRH. A gender transformative approach fosters critical examination of gender norms and dynamics; strengthens or creates equitable gender norms, roles and dynamics; and changes inequitable gender norms and power relations (Interagency Gender Working Group, 2013). A family planning intervention that engenders couple communication for healthy timing and spacing of pregnancies, and a MH intervention that engages with mothers, fathers and community leaders to address harmful social norms are examples of transformative approaches. A gender transformative approach is vital to adolescent and women's health and wellbeing, including SRH and MH, as it recognizes and acts to change the influence of harmful gender norms, roles, power dynamics on health, access to and the use of health products and services, to ultimately better health outcomes (Muralidharan et al, 2015; George et al 2020).

Figure 4: The gender equality continuum (Muralidharan et al, 2015)



Discussions with experts revealed that gender transformative approaches may directly focus on achieving health outcomes (e.g., gender transformative comprehensive sexuality education, pleasure-based sexuality education) or address health outcomes indirectly by primarily tackling gender, power and patriarchy. Interventions taking a gender transformative approach may address either MH/MHM or SRH, not both; yet, the effect of the intervention directed at one issue potentially carries over to the other aspects of health as it acts on shifting norms, roles and on creating positive, equitable relationships. These insights are supported by research as well. A 2015 review of gender integrated health programs in LMICs found that gender transformative health programs had one or more of the following characteristics: 1) empowered disadvantaged groups, promoted critical reflection, and fostered social and behaviour change; 2) promoted equitable relationships and decision making; and 3) empowered girls and women through education, economic opportunities and collective action (Muralidharan et al, 2015). Informed by these findings, we identified the following intervention modalities based on approaches promoting gender equity that integrate MH and SRH:

1. SBCC addressing MH related social norms and taboos
2. Interventions that promote equitable relationships and decision making through life skills, comprehensive sexuality education, and pleasure-based sex education
3. Interventions that empower youth through education and collective action

3.3.1 SBCC addressing MH related social norms and taboos

MHM interventions, while focused on awareness, menstrual products and WASH facilities, acknowledge the role of gender in the form of deep-rooted social norms, and attempt to address them to varying extents. Socio-cultural norms shaping the experience of menstruation, access to and use of menstrual products and WASH facilities, and even disposal have been and are tackled through awareness sessions, SBCC interventions, and life skills interventions. Addressing deeply entrenched religious norms is challenging; however, other social norms and taboos related to food and social interactions and mobility have been tackled through thoughtful interventions. For instance, awareness sessions that explain the process of menstruation and its role in reproductive health help counter the perception of menstrual blood and the person who menstruates as impure. Understanding what happens to the body during menstruation and the need for balanced nutrition can overcome some food related restrictions. MHM interventions use interactive games in group settings to identify and address social norms and taboos related to menstruation through practical and context appropriate solutions. The role of facilitators is key, and they often undergo intensive training to first overcome their own inhibitions, misconceptions, and beliefs about the impurity of menstrual blood and people who menstruate before they can conduct such sessions with girls and women.

Box 16: WASH United Ruby's World

Developed by WASH United, Ruby's World is an educative guide for menstrual health and hygiene management. It educates, engages and empowers girls to manage their menses healthily using stories and activities with groups of girls. Girls are educated on menstruation, changes that occur during puberty and various types of menstrual products. They are empowered to make choices for themselves and challenge menstrual myths and taboos. Girls also grow in confidence and are motivated to engage in the topic and support one another. External evaluations of trainings using the guide found:

- 70% of girls were more knowledgeable about menstruation and MHM
- 24% decrease in the proportion of girls who were worried and upset about their periods
- 27% increase in the number of girls who were comfortable talking about periods
- 72% of girls who felt they received more support from peers after the sessions

Further information on the guide can be found here.

Box 17: UNICEF's GARIMA Program – an SBCC approach to MHM

The GARIMA (Girls' Adolescent and Reproductive Rights: Information for Management and Action) is a menstrual hygiene program that worked with adolescent girls and their immediate influencers to engender positive social norms and healthy practices around menstrual hygiene. GARIMA was implemented by UNICEF in partnership with local NGOs using an innovative SBCC approach to address restrictive and harmful social norms associated with menstruation at the individual and community levels. Such an approach focused on the individual (i.e., adolescent girl), seeking to change behaviours through improved knowledge, attitudes, and practices using multi-media channels. Additionally, the approach brought about social change in the community, with the aim to transform power relations within social and political institutions (UNICEF, 2015[10]). The program used a multimedia communications package and leveraged community level groups, peer educators, field facilitators, frontline workers, and school teachers to address restrictions and existing social norms around menstruation, physiological reasons for menstruation, and hygiene management.

An evaluation of the SBCC component of the intervention by Ramaiya et al (2019) found that adolescent girls in the high "encoded exposure"[11] group had significantly higher knowledge about puberty and reproductive parts (AOR: 2.03 (95% CI: 1.31 – 3.15)), positive attitudes towards gender (AOR: 1.48 (95% CI: 1.02 – 2.16)) and higher levels of some discussion and dialogue related to menstruation and associated restrictions (AOR: 1.41 (95% CI: 1.04 – 1.92)). Sood et al (2020) in their analysis found that exposure to the intervention was positively associated with significantly higher menstrual hygiene practices related to adequate preparation and storage of clean absorbents, adequate changing of absorbents during the day, adequate hygiene and disposal. Further, the evaluation found that girls exposed to the GARIMA initiative had significantly more positive MHM norms compared to girls from the comparison group (43.99% and 21.11% respectively). Girls in intervention villages reported challenging social norms and restrictions related to clothes they were not allowed to wear, eating prohibited foods, greater mobility to places they were not permitted to go earlier, and participating in forbidden social and religious activities. NGO staff who were engaged in the program note that while the program has concluded, girls who participated in the intervention felt confident to seek opportunities for their higher education, health services, and even livelihoods, indicating that the approach had a ripple effect on other areas of their lives (WaterAid India and UNICEF, 2022).

3.3.2 Interventions that promote equitable relationships and decision making through comprehensive sexuality education and pleasure-based sex education

CSE is a curriculum-based process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality. It equips children and young people with the knowledge, skills, attitudes and values that will empower them to realize their health, wellbeing and dignity, develop respectful social and sexual relationships, consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives (UNESCO et al 2018). Effective CSE is scientifically accurate, incremental, age and developmentally appropriate, curriculum based, informed by a human-rights approach, based on gender equality, culturally relevant and context appropriate, transformative, and engenders the ability to develop life skills needed to support healthy choices (UNICESCO et al 2018). CSE embodies a life skills approach, going beyond education about reproduction,

[10] *UNICEF. (2015). Behaviour and social change. https://www.unicef.org/cbsc/index_42352.html*

[11] *Encoded exposure was estimated based on both dose (exposure to the intervention) and recall (of the intervention)*

disease and risky practices and behaviours, taking a "balanced and comprehensive approach" providing a platform to present the positive aspects of reproduction and sexuality, such as respect, autonomy, and equality in relationships (UNESCO et al, 2018). CSE curriculum covers a range to topics related to SRHR, and is tailored to meet the socio-cultural realities of implementation contexts. While such responsiveness is critical, UNESCO and partners strongly state that the omission of key topics essential to CSE (one of which is menstruation) will undermine its impact - "the failure to discuss menstruation can contribute to the persistence of negative social and cultural attitudes towards it. This may negatively impact the lives of girls, contributing to lifelong discomfort about their bodies, and leading to reticence about seeking help when problems arise" (UNESCO et al, 2018). CSE has eight fundamental components, and menstrual health can be incorporated into several of these (UNESCO et al, 2018).

Eight components of CSE	Incorporating menstrual health
1. Relationships	Communicating about menstruation, menstrual hygiene, menstrual needs with family, peers
2. Values, rights, culture and sexuality	Social and cultural norms around menstruation
3. Understanding gender	Social and cultural norms around menstruation
4. The human body and development	Menstruation as an important aspect of puberty, reproduction, reproductive and sexual anatomy, and body image
5. Sexual and reproductive health	Understanding menstruation and the menstrual cycle from the lens of pregnancy and pregnancy prevention, RTIs, menstrual syndromes/ conditions
6. Sexuality and sexual behaviour	
7. Skills for health and wellbeing	Menstrual hygiene practices (access to and use of safe and effective menstrual products/materials) Health seeking for menstrual problems and conditions
8. Violence and staying safe	Addressing violence as a result of menstrual taboos and restrictions

An extension of CSE is pleasure-based sex education that emphasizes that sexual activity should be pleasure focused, normalizing pleasure in sex and relationships. Using the pleasure lens, these programs equip youth with essential skills of communication, emphasizing mutual respect and consent. A recent article proposed that pleasure-based CSE will bring positive outcomes, including: risk reduction, cultivating healthy relationships, celebration of sexual diversity, exercise of sexual rights, empowerment, consent, and reduction in GBV (Mark, Corona-Vargas, Cruz, 2021). In India, only one known organization, Uninhibited, is currently piloting a pleasure-based approach to SRH and MH.

Box 18: Chhaa Jaa – a digital approach incorporating menstrual health and hygiene into SRHR, with empowerment and engagement as central

Chhaa Jaa by Girl Effect, is a digital-first youth brand that supports girls to make choices about their health and relationships, from accessing information about their body and health care, as well as contraceptive use and education choices. Chhaa Jaa uses social media content, and a sex and relationships chatbot to reach girls across India, having reached 10 million girls as of 2022. The intervention uses normalizes taboos topics and creates relatable peer role models that builds girls' sense of self, her identity, and importantly, her ability to ask questions about issues that matter to her, her body, and relationships.

Chhaa Jaa communicates with girls through a web video series, social media and a website, a girls only Facebook community, a sex and relationships chatbot, as well as Technology Enabled Girl Ambassadors.

Chhaa Jaa incorporates menstrual health into its digital content, providing information and support on aspects such as puberty and the body, menstrual cycle and its link with pregnancy, and menstrual problems, including access to medical professionals and services for any health issues. Importantly, the digital platform encourages conversations around social norms and pressures related to SRH, including menstruation. Information about menstrual product access and disposal is limited. A snapshot of their materials on MH can be accessed here.

3.3.3 Interventions that empower youth through education and collective action

Gender transformative strategies can address structural barriers that prevent women and girls from improving their health, in response to restricted opportunities for education, livelihood, and community participation, that undermine girls' and women's ability to engage in healthy behaviours, make healthy decisions, and even seek healthcare. Such interventions create opportunities for continued education, engagement in community processes and in collective action for upholding/advancing rights.

Box 19: Slum Soccer

Slum Soccer programs provide girls aged 12-18 years with access to sports facilities, life skills education, and even basic computer literacy. Through football, girls are taught essential life skills such as inter-personal communication, teamwork, resilience, and begin to examine gender roles and norms in their own lives. The very act of girls from rural areas and low-income urban areas actively participating in spots such as football challenges female gender roles. MHM is addressed through this program as an important component of their health and hygiene as teenagers. The program aims to build the confidence and independence of young women.

Box 20: Udaan – MH a part of a 360-degree approach to preventing adolescent pregnancy in Rajasthan

Udaan by IPE Global takes a comprehensive approach towards the pressing issue of adolescent pregnancy. Implemented in Rajasthan, the program embodies a multi-sectoral approach to avert adolescent pregnancy by keeping girls in schools to complete their secondary education, providing comprehensive SRH information, enhancing contraceptive choice and access, and creating greater awareness about social entitlements available to girls to avail of essential health and education services. The program leverages Government platforms and programs (schemes) focused on health and education for scale up.

Schools were identified as the ideal platform to reach girls, and create peer leaders who can communicate essential information to peers who have discontinued their education. Menstruation and menstrual hygiene are a part of the curriculum, and not a separate program. Contraceptive counselling explains the link between the menstrual cycle and pregnancy, and emphasizes how understanding of the cycle is fundamental to planning and preventing pregnancy. In this program, MH is a part of the solution to adolescent pregnancy, and is addressed through sub-interventions that enable girls to complete their secondary education, and plan their pregnancies once married. More information on Udaan can be accessed here.

Box 21: Gender Equitable Movement in Schools (GEMS)

GEMS is a unique school-based program that aims to promote gender equity, re-define masculinity, and prevent all forms of violence among male and female adolescents. It is also one of the few interventions of this sort that has been evaluated, providing valuable insights into what works with school age children to transform inequitable gender norms.

GEMS was implemented with young adolescents aged 12-14 years (grades 6-8), engaged both girls and boys, adopted a gender transformative approach, and leveraged the school setting to facilitate normative change. GEMS is based on the cognitive-affective approach and life-skills to bring transformative change that is sustained over time (Achyut et al, 2017). The comprehensive approach is based on core components, including:

- Group Education Activities (GEA): A set of 22 activity-based discussions conducted in schools over a two-year period with all students
- GEMS school-based campaign: a series of interactive events to create school-wide discourse on relevant topics using competitions, games, role plays and pledges
- GEMS diary: a book for each student that has games, activities, quizzes and messages that reinforce classroom sessions, and help each child take learnings to their home environment
- Teacher training and support: Teachers supporting the GEMS program undergo intensive training to empower them to contribute towards the transformative change
- Parent and community outreach: strengthening interface with parents through campaigns, and facilitating discussions during school-based forums such as the School Management Committee, and parent-teacher meetings

An evaluation of GEMS in Jharkhand schools found that students who were exposed to more GEMS sessions showed that students who attend more GEMS sessions were more likely to express greater gender equitable attitudes than students who attend fewer sessions, alluding to the value of GEMS as an intervention that incrementally address aspects of gender (Achyut et al, 2017).

Box 22: The Youth Parliament (YP) Foundation's feminist and rights-based interventions

The YP Foundation is a youth-led organization that address health equity, gender justice, sexuality rights, and social justice by facilitating young people's feminist and rights-based leadership. The underlying theory of change is to empower young people to realize their rights by enhancing their access to information, services and leadership opportunities. The YP Foundation runs several programs that address SRH and MH directly and indirectly. The organization believes that MH is an integral part of SRH, and their feminist and rights-based leadership approach to various youth issues will inevitably address SRH and MH.

The Feminist Adolescent and Youth Led Action Project focuses on SRHR through stigma free and rights affirming CSE sessions. The program further helps youth advocate for access to services and rights with their peers, parents, community members, as well as with program implementers and policy makers.

The YP Foundation's Access Project is an evidence generation and training programme that works towards advocating for young people's right to quality health services without judgement, stigma and age-related barriers. It aims to bridge the gap between young people and service providers by pushing for the inclusion of young people's voice in service delivery, through creating resources and digital systems on youth-friendly health service provision; and engaging with health facilities, service providers and policy-makers. This program has four components, all of which embody a gender and rights perspective: 1) building youth capacity to conduct audits , create awareness amongst their peers on their right to SRH services, and mobilize demand for better quality SRH services; 2) train service providers (at the community and health facility levels) to provide gender responsive and youth-adolescent friendly health services; 3) create resources for service providers, and operate a digital application for young people to monitor service provision in their facility; and 4) advocate with service providers, Government officials and policy makers to improve the quality of adolescent and youth health services.

Gender-integrated programs, particularly those transforming inequitable gender norms, roles and power dynamics, can bring significant benefits to health, including the integration of MH and SRH. Some of the compelling reasons to adopt this approach for MH-SRH integration are:

- Emphasis on comprehensive SRH with a focus on health, wellbeing, self-care, going beyond disease and risky behaviours
- Opportunity to address the underlying and pervasive issues of gender inequality, social and cultural norms, respect and communication within relationships, that affect SRH and MH
- Opportunity to address critical issues affecting adolescents and young people, particularly early marriage, discontinuing education, participation in the informal workforce (linked with discontinuation of education), and GBV
- Opportunity to empower adolescents and youth with education on rights and entitlements, support communities to mobilize demand services for MH and SRH, and beyond
- Creation of peer support networks, transform attitudes of household decision makers and community influencers, to support and sustain healthy practices and attitudes towards MH and SRH
- Engender positive and supportive attitudes among frontline workers and health care providers across cadres who provide outreach and health services on a range of MH and SRH issues across the lifespan. Positive provider attitudes are particularly relevant for interventions geared towards meeting MH-SRH needs of adolescents and youth, unmarried people, persons with gender diverse identities, and those who are vulnerable owing to their social status (e.g., sex workers, incarcerated women)

Recommendations for the integration of MH and SRH

4

MH is a vital component of SRH, and is integral to "the continuum of sexual and reproductive health across the life course" (Wilson et al, 2021). Both MH and SRH have strong common determinants and shared outcomes, providing fertile ground to support and strengthen integrated programming, policy and research. Given the current state of siloed policy and program interventions for MH and SRH in India (and across the world), the case for integration must be made and demonstrated across domains of policy, implementation and evidence generation, using insights and successes from each of these domains to inform and strengthen action in others.

Integration of MH and SRH can take shape along a continuum, and within this continuum, can take a products and services approach or gender-transformative approach. A life course approach that supports integration of MH and SRH from puberty (and even before menarche, where possible) till menopause, is important to ensure health and wellbeing. India is well placed to support and champion MH-SRH integration, having a rich foundation of MH and SRH (including adolescent health) policy and programs, through public sector and NGO efforts. The table below presents opportunities to strengthen MH-SRH integration through ongoing Government of India initiatives across relevant sectors.

Figure 5: Framework for integration of MH and SRH in India

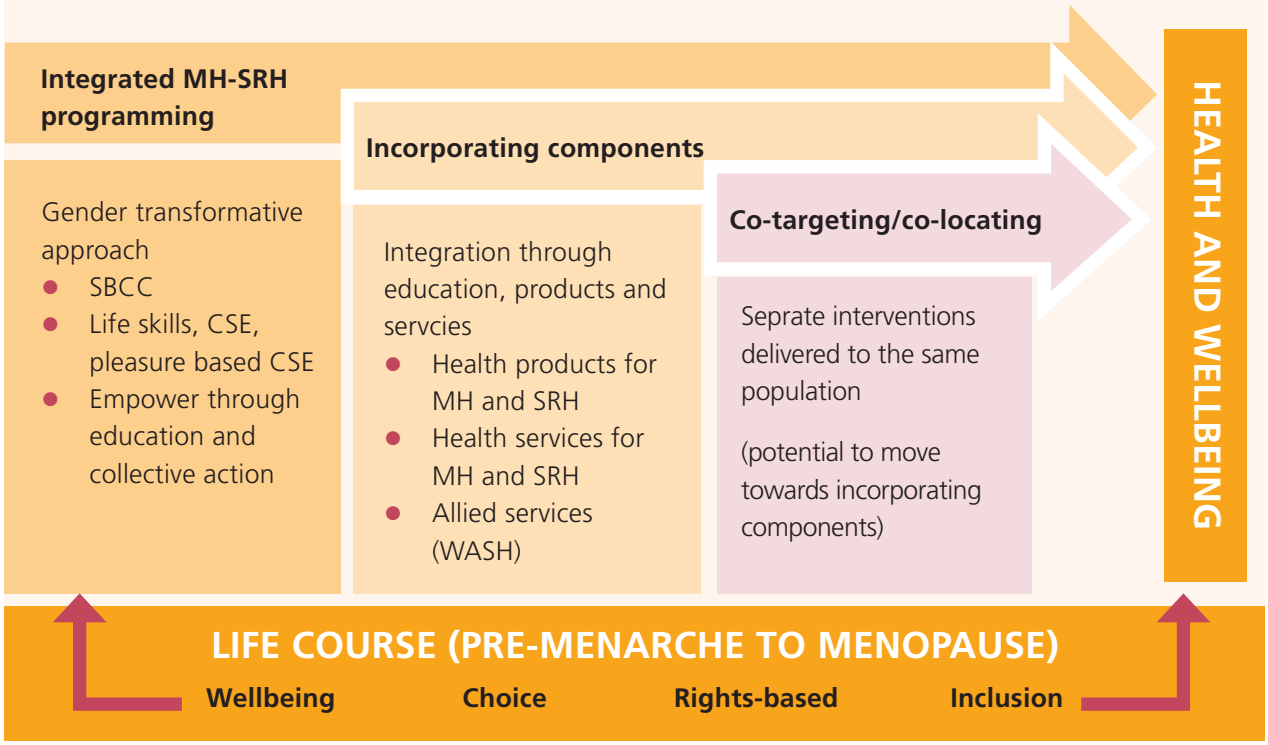


Table 3: Integration of MH-SRH in Government of India initiatives

Sector		Initiatives
Health Ministry of Health and Family Welfare	Adolescent Health	• Rashtriya Kishor Swasthya Karyakram • School Health and Wellness Program • Adolescent friendly health clinics • Weekly iron folic acid supplementation • Peer Education Program (*Saathiyas*)
	Family Planning	• Provision of contraceptives and family planning counselling (spacing and limiting methods, emergency contraceptives) • Mission Parivar Vikas • Antara Program (for injectable contraceptive MPA)
	Maternal health	• Comprehensive abortion care
	Other	• Kayakalp (improving WASH infrastructure in health care facilities)

Contd...

Table 3: Integration of MH-SRH in Government of India initiatives		
Sector		**Initiatives**
Nutrition Ministry of Women and Child Development	Nutrition	• POSHAN Abhiyan • Anganwadi services • Scheme for Adolescent girls
	Mission Shakti (empowerment)	• Beti Bachao Beti Padhao Scheme • Mahila Shakti Kendra Scheme
	Other	• Gender Budgeting
Education Ministry of Human Resource Development		• School Health and Wellness Program • MHM programs delivered through State initiatives
Water, sanitation and hygiene Ministry of Jal Shakti	Sanitation	• Swachh Bharat Mission- Grameen • Swachh Bharat Mission – Urban • Swachh Vidyalaya
	Water	• Jal Jeevan Mission
Rural Development Ministry of Rural Development		• National Rural Livelihoods Mission

We present five action areas to support integration of MH and SRH in the Indian context, relevant for Government and non-Government stakeholders.

Action area 1 Make the case for MH-SRH integration in policies, programs and research	**Action area 2** Collate and generate evidence for and demonstrate MH-SRH integration
Action area 3 Build understanding and capacities for MH-SRH integration at all levels	**Action area 4** Ensure a rights-based and inclusive approach to MH-SRH integration
Action area 5 Foster collaboration across organizations working on MH and SRH to support the above	

Action area 1: Make the case for MH-SRH integration in policies, programs and research

Integrating MH and SRH will bolster actions to meet goals related to health, empowerment, and rights.

- Outline linkages between SRH and MH, highlighting MH as a critical pathway to improving SRH across the life course from menarche to menopause

- Highlight common outcomes and goals, and build the narrative for health, wellbeing, gender equity, and human rights across the life course
- For programs that can support integration of MH and SRH, outline pathways for integration that are along a continuum, moving from separate programs to programs that reach common groups and communities (co-target and co-locate) to those that incorporate some elements of integration through products and services, to those that implement integrated programs where possible. A phased approach to integration may be taken
- Engage relevant stakeholders to collaboratively design integrated MH-SRH interventions. The linkages between programs implemented by different Government Departments can be emphasized, with recommendations for collaborative policy initiatives, program implementation and capacity building of relevant stakeholders
- Identify avenues for integration through existing initiatives for adolescent health, SRH, family planning and maternal health services, and other health services such as HIV testing, counselling and treatment, and cancer screening
- Identify and engender champions and leadership for MH-SRH integration, across sectors (e.g., health, nutrition, education, WASH, women empowerment and livelihoods) and stakeholder groups (i.e., Government, NGOs, donors, private sector)
- Ensure a rights-based and inclusion lens to integrated programming efforts, reaching those who are typically missed by routine services
- Identify and address weak areas of MH and SRH programming, particularly menstrual disorders, peri-menopause and menopause

Action area 2: Collate and generate evidence for and demonstrating MH-SRH integration

Evidence for MH-SRH integration can build the case for integration, bolster integrated policy and programming, and demonstrate the impact of an integrated approach.

- Support evidence generation on MH-SRH integration across the reproductive life span, and with different groups:
  - Programmatic illustrations of MH-SRH integrated programs
  - What works, with whom, and how
  - Scaling integrated programs, particularly through Government programs
  - Innovations/innovative approaches (e.g., pleasure-based sexuality education, digital health interventions)
  - Reaching vulnerable and marginalized groups with integrated and responsive programs
- Establish strong and joint monitoring mechanisms for MH-SRH integration:
  - Review and update core indicators for MH and SRH programs, and support the inclusion of MH related indicators in SRH surveys and studies, and SRH related indicators in MH focused research
    - Review and update monitoring information systems to incorporate relevant indicators for MH-SRH integration
    - Review and update health surveys to incorporate indicators in support of MH-SRH integration
  - Develop monitoring, assessment and evaluation frameworks that have common SRH and MH indicators and linked outcomes, and that support or make the case for integrated programming
- Disseminate promising approaches, research on SRH-MH integration with all relevant stakeholders across sectors that can support integrated programming

Action area 3: Build understanding of and capacities for MH-SRH integration across the life course at all levels

Enhancing capacities of all levels of stakeholders across relevant sectors can enable understanding of the potential and power of MH-SRH integration towards shared outcomes, as well as foster collaborations towards the achievement of common goals

- Strengthen the capacities of Government and NGO stakeholders at the national and state levels to integrate MH and SRH in policies and programs
  - Make the case for MH-SRH integration in meeting shared goals related to health and wellbeing, as well as educational attainment and gender equity
  - Strengthen the capacity of those engaged in program design to develop and provide operational guidance in support of integrated interventions
- Identify and articulate actions in allied sectors of education, nutrition and WASH that can support MH-SRH integration through sector specific efforts
- Build the capacities of frontline workers across development sectors to deliver interventions that integrate MH-SRH
  - Train frontline workers across relevant sectors addressing MH and SRH (e.g., health, nutrition, education, WASH, livelihoods, rural and urban development)
  - Plan for phased training that first increases understanding of the intersectionalities between MH and SRH, moving towards integrated delivery of interventions, particularly through existing channels for products and services
  - Support frontline workers with essential communication tools to support integrated efforts on ground
- Private sector:
  - Understand the role of the private sector in addressing integration (e.g., medical services for menstrual disorders like PCOS and endometriosis, as well as supporting women through peri-menopause and menopause)
- Donors
  - Educate the donor community on integrated MH-SRH programming, and the need for support to build, demonstrate, assess and share the results of such an approach

Action area 4: Ensure a rights-based and inclusion approach to MH-SRH integration

A rights-based and inclusion focus will enable policies and programs supporting MH-SRH integration to frame and implement interventions from a wellbeing lens (beyond treatment focus) and to leave no one behind

- Expand *services* and *products* to incorporate access to comprehensive information, choice, support (at the very minimum)
- Focus on the life span, moving from reproductive events to address MH-SRH integration from a health promotion and wellbeing perspective
- Identify and reach marginalized populations, communities in vulnerable circumstances, and hard to reach populations, using an integrated approach to address their needs in a comprehensive and responsive manner

Action area 5: Foster collaboration across organizations working on MH and SRH, and allied sectors to support the above

- Encourage dialogue and sharing across sectors – health, nutrition, WASH, education, empowerment, and livelihoods that address MH and/or SRH directly or indirectly
- Engage multi-sector stakeholders in evidence dissemination and advocacy efforts in support of MH-SRH integration

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