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Menstruation and Marginalization

Socio-cultural Barriers and Policy Failures Affecting Girls in Rural Kashmir

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Image Credit: Mukhtar Khan/AP



Sarah Sikandar is a Social Impact Design Fellow based in **Jammu and Kashmir** and is currently a third-year student with interests spanning literature, climate, policy, and creative expression. Her work brings together research and storytelling through engagements with ecological and feminist thought, poetry, fiction, and visual narratives.

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List of Abbreviations

ASHA - Accredited Social Health Activist
J&K - Jammu & Kashmir
MHS - Menstrual Health Scheme
NHM - National Health Mission
RKSK - Rashtriya Kishor Swasthya Karyakram
RTI - Reproductive Tract Infection

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Executive Summary

Menstrual health management (MHM) remains a significantly under-addressed and under-studied aspect of the well-being of adolescent girls in India, especially in conflict-affected and culturally conservative regions such as Kashmir, India. This mixed-method study examines the effect that socio-cultural taboos around menstruation have on adolescent girls, and the effectiveness and uptake of menstrual health schemes in rural Kashmir, with a focus on the district of Sopore. It is based on a structured questionnaire that was administered to 88 school-going girls aged 12–17 across three schools, alongside focus group discussions (FGDs) with students and key informant interviews (KIIs) with teachers. This study integrates quantitative and qualitative findings. Results indicate that the girls do demonstrate awareness of menstruation, but the persistence of cultural restrictions, taboos, medical mistrust and shame-based narratives continue to operate against them, and are compounded by the failure of implementation of government schemes. Sanitary pads and pain medication

available at the surveyed schools were funded by school budgets and individual teachers, and not by the Menstrual Hygiene Scheme (MHS) under the National Health Mission (NHM) or any other Kashmir-specific initiative. Notably, 62% of menstruating girls reported missing school due to their periods, 99% reported experiencing menstrual pain, and medicine was taken by fewer than 10% of girls due to medical mistrust perpetuated by family and community. The paper argues that treating MHM as a logistics problem, one that can be solved by product distribution alone, misreads the nature of the barriers that these girls face. Effective policy must engage with both the taboos and the governance failures that end up making these girls suffer.

Keywords: Menstruation, Menstrual Health Rural Kashmir, Menstrual Health Scheme, National Health Mission, Socio-Cultural Barriers, Policy Failures, Adolescent Girls

1. Introduction and Literature Review

Menstruation is a physiological process experienced by roughly half the world's population for a significant portion of their lives, yet remains one of the most under-addressed areas of public health in the world, especially in the Global South. A recent study on India by the United Nations International Children's Emergency Fund (UNICEF, n.d.a:) reveals that half of the adolescent girls in India cannot afford sanitary napkins during menstruation. This statistic is especially concerning when we consider the fact that India is home to 20% of the world's menstruating adolescents (Omidvar, 2018). Still, menstrual health management (MHM) in India is ridden with shame, socio-cultural taboos, infrastructural poverty, and policy failures. This is particularly acute in India's rural and conflict-affected regions. The Union Territory of Jammu and Kashmir, and Sopore district within it, offers a unique case study in which cultural conservatism, a history of conflict and geographic isolation compound the barriers that adolescent girls face in managing their menstruation.

1.1 Global and Indian Context of Menstrual Health Management

The evidence base on menstrual health in low-and-middle-income countries has grown considerably since the early 2000s. Sumpter and Torondel's (2013) systematic review of MHM interventions identified the consequences of inadequate MHM support resulting in an increase in school absenteeism, restricted mobility and the continued use of unhygienic materials leading to reproductive tract infections (RTIs). The review found that infrastructural provision, such as washrooms and disposal facilities, while necessary, remained insufficient without accompanying shifts in social norms. Mahon and Fernandes (2010) situate MHM within the broader WASH (water, sanitation, and hygiene) governance framework, arguing that menstruation's exclusion from mainstream WASH policy reflects its gendering as a private, female problem rather than a public health obligation. This framing has direct implications for scheme design. In the Indian context, the National Family

Health Survey data have documented low sanitary pad use, high rates of school absenteeism during menstruation, restricted mobility and widespread reliance on cloth among rural adolescents (Sharma, 2020; Garg & Anand, 2015).

Sharma's (2020) national assessment found that while sanitary pad availability had improved in some states following the NHM's Menstrual Hygiene Scheme, disposal infrastructure and washroom quality remained inadequate. Garg and Anand (2015) identified culturally transmitted beliefs including those around dietary restrictions, mobility, prayer and contact taboos, and identified these as primary drivers of shame and concealment. Their findings in North Indian contexts are relevant to the Kashmir valley's socio-cultural geography.

Chaliawala's (2023) narrative review of MHM interventions concluded that multi-component interventions that combine education, product provision and infrastructure are significantly more effective than product-only schemes. Yet the dominant design of Indian government schemes remains product-centric, a gap that this study's field data corroborates. Achuthan's (2025) study extends this critique further by arguing that the discourse of "pad distribution" depoliticizes menstrual health by positioning it as a consumer access problem rather than a structural gender justice issue.

1.2 Socio-Cultural Barriers: Shame, Silence, Restriction and Taboos

Menstruation in South Asian rural contexts is widely governed by taboos restricting menstruating girls from entering kitchens, places of worship, public spaces and from physical activity including running (Ramesh, 2022; Garg & Anand, 2015). These restrictions are typically inherited because of maternal figures and reinforced by the communities, which makes it harder to change in a school or educational setting. Ramesh's (2022) study of taboos and

stigma reveals the intergenerational character of these norms, and notes that daughters frequently observe restrictions their mothers or family place on them. These restrictions are often devoid of any scientific knowledge or basis but are still upheld out of social obligation.

Scales' (2019) study on socio-cultural norms and menstruation in rural Jamkhed, Maharashtra found that while younger women expressed greater scepticism toward these restrictions, they still complied due to the existing hierarchy within the household. Adiga's (2021) work in Kashmir identified the amalgamation of broader South Asian menstrual taboos and regional religious conservatism, produced such an environment in which access to menstrual health information and support was curtailed.

Medical mistrust also plays a role in limiting the access to menstrual management. Several studies have noted that the persistence of beliefs transmitted through family and communities regarding the pain-relieving medication used during menstruation limits their usage. Some beliefs include that uptake of this medication may cause long-term reproductive harm, including infertility or organ damage (Garg & Anand, 2015; Ramesh, 2022). This mistrust reflects a broader deficit in health communication between communities and health systems.

1.3 Scheme Architecture and Implementation Failure

The Menstrual Hygiene Scheme, launched under the NHM, aims to provide subsidised or free sanitary napkins to rural adolescent girls through ASHA workers, who are meant to serve

as community health intermediaries. However, its reach has been highly uneven. Implementation varies significantly by local administrative capacity, political priority, geographical location and the social standing of individual ASHA workers within their communities (Mahon & Fernandes, 2010; Sharma, 2020).

Kashmir-specific and centrally adapted schemes face additional barriers like the history of conflict and the disruption caused by it, and a historically strained relationship between communities and institutions. In this context, a school can be aware that pads are available through NHM channels while receiving nothing, and this is exactly what this study's data shows. The gap between scheme awareness and actual scheme uptake is what is important here, and this gap remains under-examined in literature.

This paper asks: to what extent do socio-cultural norms around menstruation affect the adolescent girls, and what is the reach and effectiveness of menstrual health schemes in rural Kashmir? It pursues two objectives. The first is to examine the socio-cultural beliefs and practices surrounding menstruation among adolescent girls in rural Kashmir, and their impact on access to and use of menstrual hygiene products and facilities. The second is to assess the implementation and uptake of existing menstrual health schemes, including the Menstrual Hygiene Scheme under the National Health Mission and Kashmir-specific initiatives, and to identify the barriers limiting their effectiveness.

2. Methodology

2.1 Research Design

The study uses a mixed-methods design, integrating quantitative data from structured questionnaires with qualitative data from focus group discussions (FGDs) and key informant interviews (KIIs). The approach follows a convergent triangulation model (Creswell & Plano Clark, 2017), in which the two strands are collected and analysed independently before being brought together at the interpretation stage. The design was chosen because the research questions require both the reach that 88 respondents can provide and the interpretive depth that qualitative methods provide, especially for understanding how the socio-cultural norms operate in practice and what girls' experiences actually looks like.

The study is grounded in the feminist research ethic of the author that treats adolescent girls not only as sources of data but as important stakeholders in the study, their accounts of their experiences constituting primary evidence for the study. Methodological choices, including use of local languages during the questionnaire and focus group discussions (FDGs) and the option to skip any question, along with absence of teachers or male students, were designed to minimise coercion and compliance.

2.2 Study Site and Sampling

Fieldwork was conducted across three schools in Sopore, a town in Baramulla district in the Kashmir valley. Sopore was selected for its predominantly rural population and research access. A total of

Table 1. Sample Demographics

Characteristic	#	Detail
Total Respondents	88	Aged 12-17
Active Menstruators	73	Used as denominator for menstruation specific %
Not Menstruating Yet	15	Retained in dataset, excluded from % calculations
Age Distribution (Q1)	—	"12 (n=3), 13 (n=21), 14 (n=29), 15 (n=27), 16(n=4), 17 (n=4)"
Village/Area (Q2)	—	12 villages; Wadura (n=42) largest single cluster
Mean Age at Menarche (Q3)	13	Modal age 13 (n=37 of 73)

Table 2. Cross-School Comparison of Staffing, Infrastructure, ASHA Worker Visit and Scheme Delivery

School	Female Teachers	Incinerator	Dustbin w/ lid	ASHA Worker Visit	Scheme Supply
School 1	2	Installed, non-functional	No	Never	Once in 3 years
School 2	2	None	No	Never	None
School 3	5	Installed, non-functional	Yes	Once (upon request)	None

88 school-going girls aged 12-17 participated. Participants were picked across the three schools using purposive sampling, targeting the age group most likely to have experienced menarche and to have engaged with school-based MHM provisions. Of the 88 respondents, 15 had not yet begun menstruating at the time of data collection. Their responses are retained in the dataset and reported where relevant but excluded from menstruation-specific percentage calculations which gives an active menstruator base of $n = 73$. Table 1 summarises the sample.

The three schools varied in size, female teacher staffing, student quantity and infrastructure quality, providing useful comparative variation within the qualitative strand. The first and the third schools were government schools, and the second school was a government-aided school. Table 2 summarises the variation.

2.3 Data Collection Instruments

The primary quantitative instrument was a structured questionnaire of 28 items, including open-ended reflection questions, organised into six thematic sections: demographic information; first period and early knowledge; support and communication; cultural restrictions; school experience; and product access. Questions draw on binary, multiple-choice, select-all-that-apply, and short open-answer formats. The questionnaire was designed by the researcher and administered in English, Kashmiri and Urdu. Two FGDs were conducted in each school: one with student groups, and one with female teachers. Both followed semi-structured guides covering peer communication habits, responses to unexpected menstruation at school, use of available pads and medicine, infrastructure adequacy, and the impact of female teacher scarcity. KIs with teachers focused on scheme uptake, ASHA worker engagement, training, and staffing.

2.4 Data Analysis

Quantitative data were analysed using descriptive statistics (frequencies and percentages) computed manually and verified across both the

$n = 88$ total and $n = 73$ active menstruator sub-samples.

Cross-tabulations were used where relevant, including to examine the relationship between washroom infrastructure and pad-changing behaviour.

Qualitative data from FGDs and KIs were analysed using Braun and Clarke's (2006) six-phase thematic analysis framework: familiarisation; initial coding; theme searching; theme review; theme definition and naming; and write-up. Codes were generated inductively and analysis was conducted manually. Five themes emerged and are reported in the Results section.

2.5 Integration and Triangulation

Quantitative and qualitative findings were integrated at the interpretation stage following the convergent triangulation logic. For instance, where high rates of reported pain align with FGD accounts of medication refusal is treated as mutually reinforcing evidence. Where they complicate each other, the divergence is treated as analytically significant and foregrounded in the Discussion section. The clearest example of this is the finding that 100% of schools reported pad availability, which sits against qualitative evidence that provision is self-funded by teachers rather than delivered through any government scheme.

Ethics

Verbal informed consent was obtained from all participants before data collection, along with written consent obtained separately. Participants were told the study was conducted by an Social Policy Research Foundation (SPRF) Fellow, that their names would not appear in any output, and that they could decline to answer any question at any moment during the questioning. Given participants' ages, school principals and teachers were briefed and institutional consent obtained prior to questioning. Data is stored securely and anonymised throughout. The study received no funding from any government or scheme-linked body and ensures independence of analysis.

3. Results

The results are presented in two parts corresponding to the study's two objectives, followed by the qualitative themes from FGD and KII analysis. Unless otherwise noted, percentages for menstruation-specific variables are calculated against the active menstruator base of $n = 73$. Table 3 summarises the key quantitative findings before the detailed discussion below.

3.1 Objective 1: Socio-Cultural Beliefs and Their Impact on MHM

Most participants encountered their first menstruation without prior knowledge: 54.8% ($n = 40$ of 73). Among those who did, the source was either the mother (12 of 88 total respondents), other relatives such as cousins or aunts (12), friends (12), and sisters (10). Only two respondents cited a teacher, which suggests that formal school-based menstrual health education has not functioned as an information channel for these girls at all. The emotional experience of first menstruation was predominantly negative: 52.1% (38 of 73) reported feeling scared, 19 felt confused, 8 felt nervous, and 4 felt ashamed. Only 4 reported feeling normal. This reflects the absence of normalising discourse around preparing girls that have yet to menstruate for their first period. The emotional experience of

first menstruation was predominantly negative, with fear as the dominant response, as shown in Figure 1.

Cultural restrictions are widely observed. Of the 73 active menstruators, 44 (60.3%) reported always following restrictions, 25 sometimes, and only 4 never. The most commonly cited restrictions involved mobility and physical activity (53 respondents) particularly running and playing, and food, specifically avoidance of curd and tangy foods (35 respondents). Ten respondents listed school attendance itself as a restriction, which can have a significant impact on their education. This is summarised in Figure 2.

Personal avoidances beyond family-prescribed restrictions were the same categories: mobility (35 responses), food (19 responses), with 11 respondents reporting no personal avoidances. This suggests that culturally transmitted restrictions have been internalised as personal preference or habit. This is consistent with Ramesh's (2022) findings on the normalisation of taboo compliance.

Pain is pervasive in this sample. 99% (72 of 73) reported experiencing pain during their period.

Table 3. Summary of Key Quantitative Findings

Finding	Value	Base
No prior knowledge before first period	54.80%	$n=73$
Felt scared at first period	52.10%	$n=73$
Always follows cultural restrictions	60.30%	$n=73$
Experiences pain during menstruation	99%	$n=73$
Ever takes available pain medication	10.20%	$n=88$
Missed school due to menstruation	~57%	$n=73$
Aware pads/medicine available at school	100%	$n=88$
Aware of a government scheme	~99%	$n=73$
Schools that received regular scheme supply	0 of 3	School level
Comfortable asking a male teacher for help	0%	$n=73$

Figure 1. Emotional Response at First Menstruation

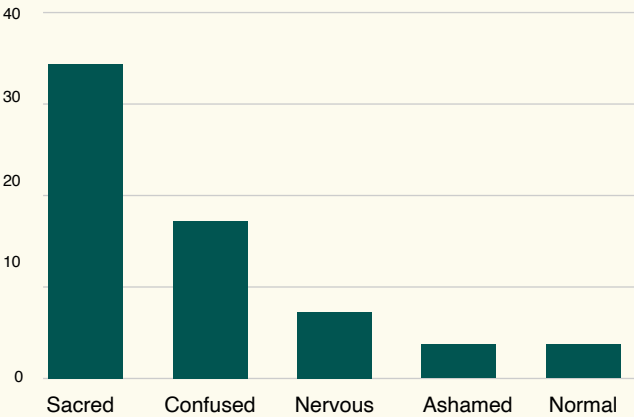


Figure 2. Most Commonly Cited Menstrual Restrictions

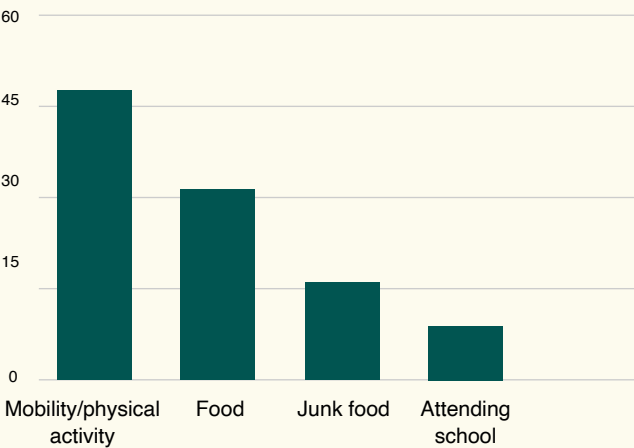
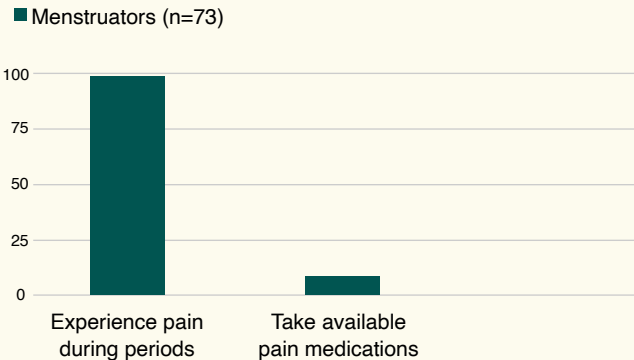


Figure 3. Pain Prevalence vs. Pain Medication Uptake



Despite this, only 9 of 88 respondents (10.2%) reported ever taking prescribed pain medication, and only when pain had become unbearable (shown in Figure 3) . FGD data provided further context: families have transmitted beliefs that pain medication damages reproductive organs, causes disease and infertility, leading girls to refuse medication that is available to them at school. The 100% medicine availability figure from the questionnaire data, then, is misleading on its own. There is availability but without uptake, and it is driven by inherited medical mistrust rather than failure of access.

Communication patterns within the home included 44 respondents reporting that they could talk to their mother; 28 to a sister; 10 to other relatives (aunt/cousin); 15 to no one. Outside the home, 72 could talk to friends, and 5 to both friends and classmates. Only 1 reported comfort with a teacher, and 12 reported nobody. FGD data complicated this: while girls reported being open

with close friends, these conversations were reported to be shallow. The girls noted that they discuss who has or hasn't started menstruating but don't exchange any important knowledge because their peers know as little as they do. Openness, in this context, does not lead to information access.

Shame is mediated by both the culture and the structure. Girls' reluctance to seek help is a product of internalised shame, and the absence of female teachers that could help correct this. Several FGD participants noted they would be comfortable asking for help only from a female teacher, and that they would never ask a male teacher This reflects the cultural norm against discussing menstruation with men is real and embedded into the social fabric of rural society, it is a barrier for the girls and can be managed by either normalising discussing it with males or by making better staffing decisions that accounted for the comfort of the girls.

3.2 Objective 2: Scheme Implementation and Structural Barriers

The gap between scheme presence and actual scheme delivery is the defining finding of this study. All 88 respondents reported that sanitary pads and pain medication are available at their schools. These figures might suggest functioning scheme delivery, but FGD and KII data confirm otherwise; The pads and medicine across all three schools are purchased using school funds

or, frequently, from the teachers' own pockets. No school in the sample received regular supply through the Menstrual Hygiene Scheme or any other government programme. The first school reported receiving government supplies once in the past three years and was required to collect them themselves rather than receiving delivery at school. An incinerator was installed in 2023 but has never been made operational: teachers received no training on its use, and electricity supply issues remain unresolved. There was no follow-up to check the working of the incinerator. The second school received no materials from any scheme whatsoever. The third similarly received nothing; an incinerator was installed but rendered non-functional because teachers were told it required a specific type of pad for disposal, and those pads that were never provided.

The only ASHA worker visits across all three schools occurred in the third school, following a direct request from the headmaster, while no visit was done in any school on their own accord. Teachers at all three schools described purchasing pads and medicine independently as a practice that has become the norm, because scheme delivery has never been reliable. Inherited medical mistrust restricts menstrual pain management. The refusal of pain medication is a product of culturally transmitted narratives, and the persistence of these narratives reflect the absence of any trusted, credible health communication from a formal source.

ASHA workers are the intended delivery mechanism for the MHS, yet none of the three schools had experienced regular visits. This removes the bridge that is supposed to be at the community level and so the narratives of medical mistrust remain.

Infrastructure findings further compound this issue. All three schools have separate washrooms for girls, but girls from two schools reported that washrooms were also being used by boys or teachers, and were too dirty to use, and were also insufficient in number. Two of the three schools don't have dustbins in the washrooms, which prevents pad disposal and, consequently,

pad changing at school. 43% of the respondents reported being unable to change pads during the school day and waiting until they returned home. A delay of several hours reportedly made the respondents feel uncomfortable and made them worry about leakage. The 50 respondents who could change at school concentrated in the one school which had dustbins.

Additionally, female teacher scarcity is both a structural and a cultural barrier. Girls across all three schools reported refusing to ask male teachers for pads, permission to go home, permission to go to the washroom or any menstruation-related assistance. With only 09 female teachers across the three surveyed schools shows the limited support available for the girls. FGD discussions also reported that when female teachers are absent, girls manage independently or through peers, waiting for classes to end rather than disrupting them. They reported feeling discomfort with asking male teachers and afraid of drawing attention from male classmates, who they were afraid would make fun of them.

The argument here is that schemes, even when they are present, fail because they engage only with the logistical part of menstrual health: the supplying of pads, installation of incinerators or the provision of pain-relieving medications without addressing the social conditions that determine whether those supplies are ever accessed. In Sopore, the data revealed that pads available at schools are purchased by schools themselves or by individual teachers out of pocket. Incinerators for disposal of the pads have been installed but have never been made operational. The ASHA workers that are supposed to educate the girls on menstruation are entirely absent from the educational sphere. All these failures reinforce socio-cultural taboos because they remove any pressure that could be placed on the taboos to change, an ASHA worker could change the beliefs of so many girls, incinerators and proper dustbins would reduce the shame the girls face around disposal.

4. Discussion

The findings present a picture of compound failure: socio-cultural norms restricting the mobility, communication, and diets of the menstruating girls along with persistence of pain due to medical mistrust, the schools bearing the cost of what the schemes were designed to provide. The theoretical contribution of this paper lies in showing that these two categories of barriers, cultural and administrative, are not independent of each other but are mutually reinforcing. Female teacher scarcity makes cultural shame an obstacle that cannot be overcome by schools, because the people that would help to change the beliefs of the girls are not present in the quantity that they require.

Non-functional incinerators and the absence of dustbins lead to uncomfortable school days for the menstruating girls. Absent ASHA workers leave the inherited medical misinformation unchallenged. Policies that addresses only one side of this problem won't produce meaningful change.

4.1 Scheme Awareness Does Not Equal Scheme Reach

One of the study's most important findings is the gap between awareness of schemes and actual delivery. Teachers across all three schools knew that government menstrual health provisions exist, yet not a single school received regular supply through the MHS or any Kashmir-specific programme. The point isn't whether girls or the teachers know that pads are supposed to be available, but whether they are receiving them, and receiving them regularly, and in the quantities required through the designated government channels. And on that measure, the MHS in this sample has a reach of zero.

This aligns with Mahon and Fernandes' (2010) critique of WASH governance as structurally deprioritising menstrual health, and with Sharma's (2020) documentation of uneven NHM implementation. But the data from these schools adds something more: the gap here of scheme delivery is filled by informal school-level

measures. When teachers spend their own money on pads, they are absorbing a cost the state has formally committed to bearing. This substitution doesn't show up in scheme monitoring data, and that itself part of the problem. Without the key informant interviews (KIIs) and focus discussion groups (FDGs) the 100% pad availability figure alone would have made it look like the scheme was working perfectly.

4.2 Cultural Barriers Operate Through Structures, Not Only Attitudes

A common policy response to cultural MHM barriers is the assumption being that disseminating accurate information will weaken restrictive norms over time. The peer communication data collected in this study complicated that assumption. The girls in this sample are not opposed to communication, 82% report talking freely to friends about their periods. The barrier, then, is depth of information. Girls talk openly, but within a ceiling of knowledge that is itself a product of inadequate education and absent health worker engagement. Education and awareness delivered to girls in isolation can raise that ceiling, but it requires intermediaries such as female teachers and ASHA workers to disseminate accurate information into the community, and to the girls.

The female teacher scarcity finding matters here in particular. School staffing decisions aren't usually made with menstrual health of the students in mind, but this study shows that they function as such. The ratio of female teachers to female students directly determines whether cultural norms against seeking help from male teachers are made into real barriers for the girls or not. Two female teachers in a school of some fifty girls is not an environment that supports menstrual health, regardless of what supply is in place. The girls, then have to rely on other girls, or are left with no support. Teacher gender ratio needs to be incorporated into MHM policy frameworks as a structural determinant.

4.3 Medical Mistrust as a Distinct Policy Challenge

The finding that only 9 of 73 active menstruators take available pain medication, and that too when in unbearable pain, despite 99% experiencing pain and all schools providing medicine, is something that hasn't received enough attention in the Indian MHM literature. This is despite pain medication being a standard, guideline-recommended first-line treatment for adolescent menstrual pain elsewhere (Wall et al., 2025), underscoring that the barrier in Sopore is not clinical appropriateness but inherited mistrust. The belief that menstrual pain medication causes damage to the reproductive organs or even infertility is a targeted, gender-specific health narrative with real consequences on the wellbeing and school attendance of girls.

This mistrust and misinformation persist because no trusted authority has ever challenged it in these communities. ASHA workers would be the most natural channel for education because they have credibility and required reproductive health education. Their absence has consequences that go well beyond pad distribution and into medicine uptake and pain management. The 57% absenteeism rate to schools linked to menstrual pain was reported. A comparable study of rural adolescent girls in Pune found an absenteeism rate of 43.2% (Bodat et al., 2013), placing Sopore's 57% notably higher.

4.4 The Problem of Infrastructure

The washroom and disposal data illustrate what Ramesh (2022) and others have described as the feminisation of hygiene failure: the costs of inadequate public infrastructure fall disproportionately on girls. Girls can't change

pads at school because there are no disposal facilities and so they have to wait hours in discomfort, and risk exposing themselves to an increase in developing hygiene-related diseases. The fact that the one school with functional infrastructure showed higher rates of pad changing in school and comfortability makes the point that infrastructure is a very important determinant in MHM outcomes.

The incinerator findings are also worth dwelling on. In both schools where incinerators were installed, the equipment was rendered non-functional because of administrative failures. There was no training, incorrect installation, no consideration of electricity availability, no supply of the pad type needed, and all of this had nothing to do with girls' behaviour or cultural attitudes. Money was spent and infrastructure was installed, but the outcomes remained zero. Without follow-up or monitoring, scheme investment produces the appearance of compliance without any real benefit.

4.5 Limitations

Several limitations need to be acknowledged. The sample is confined to three schools in one district and can't be taken as representative of Kashmir as a whole. The absence of a control group or comparative district data limits causal inference. FGD data, while rich, reflects group dynamics that may have suppressed minority views. The researcher's positioning as an outsider may have shaped what participants were comfortable disclosing, despite efforts to establish rapport and ensure confidentiality. Finally, self-reported data on restriction compliance and scheme awareness may reflect social desirability instead of actual behaviour.

5. Policy Recommendations

The following recommendations are directed at the government of Jammu and Kashmir, the NHM's UT unit, school administration authorities, and district health offices. These recommendations are grounded directly in the findings of this study and address both the cultural and administrative dimensions of MHM failure documented above.

5.1 Mandate and Monitor Actual Scheme Delivery

The most urgent and the most important recommendation is a monitoring mechanism that tracks actual pad delivery to schools and on a regular schedule. Performance indicators need to shift from expenditure or installation records to confirmed uptake by the users. In Sopore, an immediate audit of which schools are self-funding MHM provisions, and at what cost, would reveal the true extent of under-delivery and provide the evidence base for remediation. This would make sure the cost is borne by the ones supposed to bear it and not the schoolteachers.

5.2 Make Sure Existing Infrastructure is Operational

Non-functional incinerators should be audited across all government schools in the district. Repair and operational training for school staff should come before any new infrastructure investment. The pattern of installation without operation documented in this study wastes public funds. Lidded dustbins should be installed as a minimum standard in all girls' washrooms where incineration isn't available to make sure the girls can comfortably change pads at school and not have to wait hours in discomfort to change.

5.3 Increase the Amount of Female Teachers Present

A minimum ratio of one female teacher per 30 female students is recommended as a starting

benchmark, framed within the broader National Education Policy commitments to gender-sensitive school environments. Similar teacher recruitment and deployment should incorporate female teacher ratios as a criterion, on the basis that female teacher presence is a determinant of girls' access to menstrual health support.

5.4 Activate and Train ASHA Workers for School-Based MHM Outreach

ASHA workers should be given a mandate for regular school visits. There should be a minimum of one visit per academic term covering menstrual health education, de-stigmatisation education, health awareness and pad distribution. Training should include evidence-based and age-appropriate messaging on menstrual pain management to directly counter the harmful narratives documented in this study. School engagement should be incorporated into ASHA performance incentive structures as a deliverable.

5.5 Integrate Menstrual Health into School Curricula

Menstrual health should be a mandatory, recurrent component of health and science curriculum at upper primary and secondary level, delivered by trained female teachers or health workers. Content should address female physiology, hygiene management, the safety of pain medication, and the cultural context of restrictions. All of this would work to validate the girls' experiences while providing accurate information. Additionally, engagement sessions with parents delivered through school events to address the transmission of misinformation in households could also prove to be really beneficial.

6. Conclusion

This study asked how far socio-cultural norms around menstruation shape access to menstrual health support in rural Kashmir. The answer, on the evidence from Sopore district, complicates the standard answer. The standard framing treats socio-cultural norms as the primary obstacles to menstrual health, and scheme delivery as the answer. This study's data suggests the causality runs the other way. In the schools studied here, schemes have not reached girls. The barriers girls face is not a consequence of cultural attitudes preventing them from using what the state provides. They are a consequence of the state not providing it.

Three findings stand out. The most fundamental is the gap between scheme awareness and scheme receipt. There was full awareness of the existence of government schemes but with zero delivery of what was promised in the scheme which reveals that awareness-based indicators are an unreliable proxy for coverage. Second, the female teacher scarcity finding reframes staffing as a health infrastructure question: cultural norms against seeking help from male teachers translate into access barriers only because staffing decisions have not accounted for them. And

because no trusted health intermediary fills the resulting educational gap, the third finding follows almost inevitably: inherited misinformation about pain medication goes unchallenged, and girls endure pain that available medicine could treat.

What this adds up to is a fundamental problem with scheme design, not just scheme delivery. The supply-side, product-centric model that has dominated scheme design spends money and produces no outcomes and installs equipment without function. An effective alternative doesn't require new schemes so much as it requires treating the existing ones as real commitments rather than completed expenditures.

The girls in this study navigate menstruation with fear, shame, nervousness and discomfort, but also with resourcefulness, and largely without institutional support. They borrow pads from friends, wait hours to change, miss school during pain and will not medicate, and continue to carry restrictions whose basis many of them privately question. They deserve more than a scheme that exists on paper.

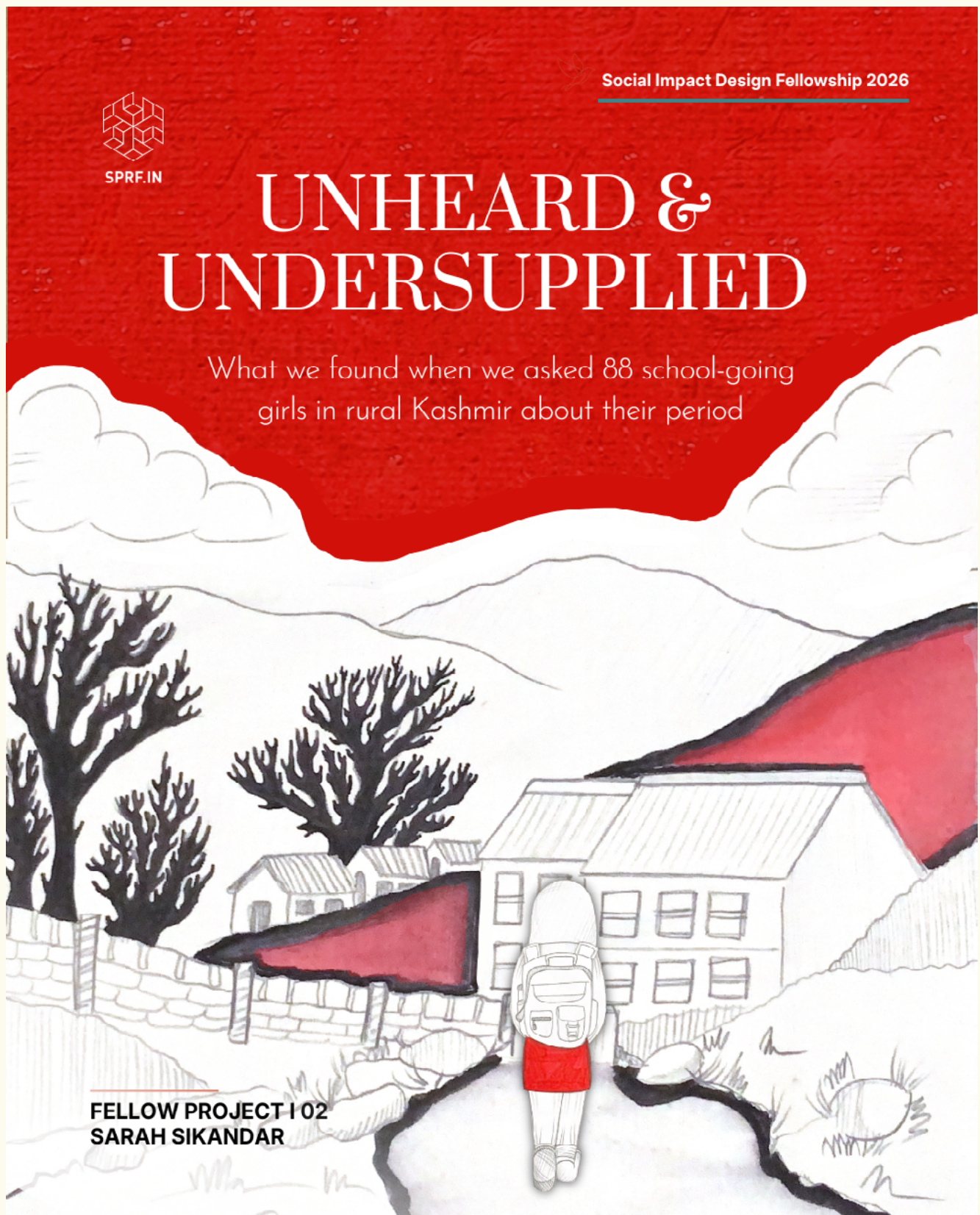
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8. Design Applications



This is the world **Zainab** lives in. She's 13 and a seventh grade student from the village Wadura in Sopore (a town in rural Kashmir) where the nearest hospital can be an hour away and the nearest conversation about menstruation, further still.

Every day, Zainab walks a few miles to school to study her favorite subjects and play with her friends. She studies in one of the three schools we surveyed.

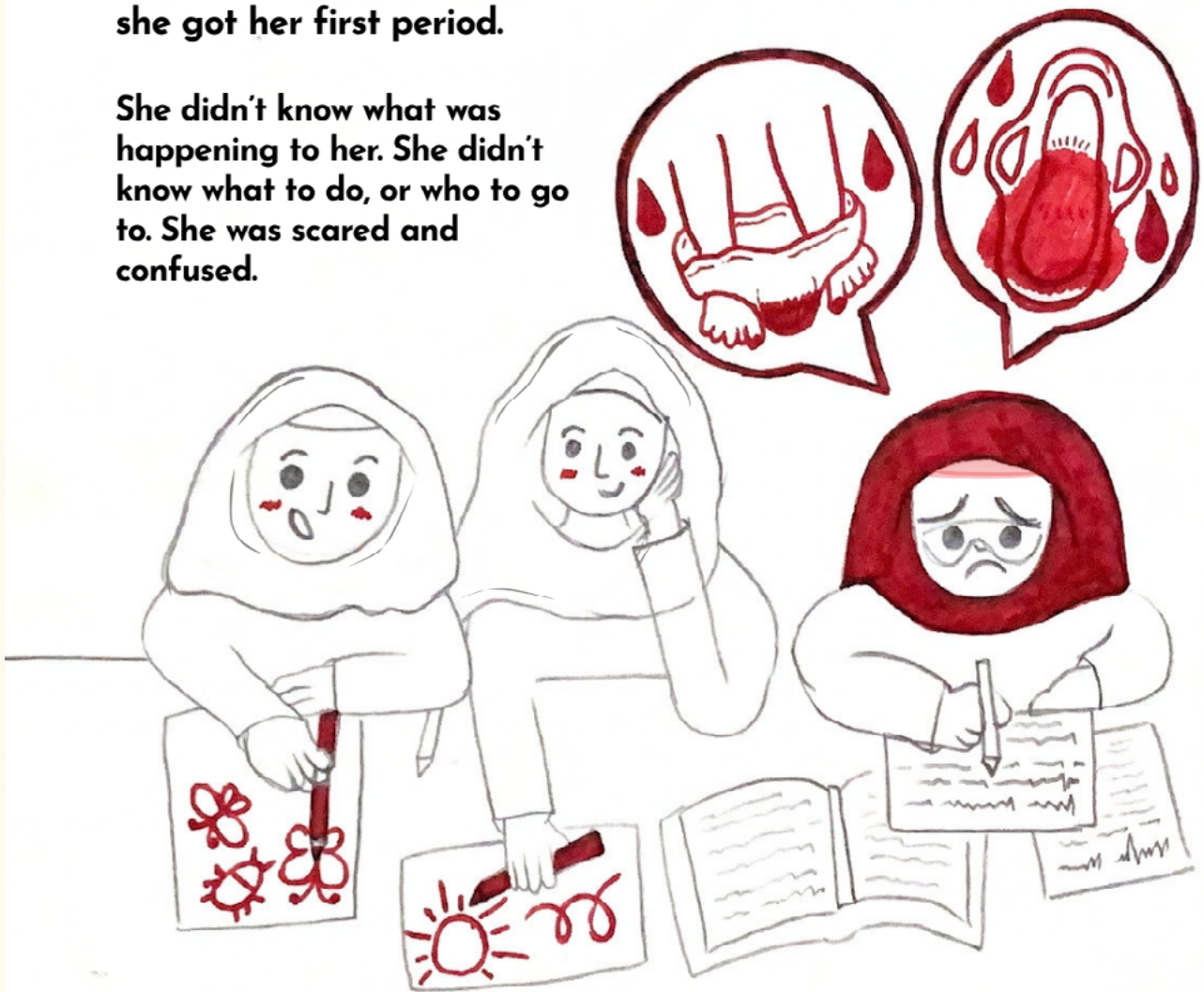
We spoke to 88 girls like her, aged 12 to 17, across schools in Sopore. This is the world they live in.





Zainab was at school when she got her first period.

She didn't know what was happening to her. She didn't know what to do, or who to go to. She was scared and confused.



Zainab was not alone in the experience. **More than half of the girls we spoke to had never heard of menstruation before it happened to them.** Nobody had told them what to do, what to expect and who to go to, when it first arrived.

By evening, someone will tell her what not to do.

***No running. No playing. No curd. No tangy food.
No school, sometimes.***

Zainab stopped playing with her friends. She wasn't the only one. **53 girls told us running and playing was the first thing they gave up, because they were told to. With their periods arrived not only pain, but restrictions. 60% of the girls said they always followed these restrictions, even if they didn't know why.**

Zainab lays in bed watching her friends play, unable to join them





The pain sets in at school the next day. The school has pain-relieving medicine for it. Zainab refuses to take it. Her family had told her it would make her infertile, that it would cause diseases and damage something inside her that she needed later. So, she sits with the pain instead.

99% of the girls experienced pain during their period. Only 1 in 10 takes medicine, that too only once the pain becomes unbearable.



There's nowhere to put it!

The pain wasn't the only thing Zainab carried throughout the day. Two of the three schools we visited had no dustbins for pads. So, she waited hours and hours, held on and sat in discomfort every class, making sure she looked okay. She bore the distress until school finally ended and she could go home and change.

A dustbin sounds like a small thing, but for Zainab, it was the difference between a normal day and an unbearable one.



The Scheme that isn't there

Zainab's school had pads and medicine. Neither of which came from where it was supposed to.

All three schools had pads and medicine. What the teachers told us was shocking: **not one pad or a tablet had come from a government scheme.**

SCHEME PROMISE

Subsidised Pads

ASHA Worker Visit

Safe Disposal

SCHOOL REALITY

Pads bought by
teachers

No ASHA Workers Visit

No Dustbins

what a
teacher said:

“if they could get the
girls what they need each
month.”

Zainab and her classmates tell us what would help

“ if the school had separate washrooms ”

“ If pads were available at home as easily. ”

“ If there was a resting room in school. ”

“ if the dustbin was in washroom. ”

“ if i could change pads in school ”

“ IF I COULD TAKE MEDICINE FOR PAIN ”

Zainab is a composite, drawn from the accounts of the 88 girls. Her story is theirs.

Ask your local school if they've recieved MHM supplies this year.

Ask if the incinerator, if there is one, actually works.

And most importantly, ask the girls what they need.



