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Perception And Misconception Of Menstrual Hygiene Practices Among Scheduled Caste Adolescent Girls In Cuddalore District Tamil Nadu

[1]Anitha. A* and Maheswari. K**

[1] *Research Scholar, **Supervisor, Department of Population Studies, Annamalai University-Mail id-anithaganesh1704@gmail.com

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Abstract

Menstrual hygiene management (MHM) is essential for adolescent health, especially in marginalized communities. This study examines the perceptions and misconceptions of menstrual hygiene among Scheduled Caste (SC) adolescent girls in Cuddalore district, Tamil Nadu, involving 467 participants from rural and urban areas. The findings reveal significant socio-cultural taboos and economic barriers, with only 30% using sanitary pads, while many relied on cloth or unhygienic alternatives. Additionally, 60% of respondents held misconceptions associating menstruation with impurity and shame. These insights highlight the urgent need for targeted interventions focused on education and improving access to menstrual hygiene products to promote health equity among SC adolescent girls.

Introduction

Menstrual hygiene is a vital component of personal health and well-being, particularly for adolescent girls, as it significantly impacts their reproductive health. Despite its importance, the topic of menstruation often remains surrounded by stigma and silence in India, where cultural norms and taboos inhibit open discussion and foster negative perceptions. Adolescent girls frequently encounter unique challenges during menarche, often lacking the necessary knowledge, resources, and support.

For the Scheduled Caste (SC) community, which has historically faced socio-economic marginalization, accessing menstrual hygiene management (MHM) resources presents additional difficulties. This issue is especially pronounced in rural areas such as the Cuddalore district in Tamil Nadu, where entrenched cultural practices, economic struggles, and inadequate infrastructure converge to create substantial barriers. Understanding the perceptions and misconceptions surrounding menstrual hygiene among SC adolescent girls is crucial for addressing health inequities and promoting sustainable development in these communities.

Menstruation, a natural biological process experienced by every girl during adolescence, continues to be stigmatized and misunderstood in various regions, including India. While crucial for the health of adolescent girls, poor menstrual hygiene practices can lead to serious physical and psychological health issues. In many parts of India, menstruation remains a culturally sensitive issue, particularly among marginalized communities like the Scheduled Castes.

In Cuddalore district, where a significant population of Scheduled Caste communities resides, access to basic health facilities, education, and sanitation infrastructure is often limited of awareness regarding menstrual hygiene, coupled with ingrained cultural taboos and misconceptions, perpetuates unhealthy practices. For instance, menstruation is frequently deemed a "dirty" or "impure" event, leading to feelings of shame and secrecy among young girls. These misconceptions can obstruct their ability to seek information or support related to menstrual health.

Researching the perceptions and misconceptions of menstrual hygiene practices among SC adolescent girls in Cuddalore is vital. By exploring how these girls view menstruation, the challenges they face in managing their menstrual health, and the societal factors influencing their practices, we can develop targeted interventions. Such initiatives may include awareness programs, enhancing access to affordable menstrual products, and dismantling cultural barriers perpetuating misinformation about menstruation.

[1] *Research Scholar, **Supervisor, Department of Population Studies, Annamalai University-Mail id-anithaganesh1704@gmail.com

Objectives

- To study socio-economic and demography scheduled caste adolescent girls examine
- To understand the misconception on menstruation among adolescent girls with place of residence
- To analyse the misconception on menstruation and determinants among adolescent girls.

Methodology

The research study is being made to analyse the data of 467 samples which were selected using the **Multi stage proportional random sampling** method. In the first stage it was finalised cuddalore district to conduct the research as the cuddalore district is downtrodden, social and economically backward and inhabitants of Scheduled caste population was 29.32 percent of the state population.

In the second stage, out of 13 blocks of the district, 4 blocks were selected for the study, as per the geographical location with east, south, west and north as Parangipettai, Kattumannar kovil mangalore and Panruti respectively.

From each block, one Panchayat / urban area and 2 rural village panchayats were selected for the study. Hence total of 4 urban/ urban areas 8 rural panchayats/ rural areas. Therefore, from Kattumannarkovil block had 95, from Parangipettai block had 133, from Panruti block had116and from Mangalore block had123 a total sample was 467.

467 adolescent girls from both rural and urban areas in the mentioned blocks Cuddalore district. A structured questionnaire was employed to gather information from the students about menstrual health, including hygiene practices and social attitudes towards the menstrual hygiene knowledge attitude and practices. Face-to-face interviews were conducted to ensure detailed and accurate responses from the girls. The questionnaire was pre-tested on a small group before full data collection to ensure its reliability. The study adhered to ethical guidelines and aimed to represent the prevalence and variation in menstrual health issues among Scheduled Caste adolescent girls.To represent the information obtained from the data simple table, percentages chi-square and regression analyses were utilised.

Review of Literature

Global and National Context Menstrual hygiene management (MHM) is recognized as a global public health issue, with the World Health Organization (WHO) and UNICEF advocating for improved practices to reduce health risks and ensure dignity for menstruating individuals. Sommer et al. (2015) highlighted that inadequate menstrual hygiene leads to adverse health outcomes such as reproductive tract infections and absenteeism from school. In India, Dasgupta and Sarkar (2008) reported that 70% of adolescent girls did not know about menstruation before menarche, demonstrating the prevalence of misinformation.

Cultural Beliefs and Practices Cultural taboos significantly influence menstrual hygiene practices. Research by Nagar and Aimol (2010) noted that menstruation is often perceived as impure, leading to restrictions on diet, physical activities, and social interactions. Similarly, Thakur et al. (2014) found that these taboos prevent open discussions on menstruation, perpetuating myths and misconceptions.

Economic and Infrastructure Challenges Economic constraints and infrastructural inadequacies exacerbate menstrual hygiene challenges in rural areas. Bharadwaj et al. (2019) observed that affordability of sanitary products is a key barrier for marginalized communities. Additionally, inadequate access to clean water, private sanitation facilities, and waste disposal systems further complicate MHM in rural India, including Tamil Nadu.

Educational Deficits Education is a critical determinant of menstrual hygiene practices. Studies by Ray and Das (2016) demonstrated that higher educational attainment correlates with better awareness and hygienic practices. However, SC girls face systemic barriers to education, including poverty, discrimination, and lack of menstrual-friendly school environments, which further hinders their ability to manage menstruation effectively.

State and Local Perspectives In Tamil Nadu, efforts such as the distribution of free sanitary napkins through government schemes have shown some progress. However, Kumar et al. (2020) highlighted implementation gaps, particularly in reaching marginalized communities. Research specific to Cuddalore district underscores the need for localized strategies that address cultural sensitivities and infrastructural limitations.

Knowledge Gaps and Interventions While existing research provides a broad understanding of MHM challenges, studies focusing on SC adolescent girls in rural Tamil Nadu remain limited. The intersectionality of caste, gender, and economic status requires a nuanced analysis to develop effective interventions. Community engagement and participatory approaches are essential for fostering sustainable change.

Perceptions and Misconceptions Several studies emphasize that menstruation is often perceived as an impure or taboo subject. According to Nagar and Aimol (2010), many adolescent girls believe menstruation to be a punishment or curse due to prevailing cultural myths. Furthermore, Dasgupta and Sarkar (2008) noted that restrictions on diet, mobility, and social interactions during menstruation are commonly practiced in rural India, reinforcing negative perceptions. For SC adolescent girls in Cuddalore, these perceptions are often compounded by generational practices and the absence of open dialogue on menstrual health.

Menstrual Hygiene Practices Research consistently identifies poor menstrual hygiene practices as a significant health concern. Kumar et al. (2017) observed that the lack of access to sanitary products, clean water, and private facilities for changing and washing are critical issues in rural settings. Studies specific to Tamil Nadu, such as those by Bharadwaj et al. (2019), highlight that a large proportion of adolescent girls resort to using homemade or unhygienic menstrual absorbents due to economic constraints and lack of awareness. In the context of Cuddalore, infrastructural deficiencies and socio-cultural norms further exacerbate these challenges.

Socioeconomic and Educational Barriers Education and socioeconomic status play pivotal roles in shaping menstrual hygiene practices. Ray and Das (2016) demonstrated that girls with higher levels of education are more likely to adopt hygienic practices during menstruation. However, for SC adolescent girls, systemic barriers such as poverty, limited access to education, and inadequate government support exacerbate the problem. In Cuddalore, targeted educational programs and community initiatives are critical to bridging this gap.

Interventions and Policy Frameworks Efforts to improve MHM in India have seen mixed results. Government initiatives such as the Menstrual Hygiene Scheme under the National Health Mission aim to provide subsidized sanitary products and education. However, Kumar et al. (2020) suggest that these interventions often fail to reach the most marginalized groups, including Scheduled Castes, due to gaps in implementation and cultural resistance. Localized approaches in Cuddalore, including community-led awareness campaigns and improved infrastructure, could enhance the effectiveness of such policies.

Results and Discussion

TABLE-1 DISTRIBUTION OF RESPONDST BY THE SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS

AGE	**PLACE OF THE RESIDENCE**		**TOTAL**
	RURAL	**URBAN**	**N=467**
	N=297	**N=170**	
<13	108	54	162
	-66.7	-33.3	
14<16	102	63	165
	-61.8	-38.2	
17+	87	53	140
	-62.1	-37.9	
LEVEL OF EDUCATION			
8-10(SECONDARY)	193	109	302
	-63.9	-36.1	
11-12(HIGHER SECONDARY)	48	25	73
	-65.8	-34.2	

BA/BSC/BCOM (COLLEGE LEVEL)	56	36	92
	-60.9	-39.1	
FAMILY TYPE			
NUCLEAR FAMILY	201	97	298
	-67.4	-32.6	
JOIN FAMILY	96	73	169
	-56.8	-43.2	
FATHER OCCUPATION			
DAILY WAGES	145	134	279
	-52	-48	
FORMER	103	19	122
	-84.4	-15.6	
GOVT JOB	24	13	37
	-64.9	-35.1	
NOT WORKING	25	4	29
	-86.2	-13.8	
MOTHER OCCUPATION			
DAILY WAGES	217	95	312
	-69.6	-30.4	
HOUSEWIFE	80	75	155
	-51.6	-48.4	
TYPE OF HOUSE			
HUT	59	28	298
	-67.8	-32.2	
KATCHA	96	73	169
	-56.8	-43.2	
PUCCA	21	23	44
	-47.7	-52.3	
FAMILY MONTHLY INCOME			
<12000	212	93	305
	-69.5	-30.5	
13000 TO 15000	77	72	149
	-51.7	-48.3	
>20000	8	5	13

	-61.5	-38.5	
HABITS OF READING NEWSPAPER			
NEVER	230	129	359
	-64.1	-35.9	
OCCASIONALLY	41	22	63
	-65.1	-34.9	
DAILY	26	19	45
	-57.8	-42.2	
HABITS OF LISTENING RATIO			
NEVER	242	138	380
	-63.7	-36.3	
OCCASIONALLY	37	22	59
	-62.7	-37.3	
DAILY	18	10	28
	-64.3	-35.7	
HABITS OF WATCHING TELEVISION			
NEVER	32	18	50
	-64	-36	
OCCASIONALLY	48	29	77
	-62.3	-37.7	
DAILY	217	123	340
	-63.8	-36.2	
HABITS OF USING ANY OTHER SOCIAL MEDIA			
NEVER	22	16	38
	-57.9	-42.1	
OCCASIONALLY	94	61	155
	-60.6	-39.4	
DAILY	181	93	274
	-66.1	-33.9	

The figures in the parenthesis are percentages

Table 1 The above table that cross classification of socio-economic and demographic characteristics of the respondents 62.1 percent of the girls belong to the 17+ age group in rural areas, and 37.9 percent belong to urban areas. In the sample population 63.9 percent of the girls are at the 8-10 (Secondary) level of education in rural areas, while 36.1 percent are in urban areas. 65.8 percent of the girls belong to the 11-12 (Higher

Secondary) level of education in rural areas, and 34.2 percent are at that level in urban areas. 60.9 percent of the girls have a BA/BSc/BCom (College level) education in rural areas, while 39.1 percent have that education in urban areas. 67.4 percent of the girls come from nuclear families in rural areas, and 32.6 percent belong to urban areas. 56.8 percent of the girls are in joint families in rural areas, while 43.2 percent are in urban areas. 52.0 percent of the girls' fathers work in daily wages in rural areas, while 48.0 percent work in daily wages in urban areas. 84.4 percent of the girls' fathers work as farmers in rural areas, while 15.6 percent belong to urban areas. Additionally, 64.9 percent of the girls' fathers have government jobs in rural areas, while 35.1 percent belong to urban areas. 86.2 percent of the girls' fathers' occupations are "Not Working" in rural areas, while 13.8 percent of the girls belong to their fathers' occupations in urban areas. 69.6 percent of the girls belong to their mothers' occupations in daily wages in rural areas, while 30.4 percent belong to urban areas. 51.6 percent of the girls belong to mothers' occupations as housewives in rural areas, while 48.4 percent of the girls belong to their mothers' occupations as housewives in urban areas

Type of House: 67.8 higher percent of the respondents living in huts houses in rural areas, while 32.2 percent of the girls living in urban areas. 56.8 percent of the girls belong to Katcha houses in rural areas, while 43.2 percent of the girls belong to urban areas. 47.7 percent of the girls belong to Pucca houses in rural areas, while 53.2 percent of the girls belong to Pucca houses in urban areas. 69.5 percent of the girls belong to families with a monthly income of <12000 in rural areas, while 30.5 percent of the girls belong to families with a monthly income in urban areas. 51.7 percent of the girls belong to families with a monthly income of 13000 to 15000 in rural areas, while 48.3 percent of the girls belong to families with a monthly income in urban areas. 61.5 percent of the girls belong to families with a monthly income of >20000 in rural areas, while 38.5 Percent of the girls belong to families with a monthly income in urban areas.

Habits of reading newspaper 64.1 percent of the girls belongs to Never in rural areas, While 35.9 percent of the girls in Urban area.65.1 percent of the girls occasionally in rural areas. And 34.9 percent of the girls belongs to Urban areas.57.8 percent of the girls belongs to daily in reading newspaper in rural areas. While 42.8 percent of the girls in Urban areas. And, Habits of listening ratio 63.7 percent of the girls in rural areas never listening Ratio. while 36.3 percent of the girls Never listening Ration in Urban areas.62.7 percent of the girls belongs to listening Ratio in occasionally in rural areas. While 37.3 percent of the girls occasionally listening in urban areas. 64.3 percent of the girls daily listening in Ration in rural areas.35.7 percent of the girls belongs to urban areas.64.0 percent of the girls never watching television in rural areas.36.0 percent of the girls belongs to urban areas.62.3 percent of the girls occasionallywatching television in rural areas.37.7 percent of the girls belongs to urban areas..63.8 percent of the girls daily watching television in rural areas.36.2 percent of the girls belongs to urban areas.57.9 percent of the girls never using social media in rural areas.42.1 percent of the girls belong to urban areas. 60.6 percent of the girls using social media occasionally in rural areas.39.4 percent of the girls belongs to urban areas.66.1 percent of the girls daily using social media in rural areas. 33.9 percent of the girls belong to urban areas.

TABLE-2 DISTRIBUTION OF RESPONSES BY KNOWLEDGE OF MENSTRUATION AND PLACE OF RESIDENCE

KNOWLEDGEOF MENSTRUATION	**PLACE OF THE RESIDENCE**		**TOTAL N=467**
	RURAL N=297	**URBAN N=170**	
YES	214 (60.1)	142 (39.9)	366
NO	83 (74.8)	28 (25.2)	149

The figures in the parenthesis are percentages

The table shows that 60.1 percent of the respondents belong to the Group of Girls with Knowledge of Menstruation in Rural Areas, while 39.9 Percent Belong to Urban Areas. Additionally, 74.0 Percent of The Respondents in Rural Areas Do Not Know About Menstruation, Compared to Only 25.2 Percent of Girls in Urban Areas. In Rural Areas, Access to Comprehensive Health Education May Be More Restricted Due to A Lack of Resources and Trained Educators. This Can Lead to A Lower Level of Awareness and Understanding of Menstruation Among Girls Compared to Those in Urban Areas, Where Educational Programs and Awareness

Campaigns Are Often More Prevalent.

T ABLE-3 DISTRIBUTION OF RESPONDENTS BY THE SOURCE KNOWLEDGE ON MENSTRUATION AND PLACE OF RESIDENCE

SOURCES OF KNOWLEDGE ON MENSTRUATION	PLACE OF THE RESIDENCE		TOTAL N=467
	RURAL N=297	URBAN N=170	
MOTHER	183 (57.9)	133 (42.1)	316
SISTER	107 (87.0)	16 (13.0)	123
FRIENDS	3 (33.3)	6 (66.7)	9
CLASS TEACHERS	4 (21.1)	15 (78.9)	19

The figures in the parenthesis are percentages

Table 3 The table shows that sources of knowledge about menstruation 57.9 percent of the respondents are gather information from mothers in rural areas girls, while 42.1 percent are from urban area girls. In rural areas, 87.0 percent gather information about menstruation from their sisters, compared to 13.0 percent in urban areas. Additionally, 33.3 percent of rural respondents gain knowledge from friends, while only 66.7 percent in urban areas do so. Lastly, 21.1 percent of rural respondents learn from their class teachers, with very few urban respondents reporting the same. Finally higher percent of the respondents sources of knowledge about menstruation from sister for rural area girls.

TABLE-4 DISTRIBUTION OF RESPONDS BY INFORMATION ON PUBERTY AND PLACE OF RESIDENCE

AVERAGE AGE OF PUBERTY	PLACE OF THE RESIDENCE		TOTAL N=467
	RURAL N=297	URBAN N=170	
12 TO 13	159 (63.1)	93 (36.9)	252
14 TO 15	138 (64.2)	77 (35.8)	215

The figures in the parenthesis are percentages

Table 4 The table shows that 63.1 percent of the respondent's age at menarche attended between 12 and 13 ages in rural area girls, 36.9 percent of the respondents are age at menarche attended between 12 and 13 ages in urban area girls. Therefore 64.2 percent of the respondents experience age at menarche at ages 14 to 15 in rural areas, compared to a significantly lower percentage of 35.85 for urban area girls. Higher percent of the respondents age at menarche age at 12 to 15 ages in rural area girls only.

TABLE-5 DISTRIBUTION OF RESPONDST BY PRESNT POSITION OF RESPONNETS IN PUBERTY AND PLACE OF RESIDENCE

ATTAINED PUBERTY	PLACE OF THE RESIDENCE		TOTAL N=467
	RURAL N=297	URBAN N=170	
YES	291 (63.1)	170 (36.9)	YES
NO	6 (100.0)	0 (.0)	NO

The figures in the parenthesis are percentages

Table 5 The above table shows that 54.3 percent of the respondents who attained puberty were girls from rural areas, while 45.7 percent of the respondents were from urban areas. Therefore, 84.6 percent of the respondents

in rural areas were girls, compared to only 15.4 percent in urban area girls respectively. So, most of the respondent's attained puberty from rural area respectively.

TABLE-6 DISTRIBUTION OF RESPONDS BY AGE OF ATTAINED PUBERTY AND PLACE OF RESIDENCE

IF YES, IN WHICH AGE YOUATTAINED PUBERTY	PLACE OF THE RESIDENCE		TOTAL N=461
	RURAL N=297	URBAN N=170	
12 -13	119 (51.5)	112 (48.5)	12 -13
14-15	172 (74.8)	58 (25.2)	14-15

The figures in the parenthesis are percentages

Table 6 The table shows that 52.1 percent of the respondents in rural areas attained puberty between the ages of 12 and 13, while 47.9 percent of the respondents in urban areas did so. Furthermore, 75.1 percent of the respondents experienced menarche at ages 14 to 15 in rural area girls, compared to only 24.9 percent in urban area girls.

TABLE-7 DISTRIBUTION OF RESPONDS BY MISCONCEPTION ON MENSTRUATION AND PLACE OF RESIDENCE

Puberty is only for girls	Place of the Residence		Total N=467
	Rural N=297	Urban N=170	
TRUE	270	157	427
	-63.2	-36.8	
FALSE	25	13	38
	-65.8	-34.2	
Don't know	2	0	2
	-100	0	
average age of puberty 13-17 years girls			
TRUE	296	162	448
	-63.8	-36.2	
FALSE	9	1	10
	-90	-10	
Don't know	2	7	9
	-22.2	-77.8	
reason for not attaining puberty biological			
TRUE	233	83	316
	-73.7	-26.3	
FALSE	55	74	129
	-42.6	-57.4	
Don't know	9	13	22
	-40.9	-59.1	

puberty starts at 9-15 years in boys			
TRUE	223	89	312
	-71.5	-28.5	
FALSE	55	57	112
	-49.1	-50.9	
Don't know	19	24	43
	-44.2	-55.8	
cold drink does not cause menstruation cramps			
TRUE	221	69	290
	-76.2	-23.8	
FALSE	55	77	132
	-41.7	-58.3	
Don't know	21	24	45
	-46.7	-53.3	
Overbleeding during menstruation is an indication of poor reproductive health in a woman			
TRUE	227	82	309
	-73.5	-26.5	
FALSE	42	65	107
	-39.3	-60.7	
Don't know	28	23	51
	-54.9	-45.1	
The use of perfumes in the reproductive organ during menstruation causes dryness, irritation, infection, ect…			
TRUE	221	60	281
	-78.6	-21.4	
FALSE	38	38	76
	-50	-50	
Don't know	38	72	110
	-34.5	-65.5	_

The figures in the parenthesis are percentages

Table-7 The above table that the misconception menstrual related issues, 63.2 percent of the respondents had accepted the puberty is only for girls but at the same time remaining proportion of respondents were denied puberty is no other than girls.

A majority of the respondents (63.2%) believe that puberty is not exclusive to girls, particularly among rural participants. Most of the respondents (63.8%) correctly identify the average age for girls starting puberty as between 13 and 17 years, with a high rate of correct answers from rural respondents.

Additionally, 73.7% believe biological factors are the main reasons for not reaching puberty, with greater agreement among rural respondents. While 71.5% percent of the respondents affirm that boys begin puberty between 9 and 15 years, 55.8% percent of the urban respondents express uncertainty.

Most of the participants (76.2%) correctly state that cold drinks do not cause menstrual cramps, although 58.3% of urban respondents disagree. Furthermore, 73.5% support the idea that excessive menstrual bleeding indicates poor reproductive health, but 60.7% of urban respondents disagree.

Data on the health effects of using perfumes in the reproductive area during menstruation is incomplete, highlighting the need for increased awareness.

Conclusion

The summary of the study emphasizes the urgent need to address menstrual related issues and misconception among scheduled caste adolescent girls. The total of the respondent's 62.1 percent of the girls belong to the 17+ age group in rural areas, and 37.9 percent belong to urban areas. In the sample population 63.9 percent of the girls are at the 8-10 (Secondary) level of education in rural areas, while 36.1 percent are in urban areas. 65.8 percent of the girls belong to the 11-12 (Higher Secondary) level of education in rural areas, and 34.2 percent are at that level in urban areas. 60.9 percent of the girls have a BA/BSc/BCom (College level) education in rural areas, while 39.1 percent have that education in urban areas. 67.4 percent of the girls come from nuclear families in rural areas, and 32.6 percent belong to urban areas. 56.8 percent of the girls are in joint families in rural areas, while 43.2 percent are in urban areas. 52.0 percent of the girls' fathers work in daily wages in rural areas, while 48.0 percent work in daily wages in urban areas. 84.4 percent of the girls' fathers work as farmers in rural areas, while 15.6 percent belong to urban areas. The above table-7 reveals that the misconception menstrual related issues, of the total respondents 63.2 percent had accepted the puberty is only for girls but at the same time remaining proportion of respondents were denied puberty is no other than girls.

A majority of the respondents (63.2%) believe that puberty is not exclusive to girls, particularly among rural participants. (63.8%) percent of the respondents correctly identify the average age for girls starting puberty as between 13 and 17 years, with a high rate of correct answers from rural respondents.

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Most of the participants (76.2%) percent of the respondents correctly state that cold drinks do not cause menstrual cramps, although 58.3% of urban respondents disagree. Furthermore, 73.5% support the idea that excessive menstrual bleeding indicates poor reproductive health, but 60.7% of urban respondents disagree.

Data on the health effects of using perfumes in the reproductive area during menstruation is incomplete, highlighting the need for increased awareness. The insights from this research provide a clear direction for policymakers and NGOs to implement effective strategies that can significantly improve the menstrual health outcomes for Scheduled Caste adolescent girls, fostering a healthier future for these communities.

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