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A Descriptive Study On Menstrual Hygiene Practices And Social Stigma Among Married Women

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ABSTRACT
Menstrual hygiene is an unexplored but very important areas in the discourse of public health, especially in socio-culturally diverse environments that involve married women as the subjects of discussion. In this paper, the researcher will examine the practice of menstrual hygiene and the magnitude of social stigmas among married women with the focus being on the behavioural patterns and awareness and accessibility of sanitary products and social-cultural constraints. The structured questionnaires that were used to collect the data were structured according to a descriptive cross-sectional design using structured questionnaires that were given to 300 married women aged between 18-49 years. The hygiene practices evaluated during the study are the nature of the absorbent being used, the rate at which the materials are changed, how the material and personal hygiene practices are disposed of. Meanwhile, it also examines such factors as menstrual restrictions, communication barriers, and perceptions of impurity that are related to stigmas. Results of the statistical analysis show that menstrual hygiene practice, education, and income level have significant associations. Results suggest that although the level of awareness has improved, traditional beliefs and stigma have not disappeared, and affect hygiene behaviour and psychosocial well-being. The study notes that hygiene management as well as the deep-rooted stigma requires specific intervention, including awareness at the policy level.

INTRODUCTION

In most societies, menstruation is a natural biological process, which is experienced by all women of reproductive age, yet remains shrouded in silence, misinformation and even socio-cultural taboos in many societies. Although over the last few years a lot of attention has been paid to adolescent girls in the context of menstrual hygiene studies, the topic of married women has been relatively under-researched. Not only by personal knowledge and economic status, but also by marital roles, family expectations, and cultural norms, their experiences are shaped.
Menstrual hygiene management can be defined as the utilization of clean menstrual materials to absorb or collect blood, ability to change the materials in privacy as much as possible and access to clean washing and safe disposal facilities. Poor menstrual hygiene practices may result in an infection of the reproductive tract, infection of the urinary tract, and other complications (Reena et al.,2025). However, it is not just a case of physical well-being but also a case of psychological pressure and social marginalization.
Social stigma and associated with menstruation takes different forms like restricted movement, restrictions on foods, exclusion and lack of open communication of the same. Such types of limitations are prevailing among married women who might feel that these restrictions are more stringently enforced at home (Hegde et al.,2025). The combination of gender norms, patriarchy and the absence of autonomy add to their vulnerability.
The current study will give a clear picture of the menstrual hygiene and social stigma among married women. It tries to establish the patterns of behavior, the determinants that influence this practice as well as the degree to which stigma can impact daily lives. The study, by targeting this group, adds to a more holistic view of menstrual health and helps to identify areas of need.

Review of Literature

Reena (2025) also confirms that the psychological and social consequences of failure to adequately manage menstrual hygiene has devastating effects among women in the less fortunate societies. The paper indicates that lack of access to sanitary products, lack of privacy, and lack of knowledge not only pose risks to physical health, but also cause emotional distress. Women with poor menstrual hygiene are most likely to report feeling shame, embarrassment and anxiety which are further reinforced by taboos of menstruation (Reena et al.,2025). The author underlines that these psychological effects are further helped in marginalized settings where it is not suggested to discuss menstruation openly. Another important dimension that has been identified as a critical one, is social exclusion, where women are often denied the chance of engaging in the daily activities, including religious activities and community meetings. The article also notes that these restrictions contribute to the development of a low level of self-esteem and promotes unequal gender relations. Reena (2025) also mentions that the poverty-gender discrimination intersectionality leads to the vicious cycle of women not being able to use proper hygiene facilities and continuing the stigmatization and health risk cycle. The paper emphasizes the importance of community-based

initiatives, awareness, and better access to affordable menstrual hygiene products to achieve the physical and psychological dimensions of menstrual hygiene. The results indicate that the reduction of stigma and the enhancement of the quality of life should be facilitated through a holistic approach, which should incorporate health education, social change, and support of the policy.

The beliefs and perceptions of married men, as observed by Hegde (2025), are crucial in influencing menstrual hygiene practices in homes. The qualitative study analyses the effects of the perception or lack of perception of men in the provision of resources and the extent of support given to the women during the menstrual period. The author finds out that most men know very little about the menstrual health, and are often inclined to regard it as the secret or taboo topic, which should not be openly discussed. This lack of knowledge is one of the reasons why women lack enough support such as unwillingness to buy sanitary products or invest in proper sanitation facilities (Hegde et al.,2025). The attitudes are further supported by the norms of patriarchy, which depict menstruation as a problem of women only and men should not be involved in anything significant and essential. However, the study also reveals the situations when more supportive behaviors like supporting access to hygiene products and encouraging open communication are more apt to happen when more men are aware of the problem. The results suggest that engaging men in menstrual health education can be very effective in changing household-level practices and decrease stigma. The reason why the author believes that it is necessary to change the perception of men so that it can create an enabling environment in which women can attend to menstruation with dignity. It is concluded that gender-inclusive programs are needed to resist the prevalent norms and encourage collective accountability in managing menstrual hygiene.

Pao (2023) believes that social stigma of menstruation is deeply rooted in cultural and social systems, affecting attitudes and behaviors of various groups of people. As it is shown in the review, the notion of impurity and pollution is traditionally associated with menstruation, which leads to the fact that multiple forms of discrimination and exclusion do exist. Women are usually subjected to restrictions during their menstruation period which limit them in their participation in social, religious and domestic life. Pao (2023) suggests that the cultural discourses, religious interpretations, and intergenerational transmission of norms all support these stigmatizing beliefs (Pao et al.,2023). The paper highlights the fact that not only does stigma have a physical impact on the health of women, by making them discouraged to engage in proper hygiene practices, but also has a heavy psychological impact on women in the sense that they are made to feel inferior and socially isolated. The author also mentions that the absence of open discussion about menstruation is also a factor in misinformation and strengthen of negative perceptions. The review suggests that entire steps will be taken, which will address the culture and structure of stigma. These are the campaigns on education, community participation and enacting of policies that would normalize menstruation and gender equality. Pao (2023) concludes that a collective action is necessary to overcome the deeply held beliefs and offer a supportive environment to women to break this cycle of menstrual stigma.

According to Chuwan (2026) the consequences of menstrual stigma are far reaching when considered in relation to the reproductive health as well as the educational achievement of women. In the paper, the author will talk about the barriers to academic participation caused by taboos on menstruation, particularly in young women. The menstrual restrictions (absence of school or limited mobility) are one of the causes of poor performance in school and high rates of dropouts as indicated by Chuwan (2026). The author notes that the lack of sanitation facilities and the availability of menstrual hygiene products also contribute to these challenges. Social stigma also serves as an inhibitor to an open discussion, therefore depriving women with an opportunity to receive support or information (Chuwan et al.,2026). The paper also discusses the overall effect of stigma on reproductive health in that misinformation and inadequate hygiene practices expose one to the risk of infections and other health complications. Chuwan (2026) identifies that the problem of menstrual stigma needs to be addressed to provide gender equality in education and health. In the study, it is suggested that concerted efforts are carried out through development of infrastructure, health education and community awareness campaigns. The obstacles that women must overcome can be decreased by going against the cultural norms and accessing resources more easily, which will have a positive impact on their overall well-being.

A mixture of socio-economic, cultural, and educational factors has an effect on knowledge, attitudes, and practices related to menstruation among early reproductive-aged women (Siddique, 2023). The survey conducted cross-sectionally indicates that there are considerable gaps in awareness with a significant number of women not having the relevant information on menstrual health. Siddique (2023) finds out that misconceptions and myths are rather widespread and can lead to unsafe hygienic behaviors such as changing absorbents seldom and using wrong methods of disposal. One more aspect of the research is that cultural beliefs affect the attitudes toward menstruation, it might lead to stigma and behavioral inhibition. Women who are more educated and have access to information are more likely to exhibit better hygiene and have more positive attitudes. The research illustrates the importance of the educational interventions based on particular aspects to foster knowledge and promote safe performance. It is also noted by Siddique (2023) that healthcare providers and community programs can play a crucial role in disseminating the correct information and overcoming the misconceptions. The findings suggest that a multi-faceted intervention, which involves education, access to resources, and efforts to break the cultural expectations of women is necessary to improve the menstrual health of women.

According to Khan (2024), the management of menstrual hygiene in women with disabilities has its own problems, which are not usually considered by the general population of the researchers and practitioners in the field of health. The study indicates that women with disabilities face more problems including, their inability to move freely, absence of sanitation facilities, and the fact that they have to have caregivers to help them manage their menstrual cycle. Khan (2024) explains that the existence of social stigma and discrimination only exacerbates these problems and further marginalize this population. In the study, majority of women with disabilities lack access to the appropriate hygiene products and information that are increasing their susceptibility to health risks. The attitudes and knowledge of caregivers is also a major factor towards development of hygiene practices and poor management is a result of lack of awareness among the caregivers (Khan et al.,2024). The paper points out that there is a need to have inclusive policy and intervention to meet the particular needs of women with disabilities. This includes the provision of convenient infrastructure, provision of tailor-made education curricula and training of care-givers. Khan (2024) finds that there is a need to provide equitable access to menstrual hygiene management to promote the health, dignity and rights of women with disabilities.

METHODOLOGY

3.1 Research Design

Research design: The research design is descriptive cross-sectional research design to effectively investigate menstrual hygiene practices and prevalence of social stigma in the married women. This is the appropriate design to be in a position to take a snap

shot of the present situation, behaviours and perceptions of a specific population at a certain time of the year (Mudi et al.,2023). The descriptive nature of the study gives the option to register the patterns of the menstrual hygiene management that includes the type of material used, the hygiene maintenance behavior, and the disposal practices. At the same time, it helps to identify socio-cultural norms and stigma-related experience without trying to change or impact the responses of the participants.

The research design that would be suitable to carry out a research study that aims to investigate the relationship between the variables, including education, income, and hygienic practices. The design can also be used to compare the results across various socio-demographic groups, and observe the differences in menstrual hygiene practices and stigmatizing experiences. The ecological validity of the study and the capacity of the study to reflect the lived experiences of married women make it a reliable research when it comes to insights into the lived experiences of married women.

3.2 Study Area and Population

In order to offer a representation of the different socio-economic and cultural settings, the study was conducted in a chosen urban and semi-urban locations. The urban areas were observed to have a relatively higher access to healthcare facilities, sanitation facilities, and education facilities, but in most cases there was low access to good sanitation and health facilities. Both settings enable a comparative comprehension of the effects of environmental and socio-economic conditions on menstrual hygiene practices and stigma.

The target population was a married woman between the age of 18 and 49 years old, which is the reproductive age group. The group was selected as it is directly related to the health of menstruation and it is exposed to the demands of the family and society with regard to menstruation (Meher et al.,2023). The criteria was women who had menstruated in the last six months as they may be able to provide accurate and recent information about the practices and experiences of women. Women who had severe health conditions which might interfere with menstrual patterns or those who are not willing to give informed consent were not included in the study.

The fact that married women are chosen as the target group is rather significant, as the life of women is formed by the relations with the husband, housekeeping, and cultural requirements, depending on the family set-up. Such a group may have special needs like restrictions by the in-laws and a deficiency of autonomy in decision making as far as health and hygiene is concerned.

3.3 Sample Size and Sampling Technique

There was a total of 300 people identified to be adequate in respect of representation and statistical integrity (King et al.,2025). The sample size was considered to be sufficient to reflect variability in menstrual hygiene practices and stigma among the various socio-demographic groups. Stratified random sampling was used to increase representativeness and minimize sampling bias.

Key variables such as the level of education and the socio-economic status were used to stratify based on the key variables known to influence menstrual hygiene practices. The people were classified into various levels which include no formal education, primary education, secondary education and higher education among others and low, middle and high-income groups. In each stratum, participants were randomly selected in order to have proportional representation.

This sampling approach will also make sure that all the subgroups in the population are adequately represented, and will consequently increase the generalizability of the findings. It also permits subgroup analysis and, as a result, the study can be able to identify patterns and discrepancies of hygiene practices and stigma amongst various educational and economic backgrounds (Yaaqoob et al.,2025). Random selection of all the strata reduces selection bias and increases the validity of the findings.

3.4 Data Collection Tools

Data was collected using a structured questionnaire basing on the demographic attributes, menstrual hygiene practices, and social stigma. The questionnaire has been designed following the available literature and standardized instruments are used in the research on menstrual health and they ensure that the content validity and relevance of the study objectives.

Questions in the demographic section of the questionnaire were related with the demographic information, including age, education level, occupation, monthly household income, family type, and place of residence (Adhikari et al.,2025). This information offers a contextual background in the analysis of differences in hygiene practices and stigma.

The second part involved menstrual hygiene behaviours. It had questions on the type of absorbent applied, how regularly the menstrual materials were changed, how often the reusable materials were washed, water and sanitation facilities and disposal practices. The other questions were used to measure the level of knowledge on hygienic practices and sources of information on menstrual health.

The third part examined the social stigma related to menstruation. It also contained items about the restriction during menstrual period, exclusion of religious activities, restriction of cooking or domestic chore and restriction of social interactions. The perceptions of menstruation such as beliefs about impurity and cleanliness and the patterns of family communication were also discussed (Gurung et al.,2023). The respondents were asked to describe their comfort levels in talking to their spouses, family members and healthcare providers about menstruation.

The pre-tested questionnaire on a small scale was used to identify the ambiguities, and to make questions clear. Feedback was consumed in coming up with required changes that would make it more reliable and comprehensive. Face-to-face interview was used to get data since it is the best way to get a correct response to the questions and to assist the participants who might have had a problem with understanding the questions.

3.5 Data Analysis

The data obtained were coded and inputted in statistical software in order to analyze them. Data cleaning procedures have been conducted to ensure that they do not have any inconsistency, omissions or outliers (Kpodo et al.,2022). The data summary and an overview of the menstrual hygiene practices and factors related to stigma were summarized with the help of descriptive statistics. Frequencies and percentages were used to calculate categorical variables whereas mean and standard deviation were used to calculate continuous variables.

The relationship between variables was tested using the inferential methods of statistics. Chi-square test was used to assess the relationships between socio-demographic variables, e.g., education and income, and menstrual hygiene practices. The test is appropriate when dealing with categorical data and when it is appropriate in determining whether differences observed among the groups are significant.

Some other analyses were carried out to investigate the correlation between the variables associated with stigma and the hygiene practices. The patterns and trends were determined by applying cross-tabulation and the level of significance was used to determine the strength of association. Analysis was also considered to be able to interpret the results in the correct way because it also took possible confounding factors into account.

The results were also presented both in tabular and charted format so that they can be easily understood and interpreted (Badiger et al.,2025). The analytical method will give a complete overview of the factors that affect the menstrual hygiene practices and the degree of social stigma among married women.

RESULTS

4.1 Demographic Profile

The demographic profile of the respondents provides a background of socio-economic and educational background in which menstrual hygiene practices and stigma are influenced. The percentage of the sample outstanding in the age group of 2635 years was the largest percentage of the sample which was 42 percent and it represented a high percentage of the sample. A high degree of household chores and a high degree of participation in family and community life generally characterize this age group and may influence both hygiene practices and cultural conformity practices (Minnal et al.,2025). The women of this group might also be better trained on how to handle menstruation but still their practices are affected by the socio-cultural context in which they live.

The proportion of the people who had attended secondary education was quite high, that is, 38 percent. This level of education implies the intermediate level of literacy and potential access to the health-related information. However, the fact that 22 percent of the participants did not even have basic education highlights the presence of a very large gap in access to basic knowledge and awareness (Dutta et al.,2024). Education level is also highly important in identifying the attitude towards menstrual hygiene that dictates the kind of materials used, and the knowledge of the hygienic practices. The better educated women are more likely to be in a better position to get reliable information, to challenge the traditional stereotypes and adopt safer hygiene practices.

Socio-economic distribution of sample indicates that 46 percent of the sample was in low-income households. This is a key discovery because economic limitations have a direct impact on the affordability and accessibility of sanitary products. Women with low-income statuses are more prone to use reusable materials like cloth, which may not necessarily be kept in a hygienic condition. Financial constraints also impact on access to proper sanitation facilities like personal toilets, well-developed disposal systems. The interrelation between economic status and menstrual hygiene practice illustrates the importance of taking affordability and access into account in population health programs.

These factors together show that menstrual hygiene practices and experiences of stigma can be influenced by a combination of these factors (Ubochi et al.,2023). These problems combine to create various degrees of awareness, access and abidance to cultural norms which in turn constitute the overall experiences of married women..

4.2 Menstrual Hygiene Practices

The analysis shows that there is a difference in the hygiene practices depending on the level of education and their income.

Parameter	Category	Frequency (n=300)	Percentage (%)
Type of Absorbent	Sanitary Pads	168	56
	Cloth	102	34
	Others	30	10
Frequency of Change	2–3 times/day	120	40
	4–5 times/day	96	32
	Once/day	84	28
Disposal Method	Dustbin	150	50
	Open Disposal	90	30
	Burning	60	20
Personal Hygiene	Regular Washing	198	66
	Irregular Washing	102	34

The analysis of menstrual hygiene behaviour indicates that there exists such a variation in terms of socio-economic and educational backgrounds. The data show that 56% of the respondents confirmed that they used sanitary pads as the main absorbent, which means that the number of people who adopted modern hygiene products is relatively high (Amin et al.,2022). However, a very high proportion, 34% still used cloth and 10 percent used other materials. The fact that cloth is used also points to the fact that past practices still exist and could be stimulated by any of the previously stated reasons.

How many times menstrual absorbents are changed is a very significant measure of hygiene. The findings reveal that the participants who switched their absorbents switched them an average of two to three times a day (40% of the participants), and those who switched their absorbents four to five times a day (32% of the participants). However, only a quarter of the respondents changed the absorbents at least once a day which is considered as being poor in terms of hygiene (Kau et al.,2026). The high risk of infections and discomfort may also be related to the high frequency of the substitution of absorbents. This habit is typically associated with the inadequate access to resources, ignorance or restrictive environments, which limit the possibilities to manipulate materials.

The difference in disposal practices was also different between the participants. Fifty percent of the respondents (50) indicated that they dumped their menstrual waste in dustbins thus showing that some respondents had had access to waste management facilities. However, a third were engaging in open disposal and a fifth of them were burning. Open disposal is a threat to the environment and other health hazards, as it is contaminated and exposes pathogens, and burning can result in harmful emissions. The absence of infrastructure and lack of knowledge on the proper disposal of these wastes is an indicator of such practices.

The practice indices of personal hygiene were assessed by the level and frequency of washing habits during menstrual period (Yasmin et al.,2026). The results indicate that two-thirds of the respondents were regular washers with two-thirds of the respondents having unpredictable washing habits. Washing should be done regularly to keep clean and prevent infections and the proportion of irregular practices observed indicates a need to improve awareness and access to water and sanitation facilities.

In general, the results show that although there has been an improvement in the use of sanitary products and hygiene practices, there are still significant gaps. The effect of economic and infrastructural limitations is pointed out by the use of cloth, low frequency of changing absorbents, and unsafe procedures of disposal. These practices shed light on the need of certain interventions, which also need to address the element of awareness and access.

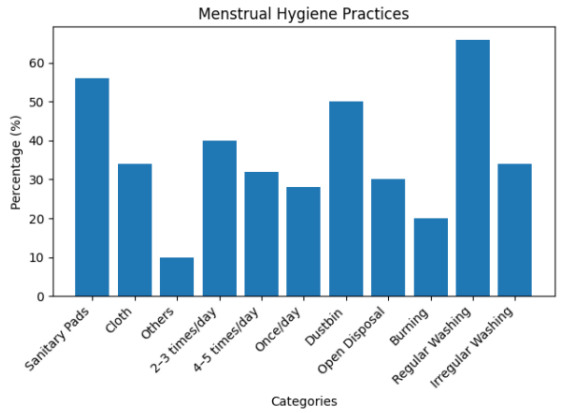

Figure: Menstrual Hygiene Practices

4.3 Social Stigma Indicators

Stigma Factor	Response	Frequency	Percentage (%)
Restricted from Religious Activities	Yes	210	70
Restricted from Kitchen Work	Yes	180	60
Avoid Social Interaction	Yes	144	48
Open Discussion with Family	No	198	66
Perception of Impurity	Yes	222	74

The analysis of the signs of social stigma reveals the fact that they are still there with restrictive beliefs and practices that refer to menstruation (Adhikari et al.,2025). A better part of the population, 70 percent claimed to have been deprived of the right to attend religious services during menstruation. This restriction is reflective of some of the most entrenched cultural beliefs that menstruation is impure and since it is not regarded as a form of spiritual purification, one is excluded.

Similarly, 60 percent of those interviewed reported that they were limited in kitchen chores, in other words, menstrual women are often not engaged in food preparation and housework. This tradition promotes the image of purity and restricts the role of women in everyday life. Nearly half of the interviewed who are 48% said that they avoid social interactions during menstruation either due to discomfort or pressure to do it. Such rejection results in social isolation and enhanced stigma.

Other communication patterns within the family that show the level of stigma. Another big percentage of the participants 66 also indicated that the issue of menstruation is not openly discussed in the family. The result of this inability to communicate is a situation where the actual information about menstrual hygiene is not disseminated due to this lack of communication. It is also limiting the ability of women to seek support, or raise concerns as far as their health is concerned.

The stigma associated with menstruation was found to be deep rooted in the cultures of the people by 74% of the respondents who reported that the stigma was deeply rooted in the cultures of the people (Oishwik et al.,2026). This attitude impacts conduct and strengthens limitations, generating a discrimination and silence cycle. The results reveal that social stigma is not just prevalent, but also embedded, and leaves a significant impact on the physical and mental health of women.

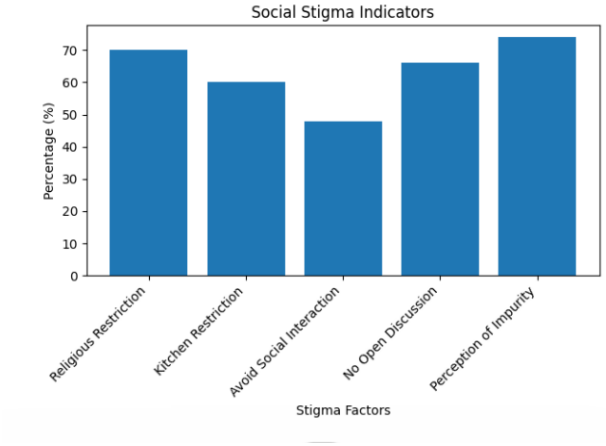

Figure: Social Stigma Indicators

4.4 Association Between Education and Hygiene Practices

The statistical analysis shows that there exists a significant relationship between the education level and menstrual hygiene practices with a p-value of less than 0.05 which indicates that there is a significant relationship between the education level and menstrual hygiene practices. Women who had attained higher level of education had higher chances of using sanitary pads, practicing regular hygiene practices and practicing safe disposal practices (Singh et al.,2025). When women are educated, awareness will be increased and information will be available, so women can make informed choices regarding their health.

Quite the contrary, less educated women had greater possibilities of relying on the traditional procedures, such as the use of cloth and the frequent replacement of absorbents. They were also more likely to adhere to restrictive cultural beliefs, and experience more stigma. The results indicate that education is a critical factor that determines behavior and attitudes and influences the adoption of hygienic practices and rejection of harmful norms.

The education-hygiene nexus is important in that educational interventions can be used to enhance menstrual health (Becker et al.,2024). Awareness-raising, provision of correct information, and dispelling of myths interventions can assist in promoting the desirable changes in the behavior. Education also enables women to become empowered to challenge the traditional beliefs and demand their rights hence limiting the impact of stigma.

On the whole, the results show that the demographic variables, hygiene behavior, and social stigma are interdependent. Education emerges as one of the key determinants that influence the practices and perceptions and consequently the need to have comprehensive strategies that integrate education, economic support and cultural transformation.

DISCUSSION

Figure: Social Stigma Indicators
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CONCLUSION

The study provides an elaborate explanation of the menstrual hygiene and the social stigma of married women. It demonstrates that even though the fact that some steps have been taken is as far as the level of awareness and use of the product is concerned, there are still some problems. Poor infrastructure, economic factors, and the holding of vehement cultural beliefs are still a hindrance to safe and dignified management of menstrual hygiene. The continuation of social stigma highlights the importance of beyond hygiene education interventions. The programs must be directed to alter the attitude within the society, promote open communication and empower women to make informed decisions. Community based activities, involving men in awareness campaigns and policy actions to improve access to affordable sanitary products are needed.

The results indicate that menstrual health is not just a personal concern but a social justice and health issue in the community. To address it, an overall approach must be formulated which integrates education, infrastructure, and cultural change. They will assist in attaining improved health results, degree of dignity and elevated degree of gender equality.

Implications for Future Research

The future research needs to examine longitudinal trends to determine how changes occur with time and measure the effects of interventions. A number of comparative studies with different cultural settings might lead to a better realization of the position of societal norms. Also, qualitative research on lived experiences can be used as a complement to quantitative results and provide a more refined view of the menstrual health of married women.

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