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Research Article

Menstrual Health Awareness, Social Taboos, and Gender Perceptions Among Bhil and Bhilala Women in Urban Informal Settlements of Indore: An Exploratory Study

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Abstract

Menstruation is a natural physiological process that remains deeply entangled with social taboos, cultural restrictions, and gendered power structures in India, particularly among marginalised communities. This exploratory study examines menstrual health awareness, hygiene practices, social taboos, household pressures, and gender perceptions among Bhil and Bhilala tribal women residing in Avantika Nagar, an urban informal settlement in Indore, Madhya Pradesh. Using purposive sampling, 25 participants with 15 Bhil and 10 Bhilala women aged 15 years and above were recruited through trained female community data collectors. Findings indicate that 80% of participants had no knowledge of menstruation before their first period; fear was among the most commonly reported first reactions; and all participants perceived menstruation as impure in some form, regardless of educational level. Descriptive cross-tabulation did not reveal a clear pattern linking mother's educational attainment to daughters' menstrual awareness. The Bhilala community demonstrated comparatively higher awareness than the Bhil community. These findings are situated within frameworks of gender theory, social constructivism, and intersectionality, and suggest that cultural taboos persist in urban informal settlement contexts and are not automatically resolved by residential migration alone. The study identifies gaps in community-based menstrual health interventions and proposes gender-sensitive recommendations for urban health policy. Given the small and exploratory sample, findings should be interpreted as context-specific insights rather than generalisable conclusions.

Keywords:

Menstrual Health, Menstrual Hygiene Management, Urban Informal Settlements, Tribal Women, Bhil, Bhilala, Social Taboos, Gender Inequality, Intersectionality, Urban Migration

How to Cite This Article

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Introduction

Menstruation is a universal biological process, yet it remains one of the most socially regulated, stigmatised, and silenced aspects of women's lives across India. For tribal women who have migrated from rural communities to urban informal settlements, this silence is compounded by the simultaneous disruption of traditional kin-based support networks and the absence of adequate institutional healthcare infrastructure in slum settings. Indore, as a rapidly urbanising commercial capital of Madhya Pradesh, attracts significant labour migration from the state's tribal belt. Bhil and Bhilala women who settle in its peripheral informal settlements navigate culturally inherited practices around menstruation within specific material constraints: limited access to private toilet facilities, shared water infrastructure, minimal domestic privacy, and economic conditions that make commercial sanitary products unaffordable for many households.

Recently, the National attention to menstrual health and hygiene management (MHM) has grown substantially, particularly by campaigns such as #EndPeriodShame, and endorsement by government-subsidised sanitary napkin schemes under the Pradhan Mantri Jan Dhan Yojana. Despite the policy attention, evidence on the lived experiences of tribal migrant women in urban slums remains limited. Most academic studies examine either rural tribal communities in their places of origin or urban women within the broader umbrella, without attending to the specific intersection of tribal cultural practices, post-migration dislocation, and urban marginalisation (Gupta et al., 2025; Mukherjee et al., 2024).

This study addresses a specific and underexplored research gap: no published study has systematically examined menstrual health awareness and practice among Bhil and Bhilala women within the context of urban informal settlement living in central India. While these communities have been studied in their rural districts of origin, primarily in Jhabua and Alirajpur- their post-migration experience in cities like Indore has received no systematic scholarly attention. Indore is a particularly relevant site because it is among the fastest-growing Tier-II cities in Madhya Pradesh and draws substantial labour migration from the tribal belt, making it a natural destination for Bhil and Bhilala families. The informal settlements surrounding its industrial periphery house significant concentrations of these communities, yet remain entirely absent from MHM research. Primary data collected from 25 community members in Avantika Nagar, Indore, addresses this gap directly.

To the best of the author's knowledge, no published study has systematically examined menstrual health practices and perceptions among Bhil and Bhilala women in the specific context of urban informal settlements in central India. By collecting primary data from 25 community members in Avantika Nagar, this study begins to address that gap, while remaining appropriately modest about the generalisability of its findings given the exploratory sample. Given the exploratory and small-scale nature of this study, the findings are intended to generate contextually grounded insights rather than population-level generalisations, and should be read as a basis for further, larger-scale research.

This study is guided by the following research questions:

(1) What is the level of menstrual health awareness among Bhil and Bhilala women residing in Avantika Nagar, Indore?

(2) What social restrictions, cultural taboos, and household pressures shape their menstrual experiences in an urban slums context?

(3) Is there a discernible descriptive pattern between mother's educational attainment and daughters' prior menstrual awareness?

(4) How do Bhil and Bhilala communities compare in their menstrual knowledge, hygiene practices, and gender perceptions?

These questions are addressed through descriptive frequency analysis and thematic interpretation of primary data collected from 25 participants in 2024.

Literature Review

Menstruation, Social Taboo, and Silence in India

Menstrual taboos in India are structurally embedded in social life in form of religious frameworks, caste norms, and gendered household system going beyond the context of both urban and rural regions (Garg&Anand, 2015). (Dambhare et al ., 2012), studying school-going adolescent girls in central India

identified social silence around menstruation as a primary driver of inadequate self-care, and documented dysmenorrhoea, numerous restrictions, and behaviour leading to poor health and hygiene management. The mean menarche age in their study was 13.51 years is consistent with the mean of 12.72 years documented in the present study, a useful regional benchmark.

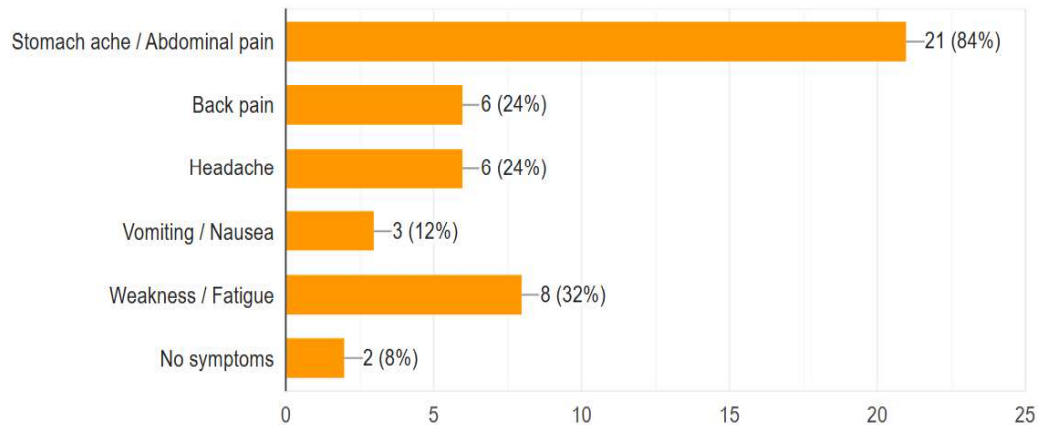
(Chothe et al ., 2014) found that one in six girls had encountered questions about menstrual myths and taboos without preliminary education, displaying that institutional schooling does not substitute for open family communication. (Shah et al ., 2013) in a study of tribal adolescent girls in rural Gujarat, found that the majority study participants of study used old cloth or flannel during menstruation, with sanitary pad use limited to approximately 32% of respondents, a finding attributes preference of cloth based on cultural acceptability rather than mere ignorance. In our study it is found that Majority females (Around 52% using old cloth during Periods), On a positive side around 24% of females admit that they use sanitary pads during that phase. However, 17 females (around 68% of the total study participants) confirmed that they are aware of sanitary pads but do not use them. (Mukherjee et al ., 2024), in a cross-sectional study of approximately 530 tribal married women in West Bengal, found that cultural restrictions on menstrual practice remained prevalent regardless of family structure.

Taken together, these studies point to several areas of agreement in the literature: menstrual taboos in India are structurally reproduced rather than simply inherited; awareness of hygienic alternatives does not automatically translate into their adoption; and family communication, particularly maternal communication, remains a central yet unreliable channel for menstrual health knowledge. Where studies diverge is on the relative influence of education: some research suggests educated mothers improve daughters' menstrual knowledge (Rana&Jami, 2018), while others, including the present study, find no such clear pattern (Dambhare et al ., 2012). This divergence suggests that education's effect on menstrual norms is highly context-dependent and mediated by cultural and social structures that operate independently of formal literacy. The present study contributes to this debate by examining these dynamics in an urban slum setting that earlier literature has not addressed.

Tribal Women's Menstrual Health: Bhil and Bhilala Contexts

Research on Bhil and Bhilala communities specifically addressing the health and hygiene issue is limited. (Khanna et al ., 2005), in their study on Bhil women in Rajasthan, identified silence, and ritual impurity structured the menstrual experience to great extent, where mothers, sisters and friends functioning as the primary information channel on menstrual hygiene management. (Kapoor&Kumar, 2017) in the study of women from Saharia tribal community in Madhya Pradesh, documented the aspect of menopause related to absence of formal health engagement. Both the studies established that menstrual health and hygiene knowledge requires an active, supported knowledge transfer which is systematically undermined by the cultural silence that this study also documents.

(Mane et al ., 2012) identified the mean menarche age as 13.09 years on comparing two tribal groups in Bijapur, Karnataka, and documented that the majority of girls experienced abdominal pain as the physical symptoms during the first experience. The findings are consistent with the present study's outcomes that a majority of participants (72%) experienced stomach ache during menstruation.



Kumar (2020) further added that when it comes to improving the tribal menstrual health the education attainment combined with socioeconomic changes have the immense potential, for improving tribal menstrual health, although the present study's data suggest that this relationship is neither automatic nor linear.

Urban Migration, Slums, and Menstrual Health

The relationship between urban migration and health outcomes for tribal communities in India is among the most complex and underexplored areas in the literature. (Akter et al ., 2008) showed how circular migration from Madhya Pradesh's tribal areas creates distance among close social circle and family ties that people rely on to pass down knowledge related to health and hygiene management, especially about the bodily phenomenon. When a woman moves from Jhabua to Indore, she leaves behind the close circle of female relatives and neighbours through whom knowledge about menstrual management would typically be passed.

Life in urban informal settlements adds further specific challenges. Many households lack private toilet facilities, washing spaces are shared, and the inability to dispose of menstrual waste discreetly compounds the experience of stigma that cultural taboos already produce. While ASHA workers and Anganwadi centres are present in principle, the present study found that very few participants had been reached by any such outreach on menstrual health matters , a finding that points to a significant gap between institutional presence and actual programme reach. (Gupta et al ., 2025), in a community-based cross-sectional study of adolescent girls in urban slums of India, found that menstrual hygiene practices were significantly influenced by both socioeconomic determinants and prevalent social norms- a pattern consistent with the present study's findings. Taken together, these studies establish three consistent patterns in the literature.

First, menstrual taboos in India are actively reproduced through social and religious norms rather than simply inherited passively. Second, awareness of hygienic alternatives, including sanitary pads, does not automatically translate into their adoption, given that cultural acceptability, cost, and community expectations function as independent barriers. Third, family communication, particularly maternal communication, is an unreliable channel for menstrual health knowledge even when mothers are educated. The present study adds to this body of evidence by examining these dynamics in an urban informal settlement context involving two specific tribal migrant communities, a setting and population that earlier literature has not systematically addressed.

Theoretical Framework

Gender Theory

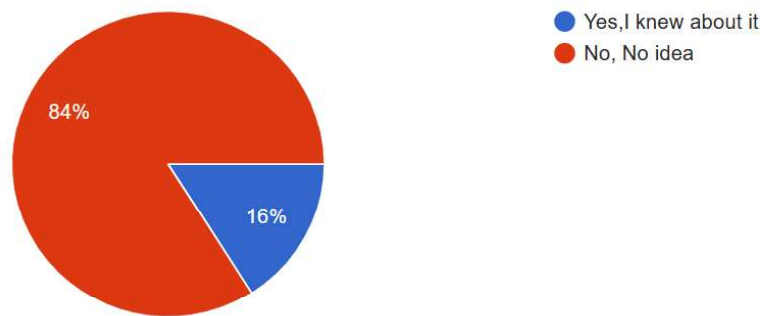
This study draws first on feminist gender theory, particularly Butler's (1990) account of gender as constituted through repeated social acts rather than biological fact. Applied to menstruation, Butler's (1990) framework directs attention to how menstrual taboos are not natural properties of the female body but active social productions, constituted through repeated acts of restriction, silence, and exclusion, that mark menstruating women as unreliable, impure, and in need of behavioural management (Butler, 1990). The taboo is not discovered; it is performed and re-performed across generations until it appears inevitable. The finding that all 25 participants regardless of age, education, or income perceived menstruation as impure in some form is powerful evidence for the social constructivism of this perception as it deeply reflects socialised normative frameworks that education has not disrupted.

Social Constructivism

Social constructivism directs attention to how knowledge about menstruation is produced, transmitted, and utilized through social processes. The systematic withholding of menstrual information from girls before menarche, resulting in 84% of participants having no prior knowledge. The systematic withholding of menstrual information from girls before menarche resulting in 80% of this study's participants reporting no prior knowledge, is not a neutral information gap but a deliberate social silence that is actively maintained by the same cultural norms that designate menstruation as an unsuitable topic for open conversation. As a result, girls' initial encounter with menstruation is shaped not by biological understanding but by a framework of rules, restrictions, and implicit shame. This social management of bodily knowledge is a central mechanism through which gendered norms are reproduced across generations, and it operates independently of formal education levels, as the present study's data demonstrate.

Did you know about menstruation before your first period?

25 responses



Intersectionality

Intersectionality framework is essential for understanding the specific compound vulnerabilities documented in this study (Crenshaw, 1989). Participants are simultaneously tribal women, urban migrants, residents of informal settlements, and members of specific religious communities (Christian Bhil and Hindu Bhilala). Each of these identity dimensions generates distinct constraints on menstrual health knowledge, practice, and experience, and their intersection produces a compound vulnerability that no single-axis analysis can adequately capture. The finding that the Bhilala community demonstrates higher awareness than the Bhil community, for example, cannot be explained by education levels alone but requires attention to the different religious and cultural frameworks governing menstrual knowledge transmission in the two communities.

Methodology

Research Design

This study adopts an exploratory mixed-methods design, integrating semi-structured qualitative interview data with descriptive quantitative frequency analysis with cross-tabulation. The exploratory design reflects both the limited literature published on specific population and context, with the epistemological conviction that understanding menstrual experience in this setting requires attending to the particularity and depth of women situated knowledge rather than testing pre-specified hypotheses. The qualitative dimension including the interview responses, participant narratives, and contextual observations gathered through community-facilitated data collection provides the frame within which the quantitative frequency data gathers analytical meaning of phenomenon. It is important to clarify how the quantitative and qualitative components relate to one another in this study. The quantitative dimension, descriptive frequencies and cross-tabulations, provides a structured overview of patterns across the 25-participant sample. The qualitative dimension, thematic analysis of open-ended responses and participant narratives, provides interpretive depth that frequency counts alone cannot convey. These components are not treated as parallel

analyses but as mutually informing: numerical patterns are contextualised through the themes that emerged from participants' own words, and the qualitative themes are grounded in and checked against the frequency data. Given the small sample size, all frequency findings are presented as descriptive observations about this specific community at this specific time, and not as evidence for broader population-level claims.

The quantitative dimension descriptive frequency analysis and cross-tabulation provide a structured overview of patterns across the sample. The qualitative dimension thematic analysis of open-ended interview responses and participant narratives provides interpretive depth that the frequencies alone cannot convey. Crucially, these two components are not treated as separate analyses but as mutually informing: numerical patterns are interpreted through the themes that emerged from participants' own words, and qualitative themes are grounded in and checked against the frequency patterns. This integration follows the exploratory sequential approach, in which qualitative insight guides and contextualises quantitative description rather than providing a separate parallel analysis

Study Setting

The study was conducted in Avantika Nagar, an urban slum in Indore, Madhya Pradesh. Indore a commercial capital of Madhya Pradesh, and Avantika Nagar is one of several urban slums where migrant tribal families can be seen working in construction, domestic service, and small-scale manufacturing. The slum comprises of significant populations from Bhil and Bhilala communities who migrated from Jhabua and Alirajpur districts of Madhya Pradesh's tribal belt. The area is characterised by high population density, lacks formal sanitation infrastructure, lack access to health services, and zero private spaces, directly impacting the menstrual health challenges documented in this study.

Participants and Sampling

A total of 25 female participants were recruited using purposive convenient sampling: 15 from the Bhil community and 10 from the Bhilala community. Inclusion criteria required female gender, residence in Avantika Nagar, personal experience of menstruation, age of 15 years or above, and provision of informed verbal consent. Exclusion criteria were inability or unwillingness to provide consent and age below 15 years. Participants from the 15–25 age group included women aged 15 to 17 years. For these younger participants, community data collectors additionally obtained verbal assent from the participants themselves and verbal permission from a parent or guardian present in the household before any interview was conducted, consistent with ethical best practice for research involving minors in community settings where written literacy is variable.

The sample was not designed to be statistically representative of the wider community but to provide a sufficient range across age groups (15–25 years: 40%; 26–35 years: 32%; 36–45 years: 20%; 46–50 years: 8%), tribal affiliations,

educational levels, and family income categories for exploratory comparative analysis. The mean age of participants was 24.56 years.

Data Collection

Data were collected through semi-structured interviews administered using a Google Form covering six thematic domains: (1) socio-demographic profile; (2) menstrual awareness and first experience; (3) hygiene practices; (4) social restrictions and taboos; (5) household pressure and family dynamics; and (6) urban contextual factors including access to sanitary products and health information since residing in Indore. The instrument was designed in English, translated into Hindi, and reviewed by both community data collectors for linguistic ease and cultural appropriateness before use.

A critical feature of the data collection design was the use of trained female community data collectors rather than direct researcher-participant interaction. Two female community members from Avantika Nagar, who were familiar to and trusted by participants in both the Bhil and Bhilala communities, were selected for this role. They received two structured training sessions covering: the study's purpose and ethical procedures; the instrument's questions and the intent behind each; verbal consent and assent procedures, including specific guidance for participants aged under 18; procedures for managing distress or discomfort during the interview; and guidance on recording responses accurately on the Google Form platform. The training was conducted by the researcher in Hindi and included a pilot administration with two community members not included in the study sample, which resulted in minor wording clarifications to three questions before formal data collection commenced.

Responses were recorded on printed document (in hindi language) and then entered into the Google Form after the end of each interview session and submitted digitally, generating a structured dataset validated for completeness before analysis. The reason behind this approach was first, to reduce social desirability bias that direct researcher presence might generate on a sensitive topic in a close-knit slum community; second to ensure and even enhance the cultural safety and communicative comfort for study participants; lastly to enable data collection within the logistical constraints of the researcher ongoing employer engagement.

Data Analysis

Quantitative data were analysed using descriptive frequency analysis and cross-tabulation. Where the paper refers to patterns in the relationship between two variables, for example, between mother's education and daughters' menstrual awareness- results are described as reflecting or not reflecting a clear descriptive pattern, without claims of statistical significance, as no inferential statistical tests were conducted. Qualitative responses from open-ended interview questions were analysed using manual thematic analysis following Braun and Clarke's (2006) six-phase framework. Thematic analysis proceeded as follows. During familiarisation, the researcher read all 25 responses in both Hindi and English

multiple times before generating any codes. Initial coding labelled recurring patterns in the raw data, for example, "fear at menarche," "religious restriction during menstruation," "mother's silence on the topic," and "awareness of pads but preference for cloth." These initial codes were then grouped into broader thematic clusters: codes relating to religious, food, and spatial restrictions clustered into the theme of "menstrual taboos and religious restrictions"; codes relating to first reactions and information sources formed the theme of "gender perceptions and menstrual awareness"; codes relating to mother-daughter communication and the influence of elder women formed the theme of "household pressure and family dynamics"; and codes relating to hygiene product choice and impurity perception formed the theme of "stigma around hygiene practices." Each theme was reviewed against the full dataset to ensure it was grounded in evidence from multiple participants rather than isolated individual responses. Participant quotations selected for the findings section were chosen because they represent patterns observed across the data, not because they are exceptional cases.

Ethical Considerations

This study was conducted in adherence to standard ethical principles governing social science research involving human participants. The following safeguards were implemented throughout.

Voluntary informed consent. Before each interview began, community data collectors explained the study's purpose, voluntary nature, and participants' right to withdraw at any time without consequence. Verbal informed consent was obtained from every adult participant. No participant was coerced, offered incentives, or pressured to take part. The verbal consent procedure was adopted in place of written consent for two reasons. First, the sample included participants with variable literacy levels, and written documentation cannot be assumed to be fully readable by all. Second, in urban informal settlement contexts, the presentation of formal written documents by an unknown researcher can generate anxiety about administrative or legal consequences, a documented barrier to research participation in marginalised communities (Gupta et al., 2025). The verbal consent procedure was followed consistently across all 25 participants and was rehearsed with data collectors during training.

Consent and assent for minor participants. Among participants aged 15–25, some were aged 15 to 17 years at the time of data collection. For every participant aged below 18, community data collectors obtained two forms of permission before proceeding: first, verbal assent from the participant herself confirming that she understood the study and was willing to take part; and second, verbal permission from a parent or guardian who was present in the household. No minor was interviewed without both forms of permission. Data collectors were trained specifically on this procedure and it was verified for each under-18 participant before their interview commenced.

Confidentiality and anonymity. No names, contact details, or personally identifying information were recorded at any stage of the study. Participants are identified in this paper only by community affiliation (Bhil or Bhilala) and broad

age group where their words are quoted. All digital data stored on the Google Form platform was secured in a password-protected account accessible solely to the researcher and has not been shared with or disclosed to any third party. Data was used only for the purposes of this study.

Sensitive topic management. Given the socially stigmatised nature of the research topic, community data collectors were trained to monitor participants for signs of distress and to stop the interview immediately if any participant appeared uncomfortable. Participants were reminded at the start of each session that they did not need to answer any question they found uncomfortable, and this was presented as part of the standard opening of each interview rather than as an afterthought.

Absence of formal institutional ethical approval. This study did not obtain formal institutional ethics board approval prior to data collection. This is explicitly acknowledged as a limitation of the study. The research was conducted as an independent community-based enquiry undertaken outside a formal institutional research programme, and no ethics committee application was submitted at that time. The study involves no clinical procedures, biological specimens, identifiable personal data, or data linkage. Nevertheless, the absence of formal ethics review means that the safeguards described above were implemented by the researcher independently rather than verified by an external committee. The researcher acknowledges this as a methodological weakness and commits to obtaining full institutional ethical clearance before conducting any follow-up or expanded research.

AI use. AI-assisted writing tools were used for structural drafting support during the preparation of this manuscript. The author takes full intellectual responsibility for all content, analytical claims, interpretation of findings, and factual accuracy throughout. No AI tool was used for data collection, data analysis, coding, or the generation of research findings.

Positionality and Researcher Reflexivity

The researcher is a male sociologist based in Indore, working outside the tribal communities under study. This positionality introduces several risks that the study design sought to mitigate: the risk that a male researcher's direct presence would inhibit honest response on a gendered bodily topic; the risk that outsider framing would impose categories on participants' experience; and the risk that logistical constraints would compromise data quality. The use of female community data collectors from within the communities addressed the first two risks directly.

Results and Findings

Socio-Demographic Profile

Table 1 presents the socio-demographic profile of the 25 participants. The sample comprises 15 Bhil women (60%) and 10 Bhilala women (40%). 84% of total participant were literate with at least primary education completed and 16% were illiterate. Regarding religion, all Bhil participants were identified as Christian and all Bhilala participants identified as Hindu; this results in 13 Christian respondents (52%) and 12 Hindu respondents (48%) figures that reflect the community sample structure rather than religious diversity within either community. The largest income group (48%) reported an annual family income of ₹30,000–₹40,000.

Table 1. Socio-Demographic Profile of Respondents (N = 25)

S.No.	Variable	Category	Frequency	Percentage (%)
1	Age Group	15–25 years	10	40%
		26–35 years	8	32%
		36–45 years	5	20%
		46–50 years	2	8
		TOTAL	25	100%
2	Tribal Community	Bhil	15	60
		Bhilala	10	40
		TOTAL	25	100%
3	Religion	Christian (all Bhil)	13	52
		Hindu (all Bhilala)	12	48
4	Literacy Status	Literate	21	84
		Illiterate	4	16
		TOTAL	25	100%

Note. All 15 Bhil participants identified as Christian and all 10 Bhilala participants identified as Hindu, yielding 13 Christians (52%) and 12 Hindus (48%) in the religious identity variable as recorded in the instrument.

Age at Menarche

Table 2 presents the distribution of age during first menarche of the two communities. The combined mean age at menarche is 12.72 years. Bhil participants experienced menarche predominantly at ages 14–15 (73.3%), while Bhilala participants experienced menarche earlier, predominantly at ages 11–13 (70%). This inter-community difference in menarche timing is consistent with nutritional and developmental patterns documented in the broader tribal health literature (Mane et al., 2012).

Table 2. Age at Menarche by Tribal Community

S.No.	Age at Menarche	Bhil (f)	Bhil (%)	Bhilala (f)	Bhilala (%)
1	Do not recall	1	6.7	1	10.0
2	11 years			2	20.0
3	12 years			2	20.0
4	13 years	2	13.3	3	30.0
5	14 years	5	33.3		
6	15 years	6	40.0	1	10.0
7	16 years	1	6.7	1	10.0
Total	25	15	100.0	10	100.0

Note: Mean age at menarche (combined) = 12.72 years. Bhilala community shows earlier menarche onset (70% between 11–13 years of age) compared to the Bhil community (73.3% between age 14–15).

Menstrual Awareness Before Menarche and Effect of Mother's Education

Across the combined sample, 80% of participants (20 of 25) reported having no knowledge of menstruation before their first period. This figure applies to the full sample of 25 participants, not only to the adolescent sub-group. Bhil participants showed lower prior awareness (13.3%, $n = 2$ of 15) compared to Bhilala participants (30%, $n = 3$ of 10). The awareness figures cited in the abstract (80% with no prior knowledge) and in the text are consistent and refer to the full sample of 25.

Table 3 presents a cross-tabulation of mother's educational level with daughters' menstrual awareness. The descriptive data do not reveal a clear pattern linking maternal education to prior menstrual awareness. Among Bhil participants, two who reported prior awareness had mothers with no education and with graduate-level education respectively. Among Bhilala participants, those who reported awareness came from households where mothers had primary, pre-secondary, and graduate education. These descriptive patterns suggest that maternal education alone does not determine whether menstrual knowledge is transmitted before menarche, consistent with Damhare et al. (2012). As no inferential statistical test was conducted, no claim of statistical significance is made; the pattern described is a descriptive observation.

Table 3. Mother's Educational Attainment Cross-Tabulated with Daughters' Prior Menstrual Awareness (Full Sample, N = 25)

	Mother's Education	Bhil Aware	Bhil (Not Aware)	Bhilala Aware	Bhilala (Not Aware)	Total Aware	Total (Not Aware)	Total (n)
1	Not educated / Illiterate	1	10	1	4	2	14	16
2	Primary education	0	2	1	1	1	3	4

3	Pre-secondary			1	1	1	1	2
4	Higher / Graduate	1	1	0	1	1	2	3
Total								25

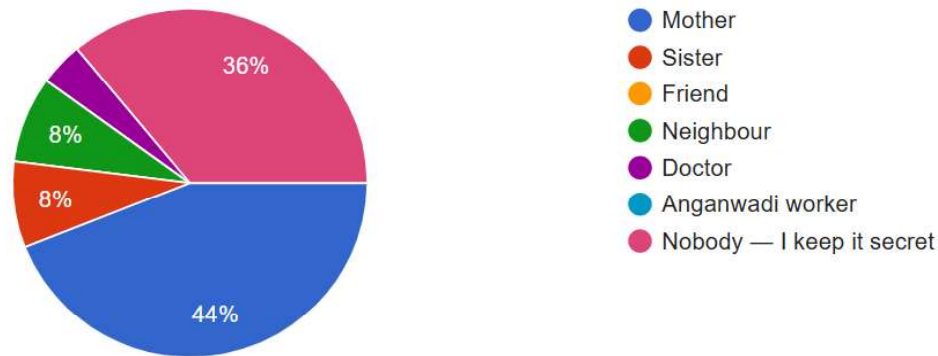
Note. Table refers to the full sample (N = 25). No inferential statistical test was conducted. Patterns are described at the descriptive level only. Aware = reported knowing about menstruation before menarche; Not = reported no prior knowledge.

The absence of any maternal preparation before menarche is illustrated directly in participants' own accounts. One Bhil participant (aged 22) recalled: "My mother never told me anything. When it happened for the first time, I thought I was very sick. I was crying. My elder sister came and told me to be quiet and showed me what cloth to use. Even now we do not speak of it openly." A Bhilala participant (aged 19) shared: "My mother knew about periods but said nothing to me in advance. I think she thought it was better for me not to know. When it happened, she just said 'this is women's work now' and handed me a cloth." These accounts illustrate that the absence of information is not incidental but structured, mothers who themselves learned menstruation through a framework of silence reproduce that silence with their own daughters, regardless of their educational level. This is consistent with the social constructivist argument that the withholding of menstrual knowledge is a practice that perpetuates itself through social transmission rather than through any deliberate individual choice.

These accounts, which are representative of a broader pattern in the data, demonstrate that silence is not a passive absence of information but an actively maintained social practice- the deliberate withholding of knowledge that serves to present menstruation as something governed by rules rather than understood through biology.

Social Restrictions and Perceived Impurity

All the 25 study participants irrespective of education level, age, or income perceived menstruation as impure in some form- either as completely impure or impure to some extent. Religious restrictions (for example, prohibition from entering places of worship or participating in religious activities) were reported by 48% of participants during menstruation; food restrictions by a further 48%. Additional reported restrictions include compulsory bathing, separate sleeping arrangements, prohibition from touching certain objects or persons, denial of using the mirror, and restriction from attending school and leaving the home.



Participants' own accounts illustrate the social character of these norms. One of the Bhil respondents (age 24) said:

"We restrict ourselves from sharing information about menstruation with our grandmother because of her conservative opinions leading to numerous other restrictions such as on food, daily routine, and hygiene".

A Bhilala respondent (age 20) observed:

'Sometimes I am more comfortable sharing this with a neighbour than with my own family members, because family members, particularly mother, have not created an atmosphere at home where such topics can be discussed openly. These statements highlight the prevalent norm of silence and the strategic navigation that participants have developed in response to it.

A third participant (Bhil, aged 31) offered a perspective that illuminates an important tension specific to the urban setting: "In the village, everyone knows these rules and no one questions them. Here in Indore, you see other kinds of women, you know not everyone follows the same restrictions. But inside the house, my mother-in-law still enforces everything. She does not accept that things can be different here." This account captures a dynamic that intersectionality illuminates clearly: exposure to a wider range of social norms through urban living does not automatically dissolve household-level cultural regulation, particularly when elder women retain authority over domestic space. The urban context creates the possibility of norm contestation without guaranteeing its outcome.

A third participant (Bhil, aged 31) offered a perspective that illuminates the intersection of urban living and cultural restriction:

"In the village, everyone knows these rules and follows them without question. Here in Indore, it is different because you can see other people's habits and you know there are women who do not follow the same restrictions. But inside the house, the grandmother still enforces everything. She does not understand that things can be different here."

This account captures a tension that is specific to the urban migration context: participants are exposed to a wider range of social norms through urban

living, yet the household remains a site of persistent cultural regulation, often enforced by older female family members whose authority within domestic space has not been diminished by the urban environment.

However, there are community health resources, such as ASHA workers and numerous Anganwadi centres to provide guidance and information on the same. Despite this latent preference for institutional contact this study identified one notable finding: 44% of participants indicated that they would be more comfortable discussing menstrual health with an Anganwadi worker than with family members, while the remaining 56% prefer to keep it a secret. This is something that should make urban health planners and policymakers to rethink the outreach and implementation approach regarding the menstrual health and hygiene.

Hygiene Practices and Physical Symptoms

Among Bhil participants, 73.3% reported normal blood flow, while 20% reported more than normal (heavy) flow and 6.7% reported scanty flow. Among Bhilala participants, 40% reported normal flow, 50% reported scanty flow, and 10% reported heavy flow. The proportion reporting heavy or potentially abnormal flow in the combined sample approximately 30% is clinically noteworthy and points to an underserved need for gynaecological health access in this population. Stomach ache was the most frequently reported physical symptom (72% of the total sample combined of Bhil and Bhilala), followed by back pain, headache, and general weakness.

Regarding hygiene practices, old cloth and flannel cloth remained the most commonly used absorbents across both communities, with 52% (Combined) using old cloth and a further remaining 48% use flannel. Approximately 24% of participants reported using commercial sanitary pads. Notably, 68% of the combined sample (17 participants) stated that they were aware of sanitary pads as an option but did not use them. Despite awareness regarding sanitary pads, the most commonly used absorbents still remain the old cloth and flannel cloth, this is consistent with findings of (Shah et al., 2013) that cultural preference for cloth reflects acceptability rather than lack of awareness.

Table 4. Summary of Key Findings by Community

Finding	Bhil (n=15)	Bhilala (n=10)
No prior knowledge before menarche	13/15 (86.7%)	7/10 (70.0%)
Perceived menstruation as impure	15/15 (100%)	10/10 (100%)
Used old cloth / flannel as absorbent	Majority (>70%)	Majority (>60%)
Normal blood flow	11/15 (73.3%)	4/10 (40.0%)
Stomach ache reported	Majority	Majority
No menopause awareness (women 36–50)	5/5 (100%)	0/2 (0% aware)
Religion	All Christian	All Hindu

Note: Summary figures are approximations from descriptive frequency analysis. The figures are self-reported responses.

Menopause Awareness

Among the seven women aged 36–50 in the sample, only two Bhilala women (20%) reported any knowledge of menopause, while no Bhil women show awareness of menopause in our study. The remaining 80% either had no knowledge or treated the phenomenon of menstruation as a natural requiring no specific health awareness. This finding is consistent with (Kapoor&Kumar, 2017)and (Mouli&Patel, 2020), indicates that menstrual health knowledge gaps extend across the life course and are not limited to adolescent experience.

Discussion

Cultural Norms Persist Beyond Urban Relocation

The most significant aggregate finding of this study is that migration to an urban slum has not disrupted the cultural norms of menstrual silence, restriction, and impurity perception that characterise Bhil and Bhilala communities from their origin. All 25 participants perceived menstruation as impure; 80% had no prior awareness at menarche; and comprehensive religious and social restrictions were reported across both communities. This finding challenges the implicit assumption in urban public health discourse that urbanisation has a potential protective factor for Menstrual health and hygiene outcomes among females from migrant communities.

Further the intersectionality framework can explain the persistence of these norms in urban slum context analytically. The vulnerable intersections such as tribal affiliation, gender perception, migration status, slum residence, economic hardships, that characterise these women's position in the urban social structure also isolate them from the formal health and educational systems due to numerous reasons. In our study only 2% of participants remembered contacted by ASHA workers during menstruation. This gap between presence of institutional health and education infrastructure and its outreach is the central to MHM challenge in urban slum context. Butler's (1990) concept of gender performativity offers a useful interpretive lens here. The cultural norm of menstrual silence is not simply a belief that people hold; it is a practice that people enact and re-enact, often without conscious deliberation. An ASHA worker arriving at a household to discuss menstruation is disrupting an enacted norm , a disruption that the household may resist not because the norm is consciously defended but because deviation from it feels socially dangerous. Intersectionality (Crenshaw, 1989) adds a further layer: tribal women in urban slums face simultaneously constrained access to state services, formal health systems, and household support. This layered exclusion means that the gap between institutional presence and actual reach is not primarily a programme design failure but a structural social problem that requires community-embedded and culturally sensitive responses.

Mother's Education and the Limits of the Information Model

The absence of a clear pattern linking mother's educational attainment to daughters' menstrual awareness is one of the most policy-relevant findings in this study. These findings invite scepticism toward the dominant information deficit model that underpins many MHM interventions- the assumption that increasing women's educational attainment will progressively reduce menstrual taboos and improve health outcomes. While this association may hold in some contexts, the present study's descriptive data suggest it does not hold consistently in this community setting. It is important to note, however, that the study's small sample prevents any definitive conclusions; the finding is offered as a context-specific observation that warrants investigation in larger studies. The data is also, consistent with (Dambhare et al., 2012), suggesting that cultural norms and related education operate in relatively independent domains. A mother who is educated but internalised menstruation as topic of silence or discomfort may not discuss it with her daughter openly, regardless of her literacy levels or urban setting in which they live.

Urban-Specific Constraints

Specific challenges are introduced when residing in an urban slums post migration that further compounds the cultural taboos. First and foremost is the absence of private toilet facilities, a characteristic of almost all the households in Avantika Nagar with no pucca houses, makes menstrual hygiene management publicly visible activating the experience of shame and difficulties in maintaining proper hygiene. Followed by the lack of financial and other resources of urban slum households, as despite awareness it makes regular use sanitary pads unaffordable for maximum of study participants. Lastly the migration from tribal to urban regions establish a break of kin networks and social advice groups making maternal and sisterly guidance primary channel of menstrual information in the communities of origin which are often imperfect, in the urban settings. It would, however, be analytically incomplete to present these women solely as constrained by circumstances. Several participants showed deliberate and quiet navigation of the norms governing their lives. Some reported confiding in trusted neighbours rather than family members when they needed practical guidance on menstruation. Others reported maintaining hygiene practices privately that they did not disclose to household members who might disapprove. A small number reported using sanitary pads without telling elder family members. These are modest strategies within structurally constrained conditions, but they constitute a form of agency, what social constructivism would describe as the negotiation of norms from within, rather than passive acceptance. Community health programmes that recognise and engage with this existing agency, rather than treating participants as recipients of health education, are likely to be more effective and more respectfully designed.

Conclusion

This study has examined menstrual health awareness, hygiene practices, social taboos, and gender perceptions among 25 Bhil and Bhilala women in

Avantika Nagar, an urban informal settlement in Indore. The findings demonstrate that cultural norms of menstrual silence, impurity, and restriction persist in a post-migration urban context, and that the structural conditions of slum life add specific material constraints to these inherited cultural burdens. Three contributions are made: the documentation of urban persistence of tribal menstrual taboos; the descriptive finding of no clear pattern between maternal education and daughters' menstrual awareness; and the revelation of meaningful intra-tribal variation between Bhil and Bhilala communities.

The theoretical contributions of the study lie in its integrated use of gender theory, social constructivism, and intersectionality to argue that menstrual taboos are not pre-social residues that education or urbanisation will automatically dissolve but are actively reproduced through intersecting structures of gender, caste, religion, and class. Policy interventions that treat MHM as solely an information gap problem will not address these structural mechanisms.

The policy implications are specific. First, ASHA worker outreach in areas housing tribal migrant communities should be redesigned around the specific cultural and social context of Bhil and Bhilala women, including the provision of gender-safe spaces for MHM discussion that are not accessible through standard household visits. Second, subsidised sanitary product distribution should be integrated into the household-level welfare provisioning that already reaches informal settlements through the Public Distribution System and ICDS, rather than relying on women's individual purchase capacity. Third, urban development frameworks including the Smart Cities Mission and the PMAY-U slum rehabilitation programme should incorporate private sanitation access as an MHM-enabling infrastructure requirement.

The study's limitations require transparent acknowledgement and must inform how its findings are received. The sample of 25 participants, selected through purposive convenient sampling from a single settlement, is appropriate for exploratory research but does not permit statistical generalisation to the broader Bhil and Bhilala populations or to tribal migrant women in Indian cities more widely. All findings should be read as contextually grounded, hypothesis-generating insights rather than definitive evidence. The use of community data collectors, while ethically and practically appropriate in this context, introduces a layer of mediation between participant responses and researcher interpretation that cannot be fully eliminated. The instrument was piloted but not formally validated against a standardised scale. The absence of formal institutional ethics board approval is acknowledged as a significant methodological limitation, as detailed in Section 3.6. The inter-community comparisons between Bhil and Bhilala participants are based on sub-groups of 15 and 10 respectively, which limits the reliability of any comparative claims; these are offered as descriptive observations to motivate future investigation rather than conclusions. Future research should pursue larger, multi-settlement samples to enable inferential statistical analysis; longitudinal designs to track how menstrual norms adapt across years of urban residence; comparative studies between communities of different religious compositions to rigorously examine the religious-cultural dimension of menstrual knowledge transmission; and community-participatory

research designs that involve Bhil and Bhilala women as co-researchers from the outset.

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Authors' Contributions

Author conceived the study design, adapted and piloted the research instrument, coordinated community data collection, conducted the thematic and descriptive analysis, and drafted and revised the manuscript in its entirety. The author has read and approved the final version of the manuscript.

Conflicts of Interest

The author declares that they have no competing interests.

Ethical Approval

This study was conducted in adherence to the ethical principles of social science research involving human participants. Verbal informed consent was obtained from all adult participants; verbal assent from minor participants (aged 15–17) was obtained alongside verbal permission from a parent or guardian. Full anonymity was maintained. No institutional ethics board approval was obtained prior to this study; this limitation is explicitly acknowledged in Section 3.6, and the author commits to seeking formal ethics committee approval for any follow-up large scale research.

AI Use Declaration

AI-assisted writing tools were used for structural drafting support in preparing this manuscript. The author takes full responsibility for the intellectual content, analytical claims, interpretation of findings, accuracy of data, and all statements made in the paper. No AI tool was used for data collection, data analysis, or production of the research findings.

Originality and Plagiarism Declaration

The author confirms that this manuscript is original, has not been previously published, and is not under consideration by any other journal or publisher at the time of submission.

Data Availability Statement

The primary data collected through semi-structured interviews using Google Forms is held securely by the author. Anonymised data may be made available to the journal editors or peer reviewers upon reasonable request.

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