

‘Menstrual blood is bad and should be cleaned’: A qualitative case study on traditional menstrual practices and contextual factors in the rural communities of far-western Nepal

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Abstract

Objective: Unhealthy menstrual practices and the contexts surrounding them should be explored and clearly understood; this information could be useful while developing and implementing interventions to increase hygienic practices during menstruation and consequently increase health and well-being of women. Therefore, this study was conducted to explore traditional menstrual practices and the contextual factors surrounding the practices in the rural communities of far-western Nepal.

Methods: This was a qualitative case study conducted in the Achham district of Nepal. Semi-structured interviews were conducted among four women, three men and two female community health volunteers to collect data and thematic analysis was performed to analyze the data.

Results: We found two commonly reported menstrual practices: seclusion practice (Chhaupadi) and separation practice. In the Chhaupadi practice, women are secluded to stay in a small shed away from the house and restricted to wash or take a bath in public water sources for 5–7 days of the periods, whereas in the separation practice, women can stay in the house, but they still have several restrictions. The contextual factors that were reported to influence the cultural practices are as follows: cultural beliefs that symbolize menstruation as impure, menstrual stigma, poverty, illiteracy, the influence of traditional healers and family members, and limited effect of Chhaupadi elimination interventions. We also found that some development in the reduction of cultural myths and practices is happening, but the rate of change is rather slow.

Conclusion: Most of the Nepalese women, especially in the rural areas of far-western Nepal, are forced to follow the harmful menstrual practices because of the socio-cultural context surrounding their lives. We believe the findings of this study would be relevant in terms of developing and implementing further menstrual health-related, community-based interventions that will be responsive to the local cultural context, beliefs, and practices.

Keywords

Chhaupadi, contextual factors, menstrual health interventions, menstrual stigma, Nepal, traditional menstrual practices

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Introduction

Menstrual beliefs and practices are often culturally constructed.¹ In some cultures, menstruation is considered a sign of physical maturity and fertility; however, in some, it is considered a source of pollution and impurity.^{2,3} Several studies have indicated that menstruation is subjected to several forms of stigma in many communities.^{1,2,4} For instance, in some communities, women fear revealing about their periods, and hide it from the male (family) members and, have

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restrictions in relation to daily activities, foods and clothing during their periods.² In addition to social stigma and traditional practices, physical symptoms, such as menstrual cramps, feeling sick or disgusted, or experiencing disruptions of mood, aggravate menstrual experience, and thus, women are more likely to report negative attitude toward menstruation.^{4,5} The way menstrual beliefs and practices prevail in many societies, in one way or the other, impacts women's emotional state, mentality, lifestyle and most importantly, health.⁵

Menstrual health management (MHM) has received some attention over the last decade in low- and middle-income countries (LMICs), and alongside several interventions (e.g. awareness-raising interventions and interventions to provide sanitary products, such as menstrual cups and disposable sanitary pads) have been implemented in practice.^{6–8} The ultimate goal of the MHM interventions is to ensure that women and girls can manage their periods in a way that is not only healthy but that enables their full participation in school, work and other activities.⁵ Although current results of these interventions are promising, there is still insufficient evidence to establish their effectiveness in terms of positive menstrual health outcomes in LMICs and there is the lack of evidence on MHM in different cultural contexts.⁵ In addition, it is argued that, wealthy, urban and educated women are more likely to participate in these interventions, and women who belonged to vulnerable population groups and those living in remote and rural areas are often underrepresented.⁸ Kuhlmann et al.⁶ reported that girls and women residing in the rural areas of LMICs have poorer menstrual health and hygiene status, and the MHM interventions have been less effective in rural areas because of the influence of underlying local-contextual factors (e.g. lack of familial and social support, and lack of cultural acceptance of menstrual health products).

In Nepal, several MHM interventions have been implemented in practice over the last decade. The examples of the interventions include the following: developing the national guideline for MHM, legislation against menstrual seclusion, education and awareness programs on menstrual health and hygiene (e.g. education on menarche, healthy menstrual practices, use of menstrual aids such as sanitary napkins and management of menstrual disorders), incorporating the topic of menstruation health in school curricula and construction of toilet facilities in the schools.⁹ A recent quantitative study has reported that certain ethnic groups, especially in the rural areas, have largely fallen behind in terms of menstrual health outcomes, and these blanket menstrual hygiene management programs may not be sufficient for improving menstrual knowledge and practices among the population groups who live in the rural areas.¹⁰

In many rural communities of Nepal, menstruation is generally considered unholy and impure, and menstrual restrictions and social stigma are prevailing.^{1,4,11,12} Kadariya and Aro¹³ reported that almost 90% of women and girls throughout the country experience some form of restrictions or

exclusions during their periods. For instance, in the rural areas of mid- and far-western regions of Nepal, a practice to seclude women in a shed away from the house during periods called “Chhaupadi” is widespread, and this practice is largely considered the most extreme form of menstrual restrictions.⁹ Especially, the far-western region of Nepal is developmentally poor and lacks access to health care, and therefore, traditional menstrual beliefs and practices might be more pronounced in the rural communities of the far-western region of Nepal impacting women's health due to limited access to health and family care.^{5,14} The prevailing menstrual beliefs and practices, such as Chhaupadi, had led to increased rate of women's reproductive health problems, such as pain in lower abdomen, subfertility, urinary problems and abdominal lumps.^{1,4,12,13,15}

A qualitative exploration of context-specific information, such as cultural (indigenous) beliefs and practices, could be imperative to tailor the existing MHM interventions into local context to achieve positive outcomes.¹⁰ For instance, without a consideration of the local context, the resources provided by the MHM interventions (e.g. sanitary pads, toilets and other facilities) will often go unused, or will be used in a manner not intended by the program managers.⁹ In addition, unless the prevailing traditional beliefs and practices are clearly understood, it is difficult for health and social workers to serve as sources of information or make a direct impact on changing women's menstrual health and hygiene-related practices.¹⁶ Therefore, in this study, we opted for a qualitative case study approach to explore the traditional menstrual practices and the contextual factors surrounding the practices in the rural communities of the far-western region of Nepal.

Methods

A qualitative case study was conducted in the Achham district of Nepal. It was assumed that the reality surrounding menstrual practices is constructed among the community members through shared beliefs and understandings developed socially and experientially. Thus, a qualitative case study would contribute to the understanding of a complex phenomenon, such as menstrual practices, and the context surrounding it.¹⁷

Study context

This study was conducted in Kuika, one of the poor villages nearby Mangalsen municipality (the headquarter) of the Achham district of Nepal. Achham is one of the poorest and least developed hill districts in the far-western region of Nepal (human development index scores: Kathmandu-0.632; Achham: 0.378).¹⁴ In Achham and other districts in the far-western region of Nepal, there are deeply rooted social issues, such as cultural misbeliefs, traditional health practices, caste-based and gender-based discrimination and exploitation.

Thus, for the reasons to understand and insure equity in health and well-being among Nepalese women, it is important to explore unhealthy cultural practices prevailing in the rural and poorer areas of Nepal.

Participants and sampling

This qualitative case study entailed studying the community residents that included women, men and female community health volunteers. The inclusion criteria were being at least 18 years old and showing willingness to participate in the study after being informed about the study purpose.

Participants were approached using a combination of purposive and snowball recruitment strategies. At first, a local community health worker was explained about the research purpose and requested to suggest a woman and a man to interview. Then, each participant was personally visited at his or her house in a locally convenient time to invite for the interview. Each participant was also purposively asked to suggest another participant who might have a different opinion or experience.

The reason behind inviting men for an interview was that they are the influencers in the family and neighborhood and might have witnessed women's menstrual experiences as an observer. The female community health volunteers are local women trained to provide some basic health services. They also serve as the members of women's group, a non-political group to meet every month and discuss about women's empowerment and mobilization, and poverty alleviation.¹⁸ We assumed that these women could explain their own beliefs and experiences and describe how they had been contributing to improve menstrual health and well-being in the community.

Data collection

A semi-structured interview guide was prepared in English and then translated into Nepali. We translated some Nepali words into the local dialect to avoid misinterpretation of the questions. The translated version in Nepali was then discussed with a community health worker familiar with Nepali and the local dialect, and discrepancies were reconciled.

We opted for a hybrid approach in our interviews, which began with one or two broad open questions, followed by a set of narrower a priori questions. We started the interview by asking questions that relate to the experiences and thoughts of the participants, and then probed further into our a priori topics according to the participants' initial thoughts. The a priori topics were the ones that were created in establishing our interview question guide.¹⁹

All interviews were undertaken by S.B. in May 2018. All the interviews were conducted in the participants' house and no other family members were present during the interview. Interviews lasted on average 35 min, ranging between 25 and 50 min. None of the researchers had prior knowledge of the

participants. A verbal informed consent procedure was completed with each participant. The participants were also asked for their consent to tape record the interview. Ethical clearance for the study protocol was provided by the Ethical Review Committee of Nepal Health Research Council (Reg. no. 258/2015).

Given the lack of transportation facilities in Achham, we were somewhat limited in options for recruiting participants and thus approached six women and three men nearby Mangalsen municipality (Kuika village) of the Achham district for the interview, and all agreed to participate in the study. Out of the nine participants, eight were married, six were literate and five belonged to the family having a good socio-economic status. The mean age of the participants was 36 years (see Table 1).

Positional stance

The main researcher (S.T.) is a Nepalese man familiar with the local dialect and culture. He had experiences of conducting other qualitative research projects in the far-western region of Nepal. The female researcher (S.B.) is a Nepalese woman born and socialized near to Achham and is familiar with the local dialect and culture. She is well-trained in qualitative research and is experienced in conducting qualitative research in the far-western region of Nepal. Both researchers were born and raised in a community where menstruation is tabooed. The female researcher conducted all the interviews, wrote down memos during and after each interview and discussed her interpretations with the main researcher.

Data analysis

Data for analysis included transcripts of audio recordings from the in-depth interviews. The second author (S.B.) transcribed all the recordings in English, and the main researcher (S.T.) checked for the quality. Necessary reconciliations were made after the discussion.

We opted for a thematic approach to data analysis and used Nvivo-10 software to support the analysis. The analytic process followed a hybrid approach using a set of a priori themes that were developed before examining the data and the codes or themes that were developed inductively by examining the data.¹⁹ The latter process included thoroughly reading the transcripts and labeling the codes in each line expressing a concept related to the phenomenon under study, which produced over 50 initial codes. The conceptual sub-themes that emerged from the data were created from the initial codes based on repeating ideas that were similar in meaning and the relationships that appeared between the codes. All the themes were (see Table 2) looked for patterns across all the data to understand the phenomena. This process involved the description and interpretation of data with a focus on participants' accounts of their beliefs, experiences and the meanings they attributed to them.

Table 1. General information about the study participants.

| Participants | Gender | Age (years) | Marital status | Education | Occupation | Economic status | Menstrual practice |
|--------------|--------|-------------|----------------|------------|-----------------------------|-----------------|------------------------------------|
| 1 | Female | 44 | Married | Illiterate | Housewife | Good | None |
| 2 | Female | 30 | Married | Literate | Housewife | Poor | Separation (seclusion in the past) |
| 3 | Female | 31 | Married | Literate | Housewife | Poor | Separation (seclusion in the past) |
| 4 | Female | 40 | Widowed | Illiterate | Housewife | Poor | Seclusion |
| 5 | Female | 28 | Married | Literate | Community health volunteers | Good | Separation |
| 6 | Female | 38 | Married | Literate | Community health volunteers | Good | Seclusion |
| 7 | Male | 45 | Married | Literate | Local leader | Good | – |
| 8 | Male | 27 | Married | Literate | Local leader | Good | – |
| 9 | Male | 45 | Married | Illiterate | Migrant laborer | Poor | – |

Table 2. Coding tree.

| Categories | Broader codes | Codes |
|---------------------|---|--|
| Menstrual practices | Seclusion | Secluded in the shed away from the house; food brought to the shed by the family members; not allowed to wash or bath in the river; untouchability; no intimate relationship even with husband |
| | Separation | Sleeping in the same house but in a separate room; using separate utensils and beddings for 5–7 days; no entry in the kitchen; untouchability; no intimate relationship even with husband; staying in a separate room in the house instead of a shed |
| Contextual factors | General perception | Menstruation symbolizes impurity and dirt; practices to please the God; belief that other women should also practice the tradition; fear that bad things happen if menstrual practice is not followed; it brings misfortunes and accidents; one could be attacked by a leopard; death of buffaloes and cows; brings illness in the family; death of the woman due to bloody vomiting; fear of snakes, scorpion and strangers entering the shed |
| | Family members | Practices enforced by the parents or parents-in-law; practice being taught by the older generation |
| | Social stigma | Neglect; hesitated to visit for tea or during festivals (social exclusion); gossiping; verbal assault; forbid the menstruating women to bring utensils and cloths near to them; untouchability; denial |
| | Traditional healers | Traditional healing practice; traditional healers regard menstruation as bad; witchcraft |
| | Poverty and illiteracy | Poverty; building concrete sheds out of the house; influence of the incentives; lack of education; lack of awareness |
| Interventions | Women development group formed; local awareness programs; Chhaupadi free area declaration; menstrual sheds being destroyed; change in the pattern of practice; empowerment; increased hygiene and sanitation; legislation against Chhaupadi; incentives provided for the participation in the program | |

Controlling for the quality of the study

S.B. was involved in face-to-face contact with the study participants considering all the probable ways in which interactions with participants might be influenced by her professional background, experiences and prior assumptions. We organized informal meetings with one community health worker to provide input into the preliminary study findings. This process insured credibility and consistency of the research findings to the people we interviewed and to the research context.²⁰ Potential interpretations were provided by the last author (A.R.A.) who belonged to a completely different socio-cultural context assuming that it would be helpful to correct for potential over- or under-interpretation and to frame the findings conceptually.

Results

There were two categories developed from analyzing the interview transcripts: “traditional menstrual practices” and “contextual factors influencing the practices.”

Traditional menstrual practices

Among the six women participating in the study, five women were following traditional menstrual practices, while one was not. There were two major types of traditional practices that were mentioned by all the participants: the seclusion practice (Chhaupadi) and the separation practice. Two women had been following the seclusion practice (Chhaupadi), two

followed the seclusion practice in the past and then converted to the separation practice, and one followed only the separation practice.

The seclusion practice: Chhaupadi. The women who had been practicing the seclusion practice or who had practiced it in the past responded that they had to spend 5–7 days of the periods in a small shed away from the house. They explained that most menstrual sheds were very small, had thatched roofs and had walls. The sheds used to be far from the house and in the recent years they were located closer to the house. The clothes used during periods should not be taken inside the house and should be kept in the shed. The women were brought food by the family members to the shed and the utensils used while eating foods and having drinks should be cleaned by the women themselves. During the periods, the women were also not allowed to enter the house; touch other members of family and neighbors; enter the temple; and wash or take a bath in the river or public water sources. The male members including the husband were restricted to go near to the shed.

All the women practicing the tradition agreed that they learned about the tradition from their mother, who also used to practice it. Four women (Participant no. 2, 3, 4 and 6) explained that it was difficult for them to stay in the shed during rainy season and winter, as the clothes and beddings were wet and cold, and they could not sleep in the night. One of the women mentioned that her legs were bitten by an unknown insect which could be scorpion. Other women also reported fearing of snakes, scorpion or strangers entering the shed.

One woman (Participant no. 1) who did not follow the tradition, explained that spending a night in the shed would be a bad experience for women. She put it this way:

Chhaupadi is bad! If people don't practice Chhaupadi, women can sleep on their own bed, can clean up and bathe nicely. Now, if a woman should practice Chhaupadi, she will be given a small piece of mat, she needs to sleep on it, and will be scoffed by mosquitoes; snakes may bite her; may be some strangers will just grab her during the night. People should be aware of what might happen to them in those conditions.

The separation practice. Two women who used to practice Chhaupadi before reported that they stopped going to the shed during their periods and started staying and sleeping in the same house, but in a separate room. They used separate cloths and utensils and were forbidden to cook food in house, enter the God's place, celebrate the festivals and touch the water sources. They had to wash their cloths themselves and take a bath on the fifth day of their period for cleansing purposes. They were not allowed to touch any other members of the family and especially touching male members was considered bad. Sharing a bed with other female members of the family or also with the husband was not allowed. The other family members and people were forbidden to eat the food or drink the water touched by the women. The separation was

strictly followed for 5–7 days of the periods. A woman (Participant no. 5) put it this way:

If people in my home are not well, maybe it is because of some other problems, but I fear that it is because of God or because of not following the tradition. In my house, we have a separate room to sleep during my periods. I do not go to the kitchen and do not touch the water jar.

Contextual factors influencing the menstrual practices

We identified six overarching major contextual factors influencing the menstrual practices: traditional beliefs, social stigma, poverty, illiteracy, role of traditional healers and family members, and limited effect of the MHM interventions.

Traditional beliefs. All the participants strongly believed that menstruation was generally perceived as the symbol of impurity. Five women practicing the tradition perceived being impure and dirty during menstrual period and believed that they should be practicing the menstrual traditions during the periods. One of the women imagined that if she would not practice the tradition, she might feel bad and uncomfortable to stay close to other family members. She put (Participant no. 2) it this way:

Menstrual blood is bad and should be cleaned. If I don't follow the tradition, I will have bad dreams in night, and there will be problems in the family. If I don't do it, my heart will not be happy. It will be difficult to stay close to other people; I would not feel comfortable.

Among the participants, four women and two men believed that if women in the family would not follow the traditions, some problems would happen in the family. The common examples of the problems explained by the participants were as follows: family members would be attacked by a leopard, family members being ill, death of the family members due to bloody vomiting, destruction of the crops and sudden death of the livestock (e.g. buffaloes and cows). One of the women mentioned that her grandmother had her neck turned completely opposite for 7 days of the period because she did not inform other family members about the period and did not follow the tradition. She also imagined that one of the reasons for not having any troubles in her life was because she had always been punctual on her menstrual practices.

Two women reported that even though they practiced the tradition, they did not believe that it would cause a problem in the family if someone does not follow the tradition. They also said that they never heard or saw anything bad happening to the people who did not follow the tradition in their neighborhood. One of the two women (Participant no. 3) put it this way:

No! I don't think that anything bad will happen if we do not go to the shed or follow the practices in the periods. But since we

have been told that we must follow the practices from very early age, and we have been doing it.

Social stigma. Three women (Participant no. 1, 4 and 6) imagined that people would talk bad about the woman who does not practice the tradition, and people in the neighborhood would get angry to the woman and might blame her if bad things happen in their family. The community members might also forbid the menstruating women entering their houses and insist not to bring utensils and cloths near to them. One of the women (Participant no. 1) mentioned:

I have heard that, if a woman who does not practice the tradition had been to someone's house and, let's say, the person started having pain in his/her hands, he/she will blame the woman for having the pain. No matter what, people can always blame the woman who do not go to the shed.

One of the male participants (Participant no. 7) explained that, after his wife stopped going to the shed and stayed at home during her periods, his neighbors started neglecting his family and hesitated to visit his house for a cup of tea or for other reasons. He opined that the neighbors might have believed that they would be cursed by the God if they would touch the woman who does not follow the tradition. He (Participant no. 8) put it this way:

I have allowed my wife to stay in a separate room during menstruation. For more than a year, people in the neighborhood hesitated to come to my house for a tea and talking to us because my wife did not follow Chhaupadi. They believe that they will be cursed if they touch a woman who does not follow Chhaupadi.

Poverty and illiteracy. The two male local leaders participated in the study imagined that poverty was the reason why women were forced to practice the tradition. One of them explained that, many households had no extra rooms in the house for women to stay during the periods and therefore, women had to stay outside in the menstrual shed. Both the local leaders and two female community health volunteers also believed that, because most of the women were not educated, lack of awareness was one of the reasons why women would continue following the tradition in the rural areas.

One of the male participants (Participant no. 7) stated that he along with his neighbors had jointly built a bigger menstrual shed so that all the women in the neighborhood can stay together during their periods and could protect each other from outsiders. One other man (Participant no. 8) mentioned that some families with good income destroyed the previous sheds and built a new outdoor toilet with an extra room, so that women could stay there during the periods. He said:

Now, people have been making a different kind of menstrual shed. They make a toilet downstairs and stay on the first floor during periods. They put straws on the roof to cover it. Whatsoever, this is also Chhaupadi; I can say, the villages have been declared Chhaupadi free just on paper.

Role of traditional healers and family members. All the women opined that they would seek help from the traditional healers for help if something goes wrong with the family members or livestock. Five women who practiced menstrual restrictions believed that the traditional healers can talk to the God and could identify whether the god was angry on the women in the family because of not following the menstrual practices. They believed that not following the menstrual tradition was a bad omen, and only the traditional healers could perform worshipping rituals to please the gods and prevent the omen.

Two women mentioned that the practice could be less strict if the women were not living with older generation and with parents-in-law. They explained that the parents-in-law would not eat the food prepared by them and behave differently and therefore, they would rather follow the tradition. They believed that, by doing so, they would not be blamed if anything bad would happen in the family. One of the women strongly insisted that she would also make her daughter follow the traditions.

Limited effect of the MHM interventions. All the participants reported being aware of several MHM interventions implemented by the government and local organizations. The interventions cited by the participants were as follows: specific awareness programs against Chhaupadi (such as, key messages through radio: Chhaupadi is criminalized, Chhaupadi should be eliminated; Chhaupadi free area declaration; door-to-door mobilization of local women development group; destroying menstrual sheds) and other awareness and education program related to menstrual hygiene.

Seven out of nine participants reported having heard of or being participated in Chhaupadi elimination interventions in their community. The participants reported hearing on the radio about the stories of the deaths of women in the menstrual shed due to snake bite and the public messages discouraging Chhaupadi. The female health volunteers mentioned that they, as the members of local women development group, had helped to organize locally the door-to-door awareness programs against Chhaupadi practice and had received monetary incentives for actively contributing in the program. They further explained that menstrual sheds in a few villages had been destroyed and those villages had been declared Chhaupadi free.

One woman (Participant no. 2) expressed that after taking part in the interventions, herself and some of the women in her neighborhood stopped staying in the menstrual shed and started staying in a separate room in the house during their periods. Another participant (Participant no. 1) explained that, even though her father was a traditional healer, he prohibited her to stay in the shed during periods and let her stay in the house. Her father believed that it was not necessary to stay in the shed, but it would be important that the separation practices be strictly followed. She put it this way:

There are many Gods, I cannot please all of them. Now if a God is angry for not practicing the practices, then He can curse me.

But I won't stop cooking my own food, taking care of my cattle and staying in my own house. I haven't ever practiced it so far and will not practice it ever.

One of the male participants (Participant no. 7) who had himself participated in the program and had worked with other women in the programs mentioned that, among the women who seemed to be working against the menstrual myths and practices during the day time, most of them might privately spend their nights during their periods in the sheds. He added that the women contributed in such programs for the sake of incentives. Two participants (Participant no. 4 and 6) mentioned that they had never directly participated in any activities or programs related to Chhaupadi elimination and MHM in their locality.

Discussion

Our study noted that, the practice of Chhaupadi, which is prevailing in the rural areas of the far-western part of Nepal, can create circumstances to increase women's vulnerability to a variety of health consequences, such as illness due to exposure to cold, problems due to sleeping or living in unhygienic conditions, animals and snakebites, rape and sexual assaults. Besides, most women following the traditional practice experience cramps and other menstrual health problems, and some experience them much worse than the others.⁴ Due to the influence of traditional menstrual beliefs and practices, the health problems of the women, such as dysmenorrhea and heavy bleeding, are often not heard by the family members and proper medical care would never be sought. Thus, such menstrual practice generally interrupts women's ability to access health care.¹⁶

Chhaupadi has been noted to challenge fundamental human rights and central ethics principles, and this practice has already been penalized by law since 2005.¹³ According to the law, any family member who forces a woman to practice "Chhaupadi" can be punished with a jail sentence of 3 months and/or a fine of about \$30. For the penalties, a woman would in principle have to file a complaint to the police against a family member or someone would have to do this on her behalf. Till date, not a single police complaint against Chhaupadi has been filed in Achham and other neighboring districts (e.g. Dailekh) and thus, authorities are facing an immense challenge in implementing the law.²¹ And, still the majority of women in far-western Nepal are practicing the Chhaupadi tradition.²² For a girl or women to file a report against her family for imposing this custom, a proper mechanism of reporting a file at the local level (e.g. schools, neighborhood or local club house) should be in place. This is only possible through the coordination between the police and local community resource groups, such as schools, child clubs, local women's groups, mothers' groups and local organizations.

Menstrual health and hygiene has been a neglected issue, especially in the rural areas.¹⁶ Therefore, we would like to emphasize on the need of menstrual hygiene management

interventions that should be prioritized and targeted to the women in the rural areas.⁶ For instance, women in the rural area are less likely to have knowledge and access to disposable sanitary pads and are often using the available towels or cloths.¹¹ Moreover, our study found that there is general lack of education and awareness on menstrual hygiene among parents, family members and community people in the rural areas.¹⁵ Although there are MHM interventions targeting inclusion of menstruation and sexual health in school curricula, such courses, however, are less likely to be taught and discussed in the classroom because of wider cultural taboo, perceived shame and stigma.²³ As such, integrating topics relevant to menstrual health and hygiene into the school curriculum remains a challenge, alongside teachers' confidence and willingness to teach the subject in Nepal.²⁴ The general lack of knowledge about menstrual hygiene, use of re-usable cloth rags instead of disposable sanitary pads and engaging in traditional practices can further contribute to a lot of other problems, such as skin diseases and systematic infections.²⁵

Our study provides some contextual information about why the existing interventions (e.g. awareness raising, formation of women's group, incentive provision and legislation) conducted to eliminate Chhaupadi in the far-western region of Nepal had limited effectiveness. Based on our findings, we can say that some development in the reduction of cultural myths and practices is happening (e.g. building better and common sheds, and moving from sheds to separate rooms) but the rate of change is rather slow, and it is completely unclear whether the interventions have been effective to create changes in people's attitudes. These interventions may have created intergenerational tension between tradition and modernity at the local level, especially in the rural areas. For instance, from our study, we learned that there may be a discrepancy that younger menstruating girls or women, even though they are aware of menstrual health and hygiene, may fail to convince their mothers or mothers-in-law or other family members, and break the tradition.¹

The interventions that aim to change harmful traditions need to robustly combine different community-based strategies in addition to the awareness-raising strategies to fight against an integral part of the socio-cultural and intergenerational forces.^{26,27} We also strongly advice program managers to take the local context (such as community-based values and beliefs, social stigma, intergenerational communication and influence of traditional healers) into account while designing and implementing menstrual health interventions. One way to do so is to directly involve and engage the local community people and resource groups (e.g. the traditional or religious leaders, community health volunteers, local women's group and school teachers) in the process of planning and implementation of such interventions, which can be more responsive to the local context and cultural groups.^{26,28} We also believe that an appropriate response to this complex issue requires a range of research and programming collaboration across the social sciences, water, sanitation, and health and education disciplines.

Our study reported that menstruation is subjected to various kinds of social stigma. The young girls or women dealing with menstrual stigma could represent a conflict between what has been referred to as enacted and felt stigma. Enacted stigma refers to overt discrimination to them due to socially unacceptable actions (such as separation and seclusion) and felt stigma is characterized by a sense of shame for the cultural violation and fear of encountering the enacted stigma.²⁹ Working in Nepal, Crawford (2014) has noted that women have already coped with menstrual stigma and one of the coping mechanisms is the acceptance of attributions of impurity and inferiority, and label it as traditional cultural practice and participate in all the practices and customs of menstruation.¹

In past days in Nepal, people living with leprosy used to be secluded from the community and they had to spend the rest of their lives in a shed far from the community. The community people would not allow the people with leprosy to enter the community fearing the transmission of the disease.³⁰ Similar practices have also been observed with the people living with HIV in some communities in Nepal.³¹ Based on our findings, we can say that menstruation is a similar example of what the community perceive as impure and harmful, and therefore, the people with stigmatized identity (e.g. leprosy, HIV and women having periods) have been treated so badly. The manifestation of stigma for menstruation compared to that of HIV and leprosy can be perceived less harmful, but, in general, any sorts of practice of seclusion and discrimination would dehumanize the person and he or she will suffer felt stigma (e.g. fear and guilt) and lack support and care throughout the life.²⁹ Therefore, the interventions aimed at eliminating the harmful traditions and increasing hygienic practice surrounding menstruation need to also incorporate stigma-reduction strategies (e.g. normalizing menstruation through advocacy and education: *Breaking the Silence* campaign).¹

Our study has some limitations. First, we have a very small purposive sample, which may have not been enough to generate data saturation and the participants recruited may not represent all the members of the population segment studied. May be, younger generation might perceive things differently than the older ones, and we were also unable to recruit participants of various age groups, which could have impacted the richness of the data. Second, the question guide used in this study was neither validated nor pilot tested. Third, the findings could have been partially influenced by researchers' subjectivity. However, the female researcher (second author), who conducted and moderated all the interviews, is well-trained and skilled in conducting qualitative interviews, who could potentially respect neutrality and control personal bias and expectations. We also attempted to decrease the limitations by maximizing the responses by interviewing community residents with different profiles, which helped to triangulate the information from different background of participants. Finally, due to a very small sample size, our study may not have adequately reflect on all the contextual insights

on existing traditional menstrual beliefs. Since the scope of this study was purely exploratory, the applied qualitative method can be believed to generate enough information to understand the phenomenon under study and provide a relevant basis for the future studies in this area.

Conclusion

In the rural communities of far-western region of Nepal, one of the most peculiar menstrual practices is that, women during periods are even banished to sheds, which is known as Chhaupadi. The contextual factors influencing the menstrual myths and practices are as follows: traditional beliefs, menstrual stigma, poverty, illiteracy, role of traditional healers and family members, and limited effect of Chhaupadi elimination interventions. There has been some development in the reduction of cultural myths and practices, such as building better and bigger sheds for several women to share or allowing menstruating women to stay in separate rooms in the homes. However, the rate of change is rather slow, and the situation is still far from full participation of women in their family and social life during their periods. We emphasize the need of targeted menstrual hygiene management interventions (e.g. school health education on menstrual health and hygiene to foster change in young generations; menstrual hygiene education to the parents) in combination with menstrual stigma-reduction strategies to effectively increase knowledge and practice related to menstrual health and hygiene. We also advice program managers to take the local context into account, while developing and implementing menstrual health interventions in the community, so that these interventions be more responsive to the local context and cultural groups.

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Declaration of conflicting interests

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Ethical approval

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Informed consent

Verbal informed consent was obtained from all subjects before the study. Since a clear majority of women in far-western Nepal are illiterate and they also need a consent of their partners to read and sign a

document for a written informed consent procedure because of the socio-cultural context, a verbal consent procedure was considered appropriate. The verbal consent procedure was tape recorded and this procedure was approved by the NHRC ethical review board.

Supplemental material

Supplemental material for this article is available online.

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