

Challenges faced by ASHA Workers in Implementing the Menstrual Hygiene Management (MHM) Scheme in Moga District of Punjab

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Abstract: Menstruation is a normal bodily process, although experiences such as pain, bleeding and other symptoms can differ from person to person. Although menstruation is biological, the way it is understood and experienced is shaped by society. Beliefs about menstruation, the willingness of families to discuss it, and access to information, products and private facilities can influence how adolescent girls manage their periods. Menstruation is a normal biological process, but managing it requires more than access to a menstrual product. Menstrual Hygiene Management (MHM) includes the use of clean menstrual materials, privacy to change them when needed, water and soap for washing, and safe facilities for disposal. In 2011 the Ministry of Health and Family Welfare introduced the Menstrual Hygiene Management (MHM) scheme for adolescent girls aged 10-19 years in rural areas. ASHA workers have a direct role in implementing the scheme. This paper highlights the problems faced by ASHA workers in promoting the Menstrual Hygiene Scheme in Moga District of Punjab. By addressing the specific difficulties identified in this study may help ASHA workers provide more consistent information and support to adolescent girls.

Keywords- Menstruation, Menarche, Menstrual Hygiene Management (MHM)

Introduction

Menstruation is a natural process within the menstrual cycle. During the cycle, hormonal changes cause the lining of the uterus to thicken. The first menstrual period, known as *menarche*, is an important event in adolescence. Menstruation is a normal bodily process, although experiences such as pain, bleeding and other symptoms can differ from person to person (World Health Organization, 2026). Although menstruation is biological, the way it is understood and experienced is shaped by society. Beliefs about menstruation, the willingness of families to discuss it, and access to information, products and private facilities can influence how adolescent girls manage their periods. Where menstruation is associated with shame or restrictions, girls may find it difficult to ask questions or seek support. Its social meaning is therefore relevant to their dignity, participation in everyday life and access to menstrual health information. This is why a study of the Menstrual Hygiene Scheme must consider both the physical needs of adolescent girls and the social setting in which ASHA workers communicate with them (WHO, 2026; UNICEF, 2019).

Stigmatization of menstruation, female subordination and the impact on gender identities creates a feeling of helplessness and of being treated unfairly because of their menstruation. These sentiments tend to be accompanied by feelings of hatred to their own body. In India, menstruation is referred to colloquially as “Mahina Chal Raha Hai” (monthly occurrence), “Pair Chale” (bleeding) “Time Aana” (period time). Many religious norms and practices in India are patriarchal in nature and they represent patriarchal views. Patriarchy plays a pivotal role in India in restricting and or changing practices and perceptions about women’s reproductive rights, and sexuality rights. For instance, creating embarrassment and humiliation around menstruation and regulating social exclusion and taboos to exclude and marginalize women during their period. The male members in many societies in India influence and make decisions regarding various cultural and religious practices to be followed. For changing attitude and practices, it is important to keep male members educated and informed in conversation surrounding menstruation (Sommer, 2010).

Menstrual Hygiene Management (MHM)

Menstruation is a normal biological process, but managing it requires more than access to a menstrual product. Menstrual Hygiene Management (MHM) includes the use of clean menstrual materials, privacy to change

them when needed, water and soap for washing, and safe facilities for disposal. It also requires accurate information so that menstruation can be managed with dignity and without fear. Menstrual health is therefore connected to broader conditions such as sanitation, education and gender equality (United Nations Children's Fund, 2019).

Adolescence is an important stage for menstrual health education because girls may begin menstruating with limited knowledge of the menstrual cycle and its management. Social norms and silence surrounding menstruation can make it difficult for them to ask questions or seek support. Even when menstrual products are available, a lack of privacy, washing facilities or safe disposal arrangements may prevent girls from managing menstruation comfortably. Addressing menstrual hygiene consequently requires attention to information, facilities and the social environment, alongside the supply of materials (UNICEF, 2019).

In India, the **Ministry of Health and Family Welfare** introduced the Menstrual Hygiene Management (MHM) scheme for adolescent girls aged 10-19 years in rural areas. Its stated objectives are to increase awareness of menstrual hygiene, improve access to and use of sanitary napkins, and encourage their safe, environmentally appropriate disposal. The scheme thus provides a government programme through which aspects of the broader goal of MHM are addressed at the community level (National Health Mission, 2015).

The major objectives of the scheme are:

- To increase awareness among adolescent girls on Menstrual Hygiene
- To increase access to and use of high-quality sanitary napkins to adolescent girls in rural areas.
- To ensure safe disposal of Sanitary Napkins in an environmentally friendly manner.

The scheme was initially implemented in 2011 in 107 selected districts in 17 States wherein a pack of six sanitary napkins called "Freedays" was provided to rural adolescent girls for Rs. 6. From 2014 onwards, funds are now being provided to States/UTs under National Health Mission for decentralized procurement of sanitary napkins packs for provision to rural adolescent girls at a subsidized rate of Rs 6 for a pack of 6 napkins. The ASHA workers will continue to be responsible for distribution, receiving an incentive of Rs 1 per pack sold and a free pack of napkins every month for her own personal use. She will convene monthly meetings at the Anganwadi Centres or other such platforms for adolescent girls to focus on issue of menstrual hygiene. A range of Information, Education and Communication (IEC) material has been developed to create awareness among adolescent girls about safe and hygienic menstrual health practices which includes audio, video and reading materials for adolescent girls and job-aids for ASHAs and other field level functionaries for communicating with adolescent girls.

Accredited Social Health Activists (ASHAs) have a direct role in implementing the scheme. Along with distributing sanitary napkins, they are expected to convene monthly meetings with adolescent girls to discuss menstrual hygiene and related health matters. The scheme's operational guidelines also provide for ASHA training and educational materials to support this work. Their position within the community makes their experiences especially relevant to understanding how the scheme is delivered in practice (Ministry of Health and Family Welfare, 2019).

Significance of the study

India is a country of contrasts, with extreme wealth and poverty and gender-related disparities, resulting in significant variation in health and social indicators among girls and women. Recognizing the relevance of Menstrual Hygiene Management to the health, the Government of India has initiated an array of policies and programmes. The responsibilities assigned to ASHA workers involve both communication with adolescent girls and the practical distribution of menstrual materials. Examining how they carry out these responsibilities can reveal where further training, supplies, coordination or community support may be needed. In this context, the present study examines the problems faced by ASHA workers in promoting the Menstrual Hygiene Scheme in Punjab. It focuses on frontline workers may contribute to a clearer understanding of the gap, if any, between the scheme's stated objectives and its implementation at the community level. This study is significant because it examines the experiences of ASHA workers in Punjab and identifies the difficulties they face while carrying out this work. By focusing on frontline workers, it can help explain how MHM activities operate at the community level and provide evidence for improving training, supplies and community engagement.

The objective of the study was to understand the challenges and difficulties faced by the ASHA workers while performing their duties.

Research Methodology

- **Locale of the study:** The research was conducted in the Moga District of Punjab. As a pilot project the scheme was initially started in Moga, Firozpur, Muktsar, Bathinda and Faridkot. In January, 2018 NITI Aayog announced “**Transformation of Aspirational Districts**” Programme which aims to transform and uplift 117 backward districts in India in terms of basic amenities, infrastructure facilities, health facilities, standard of living etc. Among 117 backward districts of India, Moga and Firozpur districts of Punjab were included in this Programme. As per census 2011, Moga in comparison with Firozpur is highest in terms of population, area and density of population. Therefore, Moga as a district was selected for the study. Moga is divided into 3 blocks: **Bagha Purana, Moga and Nihal Singh Wala**. From these three blocks the village having the maximum and minimum population were taken into account. From these selected villages ASHA workers were selected for the study.
- **Selection of the respondents:** For the selection of ASHA workers, a register was procured from Community Health Centers (CHCs) where they were registered. From this register, amongst all the six villages, Nihal Singh Wala and Didarewala from Nihal Singh Wala Block, Samalsar and Panjgrain Khurd from Bagha Purana Block, Buttar and Buttar Khurd from Moga Block, ASHA workers were selected by proportionate stratified sampling method.
- **Tools of Investigation:** The data was collected with the help of interview schedule. Focused Group Discussions method was incorporated in the study.

Challenges and difficulties faced by ASHA workers while performing their duties

Under the Menstrual Hygiene Management (MHM) Scheme, Accredited Social Health Activists (ASHAs) are expected to distribute sanitary napkins and hold monthly meetings with adolescent girls on menstrual hygiene and related health concerns. These duties require ASHAs to do more than deliver a product: they must explain menstrual health, answer questions and communicate with girls in a manner that respects their privacy. ASHAs play a multifaceted role in promoting menstrual hygiene practices by conducting home visits, organizing group meetings, facilitating school awareness sessions, counselling adolescent girls, distributing sanitary products, and maintaining records (Singh, 2015). The scheme’s operational guidelines also assign responsibilities for training, educational materials and the regular supply of napkins to other levels of the health system. The effectiveness of an ASHA’s work therefore depends partly on the support and resources available to her (National Health Mission; Ministry of Health and Family Welfare 2015). The following aspects highlight the challenges faced by ASHA workers in performing their duties:

- **Activities performed to promote the MHM Scheme:** Studying the activities performed by ASHA workers to promote the Menstrual Hygiene Management (MHM) Scheme helps in understanding their engagement and participation in spreading awareness. These activities may include door to door visits, group meetings, counselling of adolescent girls, distribution of sanitary napkins and maintaining records etc. (Kok, 2015). Out of the total 28 respondents, 17 workers, accounting for 60.72 percent, reported that they were involved in record maintenance. This indicates that administrative work forms a major part of their role in implementing the scheme. This activity was widely practiced across almost all villages, with complete participation observed in villages like Didarewala and Buttar Khurd. In comparison, activities that involve direct interaction with the community were less frequently performed. Door-to-door visits was reported by only 3 respondents that is 10.71 percent, showing that only a small number of workers actively visit households to spread awareness. Similarly, counselling of adolescent girls was also carried out by 3 respondents that is 10.71 percent, mainly concentrated in villages such as Samalsar and Panjgrain Khurd, indicating that this activity was limited to specific areas rather than being widespread. The distribution of sanitary napkins was performed by 4 respondents that was 14.29 percent, making it slightly more common than other outreach activities, but still not widely practiced. This activity was mainly seen in villages like Nihal Singh Wala and Buttar, suggesting that supply-related responsibilities were handled by selected workers. Group meetings was the least performed activity, with only 1 respondent that is 3.57 percent. This suggests that community-level awareness through meetings or collective discussions were rarely organized. At the village level, differences were noticeable. Some villages, such as Nihal Singh Wala and

Samalsar, show involvement in a variety of activities, whereas others like Didarewala and Buttar Khurd reported very limited activities beyond record maintenance. Overall, the findings indicate that ASHA workers were more engaged in record-keeping than in community outreach activities. While some efforts were made in awareness generation through visits, counselling, and distribution, these were limited in comparison.

- **Effect of workload and time constraints on performance:** Workload and time constraints have a significant impact on the performance of ASHA workers while using the Maternal and Health Management System (MHMS). However, the increasing workload and strict time limits often create challenges that affect their efficiency and quality of work (Scott, 2019). The distribution of ASHA workers regarding how workload and time constraints affect their performance indicated that out of total 28 ASHA workers, a significant proportion of 12 respondents, that is 42.86 percent, reported that workload and time constraints always affect their performance, highlighting that nearly half of the ASHA workers consistently face pressure due to heavy responsibilities and limited time. Additionally, 11 respondents, accounting for 39.29 percent, stated that these constraints sometimes affect their performance, suggesting that for many workers, the impact varies depending on workload intensity and circumstances. A small proportion of 4 respondents, that is 14.28 percent, reported that such constraints rarely affect their performance, while only 1 respondent, that is 3.57 percent, indicated that workload and time constraints never affect their work, showed that very few were free from such challenges. Village-wise analysis revealed that in areas like Nihal Singh Wala and Buttar, a higher number of respondents reported that workload always affects their performance, whereas in Samalsar, most respondents indicated that it sometimes affects them. In contrast, Panjgrain Khurd showed a mixed pattern, with some respondents indicated that workload did not affect them. Overall, the findings clearly demonstrated that workload and time constraints was a major challenge for ASHA workers, significantly influencing their efficiency and ability to carry out responsibilities effectively.

- **Adequacy of resources and materials:** The adequacy of resources and materials for ASHA workers across different villages, indicated whether the supplies provided was sufficient or not. The findings of the study showed that out of total 28 ASHA workers, 16 respondents, accounting for 57.14 percent, reported that resources and materials were not sufficient, while 12 respondents, that is 42.86 percent, stated that they were sufficient, and highlighting a gap in the availability of essential supplies. Village-wise analysis revealed that in Nihal Singh Wala, most of the respondent's that is 87.5 percent reported insufficiency, indicating a significant shortage in that area. Similarly, in Didarewala and Buttar Khurd, all or most respondents reported lack of sufficient materials. In contrast, villages like Samalsar and Buttar show relatively better availability, where a higher number of respondents reported sufficient resources. Panjgrain Khurd presents a mixed response, with more respondents indicating insufficiency than sufficiency. These variations suggested that the distribution of materials was uneven across villages. Overall, the findings indicated that while some areas were adequately supported, more than half of the ASHA workers face shortages, which may hinder their effectiveness in implementing health programs, emphasizing the need for improved and consistent supply of resources and materials.

- **Adequacy and continuity of incentives or honorariums:** ASHA workers are primarily compensated through performance-based incentives rather than fixed salaries. According to the Ministry of Health and Family Welfare, these incentives are tied to specific activities such as facilitating institutional deliveries, ensuring immunization, and promoting family planning. However, when the amount of these incentives is inadequate relative to their workload and responsibilities, it can reduce their motivation and effectiveness (Ministry of Health and Family Welfare, 2014). The findings clearly indicated that out of total 28 ASHA workers, a large majority of respondents that is 20 accounting for 71.43 percent, reported that the incentives were inadequate, and highlighting a major concern among ASHA workers regarding compensation. A small proportion of 4 respondents, that is 14.28 percent, stated that incentives were adequate and timely, while only 4 respondents, that is 14.28 percent, reported that incentives were adequate but delayed or that they were unaware of the payment status. Village-wise analysis showed that in Nihal Singh Wala and Didarewala, all respondents reported incentives as inadequate, reflecting widespread dissatisfaction in these areas. Similarly, in Buttar and Buttar Khurd, most respondents expressed concerns about insufficient incentives. However, Samalsar village stands out slightly, where 3 respondents, that is 37.5 percent, reported receiving adequate and timely incentives, though the majority of 5 respondents, that is 62.5 percent, still faced inadequacy. Panjgrain Khurd also reflects complete inadequacy, with all respondents indicated dissatisfaction. Overall, the findings suggested that inadequate incentives and honorariums was

a significant challenge faced by ASHA workers, which may affect their motivation, job satisfaction, and overall performance. This highlighted the urgent need for improving the remuneration system, ensuring timely payments, and providing fair compensation to support and motivate ASHA workers in effectively implementing health schemes at the community level.

- **Face social, cultural, or gender-related barriers:** The ASHA workers often face a range of social, cultural, and gender-related barriers while implementing schemes like Menstrual Hygiene Management (MHM), which significantly affect their effectiveness at the grassroots level. One of the major challenges is social stigma and taboos surrounding menstruation. In many rural communities, menstruation is still considered a sensitive or “impure” topic, making it difficult for ASHA workers to openly discuss menstrual hygiene with adolescent girls and women (Sommer, 2015). The distribution of ASHA workers based on whether they face social, cultural, or gender-related barriers while implementing the scheme clearly indicated that such barriers were highly prevalent across the study area. Out of the total 28 respondents, a significant majority of ASHA workers, that is 26, accounting for 92.86 percent, reported that they face social, cultural, or gender-related barriers, while only 2 respondents, that is 7.14 percent, stated that they do not encounter such challenges. This showed that these barriers were almost universal and represented a major obstacle in the effective implementation of the scheme. At the village level, the trend remains consistent. In Nihal Singh Wala and Didarewala, all respondents reported facing these barriers, indicating a complete prevalence in these areas. Similarly, in Panjgrain Khurd and Buttar Khurd, all ASHA workers acknowledged the existence of such challenges. In Samalsar (12.5 percent) and Buttar (14.29 percent), although a small number of respondents reported not facing barriers, the overwhelming majority still experienced them. These barriers include menstrual taboos, cultural restrictions, gender inequality, hesitation in discussing reproductive health, and lack of family or community support. Such factors can hinder open communication with beneficiaries, reduce participation in awareness programs, and limit the acceptance of menstrual hygiene practices. The data highlighted that social, cultural, and gender-related barriers were widespread and critical issue faced by ASHA workers.

- **Administrative or documentation challenges:** Many ASHA workers face difficulties due to lengthy paperwork, repeated data entry, and strict reporting formats, which can increase their workload and reduce the time available for community interaction and awareness activities. Additionally, frequent changes in reporting requirements or formats may create confusion among ASHA workers (Gopalan, 2012). The distribution of ASHA workers based on whether they face administrative and documentation challenges revealed that out of the total 28 respondents, 24 ASHA workers, accounting for 85.72 percent, reported that they faced administrative or documentation challenges. This showed a high level of administrative difficulty across all blocks. While only 4 ASHA workers, that is 14.28 percent, reported that they did not experience these issues. Village wise trend showed that in villages like Didarewala, Panjgrain Khurd and Buttar Khurd, every single worker reported having difficulty. Even in the areas with fewest complaints, the workers still struggled with the administrative and documentation challenges.

Conclusion: The study can be concluded by saying that ASHA workers play a crucial role in the implementation of Menstrual Hygiene Management (MHM) scheme. The present study examined the challenges faced by ASHA workers in promoting Menstrual Hygiene Management (MHM) among adolescent girls in Punjab. It focused on certain operational challenges, including insufficient resources, workload pressures, and prevailing social and cultural barriers, which can affect their performance and outreach. Overall, the research emphasized that while the MHM Scheme was being implemented effectively with active participation from ASHA workers, there is a need for continuous support in terms of resource availability, strengthened awareness strategies, and addressing socio-cultural constraints. Enhancing these aspects will not only improve the efficiency of ASHA workers but also ensure better health outcomes, increased awareness, and adoption of safe menstrual hygiene practices within rural communities. The study highlights that effective menstrual hygiene promotion depends not only on the efforts of ASHA workers but also on the resources, training and community support available to them. Addressing the specific difficulties identified in this study may help ASHA workers provide more consistent information and support to adolescent girls. It can be concluded by saying that strengthening awareness among adolescent girls and providing adequate support to ASHA workers are essential for ensuring safe, hygienic, and dignified menstrual practices, ultimately improving overall community health.

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