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Menstrual Practices across Generations: A Tribal Case Study from Jhargram district of West Bengal

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Abstract

Menstrual health practices are deeply embedded within cultural norms, beliefs, and intergenerational knowledge systems. While access to menstrual hygiene information and products has improved in many parts of India, socio-cultural restrictions surrounding menstruation continue to shape women's experiences. This qualitative communication examines menstrual beliefs and practices across three generations of tribal women within a single family in rural West Bengal. Semi-structured interviews were conducted with members of three generations, and data were analysed using thematic analysis. The findings reveal both persistence and transformation in menstrual practices. Older generations reported stronger restrictions, ritual impurity beliefs, and reliance on traditional absorbents, whereas younger women demonstrated greater awareness of menstrual hygiene and increased use of sanitary products. However, certain cultural restrictions remain embedded within family and community expectations. The study highlights the coexistence of continuity and changes in menstrual health practices and underscores the importance of culturally sensitive menstrual health education.

Keywords: Menstrual health, Generation, Attitude, Knowledge, Practice, Theme, Tribal, West Bengal

1. BACKGROUND

Menstruation is a biological phenomenon but remains surrounded by silence, stigma, and culturally embedded restrictions in many societies. In India, menstrual practices are often shaped by religious beliefs, gender norms, and social expectations that regulate women's behaviour during menstruation (Patil et al., 2011; Mason et al., 2013; Garg et al., 2001) [1,2,3]. These practices may include restrictions on food preparation, participation in religious activities, and social interactions. Research has shown that menstrual stigma contributes to secrecy, misinformation, and limited communication about menstruation among adolescents and families (Johnston-Robledo et al., 2013) [4]. In many communities, knowledge about menstruation is transmitted primarily through female relatives, reinforcing intergenerational continuity in beliefs and practices (Bobel, 2010) [5]. Despite growing attention to menstrual hygiene management globally, women and girls in low- and middle-income countries continue to face challenges related to sanitation, access to menstrual products, and culturally rooted stigma (Hennegan, 2017; Sumpter and Torondel, 2013; McAllister et al., 2025) [6,7,8]. In India, socio-cultural perceptions of menstruation strongly influence hygiene practices and menstrual experiences among women and adolescent girls (Patil et al., 2011) [1].

While several studies have explored menstrual hygiene practices among adolescents with quantitative records, fewer studies examine intergenerational differences in the practice and knowledge transfer within families, and the perceptions of the participants. Understanding how menstrual beliefs evolve across generations can provide insight into how social change, education,

and health awareness reshape menstrual practices. This communication therefore explores menstrual perceptions and practices among three generations of tribal women within a rural family in West Bengal, highlighting patterns of continuity and change.

2. DATA AND METHODS

A qualitative case-based approach was adopted to explore menstrual practices and experiences across three generations of a single family. Semi-structured in-depth interviews were conducted with women representing three generations within a single tribal family in rural West Bengal, India. Participants included: an elderly woman- the grandmother generation (G1), a middle-aged mother- mother generation (G2), and a young adult daughter-daughter generation (G3).

Interviews focused on menstrual knowledge, restrictions, practices, and perceptions surrounding menstruation. All interviews were audio-recorded, transcribed verbatim, and translated into English.

To address the potential recall bias, particularly in retrospective narratives from older participants, the interviews were designed to focus on routine practices and culturally embedded norms that are more consistently retained over time. In addition, an intra-family triangulation approach was applied, whereby accounts from the grandmother (G1) were cross-checked with narratives from the mother (G2) to identify consistency and recurring patterns in reported experiences. This approach helped enhance the credibility and reliability of the qualitative data.

Data were analysed using thematic analysis, following the approach described by Braun and Clarke (2006) [9]. Coding was conducted iteratively, allowing themes and subthemes to emerge from the narratives.

3. RESULTS

Table 1 presents the basic demographic profile of the three participants representing different generations within the family. The older generation (G1), the grandmother, was a 56-year-old homemaker with no formal education. The middle generation (G2), the mother, was 39 years old, also a homemaker, and has completed education up to Class V. The younger generation (G3), the daughter, is 17 years old, currently a student enrolled in higher secondary education (Class XI). These characteristics reflect not only generational differences in age but also variations in educational exposure and life stage, which are relevant for interpreting differences in menstrual knowledge, attitudes, and practices.

Table 1. The characteristics of the participants

Older generation=Grandmother=G1 (56 year) - Homemaker-No education
Middle generation=Mother=G2 (39 Years)-Homemaker- Educated upto class 5
Younger generation=daughter=G3(17 years)-Student- High school Student(class 11)

The findings from the ethnographic fieldwork are presented as follows:

3.1 Persistence of menstrual taboos

Participants from older generations described menstruation as a state of impurity requiring physical and social separation. Restrictions included avoiding kitchens, sleeping separately, and refraining from religious activities. Participants from the grandmother generation (G1) reported strict adherence to menstrual taboos during their reproductive years. However, despite following these practices, they rarely transmitted detailed knowledge about menstruation to their daughters. The grandmother (G1) described several restrictions and taboos related to food and kitchen activities during menstruation. She explained, "I was restricted from touching many foods in the kitchen, and only plain beverages were cooked, my in-laws took the responsibility then." Women in the mother generation (G2) largely continued to follow the same practices they had observed in their families. These behaviours were shaped by both maternal and marital household

expectations. As women of mother generation (G2) stated, “What can I do? My mother as well as my mother-in-law strictly followed these rules, so I also continued the same pattern.” On the other hand, women of daughter generation (G3) demonstrated greater flexibility in following menstrual restrictions. As she (G3) was not yet married and remained within her natal household, she sometimes chose not to follow certain rules, and her mother occasionally permitted this. The daughter explained, “I follow the same pattern, but sometimes I do not follow the rules when I feel pain.” These narratives indicate that while menstrual taboos continue to persist across generations, younger women may exercise greater agency in negotiating these practices within the family context. Such practices reflect broader cultural constructions of menstruation as polluting or impure.

3.2 Intergenerational transmission of knowledge

The study revealed that menstrual knowledge was largely transmitted within the family, primarily through mothers and grandmothers. However, the depth and clarity of knowledge shared varied across generations. Older women (G1) often passed down practices and restrictions without providing detailed explanations about menstruation itself. This reflects patterns observed in other Indian communities where menstrual education occurs informally within families rather than through formal public health systems. The grandmother generation (G1) described experiencing strict menstrual restrictions but reported limited discussion about the biological aspects of menstruation. Their understanding was largely shaped by cultural practices and household rules rather than explicit health education. Grandmother (G1) explained: *“During my time, we followed many restrictions. I told my daughter to use new cloths and deposit it carefully.”* Women in the mother generation (G2) reported learning about menstruation primarily through observation and guidance from elder women in the household, but without clear knowledge. Rather than receiving detailed explanations, they (G2) were instructed to follow the same practices practiced by their mothers and mothers-in-law without any further change. As women of mother generation (G2) stated, *“I follow the same earlier pattern shared to me. I was bound to use cloths though sanitary pad were slightly available in earlier days. Now-a-days I use and told my daughter to use sanitary napkins.”* In contrast, women of daughter generation (G3) demonstrated greater awareness and a more flexible approach toward menstrual practices. While they acknowledged the family traditions, they sometimes negotiated or selectively followed the rules based on personal comfort and circumstances. Women of daughter generation (G3) explained: *“I follow certain pattern but not all, my mother told me to use new tools, no restriction in food taboos, suggested by schools that menstruation is a normal biological phenomenon.”* These suggest that while menstrual knowledge continues to be transmitted across generations within families, younger women are increasingly questioning or modifying traditional practices. The findings highlight a gradual shift from strict adherence to cultural norms toward a more negotiated and individualized approach to menstrual management.

3.3 Changes in menstrual hygiene practices

Significant changes were reported in menstrual hygiene materials. The grandmother generation (G1) described of using cloth pieces that were washed and reused, while younger participants reported using commercially available sanitary pads. Improved availability of menstrual products and awareness campaigns towards public health have contributed to such shifts in hygiene practices. Grandmother (G1) says, *“I used clothes, as my mother do, during my times, sanitary napkins were unavailable during my time. I have faced several health problems for this”*. Women of Mother Generation (G2) said, *“I used cloths in earlier times, but later affected by serious health problem. Later, doctor suggested of using sanitary napkins, and reliable, more comfortable, less problematic.”* While daughter generation (G3) reveals, *“I don’t even think that I could use cloths.”* The changing scenario of the use of healthy practice and knowledge regarding menstruation indicated towards better public health trajectories.

3.4 Gradual transformation of attitudes

Older generation (G1) women believed menstrual blood as *bad blood*, impure, having lesser knowledge about its biological phenomenon. Younger participants (G3) expressed more openness

in discussing menstruation and demonstrated greater awareness of hygiene and reproductive health. However, some traditional restrictions remained within the household, suggesting that cultural norms evolve gradually rather than disappearing completely. Although, the grandmother and mother generation were not prefer to talk a single thing about menstruation or its problems in public places such as at hospitals, or in Self-help-group (SHG) meeting. Woman of younger generation (G3) was not shy to talk in meetings, or in hospitals. All these information they received from the health worker *didis*, and from their schools. Woman of Grandmother Generation (G1) reported, *"I have never seen any support from family support or governmental support. The attitudes were largely restricted within"*. Mother (G3) shared, *"the attitudes remain same, but increasing knowledge and support from family and later health worker *didis* increased and helped"*. On the other hand, Daughter (G3) shared, *"why afraid of it. My school teachers explained us that it is a biological phenomenon, it need hygiene practice and not a matter of shy."*

3.5 Health problems and care-seeking behavior

The shift in the perception and management of menstrual-related health problems, moving from silent endurance and home-based remedies among older women to increasing engagement with community health workers and formal healthcare services among younger women. Among the woman of grandmother generation (G1), menstrual pain was largely normalized and treated as an inevitable aspect of womanhood, rarely discussed or medicalized. The increased incident of anameia, excessive blood loss was sometimes followed by the death of woman, however, largely ignored. Grandmother (G1) explained, *"we never spoke about pain and blood loss. I used to lie on the bed for long time, using a cloth soaked in hot water around my abdominal region."* It reflect a pattern of silent endurance and reliance on domestic remedies shaped by cultural norms and limited healthcare access. Woman of grandmother generation (G1) remarked, *'I saw many of my friends feel tremendous pain and excessive blood loss but not ready to go to hospital, like me.'* Woman of mother generation (G2) represented a transitional phase in which women began interacting with frontline health workers, particularly Accredited Social Health Activists (ASHAs), although many had already experienced menstrual problems earlier in life. Mother (G2) stated, *"I told to ASHA about our problem, but they are recent workers, I had already faced problems. They provide with iron tablets"*, indicate the gradual introduction of community-based health support. In contrast, the younger daughter generation (G3) demonstrated greater openness in discussing menstrual discomfort and a stronger inclination toward institutional care. Woman of daughter generation (G3) noted, *"I used to go to the doctor for treatment. The doctor prescribed tablets for pain. However, I also felt shy as the doctor was male,"* reflecting both increased health-seeking behaviour and persistent gendered discomfort within clinical settings. Younger women also described actively consulting ASHA workers as an initial step in care-seeking, as illustrated by participant (G3) explained, *"I share problems with ASHA *didis*; in serious condition we go hospital. We receive iron tablets from ASHA *didis* as well as from schools"*. The regular intervention through medical and health seeking behavior and practices significantly improve the situation as illustrated from the excerpts.

3.6 External influences as awareness and discomfort

The external factors such as improvements in sanitation, increasing governmental initiatives, and expanding media representation—have contributed to gradual improvements as well as discomfort in menstrual health awareness and practices. However, these changes remain uneven, as infrastructural limitations, gaps in policy implementation, and persistent socio-cultural norms continue to shape women's experiences. The findings suggest that transformation in menstrual health awareness is ongoing, yet mediated by deeply rooted cultural sensitivities. Media exposure, in particular, emerged as both enabling and constraining. The grandmother (G1) reported no exposure to media or public messaging on menstruation during her time, as knowledge remained confined within the household. As she explained, *"In our time, we never saw or heard such things outside; these matters were not shown openly."* She further indicated that such public displays would have been considered inappropriate, reflecting a strong culture of silence and privacy surrounding menstruation in her generation. Participants from the mother generation (G2) noted that advertisements related to menstrual products have increased public visibility, but at the

same time generate a sense of discomfort. As G2 participant explained, “*Wall-writing ads on use of sanitary napkins at government hospital buildings create shyness in one hand and silent awareness on the other hand among people.*”. A similar ambivalence was expressed by the daughter generation (G3). As she stated, “*Advertisement is okay but uncomfortable in front of family or in public places.*” These narratives suggest that although media has played a role in expanding awareness and partially normalizing menstruation, its impact remains conditioned by prevailing norms of modesty and silence. As a result, media interventions may not fully eliminate stigma but rather coexist with, and at times reinforce, feelings of self-consciousness and discomfort.’

4. DISCUSSION

The findings demonstrate the coexistence of continuity and change in menstrual knowledge and public health practices across generations within the studied family. Older participants described menstruation primarily through the framework of restriction, silence, and endurance, reflecting long-standing cultural norms that associate menstruation with impurity and behavioural regulation. Similar restrictions related to food preparation, social interaction, and religious participation have been documented in several Indian studies (Garg et al., 2001; Patil et al., 2011; Lim et al., 2021) [3,1,10]. These practices indicate how menstrual behaviour is socially regulated and transmitted through family-based knowledge systems.

At the same time, generational changes were evident in menstrual hygiene practices and health-seeking behaviour. While older women reported using reusable cloth materials, and relying on home-based remedies, younger participant described regular use of sanitary napkins and greater willingness to consult healthcare providers. Such transitions correspond with broader improvements in menstrual hygiene awareness and access to sanitary products observed in low- and middle-income settings (Hennegan et al., 2019; Sumpter and Torondel, 2013) [6,7]. Increased engagement with community health workers, particularly Accredited Social Health Activists (ASHAs), further reflects the growing role of public health initiatives in promoting menstrual health education (Sommer and Sahin, 2013; Jewitt and Ryley, 2014) [11,12].

Despite these improvements in health seeking behaviors, the persistence of certain restrictions and feelings of embarrassment in clinical settings indicates that menstrual stigma remains embedded within social structures. The findings suggest that while younger women increasingly adopt improved hygiene practices and health-seeking behaviours, cultural norms continue to shape menstrual experiences (Babbar and Ojha, 2026) [13]. Addressing menstrual health therefore requires not only improved access to resources but also culturally sensitive efforts to challenge stigma and encourage open communication about menstruation.

Being an isolated tribal village, most health-seeking behaviors and essential healthcare facilities were lacking. Therefore, there is a strong need for policymakers, public servants, and social workers to intervene in order to ensure a better future (McAllister et al., 2025) [8].

5. CONCLUSION

The present qualitative study highlights how menstrual beliefs and practices evolve across generations while maintaining certain forms of stigma within a rural tribal family in West Bengal. While younger women demonstrate improved awareness and hygiene practices, traditional restrictions and socio-cultural norms continue to influence menstrual experiences. Interventions aimed at improving menstrual health should therefore consider the role of family dynamics and intergenerational knowledge transmission in shaping menstrual practices.

In this context, actionable recommendation in strengthening menstrual health education through frontline health workers, particularly ASHA workers, along with school-based awareness programs is essential. Encouraging open intergenerational communication within families may help reduce stigma and improve knowledge sharing. Additionally, ensuring consistent access to affordable sanitary products in tribal areas, improving gender-sensitive healthcare services, and

integrating menstrual health into targeted tribal public health programs are critical steps toward addressing both structural constraints and persistent socio-cultural barriers.

6. LIMITATIONS

The present study was based on a qualitative single-case design, focusing on one tribal family, which limits the scope for statistical generalization. While the approach provides in-depth, context-specific insights into the intergenerational transmission of menstrual beliefs and practices within a shared socio-cultural setting, the findings are not representative of all tribal communities in West Bengal. Instead, they should be interpreted as indicative and exploratory, highlighting patterns that may inform future, larger-scale studies.

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Informed Consent: Informed consent was obtained from all participants before conducting the interviews.

Data Availability Statement: The data supporting the findings of this study are not publicly available due to confidentiality and privacy considerations but may be made available from the corresponding author upon reasonable request.

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