



RESEARCH REPORT 2025

National Study on
Menstrual Health
and Hygiene in
Sri Lanka



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Introduction

Menstrual health and hygiene are essential components of public health, gender equality, dignity, education, work participation, and overall well-being. In Sri Lanka, menstruation is an everyday reality for women and girls, yet it is often shaped by silence, stigma, misinformation, social norms, cost barriers, and unequal access to safe menstrual products, sanitation facilities, and reliable health information.

The National Research on Menstrual Health and Hygiene in 2025 marks the first national study on menstrual health and hygiene in Sri Lanka. This national scope provides a strong evidence base to understand menstrual health and hygiene across diverse geographic, social, and living contexts by generating timely and nationally relevant evidence on the knowledge, attitudes, practices, needs, and lived experiences related to menstruation.

This research was conducted by the Health Promotion Bureau of the Ministry of Health, with funding support from the United Nations Population Fund. The collaboration reflects a shared commitment to improve access to accurate information, reducing stigma, strengthening supportive environments, and informing policies and programmes that respond to the real needs of women and girls.

The findings of this study are expected to support evidence-informed action across health, education, water and sanitation, social protection, workplace well-being, youth services, and community engagement. By identifying gaps, barriers, and opportunities, this report aims to guide practical interventions that promote safe, informed, dignified, and equitable menstrual health practices throughout Sri Lanka. The evidence presented in this report is intended to support stronger national dialogue and more responsive programming, so that menstruation can be managed with dignity, confidence, and adequate support by all Sri Lankans.

Citation

Batuwanthudawe, B. K. R. , Fernando, W.M.P.A., Tennakoon, G. M. J., Wijesinghe, S. & Wijesinghe, M. S. D. (2025). National research on menstrual health and hygiene: Sri Lanka, 2025. Health Promotion Bureau.



Message from the Secretary, Ministry of Health & Mass Media

It is with great pleasure that I present this message for the launch of the Research Report on the National Research on Menstrual Health and Hygiene in Sri Lanka 2025.

Menstrual health and hygiene is a vital component of women's and girls' health, dignity, education, participation, and overall well-being. For many years, menstrual health has not received the level of open discussion, policy attention, and coordinated action it deserves. This national research marks an important step in addressing that gap through steadfast evidence.

The findings of this research provide a timely understanding of menstrual health knowledge, practices, barriers, social norms, access to menstrual hygiene products, and service-related needs in Sri Lanka. These findings will be useful for policymakers, health professionals, educators, development partners, and community-level stakeholders who are working to improve the health and well-being of women and girls.

I urge all relevant stakeholders to use the evidence generated through this report to guide programmes, strengthen health education, improve access to accurate information, reduce stigma, and support practical solutions for menstrual health and hygiene across the country. Menstrual health must be addressed with sensitivity, respect, and a clear commitment to equity.

I wish to commend the Health Promotion Bureau for conducting this important national research. I also extend my appreciation to the United Nations Population Fund for providing financial support for this timely initiative.

With coordinated action across the health, education, social, and community sectors, the findings of this report can contribute to a healthier, more informed, and more supportive environment for women and girls in Sri Lanka.

Dr. Anil Jasinghe

Secretary, Ministry of Health & Mass Media



Message from the Director General of Health Services

I am pleased to send this message on the occasion of the launch of the research report of the National Research on Menstrual Health and Hygiene in Sri Lanka 2025.

Menstrual health is an essential public health concern. It affects physical health, mental well-being, school attendance, work participation, dignity, and social inclusion. Ensuring that every girl and woman has access to correct information, supportive services, safe facilities, and affordable menstrual hygiene options is a shared national responsibility.

The Ministry of Health has continued to promote health education, reproductive health, adolescent health, and community-based health promotion through its national and field-level services. This research provides important evidence to further strengthen these efforts and to identify areas that need focused attention.

The National Research on Menstrual Health and Hygiene in Sri Lanka 2025, conducted by the Health Promotion Bureau, provides valuable information on the present situation in the country. It will help health and non-health sectors to understand the needs of different population groups and plan suitable interventions.

I expect all relevant stakeholders to use the findings of this report to improve menstrual health education, reduce misconceptions, support behaviour change, and strengthen services at national, provincial, district, and community levels.

I congratulate the Health Promotion Bureau and the research team for successfully completing this important study. I also acknowledge UNFPA for its support towards generating evidence for better public health planning in Sri Lanka.

Dr. Asela Gunawardena

Director General of Health Services

Ministry of Health



Message from the Deputy Director General, Public Health Services II

I am pleased to send this message regarding the successful completion of the National Research on Menstrual Health and Hygiene in Sri Lanka 2025.

Menstrual health and hygiene remains an important yet often under-discussed area in public health. It is closely connected to adolescent health, reproductive health, school health, gender equality, sanitation, social support, and access to correct information. Addressing menstrual health requires evidence-based action and collaboration across sectors.

This national research is particularly important because it provides current evidence on menstrual health-related knowledge, attitudes, practices, challenges, and needs among the population. The findings will help identify priority areas for health promotion, service improvement, communication interventions, and supportive policy action.

The Health Promotion Bureau has played an important role in conducting this research and bringing attention to a subject that affects the daily lives of many girls and women in Sri Lanka. The funding support provided by UNFPA is also gratefully acknowledged.

I expect the findings of this report to be used by health staff, education authorities, community organisations, policymakers, and development partners to plan and implement practical interventions. These efforts should aim to improve menstrual health literacy, reduce stigma, promote safe hygiene practices, and ensure that girls and women can manage menstruation with dignity.

I thank the research team, technical contributors, field-level staff, and all participants who supported this valuable national study.

Dr. Vindya Kumarappeli

Deputy Director General (Public Health Services II)
Ministry of Health



Message from the Director, Health Promotion Bureau & Mass Media

The National Research on Menstrual Health and Hygiene in Sri Lanka, 2025, conducted by the Health Promotion Bureau with partnership with the United Nations Population Fund (UNFPA), provides important national evidence on the menstrual health knowledge, practices, and challenges faced by girls and women across the country.

Menstrual health and hygiene directly influences well-being, school attendance, workplace participation, mental well-being, health-seeking behaviour, and the dignity of girls and women. However, it has remained an area that requires stronger evidence, greater attention, and more coordinated action within national health planning.

This study examines key areas including menstrual knowledge and awareness, access to hygiene products and sanitation facilities, sociocultural beliefs and stigma, and the health-seeking behaviours of girls and women in relation to menstruation. The findings provide a strong basis for strengthening national menstrual health and hygiene guidelines, school health and WASH programmes, and broader adolescent and reproductive health strategies.

The Health Promotion Bureau appreciates the funding and technical support extended by UNFPA for this important work. We hope the evidence generated through this study will guide advocacy, policy development, and programme design to improve menstrual health outcomes for girls and women in Sri Lanka.

Dr. Ranjith Batuwanthudawe

Director, Health Education and Publicity
Health Promotion Bureau, Ministry of Health



Message from UNFPA Sri Lanka Representative a.i., Phuntsho Wangyel

It is an honour to support the National Study on Menstrual Health and Hygiene in Sri Lanka, the country's first nationally representative study on menstrual health, conducted by the Health Promotion Bureau of the Ministry of Health with technical and financial support from UNFPA.

This landmark publication shines a light on an essential yet often overlooked issue of human rights, public health and gender equality. By capturing the knowledge, attitudes, practices and lived experiences of women and girls across Sri Lanka, it provides a robust evidence base to inform policies,

programmes and investments.

Menstrual health is fundamental to the health, dignity and well-being of women and girls. When individuals have access to accurate information, affordable menstrual products, clean water and sanitation facilities, and supportive environments free from stigma and discrimination, they are better able to participate fully in education, work and community life. Advancing menstrual health is therefore essential to achieving the Sustainable Development Goals, particularly those related to health, gender equality, clean water and sanitation, and reducing inequalities.

This study demonstrates that menstrual health cannot be viewed in isolation. It intersects education, nutrition, water, sanitation and hygiene (WASH), gender based violence prevention, disability inclusion, social protection, and humanitarian preparedness.

As Sri Lanka strengthens its resilience to climate change and disasters, it is essential to ensure uninterrupted access to menstrual health information, safe sanitation facilities, clean water, and essential menstrual products during emergencies to protect the health, dignity, and safety of women and girls.

We hope that this study will serve as a vital tool for evidence informed decision making across a wide network of stakeholders. The findings of this study offer actionable insights for sectors supporting Sri Lanka's efforts to build more inclusive, equitable and responsive systems.

By generating timely, nationally relevant evidence across diverse geographic and social contexts, this report provides the definitive evidence base needed to dismantle barriers and ensure that menstruation is managed with dignity, confidence and adequate support.

As Sri Lanka advances its sustainable development agenda, investing in the health, rights and agency of women and girls remains essential for building resilient families, communities and institutions. UNFPA remains steadfast in its commitment to supporting the Government of Sri Lanka and our partners in strengthening data systems, advancing sexual and reproductive health and rights, promoting gender equality and bodily autonomy and translating evidence into impactful policies and programmes. Together, through sustained partnership, evidence informed decision making and inclusive action, we can ensure that every woman and girl in Sri Lanka is empowered to realize her full potential, and that no one is left behind.

Thank you

Phuntsho Wangyel
Representative a.i.
UNFPA Sri Lanka

List of Abbreviations

A/L	Advanced Level
CAPI	Computer-Assisted Personal Interviewing
DCS	Department of Census and Statistics
DEFF	Design Effect
ERC	Ethics Review Committee
FGD	Focus Group Discussion
G.C.E.	General Certificate of Education
GN	Grama Niladhari
GPS	Global Positioning System
HPB	Health Promotion Bureau
IDI	In-Depth Interview
JMP	Joint Monitoring Programme
KAP	Knowledge, Attitudes, and Practices
KII	Key Informant Interview
MHH	Menstrual Health and Hygiene
MHM	Menstrual Hygiene Management
NIHS	National Institute of Health Sciences
O/L	Ordinary Level
PCOS	Polycystic Ovary Syndrome
PPI	Period Poverty Index
SDG	Sustainable Development Goal
SDGs	Sustainable Development Goals
SPSS	Statistical Package for the Social Sciences
TV	Television
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

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Executive Summary

Menstrual health is a critical determinant of health, dignity, education, gender equality, and social participation. In Sri Lanka, it affects more than 5.5 million women and girls of reproductive age, yet menstruation remains under addressed in policy, service delivery, public discourse, and daily social practice.

The Menstrual Health and Hygiene Study 2025 provides Sri Lanka's first nationally representative evidence base on menstrual knowledge, attitudes, practices, barriers, access, and lived experiences. The study used a mixed-methods design, combining a national quantitative survey with qualitative discussions and interviews. The quantitative component covered 3,010 women and girls aged 16 to 50 years from urban, rural, and estate sectors across Sri Lanka. Findings are presented at national level and disaggregated by sector and age group to identify inequities that require targeted action.

The findings show that menstruation in Sri Lanka is both a public health and human rights issue. While many women and girls have basic knowledge of menstruation and use hygienic menstrual materials, significant barriers remain. These include limited preparedness before menarche, stigma, misconceptions, affordability pressures, uneven WASH facilities, unsafe disposal practices, poor menstrual health-seeking behaviour, and restrictions that affect education, work, mobility, and dignity.

Key Findings

Menarche, and early awareness

Most women and girls experienced menarche between 11 and 15 years, with age 13 being the most common. The mean age of menarche has declined among the 16 to 19 age group, falling below 13 years. This points to the need for menstrual education before early adolescence. Preparedness before first menstruation remains inadequate. Half of respondents were not aware of menstruation before menarche, with the lowest awareness reported in the estate sector. Mothers were the main source of information, followed by teachers and female relatives. Although many respondents reported comfort in receiving information, a sizeable proportion, especially in estate communities, reported discomfort. This confirms that menstruation is still difficult to discuss openly in many families and communities.

Information-seeking and support

Information-seeking on menstrual health is moderate. About half of respondents had actively sought information, mainly through the internet and social media. Traditional sources, such as television and radio discussions, also remain relevant. These findings show that digital platforms are important, but they should be supported with accurate, age-appropriate, and culturally sensitive information. Health-seeking for menstrual concerns remains low. Only a minority of respondents sought professional support for menstrual problems. Younger women showed greater willingness to consult health professionals, but family-based support remains central. Mothers and partners were the main sources of support during menstruation. This indicates the need to strengthen family, school, community, and primary health-care support systems.

Knowledge on menstrual health and hygiene

Foundational knowledge on menstruation is strong. Most respondents recognized menstruation as a normal biological process and were aware of the usual duration of menstruation and cycle length. However, important misconceptions persist. A large proportion of respondents still perceived menstruating women as unclean. Some believed that menstruation stops after sexual activity, while fertility-related knowledge was limited. These misconceptions were more common in estate communities, showing a clear gap in menstrual health literacy. Correcting these gaps is essential for health, dignity, and informed decision-making.

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Cultural beliefs, attitudes, and taboos

Attitudes toward menstrual education are positive. Most respondents supported educating girls before menarche, and a large majority also supported menstrual education for boys. This creates an important opening for school-based and community-based education. At the same time, emotional responses to menarche remain largely negative. Fear and embarrassment were common first reactions. Although many respondents rejected restrictive taboos, a notable proportion still experienced restrictions during menstruation, especially in rural areas. Stigma and social norms continue to affect how women and girls move, participate, eat, exercise, and interact with others during menstruation.

Hygiene practices and menstrual materials

Disposable sanitary pads were the most commonly used and preferred menstrual material. A smaller proportion used both pads and cloths, while use of reusable pads, menstrual cups, tampons, and period panties remained very low. Hygiene practices were generally strong, with high levels of handwashing after changing menstrual materials, frequent genital washing, and regular use of soap. However, menstrual tracking practices remain limited. Less than half were aware of menstrual calendars or trackers, and those who tracked their cycle mainly used wall calendars rather than mobile applications. Menstrual tracking can support early identification of irregular cycles, heavy bleeding, and other menstrual health problems. It should be promoted as part of wider menstrual health education.

Access to WASH facilities and disposal

Access to menstrual hygiene facilities is strongest at household level. Most respondents reported access to toilets, washing facilities, soap, disposal options, and private spaces for changing at home. Schools also had generally high availability of toilets and washing facilities, but soap, disposal facilities, and private changing spaces were less consistent. Workplace facilities were comparatively weaker, particularly private spaces for changing. Disposal practices raise environmental and public health concerns. Burning was the most common method of disposal, followed by burial and flushing. These practices point to gaps in safe menstrual waste management. Better disposal systems are needed in homes, schools, workplaces, public institutions, and community settings.

Access to menstrual materials and affordability

Most respondents reported no major difficulty accessing menstrual materials during menstruation. However, access problems were higher in the estate sector and among younger respondents. Quality concerns were also more common in estate communities. Most women and girls were able to access their preferred menstrual material. Among those who could not, affordability was a major reason. Average monthly spending on menstrual materials was around Rs. 500, with a median of around Rs. 400. For low-income households, this cost can still be a meaningful burden, especially when combined with transport, household responsibilities, school needs, and other health expenses. Affordability must therefore be understood as one part of a wider access issue. Menstrual equity requires reliable availability, acceptable quality, product choice, safe use, and dignity, especially for estate, rural, low-income, and school-going populations.

Menstrual discomfort, disorders, and health-seeking

Menstrual discomfort is common. Abdominal pain was the most frequently reported symptom, followed by headaches and emotional changes. Although many respondents were aware of pain management options, many did not take active steps to manage symptoms. Among those who did, most relied on over-the-counter medicines. Few consulted doctors. Only a small proportion reported diagnosed menstrual disorders, including premenstrual syndrome, PCOS, endometriosis, and cysts. This may reflect low awareness, limited diagnosis, stigma, or poor health-seeking rather than low true burden. Menstrual pain and related symptoms should be treated as valid health concerns, not as issues women and girls must silently tolerate.

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Impact on daily life

Menstruation affects daily life, schooling, work, sports, social participation, and personal dignity. Many respondents reported difficulty bathing in shared or public facilities. A considerable proportion reported challenges with work attendance, school attendance, and sports. Among students, pain was the main reason for absenteeism, followed by fear of unexpected bleeding, menstrual symptoms, and lack of clean toilet facilities. Among working women, pain was also the main reason for absenteeism. These findings show that menstrual health has direct effects on education, productivity, confidence, and participation.

Period poverty

Period poverty in Sri Lanka is multidimensional. It is not limited to the inability to buy menstrual products. It includes affordability, reliable access to safe and preferred products, privacy, toilets, water, soap, safe disposal, accurate information, freedom from stigma, and the ability to participate in school, work, family, and community life. The Sri Lanka Period Poverty Index provides a national measure of menstrual health deprivation across five domains: access to menstrual products, privacy, toilets and water, safe disposal, access to information and education, and stigma, restrictions, and participation impacts. The overall PPI score of 0.45 indicates moderate period poverty, meaning that women and girls experience deprivation across roughly two of the five domains assessed. The highest deprivation was seen in stigma, restrictions, and participation impacts, with a score of 0.65. This shows that social norms remain the strongest barrier, even where products and facilities are available. Privacy, toilets, and water also showed moderate deprivation, as did safe disposal and access to menstrual information or education. Estate-sector women and girls experienced the highest overall period poverty, with a PPI of 0.51, compared with rural and urban sectors. Estate communities showed particular disadvantage in access to products, information and education, and stigma. The 16 to 19 age group was also highly vulnerable, with the highest overall PPI and severe deprivation in privacy, toilets, water, and safe disposal. These findings show that period poverty should be treated as a national equity issue. It requires coordinated action across health, education, WASH, gender, labour, social protection, and environmental sectors.

RECOMMENDATIONS

1. Recognize menstrual health as a national public health and equity priority

Menstrual health and hygiene should be formally recognized as a public health, education, gender equality, WASH, labour, and social protection priority. National policies and programmes should move beyond product access alone and address the full range of barriers that affect dignity, health, education, work, and participation.

A coordinated national response is needed across the Ministry of Health, Ministry of Education, WASH authorities, labour institutions, local government, social protection systems, civil society, and development partners

2. Strengthen menstrual education before menarche

Menstrual education should begin before the usual age of menarche. The study shows that many girls are still unprepared for their first period, despite the declining age of menarche among younger adolescents.

Age-appropriate menstrual education should be introduced early in schools and reinforced through family and community settings. Content should explain menstruation as a normal biological process, address body changes, hygiene, pain management, emotional responses, fertility-related knowledge, and when to seek medical care.

3. Improve the quality and reach of school-based menstrual education

Schools should provide accurate, practical, and stigma-free menstrual health education for girls and boys. Education should help girls manage menstruation with confidence and help boys understand menstruation respectfully.

Teachers should receive training, simple teaching materials, and clear guidance on how to discuss menstruation in a sensitive and factual way. School health programmes should include menstrual health as a routine topic rather than a one-time lesson.

4. Engage parents, families, and communities

Mothers remain a key source of menstrual information and support. However, family-level knowledge and comfort vary. Community education should support mothers, fathers, caregivers, partners, and community leaders to discuss menstruation openly and accurately.

Community programmes should correct myths that menstruating women are unclean, weak, restricted, or unable to participate in normal daily activities. Public messaging should promote dignity, confidence, and shared responsibility.

5. Address stigma, restrictions, and harmful social norms

Stigma and restrictions are among the strongest barriers identified in the study. They affect movement, school attendance, work, social participation, food practices, sports, and emotional well-being.

National and community-level communication should directly address shame, fear, embarrassment, and restrictive practices. Campaigns should use clear, culturally sensitive messages in Sinhala, Tamil, and English. They should include girls, boys, women, men, teachers, health workers, religious leaders, employers, and media platforms.

6. Improve WASH facilities in schools, workplaces, and public spaces

Schools, workplaces, and public institutions should provide clean toilets, water, soap, private changing spaces, functional locks, lighting, and safe disposal facilities. These facilities should be maintained regularly

RECOMMENDATIONS

and monitored for usability, privacy, and safety. Behavioural insights show cleanliness and use of WASH facilities increases with no-touch fittings like shadow / motion operated taps and flushing systems.

Priority should be given to schools and workplaces in estate and rural areas, where gaps are more pronounced. Menstrual hygiene facilities should be included in school health standards, workplace welfare standards, and public sanitation planning.

7. Ensure access to affordable and acceptable menstrual products

Most respondents reported access to menstrual products, but affordability and quality remain concerns for vulnerable groups. Estate communities, low-income households, school-going girls, and those with irregular income need special attention.

Programmes should support affordable access to safe and acceptable menstrual products. This may include school-based emergency supplies, support for low-income groups, local procurement options, and improved product availability in underserved areas.

Product access efforts should also respect choice. Disposable pads remain the most preferred product, but information on reusable pads, menstrual cups, and other safe options can be introduced where acceptable and practical. Having a range of products appealing to age, social, financial and practical variables will improve menstrual health and hygiene practices across wide range of circumstances affecting Sri Lankan women.

8. Strengthen safe menstrual waste disposal systems

Current disposal practices raise environmental and public health concerns. Burning, burial, and flushing are common, but these methods can harm health, sanitation systems, and the environment.

Schools, workplaces, health facilities, and public toilets should have safe and sustainable waste disposal systems. Local authorities should include menstrual waste in waste management planning. Disposal solutions should be practical, affordable, culturally acceptable, and suitable for both urban and rural settings.

Current categorization of menstrual waste as “home based sanitary waste” in the environment policy of 2020 should include adult diapers too considering demographic transition.

9. Improve menstrual health services and care-seeking

Menstrual pain and menstrual disorders should be treated as valid health concerns. Health workers should provide clear advice on pain management, heavy bleeding, irregular cycles, premenstrual symptoms, PCOS, endometriosis, and other menstrual health problems.

Primary care services, school health services, adolescent health clinics, and community health workers should be equipped to identify symptoms early and refer when needed. Confidential counselling should be available for adolescents and women who feel uncomfortable discussing menstrual concerns.

10. Use digital and mass media channels for accurate information

The internet and social media are major sources of menstrual health information. These channels should be used to share accurate, simple, and locally relevant information. Content should be developed in Sinhala, Tamil, and English.

Digital content should address common misconceptions, pain management, when to seek care, menstrual tracking, product use, disposal, and support services. Television, radio, and community media should also be used, especially for groups with lower digital access.

RECOMMENDATIONS

11. Promote menstrual tracking and body literacy

Awareness and use of menstrual tracking remain limited. Menstrual tracking can help women and girls understand their cycle, prepare for menstruation, identify irregularities, and seek care when needed.

Education programmes should promote simple menstrual tracking methods, including calendars, notebooks, and mobile applications where appropriate. Messaging should be practical and should avoid creating fear or over-medicalizing normal cycle variation.

12. Target support to estate communities and younger adolescents

Estate-sector women and girls show higher vulnerability across several domains, including access to products, information, stigma, and period poverty. Younger adolescents also face high vulnerability, especially in privacy, toilets, water, and safe disposal.

Programmes should prioritize these groups through targeted education, WASH improvements, school support, community engagement, and affordable product access. Interventions should be designed with local language, culture, household conditions, school environments, and service access in mind.

13. Use the Period Poverty Index for planning and monitoring

The Period Poverty Index should be used as a national tool to monitor menstrual health deprivation. It can help identify vulnerable groups, compare sectors, track progress, and guide programme planning.

The index should be reviewed and refined over time as more evidence becomes available. It should be used alongside domain-specific indicators, including product access, WASH facilities, safe disposal, information access, stigma, and participation impacts.

14. Build a national monitoring and accountability system

Menstrual health indicators should be included in routine monitoring systems across health, education, WASH, and workplace settings. Regular assessment should track school facilities, workplace facilities, product access, menstrual health education, care-seeking, absenteeism, disposal systems, and stigma-related barriers. Behaviour surveillance and insights in relation to menstrual health and hygiene should be incorporated for better planning.

Findings should be used to guide resource allocation, improve service quality, and strengthen accountability at national, provincial, district, school, workplace, and community levels.

01

Background



1.1 Menstruation

Menstruation is a natural biological process experienced by millions of individuals worldwide, thus menstrual health and hygiene remains to be a fundamental aspect of reproductive health and gender equity. Menstruation is defined as the cyclical shedding of the uterine lining that occurs when there is a decline in hormonal support, particularly following the death of the corpus luteum. This process is characterized by a series of hormonal changes and physiological responses in the female reproductive system (Krause, 2012).

Despite its universality, menstruation is shrouded in stigma, taboo, and structural neglect across many societies. While around 1.8 billion people menstruate every month, millions – even billions – struggle to manage their period in a safe, respectful way. Stigmatizing cultural norms, poverty, lack of infrastructure, and insufficient access to sanitary products all contribute to this widespread problem (UNICEF, 2018).

1.2 Menstrual Health and Hygiene

Menstrual Health and Hygiene (MHH) refer to a state of complete physical, mental, and social well-being in relation to the menstrual cycle. It encompasses both the management of menstruation and the broader systemic factors that link menstruation with health, education, gender equality, empowerment, and rights (UNICEF (2019) and the WHO/UNICEF Joint Monitoring Programme (JMP, 2012).

It means that women, adolescent girls, and all who menstruate have access to accurate and timely information about menstruation; can use safe, hygienic, and affordable menstrual materials to absorb or collect menstrual blood; have access to private, safe, and functional facilities to change and wash as needed, and to dispose of used materials safely and with dignity.

MHH also requires supportive environments—including positive social norms, access to health services, effective education systems, and enabling policies—that ensure menstruation is managed without stigma or barriers to participation in school, work, and community life.

1.3 Global situation on MHH

Worldwide, menstrual stigma manifests through avoidance, shame, and harmful myths—such as perceiving menstruation as “impure” or secret. This stigma contributes to limited mobility, missed educational opportunities, and strained mental well-being. By some estimates, less than 40% of schools globally provide menstrual education, and over two-thirds lack facilities like toilets with bins for menstrual waste, leaving many girls to “suffer in silence” during school days (Sahil Tesfu & Williams, 2025).

The taboo surrounding menstruation has deep historical roots, influencing societal attitudes and behaviours towards menstruating individuals. In many communities, menstruation is viewed as impure or shameful, leading to restricted mobility, limited access to sanitation facilities, and inadequate menstrual hygiene management practices (Garg & Anand, 2015; Syed Abdullah, 2022).

Menstrual inequities are amplified by economic inequalities, and vice versa.

In low- and middle-income countries, the cost of sanitary products remains prohibitive for many, forcing women and girls to resort to unsafe or unhygienic alternatives such as cloth, paper, or other makeshift materials. In high-income settings too, “period poverty” is increasingly recognized as a pressing public health and social justice issue, where the inability to afford menstrual products limits participation in work, school, and community life.

Menstrual health is a cross-cutting issue.

The global discourse now recognizes menstrual health not merely as a hygiene or women’s issue, but as a human rights, health, and development issue—central to achieving multiple Sustainable Development Goals (SDGs). Addressing menstrual health and hygiene comprehensively therefore requires multi-sectoral collaboration that spans health, education, gender, WASH, and labor sectors. Only by normalizing menstruation and ensuring equitable access to menstrual resources can societies advance both individual dignity and collective development.

1.4 MHH in the Sustainable Development Goals (SDGs)

Menstrual health extends beyond personal hygiene to influence health and well-being (SDG 3), education (SDG 4), and gender equality (SDG 5), while depending on access to clean water and sanitation (SDG 6). It also impacts decent work and economic growth (SDG 8) and calls for sustainable consumption practices (SDG 12).

Table 1.1: Linkages between menstrual health and the SDGs

SDG	Goal Title	Key Linkages to Menstrual Health and Hygiene (MHH)
 SDG 3 GOOD HEALTH AND WELL-BEING	Good Health and Well-being	Access to menstrual health education and care is vital for women's overall health and well-being.
 SDG 4 QUALITY EDUCATION	Quality Education	Poor WASH facilities and menstrual-related absenteeism limit girls' education; better facilities and education inclusion are needed.
 SDG 5 GENDER EQUALITY	Gender Equality	Menstrual stigma reinforces inequality; open dialogue and access to products promote empowerment.
 SDG 6 CLEAN WATER AND SANITATION	Clean Water and Sanitation	Safe water, privacy, and waste disposal are essential for menstrual hygiene but remain inadequate in many areas.
 SDG 8 DECENT WORK AND ECONOMIC GROWTH	Decent Work and Economic Growth	Lack of menstrual support at workplaces reduces productivity and perpetuates gender inequality.
 SDG 12 RESPONSIBLE CONSUMPTION AND PRODUCTION	Responsible Consumption and Production	Promotes sustainable menstrual products and better disposal to reduce environmental impact.

1.5 Sri Lankan situation on MHH

Department of Census and Statistics (DCS) mid-year estimates for 2025 reveals females account for 51.7% of the total population with 5.47 million women of reproductive age (15 to 49 years), making MHH a public health and gender equity priority for the country with impactful in numbers.

However, menstruation is remaining overlooked and often shrouded in silence in many parts of the world, including Sri Lanka due to stigma, taboos and cultural practices. Despite significant strides in healthcare and education, menstruation continues to be a taboo subject, surrounded by cultural norms and societal misconceptions that adversely affect the well-being of women and girls. Addressing menstrual health and hygiene is not only a matter of public health but also a human rights imperative, as it impacts the dignity, autonomy, and overall quality of life of menstruating individuals. The taboo surrounding menstruation has

deep historical roots, influencing societal attitudes and behaviours towards menstruating individuals. In many communities, menstruation is viewed as impure or shameful, leading to restricted mobility, limited access to sanitation facilities, and inadequate menstrual hygiene management practices (Fernando & Jayawardana, 2022). While efforts have been made to address these challenges, significant gaps persist in both urban and rural settings.

Sri Lankan literature frames menstrual health and hygiene (MHH) as both a public health issue and a gender equity concern, with stigma shaping what girls learn, what they can discuss, and how they participate in school and daily life [Agampodi and Agampodi, 2018]. Qualitative evidence from adult women also shows that menstrual problems can affect everyday functioning, while perceptions and care-seeking often depend on social norms and informal advice as much as on clinical services [Chandraratne and Gunawardena, 2011]. Among adolescents, studies document a high burden of premenstrual symptoms and related impacts on well-being, which strengthens the case for age-appropriate information and support in schools and primary care [Hemachandra and Manderson, 2009]. School-based research in Sri Lanka reports gaps in menstrual knowledge and notable effects on attendance, sports, and academic activities, alongside heavy bleeding, cycle irregularity, and reliance on peers for discussion [Kandauda et al., 2020]. Evidence from district studies and conference outputs further shows uneven menstrual hygiene knowledge and practices across settings, which points to the need for context-specific MHH programming that links education, WASH infrastructure, and accessible health services [Premkumar et al., 2020; Vishnukumar et al., 2017].

Access to affordable and quality menstrual hygiene products remains a barrier for many, with some resorting to unhygienic alternatives due to financial constraints or lack of availability, particularly in rural areas and among marginalized communities. Meanwhile, data from UNFPA Sri Lanka indicate that women and girls constitute 52% of the national population, with approximately 5.5 million of them being of reproductive age (16–50 years). This highlights the critical need to prioritize menstrual health as an integral component of national development, gender equity, and public health planning.

Efforts to promote menstrual health education and awareness have been underway, but there is still a need for comprehensive and culturally sensitive education programs addressing the gaps in coverage and quality of information provided. It is crucial to educate both girls and boys about menstruation, in break down stigma and promoting healthy attitudes towards menstruation. Schools and community organizations play a vital role in providing accurate information and creating a supportive environment for menstruating individuals.

Advocacy efforts are ongoing to prioritize menstrual health and hygiene in national policies and programs in Sri Lanka. By advocating for menstrual equity and addressing the systemic barriers that hinder access to menstrual hygiene products and education, progress can be made towards ensuring the rights and dignity of menstruating individuals in Sri Lanka.

1.6 Need for National Study on MHH

Even with global expansion and increased recognition of the importance of MHH, Sri Lanka still has a large number of data gaps at the national level, preventing the ability of policy makers, health professionals, educators, and other stakeholders to design evidence-based interventions.

A recent literature review reveals that there is a lack of nationally representative research that examines and tests the full spectrum of knowledge, attitudes, behaviours, and practices (KAP) related to menstruation across various age groups, geographic locations, and socio-economic backgrounds. The lack of comprehensive, extensive data makes it difficult to comprehend the structural issues that menstruating people deal with, such as stigma, disinformation and insufficient access to support. Therefore, it is crucial to identify and capture the lived realities of girls and women in Sri Lanka by conducting a complete and comprehensive national-level MHH survey to inform the targeted, culturally appropriate, and sustainable policy responses aimed at improving menstrual health outcomes and gender equality.

1.7 Objective of the research

This study investigated the menstrual health perceptions, experiences, and needs of women and girls of reproductive age in Sri Lanka with the objective to:

- Assess knowledge, attitudes and practices related to menstrual health and hygiene in women and girls in reproductive age in Sri Lanka.
- Understand barriers and challenges concerning menstrual health and hygiene in Sri Lanka.

1.8 About the Study

This study is a collaborative initiative between Health Promotion Bureau (HPB) of the Ministry of Health and the United Nations Population Fund (UNFPA) Sri Lanka. The partnership brings together UNFPA's global expertise in sexual and reproductive health and rights with the Health Promotion Bureau's national mandate for health education and behaviour change communication. Together, the study aims to generate robust evidence to inform policies, programs, and advocacy efforts that advance menstrual health and hygiene as a key component of public health and gender equality in Sri Lanka.

02

Methodology



This national study followed a mixed-method approach, combining a nationally representative quantitative survey with and qualitative Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs) to explore contextual factors, lived experiences, and social norms influencing menstrual health and related behaviours. The study was conducted from June to September 2025.



2.1 Quantitative Study

2.1.1. Study design

A descriptive cross-sectional study was conducted.

2.1.2. Study Setting

The quantitative survey was conducted in community-based settings covering all nine provinces of Sri Lanka and ensuring national representative sampling across the urban, rural, and estate sectors.

2.1.3. Study Period

Data collection was done conducted over a period of four months from June to September 2025

2.1.4. Study Population

The target population consisted of women and girls aged 16–50 years residing in households, selected according to the following eligibility criteria:

- **Household:** a one-person or multi-persons household consisting of one or more persons – including family members (e.g. husband, wife, and children), relatives, boarders, domestic helpers/staff, etc., who reside together and share common cooking and meal arrangements; individuals living in the same dwelling but maintaining separate meal provisions are treated as distinct households.
- **Inclusion criteria:** Resident women and girls aged 16–50 years living in the area for over one year who slept in the household the previous night.

Exclusion criteria: Individuals with psychiatric or cognitive impairments, and women who were pregnant, lactating, or post-menopausal during the study period.

2.1.5. Sample Size

The sample size was determined using the Lwanga & Lemeshow (1991) formula:

$$n = \frac{Z^2 p(1 - p)}{d^2}$$

Where:

- n = the required sample size
- Z = Confidence level = 1.962 (for 95% confidence level)
- p = Estimated proportion of the population with adequate knowledge of Menstrual Health and Hygiene (MHH). In the absence of prior published evidence on menstrual health literacy in Sri Lanka, \$p\$ was taken as 0.5 to ensure the maximum possible sample size.
- d = the acceptable margin of error (the level of precision) = 0.052

The calculation for the base sample size is as follows:

$$n = \frac{1.962^2 \times 0.5(1 - 0.5)}{0.052^2} \approx 384$$

Adjustments for Cluster Sampling

To account for the use of a multi-stage cluster sampling design, a Design Effect (DEFF) was applied. This compensates for the potential loss of sampling efficiency (homogeneity) within clusters. A Gramasewa Niladhari(GN) area was defined as a single cluster.

The DEFF was calculated using the formula:

$$DEFF = 1 + \delta (n - 1)$$

Where:

- δ = Intraclass correlation coefficient, taken as 0.3 (Benette et al.,2017)
- n = The cluster size, set at 20 households per Gramasewaka area.

The calculated DEFF is

$$DEFF = 1 + 0.3 (20 - 1) \approx 7$$

Corrected sample

The base sample size was multiplied by the DEFF to obtain the corrected sample:

$$384 \times 7 = 2,688 \approx 2,700$$

Final sample size

To maintain statistical power despite potential dropouts or incomplete interviews, a 10% non-response rate was factored into the calculation.

$$Final\ sample\ size = 2,700 + (2,700 \times 0.10) \approx 3,000$$

Total number of clusters

With a total target sample size of 3,000 respondents and a fixed cluster size of 20 households,
Total number of clusters (GN divisions) required for the study = 3000/20= 150.

2.1.6. Sampling Technique

A Stratified Multistage Cluster Sampling was used. To ensure findings were nationally representative, the following demographic quotas were applied as stratifications based on national distributions:

- Gender: 100% females to ensure lived experience of menstruation
- Sectors: Urban – 18%, Rural – 78% and Estate – 5%
- Ethnicity: Sinhalese – 74%, Sri Lankan Tamil – 11%, Muslim – 9% and Indian Tamil – 6%

A total of 150 clusters were distributed across districts in proportion to each district's share of the national population. Districts with larger population shares were allocated a correspondingly greater number of clusters, ensuring that the sample reflects the geographic distribution of the national population.

In addition, clusters were further allocated according to the population distribution across urban, rural, and estate sectors. The number of clusters assigned to each sector was proportional to its share of the population.

This proportional allocation at both the district and sector levels ensures that the final sample is representative of the national population distribution by geography and by type of locality (urban, rural, and estate).

Table 2.1: Allocation of clusters by districts and sectors

Province	District	Sample Size by Proportion	Number of Clusters			
			GN Points	Urban	Rural	Estate
Western	Colombo	316	16	14	2	0
	Gampaha	353	18	4	14	0
	Kalutara	179	9	1	8	0
Central	Kandy	201	10	2	7	1
	Matale	63	3	0	3	0
	Nuwara Eliya	139	7	0	2	5
Southern	Galle	161	8	1	7	0
	Matara	117	6	1	5	0
	Hambantota	78	4	0	4	0
Northern	Jaffna	79	4	1	3	0
	Kilinochchi	22	1	0	1	0
	Mannar	20	1	0	1	0
	Vavuniya	19	1	0	1	0
	Mullaitivu	21	1	0	1	0
Eastern	Batticaloa	76	4	1	3	0
	Ampara	100	5	2	3	0
	Trincomalee	65	3	1	2	0
North Western	Kurunegala	101	5	0	5	0
	Puttalam	254	12	0	12	0
North Central	Anuradhapura	115	6	0	6	0
	Polonnaruwa	58	3	0	3	0
Uva	Badulla	100	5	0	4	1
	Monaragala	60	3	0	3	0
Sabaragamuwa	Ratnapura	151	8	1	7	0
	Kegalle	162	8	0	8	0
Total		3010	151	29	115	7

The sampling was executed in four stages:

- **Stage 1 – District allocation:** The 150 clusters were distributed across districts proportional to the national population distribution to ensure each district was represented according to its size.
- **Stage 2 – Cluster selection:** Gramasewa Niladhari (GN) divisions were considered as natural clusters. Required clusters were randomly selected within each district using a random number generator applied to a comprehensive list of all GN divisions in the district.
- **Stage 3 – Household selection:** Within each selected GN division, up to 20 households were selected to ensure a balanced geographic distribution across the district. To eliminate selection bias, enumerators used a Random Point Locator to generate 2–3 random GPS coordinates per cluster as starting points. This avoided the tendency to start surveys in easily accessible areas like town centers. From these starting points, a systematic “right-hand rule” was applied: every second house in rural areas and every third house in urban and estate areas was approached. If a household declined to participate, the immediate adjacent household was approached. This systematic approach ensures a clear, repeatable route for data collection and helps prevent bias or overlap in household selection.
- **Stage 4 – Respondent selection:** One eligible respondent was selected randomly from all qualifying household members using the Kish Grid Method (Kish, 1949). A second visit was made if the selected respondent was unavailable. If unavailable after both visits, the household was replaced.

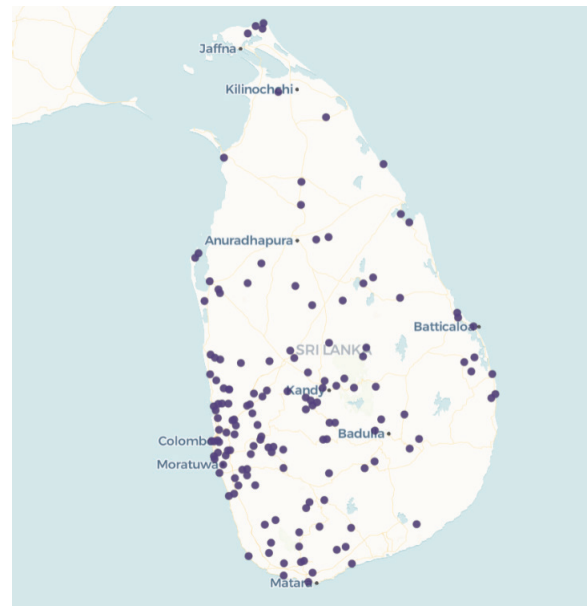


Figure 2.1: Sample distribution map

2.1.7. Study Instrument

The questionnaire was originally developed by a consultation panel from the Health Promotion Bureau (HPB).

- **Translation and adaptation:** The questionnaire was translated into Sinhala, Tamil, and English. Multiple rounds of fine-tuning were conducted to ensure the dialects were appropriate and that linguistic accuracy was maintained across all three languages.
- **Validation:** Content validity and cultural appropriateness was ensured through expert consultation. The translated versions were cross-checked for conceptual consistency.
- **Pre-testing and piloting:** A pre-test was conducted for the final questionnaire with twenty respondents in the Colombo District to assess clarity, logical sequencing, and interview duration. This was followed by a pilot survey of 30 respondents across urban and rural areas. Feedback from the pilot was used to refine the questionnaire.

To facilitate efficient field data collection, the finalized questionnaire was converted into a CAPI format.

2.1.8. Data Collection

The principal investigator and the research team facilitated and monitored the data collection process. A total of 54 female enumerators were recruited to administer the survey. Local interviewers were selected from each district based on local language proficiency and prior experience in field research. Enumerators underwent a comprehensive training on gender-sensitive interviewing techniques, handling of sensitive topics, questionnaire administration, interview procedures, mitigation of potential risks, confidentiality and ethical conduct.

Data were collected through face-to-face, one-to-one interviews using the Kobo Toolbox and CAPI software. Interviews were conducted privately in Sinhala, Tamil, or English according to respondents' preference. Each interview lasted about 30 minutes. Due to the sensitive nature of the study, appropriateness was ensured interviews were conducted in a private space within the household but away from other family members.

Data Quality Assurance

To ensure high reliability and validity, a multi-layered quality control framework was implemented as summarized in Table 2.3.

Table 2.2: Quality assurance process

Activities	Quality Assurance Tasks in brief
Questionnaire Design	All documents were internally peer reviewed by qualified researcher(s) and technical experts prior to HPB and UNFPA approval. Feedback from the pilot was incorporated to refine the questionnaire and final approval was obtained from HPB and UNFPA.
Piloting / Pretesting	The surveys were piloted in the field, and the feedback was incorporated into the survey instruments. Discussion guide pretesting was carried out for qualitative discussions
Fieldwork	Verification of GPS coordinates for spatial accuracy.
Supervision	Verification of GPS coordinates for spatial accuracy. An independent Quality Control team conducted 30% re-contacts via telephone to verify interview authenticity.
Data integrity	Scrutiny/checking of the completed questionnaire was carried out by the Freelance Supervisor. Principal Investigator and the research team cross-checked the data to ensure its accuracy
Data integrity	Analysis of "Time taken to answer each question group/complete the questionnaire" was conducted to identify and remove anomalies. Monotone pattern of answers for each respondent was evaluated using standard deviation for rating-scale questions.

2.1.9. Data Management and Analysis

To maintain high standards of analytical accuracy and reliability, a rigorous data handling and analysis protocol was followed:

- **Data Processing and Handling:**

Data collected via Kobo Toolbox were automatically transferred to a secure database and later imported into SPSS for cleaning, processing, and analysis. Logical inconsistencies and missing values were verified by trained statisticians to maintain analytical accuracy and reliability.

- **Weighting:**

The survey data were weighted following the collection of data to ensure representativeness and alignment with national distributions. Adjustments were made for variations in the sampling method and age distribution to reflect national population characteristics.

However, weighting was not required for sector or ethnicity as the randomly selected sample naturally achieved a split (Urban: 18%, Rural: 78%, Estate: 5%; and Sinhalese: 77%, Sri Lankan Tamil: 11%, Muslim: 9%, Indian Tamil: 6%) that closely mirrored national census distributions.

Statistical analysis: Descriptive statistics and cross-tabulations were used to identify patterns and trends, while basic inferential statistics were applied to test significant associations between key variables.

2.2. Qualitative study

2.2.1 Focus Group Discussions

To complement the quantitative findings and gain a deeper understanding of the issues related to Menstrual Health and Hygiene (MHH), focus group discussions were carried out.

Study population

The population included:

- Adolescent girls and women from estate, rural, and urban areas.
- Representatives from government and institutional sectors such as health, education, and urban development.

Sample size and sampling technique

A **purposive sampling method** was employed to select participants for a total of eight Focus Group Discussions (FGDs), categorized into two primary groups:

- **FGDs with Schoolgirls (n = 4):**

Four FGDs were conducted with female school students (8 participants per group; total n=32). To ensure sectoral representation, Colombo (urban), Nuwara Eliya (estate), Hambantota (rural), and Kilinochchi (rural) districts were selected. Girls only schools and mixed schools (4 above type C schools per district), were randomly selected from a sampling frame, and female students aged 16 and above who volunteered were included.

- **FGDs with Authorities (n = 4):**

Four FGDs were conducted with representatives from government and institutional sectors (8 participants per group; total n=32). Participants were selected under the guidance of HPB experts to include representatives from the Estate Development Authority, Urban Development Authority, Ministry of Education, Ministry of Health, and female office workers from both public and private sectors. For each FGD at least one participant from each category were selected. The summary of sample selection is presented in Table 2.4

Table 2.3. Summary of sample selection for FGDs

FGD	Sector	Ethnicity	Location	Target group	No. of Participants	Authority Representatives				
						Est.	Urban	Edu.	Gov. & Pvt.	Health
FGD 01	Urban	Sinhala	Colombo	Students (1AB type)	08	-	-	-	-	-
FGD 02	Rural	Sinhala	Hambantota	Students (1C type)	08	-	-	-	-	-
FGD 03	Rural	Sinhala	Kilinochchi	Students (1AB type)	08	-	-	-	-	-
FGD 04	Estate	Tamil	Nuwara Eliya	Students (1C type)	08	-	-	-	-	-
FGD 05	Urban	Sinhala	Colombo	Gov. Authorities	08	-	2	2	2	2
FGD 06	Rural	Sinhala	Hambantota	Gov. Authorities	08	-	2	2	2	2
FGD 07	Rural	Tamil	Kilinochchi	Gov. Authorities	08	-	2	2	2	2
FGD 08	Estate	Tamil	Nuwara Eliya	Gov. Authorities	08	2	1	1	2	2
Total Participants					64	32				

Study Instrument

Semi-structured discussion guides were developed and customized for each target group. The guides for schoolgirls focused on personal lived experiences and social norms, while the guides for authority representatives emphasized policy, institutional support systems, and structural challenges. This approach ensured that discussions were meaningful and addressed the perspectives of all relevant stakeholders.

Data Collection

Focus Group Discussions (FGDs) were led by trained facilitators in private, comfortable settings and lasted approximately 60 minutes. While following a planned structure, the facilitators maintained enough flexibility to allow for open, meaningful dialogue.

For sessions involving schoolgirls, school-level permission, parental/guardian consent, and the participants' own assent were secured in advance. All participants were assured that their information would be kept confidential and their identities anonymous.

Data analysis and reporting

All sessions were audio-recorded and transcribed verbatim. Transcripts in local languages were translated into English and verified by an independent reviewer against the original recordings to ensure contextual accuracy. The data were then analyzed using a pre-defined thematic framework to identify recurring patterns and key themes across the different groups.

2.2.2. Key informant interviews with stakeholders

Study Design And Population

Key informant interviews (KIIs) were conducted with key stakeholders to understand their perspectives on the barriers and challenges concerning Menstrual Health and Hygiene in Sri Lanka. The study population included adolescent girls, youth, adult women, female teachers and activist/community leaders from estate, rural, and urban areas.

Sample Size And Sampling Technique

A total of 20 respondents were selected using purposive sampling method. Selection was designed to ensure diversity in perspectives.

Table 2.4. Description of KII interviews

Target Groups of Key informant interviews	Number of Interviews
Adolescents aged 16-20 (from Urban/Rural /Estate)	04
Youth aged 21- 35 (from Urban/Rural /Estate)	04
Adults aged 36-50 (from Urban/Rural /Estate)	04
Female Teachers (from Urban/Rural /Estate)	04
Activist/Opinion Leaders in the Community	04
Total of KIIs	20

Study Instrument

For the Key Informant Interviews (KIIs), specific interview guides were prepared to explore a range of issues, including personal experiences, structural barriers, and how institutions respond to matters related to Menstrual Hygiene Management (MHM).

Data Collection

Interviews were conducted face-to-face using the interview guides, ensuring consistency and depth. All participants provided written informed consent prior to the interview.

Data Analysis

Audio recordings were transcribed verbatim. Non-English transcripts were translated into English while maintaining contextual meaning. All transcripts were cross-checked by an independent reviewer to confirm they were accurate and true to the original recordings. The data was then analyzed using a pre-defined thematic framework to identify key patterns and themes.

2.3 Ethical considerations

Ethical clearance: Ethical clearance was obtained from the Ethics Review Committee (ERC) of the National Institute of Health Sciences (NIHS), Kalutara, following a thorough review of the study protocol by an expert panel from the HPB. In addition, institutional ethical clearance was also obtained from the University of Colombo and other relevant institutional directors.

Consent: Participation was voluntary. Written or verbal informed consent was obtained from all participants. For schoolgirls, school permission and parental/guardian consent were secured alongside the participants' assent. The consent process was administered verbally in the respondent's preferred language. Participants were explicitly informed of their right to refuse any question that caused discomfort or to terminate the interview at any time without penalty.

Confidentiality: All the survey data for the quantitative survey was saved securely, with the principal investigators having exclusive access.

2.4. Limitations

A primary limitation of this study was the exclusion of females below the age of 16. Although many girls in Sri Lanka experience menarche at increasingly younger ages, this age threshold was determined in accordance with the guidelines of the Ethical Review Board to ensure ethical compliance, appropriate informed consent procedures, and protection of minors. Including participants under 16 would have required parental consent protocols, which presents practical and feasibility challenges in a study addressing a sensitive topic such as menstruation. In many cases, parents may be reluctant to allow their daughters to participate, and obtaining consent would have significantly extended the data collection process.

03

Results - Quantitative Study



3.1 Socio demographic profile of respondents

Summary:

- Respondents: 3010 women and girls, aged 16- 50 (evenly distributed across age groups).
- Ethnicity: Majority Sinhalese (77%), followed by Tamils (15) and Moors/Muslims (7%).
- Religion: Mostly Buddhists (70%), Hindus (13%), Islam (7%), Roman Catholic (7%), Christian (3%)
- Education: Highest levels at O/L (40%) and A/L (36%); only 5% had bachelor's degrees.
- Income: Average personal income Rs. 41,362; household Rs. 63,957 (higher in urban).
- Marital status: 70% married, 28% unmarried.

Response rate according to the age groups

The survey respondents selected to participate in the survey were between the ages of 16-50 years and were distributed among the following age groups as indicated in Figure 3.1.

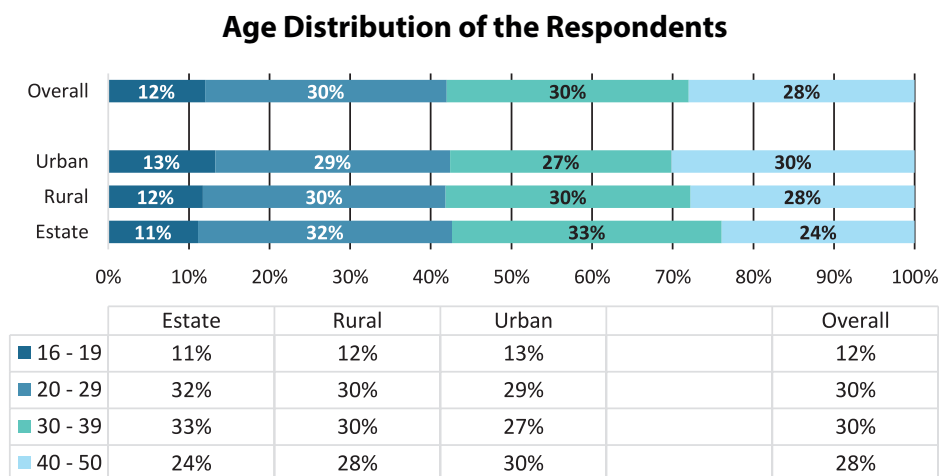


Figure 3.1: Age distribution of the respondents by sector

Base: All the Respondents (n=3010)

Ethnicity and Religion

Table 3.1 summarizes the ethnic distribution of the survey respondents. Individuals of Sinhalese ethnicity (77%) represent the highest number of respondents, followed by Tamils (17%) and Sri Lankan Moors (7%).

Table 3.1: Distribution according to the ethnicity of the respondents

Ethnic Group	Overall Frequency	Overall percentage
Sinhalese	2328	77%
Sri Lanka Tamils	324	11%
Sri Lanka Moors /Muslim	204	7%
Indian Tamil	150	5%
Burgher	3	0%
Malay	1	0%

Base: All the Respondents (n=3010)

The distribution of survey respondents disaggregated by religious identity is shown in Table 3.2. Buddhism had the highest representation among the survey sample (70%) followed by Hinduism (13%),Islam (7%), and Roman Catholics (7%).

Table 3.2: Distribution according to the religion of the respondents

Religion	Overall frequency	Overall percentage
Buddhism	2114	70%
Hinduism	383	13%
Islam	207	7%
Roman Catholic	219	7%
Christian	86	3%

Base: All the Respondents (n=3010)

Marital Status

Table 3.3 summarizes the marital status of the respondents. Majority of the respondents were married women (70%) with 28% unmarried respondents and those who are separated and widowed accounted for 2% of the total respondents.

Table 3.3: Distribution according to marital status of the respondents with age cohorts

Marital Status	Overall percentage	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Unmarried	28%	86%	52%	4%	3%
Married	70%	12%	47%	95%	93%
Separated	1%	1%	0%	1%	1%
Widowed	1%	1%	1%	1%	3%

Base: All the Respondents (n=3010)

Level of Education

Table 3.4 presents the educational background of the respondents. The Majority have completed their studies up to G.C.E. O/L (40%) and A/L (36%) Examinations. While 9% have pursued higher education 12% completed their secondary education (12%) or 2% at least has a primary education and 13 (0.4%) respondents has not had a school education.

Table 3.4: Distribution according to level of education of the respondents with sectoral division

Education Level	Overall frequency	Overall percentage	Estate	Rural	Urban
No schooling	13	0.4%	1%	0%	1%
Primary (up to grade 5)	63	2%	6%	2%	3%
Secondary (Not faced G.C.E. O/L)	362	12%	22%	11%	14%
Up to G.C.E. O/L	1216	40%	35%	42%	38%
Up to G.C.E. A/L	1086	36%	29%	37%	33%
Tertiary: diploma /certificate	116	4%	4%	4%	5%
Tertiary: bachelors	137	5%	2%	4%	6%
Tertiary: masters	12	0.41%	1%	0.16%	1%
Tertiary: PhD	1	0.04%	0%	0.54%	0%
Formal religious school	4	0.12%	0%	0.12%	0.17%

Base: All the Respondents (n=3010)

Occupation of Respondents

Majority of the women were engaged in unpaid house work (54%) higher proportions in older age cohorts while only 19% were employed with a paid work.

Table 3.5: Distribution according to level of education of the respondents with age cohorts

Occupation Type	Overall frequency	Overall percentage	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Students	361	12%	85%	6%	0%	0%
Retired	9	0%	0%	0%	1%	0%
Unpaid housework	1640	54%	8%	41%	72%	70%
Unemployed seeking a job	151	5%	3%	14%	1%	0%
Unemployed not looking for a job	232	8%	3%	19%	3%	3%
Disabled and unable to work	3	0%	0%	0%	0%	0%
Employed in the private sector	248	8%	1%	12%	8%	7%
Employed in the public sector	141	5%	0%	3%	7%	6%
Self-employed with employees	40	1%	0%	1%	1%	3%
Self-employed without employees	138	5%	0%	3%	5%	8%
Elementary Occupations (Low skilled & unskilled)	47	2%	0%	1%	2%	2%

Base: All the Respondents (n=3010)

Monthly income

Personal income

Table 3.6 depicts the average personal income of the respondents who participated in the survey, with a Median personal monthly income of Rs 40,000.00 with lowest reported in the rural sector (Rs. 20,000.00) The median personal income is slightly greater in urban areas (Rs. 45,000.00) compared to rural (Rs. 40,000) and estate (Rs. 20,000.00).

Table 3.6: Distribution of monthly personal income by sectors

Indicator of measurement	Average Amount (Overall)	Estate	Rural	Urban
Mean Value	Rs 41,284.83	Rs 31,099.26	Rs 42,009.54	Rs 43,885.39
Median	Rs.40,000.00	Rs. 20,000.00	Rs. 40,000.00	Rs. 45,000.00
Standard Deviation	Rs.27,820.81	Rs. 23,271.79	Rs. 26,009.53	Rs. 34,013.84

Base: All the Respondents (n=3010)

Household Income

The median household income per month of the respondents were Rs.50,000.00. Table 3.7 represent the distribution of household income according to different sectors with different indicators of measurement of central distribution. The household income is significantly greater in urban areas (Rs. 70,000.00) compared to rural (Rs. 50,000.00) and estate (Rs. 50,000.00).

Table 3.7: Distribution according to monthly household income by sectors

Indicator of measurement	Average Amount (Overall)	Estate	Rural	Urban
Mean Value	Rs. 63,957.88	Rs. 59,625.70	Rs. 61,481.10	Rs. 75,092.56
Median	Rs.50,000.00	Rs.50,000.00	Rs.50,000.00	Rs.70,000.00
Standard Deviation	Rs.52,278.26	Rs. 74,812.80	Rs. 49,600.78	Rs. 52,291.43

Base: All respondents (n=3010)

3.2 General information on menstruation

Summary:

- Age of menarche: Mostly between 11–15 years (average at 13 years, 29%).
- Mean age of menarche has declined to below 13 years among the 16–19 age groups
- Menstrual cycle: Average 30 days.
- Duration of menstruation: Average 5 days.

Age of menarche (First experience of menstruation)

Figure 3.2 illustrates 90% of the survey respondents had their first period when they were between 11 to 15 years old. Twenty-nine (29%) percent of the respondents claimed that they were 13 years old at the time of menarche.

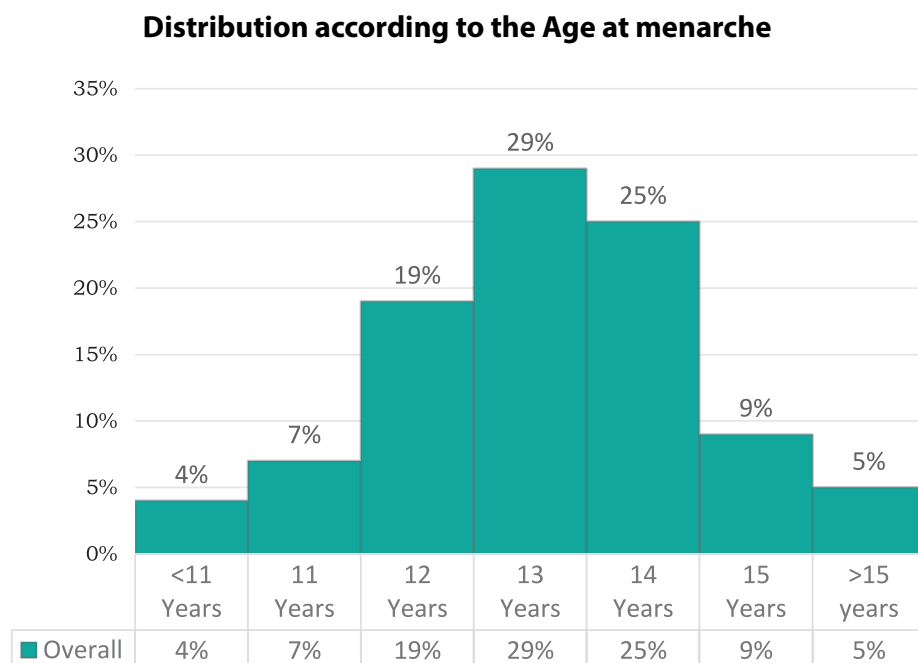


Figure 3.2: Distribution of respondents by age at menarche

Base: All the Respondents (n=3010)

Table 3.8 below shows the age distribution of the respondents according to Urban, Rural, and Estate breakdown.

Table 3.8: Distribution according to the age at menarche with sectors

Age	Overall frequency	Overall percentage	Estate	Rural	Urban
Before 11 years	129	4%	4%	4%	5%
11 Years	206	7%	4%	7%	9%
12 Years	580	19%	22%	19%	22%
13 Years	874	29%	32%	29%	29%
14 Years	760	25%	21%	27%	22%
15 Years	277	9%	11%	9%	8%
After 15 years	155	5%	6%	5%	5%

Base: All the Respondents (n=3010)

The mean age at menarche is marginally lower in urban areas (13.11 years) compared to rural (13.10 years) and estate sectors (13.22 years). Notably, a clear downward trend in the age at menarche is observed among the youngest cohort (16–19 years), born between 2005 and 2009, indicating an earlier onset compared to older age groups.

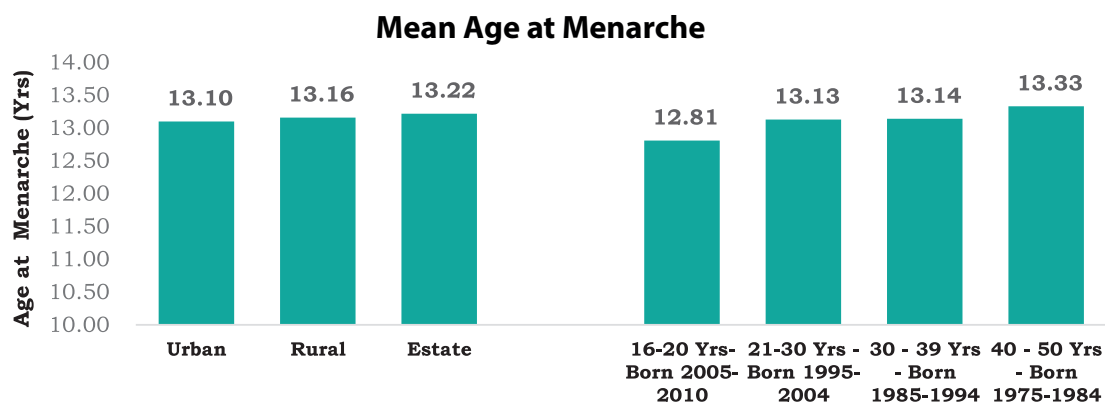


Figure 3.3: Distribution of respondents by age at menarche with age cohorts and sectors

Base: All the Respondents (n=3010)

Length of the menstrual cycle

Table 3.9 illustrates the typical length of the menstrual cycle in days of the respondents. The Mean length of menstrual cycle is found to be 30 days, with slight variation in age cohorts and sectors.

Table 3.9: Length of the menstrual cycle by age cohorts and sectors

	Average Length	Estate	Rural	Urban	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Mean Value	30 Days	27 Days	30 Days	28 Days	29 Days	29 Days	31 Days	30 Days

Base: All respondents (n=3010)

Duration of menstruation

Table 3.10 shows the duration of menstruation in days reported by the respondents, and on average, the duration is 5 days with minimal variation across age cohorts and sectors.

Table 3.10: Duration of menstruation by age cohorts and sectors

	Average Length	Estate	Rural	Urban	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Mean Value	4.74 Days	4.69 ays	4.73 Days	4.71 Days	4.55 Days	4.64 Days	4.52 Days	4.30 Days

Base: All respondents (n=3010)

3.3 Menarche & early awareness

Summary:

- Main source: Mothers (70%), followed by teachers (13%) and relatives (7–15%).
- Awareness before menarche: 50% overall, lowest in estate sector (29%).
- Comfort: 62% comfortable, 38% uncomfortable (estate respondents least comfortable).
- Satisfaction: 69% satisfied/very satisfied, with highest dissatisfaction in estates.

Pre- Menarcheal awareness

Overall, only 50% of respondents were aware of menstruation before their first experience. Awareness was lowest among respondents from the estate sector (29%) and relatively higher in rural areas (53%) and urban areas (44%). Figure 3.4 illustrates the distribution of presence of pre-menarcheal awareness across sectors and age cohorts.

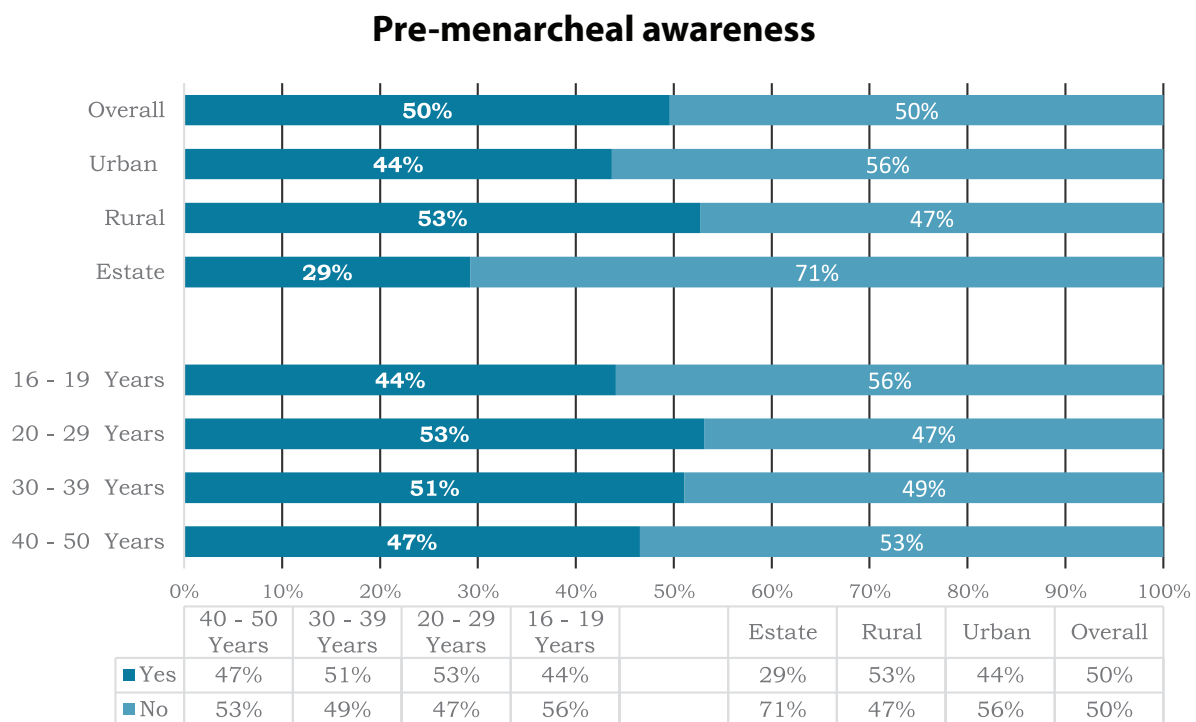


Figure 3.4: Pre- menarcheal awareness

Base: All respondents (n=3010)

Among women of different age cohorts, 20–29 years of age cohort had the highest (53%) level of awareness, while 51% of 30–39 years age cohort, 47% of 40–50 years of age cohort and 44% in the 16–19 years age cohort were aware of menstruation before their first period. Table 3.11 summarizes the presence of pre-menarcheal awareness across sectors and age cohorts.

Table 3.11: Pre- Menarcheal awareness according to age cohorts and sectors

Presence of pre-menarcheal awareness	Overall percentage	Estate	Rural	Urban	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Yes	50%	29%	53%	44%	44%	53%	51%	47%
No	50%	71%	47%	56%	56%	47%	49%	53%

Base: All respondents (n=3010)

Primary source of information on pre-menarcheal awareness

Majority (71%) identified mothers as the primary source of menstrual education before menarche. Estate (69%), urban (70%) and rural (70%) communities, reported the same trend, where mothers were the leading initial source of influence on menstrual information.

School teachers (16%) were identified as the second most common primary source of information on menstruation and same trend was observed in urban, rural and estate sectors. Extended family networks, including female relatives, such as sisters or aunts, also play a stronger role in representing 6%- 8% in all the regions.

Other sources - such as friends (5%), were cited far less frequently, suggesting that informal or impersonal channels of information have limited influence on menstrual health education. Table 3.12 illustrates the sources of information on pre-menarcheal awareness by sectors.

Table 3.12: Primary source of information on pre-menarcheal awareness by sectors

Information source	Overall percentage	Estate	Rural	Urban
Mother	70%	69%	70%	70%
Female relative	13%	9%	13%	13%
School teacher	7%	15%	7%	6%
Health care worker	3%	5%	3%	3%
Friend	0%	0%	0%	0%
Do not remember	2%	0%	2%	1%

Base: All respondents (n=3010)

Comfortable in receiving pre-menarcheal awareness

Among the respondents who were aware of menstruation before their 1st period (n=1505), 61% reported feeling comfortable when they first received information about it, while 39% of participants reported feeling uncomfortable. A majority of respondents in urban (63%) and rural (62%) sectors reported feeling comfortable, compared to a substantially lower proportion in estate areas (41%).

Feeling comfortable in receiving pre-menarcheal awareness

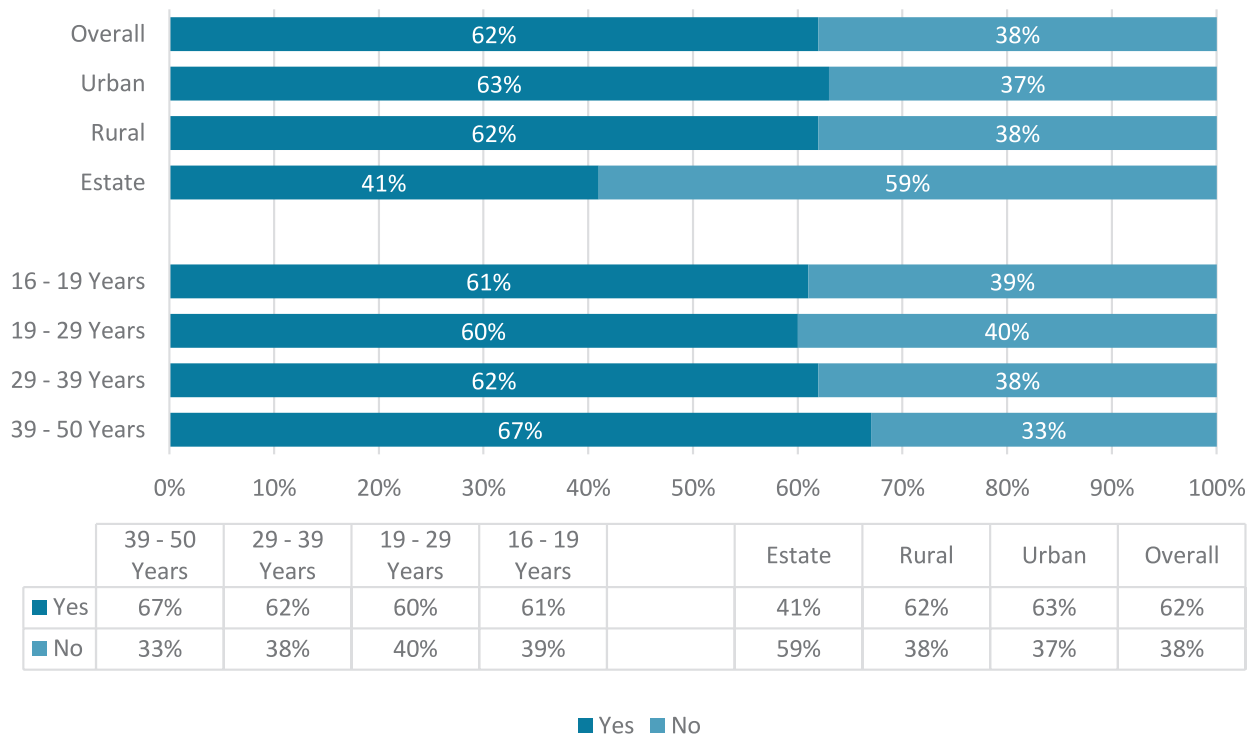


Figure 3.5: Feeling comfortable when receiving pre-menarcheal awareness

Base: Among those who had pre-menarcheal awareness (n=1505)

Respondents aged 16-19 reported the highest feeling comfortable (67%), wherein 62% of 20-29-year age cohort, 60% of 30-39-year age cohort, and 62% of the 40-50 years age cohort claimed they were feeling comfortable when receiving information about menstruation before menarche, despite being from different generations.

Table 3.13: Distribution of Feeling comfortable when receiving pre-menarcheal awareness according to sector and age cohort

Presence of pre-menarcheal awareness	Overall percentage	Estate	Rural	Urban	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Yes	61%	41%	62%	63%	67%	62%	60%	61%
No	39%	59%	38%	37%	33%	38%	40%	39%

Base: Among those who had pre-menarcheal awareness (n=1505)

Level of satisfaction with pre- menarcheal information received

Level of satisfaction with the reception of pre-menarcheal information was positive, with 71% reporting to be satisfied (15% very satisfied and 54% satisfied) and only 11% (8% dissatisfied, 3% very dissatisfied) reported no satisfaction. Satisfaction is constantly high across all age cohorts and sectors.

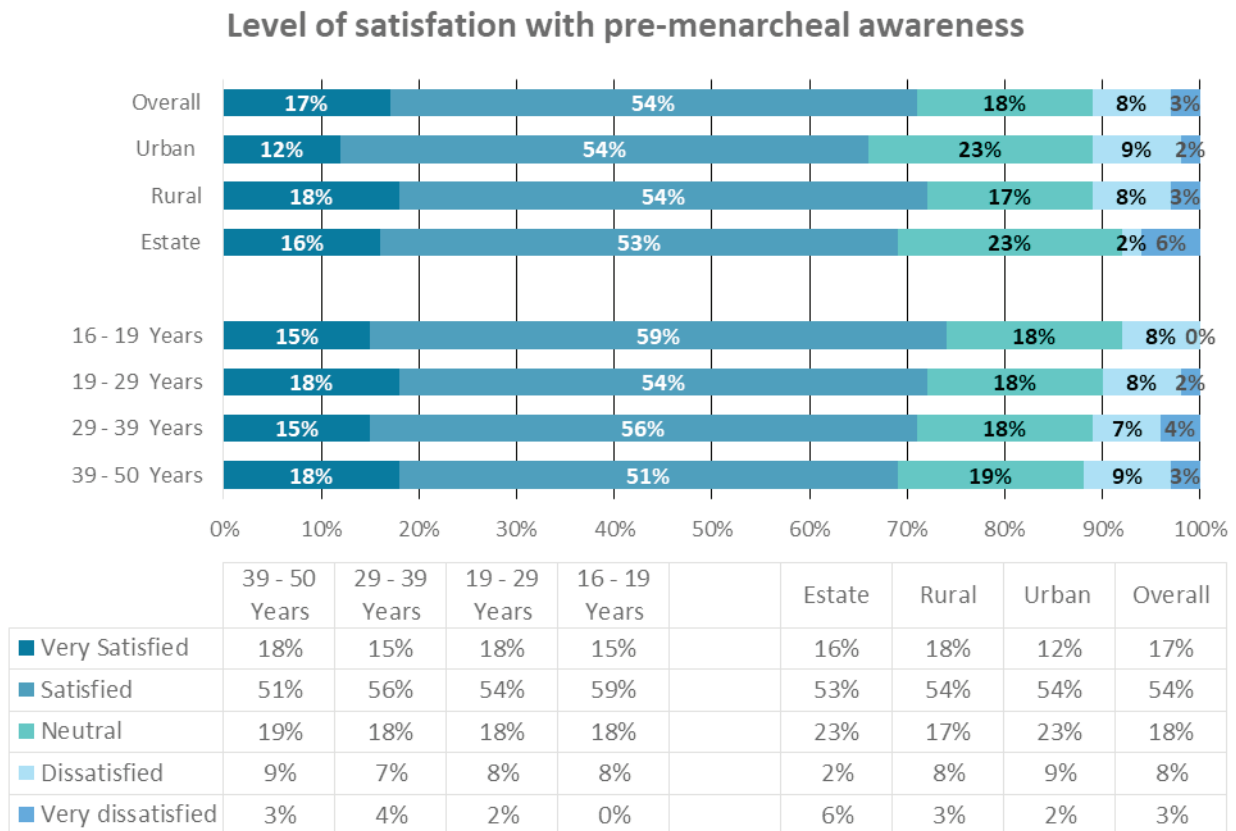


Figure 3.6: Level of satisfaction with pre- menarcheal awareness of the respondents by age cohort and sectors

Base: Among those who had pre-menarcheal awareness (n=1505)

3.4 Information and support-seeking behaviours regarding menstrual health and hygiene

Summary:

- 51% actively searched for menstrual health information; rural women (52%) most proactive.
- Main sources: Internet (45%), social media (42%), TV/radio discussions (32%).
- 26% personally knew a health worker (rural >urban).
- Support sources: Mothers (52%), partners (25%), relatives and healthcare workers also noted.

Information seeking on menstrual health and hygiene

Majority (51%) already claimed to have information seeking on Menstrual Health and Hygiene, while the other 49% did not. Rural areas (52%) showed slightly higher information-seeking behaviour when compared with urban areas (48%) and lowest was observed in estate sector (39%).

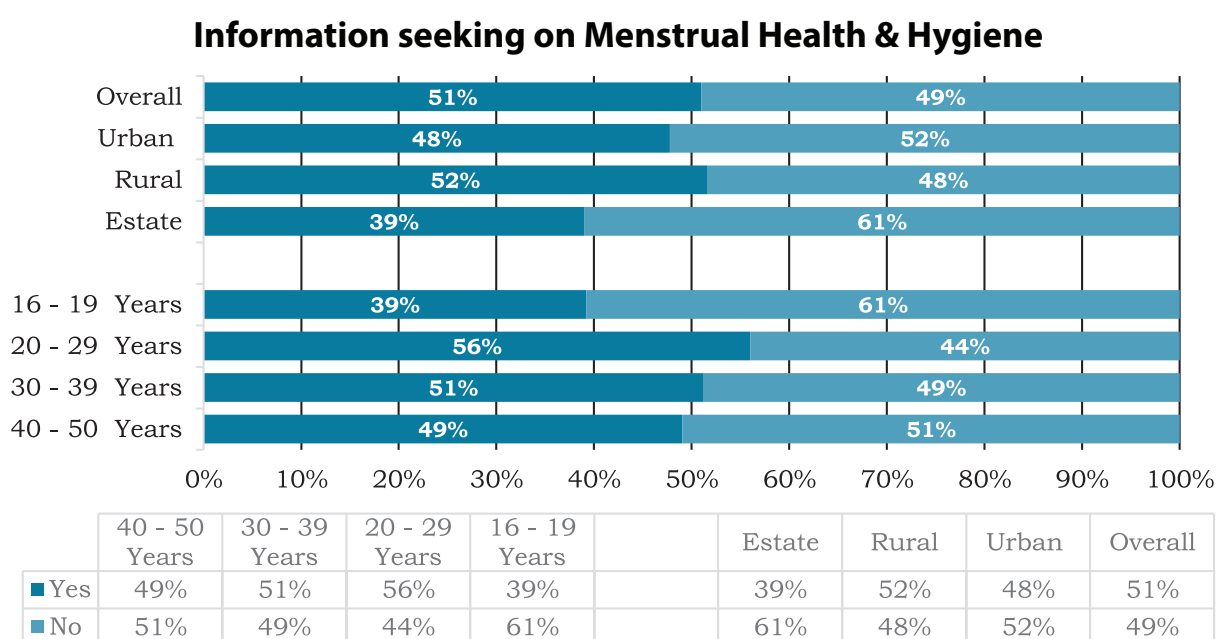


Figure 3.7: information gathering on menstrual health/hygiene

Base: All respondents (n=3010)

Sources of information on menstrual health and hygiene

The most used sources of information on menstrual health and hygiene are digital platforms, with 45% of respondents using the Internet and 42% using social media. Although less frequent, traditional media, such as through discussions of experts on television or radio discussions (32%), television/radio advertisements (12%) and newspaper advertisements (10%) were also reported to be utilized.

When asked to identify a single primary source, social media (32%) and the Internet (31%) remain the leading choices, followed by television/radio discussions (17%). In terms of perceived effectiveness, respondents consider the Internet (28%) and television/radio discussions (27%) as the best ways to receive information, while social media is slightly lower (20%).

Table 3.14: Source of information on menstrual health and hygiene by age and sectors

*Source of Information related to Menstrual Health and Hygiene	The source used to obtain information (Multiple responses)	Mostly used information source (Single response)	Best way to obtain information (Single response)
Discussions of experts on television/radio	32%	17%	27%
Television/radio advertisement	12%	5%	5%
Newspaper advertisements	10%	2%	3%
Documentary films	2%	0%	0%
Printed articles/reports	8%	3%	2%
Information on the Internet	45%	31%	28%
Social media	42%	32%	20%
Mobile messages	9%	7%	5%
Other (specify) ¹	6%	3%	10%
Base:	1535 <i>Base: Respondents who search for informatio</i>	1535 <i>Base: Respondents who search for information</i>	3010 <i>Base: All respondents</i>

¹Other- Information from health expertise (6%)

*Multiple answers were obtained.

Furthermore, stratified analysis was conducted according to sector and age cohort to identify the variations of uses of sources of information. Urban sector respondents most often access information through the Internet (48%) and social media (47%), supported by TV or radio expert discussions (35%). Rural sector respondents primarily use the Internet (46%) and social media (41%), with TV or radio expert discussions also common (32%). Estate sector respondents mainly rely on traditional media (44%) in forms of TV or radio expert discussions (20%), Television/radio advertisements (19%) and Newspaper advertisements (5%) with prominent use of social media (38%). Overall social media remains to be a common source of information across all sectors and information on Internet was less used only by estate sector (13%) while both urban (48%) and rural (46%) used it abundantly.

Table 3.15: Source used to obtain information by age and sectors

*Source of Information related to Menstrual Health and Hygiene	Overall %	Estate	Rural	Urban	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Discussions by experts on television/radio	32%	20%	32%	35%	34%	21%	34%	42%
Television/radio advertisement	12%	19%	10%	18%	11%	9%	13%	16%
Newspaper advertisements	10%	5%	11%	9%	11%	5%	11%	16%
Documentary films	2%	0%	2%	1%	2%	2%	2%	1%
Printed articles/reports	8%	6%	9%	7%	13%	5%	9%	10%
Information on the Internet	45%	13%	46%	48%	45%	56%	46%	30%
Social media	42%	38%	41%	47%	34%	49%	47%	30%
Mobile messages	9%	9%	9%	6%	6%	8%	11%	9%
Other (specify) ¹	6%	10%	7%	2%	8%	4%	5%	10%

¹Other- Information from health expertise (6%)

*Multiple answers were obtained.

Base: Respondents who search for information (n=1535)

Internet (56%) and social media (49%) was mostly used by the 20-29 age cohort with similar pattern seen among 30-39 age cohort with most often use source of information being social media (47%) and the Internet (46%). Youngest cohort, 16-19 ages mainly use the Internet (45%), with social media and also TV or radio expert discussions) tied as the next most common sources (34% each). Age cohort in 40-50 years rely most on TV or radio expert discussions (42%), while Internet and social media use drops to 30% each.

Contacts with health sector workers

Over a quarter (26%) of respondents have a personal contact to a health sector worker, while the majority (74%) do not. Urban areas report the lowest proportion of personal contacts (21%), whereas rural areas have the highest (27%), suggesting slightly stronger community-health worker ties in rural settings. The Estate sector is close to the overall average (25%). Age-wise, older respondents (30-39 years and 40-50 years) are more likely to report a personal contacts (30% each) compared to younger groups. The 16-19 age group records the lowest contacts rate (16%) and the highest “No” response (84%), indicating limited personal links to health workers among youth.

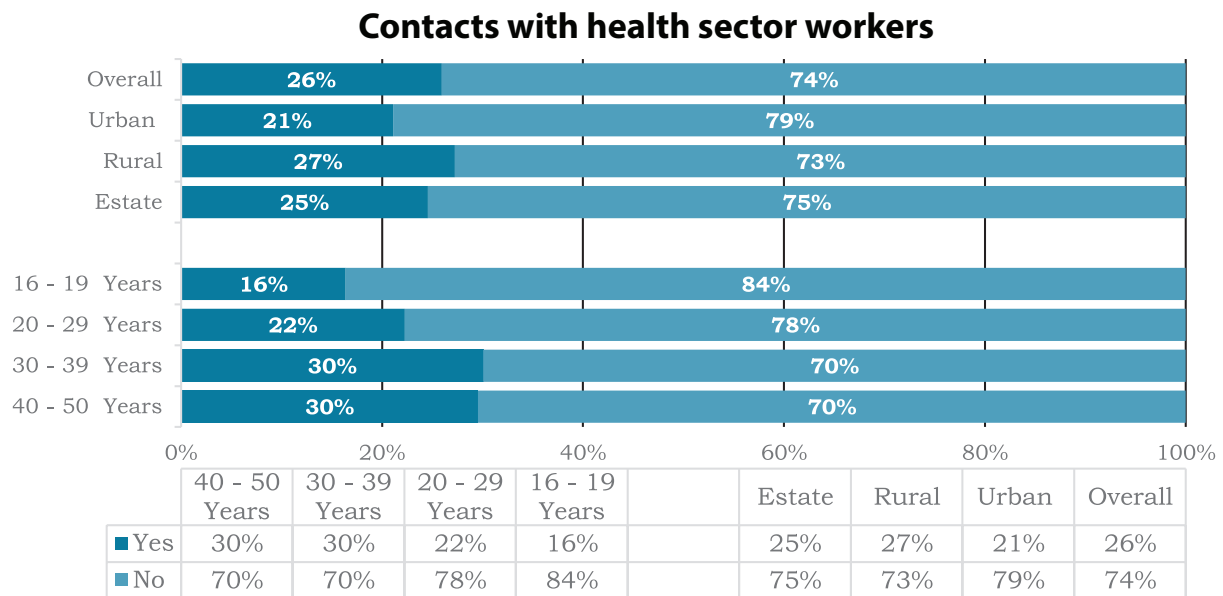


Figure 3.8: Distribution of presence of contacts with a health sector worker by age cohorts and sector

Base: All respondents (n= 3010)

Among those who claimed to personally know someone working in the health sector, the most common observed was “with a family member” (38%), of which highest in urban areas (48%) and lowest in the estate sector (25%). Friends account for 15% across all sectors, while neighbors make up 6% overall and are absent in the estate sector. Colleagues or classmates are rare (1% overall) but more notable in the estate sector (7%). Acquaintances form 39% of connections, peaking in the estate sector (54%), suggesting more distant ties in these communities.

Table 3.16: Type of relationship with the health sector worker and distribution by the sector

Relationship	Overall percentage	Estate	Rural	Urban
Family member	38%	25%	37%	48%
Friend	15%	14%	15%	15%
Neighbor	6%	0%	6%	7%
Colleague/classmate	1%	7%	1%	1%
Acquaintance*	39%	54%	40%	29%

Base: Respondents who personally know health workers (n=781)

Seeking support from a healthcare professional

Figure 3.6 illustrates 44% of respondents surveyed seek help from a healthcare professional on menstruation-related concerns. Meanwhile, 56% do not get any professional medical care for menstruation-related concerns.

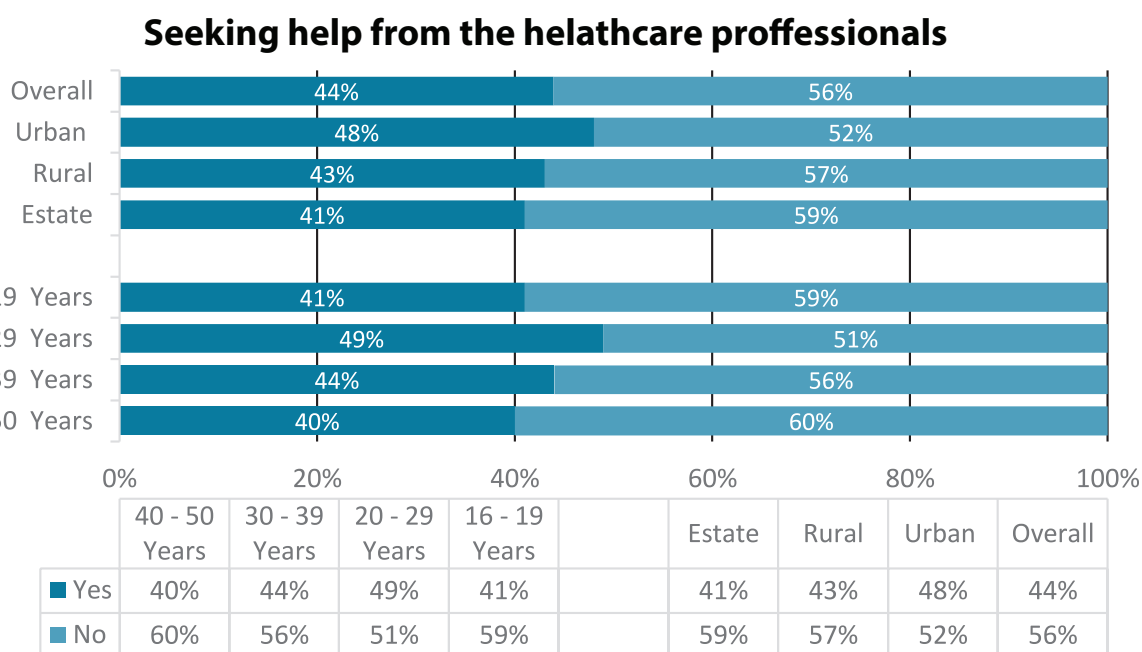


Figure 3.9: Distribution of seeking help from a healthcare professional for menstrual concerns by age cohort and sectors
Base: All respondents (n= 3010)

Only 48% of urban, 43% rural, and 41% of estate respondents seek help from healthcare professionals. Young 16-19 age cohort (59%) and the older 40-50 age cohort (60%) seems not to seek medical help while the 20-29 group (49%) records to seek for medical help abundantly.

Comfort in seeking support during menstruation

Overall, 55% of respondents reported being comfortable in seeking support during menstruation, while 45% indicated they could not. Feeling comfortable in seeking support was consistent across urban (55%), rural (55%) and estate (53%) of women. Age, however, plays a significant role in feeling comfortable in seeking support during menstruation. Younger women, particularly those aged 16–19, are much comfortable in seeking support (74%) compared with women aged 40–50 (39%).

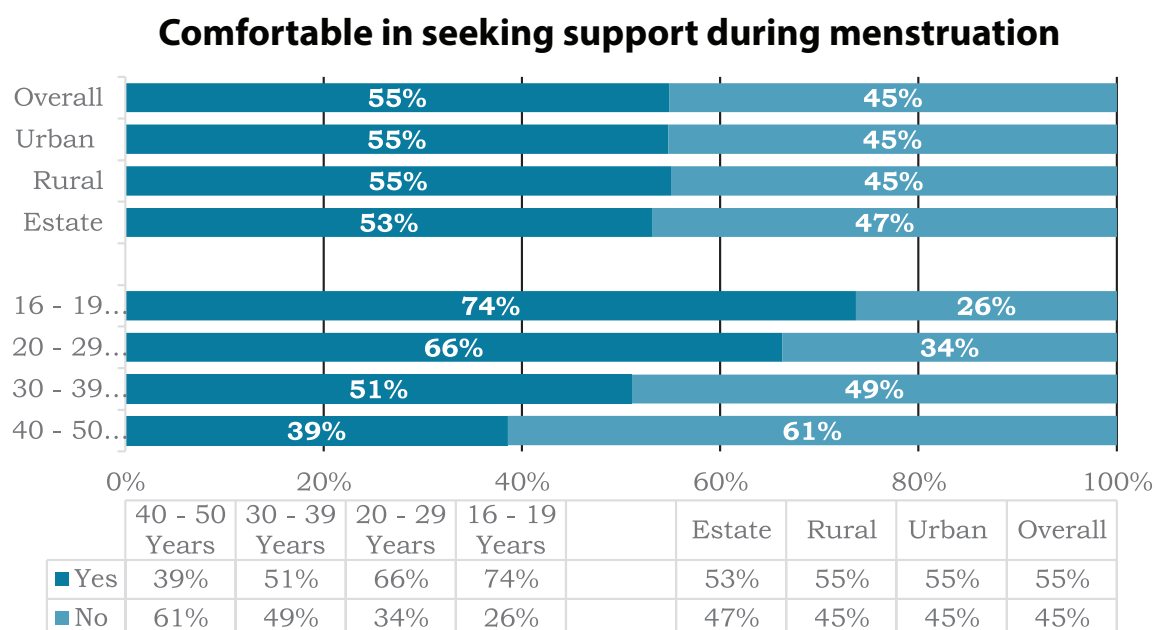


Figure 3.10: Comfort in seeking support during menstruation

Base: All respondents (n= 3010)

Source of primary support during menstruation

The primary support during menstruation was provided by mothers (52%), followed by husband/boyfriend/partners (25%). In rural (7%) and estate (10%) communities, healthcare workers also play an important role. Female relatives (9%) play an important role in estate environments in terms of providing support during menstruation. While Rural areas (30%) reported more male participation in support during menstruation, rural sector (15%) had the least.

Table 3.17: Source of Primary Support during Menstruation by sectors

*Relationship	Overall percentage	Estate	Rural	Urban
Mother	52%	49%	51%	59%
Sister	7%	14%	6%	8%
Husband/Boy friend/ Partner	25%	12%	27%	23%
Other female relative	4%	9%	4%	4%
Male family member	1%	0%	1%	1%
Friend	2%	3%	2%	2%
Health care worker	6%	10%	7%	2%
No one	2%	1%	0%	0%

Base: All respondents (n= 3010)

*Multiple answers were obtained.

3.5 Knowledge on menstrual health and hygiene

Summary:

- 64% correctly identified the uterus as the source of bleeding (lowest in estates).
- 74% aware of pain management methods.
- High knowledge of basics: cycle length (92%), duration (99%), hormonal control (90%).
- Misconceptions: 42% mentioned women are “unclean,” 26% thought menstruation stops after sex, 26% assumed it lasts lifelong.
- The estate sector showed the highest misinformation.

Knowledge of the source of menstrual bleeding

Overall, 64% of respondents correctly identified the uterus as the source of menstrual bleeding. This indicates that nearly two-thirds of women have basic knowledge about the physiological origin of menstruation. Awareness is consistent across the sectors with highest in rural (66%), 63% in urban areas, and slightly lower at estate (54%) sector.

Knowledge of the source of menstrual bleeding - identified as Uterus

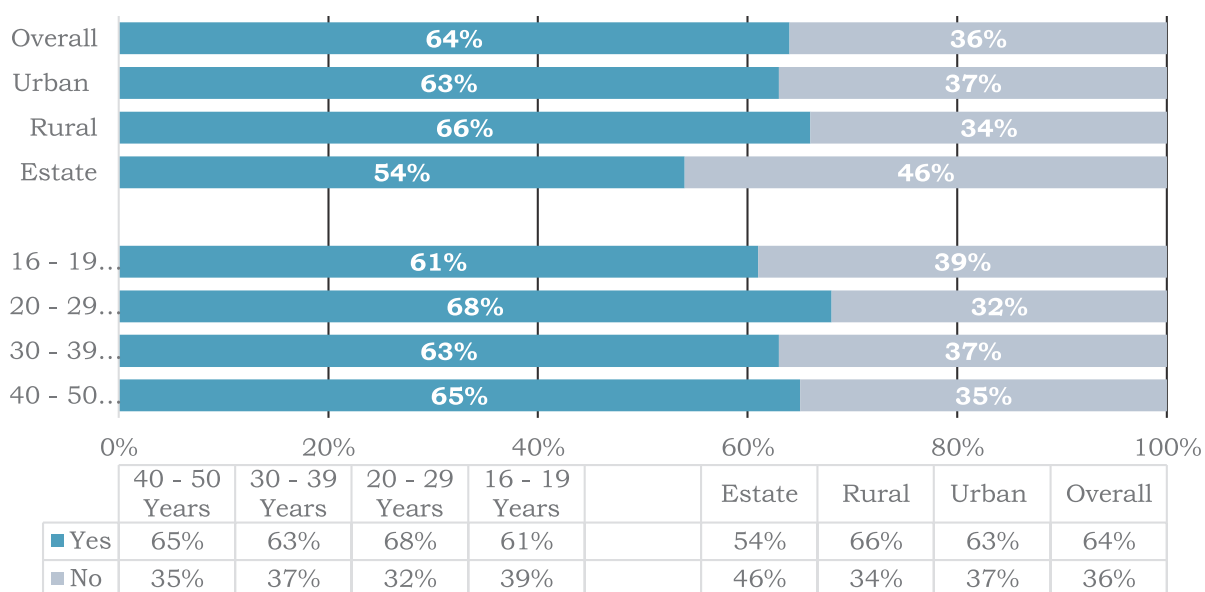


Figure 3.11: Knowledge of the source of menstrual bleeding -identified as uterus
Base: Those who said “YES” to the Uterus as the source of bleeding (n=1935)

Knowledge on menstrual pain management

Seventy-four percent (74%, n=2236) of respondents were aware about the methods that are available to manage period pain. Rural sector (75%) reported the highest-level of knowledge in pain management with 73% in Estate and 71% in Urban.

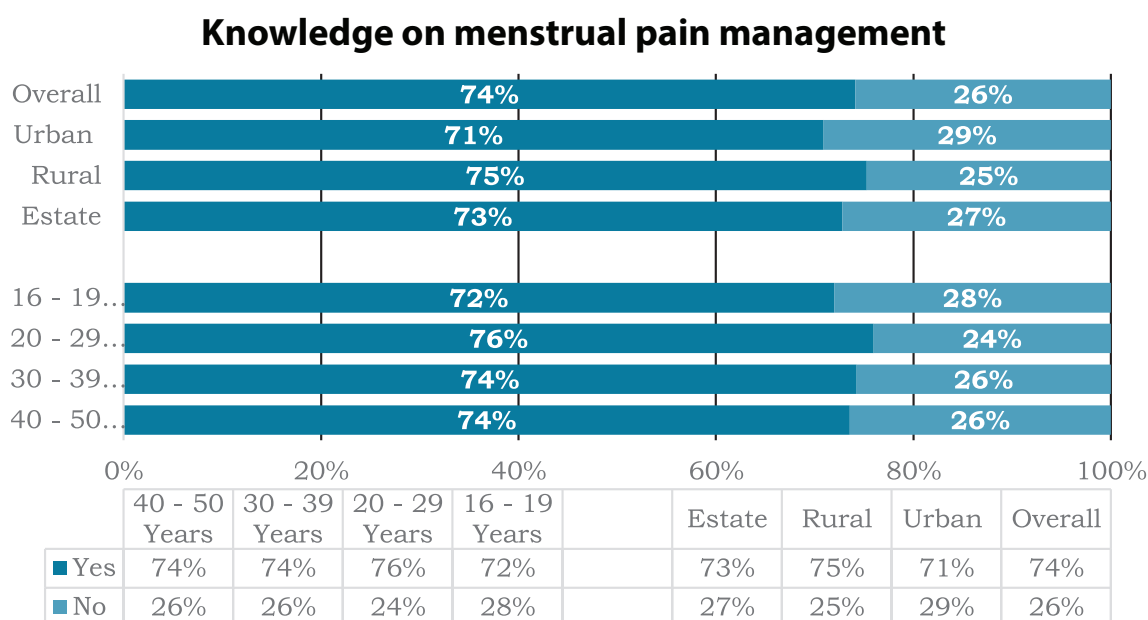


Figure 3.12: Knowledge on menstrual pain management by age and sectors

Base: All Respondents (n=3010)

Knowledge on various methods of menstrual pain management

Majority (n=2236, 74%) of the respondents were aware various methods of menstrual pain management with 76% being aware about pain relief medicines/pain killers. Conventional methods were also in popular methods with 38% claimed warm baths or applying heat would reduce the pain while 21% on herbal remedies or traditional medicine and 13% on massage or abdominal oil application.

Estate sector reported the relatively low (60%) compared to rural (76%) and urban (77%) level of awareness on pain relief medicines with 40-50 age cohort (82%) reporting the highest level of awareness on pain relief medicine. Herbal remedies and traditional medicine were less known in the estate community (9%) compared to rural (20%) and urban (30%) communities

Table 3.18: Distribution of awareness on various methods of menstrual pain management among the respondents by age and sectors

	*Overall %	Estate	Rural	Urban	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Warm bath or applying heat	38%	24%	38%	42%	42%	46%	35%	29%
Herbal remedies or traditional medicine	21%	9%	20%	30%	20%	22%	20%	22%
Diet and hydration	16%	13%	15%	18%	19%	17%	13%	15%
Use of pain killers	76%	60%	76%	77%	72%	68%	79%	82%
Massage or abdominal oil application	13%	6%	13%	15%	14%	12%	13%	13%
Light exercise or yoga	6%	3%	6%	7%	7%	8%	5%	6%
Relaxation techniques	5%	3%	6%	5%	7%	6%	5%	5%

*Multiple answers were obtained.

Base: Respondents who are aware of menstrual pain management methods (n= 2236)

Knowledge on key facts on menstruation and misconceptions

High proportion (90%), correctly recognized that menstruation is regulated by hormones, the uterine lining sheds during menstruation (87%), has a cycle length of 21–35 days (92%), lasts 3–7 days (99%), and is a normal physiological phenomenon (99%).

However, gaps in knowledge remain evident. Majority (93%) believed menstruation is the body's natural way to remove impurities. Furthermore, 42% of respondents mentioned that “a person is unclean during menstruation.” In addition, 26% had a misconception that menstruation ceases after the initiation of sexual intercourse, while 26% assumed it continues throughout a woman’s life. Fifty two percent (52%) correctly understood that women’s fertility changes within the menstrual cycle.

Inadequate knowledge is higher in estate areas, with 59% viewing women as unclean and 53% unclear about fertility. Knowledge that menstruation stops after sexual activity or is lifelong is common in urban and rural areas, showing the need for targeted education to address these facts.

Knowledge of menstruation

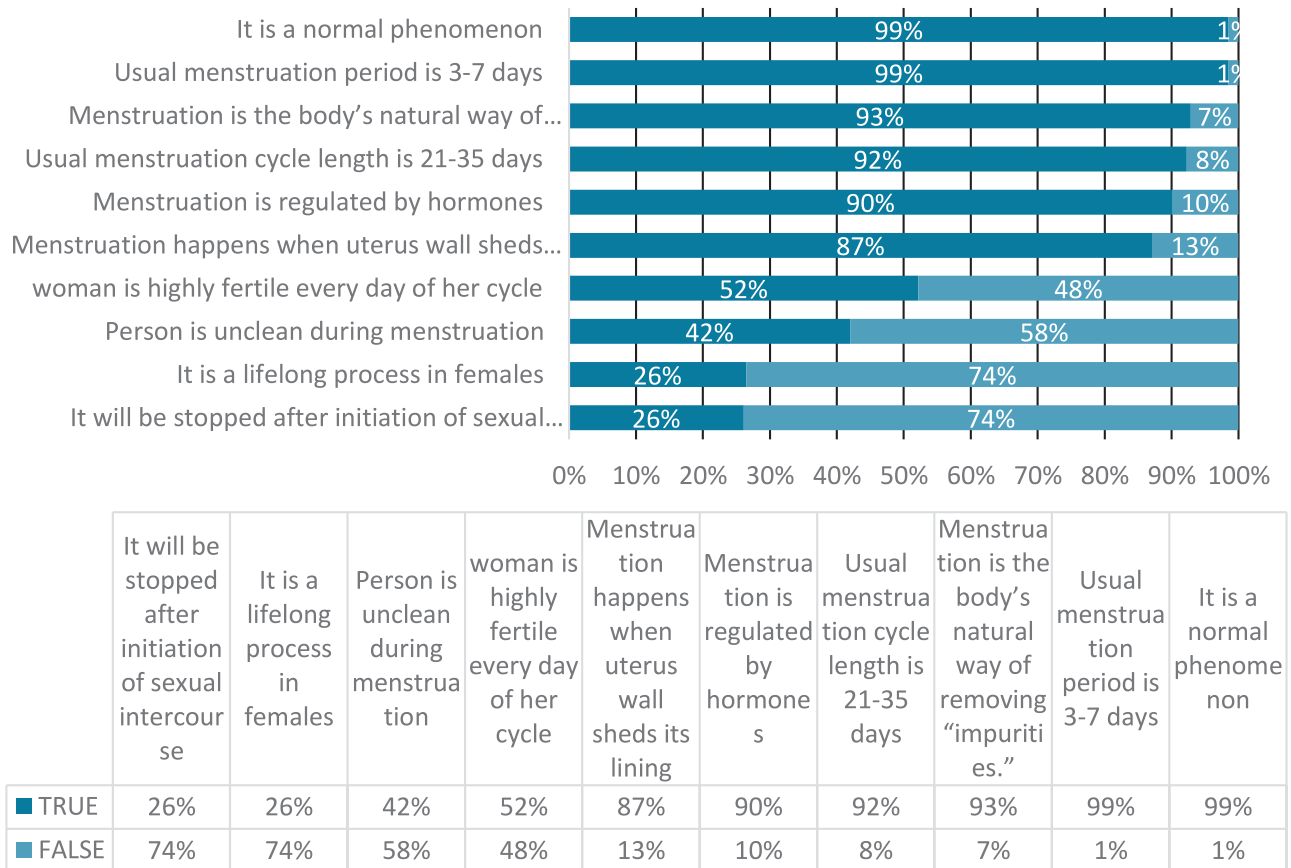


Figure 3.13: Basic knowledge on menstruation

Base: All respondents (n=3010)

3.6 Cultural beliefs, taboos and attitudes on MHH

Summary:

- 97% agreed menstruation is normal; 96% supported pre-menarche education for girls
- 82% believed that men should be educated about menstruation
- First experiences: Fear (48%) and embarrassment (24%) most common; less fear in urban areas.
- Restrictions: 34% experienced restrictions, mainly in rural areas; 60% faced none.
- Most rejected restrictive taboos (avoiding meat/fish, no exercise, etc.); only -33% supported avoiding fatty foods

Figure 3.13 depicts general attitude of the respondents towards MHH and common taboos and cultural beliefs. Menstruation is considered a normal phenomenon (97%) by a majority. Large proportion of respondents (96%) said that girls should be educated about menstruation before their menarche and 82% agreed that boys should also be educated on menstruation.

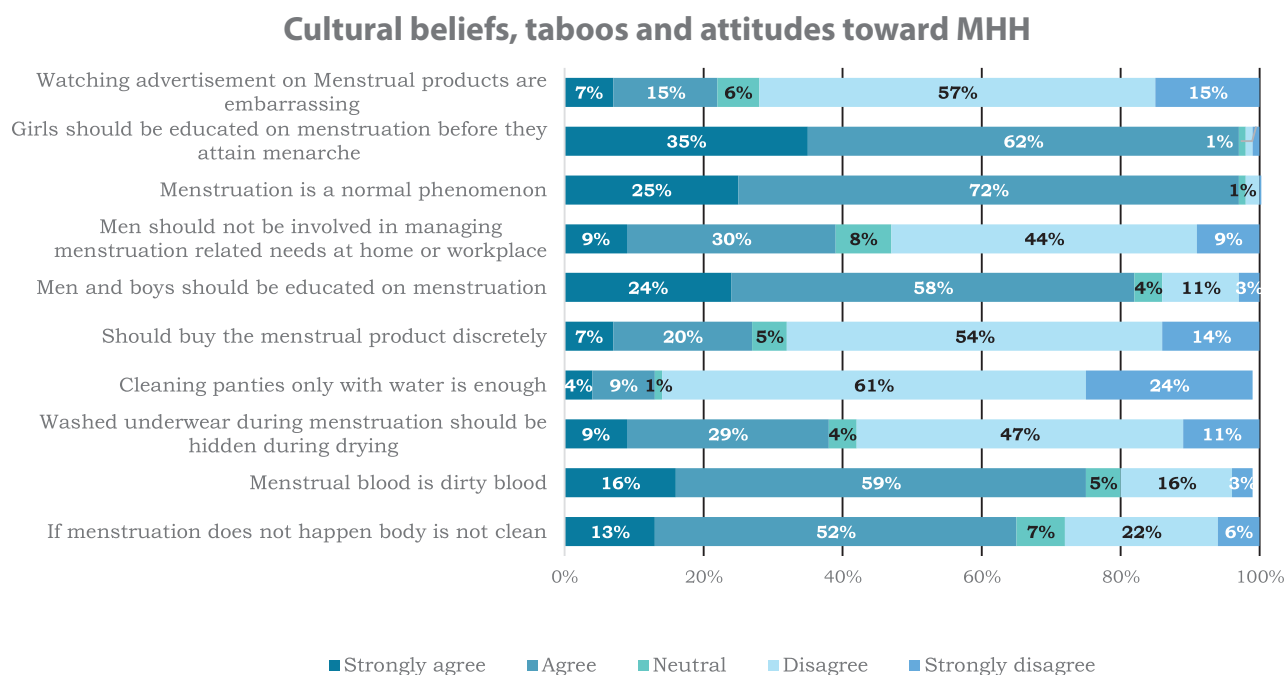
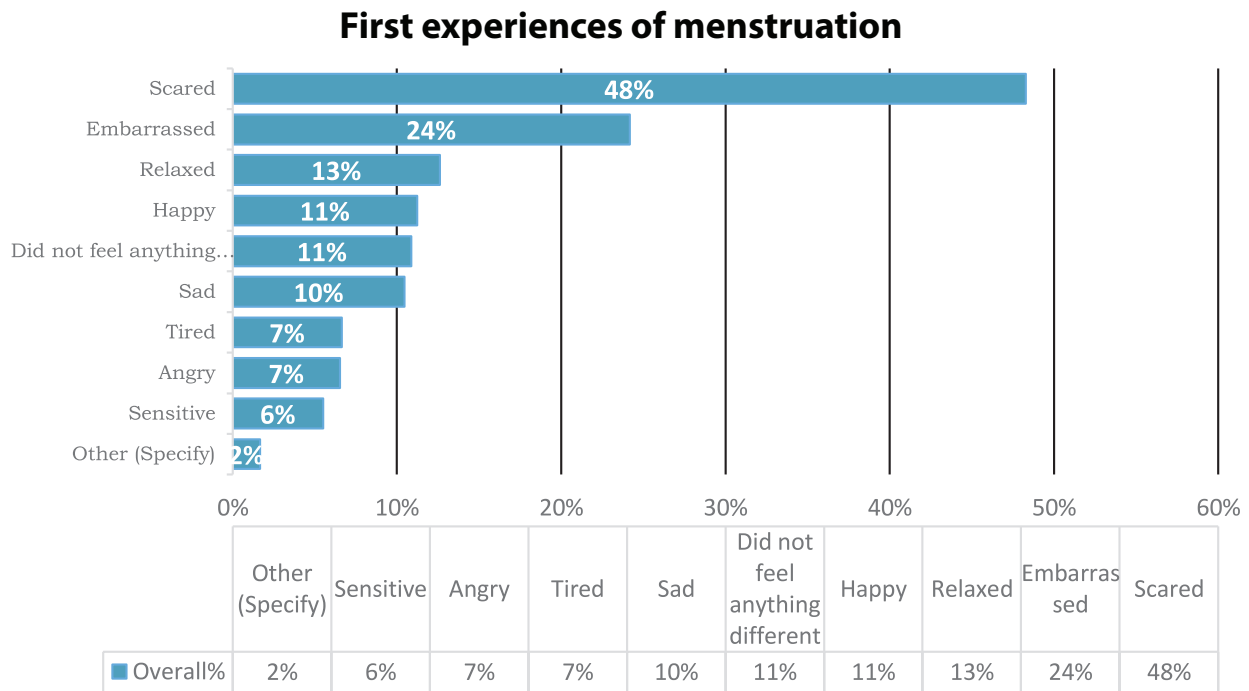


Figure 3.14: Attitudes toward menstrual health & hygiene

Base: All respondents (n=3010)

First experiences of menstruation

The most common reaction during the first menstrual experience was feeling scared (48%), followed by embarrassment (24%). Smaller proportions reported feeling happy (11%), sad (10%), relaxed (13%), anger (7%), tiredness (7%) while 11% reported they did not feel anything.



Other* - Pain/ Physical Discomfort (0.42%), Did not remember or forgot (0.38%), Didn't understand/Couldn't think/too young (0.34%)

Figure 3.15: First experiences of menstruation

Base: All respondents (n=3010)

Urban respondents reported lower levels of fear (8%) and embarrassment (5%) compared with rural (36% fear, 18% embarrassed) and estate communities (4% fear, 1% embarrassed), suggesting that girls in urban areas may have slightly better awareness or preparation. Across age groups, younger girls (16–19 years) reported lower percentages, while women aged 20–50 years showed similar levels of fear (14–15%) and embarrassment (7–8%), indicating that these negative emotions are common regardless of age.

Table 3.19: First Experiences of menstruation by age and sectors

Feeling	*Overall %	Estate	Rural	Urban	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Happy	11%	7%	12%	10%	14%	11%	11%	11%
Sad	10%	11%	10%	11%	9%	10%	10%	12%
Scared	48%	63%	48%	44%	45%	46%	51%	49%
Angry	7%	5%	6%	11%	6%	8%	5%	7%
Embarrassed	25%	18%	24%	26%	23%	23%	26%	24%
Relaxed	13%	5%	12%	16%	8%	11%	14%	16%
Tired	7%	8%	6%	10%	6%	7%	7%	6%
Sensitive	6%	1%	6%	4%	5%	6%	5%	6%
Did not feel anything different	11%	10%	11%	9%	12%	13%	8%	11%

*Multiple answers obtained

Base: All respondents (n= 3010)

Experiences of restrictions during menstruation

Overall, most women (60%) did not experience restrictions during menstruation, while 34% reported facing some restrictions and 6% experienced them occasionally. Restrictions were more common in rural areas (26%) compared with urban (6%) and estate (2%) communities. Women in 20–39 age cohort reported restrictions more frequently (10–11%) than younger women (16–19 years, 4%) and older women (40–50 years, 9%).

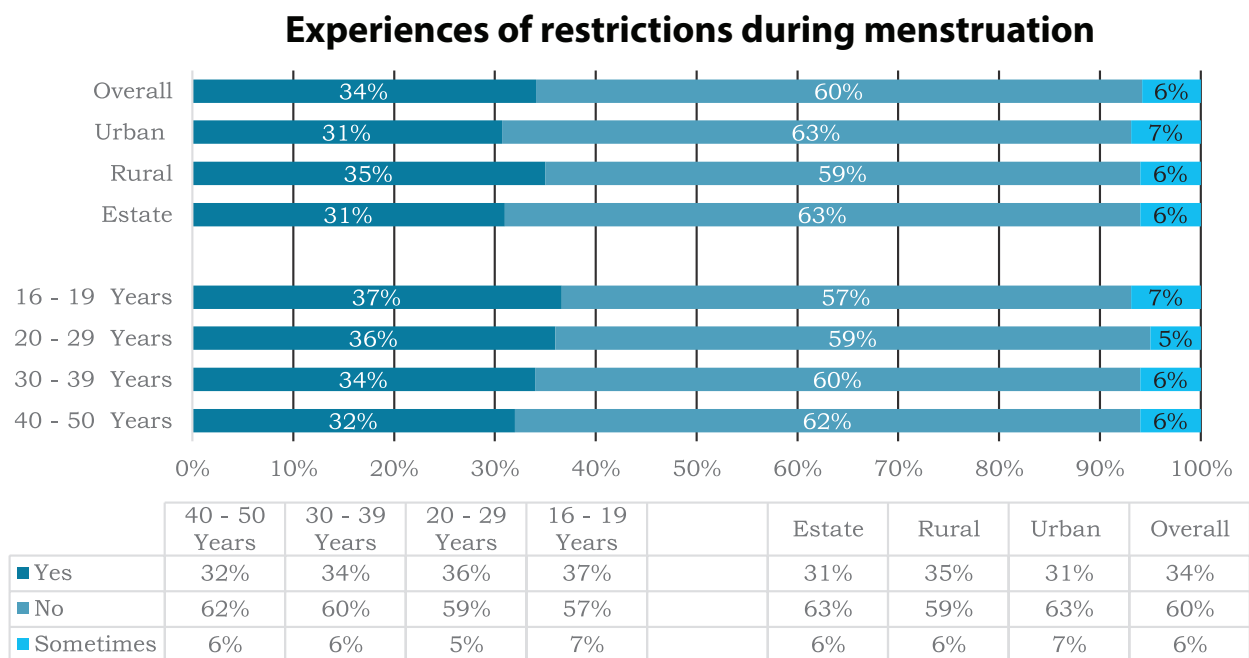


Figure 3.16: Experiences of restrictions during menstruation

Base: All respondents (n=3010)

Types of restrictions experienced during menstruation

Table 3.29 shows that the most common restriction experienced during menstruation is avoiding certain foods (62%), followed by avoiding celebrations and festivities (41%) and avoiding prayers (35%). Avoiding housework (26%) and other types of restrictions (8%) are reported less frequently. Across sectors, rural respondents report the highest prevalence of all restrictions, estate respondents show minimal engagement, and urban respondents report moderate levels of restriction. By age group, women aged 20–39 years show the highest reporting of restrictions across all types, particularly food and social restrictions, while younger (16–19 years) and older (40–50 years) respondents report comparatively lower levels of restriction.

Table 3.20: Types of restrictions during menstruation by age and sectors.

Type of Restriction	*Overall%	Estate	Rural	Urban	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Avoid celebrations & festivities	41%	47%	41%	37%	41%	43%	37%	42%
Avoid certain food	62%	59%	65%	53%	69%	63%	61%	59%
Avoid housework	26%	27%	27%	24%	36%	30%	21%	24%
Avoid prayers	35%	52%	33%	40%	31%	30%	37%	39%
Other (specify)**	8%	4%	9%	7%	4%	6%	10%	10%

**Other (specify) – Do not go out alone (1.92%), Do not bathe / no bathing first day / limited bathing (1.6%), Avoid men / distance from males / no sexual relations (1.28%)

*Multiple responses obtained

Base: Respondents claimed to have faced restrictions (n= 1987)

Taboos related to practices during menstruation

Overall, most respondents did not report taboos related to restrictive practices during menstruation. A large majority disagreed with avoiding meat or fish (85%), not touching others (85%), not discussing menstruation (83%), avoiding physical exercise (78%), or not taking head baths (75%). Similarly, 74% disagreed that activities done by menstruating women are not blessed. However, 33% considered avoiding fatty food is important.

Taboos related to menstrual practices

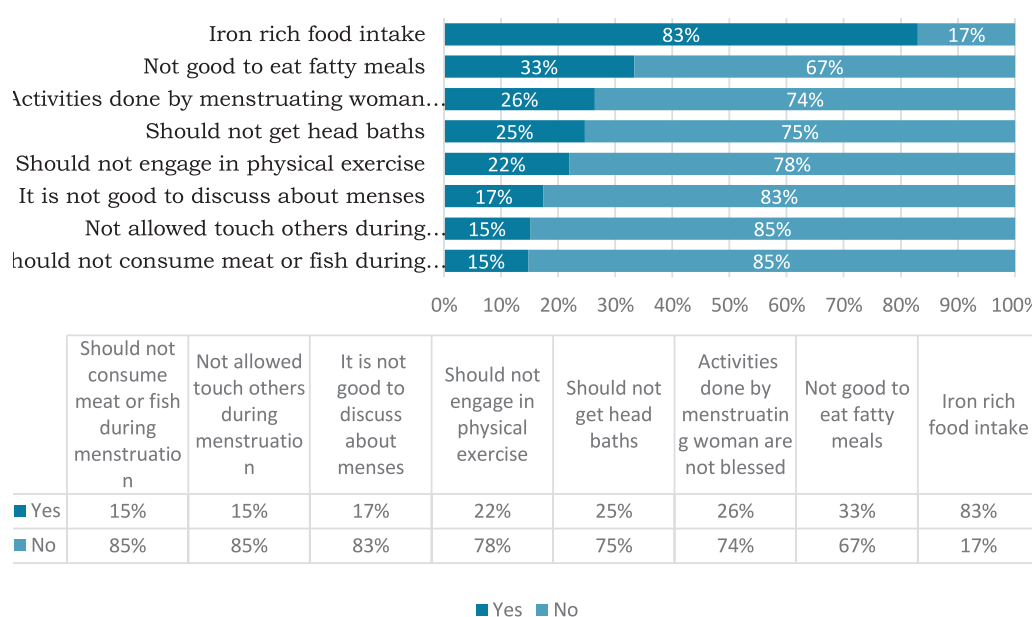


Figure 3.17: Taboos related to practices during menstruation

Base: All respondents (n=3010)

3.7 Practices of menstrual hygiene

Summary:

- Materials: 80% used disposable pads only; 92% preferred them to use. Minimal use of cloths only (4%) or cups (0%).
- Disposal: 91% could dispose of materials; burning (57%) most common, especially rural.
- Wrapping: 84% wrapped pads before disposal (highest in urban).
- Hygiene: 94% washed hands after changing pads; 80% washed genitals ≥ 3 times daily; 77% always used soap.
- Changing frequency: Most (47%) changed pads 3 times daily during heavy flow.
- Menstrual tracking: 43% aware of calendars, 41% used them; wall calendars most common.

Practices related to menstrual materials

Main menstrual material in use and preferred choice

Majority of respondents (81.2%) of respondents used only disposable sanitary pads during their last menstrual period. Both disposable sanitary pads and cloth/towel were used interchangeably by 13.3% of the respondents. However, 3.6% of respondents still use only cloth or towels, and a very few respondents preferred the alternative products such as menstrual cups, period panties, tampons.

Table 3.21: Main menstrual material in use during last menstrual period

Type of sanitary material used	Used for last menstrual period (frequency)	Used for last menstrual period (percentage)
Disposable Sanitary Pad only	2443	81.2%
Cloth/Towel only	108	3.6%
Disposable Sanitary Pad & Cloth/Towel	404	13.4%
Disposable Sanitary Pad & other options	15	0.5%
Reusable Sanitary Pad only	27	0.9%
Tampon only	3	0.1%
Menstrual Cups only	6	0.2%
Period Panties only	2	0.1%
Not Disclosed/ Can't say	2	0.1%

Base: All respondents (n=3010)

Across urban, rural, and estate communities, disposable sanitary pads are the most commonly used and preferred menstrual material. During the last period, use was highest in urban areas (90%) compared with rural (80%) and estate communities (70%). Other materials, such as reusable pads, cloth/towels, menstrual cups, and period panties, are used minimally, indicating a clear regional preference for modern disposable products due to convenience and accessibility.

Table 3.22: Main menstrual material in use during last menstrual period according to sector and age

Type of sanitary material used	Overall percentage	Estate	Rural	Urban	16-19 Years	20- 29 Years	30-39 Years	40-50 Years
Sanitary Pad (Disposable) only	81.2%	70%	80%	90%	87%	86%	81%	74%
Cloth/Towel only	3.6%	5%	4%	1%	2%	1%	3%	8%
Sanitary Pad (Disposable) & Cloth/Towel	13.3%	24%	14%	7%	11%	11%	13%	17%
Sanitary Pad (Disposable) & other options	0.5%		0%	1%	0%	0%	1%	0%
Sanitary Pad (Reusable) only	0.7%	1%	1%	0%	0%	1%	1%	1%
Tampon only	0.1%	0%	0.1%	0.2%	0%	0%	0.3%	0.2%
Menstrual Cups only	0.2%	0%	0%	0%	0%	0%	0%	0%
Period Panties only	0.2%	0%	0%	0%	0%	0%	0%	0%
Not Disclosed/ Can't say	0.2%	0%	0%	0%	0%	0%	0%	0%

Base: All respondents (n=3010)

Regardless of the current use of material, 92% of respondents preferred to use disposable sanitary pads. Only 2% preferred to use reusable sanitary napkins and 4% preferred for cloths and towels.

Table 3.23: Main menstrual material preferred to use

Type of sanitary material used	Preferred option (frequency)	Preferred option (percentage)
Sanitary Pad (Disposable)	2765	91.9%
Sanitary Pad (Reusable)	47	1.6%
Cloth/Towel	110	3.7%
Tampon	3	0.01%
Menstrual Cups	37	1.2%
Period Panties	39	1.2%
Other*	9	0.29%

*Other – Prefer not to say (0.19), Panty only (0.1%)

Base: All respondents (n=3010)

Frequency of changing of menstrual materials during the heaviest day of menstruation

Overall, most respondents changed their menstrual material three times per day (47%), followed by four times (22%) and more than four times (14%). Very few changed only once (1%) or twice (17%) during their last period. Sector-wise, urban respondents changed materials slightly more frequently, with 48% changing three times and 25% four times, while estate communities reported slightly higher rates for more than four changes (18%).

Age-wise, younger women (16–19 years) tended to change three times per day (51%), whereas women aged 29–50 years showed a slightly higher tendency for four or more changes (15–23%). These results indicate that most women maintain good menstrual hygiene by changing materials multiple times per day, with slight variations across sectors and age groups

Frequency of changing menstrual material during the heaviest day of menstruation

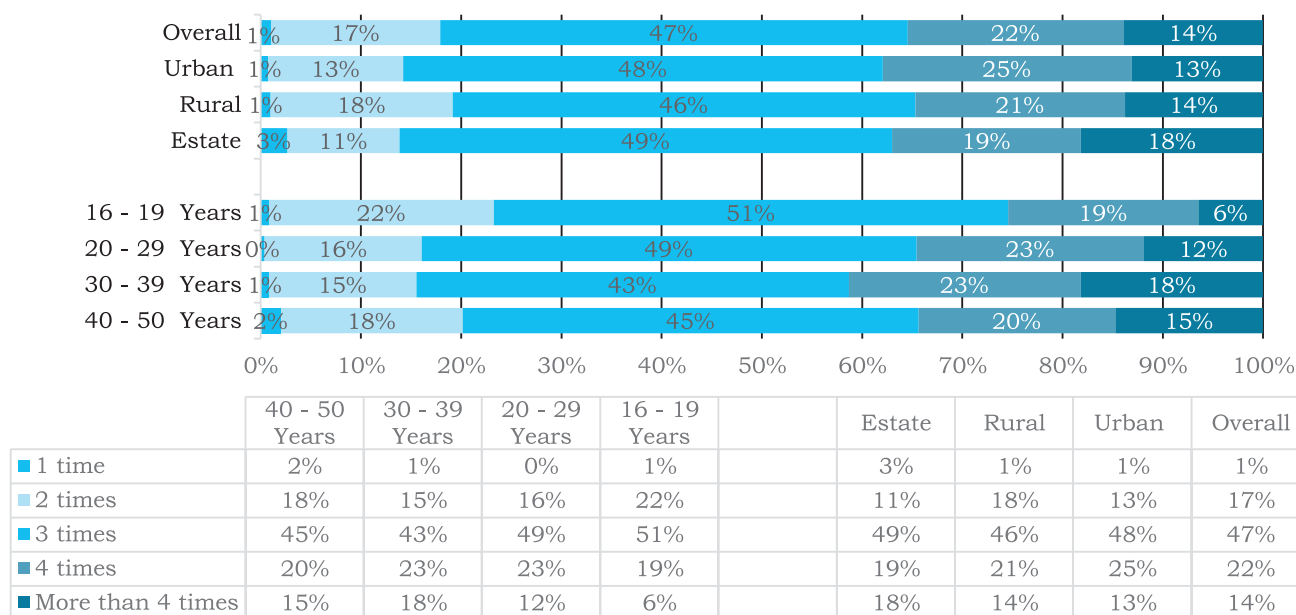


Figure 3.18: Frequency of changing menstrual material during the heaviest day of last period.

Base: All respondents (n= 3010)

Methods of menstrual material disposal

Among respondents, burning (57%) is identified as the most widely practiced method for disposing of used sanitary pads. This is followed by burial (18%), toilet disposal (12%), and municipal council collection (10%). Sector-wise differences reveal that estate respondents depend heavily on burning (46%), with a notable proportion also using municipal disposal services (7%). In rural areas, the dominant methods are burning (61%) and burial (22%), reflecting the limited availability of formal waste collection systems. Meanwhile, urban respondents show a more balanced pattern, using both burning (49%) and municipal council collection (40%), which likely reflects greater access to organized waste management.

Table 3.24: Methods of menstrual material disposal (Disposable sanitary pads by sectors)

Method of disposal of a used pad	Overall %	Estate	Rural	Urban
Burning	58%	46%	62%	49%
Burial	18%	17%	22%	6%
Toilet	12%	16%	14%	4%
Municipal council garbage collectors	11%	7%	0%	40%
Open field	0%	1%	0%	0%
Drain	0%	2%	0%	0%

Base: Those who are using disposable sanitary pad (n=2862)

Wrapping of disposable sanitary pads before disposal

Many respondents (84%) in overall, wrapped the used menstrual pad before disposal, making it a standard practice across the country. Urban (91%) and Estate (85%) reported the highest level of this practice while the communities in rural (82%) reported relatively lesser practice.

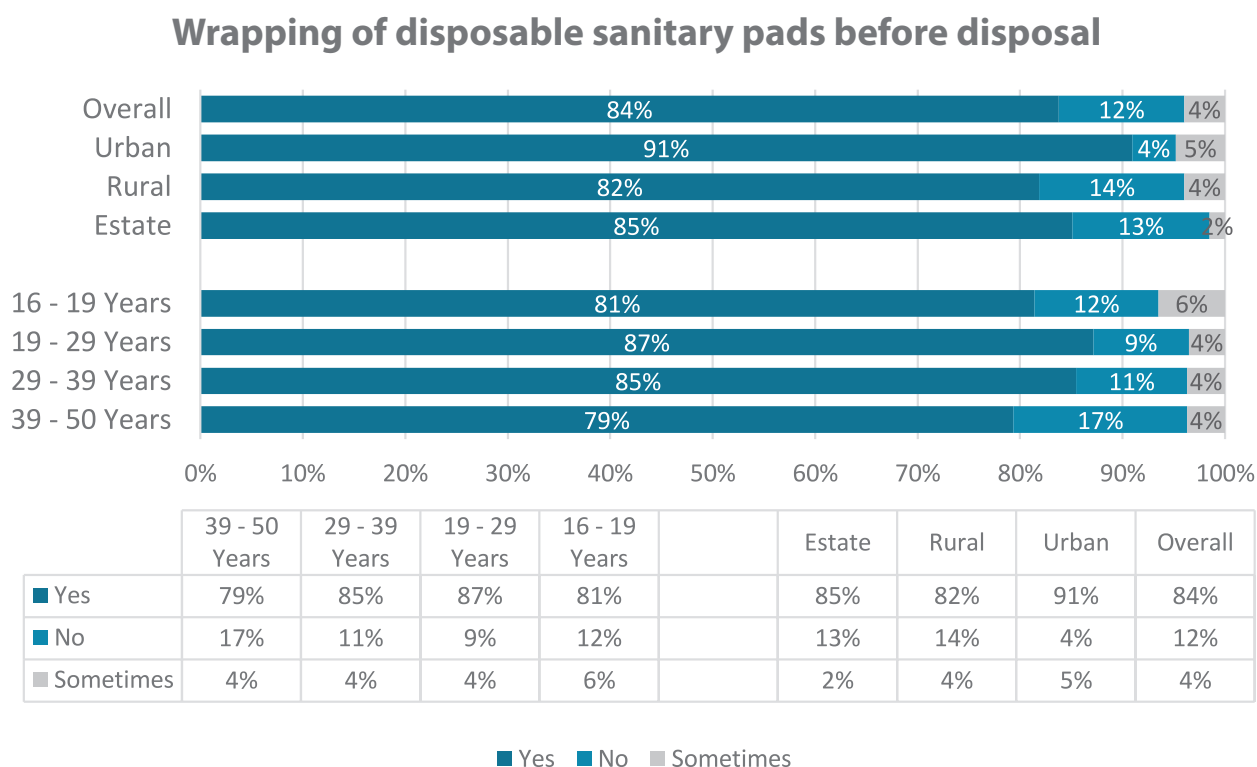


Figure 3.19: Proportion of respondents who wrap disposable sanitary pads before disposal

Base: Those who use disposable sanitary pads (n=2865)

Materials used to wrap disposable sanitary pads before disposal

Paper (40%) and cover provided by the pad (35%) were the main materials used to wrap the used disposable pad while 25% used plastic bags. Urban respondents choose plastic bag (44%) as the main wrapping material while paper (36%) was the second choice. While the cover provided with the sanitary pad was the main choice for rural (37%) and urban (30%), it remained the least choice for the estate (25%) participants.

Table 3.25: Materials used for wrap used disposable sanitary pads before disposal by sectors

What is the material you use to wrap	Overall %	Estate	Rural	Urban
Paper	40%	46%	38%	46%
Cover provided by a pad	35%	25%	37%	30%
Plastic bag	25%	29%	25%	24%

Base: Those who used to wrap disposable sanitary pads before disposal (n=2405)

Hand washing practices during menstruation

Hand washing before and after changing menstrual materials

Sixty-four (64%) of women reported washing their hands before changing menstrual materials, while 94% do so after every change of menstrual material.

Table 3.26: Hand washing behaviour before and after changing menstrual material by sectors

	Before changing menstrual materials			After changing menstrual materials		
	Every time	Sometimes	Never	Every time	Sometimes	Never
Overall	64%	15%	21%	94%	4%	2%
Estate	76%	9%	16%	97%	2%	1%
Rural	62%	15%	23%	94%	4%	1%
Urban	70%	19%	12%	91%	5%	3%

Base: All respondents (n=3010)

Personal hygiene during menstruation

Frequency of bathing during menstruation

Nearly half of the women and girls (45%) take daily baths during menstruation, ensuring health and hygiene practices.

Bathing frequency during menstruation

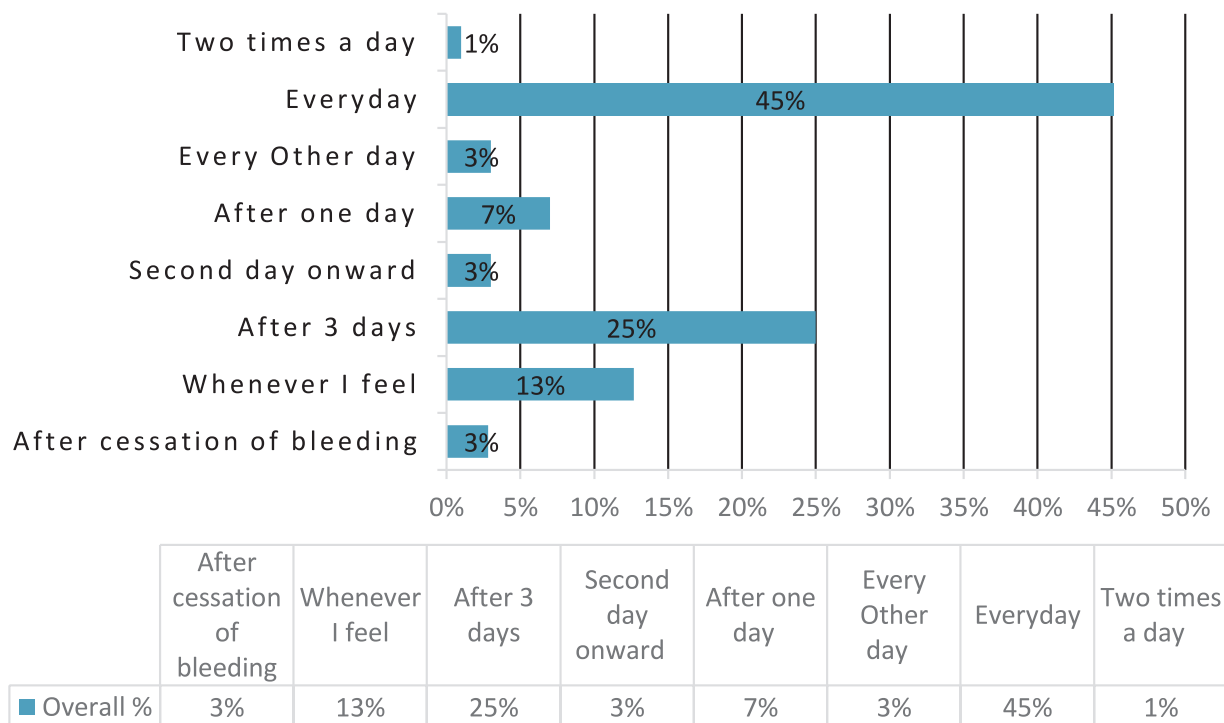


Figure 3.20: Frequency of bathing during menstruation

Base: All respondents (n=3010)

Frequency of washing genitalia during menstruation

Menstrual hygiene practices are generally good, with 80% of respondents washing their genitals three or more times daily during their periods, 7% twice daily and 2% once daily, and a very small minority waited until the end of their period. However, 11% reported cleaning every 2–3 days' time.

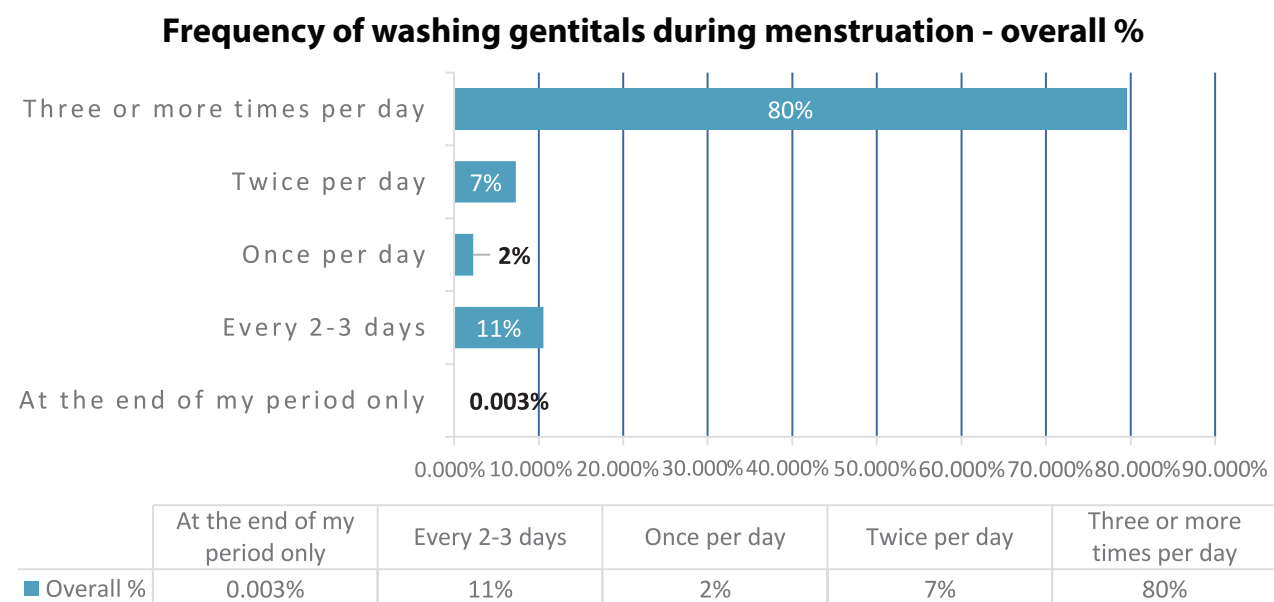


Figure 3.21: Frequency of washing genitals during menstruation

Base: All respondents (n=3010)

Table 3.27: Frequency of washing genitalia during menstruation by age cohorts and sectors

Frequency of washing genitalia	Overall percentage	Estate	Rural	Urban	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Three or more times per day	80%	74%	82%	73%	77%	79%	82%	80%
Twice per day	7%	4%	7%	8%	10%	7%	6%	8%
Once per day	2%	4%	2%	4%	2%	2%	2%	3%
Every 2 -3 days	11%	18%	9%	14%	11%	12%	10%	9%
At the end of my period day	0.31%	0%	0.15%	1%	0.43%	0%	0.42%	0.46%

Base: All respondents (n=3010)

Use of soap for genital hygiene during menstruation

Overall, 77% reported using soap every time they wash genital area during menstruation, while 19% used soap sometimes, and only 4% never used it.

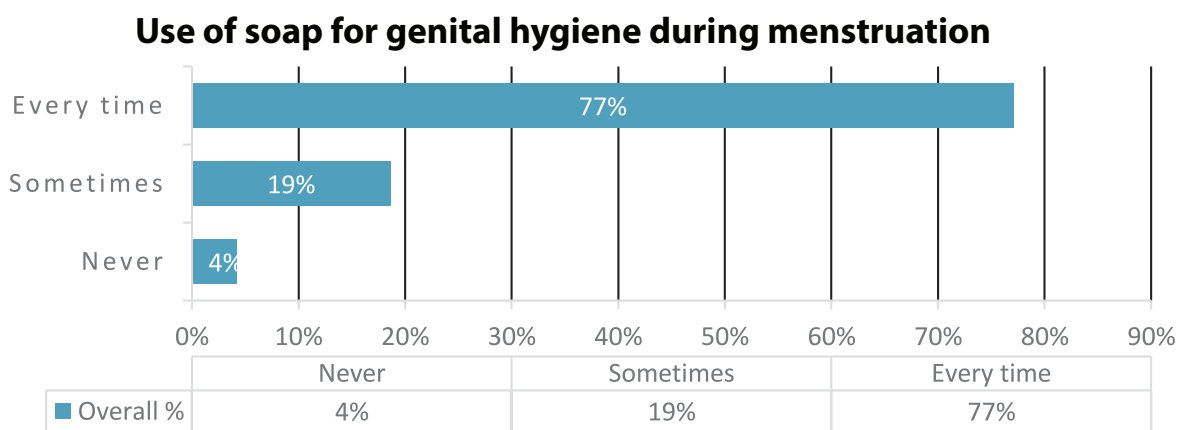


Figure 3.22: Use of Soap for genital hygiene during menstruation

Base: All respondents (n=3010)

Table 3.28: Distribution according to use of soap for genital hygiene during menstruation by age & sectors

	Overall percentage	Estate	Rural	Urban	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Every time	77%	80%	77%	77%	78%	78%	78%	75.2%
Never	4%	6%	4%	3%	3%	5%	3%	4.4%
Sometimes	19%	14%	19%	20%	19%	17%	19%	20.4%

Base: All respondents (n= 3010)

Sector-wise, many women reported using soap every time they wash genital area during menstruation, with 77% in urban and rural areas and 80% in estate communities. Only a small proportion (4%) never use soap, ranging from 3% in urban areas to 6% in estate areas, while 14–20% reported using it sometimes. Age-wise, consistent soap use is high across all groups, ranging from 75% among women aged 39–50 to 78% among those aged 16–39, with only a small fraction (3–5%) never using soap.

Frequency of changing underwear during changing menstrual material

Majority (70%) has changed the underwear when the menstrual material was changed while 28% has done it sometimes and 2% reported never changing underwear. Best practice was of changing underwear every time change of menstrual material was reported in estate sector (85%) with 70% in urban sector and 68% in rural areas. Age range 30 to 50 years reported best practice of changing underwear every time during menstrual material use, ranging from 70%–72% while 16–29 age ranges reported relatively less frequency of ranging from 66%–68%.

Frequency of underwear change during changing of menstrual material

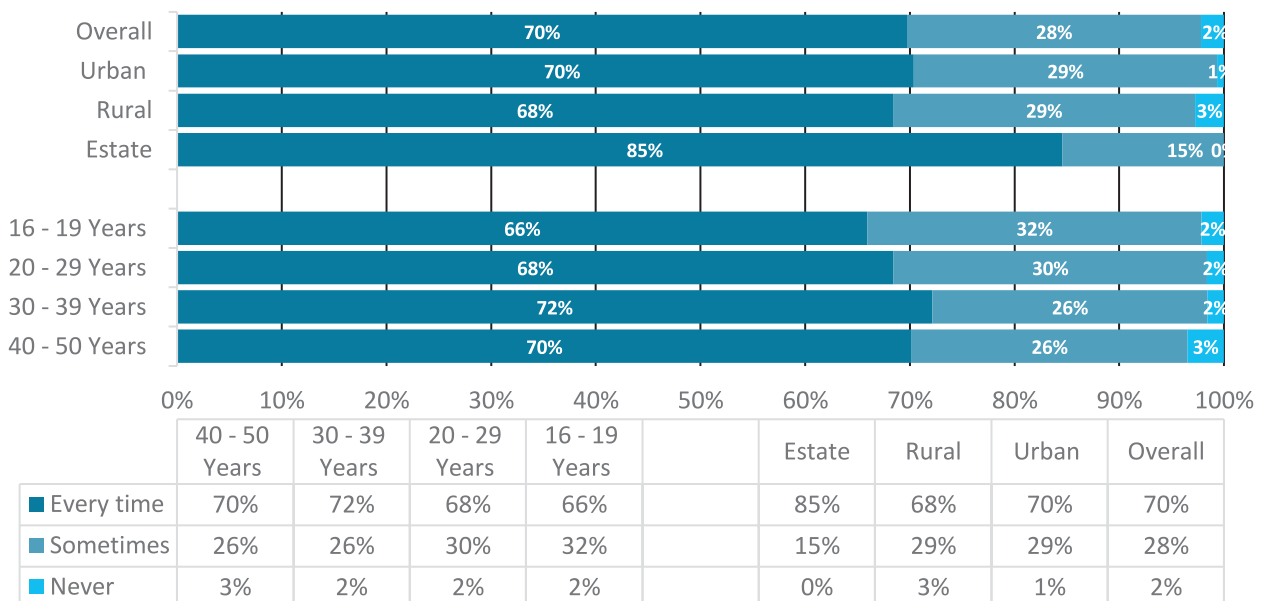


Figure 3.23: Frequency of changing underwear during changing of menstrual material

Base: All respondents (n=3010)

Menstrual tracking practices

Awareness of menstrual tracker

Awareness of menstrual tracker

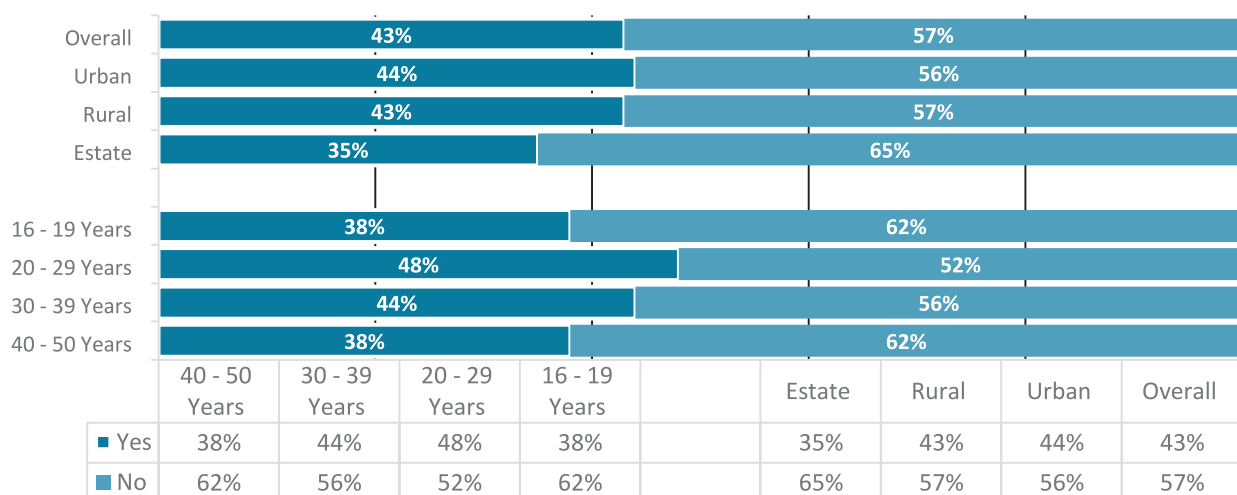


Figure 3.24: Awareness of menstrual tracker

Base: All respondents (n=3010)

Major proportion (57%) of the respondents did not have an awareness on the menstrual calendar. A similar pattern is also shown in the age categories, as a higher proportion of the respondents say they have no idea of the menstrual calendar. This was markedly observed in estate (65%) sector, while 57% of rural and 56% of urban sector remained to have no awareness on menstrual tracking.

Use of Menstrual Tracker

Among the respondent who were aware about menstrual tracker, only 40% of them were using a menstrual tracker. The trend was consistent through sectors while urban (45%) reported relatively higher use compared to rural (39%) and estate (33%) sectors. Younger ages ranging from 16-19 years (42%) and 19-29 years (45%) reported a higher use compared to the older 29-39 years (36%) and 39- 50 years (38%).

Use of menstrual tracker

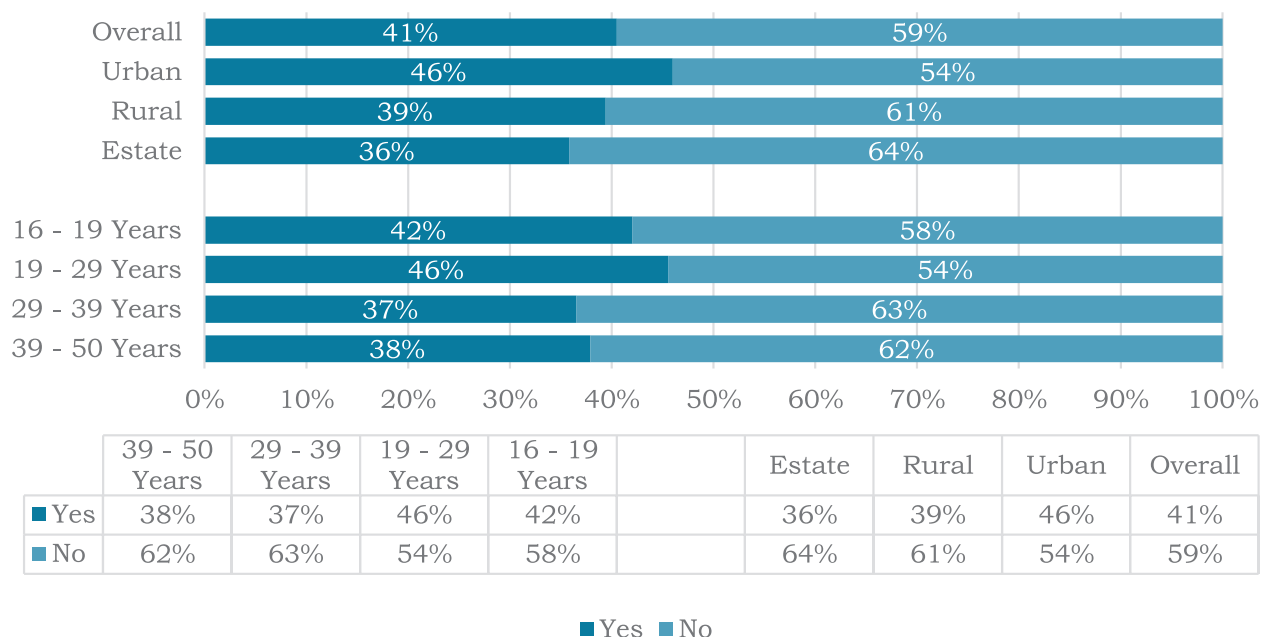


Figure 3.25: Use of menstrual tracker

Base: Respondents who are aware of menstrual calendar (n=1290)

Methods of menstrual tracking

The most common method of menstrual tracking is marking on a wall or pocket calendar (49%) while 26% of the respondents used a mobile app and 12 % did writing in the diary . Pocket calendar method was found mostly among women in the 39 to 50 age group (64%) and estate residents (55%).

Methods of menstrual tracking

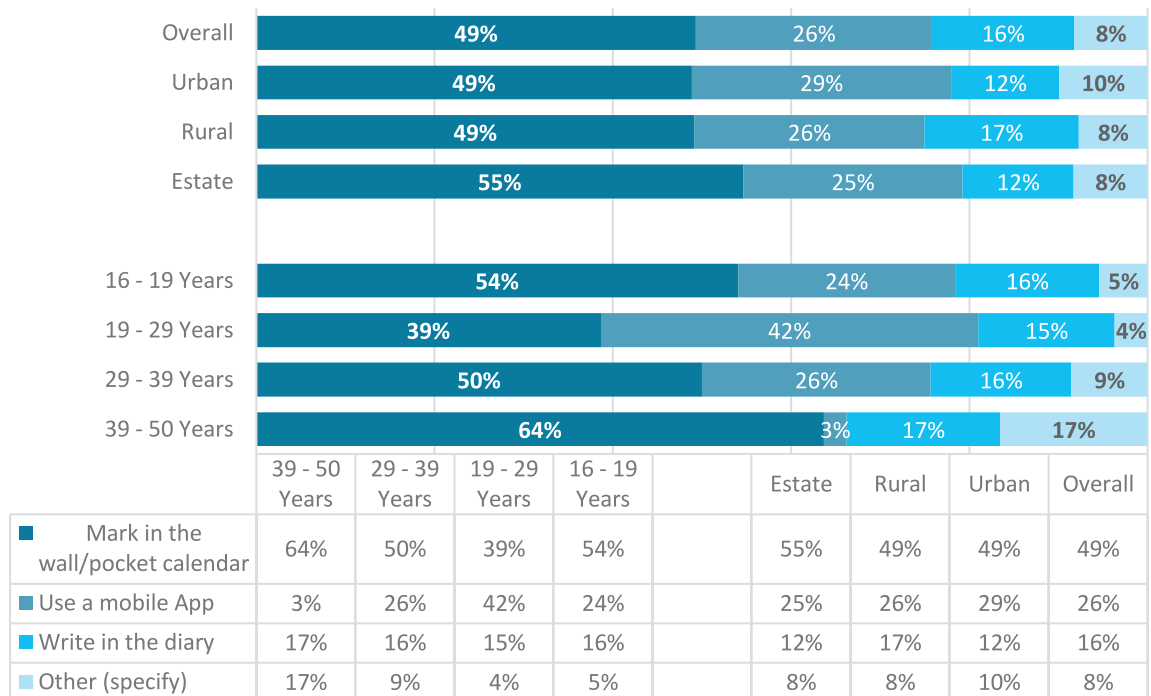


Figure 3.26: Methods of Menstrual Tracking

Base: Respondents who reported to engage in menstrual tracking (n=522)

3.8 Access to WASH facilities

Summary:

- Household level: 94–96% had toilets, washing, disposal facilities; slightly lower in estates.
- School level: Facilities available—washing (96%), toilets (97%), soap (79%), disposal (76%), private changing (85%).
- Workplace level: Washing (88%), toilets (90%), soap (85%), disposal (83%), private changing (78%).

WASH facilities in the household

Availability and satisfaction with household menstrual hygiene management facilities

A majority of (96%) of survey respondents reported having access to essential menstrual hygiene management facilities at home, including washing areas, toilets, soap, disposal options, and clean, safe spaces to change menstrual materials. Among those with WASH facilities, 84% expressed full satisfaction, 14% were somewhat satisfied, and 2% were not at all satisfied.

Table 3.29 Availability and satisfaction with household menstrual hygiene management facilities

Availability	Yes	No	Fully satisfied	Somewhat satisfied	Not satisfied at all
Washing facilities	97%	4%	84%	14%	2%
Toilet facilities	96%	4%	87%	12%	1%
Soap	96%	4%	87%	12%	1%
Disposal facilities	95%	5%	84%	14%	2%
Facilities to change material at home (clean, private, safe)	94%	6%	89%	10%	1%
Base	All respondents n=3010		Those who said “Yes” for availability of the facilities		

Base: All respondents (n=3010)

Overall, most menstrual hygiene facilities at home are available across all three sectors with slight variations in levels of satisfaction. However, a slight discrepancy exists in estate communities, where only 87% have access to disposal facilities, compared to 95% in urban and 95% in rural areas. Similarly, access to clean, private, and safe spaces for changing menstrual materials is somewhat lower in estates (87%) than in urban (96%) and rural (94%) areas.

Table 3.30: Availability of household menstrual hygiene management facilities by sectors

Question	Overall	Estate	Rural	Urban
Washing facilities	96%	94%	96%	98%
Toilet facilities	96%	94%	95%	98%
Soap	96%	94%	95%	99%
Disposal facilities	95%	87%	95%	95%
Facilities to change the menstrual material at home (clean, private, safe)	94%	87%	94%	96%

Base: All respondents (n=3010)

WASH Facilities in the school

Availability and satisfaction with menstrual hygiene management facilities in schools

According to students, schools reported availability of menstrual hygiene management (MHM) facilities, with 96% of washing facilities and 97% with toilets. Soap is available to 79%, disposal facilities to 76%, and private spaces to change menstrual materials was available to 85% of student at school. Satisfaction levels are high overall, with most students fully satisfied and only small proportions somewhat or not satisfied.

Table 3.31: Availability and satisfaction with menstrual hygiene management facilities in schools

Availability	Yes	No	Fully satisfied	Somewhat satisfied	Not satisfied at all
Washing facilities	96%	4%	73%	27%	0%
Toilet facilities	97%	3%	72%	28%	0%
Soap	79%	21%	75%	20%	5%
Disposal facilities	76%	24%	77%	22%	1%
Facilities to change material at school (clean, private, safe)	85%	15%	79%	21%	0%
Base: Respondents who reported as school pupils (n=361)			Base: Those who said “Yes” for availability of the facilities		

From the overall study population 12%(n=361) were school students with 20.5% (n=74) from urban schools, 74% (n=267) from rural schools, and 5.5% (n=20) from estate schools. Table 3.32 provides availability of MHH facilities at schools and the level of satisfaction on available facilities in rural, and estate school settings.

Table 3.32: Availability of menstrual hygiene management facilities in schools according to sectors

MHM Facility	Overall Availability	Estate	Rural	Urban
Washing facilities	96%	75%	96%	100%
Toilet facilities	97%	90%	96%	98%
Soap	79%	50%	72%	75%
Disposal facilities	76%	75%	77%	85%
Facilities to change material at school (clean, private, safe)	85%	50%	84%	100%

Base: Respondents who reported as students (n=361)

Despite the overall availability of MHH facilities at schools remained high, there was disparities observed in sectoral stratification. While Urban sector reported to have the highest availability in all facilities related to MHH, Estate sector reported a relatively low availability.

WASH Facilities in the workplace

Availability and satisfaction with menstrual hygiene management facilities at workplaces

Table 3.33: Availability and satisfaction with menstrual hygiene management facilities at workplaces

Availability	Yes	No	Fully satisfied	Somewhat satisfied	Not satisfied at all
Washing facilities	88%	12%	80%	18%	1%
Toilet facilities	90%	10%	81%	18%	1%
Soap	85%	15%	78%	21%	1%
Disposal facilities	83%	17%	83%	16%	1%
Facilities to change material at workplace (clean, private, safe)	78%	22%	78%	21%	1%
Base: Respondents who reported as working (n=614)			Base: Those who said Yes, availability of the facilities		

At workplaces, the majority of respondents reported access to menstrual hygiene management facilities. Wash facilities were available to 88% of respondents, with 80% of them fully satisfied, 18% somewhat satisfied, and 1% not satisfied. Toilet facilities were available at workplace for 90%, and of them 81% were fully satisfied, 18% somewhat satisfied, and 1% not satisfied with toilet facilities. Soap was available to 85% and of them 78% were fully satisfied, 21% somewhat satisfied, and 1% not satisfied. Disposal facilities were available to 83%, with 83% fully satisfied, 16% somewhat satisfied, and 1% not satisfied. Facilities to change menstrual materials in a clean, private, and safe space were slightly lower at 78%, with 78% fully satisfied, 21% somewhat satisfied, and 1% not satisfied. Overall, both availability and satisfaction levels indicate generally positive workplace support for menstrual hygiene management, with only a small proportion of respondents dissatisfied.

Table 3.34: Availability of menstrual hygiene management facilities in workplaces according to sectors

	Overall Availability	Estate	Rural	Urban
Washing facilities	88%	70%	88%	97%
Toilet facilities	90%	73%	91%	96%
Soap	85%	65%	87%	90%
Disposal facilities	83%	52%	79%	87%
Facilities to change material at workplace (clean, private, safe)	78%	60%	85%	87%

Base: Respondents who reported as working (n=614)

3.9 Access to menstrual materials

Summary:

- Adequate supply: Only 13% had enough; lowest in urban (7%), highest in estates (23%).
- Quality: 16% reported issues, mainly in estate areas (31%).
- Preferred materials: 91% accessed preferred products; affordability a barrier for 82% of those who couldn't.
- Alternatives: Cloths (97%) most common substitute.
- Spending: Average Rs. 500/month on menstrual products.
- Schools: 91% students had enough materials; workplaces varied.
- Affordability: 22% overall struggled, especially estates (33%).

Access of menstrual materials during menstruation

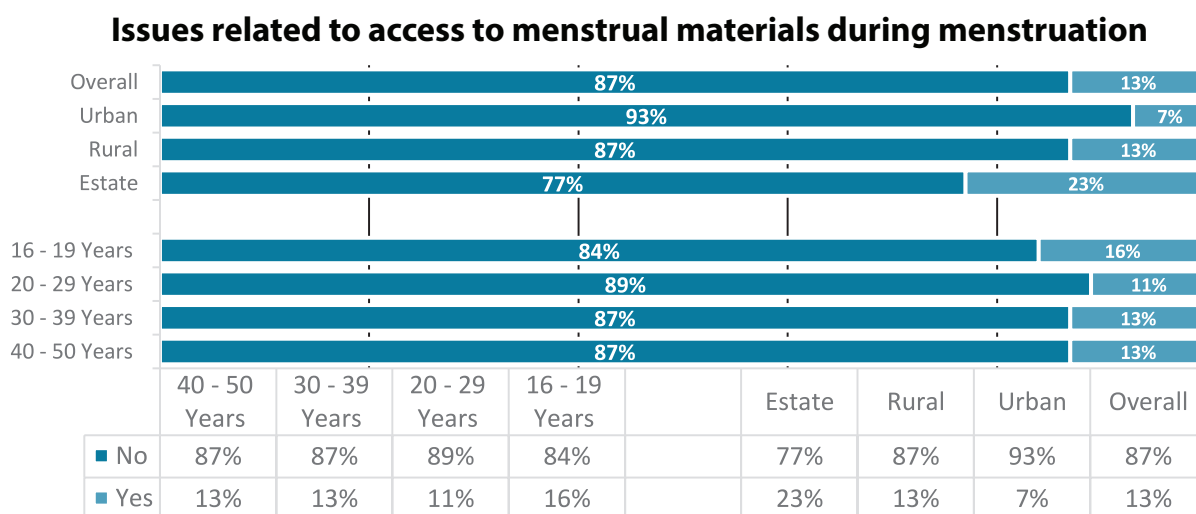


Figure 3.27 Issues related to access of menstrual materials during menstruation

Base: All respondents (n=3010)

Overall, 87% had no issues related to access of adequate menstrual materials throughout menstrual period limited, with only 13% of respondents reporting issues related to accessing adequate menstrual materials. Sector-wise, issues related to access is highest in estate areas (23%) and lowest in urban areas (7%), with rural areas at 13%. Age-wise, younger women aged 16–19 (16%) reported higher proportion of issues related to accessibility compared with women aged 20–50 (11–13%).

Issues related to the quality of menstrual materials.

Among all respondents, 16% reported experiencing issues related to the quality of menstrual materials.

Table 3.35: Issues related to quality in menstrual materials

Presence of Issues	Overall	Estate	Rural	Urban	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Yes	16%	31%	16%	11%	17%	15%	16%	15%
No	84%	69%	84%	89%	83%	85%	84%	85%

Base: All respondents (n=3010)

The estate sector respondents reported the highest proportion of quality-related issues (31%), followed by rural sector respondents (16%) and least was from urban sector respondents (11%). Across age cohorts, reporting of quality issues were relatively consistent, with 17% of those aged 16–19 years, 15% of 19–29 years, 16% of 29–39 years, and 15% of 39–50 years indicating problems with quality of menstrual material.

Access to preferred menstrual material duration of menstruation

Majority (91%) of the respondents were able to access the preferred menstrual material. Inability to access the preferred material was observed highest in the estate sector (14%) with 10% rural communities and 5% of urban communities.

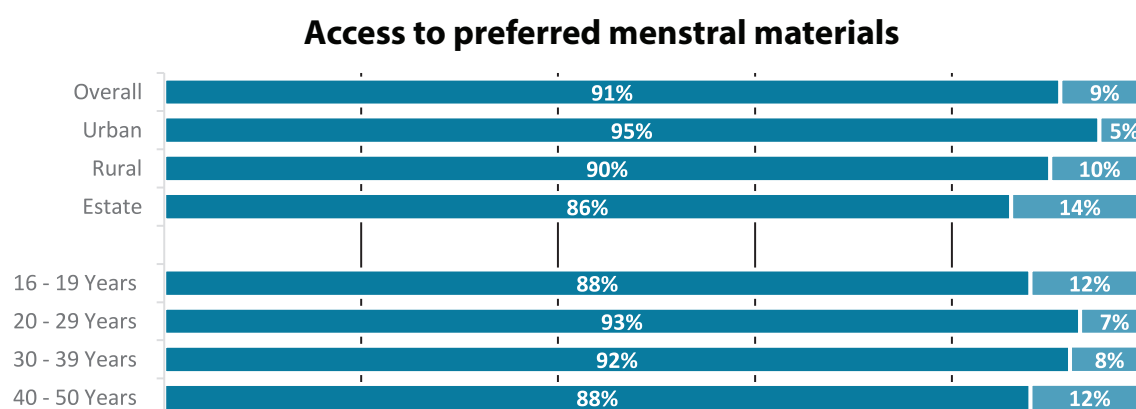


Figure 3.28: Access to preferred menstrual material duration of menstruation

Base: All respondents (n=3010)

Access to the preferred menstrual material was relatively less in 16-19 years and 40-50 years age groups.

Monthly expenditure on menstrual materials

Monthly expenditure for menstrual materials is an average mean of Rs 497 and median is Rs. 400.00 per person. Median was considered in comparisons across groups as the data had a skewed distribution.

Table 3.36: Monthly expenditure on menstrual materials by age cohorts and sectors

	Overall	Estate	Rural	Urban	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Mean	Rs.497.81	Rs.558.71	Rs.489.97	Rs.509.05	Rs.520.20	Rs.499.80	Rs.512.36	Rs.478.16
Median	Rs.400.00	Rs.450.00	Rs.412.50	Rs.450.00	Rs.435.00	Rs.450.00	Rs.460.00	Rs.390.00
Standard Deviation	Rs.280.00	Rs.505.63	Rs.346.61	Rs.389.00	Rs.439.93	Rs.352.74	Rs.365.27	Rs.359.76

Base: All respondents (n=3010)

The estate and urban sector have the highest monthly spending for menstrual material compared to other sectors, with a median of Rs 450.00 per month and 30 to 39 years age cohort reported the highest expenditure with a median of Rs. 460.00

Affordability as a barrier to using preferred menstrual materials

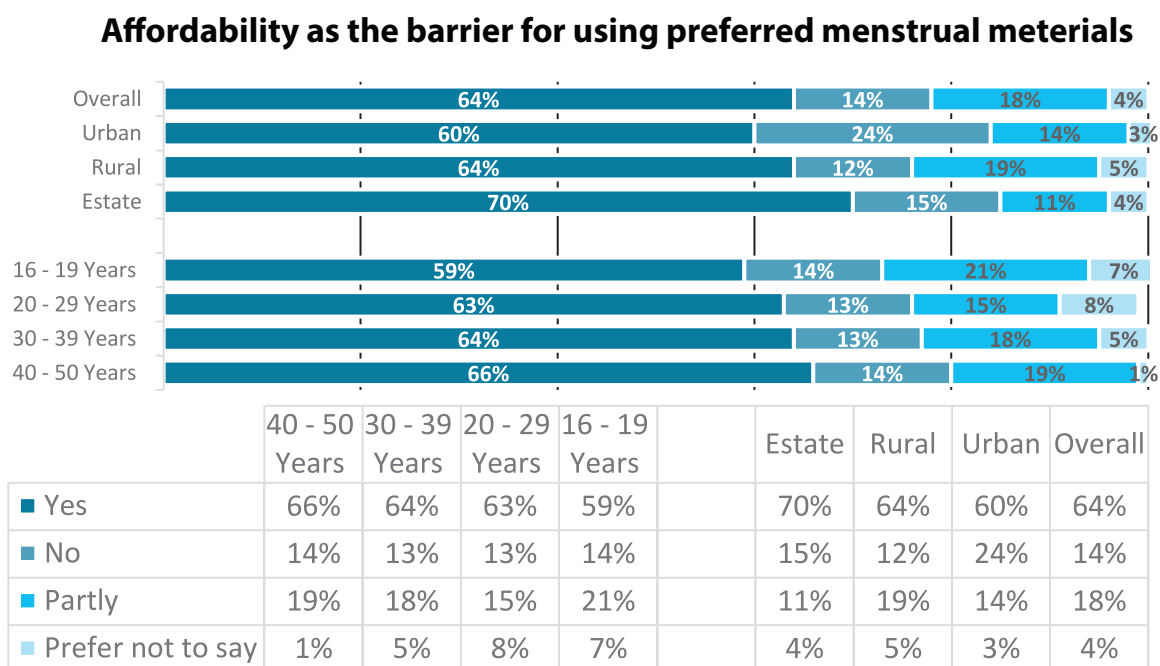


Figure 3.29: Affordability as the barrier for not using the preferred material

Base: Respondents who are unable to access preferred menstrual materials (n=286)

Among the individuals who were unable to access (n=286, 9%), 64% revealed they were not able to afford the preferred material. Affordability was a partial reason for the inability to access the preferred material in 19% while 14% revealed affordability was not the barrier.

Adequacy of menstrual materials in schools

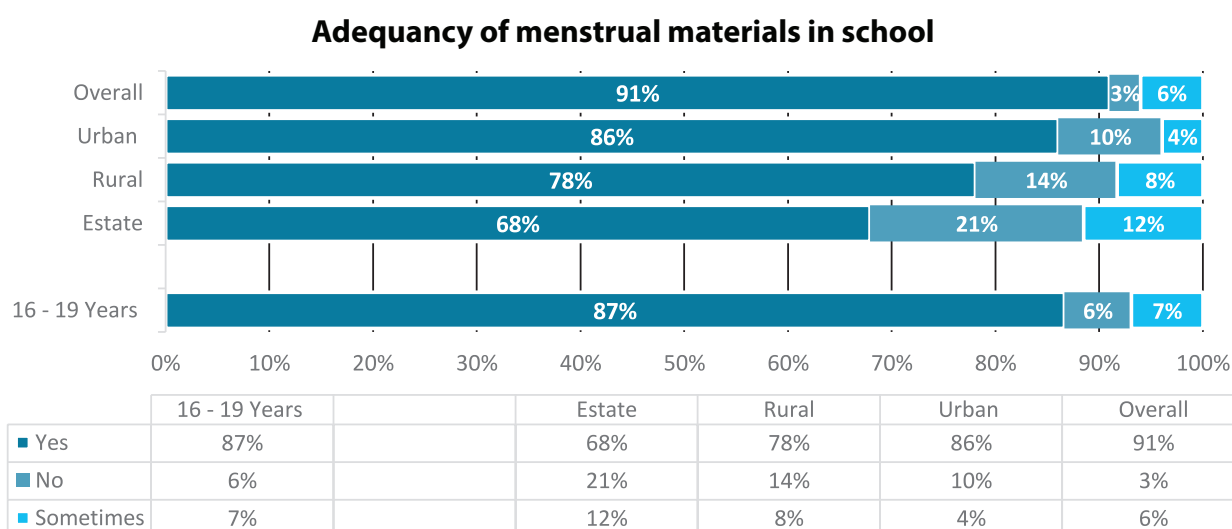


Figure 3.30: Adequacy of menstrual materials in schools

Base: Respondents who reported as students (n=361)

A large majority of students, 91% (n=328), reported that they have enough menstrual materials available to meet their needs, suggesting that schools are largely able to provide necessary supplies. However, a small proportion of students, 3% (n=10), indicated that they do not have sufficient materials, while 6% (n=20) reported that they sometimes have enough, highlighting occasional gaps in availability.

Adequacy of menstrual materials at the workplace

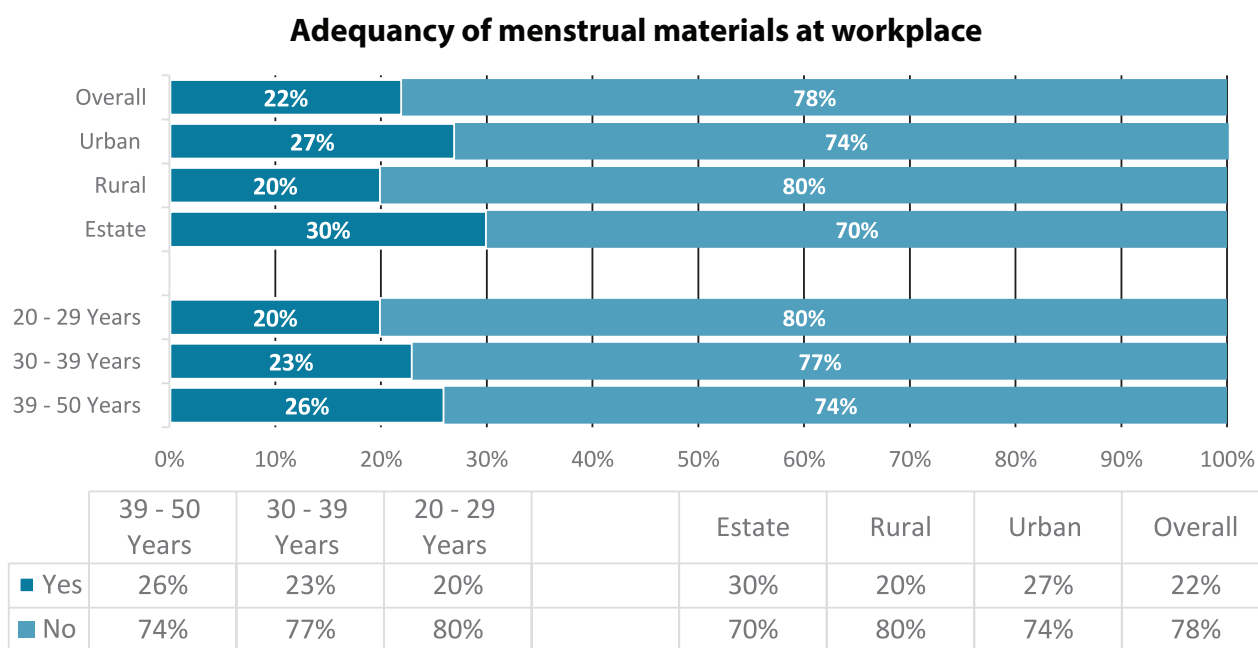


Figure 3.31: Adequacy of menstrual materials at the workplace

Base: Respondents who reported as working (n=614)

Overall, 22% (n=135) of respondents who were working reported that they have enough materials at working workplaces. But the majority (78%, n=479) said that they do not have enough menstrual materials at their workplaces. In rural areas unavailability rate is high (80%) compared to the urban (74%) and estate areas (70%). Among the age categories 20-29 years group reported a high rate of menstrual material unavailability (80%).

3.10 Menstrual discomfort, menstrual disorders and impact on life style

Summary:

- Discomfort: 75% experienced symptoms (abdominal pain 56%, headaches 21%, emotional changes 10%).
- Pain relief: 70% used over-the-counter medicines; 20% heat/baths; 12% herbal remedies; only 6% visited doctors.
- Disorders: 7% reported conditions—PMS (17%), PCOS (10%), endometriosis (7%)..
- Daily life: 43% struggled with bathing in public, 36% with work, 35% with school.
- School absence: Mainly 1 day due to pain (38%), occasional longer absences.
- Work absence: Very few reported missing work; reasons included pain, lack of facilities, or fear of bleeding.

Menstrual discomforts

Experience of menstrual discomfort

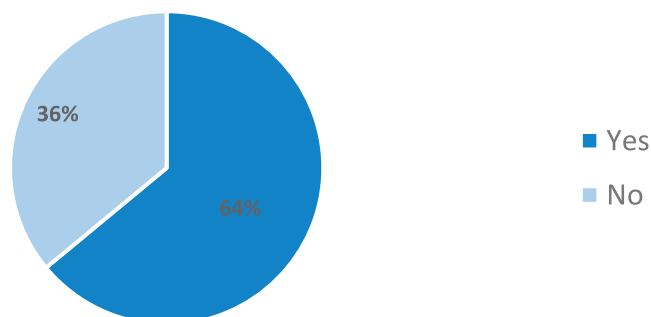


Figure 3.32: Experience of menstrual discomfort during last menstrual cycle

Majority of respondents (n=1928,64%) reported experiencing menstrual discomfort during their last menstrual cycle, while the remaining 36% indicated that they did not experience such discomfort.

Common physical and psychological symptoms during menstrual cycle

Abdominal pain was the most predominant symptom reported during the menstrual cycle, accounting for more than half of the responses (56%), followed by headache (21%) and emotional changes (10%). Less frequently reported symptoms included back pain (1.90%), leg pains/cramps (1.80%), and a category of other symptoms (7%), which encompassed hip/pelvic pain, body pain, fatigue/weakness/tiredness, and breast pain/tenderness

Symptoms experienced during menstrual cycle

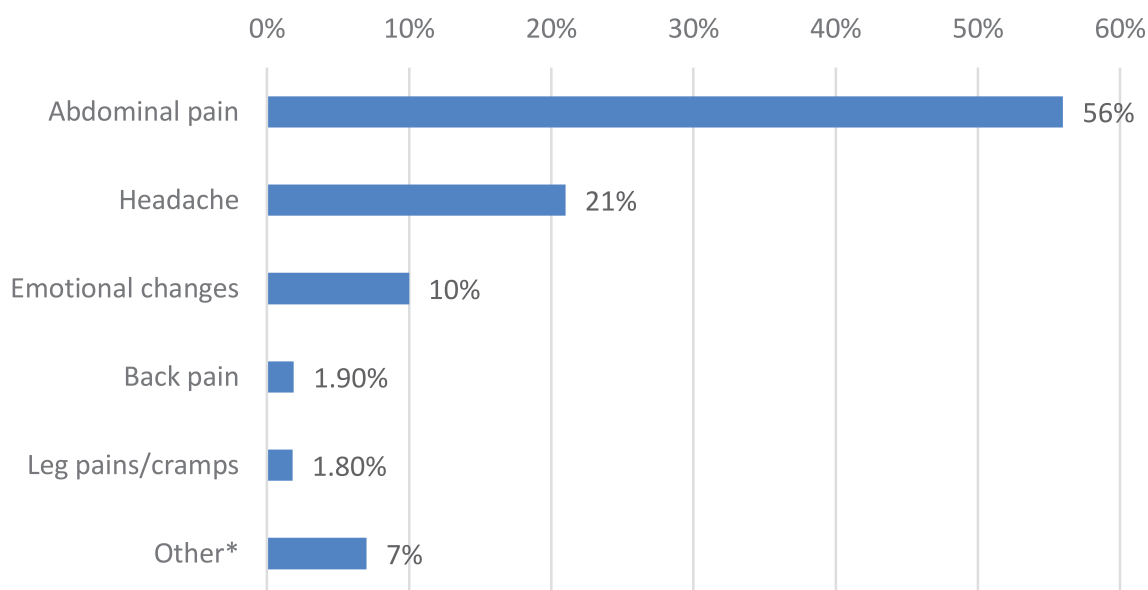


Figure 3.33: Symptoms faced during the menstrual cycle

**Multiple answers were obtained from individuals who reported to have symptoms

*Other (Specify) –Hip / pelvic pain (0.8%), Body pain / general aches (0.6%), Fatigue / weakness / tiredness (0.4%), Breast pain / tenderness (0.3%)

Base: Respondents who had experienced symptom during menstrual cycle (n=1928)

Types of pain relief methods used during menstruation

Overall, the most common method for managing menstrual pain was reported to use of non-prescribed pain-relieving medicines or pills (71%). Other commonly reported methods were taking a warm bath or applying heat (20%) and use of herbal remedies or traditional medicine (12%). Less frequently used strategies were visiting a doctor (6%), massage or abdominal oil application (5%), and managing diet and hydration (4%).

Types of pain relief methods

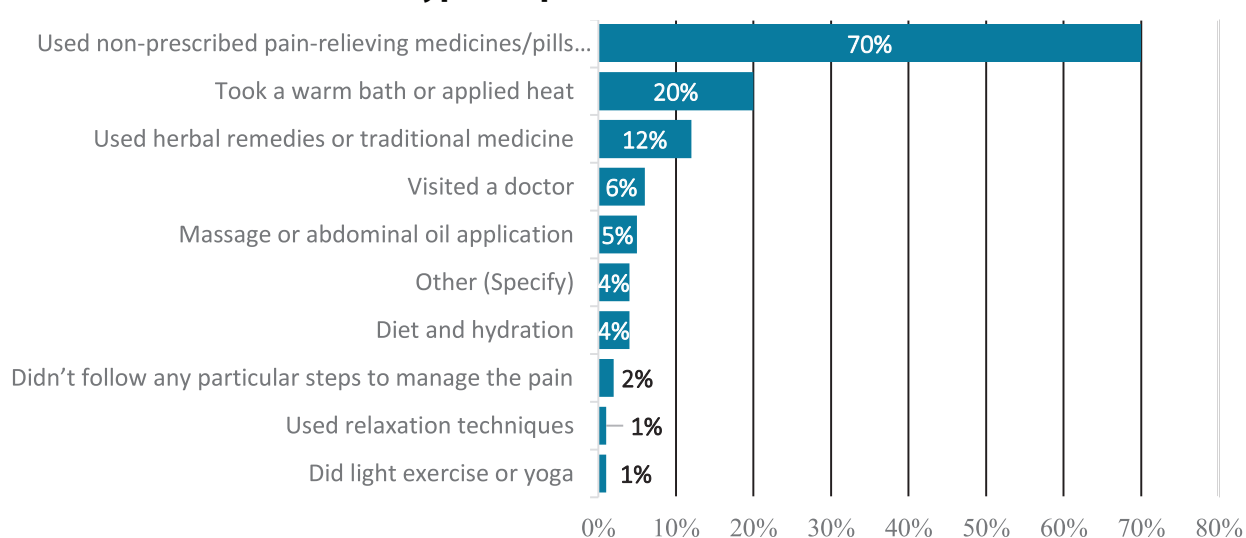


Figure 3.34: Types of pain relief methods

Base: Respondents who take steps to relieve the pain (n=1472)

Women aged 40–50 (79%) and in 30-39 years (76%) reported higher use of pain-relieving medicines compared with younger age groups of which 61% of 16-19 years and 60% of 20-29 years were using pain relief medicines.

Use of pain relief medicine was particularly common in urban areas (74%) and in rural (70%) areas and least in estate communities (53%). Use of herbal remedies was comparatively higher in estate (14%) compared to urban (12%) and rural (12%) areas.

Table 3.37: Types of methods to relieve the pain by age cohorts and sectors

Type of pain relief	Overall	Estate	Rural	Urban	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Used non-prescribed pain-relieving medicines/ pills (Paracetamol)	71%	53%	70%	74%	61%	60%	76%	79%
Took a warm bath or applied warmth	18%	15%	21%	17%	27%	29%	15%	9%
Used herbal remedies or traditional medicine	12%	14%	12%	12%	18%	13%	10%	11%
Visited a doctor	5%	5%	5%	7%	8%	6%	5%	6%
Massage or abdominal oil application	5%	7%	4%	9%	5%	6%	5%	4%
Diet and hydration	4%	10%	4%	3%	7%	4%	4%	3%
Didn't follow any particular steps to manage the pain	2%	2%	2%	1%	2%	1%	1%	3%
Did light exercise or yoga	1%	1%	1%	1%	0%	1%	2%	0%
Used relaxation techniques	1%	0%	1%	2%	1%	2%	1%	1%

*Multiple answers were obtained from individuals who were using pain relief methods

Base: Respondents who take steps to relieve the pain (n=1472)

Menstrual disorders

Menstrual-related health conditions

Documented evidence of menstrual health related condition or seeking treatment for menstrual health related condition was considered as a “menstrual health related condition”. It was recorded as recalled by the respondent or by reference to medical records if available.

Table 3.38: Presence of menstrual-related health condition

	Overall	Estate	Rural	Urban	16-19 Years	20-29 Years	30-39 Years	40-50 Years
Yes	7%	4%	7%	9%	3%	7%	8%	8%
No	93%	96%	93%	91%	97%	93%	92%	92%

Base: All respondents (n=3010)

A majority (93%) of women report never experiencing a disease condition related to menstruation which required medical attention. However, there were 7% who mentioned that they have encountered a disease related to menstruation.

Impact of menstruation on life style

Autonomy in decision-making related to menstruation

A majority (91%) of the respondents mentioned they were able to dispose of used menstrual materials and to change and clean themselves in private. The findings imply that many have access to basic facilities and privacy for menstrual care at home. However, only 55% were able to consistently wash and 54% were able to dry their menstrual materials when needed.

Autonomy in menstrual decision making

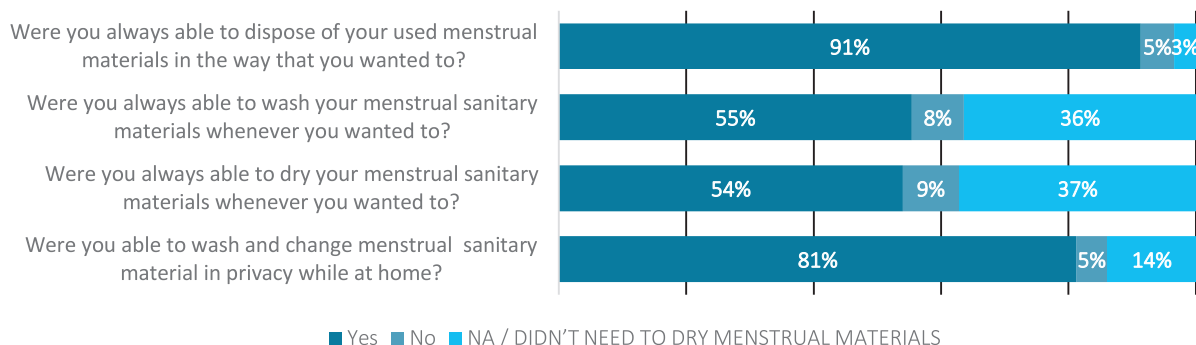


Figure 3.35: Freedom of menstrual decision making

Base: All respondents (n=3010)

Impact of menstruation in daily activities

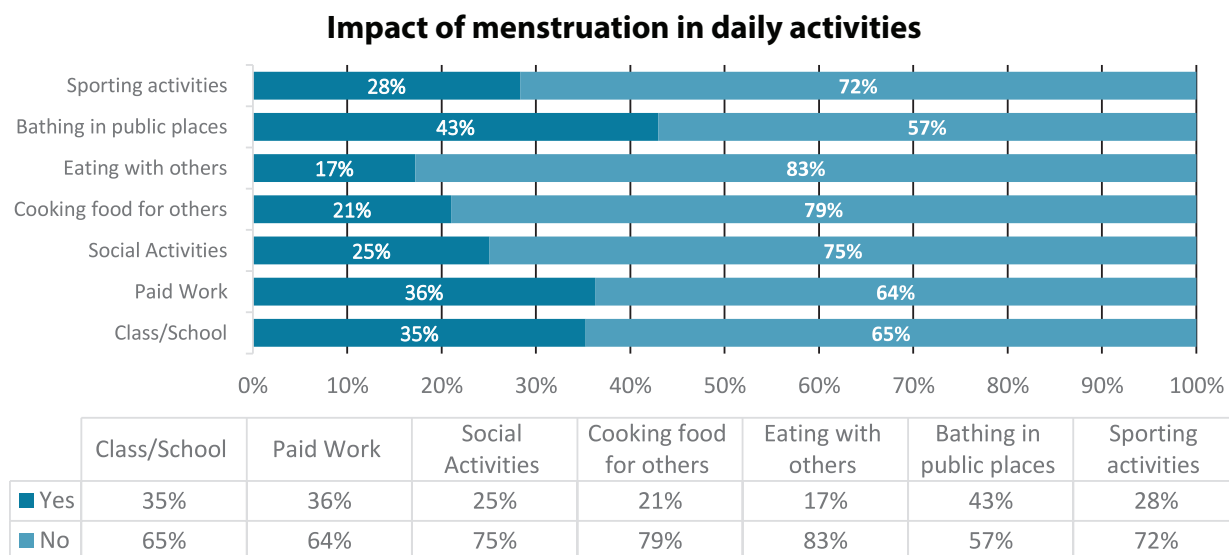


Figure 3.36 Impact of menstruation in daily activities

Base: All respondents (n=3010)

In terms of daily activities, 43% of respondents reported issues with bathing in public or common places. Difficulties with attending work were reported by 36% , while 35% identified challenges with attending school or classes. Additionally, 17% of respondents reported trouble eating with others.

Reasons for school absenteeism during menstruation

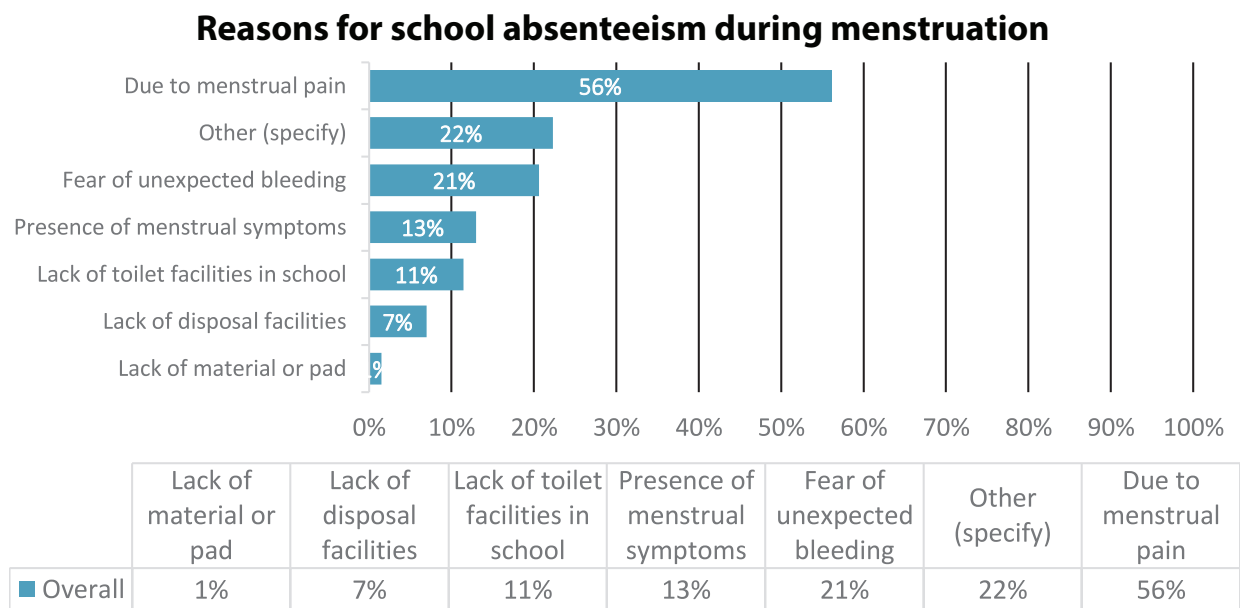


Figure 3.37: Reasons for school absenteeism

Base: Respondents who are having trouble participating in school n =126

Days missed from school

From the total respondents, 126 respondents reported school absenteeism during menstruation. Most respondents who missed school or work due to menstruation reported being absent for one day (79% overall, estate reporting one day absenteeism 100%, followed by rural (81%) and urban (64%). Absence for two days was reported by 14% overall, most of which occurred in urban areas, while three-day absences accounted for 6% and were minimal across all sectors. Only 2% reported missing more than four days, all from rural areas.

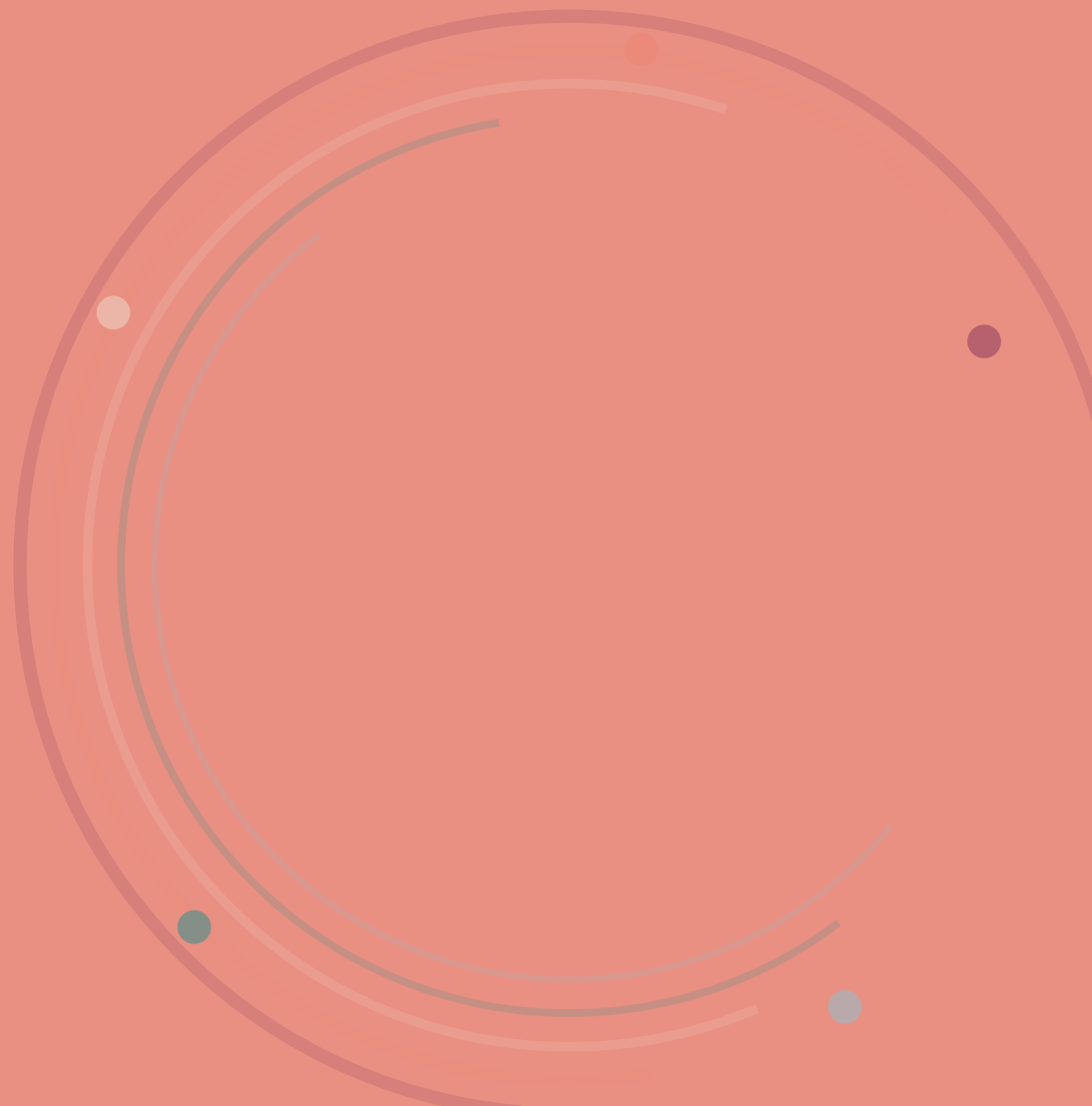
Table 3.39: Days missed from school by sectors

	Overall	Urban	Rural	Estate
One day	79%	64%	81%	100%
Two days	14%	20%	13%	0%
Three days	6%	16%	3%	0%
More than four days	2%	0%	3%	0%

Base: Respondents who are having trouble participating in school/ work (n=126)

04

Period Poverty



Period poverty is increasingly recognized as a multidimensional challenge affecting the health, dignity, education, and economic participation of women and girls. International organizations consistently define period poverty as more than the inability to afford menstrual products. UN Women defines period poverty as the inability to afford and access menstrual products, sanitation and hygiene facilities, and education and awareness required for menstrual management (UN Women, 2020). UNFPA emphasizes the economic burden of menstruation and defines period poverty as the struggle faced by many women and girls, particularly those with low income, in affording menstrual products and related needs (UNFPA, 2021). CARE International frames period poverty as the combined effect of high product costs, lack of availability, stigma, and limited education, which together undermine menstrual dignity (CARE, 2019). Plan International similarly stresses that period poverty extends beyond affordability to include lack of education and stigma that restrict participation in daily life (Plan International UK, 2018). Concern Worldwide defines period poverty as the inability to afford or access menstrual products, hygiene facilities, safe waste management, and timely information (Concern Worldwide, 2021).

In Sri Lanka, despite relatively strong national indicators in health and education, menstrual health challenges persist across socio-economic groups and geographic sectors. Barriers related to the affordability of menstrual products, the adequacy of facilities in schools and workplaces, limited access to accurate information, and restrictive social norms continue to affect participation, well-being, and dignity.

Research in Sri Lanka has begun to reflect this multidimensional reality, although the evidence base remains limited in scope and comparability. A study in Anuradhapura District identified significant barriers to menstrual hygiene, including reliance on improvised materials and strong links with socioeconomic disadvantage (Hettiarachchi et al., 2023). Evidence from rural Sabaragamuwa similarly found low use of sanitary pads and continued reliance on cloth, linked to financial constraints and limited menstrual hygiene resources (Samarakoon et al., 2024). Policy and advocacy sources have also highlighted affordability challenges, taxation burdens, stigma, information gaps, and inadequate WASH facilities as important determinants of menstrual experiences in Sri Lanka (Advocata Institute, 2022; Family Planning Association of Sri Lanka, 2025).

Together, these findings confirm that period poverty in Sri Lanka is complex and multidimensional, while also showing that existing evidence relies largely on isolated indicators and localized studies. This limits comparability across regions and population groups and underscores the need for a standardized measurement framework. The Period Poverty Index for Sri Lanka was developed to address this gap by providing a transparent, policy-relevant, and analytically feasible measure of menstrual health deprivation at the individual level, informed by international menstrual health frameworks and multidimensional measurement approaches.

Given the absence of a globally standardized Period Poverty Index, the Sri Lanka PPI was formulated by drawing on established international frameworks in menstrual health and multidimensional poverty measurement to develop a conceptually robust, analytically simple, and policy-relevant measure.

4.1 Definition of Period Poverty Index for Sri Lanka

In the Sri Lankan context, the Period Poverty Index can be defined as a multidimensional composite measure that quantifies menstrual health deprivation by counting deprivations across a set of five key domains related to menstrual management and aggregating them using equal weights.

The index reflects the breadth of menstrual disadvantage experienced by an individual rather than the severity of any single problem. It is designed to complement, not replace, domain-specific indicators.

The Sri Lanka PPI conceptualizes period poverty across five domains:

Table 4.1: Main domains of period poverty

Domain	Description
Access to menstrual products	The ability to obtain and afford safe, high-quality menstrual materials such as pads, tampons, menstrual cups, and reusable pads. This includes having a reliable supply and a choice of products that suit individual needs and cultural contexts.
Privacy, toilets, and water	The availability of clean, safe, private, and functional toilets with running water, soap, and locks. This is crucial for changing, cleaning, and managing menstruation with dignity and privacy.
Safe disposal of menstrual waste	Reflects environmental health and dignity considerations emphasized in urban sanitation and waste management literature.
Access to information on education	Comprehensive, accurate, and non-stigmatizing education about the menstrual cycle, how to manage it, and related health issues. This education should be provided to all genders to combat stigma and misinformation.
Stigma, restrictions, and participation impacts	Reflects feminist and social science research documenting how menstruation affects mobility, schooling, and work participation.

4.2. Formulation of the Period Poverty Index for Sri Lanka

The Period Poverty Index for Sri Lanka was constructed using individual-level data from the national menstrual health and hygiene questionnaire. The formulation process was designed to balance scientific rigor, transparency, and feasibility for routine analysis.

Five domains were identified based on international guidance and the structure of the national questionnaire: access to menstrual products; privacy, toilets, and water for washing; safe disposal of menstrual waste; access to menstrual information or education; and stigma, restrictions, and participation impacts.

Within each domain, relevant survey questions capturing lack of access, inability, restriction, or dissatisfaction were selected as indicators. Each indicator was coded into a binary deprivation variable, where deprivation was recorded when respondents reported inadequate access, inability to manage menstruation as needed, or restrictive social conditions.

For each domain, a domain score was calculated as the proportion of deprivation indicators experienced by the respondent. A majority-rule cutoff was then applied, classifying a respondent as deprived in a domain if they experienced deprivation in at least half of the indicators within that domain. This approach reflects cumulative disadvantage and avoids classifying individuals as deprived based on a single isolated issue.

The Period Poverty Index was calculated as the simple average of the five binary domain deprivation indicators, assigning equal weight to each domain. The resulting index ranges from zero, indicating no domain deprivation, to one, indicating deprivation across all five domains.

Table 4.2: Indicator Framework

Domain	Indicators / Questions	Deprivation Coding	
Domain 1: Access to Menstrual Products	H1: Enough materials to change as often as wanted H2: Able to use preferred menstrual material H3: If H2 = No, affordability issue H5: Enough materials at school/workplace H7_a: Issues affording materials H7_b: Issues accessing materials	H1: Yes=0, No=1 H2: Yes=0, No=1 H3: Yes/Partly=1, No/Prefer not to say=0 H5: Yes=0, No/Sometimes=1 H7_a: Yes=1, No=0 H7_b: Yes=1, No=0	Domain deprived = 1 if ≥50% of items indicate deprivation
Domain 2: Privacy, Toilets, and Water	E6b: Able to wash menstrual materials when wanted E6d: Able to change and wash in privacy at home F1_a (items 1–4): Home facilities F1_b (items 1–4): School/workplace facilities	E6b/E6d: Yes=0, No=1 F1_a: No=1, Yes not satisfied at all=1, otherwise=0 F1_b: No=1, Yes not satisfied=1, otherwise=0	Domain deprived = 1 if ≥50% of items indicate deprivation
Domain 3: Safe Disposal of Menstrual Waste	E6a: Able to dispose materials as wanted F1_a item 5: Disposal facility at home F1_b item 5: Disposal facility at school/workplace F3: Disposal method F4: Wrap pad before disposal	E6a: Yes=0, No=1 F1_a/F1_b: No or not satisfied=1, otherwise=0 F3: Municipal collection=0, Other=1 F4: Yes=0, No/Sometimes=1	Domain deprived = 1 if ≥50% of items indicate deprivation
Domain 4: Access to Menstrual Information / Education	C2: Knew about menstruation before first period C3c: Comfortable receiving information C3d: Satisfaction with information D1: Comfortable seeking help from health worker D9: Has someone to ask for support I5: Knowledge statements	C2: Yes=0, No/Don't remember=1 C3c: Yes=0, No=1 C3d: Very satisfied/Satisfied=0, Otherwise=1 D1/D9: Yes=0, No=1 I5: <50% correct=1, ≥50%=0	Domain deprived = 1 if ≥50% of items indicate deprivation
Domain 5: Stigma, Restrictions, and Participation	J2: Experience restrictions J5: Stigma statements	J2: Yes/Sometimes=1, No=0 J5: Strongly agree/Agree=1, Neutral/Disagree=0	Domain deprived = 1 if ≥50% of items indicate deprivation
Final PPI Calculation	-	D1–D5 coded 0/1	$PPI = (D1 + D2 + D3 + D4 + D5) / 5$

Validation and use of the index

To support interpretability, the index was examined against menstrual-related school and work absenteeism. Higher index values were expected to be associated with increased likelihood of missed school or work, providing face validity without implying causality.

The Period Poverty Index provides Sri Lanka with a standardized and transparent tool to quantify menstrual health deprivation, identify vulnerable population groups, and guide evidence-based policy and programmatic responses.

4.3 Period Poverty Index (PPI) Sri Lanka

Overall PPI and Main Domains

An overall Period Poverty Index (PPI) score of 0.45 suggests that, on average, women and girls in Sri Lanka experience deficiency in approximately two out of the five key menstrual health domains assessed in this study. The overall PPI 0.45 falls within the category of moderate period poverty. While this score remains below the threshold for high deprivation (≥ 0.60), it nevertheless reflects a persistent and systemic level of disadvantage that cannot be overlooked. Moderate deprivation does not imply minimal impact; rather, it points to widespread constraints that affect a substantial proportion of women and girls, particularly those in low-income, rural, and marginalized communities.

Table 4.3 : Scores for the PPI

Domain	Score	Key Interpretation
Overall PPI	0.45	Moderate period poverty (2 domains deprived)
Access to products	0.16	Low deprivation; relatively strong performance
Privacy, toilets & water	0.50	Moderate deprivation; infrastructure gaps
Safe disposal	0.46	Moderate deprivation; system-level issue
Information & education	0.47	Moderate deprivation; knowledge and confidence gaps
Stigma & Restrictions	0.65	High deprivation; dominant challenge

Domain 1: Access to menstrual products : 0.16

Low deprivation indicates that most women and girls in Sri Lanka can access menstrual products, including sufficient quantities and preferred options, although affordability challenges remain for vulnerable groups.

Domain 2: Privacy, toilets, and water for washing : 0.5

About half of respondents face inadequate or unsatisfactory sanitation, water, and privacy conditions, especially in schools, workplaces, and public spaces, affecting dignity, participation, and well-being.

Domain 3: Safe disposal of menstrual waste: 0.46

Nearly half of respondents lack access to safe and hygienic disposal options, leading to unsafe practices and highlighting gaps in waste management systems and infrastructure.

Domain 4: Access to menstrual information or education : 0.47

Many women and girls lack adequate knowledge and reliable information about menstruation, with limited preparedness and low comfort in seeking guidance due to persistent stigma.

Domain 5: Stigma, restrictions and participation impacts : 0.65

This domain shows the highest deprivation, with stigma and social norms significantly restricting mobility, participation, and well-being, even where products and facilities are available.

Table 4.4 : Period Poverty Index (PPI) by Sector & Age Cohorts

Domain	Sector			Age			
	Rural	Estate	Urban	16 - 19 Yrs	20 - 29 Yrs	30 - 39 Yrs	40 - 50 Yrs
Overall PPI	0.45	0.51	0.43	0.53	0.43	0.44	0.46
Access to products	0.17	0.26	0.10	0.14	0.13	0.15	0.20
Privacy, Toilets & Water	0.51	0.52	0.51	0.80	0.49	0.48	0.48
Safe disposal	0.48	0.49	0.40	0.60	0.44	0.45	0.46
Information & Education	0.46	0.57	0.48	0.46	0.42	0.47	0.52
Stigma & Restrictions	0.65	0.73	0.66	0.64	0.65	0.65	0.67

Women in the estate sector experience the highest overall period poverty (PPI = 0.51), compared to those in rural areas (0.45) and urban areas (0.43). Deprivation in this group is particularly severe in access to products (0.26), information and education (0.57), and with the highest stigma score (0.73) across all subgroups. Urban women consistently record the lowest deprivation scores across most domains, especially in access to products (0.10) and safe disposal (0.40), reflecting better market access, sanitation systems, and service availability. However, even in urban settings, deprivation related to stigma and social restrictions remains high (0.66).

The 15–19 age group emerges as the most vulnerable, with the highest overall PPI (0.53). This group shows especially severe deprivation in privacy, toilets, and water (0.80) and safe disposal (0.60). Women aged 19–29 and 29–39 show comparatively lower overall deprivation (0.43 and 0.44 respectively). However, deprivation in stigma and restrictions remains consistently high (0.65) across all age groups. Notably, women aged 39–50 show a slight rise in overall deprivation (0.46), particularly in access to products (0.20) and information and education (0.52).

Author's Note

The National Study on Menstrual Health and Hygiene followed a mixed-method approach combining nationally representative quantitative data with qualitative focus group discussions (FGDs) and in-depth interviews (IDIs). This report only contains the analysis and results of the quantitative data collected.

A second volume to The National Study on Menstrual Health and Hygiene containing comprehensive analysis of findings from the qualitative data will be made available imminently.

