Review article

Menstrual Health Awareness among Physically and Mentally Challenged Adolescent Girls in Suburban Odisha; Knowledge, Cultural Beliefs, Sanitary Product Access, and Educational Interventions: An Overview

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ABSTRACT:

Menstrual health and hygiene (MHH) are a most important but under-researched aspect of adolescent health, particularly in girls with physical and mental disabilities. These girls have secondary social, cultural and structural hindrances. Menstrual health among Indians is influenced by the cultural beliefs, gender norms, and lack of access to inclusive health education. In particular, such challenges are a lot more severe in sub-urban and semi-urban places. This is an overview paper that involves the compilation of the available literature, policy frameworks, and research. It explores the concept of menstrual health awareness in physically and mentally challenged adolescent girls in the suburban Odisha. The four dimensions that are interrelated, and the emphasis of the paper is knowledge and awareness about menstruation, cultural beliefs and taboos, access to sanitary products and supportive infrastructure, and the effectiveness of educational interventions in facilitating inclusive menstrual health practices. Through the interdisciplinary perspective that relies on public health, gender studies, disability studies, and education, the paper identifies areas of constant unawareness, inaccessibility, and a lack of institutional support. It further explains ethical, policy, and governance issues which can be applicable to design relationships of women-led as well as community-focused interventions. The abstract locates urgent research gaps and highlights the necessity of disability-sensitive culturally responsive and ethically informed menstrual health interventions. This paper will inform researchers, policymakers, educators, and care providers and seek to add to the creation of equitable and inclusive menstrual health policy among adolescent girls with disabilities.

Keywords: Menstrual Health and Hygiene; Adolescent Girls; Disability Inclusion; Cultural Beliefs; Sanitary Product Access;

1. INTRODUCTION

Menstrual health has come to be regarded as a major issue in the field of public health, gender equality and human right. It has aroused issues of education, dignity, social inclusion, access to healthcare, and not only biology. Menses' can be negative to the physical and psychological well-being of poor women, lower school attendance, and limit social activities. In India as in the rest of the world, misinformation, exclusion, and unequal access remain alive due to stigma, silence and the distortions of culture. Menstrual health should be addressed to attain gender equality, inclusive growth, and human dignity. Female children with physical or mental limitations have an even bigger obstacle in the form of menstrual health. They are managed by disability-related restrictions, inability to live independently, societal invisibility, and the inability to exercise control over their bodies. Daily struggles are the physical barriers, such as poor toilets, lack of assistive tools, lack of privacy, etc. Moreover, intellectually or psychologically disabled women could find it difficult to communicate, obtain minimal education in menstruation and

be informed that they are unable to know and handle menstruation. Caregivers and institutions often opt to protect and control instead of empower people and decrease bodily autonomy and informed choice. This demonstrates that thoroughly we have to have disability-sensitive menstrual health strategies that are inclusive, ethical, and rights-based [1].

The Indian culture influences the menstrual health through cultural beliefs, religious taboos, and gender norms that govern the control of the women body and movement. The forces are most prominent in the suburban and semi-urban regions where the traditional values clash with the modernity of urban living. Odisha is a convenient case study due to its diverse social and economic background and disequilibrium between health and education access. Although, the government has put in place policies to enhance complications to improve menstrual hygiene and health of the adolescents, it has not addressed the needs of girls with disabilities. Schools and health facilities are inadequately prepared; teachers and caregivers are not trained, and schools and health departments do not include the perspective of disability in their menstrual health initiatives, which prevents grassroots interventions. Paper is about menstrual health in the wider background of women-led development and inclusive health. Women-led development is all about inclusion of women and girls, hearing their voices and making community based, gender responsive decisions. The inclusion of menstrual health into this framework can be useful in addressing deeply rooted inequalities associated with gender, disability, and economic status. The health of menstruation is also related to a number of the United Nations Sustainable Development Goals with this consideration; SDG3 (Health), SDG 5 (Gender Equality) and SDG 10 (Reduced Inequalities). By providing adolescent girls with disabilities with equal access to menstrual care, the health outcomes of this group increase, gender inequality is decreased, and social exclusion is minimized [2].

The rationale of applying an overview paper is that research conducted up to date relating to menstrual health, disability, and adolescence is disjointed. Though there are studies in the field of public health, education, sociology, gender studies and disability studies, these studies are usually separated. Thus, it is necessary that we should merge these divergent views so that we have a holistic picture on the issues and interventions on physically and mentally challenged girls in their adolescent stage. An overview paper enables us to critically discuss the evidences, identify gaps, as well as integrate the policy, practice, and ethics without binding the study to one setting. The primary aim of the overview paper is to synthesize and discuss available literature, policy reports and strategies that would target the menstrual health-related knowledge to physically and mentally challenged teenage girls in suburban Odisha. The paper will examine what girls know, cultural beliefs, access to sanitary products, and the role of the educational programs all in an inclusive rights-based framework. In such a way it will become a comprehensive source of information to the researchers, policymakers, teachers, and the healthcare professionals interested in enhancing the establishment of equitable menstrual health and inclusive, feminist development.

2. CONCEPTUAL FOUNDATIONS OF MENSTRUAL HEALTH AND DISABILITY

The multidimensional concept (MDC) of menstrual health and hygiene (MHH) exists. It extends beyond dealing with menstrual bleeding but inner aspects of bodily health, mental condition, honour and partaking of society. The MHH as per global public-health agendas involves having correct information regarding their monthly bleeding, the availability of approachable and cost-effective menstrual products, water, sanitation, and hygiene (WASH) amenities, and an encouraging social climate. This is an environment where menstruating individuals must feel free to control their cycles without feeling stigmatized as being discriminated. Therefore, menstrual health is not necessarily just a biological matter but a marker of gender equity, health rights and social inclusion particularly at the adolescent stage when individuals undergo a considerable number of physiological, emotional and social transformations. The issue of menstrual health in teenagers with disabilities needs to be perceived in a subtle way when it comes to disability. During the adolescence stage, disability manifested as limits within the physical capabilities in terms of mobility or motor abilities. It may also be in the form of intellectual disabilities which interfere with cognitive processing and learning. Also, it can have psychosocial disabilities, including emotional, behavioural, or mental health ones. These forms of disability tend to interlock and play with environmental and social limitations, which form the experiences that the young people lead. In menstruating adolescents, disability can limit access to appropriate facilities, diminish chances of adequate menstrual education, and increase the dependence of the adolescents on caregivers to take care of their menstrual needs. Such dependency may undermine privacy, autonomy, and decision-making, and menstrual health is a very sensitive and under-researched topic of disability discourse [3]. Menstrual health is influenced by the interaction of gender, disability, socio-economic status and geographic location. Girls with disabilities have an additive disadvantage; gender expectations about the secrecy of discussion about their menstrual cycles, the stigma of disability means that visibility and inclusion is minimal, poverty limits access to sanitary materials and health care services, and suburban or semi-urban areas do not necessarily have special services and accommodating facilities. These reasons act in combination, contributing to vulnerability and exclusion. To view the role of structural inequalities in shaping menstrual health awareness and practices among youths, it is important to look at this issue through the intersectional perspective. A number of

theoretical perspectives shed light on the relationship between disability among menstrual health. The social model of disability argues with the medical perspective that puts disability into the individual. It demonstrates that disability is a product of societal inequalities as exemplified by unfriendly infrastructure, discriminatory attitudes, and marginalizing policies. In the context of menstrual health, the model exposes how poor sanitation amenities, absence of disability sensitive education and cultural silence on menstruation can result in disabling conditions on young girls. He or she should improve results, which is not possible without changing social systems and not the individual impairments [4].

The gender and health equity framework enrich the analysis with focusing on power relations, societal norms, or institutional practices in the context of understanding health outcomes. It perceives menstruation as a gendered experience that is influenced by patriarchal culture of norms and resource inequality. These inequities are exacerbated in girls with disabilities since they are not always included in mainstream health discourse and interventions. An equal approach towards menstrual health is the ability to consider different types of menstruation, design programs that are participative, and embrace varied menstrual experiences. The capability approach is the approach to development that was developed by Amartya Sen as the ethical and developmental approach concentrating on the real freedoms of individuals in pursuit of well-being. Based on this perspective, the health of menstrual is associated with abilities of integrity in the body, self-respect, education, and social engagements. The capabilities of the adolescent girls with disabilities are limited when they are not provided with information resources, products, and enabling environments. Promoting menstrual health in this way becomes the issue of increasing the capacity with the help of inclusive education, availability of infrastructures, and supportive care-giving [5]. These are all interrelated issues that should be addressed through an inclusive discussion on menstrual health. Such a discussion acknowledges that menstruation is a universal phenomenon that also differs depending on the person. It urges the need to incorporate the sidelined voices and that views of disability should be incorporated into the designs of health and education systems, as well as policy. Shifting menstrual health to the intersectional and rights-based theory, this paper explores the necessity of inclusive and ethical and situation-specific approaches and support to adolescent girls with disabilities.

3. MENSTRUAL KNOWLEDGE AND AWARENESS AMONG ADOLESCENTS WITH DISABILITIES

Menstrual awareness and menstrual knowledge are some of the main aspects of menstrual health and hygiene (MHH). They influence the perceptions, the coping mechanisms as well as the seeking behaviours of menstruation among adolescents. Studies always demonstrate that women with disabilities possess very poor knowledge about menstruation, as compared to women without disabilities. Such an imbalance will be due to social stigma, lack of access to formal health education, and beliefs about the ability of disabled teenagers. Therefore, menstruation can be shown as a startling, disorienting or unpleasant occurrence rather than as a regular biological phenomenon. Research studies indicate that there are variations in the menstrual awareness of physically challenged adolescents and mentally or intellectually disabled adolescents. Teens with mobility problems (or disabled) are the ones who are physically challenged, and they are typically aware of the menstrual fundamentals. However, dealing with supplies, bathrooms and privacy are real-life issues they have to deal with. Their knowledge is primarily obtained during school and peer contact although inaccessible classrooms, wash rooms and study resources are interfering with their effective attendance. My comparison is different, though, since children and adolescents with intellectual or psychosocial disabilities are likely to possess little or piecemeal information concerning menstruation. Such words as menstrual cycle, hygiene practices, and changes of body are poorly explained or even not discussed. Caregivers might be ill at ease giving this information or even feel there is no need or accordingly, it is not appropriate [6]. Caregivers play a central role in the development of adolescent menstrual knowledge when the adolescents have a disability. The initial information is normally given by mothers, female family members as well as residential carers particularly when it comes to intellectual siblings. However, the education they provide usually stops at the bleeding management technique, rather than complete menstrual education. There is a barrier due to cultural taboos, embarrassment, and fear of sparking sexual curiosity to enable an open discussion. There are instances in which caregivers simply withhold information because they think that ignorance helps the teen to avoid what is being perceived to be dangerous or socially stigmatizing. Teachers and schools also contribute to it, but the influence of these two factors is not equal. Health programs in schools are trying to push towards menstrual literacy but they do not teach inclusively. The materials are usually not conformed to a variety of learning requirements and teachers do not get to train on disability sensitive communication. As a result, the adolescents with disabilities (but more particularly those who are special or even inclusive and are not appropriately supported) might lack formal menstrual education. This undulation supports the dependency on the caregivers and minimizes the opportunities of learning with peers [7].

The medical personnel may be very helpful in data on menstruation, but health care workers almost never see the challenged teenagers face to face. The communication will be directed to the caregivers rather than the teens and this limits the ability of the teens to be independent and self-aware. A significant number of professionals are also not

trained on how to communicate complicated health issues in simple ways that are accessible to individuals with intellectual or psychosocial disability. These issues demonstrate the need to have the cooperation of health, education, and social care. It is difficult to know about menstruation due to communication barriers and learning dramas. Intellectually disabled teens can hardly understand abstract concepts such as hormone cycles. Language limits, sensory sensitivities and attention issues also can have an effect on them, particularly when the material to be covered is based on dense text. Other impediments are seen in physically challenged teens due to lack of access to assistive equipment or seclusion to discuss. Unless teachers are provided with adaptive approaches as visual aids, repetition, simple language, and hands-on learning, then menstrual education remains inaccessible [8].

There is also popular ignorance and misinformation of adolescents with disabilities documented in the literature. What most people want us to believe is that menstruation is a disease, a punishment or a condition that has to be isolated. Lack of hygiene knowledge might result in unsafe behaviour, including the prolonged retention of used materials or the refusal to take a shower. Cultural discourses tend to support these ideas, and a lack of viable and available informational sources. The consequences of poor menstrual information are broad and extensive. Adolescents are at increased risk due to lack of awareness in terms of falling ill in the reproductive tract, skin irritation, and psychological distress. Most of them develop anxiety, grace, or fear when they are on their period particularly when they are not ready to go through the changes of their bodies. Absenteeism among students is one of the cases offered with education facilities inaccessible, unsupported, or unconfident. Other than the physical and academic effects, lack of knowledge undermines the dignity, autonomy, and social engagement and perpetuates the cycles of marginalization [9].

4. CULTURAL BELIEFS, TABOOS, AND SOCIAL PRACTICES

Menstruation in India is largely connected to the cultural beliefs, social norms, and religious practices that explain the ways in which menstrual bodies are perceived and managed. It is regarded as an object of impurity, pollution or a ritual uncleanliness in most communities. Such concepts result in the limitation of activities like cooking, visiting religious ceremonies, meeting social, and mobility. This impact of these norms is high in Odisha in the suburban and semi-urban spheres where tradition is in conflict with modern education and healthcare. Despite increasing educational efforts, menstruation as a subject is still very secretive, its speech is not made overt, but rather informally passed through word of mouth. Myths perpetuate stigmatisation and silence regarding menstruation by characterising girls who menstruate as susceptible, impure or morally corrupt. It is believed by many to weaken the body, invite bad spiritual entrapment or requires integration to maintain cleanliness at home. Such beliefs do not come to the fore in the normal conversation, making the female teenagers clandestine and humiliated. To most, the beginning of menstruation is accompanied by fear and lack of understanding rather than knowledge since the subject is not discussed even in families and schools. Such silence suppresses the right information and maintains the misinformation between generations [10].

The image of disabled adolescent girls is more severely and even more insidiously restrained by the limitations of culture. The double marginalization happens because of the disability stigma which combines with the menstrual stigma. Families can interpret menstruation in a girl with intellectual or psychosocial disabilities as problematic or dangerous that could lead to the firm restrictions of movement, social interaction, and education. Menstruation in certain households is regarded as a liability instead of the logical step in the development of a person, which solidifies the negative perspective on disability and women and their body independence. Physically impaired girls can also be questioned as to determine further since their circumstances of menstrual care that requires the help of caregivers are culturally acceptable in terms of modesty and control. The family structure is very essential in determining menstrual beliefs and practices. Mothers, grandmothers and other women are the largest perpetrators of the menstrual norms, transferring the cultural information and limitations on the adolescent girls. These practices might be presented as protective by the family but when it comes down to either conformity or personal comfort or even autonomy, the family tends to stress on conformity. The power of decisions among girls with disabilities is often shifted completely towards caregivers and eliminating the opportunity to express themselves and make their own menstrual health decisions. Although they are not directly involved, the other members of the male family often contribute to making the subject of the issue hush-puppy by shaming menstruation [11]. Menstrual taboos are upheld through community demands and religion. Odisha is one of those states where during menstruation times people in many areas of Odisha tend to limit their access to temples, festival celebrations and other communal gatherings. These regulations seldom put into consideration the needs of adolescent disabled people which increases social exclusion. By shunning discussions about menstruation by schools and community organizations, girls particularly the ones with disabilities also feel that they are required to remain in the shadow during their menstrual cycles. The consequences of these taboos do not fall on deaf ears. The effect of stigma on self-esteem is incessant as girls would start feeling that their bodies are dirty or defective. Embarrassment and shame may make them remain silent and in need of help. Little freedom of movement will create barriers to education, recreation and social life. Girls with disabilities may have their limits further to divide them and become more dependent on others. The health seeking also suffers, as menstrual pain,

infections or any abnormalities could go undisclosed due to fear of facing society, embarrassment or the lack of supportive environments [12]

5. ACCESS TO SANITARY PRODUCTS AND MENSTRUAL INFRASTRUCTURE

Availability of safe, affordable, and adequate sanitary products along with positive menstrual infrastructure is an essential element to menstrual well-being and cleanliness. In the case of adolescent girls, particularly adolescent girls with disabilities, knowledge and cultural acceptance is not the only place they can be made to manage menstruation in a dignified way due to the fact that the access to menstrual materials and physical environments are major determinants of their ability to do this. In India, discrepancies in the provision of hygienic products and facilities are great. Particularly in the suburban areas and semi-urban places, these gaps are even greater, with the services usually having to lie in between urban services and rural ones. With increased market penetration and health promotion efforts, sanitary products now include disposable pads, reusable cloth pads and menstrual cups more readily available and affordable in the recent years. However, having economic limitations continues to restrict frequent access to lower socio-economic families. In the case of adolescents with disabilities, the choice of products can also be limited by physical and mental requirements. Products that often need to be changed; those that need fine motor control and those with complicated instructions can be complex to self-operate, particularly for girls with mobility or intellectual problems. As a result, caregivers tend to choose items because of convenience and not appropriateness and in some cases, they use improvised or unsanitary materials [13].

Difficulty in using the products does not just stop at availability. Without adaptive aids or other facilities, adolescents with physical disabilities can have problems positioning or changing sanitary products without assistance. Girls who are intellectually or psychosocially disadvantaged tend to be unable to comprehend the timing and method of product change and there is a risk of leakage, discomfort, and infection. Lack of guidance by the healthcare providers and insufficient access to disability-sensitive menstrual education exacerbates these issues. Consequently, menstrual management has become some form of anxiety and dependency instead of being part of individual care. There are a number of policy initiatives introduced by the Indian government to manage menstrual hygiene among the adolescents. Education programs like the Menstrual Hygiene Scheme as part of the National Health Mission, school-based sanitary napkins distribution, etc. are designed to enhance the accessibility and awareness of the product. Although such initiatives are essential steps to take, their execution is not properly disability-inclusive in most cases. The distribution systems might not extend to adolescents with disabilities who are out of school programs users or attend special education institutions. Besides, program materials and instructions are seldom tailored to meet a variety of other learning requirements, which minimizes their applicability with adolescents with intellectual disabilities [14].

A significant barrier to inclusive menstrual health has continued to be infrastructure. People should have toilets with large enough size, handrails, water, and waste disposal to manage menstruation themselves. However, in the suburban regions there are many schools, public places, and community centers which lack sanitation capability in regard to disability. Privacy and safety are lowered because of narrow doorways, lack of ramps, broken locks, and lack of water. These gaps compel the adolescent with disabilities to depend on their caretakers as well as restrict their participation in school or community activities during their menstrual periods. The other aspect that has been disregarded is disposal facilities. Hygiene and dignity in used menstrual products lies centrally in safe and secret means of disposing them. There is a lack of bins, incinerators, or waste-management systems in a great number of suburbs. The disabled adolescents usually have difficulties in locating a place to dispose, if they lack mobility, stairs, or a long walkway. The lack of good disposal alternatives may impose the need to do things the wrong way, raise environmental issues, and humiliate [15].

The disparities between the urban and suburban worlds determine access to menstrual products and infrastructure. City is normally associated with an increase in the number of products and sanitation. Conversely, the areas of suburbs are not evenly developed. They often lack a reliable funding and technical support and supervision provided in schools and health centers. Adolescents with disabilities face additional or extra gaps: there is a lack of special services, assistive technologies, and missing inclusive infrastructure. These loopholes reinforce spatial disparities in the monthly health outcomes. The dependency of caregivers is a common phenomenon in discussions regarding the problem of menstrual access and infrastructure. There is always the need of caregiver assistance, but excess dependence may destroy dignity, privacy, and autonomy. Adolescents might not like the fact that they need some kind of intimate menstrual care by others and this is particularly in institutions. The judicious balance between care and independence involves careful design of products, infrastructure, and support that will empower adolescents with disabilities without taking into account their special needs [16].

Solving this issue of access to sanitary products and menstrual infrastructure needs an integrated solution that equates between affordability, the suitability of the product, disability-friendly design and responsiveness to policy. Enhancing infrastructure, redesigning government initiatives as well as inclusive dignity-based menstrual health practices are crucial measures to attain equitable menstrual health of adolescent females with disabilities in suburban India.

6. EDUCATIONAL INSTITUTIONS AND MENSTRUAL HEALTH SUPPORT SYSTEMS

Schools play a significant role in the education of adolescents about menstruation and medical assistance of menstrual hygiene. Schools, special schools and inclusive education environments are where structured information, social interaction and health support can be gained to a great extent in the case of adolescents with disabilities. The quality of such schools in providing menstrual health makes a significant difference to attendance, involvement, pride and general health. The mainstream schools tend to cater to the general student body and might lack instruments of the menstrual health of the disabled students. Menstrual health is even a neglected concern with special schools providing personalized care, as much as their specialization is on disability-related learning. Inclusive educational environments unite both students with disabilities and without disabilities and provide an opportunity to bridge this gap. With the necessary resources, such schools would be able to not only encourage open normal discussion on menstruation but also offer students individual support when they need them. Effective inclusive paradigm, however, depends on firm institutional dedication, ready teachers and sufficient facilities [17]. School tickets the teachers take a middle stage in the menstrual health provision in schools. Their readiness, sensitivities and orientations have a direct effect on the manner of how the topic of menstruation is approached and treated in schools. Lots of teachers (primarily working in socio-culturally conservative environments) get less formal training about menstrual health education, much less about disability -inclusive ones. Through this, menstruation will be superficially handled or even avoided making stigma and silence stronger. The educators can also be uncomfortable in meeting the menstrual needs of adolescents with disabilities due to lack of knowledge or some fear of crossing the boundaries of professional works. Mensal education in school programs is not even and is usually biologically oriented and concentrates on reproductive sex organs and not whole menstrual health. The co-curricular activities like health talks and life-skills training, peer education programs can offer more flexible platforms of discussion. Nevertheless, such programs are hardly developed to accommodate adolescent disabled individuals. Educational resources might be in unaccommodating forms like simple language, visual materials, or physical materials. This restricts understanding and interaction especially among the intellectually, visually or hearing-impaired students [18]. Health rooms in schools, counselling and referral systems are needed to assist the students when facing menstrual issues. But these supports are not complete or even regularly utilized. The emergency menstrual staff, pain management, and hygiene are not trained in many schools. In the case of students with disabilities, the unsystematic assistance can make them skip school, drop out early, or also withdraw socially at such times. Additionally, the collaboration between schools, health providers, and families is not strong in most cases and that is a limitation to the effect of these intervention programs. Health education should be inclusive. These types of models emphasize participation, accessibility and the necessity to respect diversity because menstrual experience varies physically, cognitively and socially. They substitute a unified-fits-all strategy with customized teaching, assistive technology and culturally-related instruction. Provided that the students with disabilities get accurate, age-sensitive, and available menstrual information, they will be able to handle periods on their own and without anxiety [19].

Intervention strategies implemented in schools are a solid argument in favour of the positive menstrual health in the adolescent disabled student. Schools provide a constant, consistent area of activities;thus, students are able to work with the content a number of times, and also receive continuous guidance. Some examples are training teachers, initiate peer-support groups, providing available menstrual education resources, and renovate school washroom amenities. A combination of these measures creates a friendly atmosphere. Notably, schools as well identify menstrual health issues in time, and can refer students to the required health services. Concisely, schools play an important role in ensuring menstrual hygiene equity among the students with disabilities. Improving the skills of the teachers, integrating inclusive menstrual education into the curriculum, and sealing the institutional loopholes are also important steps to consider regarding conducive school environments. School based approach coordination has the ability of enhancing menstrual control, involvement and dignity of such students significantly where the schools, the facilities and emotional assistance are integrated to bring about these changes.

7. ETHICAL, POLICY, AND GOVERNANCE CONSIDERATIONS

Interventions and research on menstrual health amongst adolescents with disabilities are crucial in terms of the moral, policy and governance issues. Due to the overlap of the problems related to age, gender, disability, and socio-cultural vulnerability, ethical sensitivity needs to be addressed on all levels, starting with the development of the study and then continuing on to the implementation of the policy. Failure to consider them may further marginalize rather than promote inclusion and dignity. The most significant ethical problem of such investigation is informed consent. Adolescents with intellectual or psychosocial disabilities might be unable to comprehend well, both the aims and consequences of the study. Thus, it is necessary to get the consent of the adolescent themselves and the consent of the parents or their caregivers. Ethical practice also stipulates that the involvement must be voluntary and non-coercive and discussed in understandable terms, either through visual representation or any other means of communication. The researchers are also supposed to make

sure that the subjects are aware that they can back out at any time without any adverse effects [20].

The next ethical matters are privacy and dignity. Menstruation takes a lot of stigmatizations through the societies and adolescents who have disabilities are always vulnerable to embarrassment, exposure, or abuse. This means that, the research and programs should employ high confidentiality measures. The data collection must be done within secure and confidential environments that are friendly to the participant. Moreover, the practices that demean or missed-diagnose adolescents with disabilities are harmful, since they are infantilizing and damaging to the feeling of self-worth. The overlap between these two issues is policy gaps in the intersection between menstrual health and disability inclusion. There are numerous menstrual hygiene and disability welfare schemes in India, but they are isolated. The policy applied to menstruation tends to concentrate on a physically able, normally neurotypical population, and disability policy tends to be gender-unspecific. This division results in bad targeting, restricted access, and random implementation particularly in the suburbs and semi-urban regions [19, 20].

It is important to integrate menstrual health with disability inclusion and national development. The women-led development agenda is based on agency, leadership, and empowerment yet the adolescence disabled have no much visibility in this agenda. The need to treat menstrual health as a premise issue of embodiment control and involvement is crucial in future leadership and inclusion of women in society. This orientation is also very close to ICSSR priorities that focus on interdisciplinary research, social justice, and formulation of evidence-based policies. A synthesis paper of health, education, sociology, and disability studies can hence play a meaningful part in policy discussion and research agenda. Local systems of governance are decisive in implementing the policy. Individual institutions like the panchayati raj, urban local bodies, school management committees and self-help groups can play the role of a mediator between policy frameworks and the community realities. The public health systems, especially the frontline employees including ASHA and Anganwadi employees, are perfectly placed to provide disability-sensitive reproductive menstrual health education and care. This however needs specific training and coordination of activities of the department and accountability [20].

The social institutions, including families, school, and community-based organizations, are very important influencers of the outcomes of governance. These groups should be involved in order to minimize stigma, generate encouraging settings and sustain interventions. Active engagement of such stakeholders in policies makes them more effective and culturally suited. On this basis, the inclusive policy frameworks must assume a rights-based, life-course approach. Some of the recommendations include integrating disability-specifications into menstrual health policies, ensuring availability of essential infrastructure and communication, strengthening of ethical principles related to research and program provision, and participative governance. All these are meant to foster equity, dignity and inclusions, in such a way that teenagers with disabilities will not be sidelined in menstrual health and development agendas.

8. CONCLUSION

This is an overview because it provides evidence on several areas of study to demonstrate that menstrual health is a vital, but unfortunate, area of adolescent health primarily among girls with physical, intellectual, and psychosocial impairments. In all aspects of health, education, socio-cultural and government, the analysis finds that there are recurring knowledge gaps, access gaps, institutional gaps, and there are policy gaps. These loopholes impact disproportionately the adolescents with disabilities in the suburban and semi-urban settings. The gender, disability, poverty, and cultural stigma intergroup result in increased susceptibility of menstruation, which results in worse health outcomes, school absenteeism, loss of dignity, and decreased social engagement. Combined, these results highlight the necessity to develop an inclusive, rights-based approach to menstrual health, which extends beyond the hygienic discourse and other unified factors and focuses on the differences in body experiences and support requirements. Equipping teenage female disabled with the mechanisms and self-esteem to take care of her menstrual cycle is not only a health intervention, but also a stepping stone toward gender equality, lifelong learning, and integration into society. Inclusive menstrual health services which are based on the accessibility of education, sensitive health systems, enabling school settings, and community involvement can enhance autonomy and worthiness and minimize dependence and feeling marginalized. This empowerment is also in line with wider development objectives, such as women-leaded development, and Sustainable Development Goals on health, gender inequality, and lower inequalities. Being an overview paper, such chapter summarizes scattered evidence spanning the various fields and highlights some of the most important gaps in research. It provides important rationale to policy makers on the need to have integrated frameworks that connect menstrual health and disability inclusion; served by ethical governance and localised implementation. To the practitioners, it highlights the significance of the school based, community based, and culturally sensitive intervention. In the future, research that is socially responsive and women refrained needs to embrace participatory research methodologies, give the adolescents with disabilities and their caregivers a voice, and create evidence context-specific to translate into inclusive policies. This is necessary in efforts to make menstrual health efforts equitable, sustainable and indeed transformative.

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