Prevalence and Factors Associated with Chhaupadi in Nepal: Evidence from Nepal Multi-Cluster Indicator Survey (NMICS) 2019

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Abstract

Chhaupadi, a harmful menstrual exile practice, persists in parts of Nepal despite legal bans. This study examines the prevalence of Chhaupadi and its sociodemographic determinants in Sudurpaschim province, Nepal. Researchers analyzed data from the Nepal Multiple Indicator Cluster Survey (NMICS) 2019, a publicly available dataset from the United Nations Children's Fund (UNICEF), and the Multiple Indicator Cluster Survey (MICS). The study was limited to 1,117 women in the Sudurpaschim province of Nepal. The analysis applied chi-square, bivariate, and multivariable logistic regression. The findings reveal that a significant proportion of women in Nepal's far western region still adhere to menstrual restrictions. Results indicate that 94% of respondents avoid performing religious activities during menstruation, and 14% are kept away from school. Chhaupadi remains practiced by 17% of women overall. The practice is less prevalent among younger women (17%) than older women (21%). Logistic regression further confirmed that women with no education level (OR = 2.36, 95% CI [1.10, 5.45], $p < .05$), those living in rural areas (OR = 2.04, 95% CI [1.49, 2.79], $p < .001$), and those belonging to the lowest wealth quintiles (OR = 4.24, 95% CI [2.51, 7.17], $p < .001$) were significantly more likely to practice Chhaupadi. Despite criminalization, the persistence of Chhaupadi highlights deep-rooted sociocultural norms, economic disadvantage, and gender power relations. Effective interventions must therefore move beyond legal enforcement to include community-based norm change, female education, and gender sensitive empowerment initiatives to advance menstrual health equity and social justice.

Keywords

Chhaupadi; menstrual practices; Nepal; social norms; women's health

Background

Menstruation is a natural biological process that releases healthy blood and tissues from the uterus through the vagina and marks the beginning of womanhood. It is a major marker of reproductive health as well as vital to depict the different phases in women's lives, such as menarche, pregnancy, and menopause (Kadariya & Aro, 2015). If we consider health in relation to menstrual health, it encompasses more than just the release of healthy blood. It refers to a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity, in relation to the menstrual cycle. The definition was developed by the Terminology Action Group of the Global Menstrual Collective through a multi-stage process. It aligns closely with the World Health Organization's (WHO) broader definition of health, which highlights the various aspects of menstruation that impact overall well-being (Hennegan et al., 2021).

However, restrictions on some foods consumption during menstruation and entrenched harmful traditional practices pose significant barriers to achieving this ideal definition of menstrual health. Among them, one such practice is *Chhaupadi*, which is an extreme form of menstrual seclusion where women and girls are forced to stay in unhealthy and unsafe huts like a cowshed and are away from home during their periods. It is most prevalent in western Nepal. The term Chhaupadi is derived from two words, "Chhu" and "Padi," from the *Raute* [nomadic travelling ethnic group] dialect, who are the inhabitants of the western part of Nepal, where "Chhu" means untouchable or dirty, and "Padi" means being or becoming (Subedi & Parker, 2021; United Nations, 2020). Under this system, menstruating women are not allowed to stay with their families at home (Thapa & Aro, 2021).

Demographically, the majority of the population (81%) in Nepal follows the Hindu religion (Amaya et al., 2020; National Statistics Office, 2023; Subedi & Parker, 2021), where different types of cultural taboos, myths, and restrictions exist despite the increased level of education and empowerment of women. Following the criminalization of Chhaupadi in 2005, the Government of Nepal issued comprehensive guidelines in 2008 to eliminate the practice. Numerous awareness-raising interventions have since sought to address and transform entrenched menstruation-related taboos. Additionally, the 2015 Nepalese constitution says no one shall be subjected to any form of discrimination or untouchability, nor shall anyone be taken advantage of because of any custom, tradition, culture, or practice. Similarly, the Criminal Code Act of 2017 has criminalized Chhaupadi, stating that anyone who forces a woman to follow this custom will face a three-month jail term or a fine of NPR 3,000 (≈ USD 21) (Ministry of Health and Population [MoHP] et al., 2023; National Statistics Office, 2023; Thakuri et al., 2021).

Menstruation is often surrounded by different taboos, stigmas, and negative symbolic meanings in many countries around the world. In the Chinese context, cultural norms commonly discourage menstruating women from laundering their clothes together with those of their husbands, from occupying seats traditionally reserved for men, and from participating in public religious ceremonies. Similarly, in Bali, Indonesia, women are not permitted to enter kitchens, attend temples, or sleep with their husbands during their periods, and must keep their menstrual clothes separate (Tan et al., 2017). In Nepal, Hindu belief holds that menstrual blood is a source of pollution (Amaya et al., 2020; National Statistics Office, 2023; Subedi & Parker, 2021). Women practice *Rishi Panchami* [the festival's name] every year to purify themselves from menstrual impurities. All women and girls who have experienced menarche

are expected to participate in this ritual, which involves fasting, prayers, and water purification, believed to atone for sins associated with menstruation (Thakuri et al., 2021).

Not only is menstruation influenced by religious beliefs, but it is also directly associated with social restrictions, shame, and superstitious norms. The existing literature documents the prevalence of these restrictions across diverse cultures and traditions, including Islamic and Jewish communities; however, the nature and extent of these practices vary significantly across contexts (Kadariya & Aro, 2015; Subedi & Parker, 2021; United Nations, 2020). In Chhaupadi, women and girls spend four to twenty days during menstruation and in the immediate postpartum period in animal shelters or small huts known as *Chhaugoth*. The duration of seclusion varies by community and by the type of menstruation, including first menstruation and childbirth. During these events, girls and women are required to remain in the Chhaugoths for longer than the usual duration of the menstrual cycle.

Chhaugoths typically lack basic supplies and are often unhygienic, exposed, and unsafe. This practice has historically been observed in western Nepal, particularly in the Sudurpaschim and Karnali provinces, where it remains most prevalent. During menstruation, women are compelled to reside alone in small mud-and-stone huts that usually lack windows, doors, or secure locking mechanisms, located 20–25 meters from home (Central Bureau of Statistics [CBS], 2020; Thakuri et al., 2021). Women and girls who live in Chhaupadi huts during menstruation endure physical and psychological suffering, various forms of sexual assault, rape, attacks by wild animals, snake bites, and diseases. From a women's rights lens, Chhaupadi violates women's human rights, and Menstrual Health Management (MHM) is directly associated with it (Thakuri et al., 2021; Thapa & Aro, 2021).

The MHM is a crucial concept that addresses various menstrual restrictions, including Chhaupadi, aiming to improve the conditions for women and girls through swift and effective measures during their menstrual periods. The definition of MHM encompasses the physical requirements necessary for managing menstruation, including access to appropriate absorbent materials, privacy, hygiene facilities, and adequate sanitation, as well as mechanisms for the safe and dignified disposal of used materials without stigma or shame. It further outlines the prerequisite conditions for effective use of these resources, such as education and awareness. Moreover, MHM is closely linked to human rights principles, including the rights to water and sanitation, dignity and privacy, health, education, and safe working conditions. Gender equality is a key aspect of MHM in all respects (Hennegan, 2017).

Inadequate MHM contributes to significant health and social consequences, particularly in the context where menstruation is stigmatized and governed by harmful cultural practices. One prominent example is Chhaupadi, a tradition in which women and girls are compelled to reside in unhygienic and unsafe spaces during menstruation, thereby heightening their physical and psychological vulnerability. Globally, over 500 million women are deprived of access to adequate resources for managing menstruation, representing about one-fourth of the reproductive-aged female population (Amaya et al., 2020). When menstruation is viewed as shameful or impure, hygiene needs are often neglected, leading to poor sanitation outcomes. These challenges are directly connected to the Sustainable Development Goals (SDGs), particularly those related to good health and well-being, gender equality, and access to clean water and sanitation. Literature suggests that integrating MHM into development agendas is essential to achieving these global goals (Sommer et al., 2021). In Nepal, eliminating Chhaupadi and addressing menstrual stigma are critical steps toward achieving broader health, dignity, and gender equity objectives.

Theoretically, we understand that power derives not only from individual knowledge and influence but also from the establishment of discourse and the institutionalized patterns of inequality embedded within it, as well as the social positions that accompany them. On the other hand, disempowerment is closely connected to the denial of human rights and, consequently, contributes to a loss of autonomy (Thompson & Thompson, 2001). Men and women develop different personality traits, skills, and attitudes that influence how they use power. However, women are often seen as less effective in using power, not because they lack ability, but because they have less access to power structures. Even when women hold formal positions of authority, they may not have the same structural support or influence that men in similar roles typically enjoy. This reflects the core argument of gender and power theory, which explains how societal systems often limit women's actual power, even when their roles appear equal on the surface (Molm, 1986).

Similarly, from a social norm perspective, individuals form perceptions of these norms based on what they believe others typically do (descriptive norms) and what they believe others expect of them (prescriptive norms). In the case of Chhaupadi, many families continue the practice not necessarily out of personal belief, but because they assume others still expect and follow it. This misperception plays a critical role in sustaining practice, even as social attitudes begin to shift (Dannals & Li, 2024). In this context, understanding the prevalence and determinants of Chhaupadi is essential for designing informed policy responses and promoting menstrual health justice (Loughnan et al., 2020; Sommer et al., 2021; Thakuri et al., 2021).

Objective

This study aims to explore the prevalence of Chhaupadi and its associated factors in the Sudurpaschim province of Nepal.

Methods

This study was based on the Nepal Multiple Indicator Cluster Survey (NMICS) 2019, conducted in 2020 by the Central Bureau of Statistics (CBS) with technical and financial support from the United Nations Children's Fund (UNICEF) (CBS & UNICEF, 2020). The dataset was nationally representative and collected using a standard research questionnaire. The primary objective of the survey was to provide high-quality, internationally comparable data to assess the situation of children, adolescents, women, and households in Nepal. Additionally, the survey helps monitor progress toward developmental goals.

The survey protocol was approved by CBS in September 2018 in accordance with the Statistical Act (1958). This act authorizes CBS to conduct surveys in accordance with the government's ethics protocol. A multistage (two-stage) sampling procedure was used with urban and rural areas serving as the sampling strata. Within each stratum, Primary Sampling Units (PSU) were selected using the Probability Proportional to Size (PPS) method.

The NMICS 2019 dataset is publicly available through the UNICEF MICS website and the CBS portal for legitimate academic and research purposes (CBS & UNICEF, 2020). The data used in this study were obtained from the Official UNICEF MICS database after registration and

approval in accordance with their data access policy. As the dataset is de-identified and publicly available, no additional ethical clearance was required for this secondary data analysis.

According to the 2019 NMICS data, the prevalence of Chhaupadi was notable in Sudurpaschim and Karnali provinces, while it remained below 2% in the remaining provinces. Among these, Sudurpaschim province had the highest prevalence and the largest sample population. Therefore, this study focused on 1,117 women from Sudurpaschim province, Nepal. The statistical analysis was performed using the Statistical Package for Social Sciences (SPSS, version 23.00). For this analysis, researchers considered age, education, marital status, wealth quantile, and residence as independent variables with the prevalence of Chhaupadi as the dependent variable. First, descriptive statistics and the prevalence of different forms of menstrual restriction were depicted. For statistical analysis, the chi-square test and logistic regression were used to examine the association between these variables.

Results

In the analysis, all reproductive-aged participants were categorized into three groups: early/young-aged (below 30 years), middle-aged (30 to 44 years), and later-aged (45 years and above). Out of 1,117 women in the reproductive period, more than half (55%) were young, aged 15–29 years, while only a tenth (7%) were from a later age, 45 years and above. Similarly, the majority of the women completed secondary level education (35%), and it was followed by illiterate women, who were a third (34%). The fewest women completed higher education (5%). Furthermore, the overwhelming majority of women were ever married (77%), and more than half were from the lowest wealth quantile (60%). Women from the middle and highest wealth quintiles were nearly equally represented (20% and 21%, respectively). Likewise, the majority of the women were from urban areas, with only two-fifths (40%) from rural areas (Table 1).

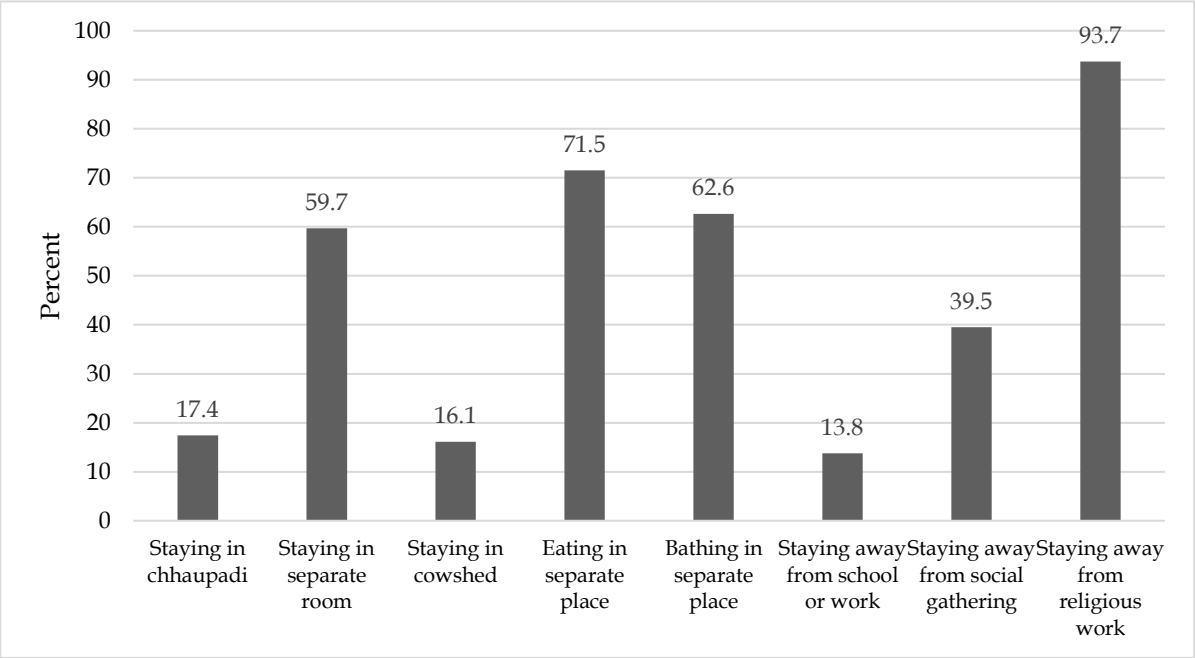
Table 1: Background Characteristics of the Respondents

Background Characteristic	***n***	**%**
Age Group		
• 15–29 years	612	54.8
• 30–44 years	425	38.0
• 45 years and above	81	7.2
Level of Education		
• Illiterate/Non-formal Education	376	33.6
• Basic (Grades 1–8)	291	26.1
• Secondary (Grades 9–12)	391	35.0
• Higher	59	5.3
Marital status		
• Ever married	854	76.5
• Never married	263	23.5
Wealth Quantile		
• Lowest	667	59.7
• Middle	219	19.6
• Highest	231	20.6
Place of Residence		
• Urban	673	60.2

Background Characteristic	*n*	%
• Rural	444	39.8
Total	1,117	100.0

During the time of menstruation, women and girls faced different forms of restriction. The findings of this study showed that the overwhelming majority of respondents (94%) faced restrictions in performing religious activities. Not only are menstruating women restricted from participating in religious activities, but a large majority (72%) also follow restrictions that prohibit them from eating in the common dining area used by other family members. Likewise, three-fifths (60%) of women were staying in a separate room during menstruation, and two-thirds of women were restricted from social gatherings during menstruation. Notably more than a tenth (14%) of women and girls were absent from school during their menstrual periods. Chhaupadi is a form of menstrual exile, and data showed that 17.4% of women (1,117 respondents) were staying in Chhaupadi during their menstrual periods (Figure 1).

Figure 1: Percent Distribution of Respondents Who Faced Restrictions During Menstruation



Note: Total Percentage may exceed 100 due to multiple responses.

Staying in Chhaupadi was analyzed according to respondents' selected background characteristics. Two-way analysis and a chi-square test were applied to demonstrate the association between these variables. The results of this study found that a lower percentage of early-aged women and girls are staying in Chhaupadi (17%) than women aged 45 years and above (21%). However, the number of later-aged women was lower. Similarly, age and staying in Chhaupadi were not significantly associated.

Regarding literacy status, a fourth of illiterate women were living in Chhaupadi, a higher proportion than among women with other educational backgrounds. Furthermore, the study reveals that the number of women practicing Chhaupadi was decreasing with increasing education, and vice versa. Notably, more than a tenth (12%) of highly educated women were found to be practicing Chhaupadi, a statistically significant difference. Likewise, ever-married

women had a higher prevalence of practicing Chhaupadi (19%) than never-married women (13%). Regarding wealth quantiles, the majority of women in the lowest wealth quintile practiced Chhaupadi (25%) more frequently than those in the middle and higher wealth quintiles, and this association was statistically significant. Likewise, a higher percentage of rural women and girls (24%) practiced Chhaupadi, nearly double that in urban areas (13%), and this difference was statistically significant (Table 2).

Table 2: Percentage Distribution of Respondents Who were Staying in Chhaupadi by Selected Background Characteristics

Background Characteristic	Staying in Chhaupadi			*p* value
	Yes		Total	
	n	%	*n*	
Age Group				.683
• 15–29 years	105	17.1	612	
• 30–44 years	73	17.1	425	
• 45 years and above	17	20.6	81	
Level of Education				.001
• Illiterate/Non-formal Education	88	23.5	376	
• Basic (Grades 1–8)	47	16.1	291	
• Secondary (Grades 9–12)	52	13.3	391	
• Higher	7	11.5	59	
Marital status				.03
• Ever married	160	18.8	854	
• Never married	34	12.8	263	
Wealth Quantile				.001
• Lowest	167	25.1	667	
• Middle	10	4.4	219	
• Highest	17	7.3	231	
Place of residence				.001
• Urban	89	13.2	673	
• Rural	105	23.7	444	
Total	194	17.4	1,117	

Note: The p values are based on the chi-square test, and p < .05 is considered statistically significant.

After identifying the statistical association between Chhaupadi practices and various background variables, researchers further analyzed the data using logistic regression. Outputs were analyzed based on Odds Ratios (OR), Confidence Interval (CI), and *p* value.

Results from binary logistic regression showed that younger-aged women were less likely to practice Chhaupadi than women aged 45 years and above, although the difference was not statistically significant. Similarly, women who belonged to the illiterate education group were 2.4 times more likely to practice Chhaupadi than those who were from the higher education level category (OR = 2.36, 95% CI [1.03, 5.44], $p < .05$). Similarly, women from the lowest wealth quantiles were four times more likely to practice Chhaupadi compared to those from the highest wealth quintiles. This difference was statistically significant (OR = 4.24, 95% CI [2.51, 7.17], $p < .001$). Women and girls from rural areas were twice as likely to practice Chhaupadi as urban women, a statistically significant difference (OR = 2.04, 95% CI [1.49, 2.79], $p < .001$) (Table 3).

Table 3: Factors Associated with Chhaupadi Practices According to Selected Background Characteristics by Using Bivariate Logistic Regression Analysis

Background Characteristic	Bivariate Analysis			
	OR	95% CI		*p* value
		LL	UL	
Age Group				
• 15–29 years	0.79	0.44	1.42	.432
• 30–44 years	0.79	0.44	1.44	.446
• 45 years and above	1			
Level of Education				
• Illiterate/Non-formal Education	2.36	1.03	5.44	.04
• Basic (Grade 1–8)	1.48	0.63	3.49	.37
• Secondary (Grade 9–12)	1.18	0.51	2.77	.69
• Higher	1			
Marital Status				
• Ever married	1.57	1.05	2.34	.27
• Never married	1			
Wealth Quantile				
• Lowest	4.24	2.51	7.17	.001
• Middle	0.59	0.26	1.33	.20
• Highest	1			
Place of Residence				
• Urban	1			
• Rural	2.04	1.49	2.79	.001

Note: Number of samples = 1,117, OR = Odds Ratios, CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit; $p < .05$ is considered statistically significant.

Discussion

Despite the strong legal provisions banning Chhaupadi, including its explicit criminalization under Nepal's 2017 Criminal Code, the practice remains widespread in specific sociodemographic contexts (Government of Nepal, 2017). This study found that Chhaupadi is particularly prevalent among women who were illiterate (23.5%), belonged to the lowest wealth quintile (25.1%), and lived in rural areas (23.7%) of Sudurpaschim province. These patterns underscore the enduring influence of sociocultural systems in sustaining menstrual exclusion, even in the presence of formal legal deterrents.

The Health Belief Model (HBM) provides a theoretical framework for interpreting these findings. This model, originally developed to explain why individuals engage in preventive health behaviors, identifies four core beliefs that influence behavior: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers (Rosenstock, 1974). In the context of Chhaupadi, many women may perceive non-compliance with menstrual restrictions as posing greater risk (e.g., social punishment, divine retribution) than the health risks associated with Chhaupadi itself. These beliefs are enduring yet modifiable through health education (Hochbaum, 1958; Rosenstock, 1974). However, despite awareness campaigns, women may still follow Chhaupadi due to perceived social and spiritual

consequences. Similarly, according to social norm theory, individuals' behavior is strongly influenced by perceived societal expectations that may not accurately reflect a community's actual behaviors or beliefs (Dannals & Li, 2024).

In Chhaupadi-practicing areas, families may enforce the practice not out of personal conviction but because they believe others still expect it. The practice is also embedded in gendered power dynamics. According to gender and power theory, social structures systematically limit women's access to power, even when they hold formal positions of authority (Molm, 1986). This theory explains why even educated or economically independent women might be unable to challenge Chhaupadi within their households or communities. Their limited access to decision-making spaces, combined with deep-seated patriarchal norms, restricts their ability to act autonomously on issues of reproductive and menstrual health. Women's perceived lower power not only curtails their voice but also increases compliance with restrictive customs.

Previous studies showed that fear-based beliefs and rumors, such as the perception that violating menstrual restrictions results in illness, accidents, or misfortune within the family or community, continue to play a significant role in reinforcing compliance with menstrual taboos. Furthermore, it also says that girls are frightened about their marriage rejection and abandonment after marriage if they do not follow the traditions (Thapa & Aro, 2021). Consistent with this literature, our findings show a high proportion of women follow restrictions in participating in religious activities during menstruation. Similar trends are observed globally. Women and girls are said to be cursed if they do not follow the menstruation-related restrictions. In specific communities, they believe that if someone touches a plant when they are menstruating, the plant will die.

A study conducted in Lumbini province, Nepal, found that most older women in Muslim communities adhered to restrictions and practices related to menstruation; however, younger generations in these communities were less rigid in their adherence to these restrictions (Subedi & Parker, 2021). Perceptions of menstruation in Malaysia differed slightly from those in Nepal. The study found that some dietary restrictions existed, and female participants believed that fish, meat, and other proteins were avoided because they can make menstruation heavier and smellier. Menstrual restrictions persist in urban populations, and many women are required to eat alone and use separate sets of dishes during their menstruation (Abdullah, 2022). In Bali, women are excluded from temples and kitchens; in China, they avoid touching men's possessions (Tan et al., 2017).

In Nepal, Rishi Panchami rituals serve to "purify" menstrual sin, reinforcing stigma (Thakuri et al., 2021). Similarly, research also found that almost all religions prohibit women from praying or touching holy books during menstruation, and comparatively more menstruation-related taboos exist in developing countries than in developed countries. A study from India found that a significant number of girls (71%) did not believe that women who are menstruating should not participate in religious ceremonies; however, more than half (57%) of girls discouraged them from praying during menstruation (Yadav, 2018). It shows that menstruation-related stigmas are common globally across cultures, with significant variations in their intensity and implications. Hence, it underlines the universal need for comprehensive menstrual health education and gender-sensitive policies.

The psychological and physical consequences of Chhaupadi are well-documented. Women face sexual assault, snake bites, exposure to cold, infections, and even death due to an unsafe hut. A study showed that more than half of the women and girls who were engaging in

menstrual exile resided in livestock sheds, ate outside of their homes, and defecated in open space. The study found that during the practice of Chhaupadi, 12% of adolescent girls were bitten by a snake, and 4% experienced physical assaults (Amatya et al., 2018). Furthermore, another report added that a woman in 2019 died due to a snake bite when she was in an isolated hut (Chhaupadi) (Amaya et al., 2020). Beyond physical risks, Chhaupadi violates women's human rights and undermines their dignity, education, and mental health.

Cultural narratives often reinforce Chhaupadi. In a study, a large number of participants from Hindu communities reported that they did not worship and use separate sets of dishes during menstruation. However, more than three-fourths of them disagreed with the practice of Chhaupadi (Mukherjee et al., 2020).

Menstrual restrictions also obstruct educational progress. Girls may miss up to four school days each month, equivalent to 20% of school time (Vashisht et al., 2018). This study also highlights the cascading effects of menstrual restrictions on access to educational opportunities. Girls' and Women's inability to attend school during menstruation perpetuates educational disparities, undermining quality education. According to data from the World Bank, girls' menstruation might cause them to skip up to four days of school every month, which would account for 10–20% of their total school time and have a significant adverse effect on their academic performance. A study of school-age children in India revealed a variety of reasons for missing class during menstruation, including discomfort, heavy bleeding, and embarrassment. Some of the girls (3.7%) had their parents forbid them from going to school while they were menstruating (Vashisht et al., 2018). Our study also shows the prevalence of school absenteeism due to menstruation. This contributes to long-term academic gaps and limits life opportunities.

Globally, over 500 million women lack access to adequate menstrual resources. Many schoolgirls still face barriers to improved sanitation facilities, and some women are unable to work effectively due to insufficient toilet facilities. As a result, a significant proportion of menstruating women continue to use unhygienic materials (Amaya et al., 2020; Real Relief, 2016). Even when resources are available, feelings of shame discourage women from using hygienic materials. In Sub-Saharan Africa, women avoid drying reusable pads in the open spaces due to cultural stigma (Amaya et al., 2020). In Jumla, Nepal, some Brahmin women are forbidden from eating rice during menstruation (United Nations, 2020).

Menstruation was considered a powerful force in ancient Greece and Rome, where it was believed that a woman who was menstruating and exposed her body could ward off hailstorms, whirlwinds, and lightning. Mahatma Gandhi, the father of the Indian nation, had discriminatory views on sex and women and said that because of their sexuality, women's souls are distorted by menstruation. They automatically stop menstruation once their souls are pure (Tan et al., 2017).

Study shows that in the majority of Asian countries, the concept of menstruation is absent from public discourse, policy, and media. Individuals are often unaware and unempowered to control such unhealthy habits and, consequently, perpetuate these taboos. Data shows that globally, the majority of male members are in leadership positions. The report "Global Health 50/50," published in 2020, is a recent example that shows 70% of males occupied leadership positions in the health sector (Global Health 50/50, 2020). Understanding the level of menstruation from a male's perspective is different and limited because they are inexperienced and far from the experienced group. They want to focus on other sectors, such as health and well-being, by excluding menstruation. The level of awareness and

empowerment is insufficient at the individual level, and, from a leadership position, the influence of community members, their views, and actions are equally important in eradicating such taboos (Amaya et al., 2020).

Effective MHM is essential and includes access to absorbent materials, privacy, sanitation, education, and elimination of stigmas. It is directly related to the Sustainable Development Goals, including good health and well-being, quality education, gender equality, and access to clean water. Initiatives in Bhutan, where Non-Governmental Organizations (NGOs) developed puberty and menstrual hygiene materials for school-level students with the help of religious leaders, are transferring accurate information about menstruation (United Nations Children's Fund [UNICEF], 2018). Such initiatives help to influence social norms and religious restrictions regarding menstruation.

Evidence from Nepal shows that 8.5% of participants perceive menstruation as a curse. Mothers (66%) play a central role in transmitting menstrual knowledge. They also often encourage menstrual restrictions (72%). Brahmin women experience stronger sociocultural and religious constraints during menstruation than women from other caste groups (Mukherjee et al., 2020). Similar patterns are evident globally. Research from Australia shows that privacy concerns limit women's ability to purchase menstrual products. This restriction undermines menstrual hygiene management. Studies across several African countries further demonstrate that menstrual exclusion practices remain widespread and socially taboo (Pednekar et al., 2022). These restrictive norms extend beyond menstruation. In Chhaupadi, postpartum women are forced to remain in isolation for 10–14 days with their newborn. This practice possesses serious health risks to both mothers and infants (Robinson, 2015).

Together, this evidence confirms that Chhaupadi is not merely a cultural tradition. Instead, it is a deeply entrenched social phenomenon shaped by belief systems, misperceived norms, and unequal power relations. Addressing Chhaupadi requires multilevel interventions. These include legal enforcement, changes in community norms, gender-sensitive education, and women's empowerment (Tan et al., 2017). Only through such efforts can menstrual justice and gender equity be advanced.

Strengths and limitations

Strengths

1. The study uses a nationally representative dataset, ensuring robust generalizability within Sudurpaschim province.
2. A multi-theoretical approach (Health Belief Model, Social Norm Theory, and Gender and Power Theory) offers a comprehensive lens for understanding the persistence of Chhaupadi.
3. Findings contribute actionable insights for programmatic interventions, particularly in low-resource and rural settings.

Limitations

1. The study is limited to cross-sectional data and cannot establish causal relationships.

2. It focused only on one province (Sudurpaschim); thus, findings may not reflect practices and attitudes in other parts of Nepal.
3. The survey lacks qualitative narratives that could provide deeper insights into the motivations behind compliance with or resistance to Chhaupadi.

Conclusion

This study demonstrates that Chhaupadi remains a persistent public health and human rights concern in Nepal, particularly within the socioculturally marginalized communities of Sudurpaschim province. Despite the existence of legal frameworks prohibiting the practices, women in the study area continue to experience menstrual exile, indicating that criminalization alone has been insufficient to eliminate Chhaupadi. Findings demonstrate that Illiteracy, poverty, and rural residence significantly increase the likelihood of adherence to Chhaupadi, highlighting the multidimensional and structural nature of menstrual exclusion. These patterns highlight the enduring impact of social norms, religious beliefs, and gendered power dynamics on shaping menstrual practices. Efforts to eliminate Chhaupadi must extend beyond legal enforcement to address the underlying social and economic conditions that sustain menstrual stigma. Strengthening female literacy, promoting economic empowerment, and facilitating gender sensitive community engagement are essential strategies. Menstrual health management must be framed as a human rights and development priority to advance health equity, gender equality, and social justice in Nepal.

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