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# The Rann They Call Home: Salt, Silence and Survival: Menstrual Health among the Agariya Women of Gujarat

**Aanya Shah**
Aditya Birla World Academy

## Abstract

The study provides community-level baseline evidence on menstrual-health experiences within an underserved Agariya population, situated across Gujarat's Surendranagar district, in two villages: Shaktinagar and Dasada. These villages are located near the eastern region of the Little Rann of Kutch in Gujarat. This study finds substantial gaps in menstrual-health awareness and access to menstrual products, underlining issues like water scarcity, sanitation, healthcare accessibility, extreme heat and occupational demands. Cloth is the predominant menstrual material, because many Agariya women have limited awareness of sanitary pads, and inadequate access to menstrual-health facilities. The proposed programme recommends immediate community-based support through health kits, awareness sessions and female-led health camps. This will be complemented by the development of trained community members through the Salt Sisters programme and enhanced healthcare referral networks. Over the longer term, these efforts should be supported by improvements in water, sanitation and sustainable waste management, integrating these efforts into existing government health and livelihood programmes.

**Keywords:** Menstrual health, Agariya women, rural India, Rann of Kutch, Gujarat.

## Introduction

Among the many marginalised and vulnerable communities in India, the Agariya community in the Little Rann of Kutch, Gujarat represents one of the most underserved yet least studied populations. The term "Agariya" is derived from the Gujarati word "Agar," meaning salt farm, and refers to individuals engaged in the traditional occupation of salt farming. The Agariya community has been involved in salt production in the Little Rann of Kutch for over 600 years, preserving a livelihood that has been passed down through generations. They reside in their native villages during the monsoon and migrate to the Little Rann of Kutch for approximately eight months each year to produce salt. While Gujarat's coastal regions produce sea salt using seawater, Agariyas manufacture crystal salt, locally known as Vadagaru or Poda, using underground brine.[1] The community faces severe hardships including improper housing, less access to potable water, no electricity and food, and limited availability to facilities like education and healthcare, as highlighted by a recent Public Accounts Committee (PAC) report.

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[1] Agariya Heet-Rakshak Manch, "About Agariya," November 21, 2020, https://ahrmindia.org/about-agariya/.

Despite producing 76% of India's salt,[2] as said by President Draupadi Murmu, these people live in makeshift shelters for 8 months a year, where they toil endlessly in isolated salt fields under extreme weather conditions. Each season, they construct temporary huts near the salt fields, as both their shelters and salt pans are washed away during the monsoon, forcing them to rebuild their homes and livelihoods annually.

In the Rann, due to the unequivocal absence of schools, students learn in buses that act as makeshift classrooms. This was started by the Gujarat Government through an initiative known as "School on Wheels or Ranshala (Desert School). This elucidates not only the absence of schools but also the broader neglect of essential public infrastructure in the remote salt pans. Most Agariya families don't have any remote access to government welfare schemes. The 4,953 sq. km Little Rann, is known as India's "Survey Number Zero" because no land survey has been conducted here since the British left. Several attempts have been made by activists working in the region to get government officials to come and see the living conditions here. Yet, the majority of the Agariyas continue to live a life of virtual non-identity and are mostly paid poorly by middlemen for their labour.[3]

The entire Little Rann was notified as a wildlife sanctuary in 1973 and, since 2006, exists inside a wild ass sanctuary (Including the Agariyas, 2016). The forest department wants the Agariyas to leave, and claims that there are no more than 300 Agariya families, who will be rehabilitated if they agree to move out, clearly showing how the Agariyas don't even have any control over the salt pans, and don't possess land ownership of any kind.[4]




Figure 1: A Map of the Rann of Kutch.[5]

[2]Suchak Patel, "Agariya Salt Farmers of Gujarat's Rann of Kutch," *Frontline*, October 16, 2025, https://frontline.thehindu.com/the-nation/agriculture/agaria-salt-workers-gujarat-rann-kutch/article70138907.ece.
[3]Digital Empowerment Foundation, "Including the Agariyas," June 3, 2016, https://defindia.org/including-the-agariyas/.
[4] *Ibid.*
[5]Google Maps, "Dasada, Gujarat," accessed September 23, 2026, https://google.com/maps/place/Dasada,+Gujarat+363750/.



Figure 2: Images of the Rann of Kutch off & during Salt Season.[6]

Furthermore, the harsh working environment exposes Agariyas to extreme climatic conditions and several occupational health risks, including musculoskeletal disorders, skin diseases and eye problems. Menstrual stigmas and inadequate access to hygiene resources contribute to poor menstrual health, with 64% of adolescent girls in India experiencing at least one menstrual abnormality[7] - a burden likely to be amplified among Agariya women.

An average Agariya family of roughly six to seven members earns approximately 7000-1200 rupees per month during their 8-month active working season, however many falls below ₹5,000 due to debts and high operational costs. Financial exploitation due to their dependence on middlemen, limit their income to only 25–30 paise per kilogram of salt, despite its much higher market value.[8]

The Gujarat government has acknowledged its complete failure in ameliorating the plight of these women, despite various government schemes.[9]

**Literature Review**

Menstrual Hygiene Management (MHM) is one of the most fundamental components of a woman's health, well-being and dignity. Despite proliferating awareness of menstrual health as a public health issue, adequate menstrual hygiene management remains unequal across India and centred only in the urban areas. The National Family Health Survey (NFHS-5)

[6] Aanya Shah, "Fieldwork Materials from Shaktinagar and Dasada, Gujarat," unpublished fieldwork materials, June 2026.
[7] S. Biswas, A. Alam, N. Islam, R. Roy, and L. Satpati, "Understanding Period Product Use among Young Women in Rural and Urban India from a Geospatial Perspective," *Scientific Reports* 14, no. 1 (2024): 5, 7, doi:10.1038/s41598-024-70383-w.
[8] "Education in the Desert: Field Notes from the Little Rann of Kutch, Gujarat – Bhavna Harchandani," *Doing Sociology*, 2022, https://doingsociology.org/2022/04/10/education-in-the-desert-field-notes-from-the-little-rann-of-kutch-gujarat-bhavna-harchandani/.
[9] "Plight of Gujarat Saltpan Women: Govt Admits All-Round Failure; Kanya Kelavni Drive for Girl Education Flops," *Counterview*, 2015, https://www.counterview.net/2015/01/plight-of-gujarat-saltpan-women-govt.html.

demonstrates that access to hygienic menstrual methods is greatly influenced by education, income, infrastructure and.[10]

In recent years, recognising menstrual health as both a public health priority and a gender equity issue have led to initiatives like Menstrual Hygiene Scheme (MHS) launched under the National Health Mission.[11] This aims to provide subsidized sanitary napkin packs (traditionally named "Freedays") to rural adolescent girls.

For the Agariya women, the menstrual challenges are intensified due to the abhorrent conditions in the Little Rann, with the limited access to water, making menstruation management considerably more difficult than other rural groups. Despite playing a quintessential role in salt production while simultaneously managing household responsibilities, their menstrual health needs have largely been neglected in discussions of occupational health and community welfare. Addressing menstrual hygiene in this context is thus not only a health concern, but also a problem of gender equality, social justice and equal rights.

Notably, the unique menstrual needs of the Agariya women remain under-researched and unsupported by government initiatives. The Government of Gujarat has addressed menstrual health for its state under its Adolescent Reproductive and Sexual Health (ARSH) programme where counselling and management for menstrual concerns are provided to the adolescents. However, this program does not address the Agariya women and only focuses on the other areas of Gujarat. The absence of public health initiatives, government reports, or any evidence pertaining to the Agariya community leaves a wide research gap that this report aims to fill.[12]

While menstruation is a biological process, it knits together the souls of the Agariya women, becoming something sacred and symbolic in their shared sense of struggle. The constant systemic neglect they face, and impending climatic conditions have hardened these women, making them highly resilient towards their impoverished lifestyle. This report aims to show how ensuring equitable menstrual hygiene management and awareness will not only improve the women's physical and mental health, but also the long-standing cycle of marginalisation, neglect and socioeconomic exploitation for the rest of their lives.

## Methodology

The study was conducted in Gujarat's Surendranagar district, specifically in the villages of Shaktinagar and Dasada, which are situated near the eastern region of the Little Rann of Kutch. These areas serve as settlements for the Agariya community and is highly characterised by its arid landscape, geographical isolation, extreme climatic conditions and saline desert terrain, resulting in limited connectivity to services and towns.

[10] International Institute for Population Sciences and ICF, *National Family Health Survey (NFHS-5), 2019–21: India: Volume I*, International Institute for Population Sciences, (2021), 118.
[11] National Health Mission, "Menstrual Hygiene Scheme (MHS)," Ministry of Health and Family Welfare, Government of India.
[12] Mayur Trivedi and Bharati Sharma, "Marginalization of the Meal Makers: Ethnographic Observations of Salt Farmers and Workers of the Little Rann of Kutch in India," *International Journal of Advanced Research* 11, no. 1 (2023): 1441, 1444–1445, doi:10.21474/IJAR01/16162.

The survey was conducted in June 2026, employing a cluster sampling technique to reach exactly 54 women across both the villages. In Shaktinagar, 24 women participated in a questionnaire that addressed their medical history, menstrual practices and their preferred solutions. The study received a largely homogenous response pattern, with women using red cloth instead of sanitary pads, and a pervasive gap in awareness on pads and hygienic menstrual practices. Here, the study adopted a simple random sampling method, where every woman had an equal chance of being selected and getting interviewed. No bias was incurred, and the method ensured that the sample was representative of the wider population, proving its reliability and generalisability of the findings.

Since the participants were unable to converse in English, the survey was conducted in Gujarati, their native language. Each questionnaire was administered individually, with the researchers recording the participants' responses. The survey allowed a deeper understanding of the women's lived experiences surrounding menstrual hygiene, and providing a personal touch that wouldn't have been achieved if the survey was just unilaterally filled.

In the second village, Dasada, two Focus Group Discussions were held with 30 women, using predominantly open-ended questions to elicit in-depth responses. This enabled the participants to speak freely about their true perspectives in a more nuanced way. A Stratified Sampling technique divided participants into two age groups (15 women in the 20-65 years, and 15 women in the 65 years+). Participants spoke and interacted with the researchers, having tumultuous discussions on their livelihoods, menstrual practices and general wellbeing, which helped to obtain a more holistic comparison across the age groups.

Prior to data collection, all participants were informed about the purpose and nature of the study, and informed consent was obtained voluntarily from each participant. Participants were assured that their responses would remain confidential, and that no personally identifiable information would be disclosed. Permission to conduct the study was obtained from the relevant village representatives prior to the beginning of the data collection.

**Findings and Analysis: Shaktinagar**

The survey conducted in the village of Shaktinagar sought to understand menstrual health and hygiene experiences of women working in Lil Runn of Kutch. A total of 24 women were questioned on menstrual product use, frequency of use, water availability, sanitation and privacy, physical symptoms, experience of urinary or reproductive infections, sources of health support, access to information, and preferences regarding menstrual health interventions. The findings presented below combine the quantitative responses with observations recorded during the field survey.



Figure 3: Image of Women from Village 1, Shaktinagar.[13]

Types of Menstrual Products Used –

| Menstrual Product used | Number Of Respondents | % |
|---|---|---|
| Cloth | 17 | 70.8 |
| Disposable sanitary pads | 6 | 25.0 |
| Reusable pads | 0 | 0.0 |
| Other | 1 | 4.2 |
| Total | 24 | 100.0 |

Frequency of Menstrual Products Used –

| Frequency of Usage of Menstrual Product | Number of Respondents | % |
|---|---|---|
| Less than 2 times | 11 | 45.8 |
| 2- 3 times | 8 | 33.3 |

[13] Aanya Shah, "Fieldwork Materials from Shaktinagar and Dasada, Gujarat," unpublished fieldwork materials, June 2026, 3.

| | | |
|---|---|---|
| More than 3 times | 3 | 12.5 |
| Depends on water availability | 2 | 8.3 |
| Total | 24 | 100.0 |

Water Availability –

| Water Availability in the Rann | Number of Respondents | % |
|---|---|---|
| Always | 1 | 4.17 |
| Sometimes | 10 | 41.7 |
| Rarely | 12 | 50.0 |
| Never | 1 | 4.17 |
| Total | 24 | 100.0 |

Availability of Private Restrooms –

| Availability of Restrooms | Number of Respondents | % |
|---|---|---|
| Yes | 12 | 50.0 |
| No | 2 | 8.33 |
| Very limited | 10 | 41.7 |
| Total | 24 | 100.0 |

Health Symptoms Faced During Menstruation –

| Symptoms | Number of Respondents | % |
|---|---|---|
| Severe Pain | 10 | 45.5 |
| Heavy Bleeding | 8 | 36.4 |

| | | |
|---|---|---|
| Itching / Burning | 5 | 22.7 |
| Unusual Discharge | 1 | 4.5 |
| Fever | 2 | 9.1 |
| Weakness / Fatigue | 7 | 31.8 |
| None | 5 | 22.7 |

Note: Multiple responses were permitted; percentages therefore do not total 100%.

Experience of Urinary or Reproductive Infections –

| Experience of Urinary or Reproductive Infections | Number of Respondents | % |
|---|---|---|
| Yes | 8 | 33.3 |
| No | 12 | 50.0 |
| Not sure | 4 | 16.7 |
| Total | 24 | 100.0 |

Sources of Menstrual Health Support –

| Sources of Menstrual Support | Number of Respondents | % |
|---|---|---|
| Family member | 5 | 20.8 |
| Female Health Worker | 0 | 0.0 |
| Doctor | 1 | 4.17 |
| Traditional Remedy | 2 | 8.33 |
| No one | 16 | 66.7 |

| | | |
|---|---|---|
| Total | 24 | 100.0 |

Comfort and Openness in Discussing Menstruation –

| Comfort Levels | Number of Respondents | % |
|---|---|---|
| Yes | 2 | 8.33 |
| Somewhat | 7 | 29.2 |
| No | 15 | 62.5 |
| Total | 24 | 100.0 |

Access to Menstrual and Reproductive Health Information –

| Access to Menstrual Information | Number of Respondents | % |
|---|---|---|
| Yes | 8 | 33.3 |
| No | 16 | 66.7 |
| Total | 24 | 100.0 |

Information Participants Would Like to Learn More About –

| Information Needs and Preferences | Number of Respondents | % |
|---|---|---|
| Menstrual Hygiene | 13 | 54.2 |
| Pain management | 11 | 45.8 |
| Infections and symptoms | 3 | 12.5 |
| Reproductive health | 4 | 16.7 |
| Nutrition and anaemia | 3 | 12.5 |
| None | 3 | 12.5 |

| | | |
|---|---|---|
| Other | 5 | 20.8 |

Note: Multiple responses were permitted; percentages therefore do not total 100%.

Preferred Menstrual Health Support –

| Priority Support Needs | Number of Respondents | % |
|---|---|---|
| Menstrual Hygiene kits | 10 | 41.7 |
| Affordable sanitary pads | 12 | 50.0 |
| Better water access | 10 | 41.7 |
| Private changing/washing space | 2 | 8.33 |
| Toilets | 7 | 29.2 |
| Health camps | 8 | 33.3 |
| Female health workers | 12 | 50.0 |
| Awareness sessions | 5 | 20.8 |
| Pain relief medicines | 2 | 8.33 |

Note: Multiple responses were permitted; percentages therefore do not total 100%.

Willingness to Use Affordable Sanitary Pads –

| Preference for Sanitary Pads | Number of Respondents | % |
|---|---|---|
| Yes | 18 | 75.0 |
| Maybe | 1 | 4.16 |
| No | 5 | 20.8 |
| Total | 24 | 100.0 |

The quantitative findings from the field survey in Shaktinagar reveal that the observations are influenced by a combination of environmental factors, water scarcity, sanitation, access to healthcare, social practices and limited health information. The women construct their own makeshift toilets due to the lack of availability of restrooms in the empty terrain of the Rann. Additionally with much analysis, it should be noted that participants' perception of having “enough toilets” reflects a considerably lower threshold of adequacy than would generally be expected by conventional sanitation standards.

Clotting/tiny lumps, scanty bleeding, rashes, cuts, heat-related irritation, and cases requiring treatment for intense pain and itching are reported during field interactions. Additionally, one participant had undergone a family-planning operation, while another reported using contraceptives. One participant appeared noticeably pale, which may suggest possible anaemia, although this was not clinically assessed. One participant reported using a medicine referred to as CHC. Most women experienced itchiness and moisture due to the intense heat, commonly using Ponds or baby powder for relief. One participant reported unusually scanty bleeding, while itchiness, cuts, rashes, and heat burns were also frequently observed.

Some women reported restrictions on touching household utensils and entering certain areas of the house during menstruation. During the survey, one woman reported having undergone a vasectomy to suppress menstruation after having 5 kids. However, many highlighted the need for improved access to healthcare professionals, citing transportation barriers to nearby medical facilities. The Agariya women were very conscious of their environment and demonstrated strong environmental awareness, with many participants reusing the menstrual cloths over and over again to minimise waste accumulation. Consequently, those open to alternative menstrual products expressed a preference for reusable, biodegradable, and compostable pads, to prevent the pads from being discarded particularly because it could contribute to pollution and affect the local wildlife and animals. Women also expressed interest in greater awareness of dietary practices and traditional methods for managing menstrual discomfort, rather than having prescribed pills that were given to them, given concerns regarding the limited availability of qualified medical professionals in their area.

The absence of hospitals within the Rann means that urgent medical care often requires difficult travel to nearby villages, highlighting the need for accessible health camps and medical services. Menstrual pain, itching, and related discomfort appeared to be highly normalised among the women, reinforcing the importance of awareness sessions to help them recognise and address menstrual health concerns.

**Findings and Analysis: Dasada**



Figure 4: Image of Women from Village 2, Dasada.[14]

In Dasada, two large focus group discussions were held where detailed, and comprehensive conversations took place covering all aspects of menstrual hygiene of the Agariya women.

Across the participants, menstrual hygiene practices were largely consistent, with no reported use of sanitary pads. Most women used reusable cloth, either sourced from home or received as a supply of thick, absorbent red cloth. These cloths were reportedly reused for approximately 2–3 years through repeated washing, with women generally changing them when they bathed.

This absence of pad usage appeared to stem from a substantial gap in awareness, with some women unfamiliar their use and disposal. Additionally, the scarcity of local shops selling sanitary products highlighted the absolute exclusion of this community, which further lacked essential resources and facilities.

Despite this, the women expressed an eagerness to learn about and adopt sanitary products, indicating awareness and accessibility as important barriers. Some women approaching menopause reported irregular periods and reduced flow. Among the younger women, approximately 10–15 participants, there was a notable interest in awareness camps, health education sessions, and improved access to healthcare. Many reported backpain, fatigue, weakness, aching pain during menstruation; these symptoms were exacerbated by physically demanding workload and extreme heat. Burning and itching of the limbs were particularly common.

Menstrual cycles for most lasted approximately 3–5 days yet work in the Rann continued throughout menstruation. Women primarily learned about menstruation from their mothers and

[14] Aanya Shah, "Fieldwork Materials from Shaktinagar and Dasada, Gujarat," unpublished fieldwork materials, June 2026, 3,6.

commonly shared this information only with their husbands, reflecting discomfort in open discussions about menstrual health. Access to healthcare was deeply concerning, with no regular visits from medical personnel, women often must travel beyond the Rann for medical attention, even for urgent needs. There was a preference for female healthcare providers, as existing interactions left many feeling inadequately informed about treatments.

For menstrual pain relief, some women reported using Chanak, a painkiller provided by a healthcare worker, while others relied on cooling powders like Palkam for heat-related irritations. Severe water shortages were a notable issue, with only one tanker serving the area every 15 days (pertaining to both villages). The absence of sanitation facilities during the eight-month salt-harvesting season compelled women to construct makeshift toilets, emphasizing the extreme lack of hygiene support. Participants expressed a need for clean water, hygiene kits, awareness sessions, and enhanced healthcare access.

Educational resources were severely limited; women indicated that the teachers were transient and learning opportunities were scarce, with only one of approximately 12–15 younger women reportedly able to read and write in Gujarati. Makeshift schools were established using old, converted buses for education in the Rann. Throughout the discussions, the group displayed a casual demeanour when addressing menstrual challenges, frequently normalizing pain and discomfort as typical aspects of their experiences.

Among the older women, many had entered menopause and no longer menstruated but emphasized ongoing water shortages, with some bathing as infrequently as once a week. They coped with extreme heat through practical adaptations such as worn-out shoes and head coverings. Although government vehicles occasionally visited the area, healthcare access remained limited. Women articulated challenges in identifying vaginal infections, describing symptoms like excessive watering of the eyes, which they attributed to heat exposure. Pain relief through Chanak was also reported, alongside the consumption of lemon water to alleviate heat-related discomfort.

**Discussions and Key Insights**

The surveys and focus group discussions in the two villages highlight significant trends in menstrual health practices among Agariya women.

A notable observation is the limited knowledge of menstrual health, particularly regarding sanitary pads, which is primarily passed down through the women's mothers, rather than formal schooling. However, there is a marked enthusiasm for participating in health camps and awareness sessions, highlighting that the issue lies not in resistance to learning, but in the lack of access to informational resources. This aligns with existing literature that underscores how factors like seasonal migration and geographical isolation hinder educational opportunities, hindering their access to resources. The CESS study on Agariya salt-pan workers indicates that family migration severely affects education and literacy, leading to stringent access to the same.[15] Similarly, Deepti Gupta's ethnographic research reveals how migration disrupts

[15] J. Sathyapalan, A. M. Bhatt, P. S. Easa, J. T. Srinivasan, N. Shukla, P. Jog, and Centre for Economic and Social Studies, *Livelihoods of Agariyas and Biodiversity Conservation in the Little Rann of Kutch, Gujarat*, CESS Monograph No. 34 (2014), 21, 23.

children's education, emphasizing that the menstrual health practices stem from a paucity of resources and environmental challenges, rather than unsanitary habits.[16]

Since the Agariya salt-pan workers experience significant menstrual health challenges influenced by their harsh environment, extreme heat, a saline atmosphere, humidity, inadequate water supply and severe lack of toilets.

In the Rann, inadequate water supply complicates the washing of menstrual cloths, and women often work in extreme heat leading to rashes and infections. There are no hospitals in the Rann, and doctors or nurses don't come frequently to help the women. One of the major concerns is that some rely on medications given by healthcare workers without necessarily having adequate awareness about their use. The absence and difficulty in transportation leads to delayed care, further amplifying the problems.

Another very prodigious trend observed is the way menstrual discomfort was highly normalised. Most appear to regard these as ordinary and unavoidable aspects of life in the Rann, which hinder their recognition of when to seek medical help. This conditioning results in insufficient government support for their health concerns. Additionally, younger women (around 20–40 years) require more menstrual health education, awareness sessions, accessible menstrual products, and regular healthcare support. In contrast, most older women (45–70 years) had reached menopause and therefore faced different reproductive-health concerns, including limited awareness of vaginal infections and health issues associated with ageing. These differences suggest that health interventions must be age-specific to effectively address diverse needs.

Other notable trends identified include the impact of limited educational opportunities on awareness of menstruation among women who often rely on family for menstrual knowledge.

This lack of education leads to limited awareness of sanitary pads and reproductive health concerns. Enhancing community health literacy could aid women in addressing menstrual health issues. Trends such as menstrual stigmas also exist but they are not uniform, with one village hesitating towards discussing menstrual concerns, whereas the other villages were more openly discussing their problems and discussed it with people apart from only their husbands. This shows how menstrual stigmas vary across villages, which may be caused due to varying availability of education and other resources.

The findings of this study reveal that the menstrual health in the Agariya community is significantly influenced by interconnected factors such as education, socioeconomic status, access to menstrual products, sanitation, water availability, and healthcare accessibility. These findings indicate extreme marginalization, with women predominantly using cloth for menstrual absorbents. A cross-sectional study conducted among 700 women in rural Odisha found that 40.6% used cloth as absorbents, while 54.9% washed and reused their menstrual materials[17] reflecting a national trend among women in India. The research points to the fact

[16] Deepti Gupta, "Seasonal Migration and Everyday Lives of Children of Salt Workers from Little Rann of Kutch, Gujarat," *IASSI-Quarterly* 39, no. 3 (2020): 491.
[17] M. R. Behera, S. Parida, H. S. Pradhan, S. Priyabadini, R. K. Dehury, and B. Mishra, "Household Sanitation and Menstrual Hygiene Management among Women: Evidence from Household Survey under Swachh Bharat

that rural representation from other regions of the country receive recognition from municipalities and the government, however the same has not been done for the Agariya community, showcasing their extreme marginalisation and negligence.

Similar data can be found from national data from NFHS-5 (2019–21). Here, the study showcases the disparity in awareness and usage of hygienic products between rural and urban areas in India (International Institute for Population Sciences & ICF, 2021). Increasing education showed a stronger association: only 43.5% of women with no schooling used a hygienic method, compared with 91.2% among those with 12 or more years of schooling. [18] While these figures cannot be directly compared because NFHS-5 represents women aged 15–24 years nationally and does not separately identify Agariya workers, they do provide a crucial benchmark, and insight into the trends seen across India. Nevertheless, this difference seen between rural and urban areas nationally reinforces the fact that the geographical isolation and exclusion of the Agariya community is a strong cause for the stringent menstrual health resources.

An important difference also emerged again in the Odisha study, where 64.6% of participants reported disposing of menstrual materials in bushes or fields.[19] On the other hand, the Agariya women were environmentally aware, and wanted to reuse the cloth to minimise polluting the Rann and harm the wildlife. They had a strong preference for reusable, biodegradable and compostable materials which showcases their humbleness and connection to nature that only few communities possess in depth.

The present study reveals a significant gap in awareness and accessibility regarding sanitary pads among women in the surveyed settlements. Many women had limited knowledge of menstrual products, with some unaware of what sanitary pads are. The absence of shops offering these products highlighted the lack of resources. Notably, the women showed a willingness to change their habits, as several expressed eagerness to learn about pads and participate in awareness sessions. This suggests that the reliance on cloth is not due to resistance but rather a result of inadequate education and resources, affecting the Agariya community.

**Implications for Menstrual Health Interventions**

The findings suggest that appropriate menstrual-health interventions for the Agariya community should incorporate initiatives beyond just basic sanitary products and instead the focus should shift to addressing the greater health and environmental conditions of the women. The provision of menstrual-hygiene dignity kits containing menstrual products, basic hygiene supplies, medicines for common concerns such as itching, and some educational material should be arranged. Furthermore, reliable access to clean water and appropriate sanitation facilities should also be part of the intervention, as that is the root cause of menstrual infections which cannot be curtailed if the sanitation does not meet usual standards. Most importantly, regular health camps within and near the Rann in the villages can be conducted by qualified

(Clean India) Mission in Rural Odisha, India," *Journal of Family Medicine and Primary Care* 11, no. 3 (2022): 1104, doi: 10.4103/jfmpc.jfmpc_1593_21.

[18] International Institute for Population Sciences and ICF, *National Family Health Survey*, 118. https://dhsprogram.com/pubs/pdf/FR375/FR375.pdf

[19] *Ibid*, 13.

female healthcare workers which could integrate medical consultation as well as awareness sessions on everything that the Agariya women are required to know for a safe, well-informed menstrual lifestyle. This would ultimately reduce the need for the women to commute out of the Rann to nearby villages, preventing the disruption of health facilities, and just making life for them less arduous.



Figure 5: Housing conditions in nearby villages vs. in the Rann of Kutch.[20]

Existing menstrual-health initiatives could be strengthened by improving their reach into the Rann and nearby villages. Regular health camps could provide recurrent medical consultations, appropriate prescriptions pertaining to the specific individual needs of the women, menstrual-health education, and distribution of health kits. Furthermore, trained female health workers could gradually build trust and encourage the women to discuss sensitive concerns more openly, while also improving the awareness of the importance of menstrual health and measures to adopt during times of difficulty.



Figure 6: An old Agariya women in her village.[21]

[20] Aanya Shah, "Fieldwork Materials from Shaktinagar and Dasada, Gujarat," unpublished fieldwork materials, June 2026, 3, 6, 11.
[21] *Ibid.*

Since participants expressed concern about menstrual waste affecting the Rann and its wildlife, products should be selected in consultation with the women, with emphasis on comfortable, reusable, biodegradable and compostable options. Awareness programmes could also be tailored by age, as an exemplified pattern showcased the varying issues faced by women of different ages, with greater emphasis on menstrual education among younger women and reproductive and post-menopausal health among older women. Most importantly, the intervention should be designed with the women rather than simply for them. This is highly crucial because the health camps and sessions should focus on strengthening the aspects of menstrual health that require the most attention, which can only truly be recognised by the women going through it themselves. Female health workers should acquire a personal relationship with the women, allowing a sense of inclusivity and shared community to foster, which will enable the women to feel safer to express. Thus, incorporating the Agariya women's preferences in all interventions will create a more impactful, conducive and safer environment for them, increasing their willingness to participate in the initiatives.

**Conclusion**

Building upon the findings identified through the baseline study, a phased intervention framework aimed at improving menstrual health of the Agariya community is proposed catering to immediate, medium-term and long-term needs.

In the short term (0-6 months), the focus is on addressing the most immediate and tangible concerns that can be instantly supported from this study. Key strategies like distributing comprehensive Menstrual Dignity and Health kits, that contain reusable/biodegradable alternatives for pads, basic hygiene supplies, safe and medically suitable ointments or medicines for itches and burns, along with clean water and hygiene information provided in their language for daily use. These kits are intended to reduce infections associated with using unhygienic materials.

Furthermore, Awareness and Behaviour Change sessions, led by qualified female health workers should be conducted to highlight the importance of the crucial; necessity of complete knowledge on healthy menstrual practices and the right medications. Establishing Health Camps in the areas near the Rann will provide easy access to medical consultations and reduce the travel burden for accessing healthcare.

In the medium-term (6-18 months), efforts will shift towards building sustained community capacity and strengthening access to healthcare. A 'Salt Sisters' programme should be implemented that identifies and trains willing Agariya women to act as community health ambassadors in each village. Strengthening the community bond, and the support within the Agariya women will consequently spread more awareness, knowledge, and methods to improve menstrual health. Regular practical sessions addressing nutrition and health assessments will help identify and treat prevalent issues which often go unnoticed.

A stronger referral system linking the salt-pan settlements with nearby health centres hospitals should also be established, to expedite the access to needed medical care, minimizing delays in treatment and enhancing overall health outcomes. Addressing these challenges is pivotal for improving health awareness and laying the foundation for sustainable health improvements.

For the long term, the focus should be on systemic infrastructure improvements and eliminating barriers to menstrual health. This includes improving access to reliable clean water, bathing facilities, toilets and basic sanitation, particularly in areas occupied during the salt harvesting season. Additionally, an environmentally appropriate management system for menstrual waste should be developed to prioritise usage of sustainable products thereby minimising environmental impacts.

Furthermore, there must be advocacy for specific inclusion of seasonally migrating salt-pan communities within menstrual-health and welfare planning, as is integrating menstrual health initiatives into broader socioeconomic programs. Such integration will address the complex interacting factors influencing women's health, ensuring comprehensive support for the Agariya community's menstrual health needs.

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