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The Role of Government Schemes in the Social Mobility and Sustainable Development of Tribal Women: An Observation on the District of Purulia

Chandrani Bandyopadhyay
Department of International Relations, Jadavpur University, Kolkata, India

Corresponding Author: *Chandrani Bandyopadhyay

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Abstract

India is a geographically, socio-economically, and politically diverse and pluralistic democratic nation. Through the harmonious bond of "unity in diversity," India has maintained both the continuity and the dynamic nature of its social mobility. It is this continuous dynamism within the social system that has accelerated the pace of India's development. The participation of various social groups in this process of social mobility and development has rendered the system even more dynamic. The central theme of this article is to examine how various government schemes—aimed at fostering development while preserving social mobility—have sustained overall social dynamism and sustainable development by driving progress across socio-economic, political, educational, health, and human resource development indicators for tribal women. India is home to various marginalised groups, and the holistic development of the nation remains unattainable without their upliftment. With the objective of achieving comprehensive national development, the post-independence Indian government has launched numerous social schemes specifically targeting backward and vulnerable sections of society. These welfare-oriented initiatives serve to accelerate the momentum of social development. This article attempts a comparative analysis of several developmental schemes—implemented by both the Central and State governments in recent times—aimed at enhancing the social mobility of tribal women as a means of fostering national development. The article discusses how various schemes designed for the upliftment of tribal communities residing in marginalised areas—with a particular focus on women—play a pivotal role in enhancing women's capabilities. Through observations conducted among tribal women residing in the marginalised areas of underdeveloped districts—such as Purulia in West Bengal—this article evaluates the role of social mobility in the lives of tribal women.

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INTRODUCTION

In a traditionally patriarchal society like India, women are often seen waging a rigorous struggle to make their voices heard across social, economic, and political spheres—and even in matters of personal decision-making. In the post-independence era, various government welfare schemes have been adopted to foster the development of marginalised communities within this patriarchal social framework. The primary objective of these schemes has been the sustainable development of these vulnerable communities, aiming to accelerate their social mobility under state supervision. Within the framework of India's Five-Year Plans—and in adherence to international human rights laws—the government has placed special emphasis on the upliftment of these vulnerable groups. Particular stress has been laid on the development of tribal communities residing in specific regions of India. The government has directed special attention toward enhancing the capabilities of tribal communities living across ten specific states and designated regions of the country. Furthermore, emphasis has been placed on the health education, public health, and the overall welfare of women belonging to these tribal communities. However, in the interest of national development, gender equality and women's empowerment have consistently been regarded as top priorities. As a nation, the primary source of India's strength lies in its immense diversity. A vibrant and dynamic young generation is currently paving the way for the country's transformation into a developed nation. Access to good health, advanced sanitation systems, and the opportunity to practice essential hygiene are among the defining characteristics of a developed state. For women in India, achieving good health is of paramount importance and an absolute necessity; yet, it simultaneously presents a formidable challenge. 'Nari Shakti' (Women's Power) serves as an indispensable prerequisite for India's economic growth. In a global context, the UNDP's Human Development Report (2010) defines national development as a comprehensive concept that places particular emphasis on the importance of access to basic life services. However, women's empowerment should not be confined solely to making women economically self-reliant; rather, equal importance must be accorded to maintaining women's health—specifically, their reproductive and gynaecological health. This research paper focuses on how government schemes play a pivotal role in fostering the social mobility and sustainable development of tribal women.

Background of the Study

India is home to 104 million tribal people, constituting 8.6 per cent of the total population. There are 705 distinct tribal groups in the country. These tribal communities are primarily concentrated in ten specific states and the states of the Northeast region. A staggering 90 per cent of this tribal population resides in rural areas. Indeed, the majority of the tribal population across India lives in rural areas—specifically within 809 administrative blocks spread across 90 districts (Anustup, Sharadiya Issue, p. 388). For these tribal communities living in marginalised regions, there has been little significant progress regarding their socio-economic status, education, or healthcare infrastructure. Their average per capita income is substantially lower than that of the rest of India's population. India's Human Development Index is typically assessed based on per capita income. However, in a traditionally patriarchal society like India, the economic standing of women is comparatively lower. In a developing nation such as India, a vast number of women lack economic independence. Yet, within tribal communities, the scenario regarding employment presents a contrasting picture. Women belonging to tribal community's lag significantly behind in the sectors of education and healthcare. Furthermore, their participation in both government employment and self-employment initiatives remains low. Tribal women also lag considerably behind in terms of social empowerment. Consequently, when it comes to inclusive social progress and sustainable development, tribal women remain collectively disadvantaged. The majority of women in India dedicate themselves to domestic chores; as a result, their average per capita income is significantly low. Moreover, when viewed through the lens of human resource development indicators—specifically health, education, and economic empowerment—women remain considerably behind. This is particularly evident in marginalised regions, where the healthcare facilities and services required by women are woefully inadequate. Those tribal communities residing in marginalised areas are often deprived of access to public healthcare services. Although various studies have been conducted regarding the socio-economic status, employment, connectivity, education, and economic affairs of tribal women, the critical issue of their inclusive progress and sustainable development has, in many instances, remained neglected. The primary objective of this research is to examine how various government schemes play a pivotal role in the development process. Specifically, it aims to shed light on the significant contribution of the government's public welfare initiatives and financial assistance toward the upliftment of indigenous women in marginalised regions, as well as toward fostering inclusive social progress.

Theoretical Frameworks

Broadly speaking, while social development and social mobility serve as key development indicators, they are also deeply intertwined with various social, cultural, and gender-based norms that, within a broader context, shape the very manner in which social mobility is understood and experienced. Bajaj, R. Y., et al. (2025) emphasise that in India—particularly among indigenous communities—social mobility is frequently shrouded in a pervasive atmosphere of social stigma, prejudice, silence, and institutional neglect. Although the present study primarily focuses on indigenous tribal women, its theoretical framework adopts an inclusive, intersectional, and multidisciplinary approach. This framework integrates core principles drawn from 'Gender and Development Theory,' the 'Social Determinants of Health,' the 'Health Belief Model,' the 'Theory of Planned Behaviour,' 'Intersectionality,' and the 'Ecological Systems Theory.' Through the lens of the Ecological

Systems Theory, the study comprehensively illuminates critical aspects of indigenous communities in marginalised regions—specifically regarding their education, health, financial capacity, self-reliance, and social well-being—thereby analysing and evaluating the holistic development of the community from the perspective of social mobility.

Current Status of Education and Public Health Among Tribal Communities:

Tribal communities inhabit the most marginalised regions of India. The population of indigenous tribes is primarily concentrated across ten states of India, as well as in the country's northeastern region. In 90 districts and 809 administrative blocks within these states, the tribal population constitutes more than 50 per cent of the total inhabitants. Furthermore, 55 per cent of the total tribal population resides in these 809 blocks, where they constitute the majority. Many endangered tribal groups also reside within these specific blocks. In West Bengal, the concentration of indigenous inhabitants is highest across six districts. Among these, the districts of Jalpaiguri, Alipurduar, Purulia, Bankura, Jhargram, and Paschim Medinipur harbour the largest numbers of tribal people. Within these districts, the Nagrakata block of Jalpaiguri, the Bandwan block of Purulia, the Ranibandh block of Bankura, the Amlashol block of Paschim Medinipur, and the Gopiballavpur block of Jhargram district record the highest concentrations of indigenous tribal residents. Across various economic and educational indicators—particularly regarding access to social amenities—the status of tribal communities consistently ranks below the national average. Malnutrition among children and women is a widespread phenomenon in these tribal-dominated areas. During various phases of the Left Front's tenure, reports regarding the deaths of tribal individuals in these marginalised regions—attributed to severe malnutrition—were frequently published in various newspapers.

Compared to traditionally privileged social groups, the child mortality rate among indigenous populations has risen from 10 per cent to 38 per cent. The maternal mortality rate among tribal communities is comparatively much higher. Among tribal populations, the mortality gap for children under the age of five has widened from 21 per cent to 48 per cent. By late 2014, in several states with high tribal populations, the mortality rate for children under five was two to three times higher than in other states. Malnutrition, food scarcity, and a lack of the necessary infrastructure for proper pediatric care are primarily identified as the root causes of this high child mortality rate. By 2011, an estimated 146,000 tribal children under the age of five were dying annually in India (estimated based on the National Family Health Survey and the 2011 Census) (Anustup, p. 389). Malnutrition is cited as the primary cause behind these child and maternal deaths within tribal communities. Due to a lack of proper planning and medical guidance, pregnant women often suffer from nutritional deficiencies; consequently, the children they deliver frequently fall victim to malnutrition. Tribal families often find themselves unable to provide the specific types of nutritious food required during pregnancy. Furthermore, these communities are often deprived of essential public health services provided by the government during the maternal period. Additionally, malaria and tuberculosis are largely responsible for the mortality of children and women within tribal societies. Although tribal populations constitute only 8 per cent of the national population, they account for 30 per cent of all malaria cases in the country—a figure that exceeds 60 per cent in cases involving P. falciparum—and represent 50 per cent of all malaria-related deaths nationwide. In terms of economic loss, this amounts to approximately 6,000 crore rupees annually (Anustup, p. 390). Among the indigenous tribal communities of West Bengal, malnutrition stands out as a leading cause of death among children and women. Moreover, tuberculosis and malaria are significantly responsible for mortality within these groups. The prevalence of pulmonary tuberculosis among tribal communities is notably higher than in the rest of the country: 703 cases per 10,000 people, compared to 256. In tribal-dominated areas, indications of certain pandemic-related shifts are becoming apparent at the primary level; simultaneously, the prevalence of non-communicable diseases is on the rise. Indeed, one in every four tribal adults suffers from high blood pressure. Reports of deaths caused by malnutrition in the tribal regions of West Bengal first surfaced in 2004. The news of deaths due to food scarcity among the Sabar tribe in the Amlasole block of West Bengal sparked a major political controversy within the state (The Telegraph, August 23, 2006). Allegations of corruption were levelled against the then-ruling government regarding the proper distribution of food supplies officially provided to tribal communities through the public rationing system. Furthermore, in 2005, reports emerged regarding the death by starvation of a tribal woman named Parvati Sabar (30). In 2011, Danish researcher Oliver Rubel highlighted these issues in a research paper; subsequently, in 2013, two significant works were published: Deepak Kumar Bar Panda's Jangalmahale Adivasi Jiban: Amlasoler Dinlipi (Tribal Life in Jangalmahal: The Amlasole Diary) and Chandan Singh's Kindling of an Insurrection: Notes from Jangalmahal* (Anandabazar Patrika, August 19, 2017). These reports of malnutrition-related deaths ignited a heated debate in both national and West Bengal politics. Criticism mounted regarding government services concerning tribal malnutrition and public health. In the 21st century, the precarious state of public health among tribal women and children in West Bengal was starkly exposed, and these deaths were frequently likened to the starvation deaths witnessed during the Bengal Famine of 1943. These issues—specifically the rights to food and public health for West Bengal's tribal communities—generated immense public outcry, which opposition political parties at the time effectively brought to the forefront of public discourse through their campaigns.

Following the change of government in 2011, special emphasis was placed on early childhood development in the marginalised tribal areas of Junglemahal. Pregnant women in these regions were provided with nutritious food through Integrated Child

Development Services (ICDS) centres. Awareness campaigns regarding nutrition were also conducted among the tribal communities. Consequently, the rate of institutional deliveries—births occurring in healthcare facilities—increased in these areas. Furthermore, there was a rise in the number of women registering for government healthcare services during their menstrual cycles. In November 2018, reports of deaths due to starvation among the tribal population once again created a stir within political circles. News emerged regarding the unnatural deaths of seven individuals belonging to the Sabar tribe from Sabartala in the Lal Ghar area of Binpur-I Block, Jhargram district. Within a span of two weeks, the deaths of four young men, one middle-aged individual, and two elderly persons reignited allegations of deaths caused by starvation and malnutrition. On November 18, District Magistrate Aisha Rani told *The Indian Express* that attributing these deaths to starvation would be incorrect. She stated that two individuals had died from tuberculosis. Regarding the two adult deaths, she noted, "We do not know exactly how they died." She added, "I visited the area myself. There was food in their homes; I saw cooking in progress. They also possess ration cards." However, even if tuberculosis was the immediate cause of death, the incident starkly exposed the inadequacy of healthcare services available to the tribal communities. The government health centres lacked the specific medical services required by the tribal population, and the administration had failed to make adequate medical arrangements for them. Overall, the incident brought to light the systemic deficiencies in public health management for the tribal communities. In the education sector, the Government of West Bengal announced various initiatives. In particular, the *Kanyashree* scheme generated immense enthusiasm among tribal students. In marginalised areas, educational instruction in the tribal communities' own indigenous languages was introduced in government institutions. Additionally, through the West Bengal government's *Sabuj Sathi* scheme—which provides bicycles to students in marginalised areas—the dropout rate among schoolchildren began to decline. Furthermore, the free distribution of textbooks and notebooks, coupled with the introduction of instruction in indigenous languages, brought about a transformative change in the education system. Moreover, under various government schemes, financial stipends for higher education are now provided to young women over the age of 18. The *Rupashree* scheme—designed to provide financial assistance for the marriages of eligible young women—has played a decisive role in curbing child marriage within the tribal communities. In the Jangalmahal region, tribal women generate employment opportunities through various self-help groups. Consequently, a continuous process of social dynamism is observed, driven by advancements in education, healthcare, and economic empowerment among the tribal communities.

Pandemics and Public Health:

Tribal communities rely heavily on forests—and consequently on nature—for their sustenance. For these communities, the announcement of the lockdown proved to be an even greater threat than the coronavirus itself. Procuring food supplies became a formidable challenge for them. The nationwide lockdown, announced by the Prime Minister of India at 8:00 PM on March 24, 2019, was a harrowing experience for the tribal population. The majority of tribal people earn their livelihood by gathering firewood from the forests or by collecting Sal leaves to sell in the local markets. With the closure of markets and marketplaces, their ability to gather fuel or sell Sal leaves came to a complete standstill. On March 20, the Chief Minister of West Bengal announced that the government would provide free rations starting April 1. Those who possessed ration cards received some food supplies through official government channels. However, those indigenous people who did not hold ration cards were left to spend their days in starvation. Subsequently, it was announced that individuals without ration cards could submit an application—providing their names and addresses—to receive ration supplies. However, these supplies consisted solely of rice and wheat. Not only are the rice and wheat provided through rations insufficient to sustain a family for an entire month, but with their sources of income completely cut off, they were reduced to a dire situation where they would eat one meal a day and go hungry for the next. Eventually, as the distress reached a critical level, the Block Administration arranged for the distribution of vegetables, lentils, soybeans, and packets of soap to the most vulnerable villages. Furthermore, various voluntary organisations extended a helping hand to tribal villages during the pandemic by providing supplies of rice, lentils, and potatoes. A survey conducted in Purulia between April 4 and 6, 2020—examining the impact of COVID-19 on thirty Sabar hamlets (*tolas*) and thirty-three individual Sabar families—revealed that the majority of the Sabar people rely on daily wage labour; yet, none of them had received their wages. In other words, due to the outbreak of the coronavirus and the subsequent lockdown, work had ceased, and they had not received their wages for that specific month or week. Consequently, despite receiving rations, the indigenous tribal communities became entirely dependent on relief aid for their survival. The Feliya Sabar Kalyan Samiti made every possible effort to assist, while the Lokeswarananda I Foundation extended relief aid not only to the Sabar community but also to the most destitute families in remote villages across every block of Purulia. The food packages provided by the Nanritam and Lokeswarananda Foundation included staples such as rice, lentils, potatoes, and soybean oil; additionally, supplemented with sugar, they contained nutritional supplements specifically tailored for children and pregnant women. During the Left Front era, the public distribution system in the Jangalmahal region served 26.8 million beneficiaries. For adults living below the poverty line, the weekly ration allocation consisted of two kilograms of rice at a subsidised rate of ₹2 per kilogram, and 750 grams of fortified wheat flour for ₹5. This ration was available to individuals with an annual income of less than ₹24,000. Early in the Trinamool Congress administration, the ration system was expanded to include those tribal communities

in Jangalmahal whose annual income fell below ₹36,000; however, the allocated quantities and prices remained unchanged. Seven blocks in Birbhum, three in West Medinipur, four in Bankura, eight in Purulia, and the entirety of the Jhargram district were officially designated as the Jangalmahal region. Following the enactment of the National Food Security Act, 2013, the categorisation of beneficiaries eligible for subsidised rations underwent some modifications. Based on a socio-economic survey conducted in 2012, eligible beneficiaries were brought under the purview of the National Food Security Act. With the support of the West Bengal government, the total number of ration beneficiaries increased significantly during the COVID-19 pandemic. Consequently, the volume of rations received by tribal families saw a substantial increase, thereby providing a temporary resolution to their food security challenges. In the post-pandemic period, the State Government continued to distribute subsidised food items among tribal communities; this initiative not only alleviated their food shortages but also contributed significantly to reducing the rates of malnutrition among women and children.

Rural Health Workers in Promoting Women's Health Awareness:

In various marginalised regions of the country where healthcare services are inadequate, rural health workers play a pivotal and often singular role in addressing issues related to women's health. Female health workers provide various forms of counselling to raise awareness among tribal women. They offer valuable guidance regarding the social deprivations and stigmas that women often face during menstruation. In particular, they educate adolescent girls—especially those attending school—on a wide range of health-related topics. They provide advice on how to utilise traditional menstrual hygiene materials in a more sanitary and hygienic manner than is customary within the community. In rural areas—particularly in marginalised pockets—rural health workers serve as the primary counsellors regarding both menstrual health and mental well-being. Across various regions of India—especially in rural areas—' Self-Help Groups' (SHGs) are playing a crucial and transformative role in raising awareness about women's menstrual health and fostering hygienic practices. From creating safe spaces for open dialogue regarding menstruation—including its various complications and the deeply entrenched social superstitions and stigmas surrounding it—to organising workshops, training sessions, and peer-to-peer learning initiatives, SHGs empower families by educating them on menstrual hygiene and safe practices, reproductive health, menstrual disorders, and the distinction between common myths and scientific facts regarding menstruation. These efforts will undoubtedly contribute to achieving inclusive social progress, the benefits of which will be enjoyed by all women within tribal communities. The primary objective of this research paper is to critically examine and assess menstrual health awareness, traditional knowledge, and the importance of menstrual hygiene among adolescent girls in tribal families.

Findings from a Grassroots-Level Observation and Field Survey:

This study attempts to shed light on public health issues concerning children and women across various blocks of the Purulia district in West Bengal. To this end, a survey was conducted across two selected blocks—encompassing five Gram Panchayats within each block, and five villages within each Gram Panchayat—to provide a research-based overview of the public health status of tribal children and women in West Bengal. Furthermore, the study sought to examine how various government schemes relevant to these tribal areas have brought about transformative changes in the sectors of education and health. The survey conducted during the research period revealed that, during the tenure of the previous government, food scarcity was a major issue in most tribal villages. The government at that time had not undertaken any significant, constructive initiatives regarding food and nutrition. Due to the marginalised nature of these tribal regions, health centres were scarce across the districts and blocks in question. Consequently, the tribal population had to rely on distant district hospitals for healthcare services. Given that many of these communities resided in remote, marginalised areas, connectivity and transportation infrastructure for reaching the district hospitals were woefully inadequate. As a result, many children and women frequently succumbed to illnesses due to a complete lack of medical treatment. During the survey, Kabari Mandi (name changed) recounted that there were no health centres in her locality; consequently, most people died due to the absence of medical care. Food scarcity was a severe and pervasive problem in the area, and issues such as malnutrition among women and children, along with various recurring ailments, were constant afflictions. Currently, with the support of the State Government, a public rationing system has been implemented to address and resolve the issue of food scarcity. Through the "Duare Sarkar" (Government at Your Doorstep) initiative, government-provided food supplies are now being delivered directly to every tribal household. As a result, the problem of food scarcity has been significantly alleviated, thereby proving highly effective in combating nutritional deficiencies among women and children. Additionally, with the State Government's assistance, primary health centres are now able to provide regular health check-ups for children and women—along with necessary medications—making it possible to treat and cure various diseases. At present, in these tribal-dominated areas, malnutrition caused by food scarcity has declined significantly compared to previous times, and the scope of public health services—particularly primary healthcare—available to children and women has expanded considerably. Furthermore, various educational schemes introduced by the West Bengal government—such as "Sabuj Sathi" and "Kanyashree"—have received an overwhelming response among tribal students. Indeed, almost every tribal family has benefited from the assistance provided through these government schemes. As a result, the incidence of female feticide in this area has declined. The rate of school dropouts among young girls has also decreased. Furthermore, various

social superstitions within the tribal social structure have diminished significantly compared to the past, and the prevalence of child marriage has dropped considerably.

CONCLUSION

The foregoing discussion reveals that, in the post-independence era, the socio-economic condition of India's indigenous tribal communities was severely underdeveloped. Although the government adopted various measures at different times, these proved ineffective in practice. These tribal communities predominantly resided in the underdeveloped districts and marginalised blocks of West Bengal. During the long period of Leftist rule in the state, reports regarding deaths caused by malnutrition among West Bengal's tribal population frequently appeared in various media outlets. The government failed to play any substantive role in enhancing the social mobility of this vulnerable community. However, following the change of government, the new administration launched various public schemes aimed at the development of tribal communities, with a particular focus on the empowerment of women. These welfare initiatives introduced by the government garnered an overwhelming response among the tribal population. Consequently, tribal society is now transitioning from a traditionally underdeveloped social structure toward a dynamic and progressive developmental society. The government's welfare schemes are playing a pioneering role in driving the development of these tribal communities.

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About the corresponding author

Chandrani Bandyopadhyay was a Research Assistant and is currently working as a Financial Coordinator and Project Support under the Indian Council of Social Science Research collaboration with Jadavpur University, School of Media, Communications and Culture and Department of English. She has done her Master's from the Department of International Relations, Jadavpur University. She is engaged in academic research and study in international relations, with interests in global politics, diplomacy, and policy analysis, contributing to scholarly discussions and expanding understanding of contemporary international issues through her academic pursuits."