A RESEARCH REPORT FROM

BIHAR







PART 1 INTRODUCTION AND METHODOLOGY

Our study was conducted in the districts of Katihar and Khagaria. These districts falling under Niti Ayog's Aspirational Districts Programme (ADP)[1] have a scarcity of school and higher education facilities.

Both the districts share the commonality of socio-economic vulnerabilities such as poverty, relatively high school drop-out rates, illiteracy and with a large number of marginalized communities living in regions that experience floods and inundation each year. In both the districts the areas under research were remote and interior tribal and Dalit villages/ hamlets.

For completing our research data collection and analysis during April 2022- Feb 2023, ten villages of Katihar and Khagaria districts were selected for field research and surveys. Following a participatory and mixed-methods approach, information was sought and processed on the local situation on Menstrual Hygiene Management (MHM), Water Sanitation and Hygiene (WASH), education, health, livelihood, income and availability of support systems to women in the selected districts. Though both districts are doing well on many parameters under the ADP such as education, literacy & infrastructure, our study indicates that the districts have much to achieve in terms of combating the silences on MHM and on the inter-sectoral perspectives and wellbeing of **'Elder and Ageing Menstruating Women' (EAMW)**[2] and of school going menstruating girls. As our interaction also included women as mothers, teachers, counsellors and caregivers of young girls within schools and families, we have also included an analysis on the barriers, enablers & menstrual wellbeing of young school-going girls, though our primary focus remained on barriers, enablers & silences on the wellbeing of **EAMW.**

We collected ethnographic data on actors, practices and discourses with an inter-sectoral and analytical perspective on MHM in the areas selected. Water, Sanitation and Hygiene (WASH), availability of community support systems, availability of schemes and education; as well as what are the felt needs of menstruating women form a vital part of this research. Data was collected through field-work, interviews, Focus Group Discussions (FGDs) and observations on MHM through women's participatory voices and opinions. 856 interviews were conducted (433 women in Katihar and 423 women in Khagaria) using the Menstrual Practice Questionnaires (MPQs) to collect data, covering populations ranging from Muslims and Desi-Palias to Mushars and Maha Dalits. Interviews and interactions took place in local language, dialects and Hindi, in whichever the women felt comfortable.

Finally our findings from primary data are examined and crystalized against the voices of key informants, and delineate the context- specific and community-specific areas of improvement ending with recommendations on the short term and mid-term enablers for combating the inter-sectoral hindrances in proper MHM.

BIHAR

Bihar located in eastern India, is surrounded by Nepal in the north, West Bengal in the east, Uttar Pradesh in the west, and Jharkhand in the south. It has a unique location advantage being close to the vast Eastern and North Indian markets, access to Kolkata and Haldia ports, and to raw materials and minerals from neighbouring states. It has witnessed strong per capita net state domestic product growth. At current prices, its per capita NSDP grew at a CAGR of 10.73% (in INR) between 2015-16 and 2020-21 (IBEF, 2023). It is one of the strongest agricultural states in the country, and the percentage population employed in agriculture is around 80%, much higher than national average. It is the fourth largest producer of vegetables and the eighth largest producer of fruits in India. Food processing, dairy, sugar,

[1] ADP aims to improve the socio-economic status of the citizens with the core principles of Convergence of Central & State Schemes, Collaboration among citizens and functionaries of Central & State Governments and district teams, and Competition among districts (Niti Aayog 2018).

[2] EAMW are the Elderly and Menstruating women beyond their school years and adolescence falling in the ages between 20-49.

manufacturing, and healthcare are some of the fast-growing industries in the state. The state has planned for the development of education and tourism, and also provides incentives for information technology and renewable energy projects (IBEF, 2023).

1.1 KATIHAR

Katihar became a separate district in 1973, and is a part of Mithila region. In 2011, Katihar had a population of 3,071,029 (males 1,600,430 and females 1,470,599, sex ratio 919 per 1000 male), with average literacy rate 52.24%, (male 59.36% and female 44.39%). The average national sex ratio in India is 940 (Census, 2011).

The district has severe water contamination with the source mainly hand pumps. The water of this district may be categorized as "hard water", and has lead concentration in the range of 0.112 mg/L to 4.91mg/l, fluoride and Fe3+ in the range of 0.004 - 0.012 and 0.40 - 1.27 mg/l respectively (Krishna, Singh & Mandal, 2009). The lead is responsible for kidney damage, neuro- problems, and mental retardation in children in the district and the low fluoride is responsible for a large number of dental caries. The very high value of iron is responsible for staining of teeth due to iron deposition on enamel, and of clothes and utensils. (Krishna, Singh & Mandal, 2009).

Ministry of Panchayati Raj in 2006 named Katihar as one of the country's 250 most backward districts, and is one of the 38 districts in Bihar receiving funds from the Backward Regions Grant Fund Programme (BRGF). It has also been included in the ADP of Government of India since 2018, to improve its socio-economic indicators. The District Administration of Katihar set up *Jeevika Yuva Paramarsh Sah Sansadhan Kendra* (JYPSSK) under ADP to support migrant workers. JYPSSK is a centre for employment and income-generating activities, focused on counseling the youth, and providing resources to support them (Niti Aayog, 2020). In various blocks, livelihood clusters and producer groups for cattle-rearing, bamboo crafts, jute crafts, protective masks, honey and mushroom production have been set up. Migrant workers' families have been provided loans to start activities like fishery, piggery, household dairy and agriculture-related works, and running shops (Niti Aayog, 2020).

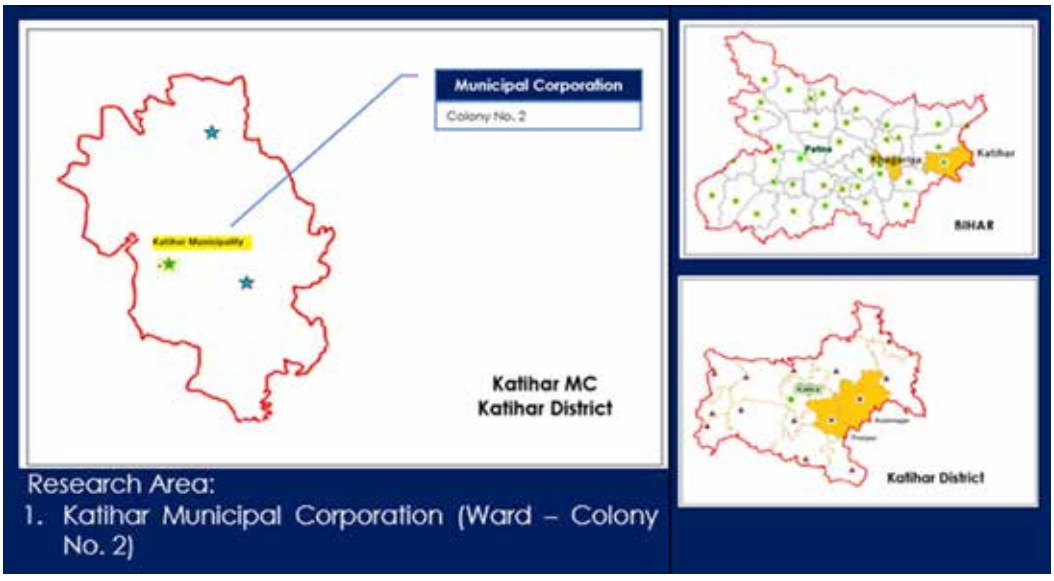
1.2 KHAGARIA

Khagaria district was a subdivision of Munger district, upgraded to a district on 10th May, 1981. In 2011, Khagaria had a population of 1,666,886 (males 883,786 and females 783,100, sex ratio 886 to 1000 males), with an average literacy rate of 57.92% (males 65.25% and females 49.56%). The average national sex ratio in India is 940 (Census, 2011).

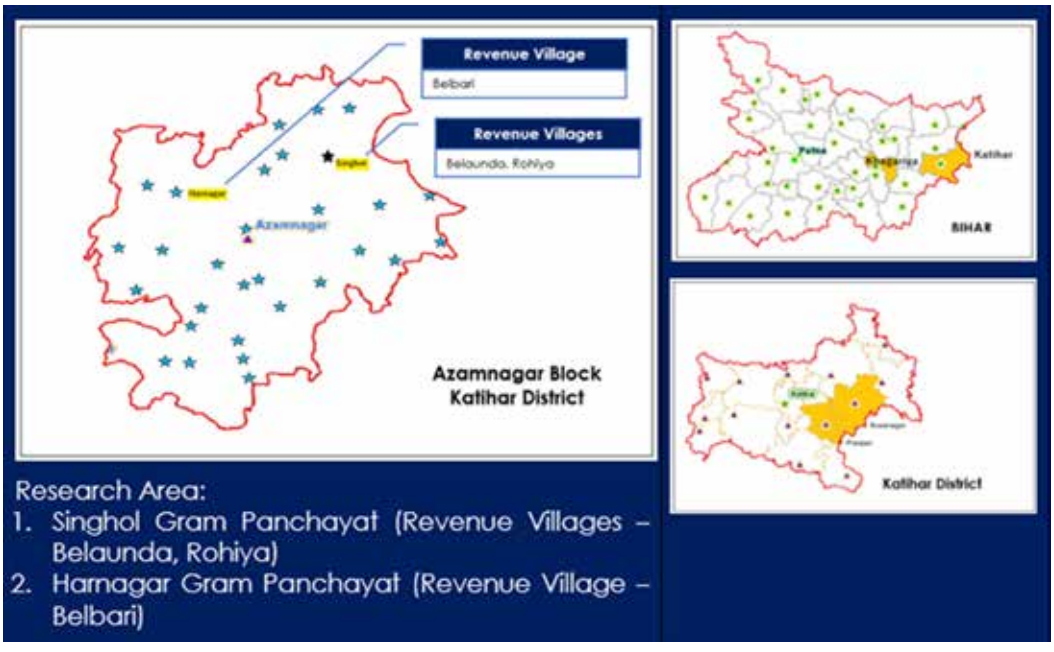
Recurrence of floods is an annual affair with five major rivers – Ganga, Gandak, Bagmati, Kamala and Koshi passing through the district. Recurrence of floods and water logging makes communication extremely difficult in rainy season and affects accessibility to health infrastructure. Under the Government of India (GOI)'s ADP, Khagaria is working on special elevated health centers for flood affected areas (Kumar, 2022). On the development front, the district secured second rank in the country in the Niti Aayog's Delta ranking on various parameters. The district performs well in the field of health, nutrition, education, agriculture, irrigation, skill development and infrastructure (The Times of India, 2022).

1.3 LIST OF VILLAGES SELECTED

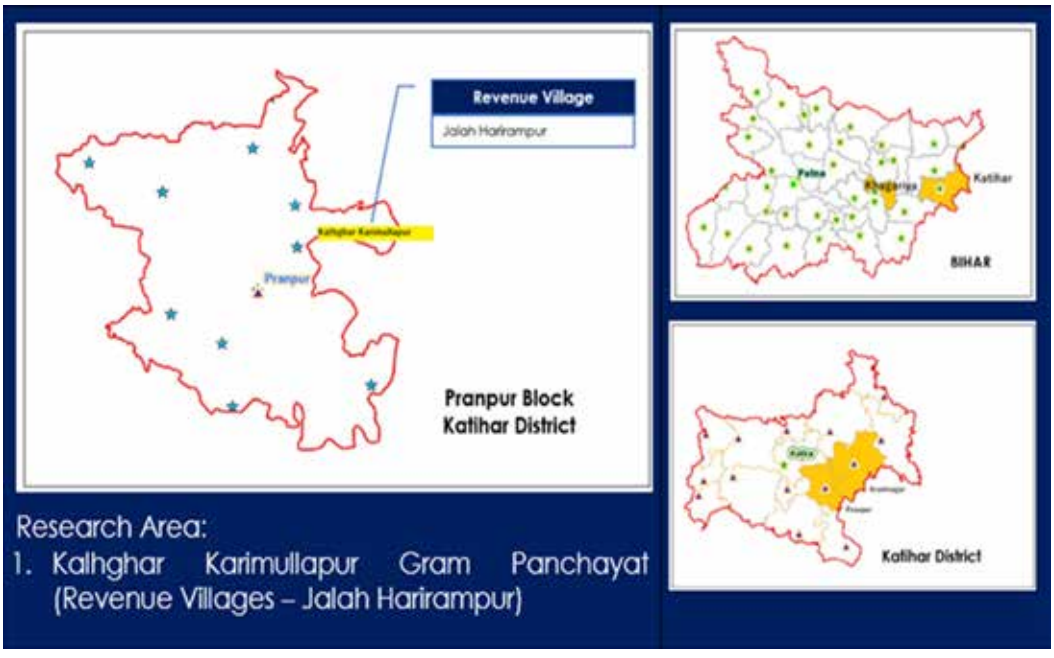
Five villages from each district were selected based on access to minority-focused villages, scarcity of safe drinking water, migration due to rainfed land, unskilled labourers, etc. In Katihar, three villages were selected from Azamnagar Block, one village from Pranpur Block and one ward in Katihar Municipal Corporation Colony No. 2. In Khagaria, four villages were selected from Mansi Block and One Village from Khagaria Block.



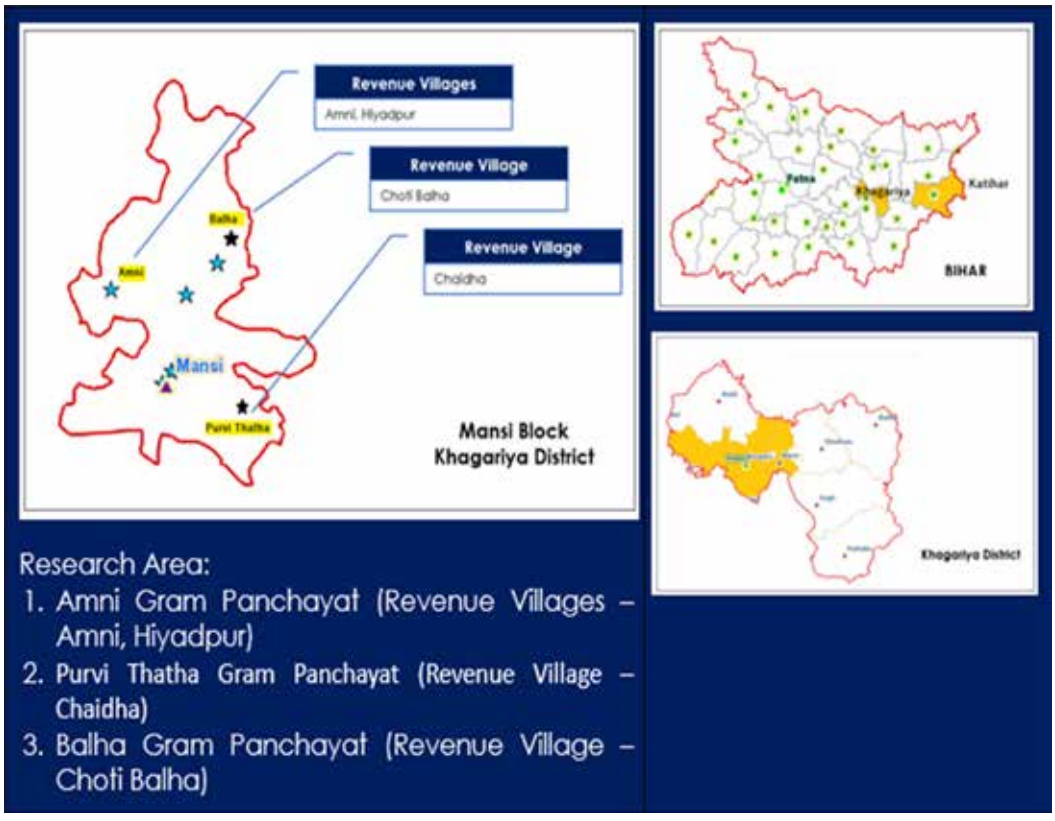
Research Area:
1. Katihar Municipal Corporation (Ward – Colony No. 2)

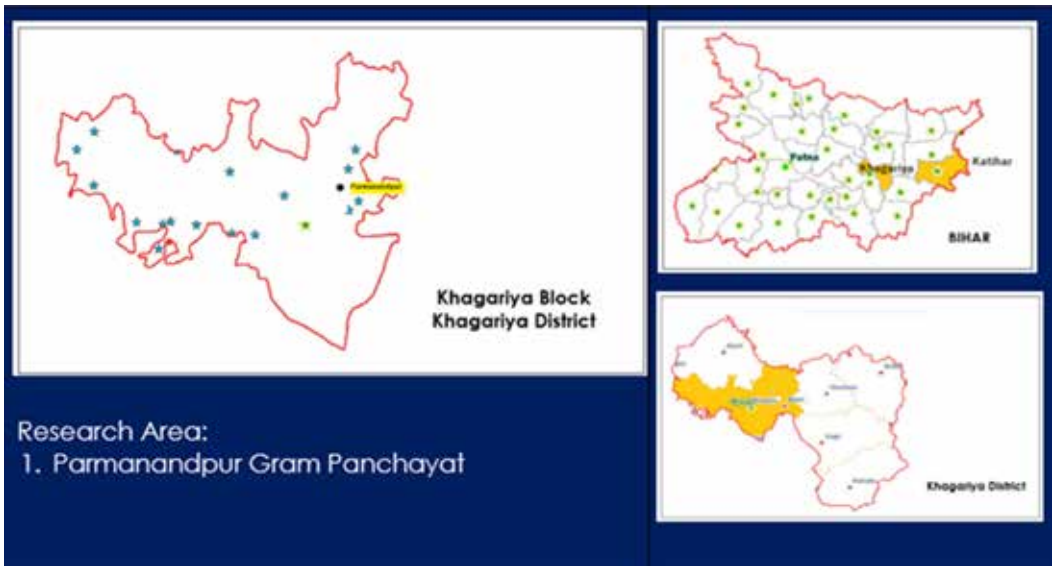


Research Area:
1. Singhol Gram Panchayat (Revenue Villages – Belaunda, Rohiya)
2. Harnagar Gram Panchayat (Revenue Village – Belbari)



Research Area:
1. Kalhghar Karimullapur Gram Panchayat (Revenue Villages – Jalah Harirampur)





PART 2 DATA TOOLS

2.1 RESEARCH TOOLS, METHODS AND THEMATIC FOCUS FOR DATA COLLECTION, CORRELATIONS AND COMMUNITY-BASED ANALYSES

Types of Interviews- Tools and Focus	Data Collection and Analysis- Methods and Themes	Bihar	
		Khagaria	Katihar
Tool 1 Menstrual Practice Questionnaires (MPQs)	Method 1 The MPQs were In-depth Interviews (IDIs) for- actor, discourse and practice- analyses	423	433

Tool 2 Menstrual Practice Needs Scale (MPNS)	Method 2 Measurement of perceptions and needs based on the last menstruation cycle	73	48
Tool 3 Key Informant Interviews (KIIs)	Method 3 Voices, Excerpts, Salient Findings and Observations	12	12
Themes: WASH, Education, and Health, Livelihood	Focus: Inter-Sectoral findings and conclusion and comparisons		

PART 3 FINDINGS FROM MPQs AND MPNs

3.1 ACTOR ANALYSIS

In this section, socio-economic profile as well as the current menstruation status of the actors is detailed.

3.1.1 DEMOGRAPHIC PROFILE OF THE RESPONDENTS

Demographic Profile	Katihar (in %)	Khagaria (in %)
Total Respondents	**433**	**423**
Peri-urban	10.4	2.8
Rural / Tribal	71.1	71.2
Urban	18.5	26.0
Mother Tongue		
Angika	0.0	99.5
Bengali	0.5	0.0
Hindi	46.4	0.0
Rajvanshi	6.2	0.0
Surjapuri	45.3	0.5
Urdu	1.6	0.0
Religion		
Hindu	81.5	99.8
Muslim	18.5	0.2
Caste/ Tribe type		
General	29.3	0.2
OBC- Other Backward Caste	64.2	4.3
SC- Scheduled Caste	4.2	33.8
ST- Scheduled Tribe	1.8	0.2
Demographic Profile	**Katihar (in %)**	**Khagaria (in %)**
MBC	0.0	11.3
BC	0.5	49.6
PVTG- Particularly Vulnerable Tribal Group	0.0	0.5

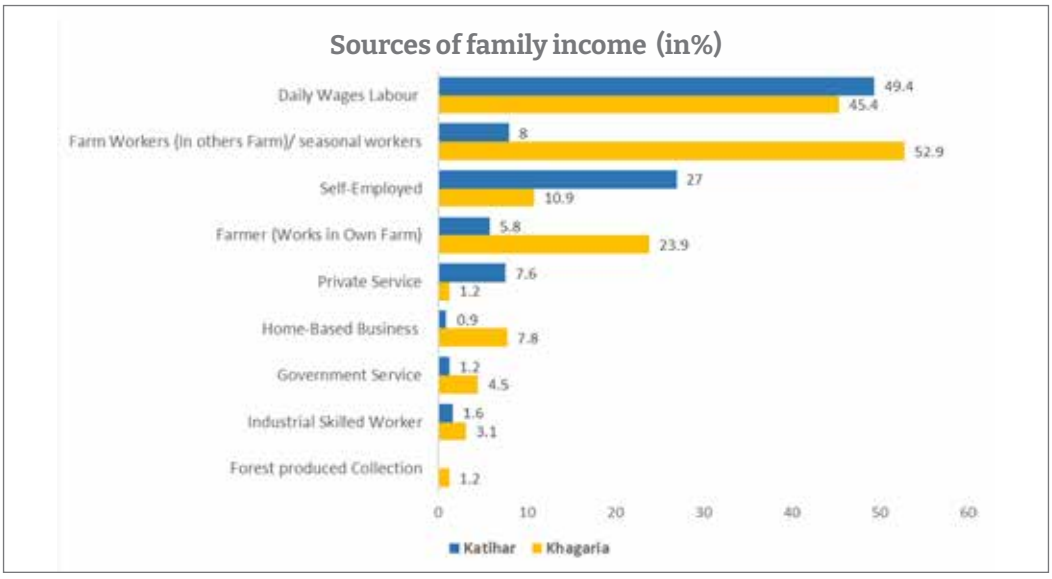
Marital Status		
Never married	3.5	0.7
Married	93.3	95.3
Widowed	3.0	3.8
Separated	0.2	0.0
Divorced	0.0	0.2

- **Community:** In Katihar almost two third respondents i.e. 64.2% were OBCs followed by General caste 29.3% and 6.5% were SCs, STs and BCs. In Khagaria, 49.6% were BC followed by SCs (33.8%) and OBC/ MBCs (15.6%) and few interviewees from General, ST and PVTGs. Specific Caste categories in both districts were as follows: General (Baniya), OBCs (Dhobi, Kahar, Koiri, Kumhar, Nhai, Thakur, Vaishya, Yadav, Kurmi), BCs (Dhanuk, Halwai, Julaha, Kalvar, Kanu, Kosare, Kushbah, Pasi, Tiyar), SCs (Badhai, Dusadh, Gurar, Musahar, Rajvanshi), and ST/ PVTGs (Gouri, Kahar, Santhal).
- **Marital status:** 94.3% of our respondents were married. The average age at marriage in Katihar was 19 years whereas in Katihar it was 17 years.
- **Children and Family Size:** Average number of children was three and the average family size was five persons.

3.1.2 AVERAGE INCOME

- **Family income:** In Bihar, median income in Katihar was in the range of 100000 INR- 150000 INR whereas in Khagaria it was found to be in the range of 75000 INR- 100000 INR. Half of the families earn from regular income sources. 53.1% of families from Katihar and 26.7% families from Khagaria derived their main income as daily wagers and unskilled workers
- **Earning women:** One-fourth of our women respondents i.e., 26.5% from Khagaria and only eight women (1.8%) from Katihar work outside and earn money, out of those six were earning in the range of 50000 INR-100000 INR per year. From Khagaria, out of 112 earning women, almost two third of women (64.3%) were earning only up to 10000 INR yearly. Whereas merely 10.7% of respondents were earning above 50000 INR per year.

3.1.3 SOURCES OF FAMILY INCOME

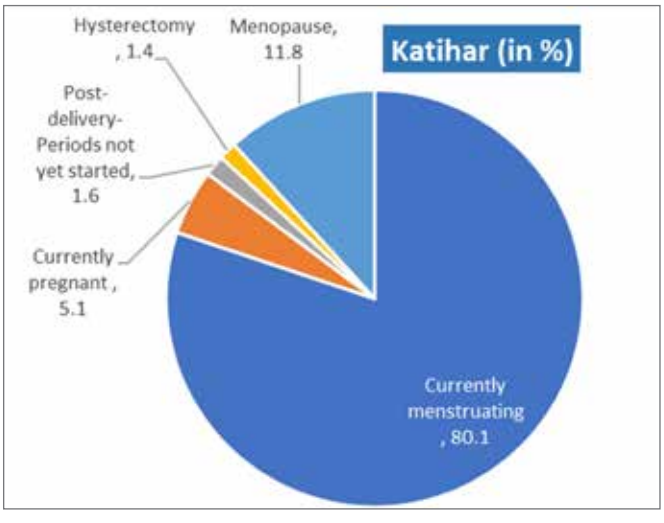


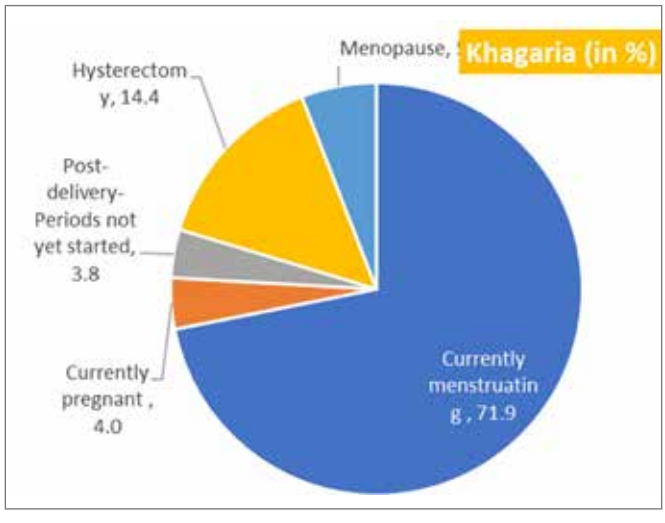
INCOME TRENDS:

- **Income Disparity in Districts:** Due to the flood-prone and/or rehabilitated areas in both districts, coupled with overall small size of farms, around half of the total families surveyed were dependent on wage-labour work.
- **Sources of Income in Katihar:** In Katihar families of 406 women (n= 433) surveyed, relied mostly on daily wage labour work. Seasonal work was confirmed by 138 families as the next major source of income followed by farming as stated by 25 of our respondents. However, 200 women also confirmed that these income sources were complemented by self-employment as a secondary source of income for their families.
- **Sources of Income in Khagaria:** Main source of income for families of 101 women (n= 423) surveyed in Khagaria was farming on their own land. In order to complement their main source of income, some families also relied on incidental labour-work (that could be agricultural or daily wages related) just as for some this kind of work constitute their main and only source of income as confirmed by 289 respondents. Seasonal work was stated by another 127 as a main or supportive source of income. Apart from this, 79 respondents informed that they also earn through home -based business.
- **Traditional Knowledge and Skills**: Out of total 856 respondents in Bihar, 198 respondents possessed traditional skills. Out of these 198 only, 38 respondents earn from their traditional skill-sets and knowledge. In Katihar, of the total 433 women surveyed, only 15 possessed traditional skills but none of them earned from the same. 183 women out of 423 from Khagaria reported that they possess traditional skills. Out of these, merely 38 earn from their skills.

3.1.4 MENSTRUATION STATUS

- **Total EAMW**: 86.8% (376 women) from Katihar and 79.7% (337 women) from Khagaria were in their active menstruating years.
- **Age at Menarche:** Average age of menarche was 13, whereas the average age of attaining menopause was 45 years.
- **Number of Hysterectomies**: More hysterectomies were found to have been done in Khagaria than in Katihar, with the average age at hysterectomy being around 33 years.





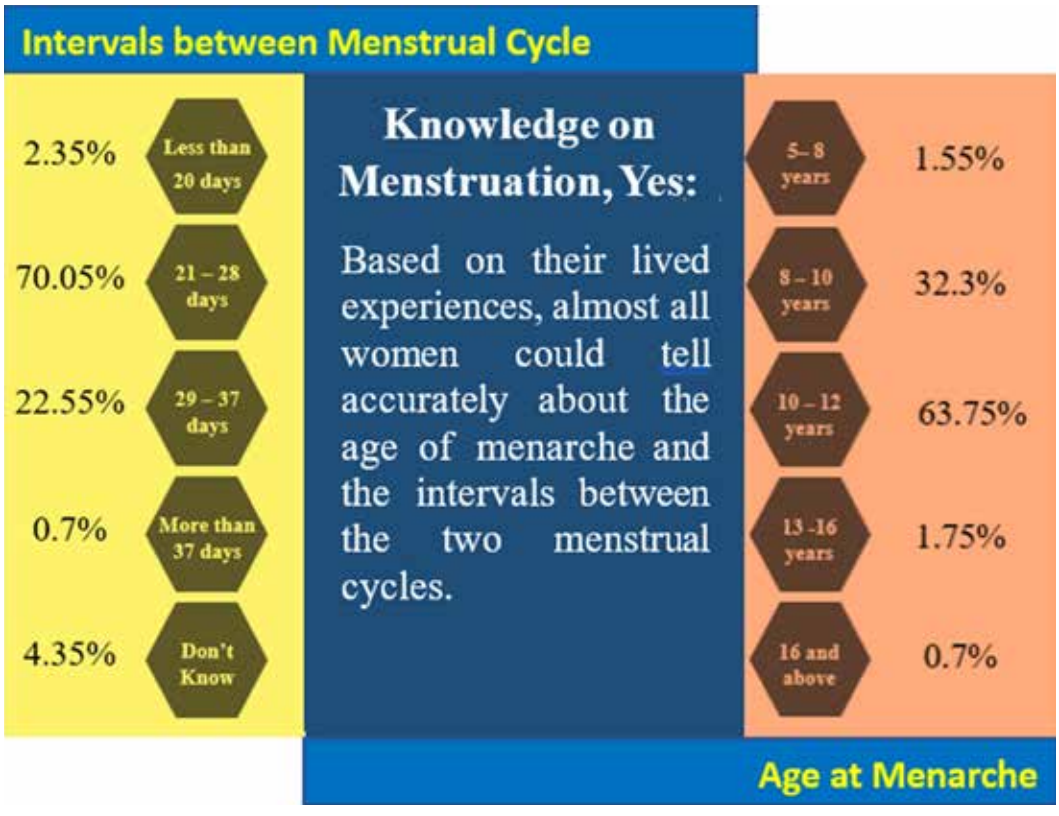
3.2 DISCOURSE ANALYSIS

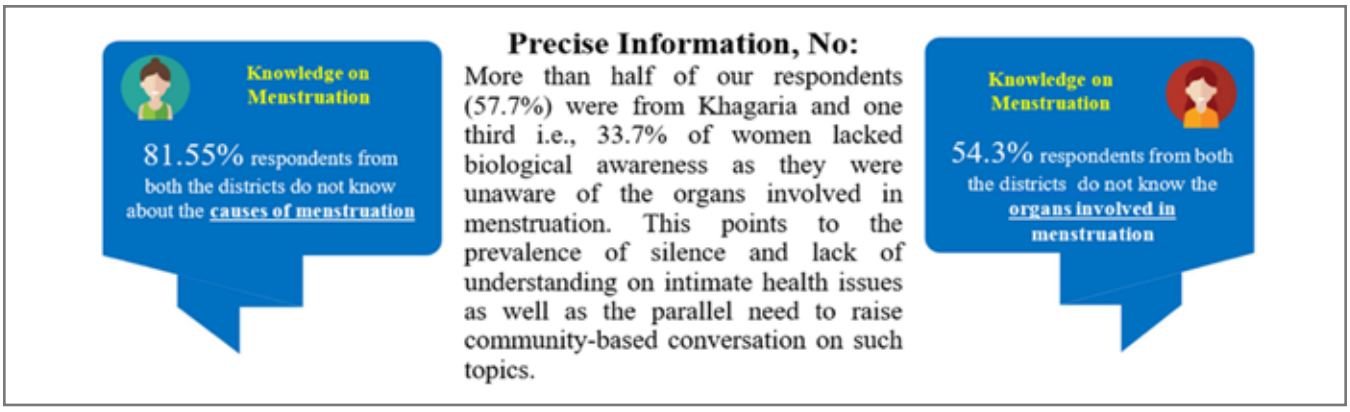
Our findings relate to levels of knowledge that respondents profess on the cause of menstruation, organs involved, and analysis of their discourses. Information from the In-depth interviews (IDI) were used to understand how much general and precise comprehension women have on menstruation as a monthly body

process. Further, we present our findings on the extent of communication or silence around the theme, with whom and how much they discussed, the issues experienced and their general observations on MHM. We also present data on educational backgrounds of women, how the women position themselves on medical care options and facilities available/ not available and their awareness on use and disposal of menstrual absorbents, health risks as well as common disorders and symptoms they experience during menstruation and hysterectomy.

3.2.1 KNOWLEDGE ON MENSTRUATION

Knowledge About Menstruation	Katihar (in %)	Khagaria (in %)
Total Respondents	**433**	**423**
Causes of Menstruation		
Hormonal change	12.0	24.8
Disease	0.0	2.8
Do not know	88.0	71.6
Natural process (naisargik/ prakrutik/ bhagwan ki den)	0.0	0.7
Organs Involved in Menstruation		
Uterus/ Birth canal	33.7	57.7
Abdomen/ Bladder	44.6	5.2
Do not know/ not answered	21.7	37.1





- **Basic Understanding: Four out of every five women (i.e. 684 out of 856 women) could not talk about the causes of menstruation. However, 92.6% of women could talk about menarche and the intervals between two menstrual cycles based on their lived experiences.**
- **Biological information: 33.7% of women from Katihar (n=433) and more than half of our respondents (57.7%) from Khagaria (n=423) lacked biological awareness as they were** unaware of the organs involved in menstruation. This points to the prevalence of silence and lack of understanding on intimate health issues as well as the parallel need to raise community-based conversations on such topics.

Knowledge gaps need to be bridged through government initiatives alongwith information exchange programmes and community dialogues with active menstruators in the age group of 19/ 20 years to 49 years. Frontline health workers at local level can play an active role.

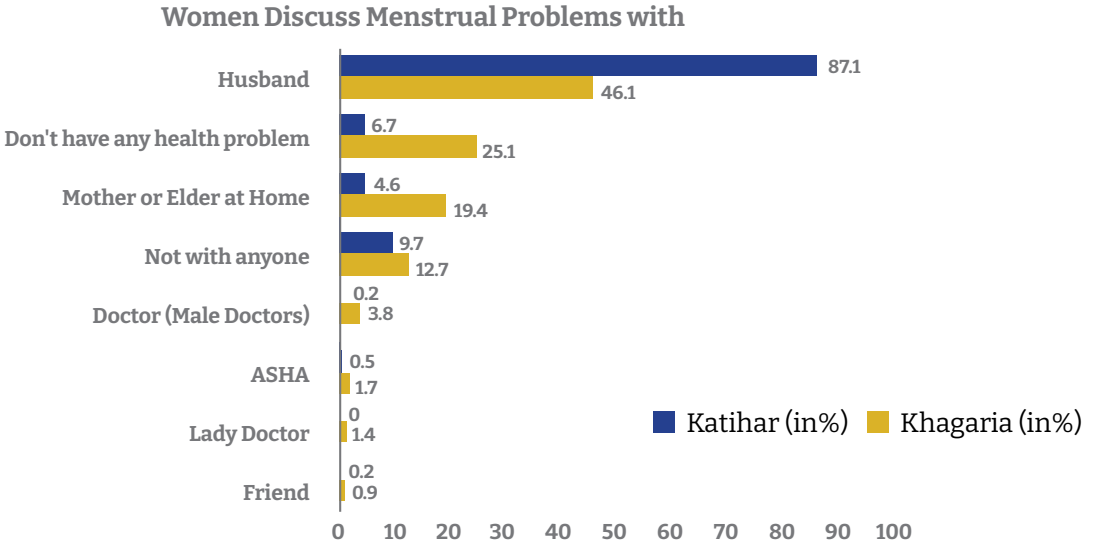
3.2.2 SOURCE OF INFORMATION ON MENSTRUATION

For young girls the top sources of information on menstruation emerged as follows:

- Top sources of information for young girls about menstruation at the time of menarche reported from both districts were parents, grandmother, sister, or sister-in-law.

Women like to discuss their menstrual problems with the following:

- **Friends:** Neighbours or friends were top sources with whom MHM related information and issues were discussed, as quoted by 89 women in Khagaria.
- **Frontline Health Workers (FHWs):** Only 29 women (6.9%) from Khagaria and very few, i.e. 3 women from Katihar, approached health support systems in the village regarding their problems on vaginal and menstrual health.

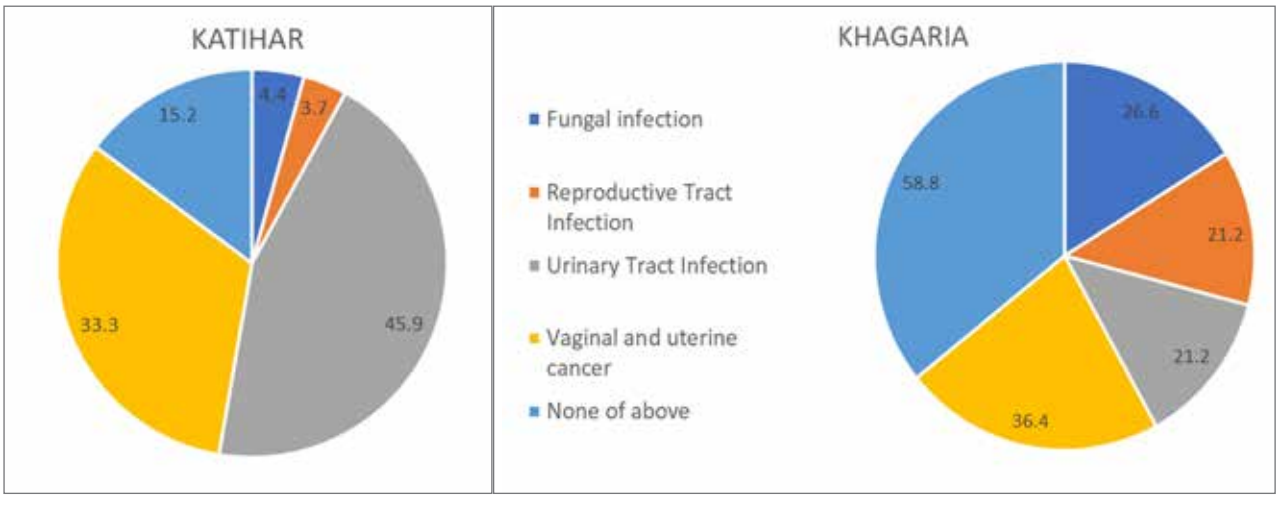


- **Spouses:** A critical finding that presents encouraging information on interpersonal relations was that 195 women from Khagaria and 377 from Katihar feel comfortable talking about menstrual problems with their husbands. If men can be oriented and stay alert and helpful on their wives' MHM issues, that would bring a positive health outcome for EAMW, besides combating the silence on it.
- **Nobody:** However, 5 of our respondents from Katihar and 46 from Khagaria either do not prefer to talk with any one and remain silent about their menstrual problems. 29 women from Katihar and 106 from Khagaria denied having any problems w.r.t MHM.

3.2.3 MENSTRUAL HEALTH, EDUCATION AND AWARENESS ON INFECTIONS

Apart from the use of different menstrual products, the study presents data on health problems which were experienced during menstruation. It was further verified whether they visit the doctor in case of any health issues or prefer to keep quiet. Adverse working conditions in or outside the home may lead to rashes, urinary tract infections (UTIs), and reproductive tract infections (RTIs) for many women, as indicated by our survey findings.

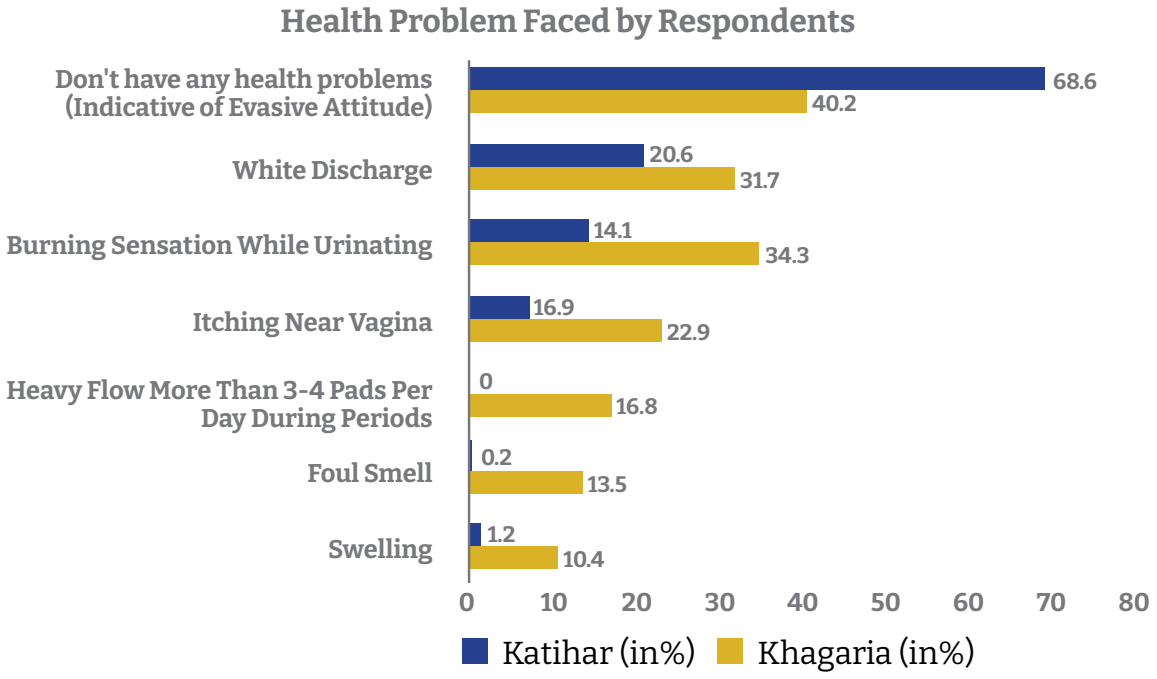
- **Widespread Ignorance**: When asked about the negative effects of poor menstrual hygiene, 15% of the women from Katihar (n=433) and almost half of the women (49.2%) from Khagaria (n=423) did not know.
- **Fungal Infections and UTIs:** However, when asked specific questions on topical infections, 14.4% (N=856) of the total women interviewed in both the districts, were aware that poor MHM could lead to fungal infections and some had also experienced these or recognised these as medical problems. Yet, in comparison to Khagaria where more than half of the women i.e., 58.8% (n=423) could not answer any query regarding compromised MHM and prevalence of infections, better responses were given by women from Katihar where 213 women (n=433) stated that poor menstrual hygiene leads to UTIs/ RTIs and another 150 stated that it leads to vaginal and uterine cancers.



- **Low knowledge on exact health risks:** Adverse health conditions while working in or outside home often lead to rashes, Urinary Tract Infections (UTIs) and Reproductive Tract Infections (RTIs). However, our findings indicate a lack of awareness on these risk factors. Not being able to understand or give answers on the relationship between MHM and rashes, infections and other risks, indicated ignorance per se.
- **No Schooling, Taboos and Communication Barriers:** However, given that speaking about periods itself is a taboo subject due to shyness/ hesitancies, therefore any generalization on awareness on MHM may be misleading. Community and area specific conclusions are a better way ahead. Around 26.2% women of both districts did not attend schools. 46% attended only up to secondary grade/ seventh standard. In other words, all these women lost the opportunity to be counseled or educated on MHM as part of school curriculum. EAMW participants in our study either were shy to speak or lacked the desire to know more about menstruation and thus effectively remained silent.

3.2.4 HEALTH SYMPTOMS DURING MENSTRUATION

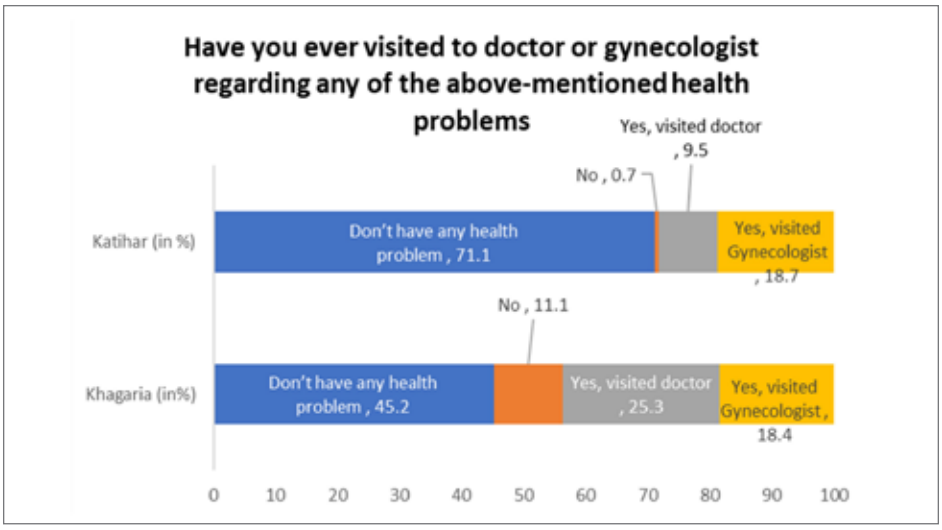
The actors reported the following symptoms and discomforts they suffered during menstruation:



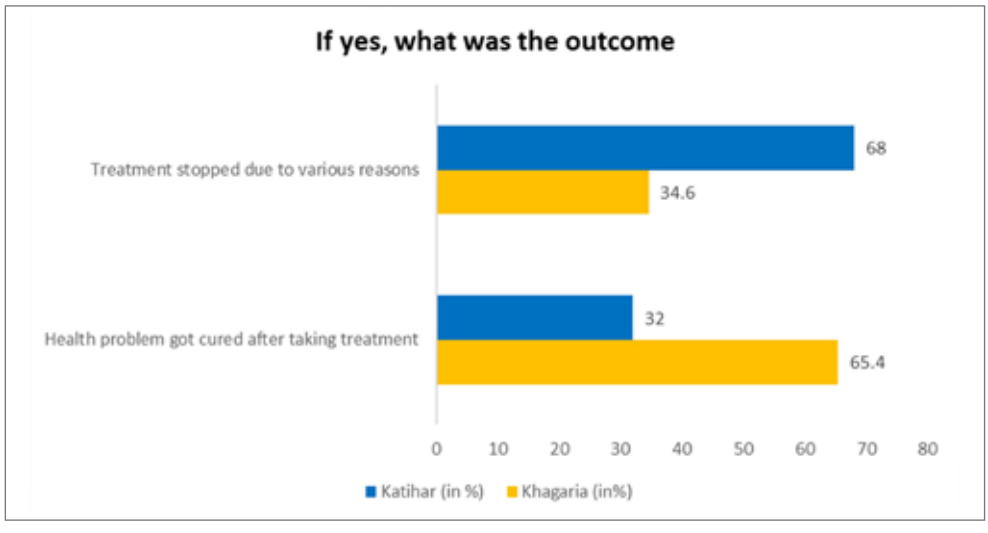
- **MHM, health and accessibility to health care**: Apart from the modes as well as patterns of awareness on MHM, the survey imparts light on the health problems undergone by participants during menstruation. For arriving at inter-sectoral findings on health management, women were asked if they visit a medical professional to resolve menstrual health issues and reasons if they do not.
- **Vaginal symptoms and attitude:** More than two thirds (68.6%) of the EAMW (n=376) from Katihar and 40.2% of respondents from Khagaria (n=337) reported that they did not have any health problems during menstruation. However, in the later part of the survey, white discharge, burning sensation while urinating, and itching near vagina emerged as the top three issues women faced due to poor vaginal hygiene. One third women reported seeking medical advice over menstrual health problems and half of them visited a doctor and got treated and cured.

Indeed, if health issues during menstruation are not resolved, and pushed to the peripheries or remain shrouded in silence, women have much to lose in social, economic and personal spheres. For combating health and hygiene related silences on periods among the EAMW, the government healthcare system must tune itself to hear their voices. In 'Excerpts and Voices', we bring community-based views and suggestions from women over this issue.

- **Consultations on MHM:** Out of a total of 856 women, 499 women (58.3%) from both districts reported that they did not have any health problems during menstruation. Out of the remaining women, 122 from Katihar (n=433) and 185 from Khagaria (n=423) reported that they went to a doctor in case they faced any kind of menstrual health problem.
- **Treatment:** Only 160 women out of the total 307 who took medical consultations in both the districts, got treated and cured. 121 women from Khagaria as compared to 31 in Katihar recovered after medical treatment. 42 women from both the districts reported that they were still under treatment for menstrual health related problems while 105 women in both Katihar and Khagaria had stopped their treatment owing to monetary barriers.

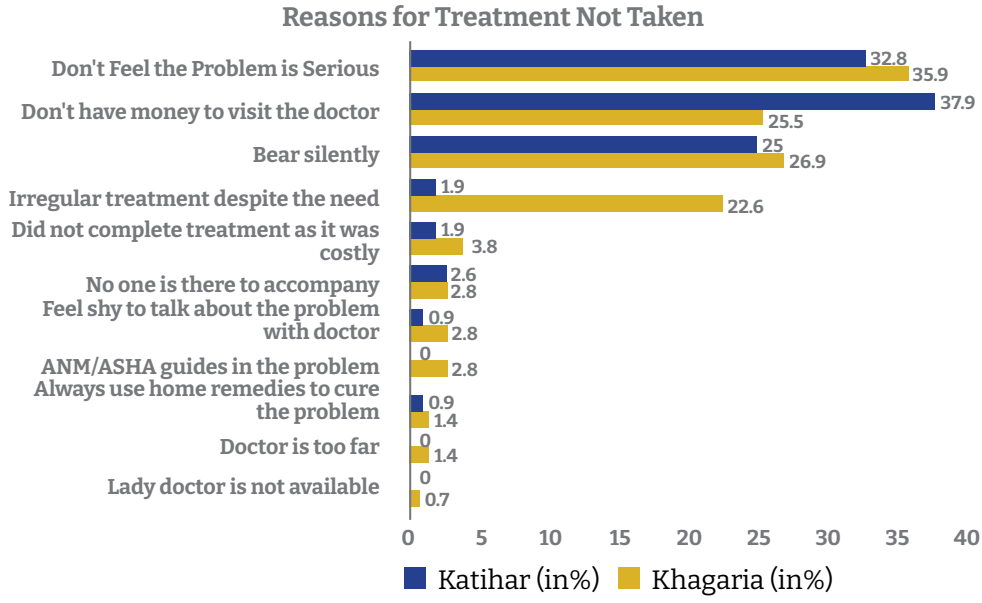


- **Neglect, hesitation and Silence:** EAMW in Katihar, despite having a better knowledge on menstruation tend to neglect health issues related to it more than the women in Khagaria, who are less informed on the issue. Nonetheless the barrier on knowledge and information exists in both the districts. This barrier is further exacerbated by the hesitation to speak on menstrual health and inability to seek medical advice on a regular basis, due to a number of reasons including poverty.
- **Medical Care, Access and Unaffordability:** Out of a total of 307 who started treatment on menstrual health related issues, 81 women (45 from Katihar and 36 from Khagaria) left their treatments incomplete due to various reasons, specially due to unaffordability. Another 24 women stopped the treatment completely because of accessibility. Rest of the 103 women, despite needing regular treatment, pursued it sporadically owing to its high cost.



Not even half of the women from these 2 districts (n=307) who needed treatment could reach a doctor for treatment and only half who reached could afford to complete the treatment. While some do not have access to healthcare, others stop the treatment due to monetary problems. Women who did not approach the doctor despite need, gave reasons such as 'do not feel the problem is serious', bear silently, feel shy to talk to male doctors where a lady doctor is not available nearby. When medical facilities are located faraway women refrain from accessing these as there is no one to accompany them, others use home remedies or rely on support from local health workers. 37.9 % women in Katihar and 25.5% from Khagaria indicated that the lack of money-in-hand was a huge deterrent to visit a doctor or pursue MHM.

3.2.5 REASONS FOR NON-TREATMENT



- **Ignorance: The main reason from 32.8% from Katihar and 35.9% from Khagaria, for not going to the doctor or gynecologist was they did not feel that the problem they face is serious.**
- **No money was the second major reason. This contributes to not talking or discussing the problem with anyone unless it becomes unbearable.**
- **No Lady doctor/ Gynaecologist: Lack of access to doctors is also a reason, specially if a lady doctor is not available nearby.**
- **Attitude (Shyness and Silence): Women feel shy to discuss the problems related to menstruation with a doctor. A total of 26% from both districts reported to bear silently and not avail treatment**.

3.2.6 HYSTERECTOMIES

In comparison to the other six states in our study, namely, Assam, Chhattisgarh, Haryana, Maharashtra, Odisha and Tamil Nadu, cases of hysterectomy at 7.8% of total respondents in both districts from Bihar, were on the higher side. Out of 856 women surveyed in the two districts, 67 had opted for hysterectomy, with 60 receiving pre and post operative counselling. 18 out of these were at the average age of 33 years, which is a very young age for such a procedure.

- **Biological Causes:**Anomalies related to menstrual cycle such as weakness due to heavy bleeding (23), irregular periods (17) and frequent periods (13) were reported in combination with other severe causes as the main cause for removing the uterus. Abdominal pains during menstruation and cramps were reported by 39 women followed by white discharge (8), Severe Pelvic Inflammatory Diseases (PID) (3), and prolapse of the uterus (5).
- **Socio-economic Causes:** Out of 61 who had undergone hysterectomies from Khagaria, two women stated that they did not find the uterus as an important part of the body after having children, another two considered periods as a hurdle while working outside and five could not afford losing daily wages as loss of stamina during menstruation made them take frequent unpaid leaves.
- **Preference to Private Hospitals:** Only 6 women out of 433 from Katihar reported having undergone uterus removal surgeries, and out of these, only 1 was operated in a government hospital, the rest all in private hospitals. Likewise, only 14 out of 61 hysterectomies from Khagaria were done in government hospitals. Women preferred to choose private hospitals because of pre-operative counseling (28), and wanting to get rid of the problem immediately (22). 23 women reported that private hospitals were convenient to reach, good for treatment (22), and were recommended by experience of family members (16), and therefore better. They indicated that access to the nearest health care facility is preferred. Average expenditure for hysterectomies in Katihar was 53000 INR and in Khagaria was 40019 INR.

- **Health Post-Hysterectomy:** Out of 67 women who underwent hysterectomies, 64 faced weakness post hysterectomy, and 47 said they are not able to work like before. 35 women stated that they were unable to lift heavy objects post-operation. Anemia (26) and backache (4) were also reported. In general the women opined that their life had became complicated after the operation,

Our findings on hysterectomies in Khagaria and Katihar indicate many women suffer serious uterine health risks due to poor personal hygiene and menstrual health issues. Others face pressures due to their husband-wife teams *(Jodis)* working together, that push women towards uterus removal. This is akin to what happens in the case of the sugarcane farming in Maharashtra. Moreover, misconceptions about uterine relevance post-motherhood abound. Further, proper MHM requirements cannot be met in exploitative labour situations due to encumbrances placed by inadequate WASH facilities. Marginalized women face complex challenges regarding their reproductive wellbeing, often leading to hasty hysterectomies. **Good MHM of EAMW should become a vital part of labour laws, and community health awareness drives.**

3.3 PRACTICE ANALYSIS

Good menstruation practices start with the usage of clean menstrual absorbents alongwith maintenance of reproductive hygiene. We studied the practices in personal hygiene such as washing genitals and hands during menstruation as well as use and disposal of menstrual hygiene products. We also bring data on how personal and community-based beliefs, customs and taboos influence MHM and self-care. Our data from Katihar and Khagaria revealed that traditional methods of MHM are preferred over pads etc, by the majority of EAMW from vulnerable sections.

- **Cloth:** Out of the total of 713 EAMW interviewed from both districts, 56.7% use only cloth during menstruation, due to easy availability, affordability and durability (161 EAMW in Katihar and 240 EAMW in Khagaria). There was also lack of awareness about modern menstrual products. Lack of financial capacity to buy MHM materials make free availability of menstrual hygiene products a better option.
- **Other Material**: Reusable sanitary pads were used by 8 and re-useable cotton/ other menstrual absorbents by 4 respondents out of a total of 713 EAMW surveyed (this totals to only 1.7% EAMW using reusable sanitary pads or cotton).

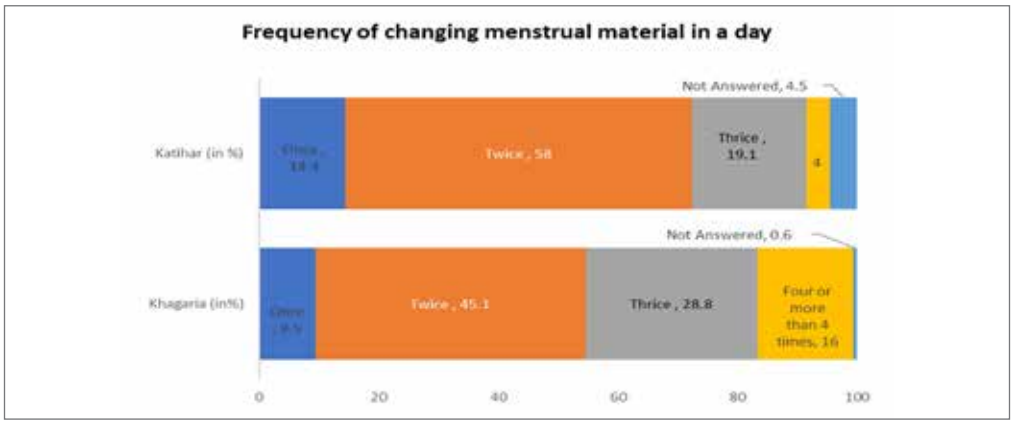
- **Combination of Pad and Cloth:** 401 (i.e. a majority) use cloth in combination with sanitary pad. The reasons behind it were mainly that cloth was more durable and easily available than pads, and was home-based and re-useable. Affordability was also the main reason for preferring cloth over pads in Katihar (reported by 63.8% of women). In both the districts, women have also stated that they need a supply of clean, traditional absorbents such as cloth during floods as even these home-based materials become difficult to get when regions become submerged.

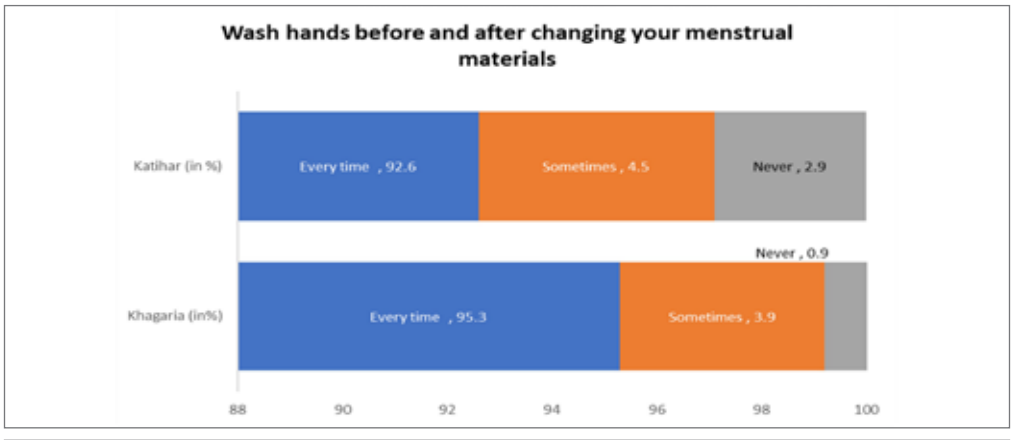
Choice of menstrual absorbents depends not only on attitudes and preferences, but also on the level of information and orientation that societies have on handling MHM. Culture, poverty, disasters as well as decision making all play a role in deciding how a woman opts to deal with MHM. Sanitary pads, for instance, were used by 232 EAMW from Khagaria and 130 from Katihar, but pads were used in combination with cloth as 75.6% from the total EAMW felt that cloth is easy to use, readily available, affordable and durable, making it a favorable choice.

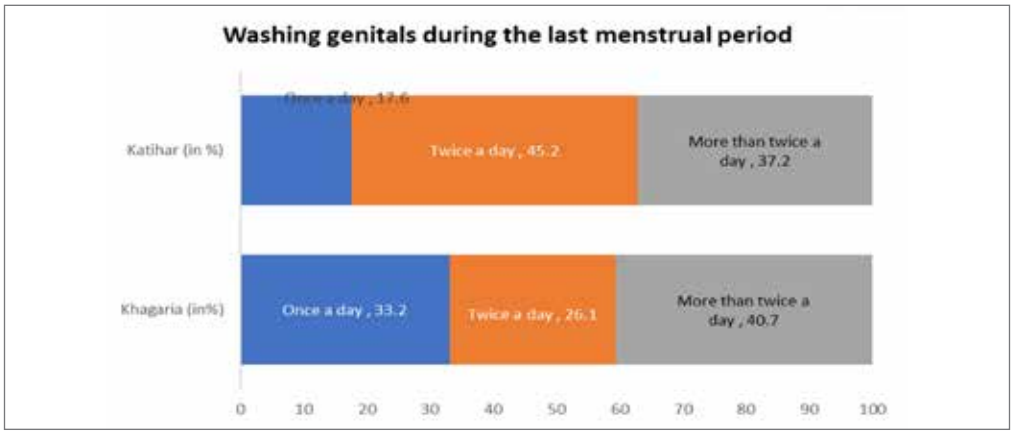
3.3.1 SPENDING CAPACITY ON MENSTRUAL HYGIENE PRODUCTS

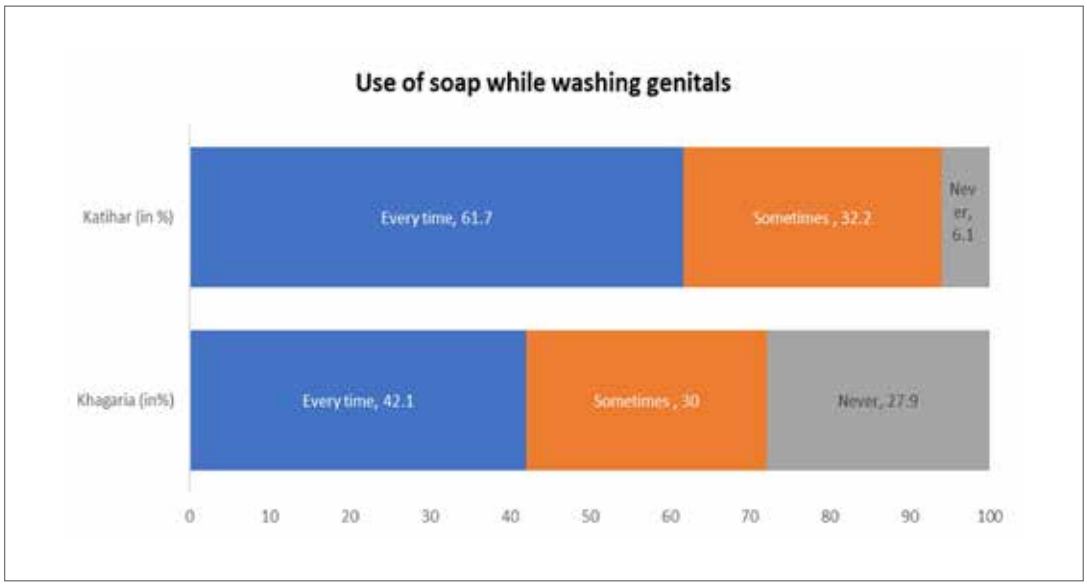
- 232 of women from Khagaria reported spending up to 100 Rupees on menstrual products whereas 130 of women from Katihar reported spending between 51-100 Rupees. Women in Katihar spend less on menstrual hygiene material and they use cloth in large numbers or a combination of pads and cloth to save money and make do with available resources.

3.3.2 PERSONAL HYGIENE PRACTICES AND WASH DURING LAST MENSTRUAL CYCLE





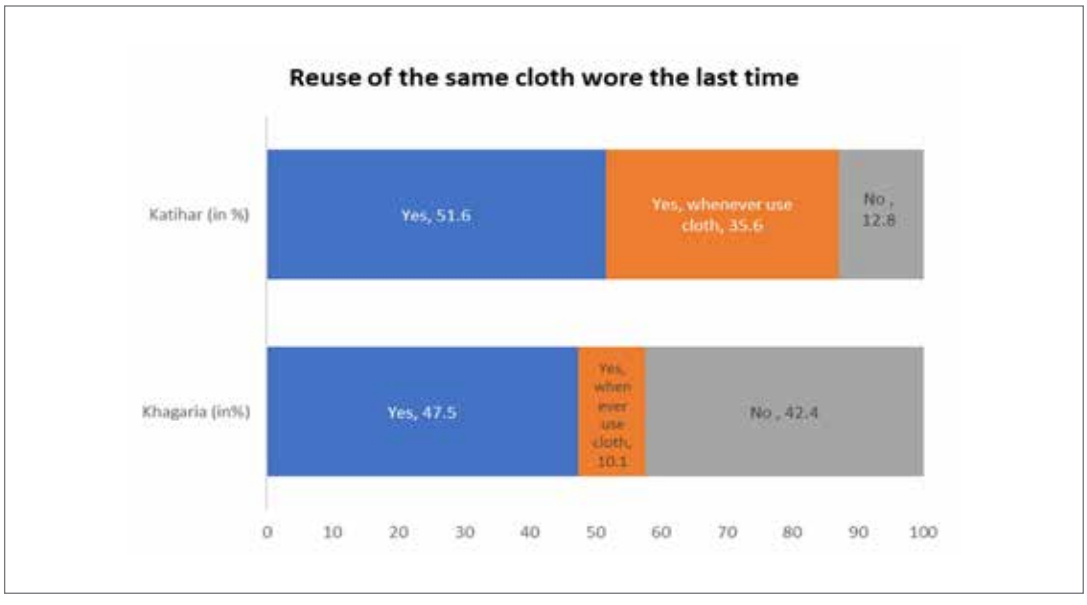


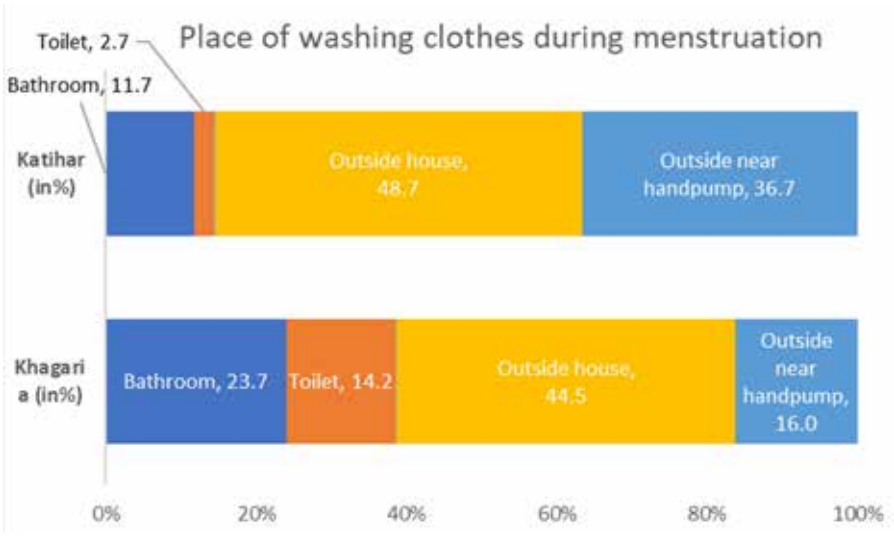


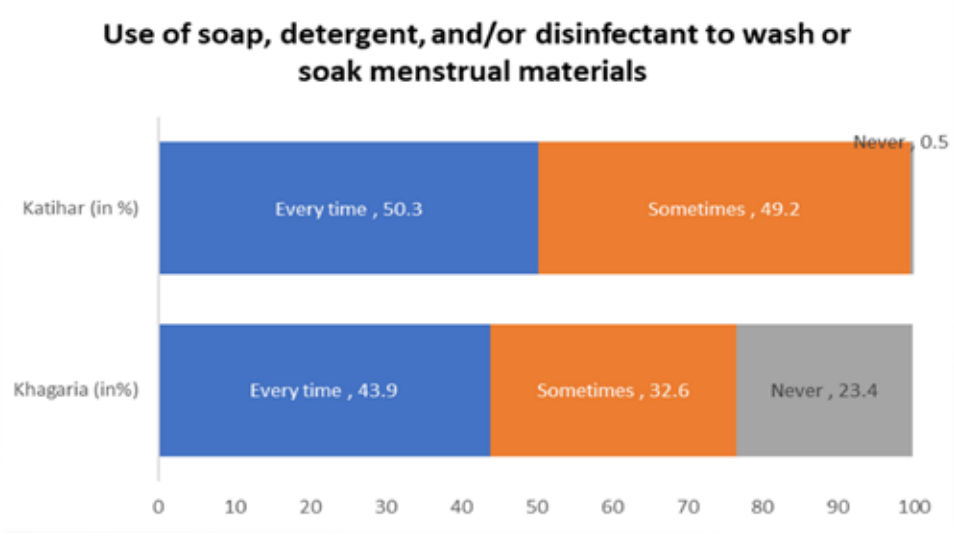
- **Frequency:** From both districts, around 85.7% out of 713 EAMW change menstrual material twice or thrice a day.
- **Washing Hands:** 93.8% EAMW from both districts wash their hands every time they use or change menstrual material. Hygiene practices were found to be equally prevalent in both districts.
- **Washing genitals during the last Menstrual Period:** 75% EAMW surveyed in both the districts washed their genitals twice a day during menstruation and all of them used soap while washing genitals every time.

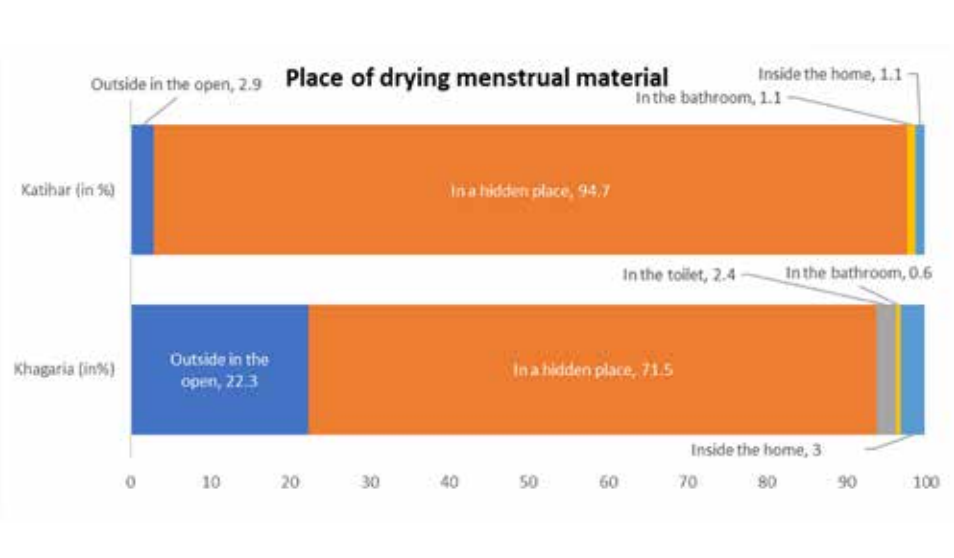
Our data indicates adequate awareness towards MHM with WASH.

3.3.3 MENSTRUAL HYGIENE PRACTICES




Place of washing clothes during menstruation
Toilet, 2.7
Bathroom, 11.7
Katihar (in%)
Outside house, 48.7
Outside near handpump, 36.7
Khagaria (in%)
Bathroom, 23.7
Toilet, 14.2
Outside house, 44.5
Outside near handpump, 16.0
0%
20%
40%
60%
80%
100%


Use of soap, detergent, and/or disinfectant to wash or soak menstrual materials
Katihar (in %)
Every time , 50.3
Sometimes , 49.2
Never , 0.5
Khagaria (in%)
Every time , 43.9
Sometimes , 32.6
Never , 23.4
0
10
20
30
40
50
60
70
80
90
100


Place of drying menstrual material
Outside in the open, 2.9
Inside the home, 1.1
In the bathroom, 1.1
Katihar (in %)
In a hidden place, 94.7
In the toilet, 2.4
In the bathroom, 0.6
Khagaria (in%)
Outside in the open, 22.3
In a hidden place, 71.5
Inside the home, 3
0
10
20
30
40
50
60
70
80
90
100

Safe hygiene practices consist of washing and timely changing menstrual absorbents during the day, as well as their proper disposal. Personal hygiene also depends on keeping genitals clean, and washing hands before and after changing the menstrual absorbent. Our survey assessed the practices followed covering hygiene during menstruation.

A SUMMARY OF PERSONAL AND MENSTRUAL HYGIENE PRACTICES:

Frequency of Changing MHM Product: From both districts, around 75.6% out of 713 EAMW responded that they change menstrual material 2-3 times daily.

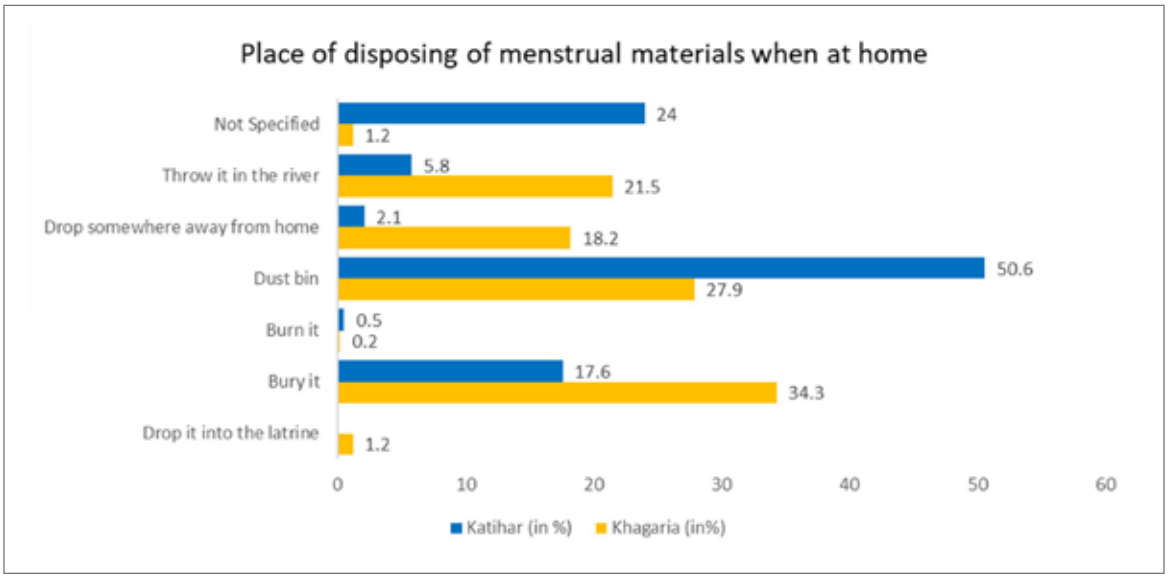
- **Washing hands at time of changing MHM Product:** In all, 669 of women stated that they wash their hands every time before and after changing menstrual material during periods. This was found equally present in both districts.
- **Use soap every time:** From both districts, three-fourths of women i.e. 535 women wash their genitals at least twice a day during menstruation, but only half 374 use soap.
- **Clean Cloth:** From both districts, 496 of women claimed to have used clean cloth during menstruation.
- **Washing practices:** 55 women out of 376 from Katihar and 129 out of 337 EAMWs in Khagaria wash their menstrual clothes in toilets or bathrooms, whereas the common practice in both districts is to wash menstrual clothes outside the house near the hand pump or well, which was followed by 525 women. 295 women from both districts use soap sometimes while washing menstrual clothes. 81 women neither use soap nor detergent in both the districts.

All the above practices highlight that around half of the women have basic facilities like water, toilet, and an affordable environment to use soap and clean clothes in both the districts, and try to adhere to hygienic practices. However, owing to lack of availability of infrastructure, resources and clean water etc. many others face gross hurdles in the way of personal hygiene and sanitary self-care.

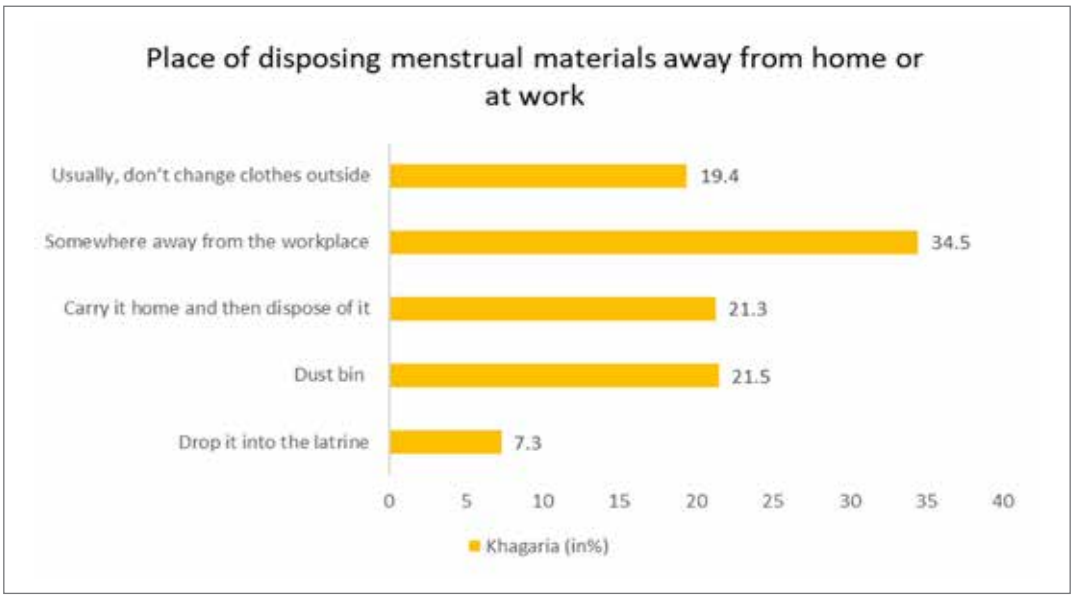
3.3.4 AREA-SPECIFIC DISPOSAL MECHANISMS

- **No specific Disposal Mechanism in place:** When asked about the system of disposal of menstrual material in their area, it was found that the women have to manage problems at their own level, as both districts do not have any organized disposal or monitoring mechanism. Responses received showed that women throw used menstrual material in open spaces, in the river or water bodies or in latrines. An organized disposal mechanism needs now to be facilitated for them alongwith raising community awareness on MHM waste management.

METHODS OF DISPOSAL IN BOTH DISTRICTS

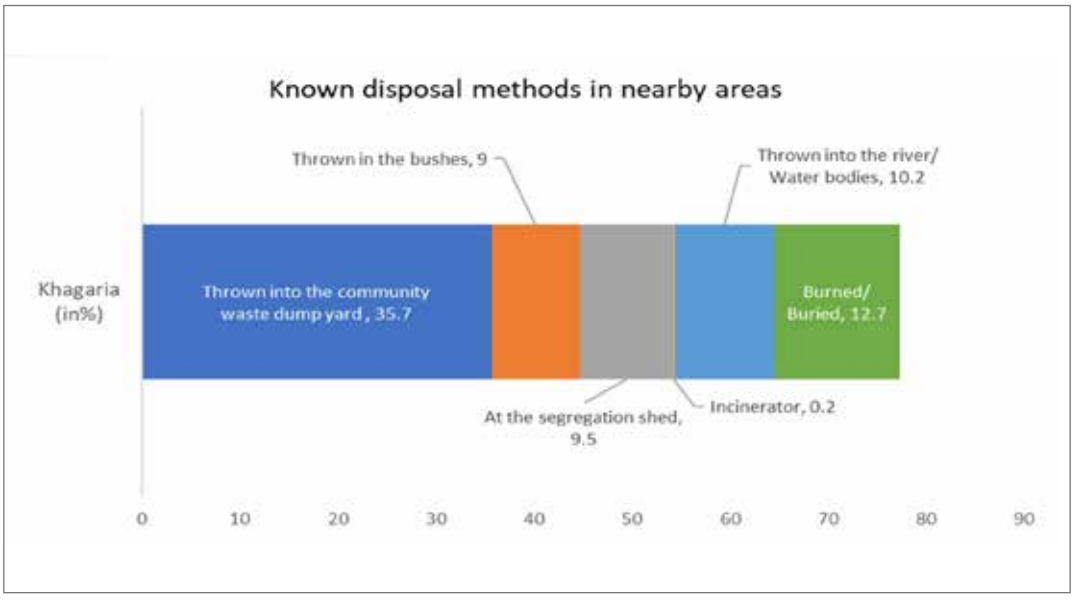


- **Top Practices of disposal at Home:** When at home, 737 EAMW from both districts throw used menstrual material in the dustbin. 221 women bury or burn the used menstrual material. Our study found that the environmentally risky practice of throwing used menstrual absorbents in the river was stated by 91 EAMW from Khagaria and 25 EAMW from Katihar. Additionally, 77 EAMW from Khagaria and 9 from Katihar throw used material in the open spaces near their homes.



- **Top menstrual product disposal practices when away from home:** When away from home, out of 423 respondents from Khagaria, 91 throw used menstrual material in dustbins, whereas 90 women do not change menstrual cloths outside home. If at all they change menstrual absorbents, they carry their used absorbents back to dispose it at home. 146 women responded that they throw used material somewhere away from home while 31 women throw it in the latrine.

KNOWN DISPOSAL METHODS IN THE COMMUNITY AS WELL AS NEARBY AREAS



151 women respondents from Khagaria opined that used menstrual material is mostly thrown in the village community waste dump and nearby areas. 38 women responded that menstrual material is thrown in the bushes and 43 said that it is thrown in the river or water bodies.

3.3.5 SOCIAL CUSTOMS, BELIEFS, MYTHS, AND TABOOS

The world of social customs, replete with its mandatory do's and don'ts in various communities represents their beliefs and mandates. Social customs, beliefs, myths and taboos form the overt and covert barriers and enablers which influence MHM practices as well as everyday experiences of menstruating women. In this respect we had quite positive findings from Katihar district rather than from Khagaria, as seen below:

Customs followed by women in reference to menstruation: Katihar District

Katihar (433 respondents)	Strongly Agree	Agree	Disagree	Strongly Disagree
I am allowed to mix with others socially during my periods.	1.2	97.9	**0.9**	0
I am not allowed to attend any social rituals during my periods.	**0.2**	**91.7**	8.1	0
I do not go to religious places during periods.	**0.5**	**94.7**	4.6	0.2
I avoid traveling during periods.	**0.2**	**34.4**	65.4	0.0
I am told to stay in the corner of the house during my periods.	0.5	2.3	97.2	0
	Yes	**No**		
I am allowed to carry out routine work at home during my periods.	**99.8**	0.2		
I am allowed to cook in the kitchen during my periods.	**99.3**	0.7		
Others in my family take care of me during periods.	**99.8**	0.2		
I have freedom to visit a doctor in case of any health issue.	**99.3**	0.7		
I am allowed only special foods during periods.	1.6	98.4		
I sit for lunch and dinner with all my family members.	97.0	3.0		

Out of 433 respondents from Katihar, almost all women reported that they were allowed to socialise during periods, carry out routine work at home, cook in the kitchen and even have freedom to visit a doctor in case of health issues. It was also seen that one third of women avoid travel during periods.

Customs followed by women in reference to menstruation: Khagaria District

KHAGARIA (423 respondents)	Strongly Agree	Agree	Disagree	Strongly Disagree
I am allowed to mix with others socially during my periods.	12.1	60.5	**24.1**	**3.3**
I am not allowed to attend any social rituals during my periods.	**9.2**	**48.2**	36.6	5.9
I do not go to religious places during periods.	**7.3**	**42.3**	35.9	14.4
I avoid traveling during periods.	**3.5**	**43.0**	44.7	8.7
I am told to stay in the corner of the house during my periods.	**5.7**	**9.5**	68.3	16.5

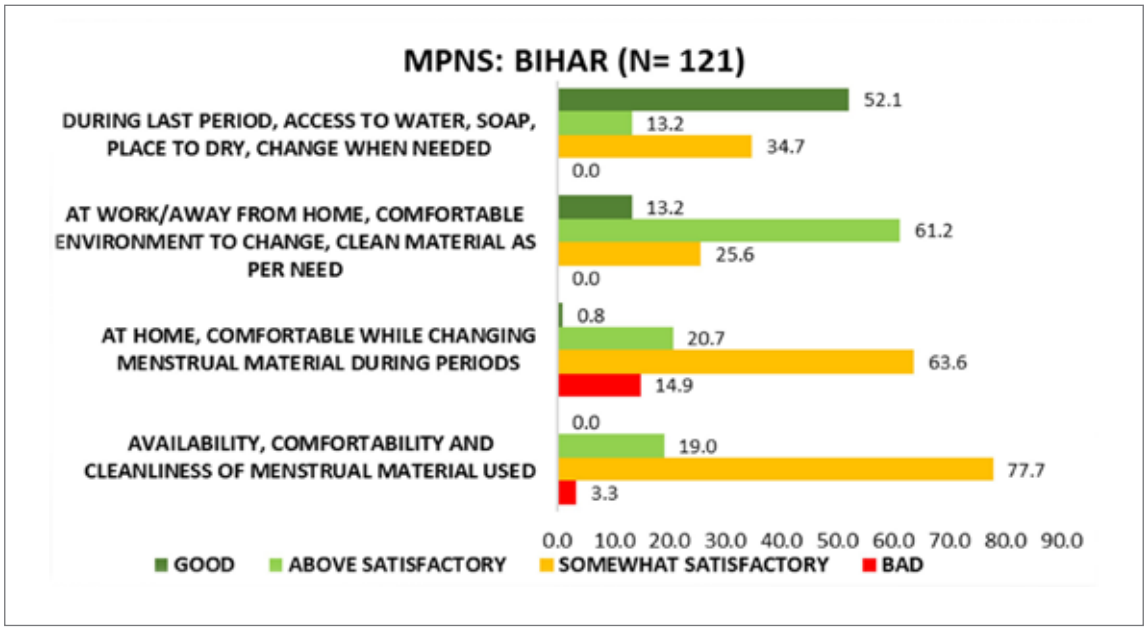
	Yes	No
I am allowed to carry out routine work at home during my periods.	**93.6**	6.4
I am allowed to cook in the kitchen during my periods.	**96.5**	3.5
Others in my family take care of me during periods.	**86.8**	13.2
I have freedom to visit a doctor in case of any health issue.	**78.7**	21.3
I am allowed only special foods during periods.	29.3	70.7
I sit for lunch and dinner with all my family members.	**83.7**	16.3

Out of 423 respondents from Khagaria, 102 (24.1%) were not allowed to socialize during their menstrual cycle. Nearly half of the women (210) do not visit religious places, 243 do not attend any social rituals and 197 avoid travel during periods. Three- fourths of the women, however, have the freedom to visit a doctor in case of any health issue.

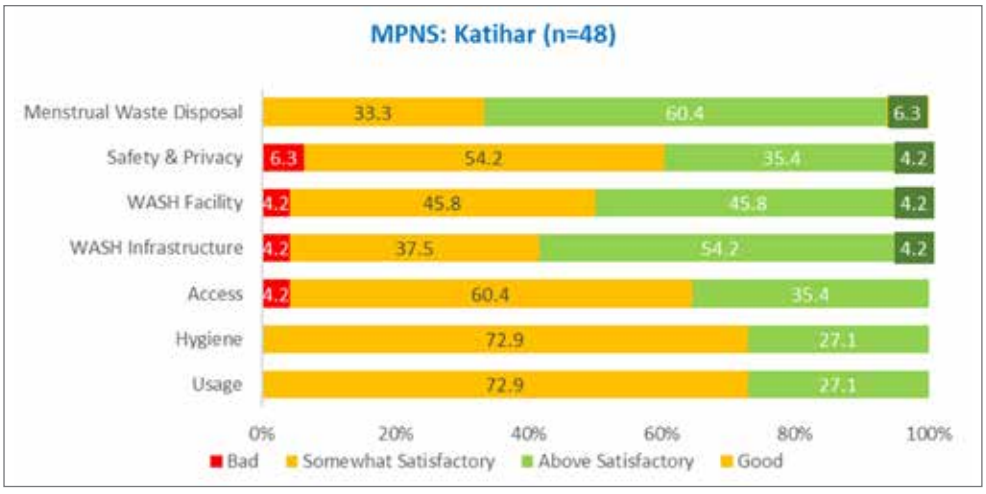
3.3.6 MENSTRUAL PRACTICE NEEDS SCALE (MPNS)

The Menstrual Practice Needs Scale (MPNS) was used to measure and assess the felt needs and experiences of women during their last menstrual period. 121 respondents from both the districts shared their perceptions/ experiences on availability of water, sanitation, hygiene, safety and privacy as well as access to menstrual absorbents. Through the use of MPNS, we were able to access the actual trends, practices and experiences w.r.t MHM, WASH, and safety in Katihar and Khagaria districts.

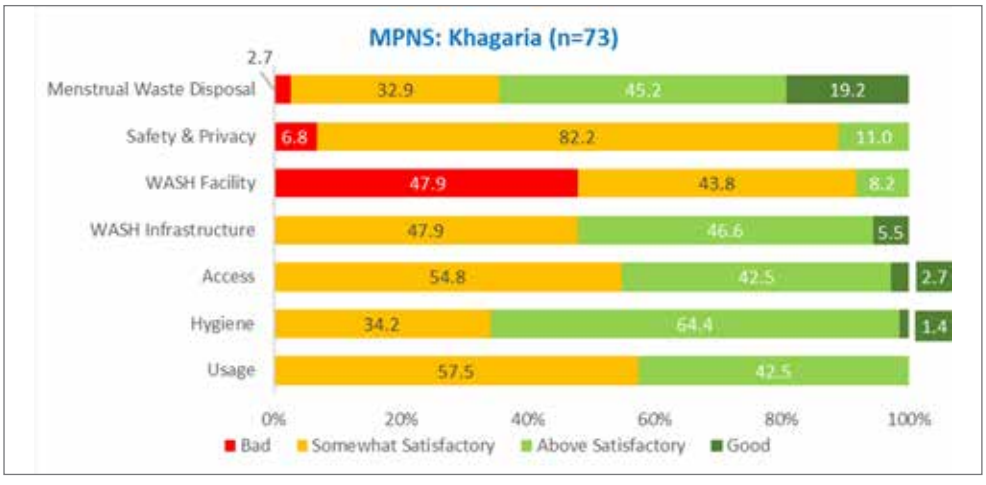
Safe hygiene practices consist of washing and timely changing menstrual absorbents during the day, as well as their proper disposal. Personal hygiene also depends on keeping genitals clean, and washing hands before and after changing the menstrual absorbent. Our survey assessed the practices followed covering hygiene during menstruation.



After being assessed on the MPNS it was observed that 77.7% of respondents rated the Availability, Comfort, and Cleanliness of Menstrual Material used at below satisfactory levels. Two thirds of the women had access to water, soap and a place to dry as well as change menstrual material at above satisfactory to good level.



➲ 48 women from Katihar when assessed on the MPNS reported that access to menstrual material, usage of desired absorbents, privacy, WASH infrastructure and facilities were found below satisfactory levels.



➲ 73 women from Khagaria, when measured on the MPNS reported that usage of desired absorbents, access to menstrual material, WASH facilities and privacy were found below satisfactory levels.

3.4 INTER-SECTORAL FOCUS

This part of our study examines vulnerabilities, issues, and risks pertaining to menstruation with respect to social as well as inter-sectoral stress factors, and we present brief inter-sectoral data analysis.

➲ As villages selected from Katihar and Khagaria districts are flood prone, water contamination and increased inaccessibility of potable water are crucial issues in these villages.

➲ Drinking water crisis, lack of electricity and lack of transport system, lack of education, and poor monetary gains, are issues faced by villagers in both the districts.

➲ Against this background, we present a brief inter-sectoral data analysis on **Migration and MHM, WASH and MHM, Education and MHM, Livelihood and MHM, and lastly, MHM and public policy.**

The villages surveyed in both the districts were SC (Scheduled Caste) and BC (Backward Classes) dominant. Above 30% of people from both districts still use open defecation suggesting that either they may not have WASH facilities, or they may not have adapted to available WASH facilities. Around three-fourths of the population had a low education level and, in some villages, there were no schools. For livelihood, people were mainly dependent on rainfed land for cultivation. More than half the population was dependent on daily labour wage. The overall narrative of different MHM practices in these villages related to- community-based vulnerabilities, socio-economic conditions and beliefs, monetary freedom and disposable income of women, besides health and education inter-sectoral factors.

3.4.1 MIGRATION AND HEALTH

- Out of a total of 433 respondents from Katihar, five families migrated for agricultural work. One for private service, and two for work in manufacturing industry. 167 families from both the districts also migrated to nearby villages as daily wage labourers.
- Nearly half of the families (n= 423) from Khagaria depend on farming along with labour work in other farms. It was found that only 20 families out of 423 from Khagaria migrated for work for a long duration. Out of the 20 migrating families, nine migrated locally for farming work; three migrated for construction and domestic work for 3-5 months. Seven families migrated for work in manufacturing industries and one to tea plantation.
- Our findings indicate that 179 out of the 186 migrant women strongly feel that their seasonal work conditions and resource scarcity influences their menstrual health negatively.

3.4.2 TRADITIONAL SKILLS AND EARNING CAPACITY

In Katihar and Khagaria 23% women practiced traditional art and craft as well as skill based work.

- In Katihar out of the 15 women who possessed traditional skills, the majority were into tailoring.
- In Khagaria out of the total number of women who possessed traditional skills and art, 119 women (n=183) practiced arts such as bamboo craft, embroidery, knitting and weaving.
- While no one reported earning from traditional knowledge and skills in Katihar, 38 women from Khagaria managed to earn using traditional skills.

Given the possibility of augmenting family income from traditional knowledge and skills, vocational courses can be organized for women struggling with economic vulnerabilities to enhance their disposable income. Affordability will empower women for better decision making on MHM and personal medical care.

3.4.3 WASH AND MHM

NFHS-5 data shows that 44.6% households in Katihar and 65% from Khagaria use an improved sanitation facility (International Institute for Population Sciences (IIPS) and ICF 2021, p. 93, 99).

WASH & MHM	Katihar (in %)	Khagaria (in %)
Total Respondents	**433**	**423**
Water Facility at Home		
Bore well/ Tube well/ Well covered	72.3	1.7
Hand pump/ Standpipe	0.5	73.3
Piped water/ Piped to yard/ Plot/ Public tap	23.1	24.6
Tanker/Truck / Cart with small tank	4.2	0.5
Toilet Facility at Home		
Individual household latrine	56.6	79.4
Community toilets	0.7	2.4
Open defecation	42.7	18.2

Type of House		
Kutcha	48.5	30.0
Pucca	21.9	50.6
Semi pucca	29.6	19.4

- **Kind of House:** Housing conditions were found to be better in Khagaria than in Katihar. 70% of women from Khagaria reported that they stay in semi-pucca or pucca houses. Whereas nearly half (48.5%) of the families in Katihar stay in kutcha houses.

  (*Pucca* houses are made of roof, wall and floor with a concrete or pucca material as compared to kutcha houses that have roofs, walls and floors all made up with non-concrete or kutcha/ makeshift material).

- **Compromised Toilet Facilities:** According to our findings, Individual Household Latrines (IHHL) are used by 56.6% families in Katihar and 79.4% in Khagaria. Pucca houses can have toilets built within as opposed to Kutcha houses where it is not possible. Though toilets were constructed under Swachh Bharat Abhiyan, 30.6% families still opt for open defecation in both districts owing to reasons like living in kutcha houses or poorly constructed toilets or due to community preference for open spaces.
- **Sanitation and Access to Water Challenge:** NFHS-5 data shows that drinking water sources have a coverage of 99.2% and 98.8% in Katihar and Khagaria. (International Institute for Population Sciences (IIPS) and ICF 2021, p. 93, 99). However, our findings indicate that only 23.8% of families (203 out of 856 surveyed) from both districts have the facility of piped water in their homes. The remaining either rely on bore wells, tube wells or hand pumps near their houses. This becomes a main everyday challenge to better hygiene including to MHM. Almost all women from both districts reported problem of presence of iron in the water and also scarcity of sufficient water for MHM in households, schools and institutions. Moreover, drinking water supply and sanitation challenges exacerbate during floods and post flood situations.

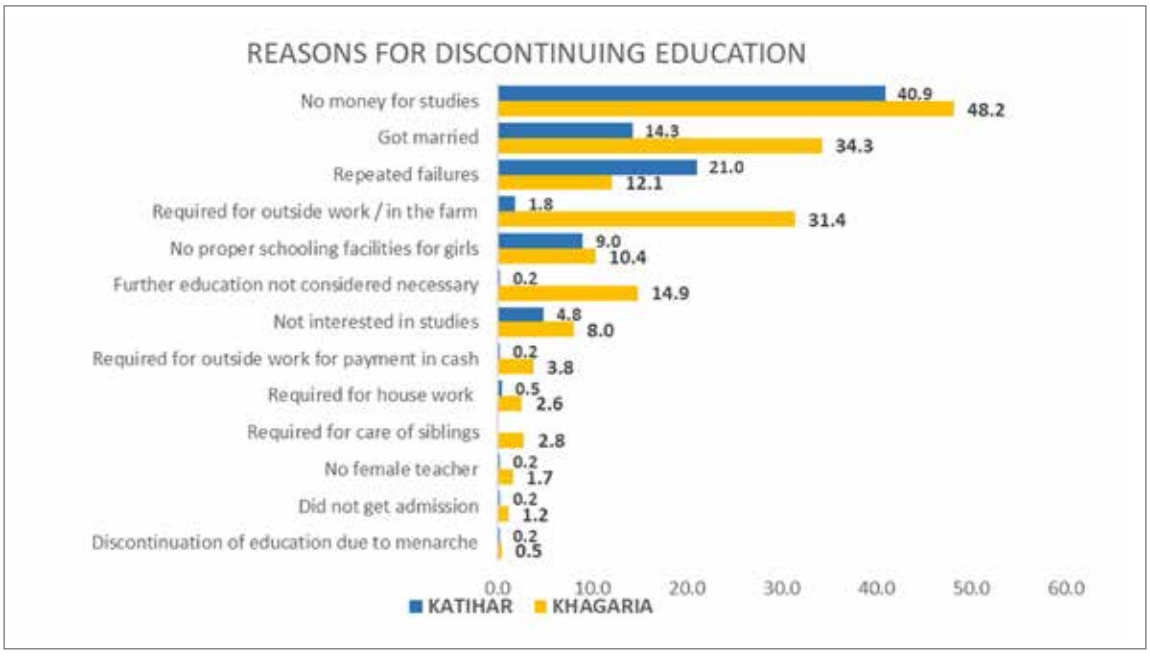
During menstruation a woman's WASH needs are relatively higher as compared to the rest of the days of the month. When a woman experiences her periods, she needs more water to clean herself for personal intimate hygiene, including after defecation. Besides, a regular supply of clean water, ensuring that a woman has the facility of a private secure place to change her menstrual absorbents and clean herself will re-confirm her sense of dignity and safety. In places such as Katihar and Khagaria, during floods and immediate post- flood situations, contaminated water and open defecation increase the risk of communicable and vector borne diseases. For menstruating girls and women, this poses a serious threat to their personal hygiene, making them susceptible to genital, uterine and urinary infections. Access to clean and functional toilets and bathroom/ bathing cubicles become a critical need during periods, both in normal times and in situations of natural calamities.

3.4.4 EDUCATION AND MHM

Out of our total respondents (N=856), 234 women had informal education whereas 224 women were illiterate across Katihar and Khagaria.

- 219 women (n=423) from Khagaria were illiterate whereas 64 had received education till the 7th standard; 90 were educated till higher secondary, and the rest 50 were educated beyond the 10th standard, including having completed graduation and post-graduation.
- In Katihar, two-third of the women (433) were educated till the 4th standard, 117 were educated till higher secondary, and another 38 were matriculates and above.

Education And MHM	Katihar (In %)	Khagaria (In %)
Total Respondents	433	423
Education		
No Education	1.2	51.8
1 Primary (1st - 4th)	65.4	6.6
2 Secondary (5th - 7th)	10.9	8.5
3. Higher Secondary (8th - 10th)	13.9	21.3
4. 12th / Undergraduate	4.2	7.6
5 Graduate and Above	4.6	4.3
Reasons For Discontinuing Education		
Lack Of Facilities	41.3	49.9
Educational Barriers	23.1	45.2
Monetary Barriers	5.1	25.8
Family Barriers	23.8	47.3



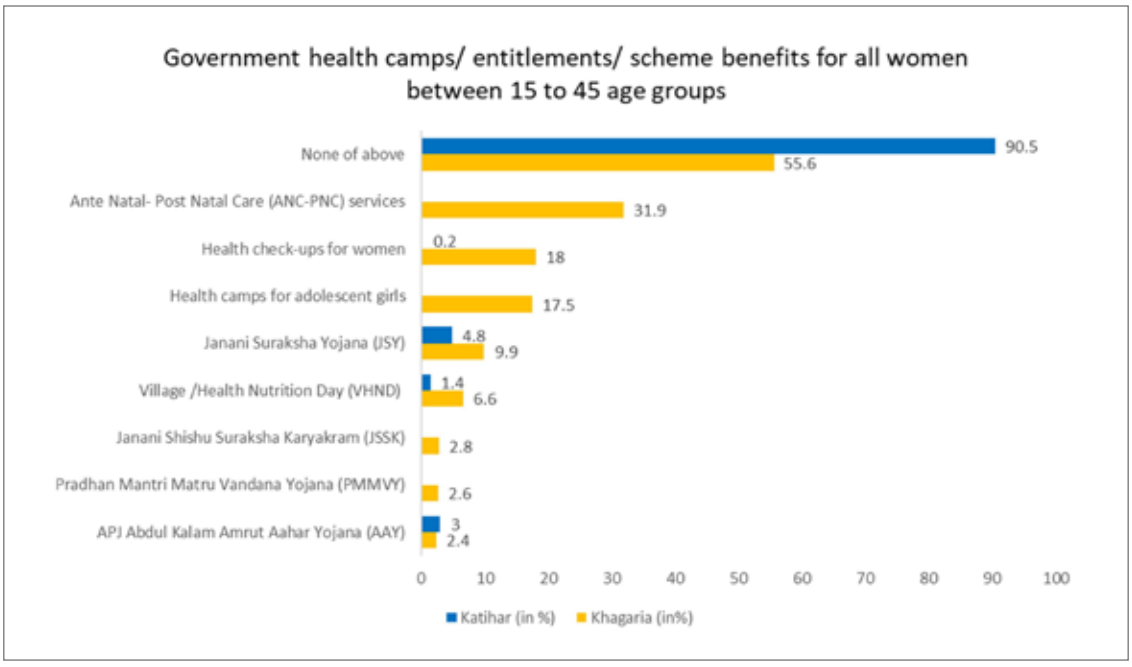
- **Bottlenecks such as Poverty**: In both districts, monetary barriers and family attitudes were the primary cause for educational discontinuity. When questioned about discontinuing education, lack of money (381) came as the top barrier in both the districts (N=856) followed by marriage (207) and family related barriers such as compulsion to work outside home (303) and education not being considered as a necessity (65). To enhance family income, women were required to do labour work on their farms or outside. As a hindsight on their educational status, women reflected that lack of proper schooling facilities in general and the non-availability of female teachers, less importance on education for girls, i.e. family-imposed responsibilities were other top reasons for them not being able to attend or complete school.
- **Failing/ Lack of Interest**: 238 of the total women respondents who discontinued education reported as not being interested in studies while 32 women left their education due to repeated failures.

- **Improper Facilities in Schools:** Other discernible hindrances to complete education related to the absence of proper schooling facilities and infrastructures for girls (83) and no female teacher (8).
- **Menarche and Marriage:** In Bihar, across our sample population 24.2% women dropped out of school and got married post-menarche and attainment of puberty. Community beliefs such as a girl being 'ready for adulthood' in early post-menarche years leads to pressure on the family to marry her off. Menarche & Menstruation emerge as a major criterion for some parents and families laying restrictions on the movement of a girl outside of home, including a preference to drop out from school. Girls being absent from school due to MHM related issues like pain etc. also leads to interruptions in education post -menarche.

3.4.5 AWARENESS TOWARDS PUBLIC POLICY AND COUNSELING ON MHM

PUBLIC POLICY

National Health Mission provides various programs for the age group of 15 to 45 years, i.e., from adolescent girls to women. There are various maternal and child health programs designed by the government of India through which menstruating women get benefits from various services and schemes. Along with other counseling sessions, if counseling on menstrual health hygiene is given to women, they would benefit in terms of being better informed and alert on MHM.



- **Significance of Public Health Facilities:** Public Health facilities usually play an important role in providing free and affordable treatment. Health support systems in India are designed such that for every 1000 population there is ASHA appointed, for around 5 to 6 villages, there is a Sub- Centre where treatment for small illnesses as well as 24/7 facility of delivery is available. After that, for every 30000 people, there is a Primary Health Centre (PHC). And as we move further, there are Rural or Sub-District hospitals, district hospitals in urban areas, municipal corporation health clinics, and hospitals
- **Accessibility and choice:** EAMW covered in this survey were asked through IDIs about the nearest accessible public health facility for getting treatment or pursuing their health issues. The nearest and most accessible public health facilities reported by the EAMW in Khagaria were District Hospital (72.6%), Community Health Centres (14.2%), and Primary Health Centre (12.5%). Around 60.7% of Katihar reported their nearest option was Sub District Hospital, followed by District Hospital (20.6%), and Primary Health Centre (10.2%). Affordability and Access to healthcare: When asked whether they get accessible/ affordable

treatment from government health facilities, 34.3% of women from Katihar did not receive treatment but 55.3% from Khagaria women responded positively. More than one-fourth i.e., 27% of respondents from Khagaria mentioned that they never visited Public Health Facilities to avail treatment.

- **Local health Services:** In Khagaria, only one-third of the women reported receiving ANC-PNC-related benefits such as maternal and child health. Only 76 women out of 423 were getting health checkups and even fewer (28) were attending Village Health Nutrition Day (VHND). Our findings indicate that though women are familiar with the services they get from the public health system, very few women knew about the schemes designed for them such as Janani Suraksha Yojana (JSY), Pradhan Mantri Matru Vandana Yojana (PMMVY) and so forth.
- **Engagement with Public Health services**: This finding indicates that if the women in these districts are ready to consult public health facilities, then distance does not play a role as much as better services and infrastructure does. Thus, they may opt for going to the District/ Sub-district Hospitals over visiting the Primary Health Centres (PHCs) and Community Health Centres (CHCs) / Rural Hospitals (RHs) etc. National Health Mission provides various programs for the age group of 15 to 45 years, i.e., from adolescent girls to women (see also, Annex I).
- **Importance of Health Camps**: Health camps, which are periodically organized in villages, are specifically important and needed in areas which are remote and cut-off or where Sub-centres are not available. Our survey findings indicate that 397 women (n=433) in Katihar and 260 in Khagaria (n=423) did not receive any scheme-based benefits and remained out of coverage of public health entitlements. According to our findings, EAMW in Katihar are less integrated with the public health system than those in Khagaria. If health camps start covering the wellbeing of EAMW in remote and isolated areas, women will stand to benefit from many health based objectives and schemes of the Indian government.

Our findings indicate that other than ANC-PNC services, women between 15 to 45 years age group are not familiar with Government health camps, entitlements, and scheme benefits for them. This is not only indicative of absence of women's voice and reach over health schemes and benefits for their welfare, but also explains their hesitation to speak and articulate on MHM concerns in day-to-day life. In this way the EAMW face a double silence as even the policy makers have so far been unable to adequately combat the silence on MHM issues.

COUNSELING

Received counseling on Menstrual Hygiene from health workers	Katihar (in %)	Khagaria (in %)
Total Respondents	**433**	**423**
No	98.2	65.7
Yes	1.8	34.3

- **Yes:** Upon being asked if they ever received any counseling on menstrual health, only 153 of our EAMW responded in the affirmative, out of which only eight women were from Katihar. Counseling on MHM was received from health workers such as ASHA, ANM and AWW.
- **No:** 278 women in Khagaria (n=423) answered no, while 425 women from Katihar (n=433) did not receive any counseling at all.

Menstrual health of women beyond school years is still a long way from being actively considered as a public policy measure in India. Owing to the vast outreach of Public Health system in India, the MHM of EAMW can get a much required boost if the issue receives adequate public policy attention. ADP districts can stand to gain by way of better health for 50% of its population if women's MHM issues are piloted as an inter-sectoral intervention cutting across education, social security, WASH and livelihood.

PART 4 VOICES, EXCERPTS AND OBSERVATIONS

As part of our research, we conducted Key Informant Interviews (KIIs) in both the selected districts. People interviewed during this exercise were important stakeholders in communities and villages such as Anganwadi workers, ANM, Doctors, Teachers, ASHA workers etc. The voices of these stakeholders are critical for the development of the community as they give a unique point of view of the village population and in a small but significant manner, have helped us analyse how to combat the silence on menstrual health issues in area-specific and community -sensitive ways. The highlights of these interviews are as follows:

Katihar (Data derived from 5 villages of the district): In Katihar, 11 respondents across 5 villages stated that their villages suffer acute water scarcity. Out of these, 7 of our key informants added that water in their villages has Iron content making it unsafe for consumption. 9 informed us that free sanitary pads were not distributed in their villages while 6 said that they were not aware of any government scheme related to menstrual hygiene. 3 confirmed the absence of any awareness generation initiative or the distribution of Iron and folic acid tablets to girls and women.

Khagaria (Data derived from 5 villages of the district): In Khagaria, 10 respondents across 5 villages stated free sanitary napkins were not distributed in their villages. 8 respondents spoke of acute water scarcities in their villages. 2 others added that the water was severely contaminated by iron. 4 confirmed the absence of awareness generation initiatives and stated they were not aware of any scheme related to menstrual hygiene. 3 of our respondents stated that their villages lack toilets. In one of the five villages in Khagaria neither the village nor the village school had toilets.

4.1 VOICES AND EXCERPTS: KATIHAR

Nirola, (Interview: 16.08.2022)[3], an **Anganwadi Worker** (AWW) in a village of Katihar district of Bihar responded that the village does not have any scheme on menstruation for school and community. Though the village had a common tube well for fulfilling water related needs, the school gets neither a water supply nor is there any toilet in its premises. It was not clear how women's WASH needs were fulfilled throughout the year. On EAMW's MHM needs in the village, she stressed upon creating awareness and suggested free sanitary pads, iron tablets, hand wash and clean water. However, she believed that, 'women should not perform pooja and should not enter the kitchen during menstruation'.

Tullo, (Interview: 31.07.2022)[4], an **ASHA worker** in a village of Katihar stated that the village had a program of providing free calcium and iron tablets but there was no such scheme for sanitary pads. On WASH, she informed that the villages had water but for general health and MHM the challenge was that it was contaminated with iron. She further added that the village needed free sanitary pads and medicine- distribution schemes for menstruating women. On taboos, she held that women 'should not' enter religious places during their periods.

Prabhawati (Interview: 21.08.2022)[5], a **Ward Member** of a village of Katihar district in Bihar stated that she was unaware of any scheme for menstruating women in the village. She further added that ASHA workers provided iron tablets to women from time to time. She added "Government does not provide resources to work, it just

[3] BR KII1 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[4] BR KII2 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[5] BR KII3 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

gives advice." On women's WASH needs, she explained that the village has *Jal Jeevan Mission* but no solution so far in sight for ridding the village of iron-contaminated water. Village School has water as well as a toilet. On taboos prevalent in her village and areas nearby, she informed us that women were considered untouchable during menstruation, not allowed to perform pooja, enter temples or go to the kitchen to cook food.

Asha (Interview: 02.09.2022)[6], an **ASHA worker** in a village in Katihar added that the village does not have any facility related to menstruation. Iron tablets are distributed for pregnant women. The village had a water tank under *Jal Jeevan Mission* but it does not have a tap. Moreover, the village does not have any school. From her account it was evident how during floods, villages became bereft of menstrual sanitation facilities and accessibility to products such as sanitary pads. Strong taboos forbid women to cook food, enter temples or consume eggs and onions during menstruation. However, the ASHA seemed to take it as a social given without much questioning.

Aparajita (Interview: 14.07.2022)[7], an **Anganwadi worker** (AWW) from a village in Katihar responded that her village does not have any facility for menstruators. AWWs distribute iron tablets but there is no scheme of sanitary pads. From her account, it was evident that the village had iron-contaminated water to the extent that villagers had to buy water for drinking and cooking. She insisted that creating awareness drives amongst EAMW and providing them with clean water, free sanitary pads, and medicinal facilities would be a good way ahead to ensure village -level MHM. On taboos and beliefs in the community, she informed that for the first three days of menstruation women, 'should not' perform pooja.

Madhu and Sulekha (Interview: 07.07.2022)[8] are ASHA **Workers** and **ANM, respectively**. ASHA workers responded that the village does not have any facility related to menstruation, ANM further added, "A free pad distribution scheme in the village used to be implemented until it changed to 250 INR annually and now it has completely stopped." On WASH they informed that the village had a tube well facility but the water was contaminated with iron. They emphasized upon creating awareness and suggested clean water, free sanitary pads, and a Primary Health Center (PHC) for menstruating women. On taboos both answered that women 'should not perform pooja, enter the kitchen, eat pickles, and should not put vermillion during menstruation.'

Pooja Devi (Interview: 05.08.2022)[9], an **AWW** of a village denied about the menstruation hygiene schemes in her village. She added there is only an iron tablet circulation scheme for pregnant women. On WASH related schemes, she claimed the village had *Jal Jeevan Mission* but it was not fully implemented. Further she added that her village needed a scheme for free distribution of sanitary pads, medicines, and Dettol. Taboos regarding menstruation included women forbidden to perform pooja, eat eggs or onion.

Kajal (Interview: 10.07.2022)[10], an **ASHA worker** in Katihar responded that the village had a programme of providing free iron tablets to women but there was no programme for free distribution of sanitary pads. She further added that under *RKSK,* the village had conducted counseling sessions for girls. On the requirement of 20-49 aged women, she suggested free distribution of sanitary pads, iron tablets, Dettol, and condoms. Further she added the village had a problem of iron in water, there is a *Jal Jeevan Mission* but not fully implemented. On taboos in the village, she informed us about the belief that women should not enter the kitchen for the first three days of menstruation.

Khushbu (Interview: 30.06.2022)[11], an **ASHA worker** in a village in Bihar added that the village had a free iron tablet distribution facility under the RKSK scheme. There is no such scheme for sanitary pad distribution. On WASH needs in community and school she answered water is contaminated, *Jal Jeevan Mission* is not completely implemented, school also had a problem of iron in water. On women's requirements she suggested educating the women about menstruation, free distribution of sanitary pads and Dettol.

[6] BR KII4 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[7] BR KII5 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[8] BR KII6 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[9] BR KII7 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[10] BR KII8 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[11] BR KII9 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

Sarita (Interview: 29.06.2022)[12], an **ASHA worker** in the village of Katihar added that the village had a programme of counseling on cleanliness especially on the theme of MHM. Free distribution of Iron tablets under the RKSK scheme. She further added that the village had a tube well for water facility but there was severe iron contamination of water, and the school also had the same tube well for school-going children. It was unclear how women's wash needs were fulfilled throughout the year. On women's requirements she suggested free distribution of sanitary pads, medicines, and Dettol.

Nitu (Interview: 21.07.2022)[13] an **ASHA worker** in a village in Bihar responded that under RKSK the village had a programme to advise women on using sanitary pads and maintaining personal hygiene. On WASH needs of the community and school she explained the *Jal Jeevan Mission* was implemented in the village and the school but it was not fully operationalised. On women's requirements she suggested free distribution of sanitary pads, medicines, and Dettol. Moreover, she added that women, 'should not cook food for the first three days of menstruation'.

Sulekha (Interview: 14.07.2022)[14] an **ASHA worker** in Katihar district of Bihar stated that two schemes, namely, Masik Dharm Swachhta Yojana and Rashtriya Gramin Swasthya Yojana were operational in village, there is also free distribution of Iron tablets and counseling for women under the RKSK scheme. On WASH needs she explained the Jal *Jeevan Mission* was not completely implemented and hence the water related needs remain unresolved. On EAMW's requirements, she suggested free distribution of sanitary pads as well as a medicine kit.

4.2 VOICES AND EXCERPTS: KHAGARIA

Manju (Interview: 10.07.2022)[15], a **teacher** in a village of Khagaria district in Bihar added that the village had a programme for free distribution of iron and calcium tablets, special leaves for menstruation women, and anti-tetanus vaccine for mothers- to-be/pregnant women. Further she added, the village does not have any specific schemes for menstrual health. On WASH needs in school and community she explained there were adequate water and toilet facilities in her village. She insisted on creating awareness among women on cleanliness and hygiene and suggested free distribution of sanitary pads and medicines for MHM. However, she was fine with women not entering the kitchen and religious places during menstruation.

Jyoti (Interview: 22.07.2022)[16], a **teacher** in a village of Khagaria district in Bihar responded that the village had free distribution of sanitary pads and medicine scheme for menstruating women. On WASH in school and community she explained that the village had *Jal Jeevan Mission*, there is a water connection in school also under this scheme, both school and community had a clean toilet facility. She added creating awareness about menstruation is very important and suggested distribution of free sanitary pads and medicine. On taboos she explained once women were not allowed to have baths and perform pooja but now the situation has changed positively.

Annupriya (Interview: 15.07.2022)[17], an **AWW i**n a village in Khagaria stated that the government lacked any scheme for menstruating women between 20 to 49 years in the village. She stated that free distribution of sanitary pads and rest during menstruation are urgent needs. Moreover, she suggested a pad making machine and potable water were urgently required in the village. On taboos she added that till a few years ago, women were not allowed to perform pooja, apply vermillion or cook. Women were even prohibited from seeing their husbands, but now the situation has changed women were freer from binding restrictions during menstruation.

Reena (Interview: 18.06.2022)[18], a **VRP (Village Resource Person) Jivika** in a village of Khagaria district in Bihar added, the government does not have any scheme for menstruation in the village. She added women were

[12] BR KII10 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[13] BR KII11 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[14] BR KII12 KR: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[15] BR KII1 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[16] BR KII2 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[17] BR KII3 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[18] BR KII4 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

taught about sanitary pads use and to take iron tablets. On WASH needs in school and village community she explained that the village had a *Jal Jeevan Mission* but it was not completely implemented. The school had water and toilet facilities and provided 150 rupees annually to girls for sanitary pads. On women's MHM requirement, she suggested distribution of free sanitary pads, pad making machine and a special room in school for menstruating girl child for rest. On prevalent taboos, her answer was that women were not allowed to perform pooja and touch objects freely during menstruation.

Pooja (Interview: 06.06.2022)[19], an **AWW** in a village of Khagaria district of Bihar stated that the village has a cleanliness program, free distribution of iron tablets from Anganwadis, and regular health check-ups for menstruating women were also organized in her village. She further stated an awareness program was conducted in her village on using sanitary pads and maintaining cleanliness during menstruation under the RKSK scheme. From her account, it was evident that there was a problem of accessibility to markets that led to the unavailability of pads and medicines because the village lies across a river. On WASH she explained, that government schemes such as *Jal Jeevan Mission* and Open defecation-free villages are a good step. Schools also had clean toilets and water facilities with handwash. She further added that lack of education was a big hurdle in achieving proper menstrual health in the village. An awareness program about menstrual hygiene should be regularly organized for EAMW. Moreover, the village needed sanitary pads, medicines, clean water, and a program on hygiene. On taboos in the village, there was a common belief that women should not touch the holy *Tulsi* (Basil) plants during menstruation.

Sangeeta (Interview: 13.08.2022)[20], a **Bachat Gat (HGS) leader** in a village in Khagaria district of Bihar responded with the scheme of free iron tablet distribution in the village but there is also an awareness program under *Rashtriya Kishori Suraksha Karyakaram* to teach women about cleanliness and health. On WASH she explained that the government has implemented *Jal Jeevan Mission* and construction of toilets in the village, but the school does not have clean toilets and there is a problem of high levels of Iron and Lead in water. Further she added that the village needed sanitary pads, a clean toilet with contamination-free water and soap. On taboos, the villagers were of the firm belief that women should not be allowed to touch the Tulsi plant during menstruation.

Neelam (Interview: 26.08.2022)[21], a **Bachat Gat leader** in a village of Khagaria informed us that the village has conducted health camps for adolescent girls, moreover, they are also advised to use sanitary pads and maintain cleanliness during menstruation under RKSK scheme. On WASH in villages and schools she added *Jal Jeevan Mission is* implemented but is insufficient. About women's requirements in the village, she added that women needed sanitary pads, medicines, clean water, and toilet during menstruation. She further suggested a menstrual health training program and a small industry of sanitary pad making. Women not allowed to touch a Tulsi plant during menstruation emerged as a taboo and firm conviction in Neelam's village too.

Sulekha (Interview: 03.07.2022)[22], a **Teacher** in a village in Katihar stated that the school had a program of free distribution of sanitary pads and iron tablets as well as free health check-ups in the Anganwadi for girls. On the requirement of women between 20-49 years of age, she opined that the EAMW needed sanitary pads/ cotton cloth, iron tablet, clean toilets and clean water. She insisted upon a menstrual health training program to teach women sanitary pad-making courses. She informed us that an organization called *Meena Manch* has conducted some educational programs in the village that leads to changing people's behavior toward menstruation. With respect to beliefs around menstruation, she preferred to share her own experience of how her husband considers menstruation as sacred and pious.

Ramdulari (Interview: 03.07.2022)[23], a **Bachat Gat leader** in a village in Katihar district stated that the village had a program of free distribution of iron tablets through the Anganwadi. On WASH needs of village and school, no scheme implementation from government but *Nav Jagriti Mission* has made a *Jaltara* for village water needs.

[19] BR KII5 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[20] BR KII6 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[21] BR KII7 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[22] BR KII8 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[23] BR KII9 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

It was unclear how women fulfilled their WASH needs throughout the year from such a source of water. From her account it was evident that the village had a problem of accessibility to menstrual hygiene materials, as the nearest place to buy sanitary pads was 20 kms away. On taboos, she answered that the village had a tradition to bathe only with 2.5 *lotas* (mugs) of water during menstruation.

Babita (Interview: 03.07.2022)[24], an **AWW** in a village in Khagaria stated that she was unaware of any scheme on menstrual hygiene in the village or in the local school. She added the village needs clean water, sanitary pads and provision of hand-wash for menstruating women. On the WASH needs in villages and schools *Jal Jeevan Mission* is implemented but there is no specific scheme for menstrual hygiene, she added.

Reena (Interview: 03.07.2022)[25] an **ASHA worker** in Khagaria stated that regular health check-ups of adolescent girls were organized in the Anganwadi. On WASH she answered that the *Jal Jeevan Mission* was facilitated in the village but not yet completely implemented. She added the village school had mineral water provision but the students had to drink tap water. Educating the girl child in villages about MHM and raising early awareness was demanded by her as a way out to address hesitations, fears, silences and myths around periods and personal hygiene.

Savita (Interview: 03.07.2022)[26] a **Bachat Gat leader** in a village in Khagaria stated that her village had a program for free distribution of Iron tablets for adolescent girls. On WASH she explained that Nav Jagriti Manch, a local *NGO* had built *Jaltara* (Recharge pits/ pipes) for water needs of the village. *Jivika* organization had conducted educational programs on menstruation in the village. Creating awareness on menstrual hygiene, free distribution of sanitary pads and medicines among women would be a desirable intervention. Savita wondered on the ironic question of how villagers considered menstruation sacred but still prohibited women from performing 'Pooja'.

4.3 SALIENT FINDINGS FROM DATA

Processing through our data from Katihar and Khagaria, we have gained some valuable insights on women's health, education, livelihood and overall community outlook on menstrual health management needs on ground.

Our findings from these districts indicate that most of the interviewees were unaware about the schemes related to menstruation in the villages. However, informants were aware of common ongoing services such as free distribution of iron tablets in the villages of Katihar and iron and calcium tablets in Khagaria. Knowledge about schemes and services as well as entitlement, other than under RKSK and Anganwadi benefits, was almost negligible. While a concern emerged for creating awareness amongst women on cleanliness and personal hygiene with respect to menstrual health, the majority of the Key Informants from these districts were in favour of following community beliefs and taboos during menstruation.

Key informants from both districts indicated that till recently there was a scheme under which pads were distributed freely but now no longer. However, when the free pad distribution facility was discontinued, a contribution of 250 rupees started being deposited annually in every girl's bank account. But this too has stopped in Katihar. Reena, a VRP (Village Resource Person) Jivika in a village in Khagaria informed us that in her village, girls were provided 150 rupees annually for sanitary pads.

It was evident from all interviews that in general, villages suffer lack of water and functional toilets. During floods, the situation gets worse as villages face severe unavailability of sanitary pads. Pooja, an Anganwadi worker, informed us that her village had a problem with accessibility when the river overflows and they become cut off from the rest of the world and have zero access to pads and medicines. In general, the villages experience a scarcity of clean drinking water, sanitary pads, and hand wash/soap for menstruating women.

On taboos most of the interviewees from these districts reported restrictions on- performing pooja, entering

[24] BR KII10 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[25] BR KII11 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

[26] BR KII12 KH: Available in Data Records, MHM and WASH Project (2022-2023) SSMF- Sulabh International

kitchens and cooking. As well as eating eggs and onions in Katihar whereas in Khagaria women were not allowed to put vermillion on their foreheads or in the hair-parting, or touch the holy *Tulsi* (Basil) plant as well as ordained to stay away from their husbands. In some villages, women were taught the value of cleanliness and hygiene, but ironically, allowed only 2.5 *lota* (mug) of water during menstruation. In Khagaria the EAMW informed us that they get special leave during menstruation which can be considered as an empathetic practice for working women and other wage earners across Bihar.

From our interactions and database pertaining to these two districts, it clearly emerges that apart from silence on MHM in terms of inter-sectoral hindrances and policy-related negligence, there are community voices that portray a negative and discriminatory attitude towards periods. These discriminatory voices, similar to our observation in other states, pertain to both men and women across social strata. Many EAMW as well as other key informants endorsed negative attitudes towards menstruation, either owing to the circumstantial difficulties in which they themselves grew up experiencing a lack of a better support system. Such voices contribute to the perpetuation of a debilitating discourse on the phenomenon. The key to combating the inter-sectoral community -based silences and barriers on MHM among women beyond school years lies in augmenting positive practices and discourses on menstruation. One of the best ways to achieve this is by involving multiple actors, key and critical stakeholders such as EAMW themselves, leaders, influencers, families, policy makers and implementers. Gender mainstreaming MHM can ensure gender equality in all activities, projects, and programmes.

4.4 RECOMMENDATIONS/ AREAS OF IMPROVEMENT

IMMEDIATE

1. **Improve Enablers:** Our data from the two districts points to the widespread prevalence as well as endorsement of menstruation related taboos amongst the actor-participants themselves. Generating physical, mental and emotional awareness on menstruation focussing on positive as well as an enabling attitude among women should form a regional target on MHM.
2. **Enable existing Village Health and Nutrition Committees (VHNCs) on MHM:** For overall capacity building on menstruating women's health and nutrition at the village level, empower the existing VHNCs to address the issue locally in Katihar and Khagaria. This would ensure a positive outcome for the nutritional well-being of tribal women living in remote and marginalized areas.
3. **Enable existing Village Water Sanitation Committees (VWSC) on MHM**: MHM drives should be conducted alongside the promotion of information on WASH. Get the enablers of WASH in tandem with community voices. The VWSC in each village is to understand the MHM barriers which need to be addressed under the national Jal Jeevan Mission (JJM) guided by a women-team. Local Community-Based Organizations (CBOs) can help mobilize community support to this end.
4. **Lady doctors in PHCs:** The presence of women medics in PHCs or visiting sub-centers regularly/ once a month to monitor the health needs of menstruating girls and women and not just pregnant and lactating mothers will help cover those who are in need of medical advice.
5. **Enable capacity building in Household Water Treatment Systems (HWTS)**: Village folk are eager to rid water of iron contamination. Holding workshops on HWTS is recommended. This initiative can be facilitated through the existing FTK (Free Test Kit) women groups under Jeevika Scheme formed under the JJM scheme etc.
6. **Free pads distribution scheme and disposal mechanisms:** Free pads distribution should be continued for school going girls and extended to elder women in the village. In fact, our key informants raised a demand that many women also need clean cloth to be made available for use during menstruation, as they prefer more traditional methods of protection and hygiene. Both systems could run parallelly for some time till sanitary pads become more acceptable. Besides, disposal mechanisms need to be operationalized at the village level.

7. **Girls Common Room (GCR):** GCR should be facilitated in each school so that menstruating girls can take rest if they need to, during school hours.
8. **Vocational Training to enhance Disposable Income:** In rural and semi-urban settings of Bihar, traditional skills can make women self-dependent. Our survey findings indicate that scarcity of cash-in-hand prevent women from being able to make decisions on medical consultations or in buying hygienic material related to their menstrual health and general well-being. This causes various kinds of diseases and discomforts, at times even leading to early hysterectomies and risks of malignancies. We, therefore, suggest that to make positive changes in women's MHM, livelihood programmes and vocational training on traditional skills and knowledge can be initiated in Bihar.
9. **More awareness drives on Menstruation**, Monthly or three-monthly compulsory and inclusive health check-ups be organized with a focus on EAMW.

SHORT TERM

11. **Include MHM Kit in Relief Distribution:** Provision and Distribution of life-saving hygiene items such as soaps, detergents, disinfectants, a sufficient quantity of menstrual hygiene products (New pads/ cloths as preferred), etcetera to be included in the list of relief materials in post-flood situations.
12. **Ensure that there are schools in villages and to make these Schools MHM Friendly:** Where there are no schools, villages must be provided with the same, and also make them MHM friendly. Capacity building of young girls towards MHM and educational continuity can happen only if schools in both the districts are equipped with proper facilities. Educating children entering puberty is a prime need in all villages. Growing girls need to have a sense of composite physical and reproductive know-how of their body and well-being. If menstruation is not given a proper introduction and interactive space in an adolescents' view and life, they go through feelings of isolation, stress, embarrassment and confusion. Making schools period-safe, in terms of knowledge and skill proliferation, sanitation and care in order to ensure continuity in education as well as proper MHM is the foremost need.
13. **WASH in Schools and Community**: Girls should be provided with separate toilets equipped with running water through tap connections and storage tanks under the JJM Scheme. Villages in both the districts have a toilet deficit and still practice open defecation. Toilets should be constructed, operationalized and have regular water supply in homes, public spaces and workplace.
14. **Micro- Credit facilities through SHGs**: Provide credit facilities to EAMW through Bihar Rural Livelihood Promotion Society (BRLPS) and other government supported credit schemes that would enhance the earning capacities of menstruating women who can thereby become active decision makers in self-care.

LONG TERM

15. **Bihar MHM Committee**: A State level Menstrual Health and Wellbeing Committee in Bihar be formed to overlook, steer and monitor MHM plans with emphasis on remote areas of Bihar and integrate them into the State and National level MHM and ADP plans.
16. **MHM at District, Block, Gram Panchayat Level**: Information, education, and communication (IEC) for menstrual hygiene education and awareness that includes information around safe menstrual hygiene products; and menstrual waste management with safe disposal facilities needs to be strengthened.
17. **JEEVIKA - A source for alternative livelihoods for EAMW**: Build capacities and skills of women from poor, marginalized households through functionally effective SHGs for gainful self-employment under Bihar Rural Livelihood Promotion Society (BRLPS).
18. **MHM at Family level:** Ensure sustainable water source along with source strengthening measures and provision of Functional Household Tap Connections (FHTCs) to all households under National Jal Jeevan Mission scheme. Consider disaster resilient WASH infrastructure for all weather access.
19. **Jal Jeevan Mission (JJM) for Institutions and MHM:** Institutional water supply under the JJM scheme should have adequate running water in girls' toilets in schools. Iron removal water treatment systems to be constructed/ installed in the village water supply scheme.

20. **Make Toilets Period Safe** Provide community toilets as well as toilets in workplaces with washing areas, bathing cubicles, and running water under SBM(G) phase II where needed.
21. **Service Continuity:** For the overall well-being of adolescent girls and all menstruating women, ensure all time (normal and disaster situations) service continuity of clean menstrual hygiene products that are 'viable' and 'preferred' by all menstruators through Government Schemes.
22. **Menstrual Waste Disposal:** More Research and Development (R&D) is essential to evolve an environment appropriate disposal mechanism for menstrual waste.

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ANNEXURE I

Criteria/ Reasons for Selection of Villages from Khagaria

Sr. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (data accessed from JJM dashboard on 02/04/23)	Total Households (data accessed from JJM dashboard on 02/04/23	Prevailing social issues/ issues of inclusion/ etc.
1	Mansi	Amni	7810	1,946	Flood prone, disaster prone and heavy migration
2	Mansi	Purvi Thatha	12,050	2348	Flood prone, disaster prone and heavy migration
3	Mansi	Balha	7,350	1575	Flood prone, disaster prone and heavy migration
4	Mansi	Amni	669 (as provided by partner)	148 (as provided by partner)	Flood prone, disaster prone and heavy migration
5	Sadar TP	Parmanpur	1962	325	Flood prone, disaster prone and heavy migration

Criteria/ Reasons for Selection of Villages from Katihar

Sr. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (data accessed from JJM dashboard on 02/04/23)	Total Households (data accessed from JJM dashboard on 02/04/23)	Prevailing social issues/ issues of inclusion/ etc.
1	Azamnagar	Singhol	769	169	Flood prone, Muslim dominated, Desi Palia dominated and Mahadalit dominated.
2	Azamnagar	Harnagar	816	182	Flood prone, Muslim dominated, Desi Palia dominated and Mahadalit dominated.
3	Pranpur	Kathghar Karimullapur	2253	481	Flood prone, Muslim dominated, Desi Palia dominated and Mahadalit dominated.

Sr. No	Block/ TP/ Municipality/ Slum/ Tribal	Proposed Gram Panchayat/ Revenue Village/ hamlet/ ward	Total Population (data accessed from JJM dashboard on 02/04/23)	Total Households (data accessed from JJM dashboard on 02/04/23)	Prevailing social issues/ issues of inclusion/ etc.
4	Colony No. 2	Katihar MC	7000 (as provided by partner)	1750 (as provided by partner)	Urban-semi urban population, backward ward, lack of pure drinking water and sanitation problems, problem of garbage, mixed population from OBC, EBC, Dalits and women.
5	Azamnagar	Singhol	3045 (as provided by partner)	674 (as provided by partner)	Flood prone, Muslim dominated, Desi Palia dominated and Mahadalit dominated.

ANNEXURE II

Important Women-Centric Schemes in Bihar

- *Mukhyamantri Balak/ Balika Bicycle Scheme*: It was started in 2006 by the chief minister Shri Nitish Kumar (JDU) through the Ministry of Human Resource and Development, Government of Bihar. The aim of the scheme is to provide cycles as an efficient means to reach school. It is hoped that this will increase the attendance and retention rate.
- *Jeevika Project*: The Jeevika Project began in 2006 under the chief Ministership of Shri Nitish Kumar (JDU) through the Ministry of Rural Development, Government of Bihar with support of World Bank, the program was to provide income opportunities to BPL families residing in rural areas. Credit linkages were established with banks from the year 2007 onwards through Jeevika. This project aims at enhancing small savings.
- *Mukhyamantri Nari Shakti Yojana*: This scheme was started in 2007 by chief minister Shri Nitish Kumar (JDU) through the Social Welfare Department, Government of Bihar. The program envisages holistic empowerment of women in the economic, social, and cultural spheres, state-wide campaign against child marriage, work for eradication of dowry and to implement Bihar State Women Empowerment Policy 2015.
- *Nai Peedhi Swasthya Karyakram*: This scheme was launched by the Chief Minister Shri Nitish Kumar (JDU) in 2011 through the State Health Society Bihar, Department of Health, Government of Bihar. This programme entails carrying out State-wide health check-ups. This data needs to be entered in software developed especially for recording and maintaining complete health records of individuals with full-fledged data analytics feature.detailed health check-up of school children across the state, up to 18 years of age. Medical teams travel the length and breadth of the state.

- *Mukhyamantri Jhuggi Jhopdi Mahila Saksharta Yojana*: This scheme was started by the chief minister Shri Nitish Kumar (JDU) in 2013 through the Social Welfare Department, Government of Bihar. The objective of the scheme is instilling literacy among women in slum areas to empower and expand their opportunities.
- *Aarakshit Rozgaar Mahilaon ka Adhikar*: Started in 2015 by the chief minister Shri Nitish Kumar (JDU) under Women empowerment policy 2015, it implements 35% horizontal reservation to women in recruitment to all cadres and services of the state under "Aarakshit Rozgar Mahilaon Ka Adhikar"
- *Bihar State Women Empowerment Policy 2015*: This policy was started on March 22, 2015 under the chief Ministership of Shri Nitish Kumar (JDU) through the Ministry of Women and Child Development, Government of Bihar. The policy strives to eliminate gender-based discrimination, caste and structural hindrances restricting women's access to social, economic, political, educational and health related resources. It will also ensure women's judicious access to resources and creation of a conducive environment for their wellbeing. The policy envisaged the establishment of Gender Resource Centre for capacity building on laws and acts related to violence and to conduct advocacy on issues related to women. A Working Women Hostel was started in Patna to provide safe accommodation to working women. Pre-examination training was imparted to the girls through the pre-examination training centers. Students' Guidance Centres established in 2011 at Chandragupta Maurya Management Institute for scheduled caste girls. Training on the computer, accounting, tally, DTH installation, spoken English, and beautician to 30% Mahadalit women out of total trainees through Bihar Mahadalit Vikas Mission under Dashrath Manjhi Kaushal Vikas Yojana and to schedule caste women under Scheduled Caste sub-plan of Special Central Assistance Scheme.
- *Bihar State Women Information and Resource Center / Gender Resource Center*: This center is operated for the collection, publication and transmission of information related to women, research, and development related work.