Menstrual Justice: A Missing Element in India's Health Policies

Swatiya Manorama and Radhika Desai

INTRODUCTION: A MENSTRUAL JUSTICE FRAMEWORK

Menstruation is a key process in a woman's life integral to her well-being and an indicator of her fertility. One expects that menstruation's contribution to the propagation of the species would lead to the valorization of both deed and doer—namely, menstruation and women.¹ Instead, globally, and in particular in India (our site of research), menstruation is largely shamed and silenced. In India, the demarcation of female bodies as menstruating bodies is embedded deeply within religious, social, cultural, and political milieu and is customarily stigmatizing (Outlook 2018; Bhartiya 2013; Johnston-Robledo and Chrisler 2011). Against this background, our chapter explores how Indian health and related policies address menstruation and menstrual health.

Within Hinduism there are two contradictory streams of belief regarding menstruation. While menstrual blood and menstruating women are seen as 'polluting' because all bodily excretions are "ritually impure" (Bhartiya 2013, 524–25; Eichinger Ferro-Luzzi 1974; Garg and Anand 2015, 184–86), the alternative 'tantric' view is that, through their menses, menstruating women embody infinite creative power and immense energy (Chawla 2002; Zsigmond 2012). The onset of menarche signifies fertility and is celebrated within many Hindu homes (Bhartiya 2013, 525; Eichinger Ferro-Luzzi 1974). For girls themselves, menarche signals the transition from childhood into the gendered construction of 'womanhood' (Manorama and Hora 2002). Girls recognize that the imposition of cultural and social controls over their pubescent bodies, their sexual and nonsexual deployment, and the manifold

Both authors have contributed equally to this work.

increased restrictions on their physical mobility in time and space ensure that they grow to be ‘women of a specific deportment’ (Kågesten et al. 2016, 2; Manorama and Hora 2002).

We argue that the state, rather than confronting this complex web of beliefs and practices centered on menstruation, chooses to endorse it. Most recently, the state support for continued exclusion of women of menstruating age from the Sabarimala temple (Outlook 2018) is the most egregious instance of the state’s role in the perpetuation of menstrual stigma. To signal the critical role of menstruation in the denial of gender justice, we propose a ‘menstrual justice’² approach. Emerging from India’s women’s health and people’s health movements (Manorama and Shah 1996; Saheli Women’s Resource Centre 2001), this approach is based on an alternative understanding of women’s biology and health. ‘Menstrual justice’ is a holistic approach that entails listening with sensitivity and respect to girls’ and women’s menstrual health needs that emerge from their sociocultural location and gendered everyday experiences (SAMA Team 2005; Rishyasyringa 2000).

The central tenet of the menstrual justice approach is that menstruation is a physiological process directly linked to psychosocial and cultural–religious aspects. Its objective is twofold: First, it seeks to make explicit all aspects of women’s lives that are linked to menstruation beyond fertility and reproduction. Second, it helps to delineate the links between this complex web of thought and practices and women’s experiences of indignity, discrimination, inequality, and injustice. It considers the specific ways in which the socio-cultural–religious discourse of menstruation and its associated practices are reflected in national policies that effect violations of women’s human rights, discrimination, and inequality. In doing so, the approach directs attention to the role of the political institutions and state policies in this process. Following an overview of the interconnections between menstruation and women’s health, we examine state policies with reference to women’s basic, psychosocial, gynecological, reproductive, and menopausal health in the context of the menstrual justice framework.

AN OVERVIEW OF INTERCONNECTIONS BETWEEN THE MENSTRUAL CYCLE AND HEALTH

Anchoring of the menstrual justice framework in meanings associated with a bodily process makes it particularly suited to address gaps in women’s health. We begin with a brief overview of the impacts of women’s health and social factors on the menstrual cycle, demonstrating the need for policy and programming that recognizes and values the full spectrum of menstruality among women throughout India’s diverse communities.

Basic Health

Basic physical and psychosocial health are crucially tied to healthy childhood development, puberty, and the onset of menarche, as well as a predisposition to menstrual health-related morbidities and mortality throughout adulthood (UNICEF 2012; Biro and Deardorff 2013; Boutot 2018). Nutritional deficiencies affect the onset of menarche and menopause, intensity of PMS symptoms, and the duration, heaviness, and frequency of one's flow (Jeejeebhoy 2000; Gokhale 1996; Patle et al. 2015; Jahangir 2018; Jungari and Chauhan 2017).

Girl-children encounter unequal access to the nutritional, medical, and emotional support systems essential to basic health (Guilmoto et al. 2018; Inamdar, Inamdar, and Sachdeva 2011). Early childhood malnutrition is the leading risk factor for disease nationwide and follows girls into adolescence and adulthood (India State-Level Disease Burden Initiative Collaborators 2017, 2446). Approximately 38% girls under five are stunted, 21% are wasted, and 36% are underweight (Indian Institute of Population Studies (IIPS) and ICF 2017). In the age group 15–19, 47% are underweight (UNICEF 2012), compared to 22.9% in the age group 15–49. Anemia is a little over 50% in both groups (Indian Institute of Population Studies (IIPS) and ICF 2017; UNICEF, n.d.). Given their scale, these nutritional imbalances have a significant impact on menstrual health, as poor nutrition can delay menarche and disrupt the menstrual cycle.

Psychosocial Health

Discrimination against the girl-child leads to the 'normalization' of malnourishment, physical abuse and a sense of powerlessness and low self-esteem among preadolescent and early adolescent girls (Manorama and Hora 2002). Indian adolescent girls already tend to experience lower self-esteem and self-confidence, diffidence, and feelings of subordination compared to boys (Karki and Espinosa 2018, 113; Manorama and Hora 2002). Their branding as 'impure' after the onset of menarche undermines the healthy development of self-confidence and emotional well-being (Bharatwaj and Sindu 2014; Kumar and Srivastava 2011; Soumya and Sequira 2016, 12). Their lack of body and menstrual literacy and knowledge affirms and amplifies the negativity toward menstruation (FSG 2016; Raut et al. 2015, 63).

Additional social control at this critical developmental juncture is one more blow to the adolescent girl's fragile psychosocial state (Blum, Mmari, and Moreau 2017). Worldwide, depression is a common consequence of these restrictions (Chandra-Mouli et al. 2017, S6). In India, psychosocial problems are a more likely cause of suicides than diagnosable psychiatric problems (Mythri and Ebenezer 2016, 493–98), and 56% of suicides of women occurred in the age group of 15–29, compared to 40% for men (Rane and Nadkarni 2014, 77).

Gynecological and Reproductive Care

Under sociocultural silence and shame and misconceptions of what constitutes a ‘normal’ period, Indian women often refrain from reporting symptoms associated with gynecological morbidities; they consider symptoms such as severe pain to be part and parcel of being women (Inamdar, Sahu, and Doibale 2013, 9; Ramasubban and Jeejebhoy 2000a, 24–25). Reproductive Tract Infections (RTIs) and menstrual disorders are among the most commonly observed gynecological morbidities (Gosalia et al. 2012; Gulati, Chaurasia, and Singh 2009; Inamdar, Sahu, and Daibole 2013; Oomman 2000) and show increased incidence in older women, poor women, women with lower literacy, married women, and women with higher gravidity and parity (Tulasi and Babu 2018, 6; Oomman 2000, 251–52). Early age at menarche has been associated with gynecological morbidities as well (Das et al. 2015, 12; Oomman 2000, 250–51).

Menopause

India’s mean age for the onset of menopause ranges between 41.9 and 49.4 years—significantly lower than the global mean of 45 to 55 (Pallikadavath et al. 2016, 367). Poor nutrition, lower socioeconomic status such as membership in a scheduled caste or tribe, adolescent pregnancy, lack of education, and exposure to strenuous work have been found to contribute to a higher prevalence of early menopause (Ahuja 2016; Jungari and Chauhan 2017; Syamala 2010, 254–55).

A high percentage of perimenopausal and postmenopausal women suffer from gynecological morbidities such as vaginal irritation, incontinence, reduced sexual desire, and mental health issues such as depression (Mishra 2011; Susila and Roy 2014, 55; Syamala 2010, 255). The symptoms are compounded by a burden of noncommunicable disease in the Indian population (Ahuja 2016; Susila and Roy 2014, 55). Despite these preliminary findings, studies of gynecological morbidity among menopausal women are rare.

The above discussion reveals high levels of ill-health among females from birth to old age that can be tied to menstrual health and body awareness. Across the life course, girls, women of reproductive age, perimenopausal, menopausal, and postmenopausal women exhibit a low level of basic and psychosocial health and a high incidence of gynecological morbidities, including menstrual health issues. In the next section, we examine India’s national health policies to assess the manner in which the state has addressed these widespread basic and menstrual health problems.

ANALYSIS OF HEALTH POLICIES: A MENSTRUAL JUSTICE PERSPECTIVE

While our analysis focuses on health policies, we also include interrelated policies in adjacent sectors such as nutrition and sanitation. This section analyzes the policies introduced above: primary healthcare, psychosocial health,

reproductive health and fertility control, and menopause. We also examine how menstrual health is addressed in sanitation policies.

Primary Healthcare

Until the formulation of India's National Health Policy (NHP) in 1983, healthcare was addressed through Five-Year Plans. The NHP 1983 endorsed the idea of "universal primary healthcare services" but rejected its concomitant goal of "free healthcare provision" on the grounds of unaffordability (Ministry of Health and Family Welfare, Government of India (MoHFWGOI) 1983). The NHP 1983 emphasized the curative approach at the expense of preventive, promotive public health, and rehabilitative aspects of healthcare (Duggal and Gangolli 2005). The NHP 1983 led to the expansion of health infrastructure (Duggal 2005, 33–34), but its expected benefits to women's health did not materialize. Health workers were not trained to cater to women's needs, and family planning and immunization took a disproportionate amount of their time (Duggal 2005, 34).

The NHP 2002 (MoHFWGOI 2002) moved away from the goal of universal comprehensive primary healthcare to a regime of public health characterized by selective care targeted at specific groups (Duggal 2005, 35). Recognizing women's poor health status (Sarojini et al. 2006, 23) and the withering of rural health capacity except for "family welfare activities" (MoHFWGOI 2002, 9), the NHP 2002 promised "top funding priority to programmes relating to women's health" (Sarojini et al. 2006, 23; MoHFWGOI 2002, 32). However, health benefits still did not accrue because the policy's approach to women's health lacked specificity (Sarojini et al. 2006, 24). While it mentioned the need to "attend to specific requirements of women in a more comprehensive manner" (MoHFWGOI 2002, 32), it did not identify a single women's health issue. The only women-specific goal it set was to reduce the Maternal Mortality Rate (MMR), revealing its reductive understanding of women's health *as* maternal health (MoHFWGOI 2002, 21).

The policy prescriptions of the NHP 2002—namely, improvement in availability and access to quality healthcare for rural populations, especially women and children—were reflected in National Rural Health Mission (NRHM) 2005 (MoHFWGOI 2015). In reality, programs of reproductive and child health and HIV/AIDS in NRHM 2005 got greater funding support over primary healthcare (Duggal and Gangolli 2005, 11). The Accredited Social Health Activists (ASHA), introduced as an interface between the village and the public health system, were given insufficient training for primary and menstrual healthcare functions, and their incentive structure was aligned to promote reproductive health and family planning (Sarin et al. 2016; Hussain 2011, 56).

Women's health was also purportedly targeted through national nutrition interventions, which can have a significant impact on improving menstrual

health. These include the Integrated Child Development Services Scheme introduced in 1975 and the Nutrition Policy of 1993. The scheme initially provided nutrition supplements only to undernourished pregnant women, lactating mothers, and children under age six (Ministry of Women and Child Development, Government of India (MoWCDGOI) 1975). The Nutrition Policy of 1993 (MoWCDGOI 1993) extended nutritional support to malnourished adolescent girls to redress high levels of undernourishment (Kanani 2002). However, the policy did not propose a plan to address intrahousehold gender discrimination toward girl-children such as underfeeding, little or no provision of nutritional foods, denial of medical treatment for ill-health, et cetera, which is the primary cause of malnourishment. The policy lacked a perspective of “women’s nutrition for its own sake” (Kanani 2002) and continued to adopt the myopic view of equating women’s health with reproduction. It failed to suggest measures to compensate the specific nutritional shortfalls of menstruating or menopausal women and to institute a research program to examine the impact of malnourishment on women’s menstrual health across the life cycle (Jeejeebhoy 2000, 145; Oomman 2000, 260; Sandoiu 2017).

The most recent National Health Policy (2017) does not address the gaps in the provision of healthcare to women either (MoHFWGOI 2017), although it has a sprinkling of ‘women’s health issues’ across its 30-odd pages. Women’s health needs are specifically addressed in the sections on reproductive health, maternal health, child and adolescent health (RMNCH+A), malnutrition, population stabilization, gender-based violence (GBV), and women’s health and gender mainstreaming. Under the subheading of “Women’s Health & Gender mainstreaming” it mentions “enhanced provisioning for reproductive morbidities and health needs of women beyond the reproductive age group (40+)” (MoHFWGOI 2017, 14); however, there is no mention of how this is to be achieved through changes in the current health programs.

The trajectory of India’s national health and nutrition policies shows encouraging growth in awareness of the need to rectify gender imbalances and to devote more resources toward improving women’s health. However, we do not yet see sufficient programmatic changes to support the implementation of these policies.

Psychosocial Health

India’s first National Mental Health Policy, adopted in 2014, mentions in its preamble the necessity to cater to vulnerable groups (MoHFWGOI 2014). Yet it fails to address the mental health consequence of high levels of stress women suffer because of gender discriminatory practices such as neglect, child marriage, infertility, failure to give birth to sons, witch-hunting, and sexual assault within marriage (Ramasubban and Jeejeebhoy 2000a, 34; Sarojini et al. 2006, 41). The policy also seems blind to the emotional anguish women suffer because of

chronic issues related to menstruation and the impact of other diseases on menstruation (Oomman 2000, 253–55; Alvergne, Wheeler, and Tabor 2018). For instance, it fails to recognize the negative psychosocial health impacts of the perception that girls and women are ‘polluting’ during menstruation (FSG 2016). Rather than mandate access to counselors and health workers equipped with gender-sensitive training on menstrual health as demanded by women’s health activists (Oomman 2000, 257–58), the policy medicalizes mental health conditions in psychiatric terms and adopts a ‘special case’ approach that does not cater to the mental health of menstruating women (Varma 2014, 45).

Reproductive Healthcare and Fertility Control

Population growth led to the integration of Family Planning Program (FPP) and health services since the Third Five-Year Plan (1961–1966) (Ministry of Health and Family Welfare, Government of India (MoHFWGOI) 2000; Visaria 2000, 335). FPP is part of a primary healthcare system whose beneficiaries were illiterate, poor, and ‘lower’ caste women. Women were provided contraceptives with little regard for their needs, and the quality of services was poor (Visaria 2000). The result was an increase in menstrual problems and RTIs from intrauterine devices and gynecological morbidities post-sterilization (Oomman 2000, 247–48). It was only in 1997 that the government accepted a women’s empowerment and comprehensive reproductive healthcare paradigm through its Reproductive and Child Health (RCH) program. The RCH included some services demanded by women activists: prevention and treatment of RTIs and sexually transmitted infections (STIs); reproductive health services for adolescents; and information, education, and counseling on health, sexuality, and gender (Sarojini et al. 2006, 28). But the government’s own review of RCH showed that critical components of reproductive and sexual health were ignored in training and implementation, resulting in a lack of treatment for contraceptive side effects and post-delivery complications. There was also a total neglect of health needs of adolescents outside marriage (Santhya 2003, 28; Sarojini et al. 2006, 31). Failure to address critical factors of the RCH approach—such as the right to information on associated risks and the unavailability of services or skilled personnel to deal with side effects of contraception—led to exacerbating women’s already poor health, including gynecological morbidities (Pachauri 2004, 18; Santhya 2003, 25–26).

Even in programs to prevent STIs, menstrual and gynecological care was not given precedence (WHO 2007, 2). There were no processes to empower women and enable them to choose their contraceptive methods or treatments for infection (SAMA Team 2005, 157; Santhya 2003, 28). The subsequent phases of RCH—RCH II (2005) and Reproductive, Maternal and Child Health, Plus Adolescents (RMNCHA+) (2013)—have made no midcourse corrections; instead, they’ve shifted the focus once again to maternal, infant, and child care (Ministry of Health and Family Welfare, Government of India (MoHFWGOI), n.d.). The implementation of RCH shows an absence of

promotion of adolescent and adult women's knowledge of their own bodies, issues of sexuality, menstrual health and hygiene, and the right to contraceptive choice without coercion. The above overview of reproductive health policies demonstrates that population control continues to be bundled within reproductive health and is least concerned with menstrual health. The RCH program does not recognize the continuities between reproductive health, general health, and women's social location.

Menopause

The NHP 2017 recognizes the health needs of women beyond reproductive age (40+) (MoHFWGOI 2017). As such, it has taken the first steps toward heeding the demands of women's health activists for policies that address women's health across the life cycle rather than merely in their reproductive years (SAMA Team 2005). However, the policy homogenizes older women; it includes women in late reproductive age, perimenopausal, recently postmenopausal, and beyond age 60, and it does not give any indication of the strategy to address health issues of this 40+age group. The health needs of this group are also covered in the 1999 National Policy on Older Persons, which was drastically revised in 2011. Like the NHP 2017, it shows awareness of the need for increased attention on older women, but its approach to issues of aging is gender-neutral (Ministry of Social Justice, Government of India 2011). Neither policy recognizes the consequences of menstrual conditions experienced before menopause and the ramifications of menopause on physical and mental health; neither articulates which treatments or procedures within existing infrastructure can be used to treat postmenopausal morbidities. Also missing is any recognition of the need for gender-specific research on issues such as detriments to women's postmenopausal longevity and long-term consequences of gynecological morbidities (ibid.; Syamala 2010; Jani and Manorama 2007).

An analysis of India's past policies on physical and mental health reveals historical approaches to women's health that are based on a myopic understanding of women as 'female reproducing bodies' who need to be managed for population stabilization and reproductive health. This limited focus has perpetuated neglect of the health needs of girl-children, prepubescent girls, and perimenopausal and postmenopausal women. It does nothing to interrupt and dismantle the cycles of menstrual stigma that compromise women's and girls' mental and physical health.

Swachh Bharat Abhiyaan (SBA): The 'Clean India Mission'

The SBA is the first large-scale government program that includes a strategy to bring out the taboo subject of menstruation (Swachh Bharat Mission 2019). This section briefly analyzes the component of menstrual hygiene management (MHM) in SBA through the lens of menstrual justice (see also Patkar

[Chapter 38] in this volume). The goals of SBA are (1) achievement of dignity for adolescent girls and women and (2) retention of adolescent girls in school (FSG 2016) through a strategy of providing sanitation infrastructure, access to menstrual products, and information, education, and communications (IEC) for MHM awareness among adolescent school-going girls, boys, and community. The aim of IEC, per its technical guidelines, is “to create awareness in order to overcome the silence around MHM and break the taboos within the broader society, communities, and also among family members” (Ministry of Drinking Water and Sanitation, Government of India, n.d., 1). The IEC material is mandated to include:

Facts about menstruation, biology and process; Frequently-asked questions and answers; Myths about menstruation and address them with facts; Case studies/experience from girls—How to stay healthy during menstruation—what protection to wear, what to eat, what exercise to take, how to keep clean, how to deal with cramps, how to clean, dry or dispose of sanitary materials, etc. (Ministry of Drinking Water and Sanitation, Government of India 2015, 13)

A close reading of the SBA guidelines for MHM shows two critical gaps, namely (1) absence of culturally embedded gender-specific understandings of menstruation and (2) linkages with public health. Both of these have consequences for girls’ and women’s menstrual health. Embodied shame, guilt, and negativity among Indian adolescent girls is not linked merely to the biology of menstruation but to the complex web of beliefs and practices of menstruation and its sociocultural and religious meanings that result in indignity and injustice. The onset of menarche is accompanied with increased disciplining on ‘how to be a woman,’ and adolescent girls’ mental health and sense of self-esteem are negatively affected (FSG 2016; Garg and Anand 2015; Karki and Espinosa 2018). The SBA does not include any programmatic interventions to address these core gender-specific aspects of menstruating adolescent girls. As argued in a 2016 landscape analysis of menstrual health in India, “the lack of psycho-social support and limited facilitator capacities miss the opportunity to build the girl’s confidence and shift inherent discriminatory social norms that define a girl’s role in Indian society” (FSG 2016, 18). SBA’s ‘theory of change’—that awareness of menstruation as a natural physiological process will remove silence, stigma, and shame—is simplistic and grossly inadequate.

India’s public health system has a vast infrastructure and network of workers at the village level—the site at which SBA is being implemented. One of the central features of any water, sanitation and hygiene (WASH) program is the connection to health. Yet the MHM Guidelines in SBA do not have any component to make visible the relationship of the menstrual cycle to basic health, psychosocial well-being, and menstrual health. The SBA envisions MHM in a restrictive manner, as an issue to be addressed *only* in the context of the period of bleeding, not across the menstrual cycle. Therefore, although its IEC

material includes information on the biology of the menstrual cycle, it does not have any programmatic component to link adolescent girls with public health.

The SBA's shortsightedness missed an excellent opportunity to link the MHM and WASH agenda with the public health agenda in spite of the RCH focus on the public health system for over two decades. The focus on 'hygiene' rather than 'health' means a lost chance to address health issues associated with the disorders of the menstrual cycle, such as dysmenorrhea, amenorrhea, menorrhagia, pelvic infections, and endometriosis, among others. The SBA, currently housed in two separate ministries (the Ministry of Drinking Water and Sanitation and the Ministry of Housing and Urban Affairs), should have invited the Ministry of Health to colead the SBA or to build the missing components required for a comprehensive menstrual health approach through revisions of the NHP 2017. Instead the NHP 2017, formulated a full three years after the launch of the SBA, only includes a stated 'intention of introducing school health programs to address issues of health and hygiene' (MoHFWGOI 2017, 11), possibly a veiled reference to menstrual health and hygiene. The NHP 2017 too has failed to grasp the opportunity offered by SBA to incorporate discourse and action to address barriers to women's menstrual health.

CONCLUSION

India's health policies (1983, 2002, and 2017) and adjacent policies on nutrition, mental health, older persons, population, and rural health have failed to address the inextricable linkage between menstrual stigma and women's basic health. The recent SBA is no exception, evident in the fact that it restricts its intervention to MHM and does not extend it to menstrual health.

We propose a new construct, 'menstrual justice,' to make explicit the links between the marking of women's bodies as inferior and the discrimination, inequality, and injustice they suffer. In particular, we oppose the use of menstruation to control women and their bodies, including the use of categories that compartmentalize women and girls: preadolescents and adolescents, women of reproductive age, and postmenopausal women. These artificial divisions ignore continuities in the underlying causes of women's experiences of ill-health across the life cycle. We contend that, in practice, women physically and psychosocially experience the health effects of having their bodies marked as 'impure' well before the bleeding begins and well after it ceases. Thus, we propose a nonreductionist approach to women's health that goes beyond the narrow confines of fertility and menstrual health: menstrual justice in health.

The menstrual justice framework provides a lens through which to comprehend the discrimination and human rights violations that are borne by women and that result from marking women primarily and exhaustively as

‘menstruating bodies’ in the specific sociocultural and religious contexts of India. Rooted in women’s rights and gender equality, this lens can serve as the basis for compelling the state to dismantle edifices built on the designation of menstruating Indian women’s bodies as ‘impure.’

NOTES

1. We recognize that the term menstruators is more gender inclusive, and nonessentializing. However, our chapter focuses on discrimination against women embedded in India’s patriarchal society, so we opted to use the terms woman and women here. The complex processes of affirmation, challenge, and discrimination against individuals who identify as Third Gender in India are beyond the scope of this chapter.
2. Margaret Johnson (2019) captures the multiplicity of axes of domination that impact women’s experiences of menstruation and suggests that Menstrual Justice is a ‘structural intersectionality.’ Our concept of Menstrual Justice has emerged from the bottom up, from Indian women’s everyday experiences of menstruation in the sociocultural, religious, and political conditions of their living.

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