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"MENSTRUAL HEALTH, CASTE TABOOS, AND HEALTHCARE ACCESS: LIVED EXPERIENCES OF DALIT WOMEN IN BELGAUM DISTRICT, KARNATAKA"

Dr. Manjula G K*

*Assistant Professor, Department of PG Study and Research in Sociology, Rani Chennamma University, Belagavi, Karnataka- 591156

Abstract

This study investigates the intersection of menstrual health, caste-based taboos, and access to healthcare services among Dalit women in Belgaum District, Karnataka. Drawing on sociological theories of intersectionality and social exclusion, the research explores how deeply caste norms entrenched and gendered cultural practices shape menstrual experiences, restrict healthcare utilization, and perpetuate health inequalities. Secondary literature shows that Dalit women experience a compounded disadvantage due to caste discrimination and gendered social norms impacting health outcomes and access to reproductive health services. Using structured interviews with 50 Dalit women respondents; this study presents quantitative and qualitative evidence on menstruation-related stigma, hygienic practices, barriers in accessing public health services, and the social implications of menstrual taboos. The findings highlight significant gaps in menstrual hygiene management, influenced by caste stigma, limited health literacy, infrastructure deficits, and cultural restrictions, particularly in rural and peri-urban areas. The study concludes that menstrual health challenges among Dalit women are not just biomedical but tightly bound to social exclusion and caste hierarchies. Policy implications include the need for culturally sensitive community health programs, targeted awareness campaigns, and improved service delivery within primary health centres. By foregrounding lived experiences, this research contributes to a deeper sociological understanding of caste-gendered health inequities in India.

Keywords: Menstrual health, Dalit women, caste taboos, healthcare access

Introduction

The intersection of caste and gender in India produces layered forms of disadvantage that profoundly shape women's health, dignity, and access to care. Women from historically marginalized castes, particularly Dalit communities, experience social exclusion not only through economic deprivation but through deeply embedded cultural norms that regulate their bodies, labour, and mobility. These structural inequalities extend into the domain of reproductive and menstrual health, where stigma, silence, and restricted access to resources converge. Sociological scholarship has long established that health outcomes cannot be understood merely through biomedical frameworks but must be interpreted within social hierarchies that determine who can access knowledge, care, and autonomy.

This study bridges that gap by examining how caste-based taboos intersect with gender norms to influence menstrual health practices and healthcare access among Dalit women in Belgaum District, northern Karnataka. Situated within a broader sociological understanding of *social exclusion*, the

study uses primary field data to explore cultural practices, social attitudes, and structural barriers affecting menstrual health.

Menstruation, though a biological process common to all women, is socially constructed in ways that reflect ideas of purity, pollution, and moral order. In caste-stratified rural Karnataka, menstrual practices are shaped by dominant caste beliefs that regulate women's behaviour during menstruation restricting their participation in household work, social interactions, and religious spaces. For Dalit women, these taboos operate alongside caste-based discrimination, intensifying experiences of isolation and indignity. As observed in *Caste, Gender and Health Inequalities: A Sociological Study of Marginalized Women* by Dr. Manjula G K (2013), caste and gender intersect to produce a "double burden" that restricts women's access to reproductive health awareness, hygienic resources, and institutional care, especially in rural settings where caste norms are rigidly observed.

Despite policy initiatives promoting menstrual hygiene awareness and free sanitary products, there remains a significant gap between policy intent and lived reality. Menstrual health challenges among Dalit women are therefore not simply issues of awareness or affordability; they are embedded in caste hierarchies, gendered socialization, and systemic exclusion from dignified healthcare access. By situating menstrual experiences within the broader framework of caste-gender relations and social exclusion, this study seeks to foreground the lived experiences of Dalit women in Belgaum District, Karnataka, and contribute to a deeper sociological understanding of how cultural taboos and institutional barriers continue to shape menstrual health inequities.

Background and Theoretical Framework

Caste, Gender, and Health Inequality

Caste in India operates as a durable system of graded inequality that distributes dignity, labour, space, and resources along hierarchical lines. For women located at the bottom of this hierarchy, caste does not act alone; it fuses with patriarchy to shape everyday vulnerabilities in education, work, mobility, and health. Dalit women therefore encounter what scholars describe as compounded or "interlocking" disadvantage gender subordination within community structures and caste discrimination in the wider social order. This dual location has direct consequences for healthcare access, reproductive autonomy, and the willingness or ability to engage with public health systems.

Sociological analyses by **B. R. Ambedkar** foreground how notions of purity and pollution structure social distance and regulate bodily practices across caste lines. Later ethnographic work by **M. N. Srinivas** and **Louis Dumont** demonstrated how ritual hierarchy becomes embedded in everyday routines, spatial segregation, and access to common resources such as water, temples, and sanitation. These structural arrangements continue to influence who uses which facilities, who shares which spaces, and whose bodies are considered polluting dynamics that become particularly visible during menstruation.

Feminist scholarship has further emphasized that women's bodies are key sites where caste discipline is reproduced. **Uma Chakravarti** argues that control over women's sexuality and bodily functions is central to maintaining caste boundaries. **Sharmila Rege** extends this argument by demonstrating how Dalit women's experiences remain marginalized even within mainstream feminist discourse, necessitating a Dalit feminist standpoint to understand health, labour, and dignity. These insights are crucial for interpreting menstrual restrictions not as isolated customs but as practices that reinforce caste order and gender control.

Menstrual health, frequently treated in biomedical and behavioural terms, cannot be adequately understood without examining these socio-cultural structures. Restrictions during menstruation such as exclusion from kitchens, water sources, religious spaces, or shared toilets are shaped by caste-coded beliefs about pollution. Studies on sanitation and access to toilets in rural India, including work by **Diane Coffey** and **Dean Spears**, show that access to sanitation is mediated by caste location and settlement patterns, affecting women's privacy and menstrual hygiene practices. Thus,

menstrual management becomes inseparable from questions of spatial segregation, infrastructure, and social dignity.

Theoretical Anchors: Intersectionality and Social Exclusion

This study is theoretically grounded in intersectionality, a framework articulated by **Kimberlé Crenshaw**, which posits that systems of oppression such as caste and genderinteract to create distinct forms of marginalization. Applied to the Indian context, intersectionality helps explain why Dalit women's menstrual experiences differ not only from men's experiences but also from those of upper-caste women.

The research also draws upon the social exclusion paradigm developed in the work of **Amartya Sen**, which emphasizes how institutional arrangements systematically deny certain groups access to capabilities, participation, and services. Social exclusion in healthcare is not merely about absence of facilities but about discriminatory practices, cultural insensitivity, and lack of dignified engagement within institutions.

Together, these theoretical perspectives enable a sociological reading of menstrual health as a site where caste hierarchy, gender control, infrastructure deficits, and institutional exclusion converge, shaping the lived experiences of Dalit women in Belgaum District.

Literature Review

- **Sharmila Rege (1998)** establishes a foundational Dalit feminist standpoint for analysing caste–gender intersectionality. Rege argues that purity pollution codes regulate women's bodies in caste society and that Dalit women's experiences are essential to understanding how stigma, silence, and control operate around menstruation and reproductive health.
- **Bama Faustina Soosairaj**, in *Karukku*, presents narrative evidence of caste humiliation shaping bodily dignity and access to shared spaces. Her reflections illuminate how shame surrounding the female body is socially produced, offering insight into the internalization of menstrual stigma among Dalit women.
- **Urmila Pawar**, through *Aaidan (The Weave of My Life)*, documents how caste taboos govern food, space, and bodily practices, including menstruation. Pawar's life history shows how ideas of impurity restrict women's participation in family and community life during menstruation.
- **P. Sivakami** explores caste oppression and gendered bodily control in her literary works, demonstrating how Dalit women's reproductive and menstrual experiences are subjected to moral surveillance and social regulation.
- **Shailaja Paik (2014)**, in *Dalit Women's Education in Modern India*, provides an intersectional account of how denial of education and health awareness limited Dalit women's knowledge of their own bodies. This historical deprivation contributes to persistent misinformation and silence around menstrual health.
- **Dr. Manjula G K (2013)**, in *Caste, Gender and Health Inequalities: A Sociological Study of Marginalized Women* published in the **Journal of Population Therapeutics and Clinical Pharmacology**, shows that humiliation, lack of awareness, and caste stigma discourage marginalized women from seeking institutional reproductive healthcare, reinforcing poor menstrual hygiene practices.

Together, these ten works provide a coherent sociological foundation demonstrating that menstrual health among Dalit women is inseparable from caste hierarchy, gender control, labour burdens, knowledge systems, and institutional exclusion.

Methodology

This study adopted a field-based empirical design to examine the lived menstrual experiences of Dalit women in **Belagavi** district, Karnataka. The respondent group comprised women belonging to Scheduled Caste (Dalit) communities residing in rural and peri-urban settings. A total sample of 50 respondents was selected using purposive sampling to ensure representation from socially and geographically diverse habitations. The sample was distributed across five villages in the district,

with ten respondents drawn from each village to enable comparative understanding of local variations in menstrual practices and healthcare access.

Data were collected through a combination of structured surveys and in-depth personal interviews. The structured survey facilitated the collection of quantifiable information on menstrual hygiene practices, access to sanitation facilities, use of menstrual products, and patterns of healthcare utilization. To complement this, in-depth interviews were conducted using an open-ended interview guide to capture personal narratives, cultural beliefs, experiences of stigma, and perceived barriers in accessing healthcare services during menstruation.

Two primary research tools were employed: a checklist to systematically record observable and factual information, and an interview guide designed to elicit detailed qualitative insights into the respondents' lived experiences. This mixed-method approach enabled the triangulation of data, enhancing the reliability and depth of the findings. The methodological design ensured that both measurable patterns and subjective experiences related to caste taboos, menstrual health, and healthcare access were adequately documented.

Table 1- Age Distribution of Respondents

Age Group	Frequency	Percentage
15–24	10	20%
25–34	18	36%
35–44	12	24%
45+	10	20%

Source: Primary data

The age profile shows that the largest group of respondents (36%) falls within the 25–34 age category, followed by 35–44 years (24%). Younger women aged 15–24 and older women aged 45+ each constitute 20% of the sample. This distribution indicates that the study captures menstrual experiences across reproductive life stages from adolescents and young adults to mature and older women. The dominance of the 25–34 group is significant because women in this age range are often actively engaged in household labour, childcare, and wage work, which may influence how they manage menstrual hygiene and seek healthcare. Inclusion of older women also allows insights into generational continuity of caste taboos and menstrual practices.

Table 2- Menstrual Hygiene Practices

Practice	Frequency	%
Use of sanitary pads	28	56%
Use of cloth	20	40%
No menstrual product	2	4%

Source: Primary data

A majority of respondents (56%) reported using sanitary pads, while a substantial 40% still rely on cloth, and 4% use no menstrual product at all. Although pad usage appears relatively higher, the continued dependence on cloth indicates economic constraints, limited availability, or lack of awareness regarding hygienic alternatives. The small percentage using no product is particularly concerning as it reflects extreme deprivation and potential health risks. These findings reveal that menstrual hygiene management among Dalit women is shaped not only by awareness but by affordability and access to resources.

Table 3- Access to Healthcare for Menstrual Issues

Access Type	Frequency	%
Public PHC visits	15	30%
Private clinic	10	20%
No access	25	50%

Source: Primary data

Half of the respondents (50%) reported having no access to healthcare for menstrual problems. Only 30% visited public Primary Health Centres (PHCs), and 20% sought care from private clinics. The high proportion of women with no healthcare access highlights systemic neglect, possible discrimination, distance to facilities, or normalization of menstrual discomfort as something not requiring medical attention. The relatively low utilization of PHCs suggests barriers such as lack of trust, poor service quality, or cultural discomfort in discussing menstrual issues with healthcare providers.

Table 4- Perceived Caste Taboos Impacting Menstruation

Belief/Practice	Frequency	%
Restricted from kitchen	22	44%
Restricted from puja rooms	18	36%
Restricted from drawing water	15	30%

Source: Primary data

The data show that caste-based menstrual restrictions remain deeply embedded in everyday life. About 44% of women reported being restricted from entering the kitchen, 36% from entering puja rooms, and 30% from drawing water during menstruation. These practices reflect enduring beliefs in purity and pollution that regulate women's mobility and participation in domestic and religious spaces. Such restrictions reinforce stigma and social exclusion during menstruation, affecting women's dignity and sense of belonging within their own households.

Table 5- Health Education Exposure

Exposure	Frequency	%
Received menstrual health information	12	24%
No information received	38	76%

Source: Primary data

A significant majority (76%) of respondents reported that they had never received any formal information about menstrual health, while only 24% had some exposure to menstrual health education. This lack of awareness contributes to misinformation, continuation of unhygienic practices, and reluctance to seek healthcare. The findings underscore the urgent need for targeted menstrual health education programs, particularly for marginalized women in rural settings, to improve knowledge, hygiene practices, and healthcare utilization.

Findings

The findings of the study reveal that menstrual health among Dalit women in **Belagavi** district is deeply shaped by caste norms, economic hardship, limited institutional outreach, and persistent stigma. The quantitative data, supported by qualitative narratives from in-depth interviews, demonstrate that menstrual experiences are not merely biological events but socially regulated practices influenced by caste hierarchy and gendered expectations.

1. Caste Taboos and Menstrual Stigma

A significant proportion of respondents reported restrictions on their participation in routine household activities during menstruation. Over 40 percent indicated that they were not allowed to enter kitchens, participate in food preparation, or access certain parts of the house. Many were also barred from religious spaces and, in some cases, from drawing water from common sources. These practices reflect enduring notions of purity and pollution associated with menstruation, which are further intensified by caste location.

Interview narratives revealed that such restrictions are often internalized as "tradition" rather than questioned as discriminatory practices. Women described feelings of shame, isolation, and lowered self-worth during menstruation. The stigma is not limited to ritual exclusion but extends to social interactions, where menstruating women prefer to self-isolate to avoid judgment. These findings indicate that caste-based cultural norms continue to regulate women's bodily practices and reinforce social exclusion within their own households and communities.

2. Limited Access to Healthcare Services

The study found that 50 percent of respondents had never accessed any form of healthcare service for menstrual discomfort, irregularities, or reproductive concerns. Only a minority visited public Primary Health Centres, and even fewer sought private medical care. The reasons cited include distance to facilities, lack of transportation, financial constraints, and discomfort in discussing menstrual issues with healthcare providers.

Several respondents expressed fear of humiliation or dismissal at health centres, suggesting a lack of culturally sensitive engagement by healthcare staff. Menstrual pain and irregularities were often normalized as routine aspects of womanhood that do not require medical attention. This normalization, combined with structural barriers, prevents women from seeking timely care and perpetuates untreated health issues.

3. Hygiene Practices and Economic Constraints

While more than half of the respondents reported using sanitary pads, interviews revealed that pad usage is inconsistent due to cost and irregular supply. Many women alternate between pads and reusable cloth depending on availability and affordability. Cloth use, though traditional, poses hygiene risks when washing and drying facilities are inadequate or when privacy is limited.

A small proportion of women reported using no menstrual product at times, relying instead on old garments or makeshift materials. This highlights the depth of economic deprivation and the absence of reliable menstrual hygiene support systems. The findings suggest that awareness of sanitary products alone is insufficient; affordability and sustained access remain critical challenges.

4. Lack of Menstrual Health Education

An overwhelming majority of respondents indicated that they had never received structured education on menstruation from schools, health workers, or community programs. Knowledge about menstruation was largely transmitted through mothers or elder women, often framed within taboos and restrictions rather than scientific understanding.

The absence of formal health education contributes to misconceptions, fear, and silence around menstrual issues. Women lacked awareness of when menstrual symptoms require medical attention and were unfamiliar with hygienic best practices. This gap reflects shortcomings in public health outreach, particularly in reaching marginalized caste communities with culturally appropriate education.

Overall, the findings demonstrate that menstrual health challenges among Dalit women are embedded within a complex web of caste stigma, economic hardship, limited healthcare access, and inadequate health education. Addressing these issues requires interventions that go beyond product distribution to challenge cultural taboos, strengthen healthcare engagement, and expand targeted awareness efforts.

Recommendations

Improving menstrual health among Dalit women in **Belagavi** district requires interventions that address not only hygiene practices but also the caste-based stigma, institutional gaps, and knowledge deficits identified in this study.

1. **Targeted health education in Dalit settlements:** Focused menstrual health education programs should be conducted directly within Dalit habitations rather than expecting women to access distant facilities. These sessions must explain menstrual biology, hygienic practices, danger signs, and women's health rights in simple, culturally appropriate language. Regular outreach by frontline workers can help replace taboo-driven beliefs with informed understanding.
2. **Community mobilisation to challenge caste norms:** Sustainable change requires engaging the broader community elders, men, religious influencers, and local leaders—to question purity–pollution beliefs attached to menstruation. Facilitated community dialogues, street plays, and women's group discussions can normalize menstruation as a health issue rather than a source of stigma. Collective reflection can gradually reduce restrictive practices within households.
3. **Incentive-based sanitary product distribution:** Although awareness of sanitary pads exists, irregular access and cost barriers prevent consistent use. Distribution of free or subsidized sanitary products through ASHA workers and Primary Health Centres should be strengthened, with monitoring to ensure regular supply in marginalized settlements. Incentives for consistent usage and safe disposal practices can further promote hygienic management.
4. **Cultural-sensitivity training for healthcare workers:** Healthcare providers at PHCs should be trained to address menstrual concerns with empathy and confidentiality. Sensitization programs can reduce unconscious caste bias and improve communication with Dalit women, encouraging them to seek care without fear of humiliation.
5. **School-based awareness involving boys and girls:** Menstrual education should be integrated into school health programs for both female and male students. Involving boys is crucial to dismantle stigma at an early age and foster supportive attitudes within families and communities over time.
6. **Integration into state health planning:** Findings from localized sociological research such as this should inform district and state health policies. Menstrual health equity must be recognized as part of reproductive health planning, with targeted strategies for caste-marginalized communities.

Conclusion

This study demonstrates that menstrual health challenges faced by Dalit women are deeply embedded in caste hierarchies, gendered cultural norms, economic hardship, and institutional neglect. Menstruation, though biological, becomes a socially regulated experience marked by stigma, restriction, and silence. Limited healthcare access, inconsistent hygiene practices, and lack of education are not isolated issues but consequences of broader social exclusion.

Addressing menstrual health inequities therefore requires more than distribution of sanitary products; it demands culturally sensitive education, community-level transformation of beliefs, and inclusive healthcare practices. By centering the lived experiences of Dalit women in **Belagavi**, this study underscores the need to view menstrual health through a sociological lens that recognizes caste and gender as central determinants of health dignity and access.

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