

Bleeding during the pandemic: the politics of menstruation

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Chennai is the capital city of the state of Tamil Nadu in the southern part of India, with a population of 7 million. As the government's flagship organisation for training state public health officers in epidemiology and health systems, we have been visiting high-risk areas in Chennai as part of capacity building for the state public health system during the ongoing COVID-19 pandemic. Metropolitan cities like Chennai are highly heterogeneous in population structure. Different income groups are settled in particular areas and the infection transmission dynamics vary across the different settlements. High-risk areas are identified based on population density and case incidence from the city's surveillance data and happen to be low-income group settlements and urban slums. People residing in urban slums constitute 29% of Chennai's population, of which half are females.¹ COVID-19 poses a disproportionate health risk to women of reproductive age in these settlements, due to a combination of factors including but not limited to economic, environmental, and socio-political influences. In this context, this article describes our observations on menstruation needs during COVID-19.

The plight of menstruating females in urban slums of Chennai

The pandemic has opened a Pandora's box for everyone, but more so for people in low-income, urban areas. The residences in the settlements have barely two rooms, housing 5–6 people. Some of the settlements are in the fringes of the city away from the hub, cut off from basic facilities. The residents are mostly engaged in some form of unorganised labour, and many experienced loss of income when the city was locked down due to

COVID-19. Active door-to-door surveillance for COVID-19 brings to light the multitude of health risks that the residents are subject to. Although both men and women in these settlements are equally exposed to risk factors, and men are much more likely to progress to severe forms of the disease, the secondary impacts of the pandemic are disproportionately borne by the thousands of girls and women who reside here, who are already marginalised.² When crisis strikes, existing vulnerabilities get exaggerated. Physical distancing amidst lockdown is practically impossible for people who live in a room of less than 2.5 square metres. Crammed spaces and having to stay indoors all day due to lockdown have meant the privacy needed for dignity during women's menstrual periods is lost. Shared toilets are scary to use now, but the only place available for most to take care of their sanitary needs. This has been compounded by the summer and the severely compromised access to safe water. The right to menstrual hygiene and dignity is affected by the denial or neglect of their right to equitable access to safe water.

The closure of shops and shutdown of transport means less availability and accessibility of menstrual hygiene provisions. Essential basic services get suspended due to higher priorities for controlling transmission of the pandemic, like recruiting more healthcare workers to supplement the heavily stretched work force, expanding bed availability for COVID-19 patients, cash transfers, arranging for food and groceries and so on. In the process, the specific needs of certain vulnerable sections of the population get deprioritised, as available resources are diverted from routine healthcare services including those for the sexual and reproductive health needs of girls and women, despite the

increased risks they face. Experiences from around the world during previous pandemics reiterate the same situation.³ Who gets what amidst the contested interests is deeply political.

The adolescent health programme *Rashtriya Kishor Swasthya Karyakram* (RKSK), launched in January 2014 under the National Health Mission, identified menstrual hygiene as a key strategic priority,⁴ to be addressed through a clinical component for the treatment of menstrual disorders, as well as through the promotion of menstrual hygiene by the provision of sanitary napkins and clean cloths to adolescent girls. Health facilities serve as depots for sanitary napkins and also to treat menstrual problems and disorders. In Tamil Nadu, sanitary pads were distributed at schools with the help of field staff involved in the school health programme *Rashtriya Bal Suraksha Karyakram*. With COVID-19, and as schools shut down, access to hygienic provisions was compromised. Although pharmacies remained open, availability does not automatically translate to affordability as families' financial difficulties during lockdown made basic provisions unaffordable. The adolescent health clinics that were intended to be safe spaces for adolescents to seek sexual and reproductive health care were running lean already and have now been shut down completely.

Implications

COVID-19 has clearly demonstrated how public health emergencies expose the fragilities of health systems. Notwithstanding these emergencies, governments should still provide healthcare services and alter conditions that create, exacerbate and perpetuate poverty, deprivation, marginalisation and discrimination. Neglecting important and essential components can have manifold implications.

Firstly, it risks the lives of marginalised populations, with increased reproductive tract infections, urinary tract infections, anaemia, restricted food and liquid intake, gender-based violence, and poor mental health.⁵ Many of these concerns, left unattended, could even prove fatal.

Secondly, if high-risk populations do not have the necessary information and means to access food, water, medicine and basic hygienic requirements, we cannot expect them to quarantine or isolate themselves or follow behavioural and public health interventions imposed on them to manage the pandemic. These types of interventions,

prescribed by epidemiologists, will prove ineffective if we neglect the basics, such as access to clean water and basic sanitary requirements, during the pandemic.

Finally, with increased domestic responsibilities, adolescent girls and working women may experience deteriorations in their health indirectly from the burdens of extra work like fetching water. The price of water from private tankers has also been exorbitantly high during the pandemic due to lockdown and motility issues. The girls and women in these water-insecure areas face narrow choices, and inability to exercise their agency in prioritising health issues over the basics like fetching water. In addition, compromises in menstrual hygiene could reflect in educational attainment and employment, with these two factors already hampered by lockdown.

The way forward: response and research

Equitable access to water should be ensured by the government for vulnerable and marginalised communities. It becomes imperative for the government to map water-insecure areas and attend to water demands by arranging tankers and alternative source of water. The lockdown has meant significant loss of livelihoods, disproportionately affecting high-risk groups. The government could take steps to ease financial burdens by subsidising or waiving water bills during the pandemic. As schools remain closed and with hospitals becoming hotspots of infection, sanitary requirements for vulnerable people need to be distributed at their doorstep. With healthcare workers burdened by COVID-19 contact tracing, testing, isolation and treatment across the country, we need to find people from other sections of the community to take over door-to-door services. In Tamil Nadu's context, non-government organisations and volunteers who are already visiting houses for mask distribution can be utilised for this purpose. This can help address period poverty to a great extent. Government and non-government organisations could take steps to inform people about the preparation of safe and healthy sanitary materials locally or at home, so that people do not have to depend on external support.

Water is often viewed as a technical field usually dominated by men, who tend to offer technical solutions to water-related problems.⁶ Adopting a rights-based approach for access to water and sanitation could provide women and girls

opportunities to exercise their agency, redress power relations and improve equitable access to water for sexual and reproductive health. A rights-based approach will challenge the structural discrimination that women face, not only within the health system but also in their public and private lives. The social and cultural factors pushing them to exclusion and discrimination need to be considered when attempting to fulfil their rights to safe water and sanitation.

The context, setting and immediate environment influence and direct the health behaviour of communities. The right to dignity and menstrual hygiene is intertwined with the right to access clean, safe water. Nevertheless, observations and inferences need to be supported and validated by rigorous epidemiological evidence. We need to scrutinise these concerns comprehensively to

understand who is really at a disadvantage and who is not, and document whether the observed disparities actually make a difference. We need to complement evidence-based approaches with rights-based approaches, so that we make strong decisions based on the best available research evidence that situates women's preferences in the local context. This is critical for tailoring the right public health interventions and effecting advocacy for the same.

Disclosure statement

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