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Ritual, Stigma, and Reproductive Health-Seeking Among Women in Assam

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ABSTRACT: Menstruation is a biological process, but across cultures it has been shaped into a set of rituals, restrictions, and taboos sanctioned by religion and community. These rituals mark the menstruating body as impure and, in doing so, extend patriarchal control over women's bodies, making the menstrual body not only biological but political. This study examines how menstrual rituals and the stigma they produce shape women's perceptions of their own bodies, and how this in turn affects their engagement with reproductive health care in Assam. Drawing on fieldwork conducted in the Charaideo district of Assam, the study is based on qualitative interviews and focus group discussions with 50 participants, including women across the reproductive life course, health professionals, traditional and faith healers, and male community members. The findings show that menstrual rituals shape women's psychological experience of their own bodies, and that this embodied experience of shame and restriction in turn affects whether and how women seek reproductive health care, through formal medical channels, informal advice, or avoidance altogether. The study argues that this ritual-derived stigma is not only a cultural or health-behaviour concern but also a rights concern, since restrictions on menstrual and reproductive care bear on women's constitutional right to a dignified life.

KEYWORDS: Menstruation, ritual, stigma, embodiment, reproductive health, Assam

1. INTRODUCTION

Menstruation is a biological process, but it does not remain only that. Across cultures, the menstruating body is treated as dirty or impure, and rituals observances, restrictions, and rites sanctioned by religion and community are the mechanism through which this belief is enforced. Through these rituals, patriarchal society regulates and controls women's bodies, which makes clear that the female body is never purely biological. It is also political.

Ritual as a category of study emerged in the nineteenth century, as scholars began systematically examining repeated human practices and their symbolic meaning. Some scholars treat ritual and belief as separate while others argue that, they are inseparable, with ritual as the vehicle through which belief becomes everyday behaviour (Bell, 2009). Rappaport (1999) similarly shows that ritual is not only performance but also speech, and that both are frequently used to politicise belief like the bodily movement, isolation, and shame during menstruation as clear examples of this. Dhall (n.d.) identifies invariance, i.e., the disciplined repetition of the same bodily behaviour over time as a defining feature of ritual, along with its dependence on symbolic objects and actions. Rituals typically mark transitions with birth, puberty, marriage, aging. Puberty rituals in particular carry weight for girls, since they symbolically install the transition into womanhood, fertility, and eventual motherhood (Dhall, n.d.).

Where ritual theory explains how menstrual belief is enacted, embodiment theory explains how it is *experienced*. Iris Young's account of female body experience argues that the body is not simply a physical object but a site of perception, shaped by the social context surrounding it (Young, 2005). Applied to menstruation, this means the shame and stigma attached to the menstruating body do not stay external as they become part of how menstruators perceive their own bodies, moment to moment, cycle to cycle. This study draws on ritual theory (Bell, Rappaport, Dhall) to understand menstrual practice as repeated, symbolic behaviour; on Young's phenomenology to understand how that practice is internalised as lived, embodied experience; and on feminist standpoint theory to treat women's own accounts of this experience as the primary evidence for understanding it. The study further draws on Bourdieu's (1990) concept of habitus to explain how ritual practice becomes internalised as unquestioned disposition rather than conscious choice, and on the concept of gender performativity to understand fertility-linked rituals as repeated enactments through which womanhood and motherhood are socially constituted.

This embodied experience does not stay confined to self-perception. It extends into health behaviour. Reproductive health is formally defined by the WHO (2019) as a state of complete physical, mental, and social well-being in matters of the reproductive system, implying a woman's freedom to make informed, autonomous decisions about her own body. In practice, however, ritual restrictions on menstruating women's mobility, speech, and self-presentation frequently generate shame that makes it difficult to discuss menstrual concerns openly, let alone seek care for them (Elliason et al., 2025). Because health practices are inseparable from the cultural systems that shape how people interpret illness and the body (Peoples & Bailey, 2011), menstruation is often read

simultaneously as impurity and as a marker of eligibility for motherhood, a duality that directly affects how women approach reproductive health services (Rothchild & Piya, 2020). Cultural stigma around sexual and reproductive health has been shown to delay women from seeking care until problems become severe (Anandini, 2025), and ritual restrictions on mobility and autonomy specifically constrain menstrual hygiene management and access to services (Thapa et al., 2019).

Much of this evidence, however, comes from Nepal and other parts of South Asia. Comparatively little work has examined how ritual practice shapes reproductive health-seeking specifically in Northeast India, and in Assam in particular, a gap that this study addresses. It is not yet well understood whether ritual-derived stigma leads Assamese women to delay care, avoid it altogether, or seek it instead through traditional or informal channels. This study therefore has three objectives: (1) to document the menstrual rituals and restrictions practised across the reproductive life course, from puberty through menopause in the study area; (2) to examine how these rituals shape women's psychological and embodied experience of menstruation; and (3) to analyse how the resulting stigma affects women's decisions to seek, delay, or avoid reproductive health care.

2.METHODOLOGY

This study follows a qualitative, interpretive approach, chosen to capture women's lived experience of menstruation and ritual practice. The research is grounded in feminist standpoint theory, which treats women's own accounts of their experience as a legitimate and necessary source of knowledge for understanding social reality. Focusing on women's perspectives in this way allows the study to examine how ritual and cultural belief shape both self-perception and health-seeking behaviour, rather than approaching these as external variables to be measured from the outside.

2.1. *Study Area*

The fieldwork for this study was conducted in Charaideo district of Assam. Four development blocks namely, Abhoypur (now known as Sonari), Mahmora, Lakuwa and Sapekhati were selected purposively. These areas were chosen because they represent diverse social and cultural settings within the district. The district has several private clinics, one civil hospital, primary health centres that serve as key public health facilities. These health institutions, along with local villages and urban areas, formed important sites for understanding women's experiences of menstrual and reproductive health care.

2.2. Sampling and Participants

Purposive sampling was used to select participants who could provide meaningful insights into menstrual practices and beliefs within their communities. A total of 50 respondents participated in the study through individual and group interviews. The participants included women from different age groups, ranging from 13 to 80 years. This wide age range made it possible to explore experiences across different stages of the reproductive life cycle, including puberty, reproductive years and menopause.

In addition to women participants, interviews were conducted with health professionals and community figures in order to understand different perspectives on menstrual health. These included doctors, ASHA workers, traditional healers, faith healers and religious practitioners. Their perspectives helped provide a comparative understanding of both medical and cultural interpretations of menstruation. Focus group discussions and individual interviews were also conducted with male participants in order to understand broader community attitudes towards menstruation. Schools, health institutions and traditional healing spaces were included in the fieldwork to explore how menstrual knowledge and beliefs circulate within everyday social environments.

2.3. Sources of Data

The study is based on both primary and secondary sources of data. Primary data were collected through fieldwork using semi-structured interviews, open-ended conversations and focus group discussions. These methods allowed participants to share their experiences and perspectives in their own words. Secondary data were gathered from books, academic journals and electronic resources relevant to the study of menstruation, culture and health practices.

2.4. Ethical Considerations

Ethical considerations were carefully maintained throughout the research process. No participant was included without their informed consent. For respondents below the age of eighteen, permission was obtained from parents or guardians before conducting interviews. When interviews were carried out in schools, prior permission was obtained from the school authorities. Participants were assured that the information they provided would be used only for academic purposes and that their identities would remain confidential.

3. DISCUSSIONS AND RESULTS

Fieldwork conducted across four development blocks of Charaideo district, Assam confirms that menstrual rituals continue to shape women's experience of their bodies and their engagement with health care. In each community, menstruation is surrounded by silence and restriction rather than open discussion. Respondents frequently referred to menstrual blood as *beya tej* (bad blood) or *latera tej* (dirty blood), describing menstruation as the discharge of impurity from the body rather than a natural biological process. Read through the ritual theory outlined earlier (Bell, 2009; Rappaport, 1999; Dhall, n.d.), this vocabulary is the everyday language

through which ritual belief is repeated and reinforced. Managing menstruation therefore becomes, for women and girls, a continuous social task centred on concealment (on being seen to not be menstruating). The following discussions examines how this concealment is lived out as embodied experience (Young, 2005), as habitus (Bourdieu, 1990), and as a set of health-seeking consequences that together answer this study's three objectives.

3.1. Concealed shyness: Ritual Influence on Menstrual Health Behaviour

Menstruation in the study area is experienced as what Young (2005) calls a lived, embodied one, shaped by how the body is perceived and judged within a social setting, rather than by anatomy or biological process alone. Field narratives from Tengaphukuri, Sonari, and Mahmora illustrate this. At Tengaphukuri Primary Health Centre, adolescent girls rarely approached doctors independently for menstrual complaints. Several described discomfort at the prospect of a male gynaecologist. A doctor at the centre observed that teenage girls typically attend consultations with their mothers rather than their fathers, and that mothers usually explain the girl's symptoms while the girl remains silent.

Read through Young's framework, the mother's role as intermediary is evidence that the girl has already internalised menstrual shame as something not to be voiced directly, even to a medical professional. ASHA workers substantiated this pattern, noting that younger, unmarried girls express far more embarrassment discussing menstrual concerns than married women, suggesting this embodied shame is not innate but socially learned and reinforced from an early age (Fingerson, 2006; McCarthy & Dutt, 2020), consistent with Rappaport 's (1999) observation that ritual restriction operates on the body and the psyche simultaneously.

3.2. Fear of Leakage and Menstrual Product Choices

This same embodied concealment as discussed above, governs a decision on the selection of which sanitary product to use. Field narratives show that adolescent girls prioritise leakage protection and visible concealment over any concern with product composition or long-term health effects. Several school students explained that they chose pads based on comfort, coverage, and the ability to prevent visible staining. One participant noted that she had switched to cotton pads only after an allergic reaction to synthetic material, not out of prior awareness of ingredients. None of the respondents reported examining the chemical composition of the products they used. In Young's terms, this is embodiment translated into consumer behaviour as the fear on revealing the menstrual blood is being managed. The fear here, is not a health risk but the risk of being *seen*, and that fear is not clinical information that drives the choice. Commercial advertising built around "leakage protection" steps into this gap, offering reassurance about concealment rather than about safety, and in doing so displaces rather than informs critical health engagement.

3.3. Cultural Beliefs and the Disposal of Menstrual Products

Practices surrounding the disposal of menstrual products also reveal the influence of cultural beliefs. Many respondents described washing used sanitary pads before discarding them, despite these being designed for single use, believing that visible menstrual blood could attract evil spirits or misfortune. As a result, pads are often washed and disposed of in secluded spaces such as backyards or behind bathrooms. Some respondents reported burning pads with kerosene to eliminate any visible trace. Okamoto (2018) describes this kind of practice as evidence of a broader gendered mindset in which shame, silence, and isolation become the default emotional register around menstruation. Medical practitioners interviewed for this study noted that disposable pads require no more than ordinary wrapping and disposal, a piece of biomedical guidance that exists in the same communities as these ritual practices without displacing them. This gap shows that ritual belief here is not a lack of access to correct information, but a separately operating system of meaning that biomedical advice alone cannot override.

3.4. The Politics of the motherhood: Ritual Expectations and Fertility

Menstrual ritual is closely tied to expectations of eventual motherhood. Among the Ahom, Sonowal Kachari, and Caste Hindu communities studied, the ritual of *Konai Kula Luwa* (taking a symbolic child in the arms) enacts this expectation directly. Fertility-linked menstrual rituals function as sites of gender performativity, occasions on which women repeatedly enact culturally scripted roles of femininity, motherhood, and reproductive responsibility, reinforcing over time the social equation of womanhood with fertility. Several respondents described motherhood as an essential, non-negotiable part of being a woman. Women unable to conceive were frequently advised toward fertility treatment, and one woman undergoing such treatment described having a child as what would make her life "complete." Daibes et al., (2018) similarly found that infertile women are often regarded as "half women," a status read as a failure of womanhood itself. Reproductive technologies such as IUI and IVF exist as medical options in the study area, but social pressure frequently converts motherhood from a choice into an obligation.

A doctor interviewed described couples selling land to afford fertility treatment. Many women turned instead to faith healers, hoping for divine intervention. In both cases, clinical and spiritual, the underlying belief is the same that a "complete" woman is one who has borne a child. One respondent described discomfort at attending a health centre alongside pregnant women, reflecting the stigma that childlessness itself carries in these communities.

3.5. Menopause, Misinformation, and Stigma

Ritual silence around the menstrual body extends into its later stages with particular consequence. Older, peri-menopausal women in the study frequently sought medical attention only once periods became irregular, sometimes fearing this signalled pregnancy rather than the onset of menopause. This confusion reflects two compounding effects of ritual silence: a genuine lack of bodily knowledge, and a deeper stigma around discussing sexuality and sexual pleasure at all, particularly past a certain age. Because menopause is frequently treated by both patients and health providers alike, as a natural, non-medical life stage rather than a phase requiring clinical attention, symptoms often go unrecognised, and women are left to manage them without support. In embodiment terms, this is the same mechanism seen in adolescence operating at the other end of the reproductive life course. A lifetime of learned silence about the body produces, in old age, not shame exactly, but invisibility. A woman's menopausal symptoms simply do not register as a legitimate health concern, to herself or to the system meant to care for her.

3.6. Rituals and Treatment Choices

Ritual belief also shapes treatment choice in ways best understood through Bourdieu's (1990) concept of habitus, the process by which repeated practice becomes internalised as an unquestioned, natural disposition rather than a consciously followed rule. This concept extends the ritual framework introduced earlier, where Bell, Rappaport, and Dhall explain ritual as symbolic, repeated action, habitus explains why that repetition eventually stops feeling like a choice at all. Many women in the study preferred consulting traditional healers for menstrual pain over visiting a clinic. Mothers frequently discouraged daughters from taking painkillers, believing this could compromise future fertility. Herbal remedies from village healers, described by respondents as *gaonlia dorob diya manuh*, became the default response to menstrual pain as a result. Economic factors reinforce this disposition rather than compete with it. The respondents opined that the traditional healers are typically more accessible and affordable than clinical services, so for many households facing financial constraint, ritual practice and economic necessity converge on the same outcome, one that also carries an implicit caste and class dimension in who can and cannot afford to choose otherwise.

3.7. Cultural Authority and Victim Blaming

Traditional healers and community belief also shape how menstrual and reproductive problems are interpreted, often in ways that place responsibility onto women themselves. Some healers linked irregular menstruation or menstrual pain to future infertility; others attributed fertility problems to women's failure to observe menstrual rituals correctly. Such explanations locate the cause of reproductive difficulty in ritual non-compliance rather than in medical or social circumstance, reinforcing the belief that ritual observance is itself a form of reproductive health maintenance. Health workers are not exempt from this logic. An ASHA worker interviewed described *Tuloni Biya*, the puberty ceremony observed in Charaideo district, as an important occasion that teaches girls their responsibilities as women. That a health worker, someone institutionally positioned as a biomedical authority endorses this framing shows how thoroughly ritual and habitus operate together. Thus, menstrual and reproductive norms are not experienced as historically produced social constructs, but as natural and self-evidently correct, even by those trained to treat the body clinically.

4. LIMITATIONS

This study has some limitations worth noting. The fieldwork was conducted in four development blocks of a single district i.e., Charaideo and while these blocks were purposively selected to capture social and cultural diversity, the findings reflect the specific ritual and community context of Upper Assam rather than the state as a whole. Assam is home to considerable linguistic, religious, and ethnic variation across its districts, and menstrual ritual practice documented here, particularly community-specific rites such as *Tuloni Biya* and *Konai Kula Luwa*, observed among the Ahom, Sonowal Kachari, and Caste Hindu communities may not extend to other communities within or beyond the state. The sample of 50 respondents, while sufficient for the qualitative, interpretive aims of this study, also limits the range of experience captured. Finally, because the research relied on semi-structured interviews and focus group discussions, findings reflect participants' self-reported accounts rather than direct clinical or observational data, and are therefore best read as an account of how menstrual ritual is *experienced and narrated*. These limitations do not undermine the study's core findings, but they do mean the conclusions should be read as context-specific rather than generalisable to Assam or Northeast India as a whole.

CONCLUSION

This study examined menstrual ritual and stigma in Charaideo district, Assam through three objectives, and the findings reveal that, first, rituals across the reproductive life course from the puberty ceremony of *Tuloni Biya* to the fertility ritual of *Konai Kula Luwa* continue to be actively observed and to carry real social weight in these communities. Second, these rituals do not remain external social rules but gradually they become embodied in Young's sense, as shame, secrecy, and self-concealment that shape how women perceive their own bodies from adolescence into old age. Third, this embodied stigma has direct consequences for health-seeking as it delays care, redirects it toward traditional healers, and in cases such as menopause, renders symptoms invisible to both women and the health system meant to address them.

The study concludes that the menstrual body is never only biological. It is a body regulated through ritual, internalised through embodiment, and naturalised through habitus which is precisely what makes menstrual and reproductive health difficult to treat as a purely clinical matter. This also carries a rights dimension that the findings make concrete: where ritual and stigma restrict a woman's ability to manage her own menstrual hygiene or seek reproductive care without shame, they restrict her right to a dignified life, a right recognised under Articles 21 and 21A of the Indian Constitution (Supreme Court Observer, 2026). Addressing menstrual stigma in Assam, this study suggests, is therefore not only a matter of health education but of enabling women's constitutional right to bodily dignity and autonomous decision-making.

Declaration: All submitted work is original and other sources are properly cited to avoid plagiarism.
Informed Consent: Verbal Informed consent was obtained from all participants prior to their participation in the study. Participation was voluntary and the respondents were informed about the purpose of the research, their right to withdraw at any stage and they are informed that data collected from the participants are for academic use only.
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