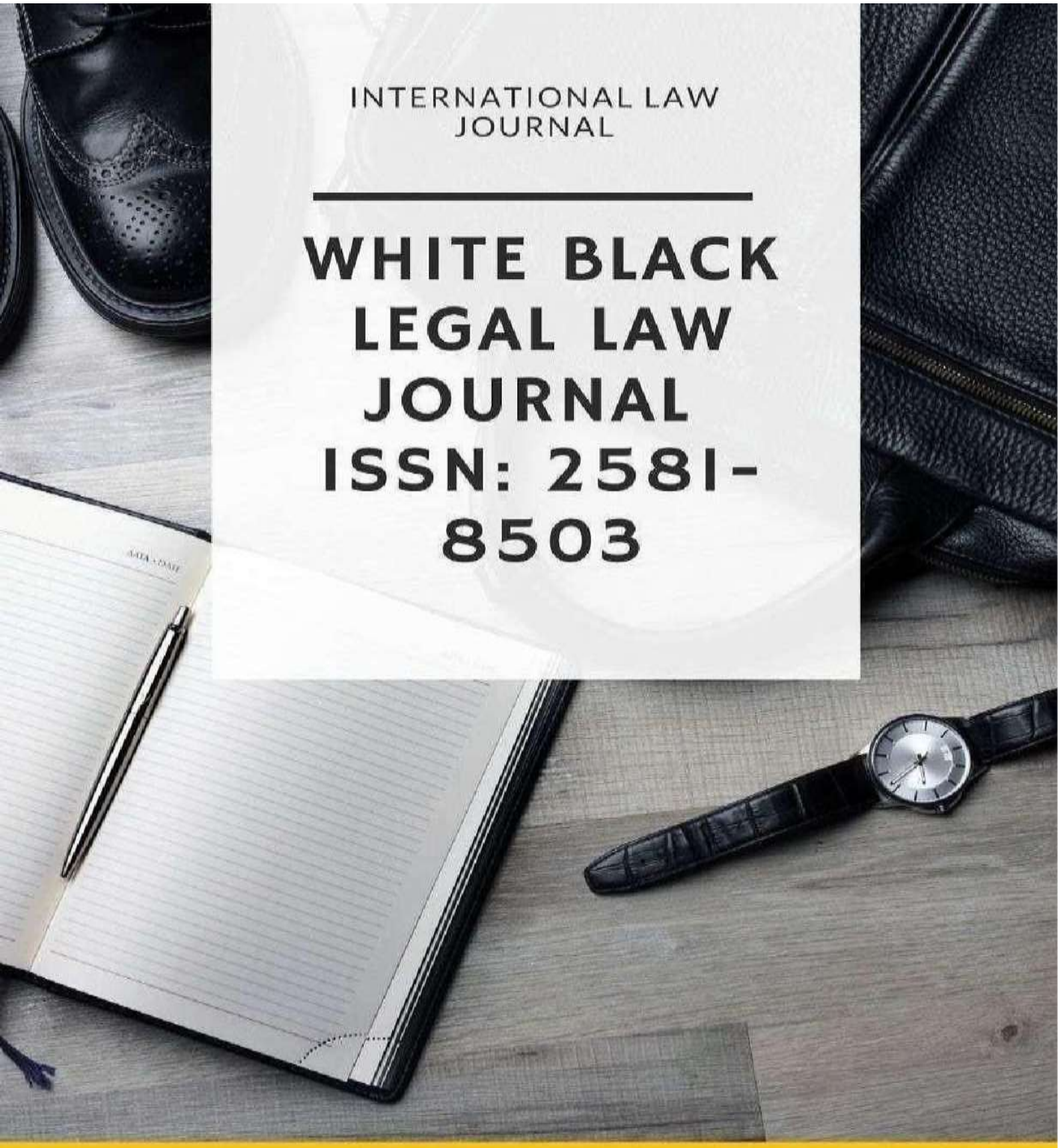

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BLEEDING RIGHTS: FORCED HYSTERECTOMIES AND SANITATION NEGLECT

AUTHORED BY - KRISHNA TIWARI
& MR. ROBERT HALAM

Abstract

This research paper explores the disturbing intersection of forced hysterectomies and systemic sanitation neglect as emblematic of reproductive injustice and structural gender-based violence in India. Across several rural and marginalized communities, particularly among female migrant workers, hysterectomies are increasingly being performed without medical necessity, often under coercion or misinformation. This invasive practice is frequently justified by exploitative employers and private healthcare providers as a means to prevent menstruation-related "inconveniences" during manual labour seasons—thus reflecting a commodification of women's bodies for productivity.

Compounding this crisis is the severe neglect of menstrual hygiene and sanitation infrastructure, particularly in rural and migratory labour camps. The absence of toilets, clean water, and menstrual products leads many women to opt for—or be forced into—surgical sterilization as a means to escape the physical and social burden of menstruation. Such choices, made under duress and poverty, challenge the notion of "consent" and expose a critical failure of the state to safeguard women's health rights.

This paper critically examines the legal, ethical, and policy failures enabling these practices. It analyses constitutional protections, international human rights standards, and Indian health and labour laws, while highlighting glaring enforcement gaps. The study also brings to light the voices of affected women and the role of non-governmental organisations in resisting these violations. Through an interdisciplinary approach combining legal analysis, public health data, and field reports, the paper argues for an urgent need to recognize forced hysterectomies and sanitation neglect as intertwined violations of bodily autonomy, dignity, and equality.

Keywords

Forced hysterectomy; menstrual hygiene; sanitation neglect; reproductive rights; bodily autonomy; gender-based violence; rural healthcare; migrant women workers; public health policy; legal accountability; informed consent; structural inequality.

Literature Review

The issue of forced hysterectomies and sanitation neglect has received growing attention in socio-legal, feminist, and public health scholarship in recent years, particularly in the Indian context. Existing literature reveals that these practices are not isolated medical occurrences but are deeply rooted in structural patriarchy, economic vulnerability, and institutional apathy.

1. **Forced Hysterectomies in India**

   Multiple reports and academic studies have documented the rise in non-medically indicated hysterectomies, particularly among poor, Dalit, Adivasi, and migrant women. A 2019 report by the *International Center for Research on Women* highlights how women in sugarcane fields of Maharashtra underwent hysterectomies under coercion from employers who deemed menstruation "inconvenient" for productivity. Similarly, a study published in the *Indian Journal of Medical Ethics* raises concerns over the lack of consent and transparency in the hysterectomy procedures conducted by private clinics in rural areas. These studies point to systemic violations of bodily autonomy and informed consent.

2. **Sanitation Injustice and Menstrual Hygiene**

   The literature further reveals how sanitation neglect—especially the absence of clean toilets and menstrual hygiene products—disproportionately affects rural women and girls. The *National Family Health Survey (NFHS-5)* and *WaterAid* reports show that many women are forced to manage menstruation in unhygienic conditions, often leading to infections and long-term health issues.[3] Scholars like Gita Sen and Nitya Rao argue that menstrual stigma and poor sanitation infrastructure reinforce a cycle of exclusion and disempowerment, making women's bodies a site of control and silence.

3. **Intersection of Health and Labour Rights**

   The relationship between women's health and labour conditions is another key area of focus. NGOs such as *MASUM* and *CHSJ* have published field-based reports linking exploitative work practices, lack of sanitation facilities, and forced reproductive decisions among migrant labourers. These findings demonstrate how labour policies

often ignore the gendered needs of women workers, leaving them vulnerable to coercion and abuse.

4. **Legal and Policy Gaps**

   While India has constitutional and statutory protections relating to health and gender equality, legal scholars like Flavia Agnes and Kalpana Kannabiran note a significant gap in enforcement and access to justice. There is minimal regulation of private health providers, weak grievance redressal mechanisms, and little emphasis on informed consent in reproductive healthcare.

5. **International Human Rights Perspective**

   From an international legal standpoint, forced hysterectomy and sanitation neglect violate rights guaranteed under instruments such as the *Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)* and the *International Covenant on Economic, Social and Cultural Rights (ICESCR)*. UN bodies have criticised member states, including India, for failing to prevent coercive medical practices and ensure menstrual dignity.

   This body of literature clearly establishes that the crisis is multifaceted—spanning health, labour, gender justice, and human rights. However, there remains a research gap in exploring the combined impact of hysterectomy and sanitation neglect as a single continuum of structural violence. This paper seeks to fill that gap by presenting an integrated legal and policy analysis, grounded in lived experiences.

Research Methodology

This research adopts a **qualitative, doctrinal, and empirical** approach to examine the intersectional issues of forced hysterectomies and sanitation neglect among women in India, particularly in rural and migratory labour contexts. It combines **legal analysis, field-based data interpretation, and rights-based frameworks** to understand how state institutions, healthcare systems, and labour structures contribute to reproductive injustice.

1. Doctrinal Legal Research

A detailed analysis of constitutional provisions, statutes, case laws, and international legal instruments has been undertaken to evaluate the normative framework governing reproductive rights and sanitation. Key legislations analysed include:

- Constitution of India (Articles 14, 15, 19, 21, and 42),

- The Clinical Establishments (Registration and Regulation) Act, 2010,
- The Right to Health initiatives under various State governments,
- International instruments such as CEDAW and ICESCR.

Judicial interpretations from the Supreme Court and High Courts relating to bodily autonomy, informed consent, and health rights have also been studied.

2. Empirical and Secondary Research

Secondary data from government reports, media investigations, NGO publications, and field-based case studies form the backbone of the empirical foundation. This includes:

- Reports from *WaterAid India*, *MASUM*, *Oxfam*, and *CHSJ*,
- Survey data from *NFHS-5* and *NSSO*,
- Interviews and testimonies of affected women documented by rights groups and investigative journalists.

These sources help provide insights into the lived experiences of women subjected to hysterectomy and those suffering due to lack of menstrual hygiene facilities.

3. Feminist and Intersectional Analysis

The research is grounded in feminist legal theory and intersectional analysis to account for the overlapping vulnerabilities of gender, caste, class, and rural identity. This approach is essential to understanding why certain groups of women—particularly Dalit, Adivasi, and migrant women—face disproportionate reproductive coercion and sanitation deprivation.

4. Limitations

While this study draws upon substantial secondary data and legal materials, the absence of direct fieldwork due to logistical and ethical constraints limits the scope for primary interviews. Nonetheless, the triangulation of legal texts, empirical data, and rights literature ensures a robust and multidimensional analysis.

Hypothesis

This research is premised on the hypothesis that:

"The practice of forced hysterectomies and the neglect of sanitation infrastructure among rural and migrant women in India constitute systemic violations of reproductive rights,

arising from inadequate legal safeguards, lack of informed consent, and gender-insensitive public health policies."

This hypothesis is grounded in the belief that these violations are not isolated incidents but are manifestations of deeply embedded structural inequities shaped by socio-economic vulnerability, caste and gender hierarchies, and weak regulatory enforcement. The paper further contends that such practices erode women's constitutional rights to health, dignity, and bodily autonomy under Articles 14 and 21 of the Indian Constitution, and contravene India's obligations under international human rights law.

Introduction

The human body, especially the female body, has long been a site of political control, economic exploitation, and cultural surveillance. In India, this control is most starkly visible in the treatment of rural and working-class women, whose health and dignity are routinely sacrificed at the altar of productivity, social stigma, and institutional apathy. Two of the most disturbing manifestations of this neglect are the rising number of **forced hysterectomies** and the **systemic failure to provide adequate sanitation and menstrual hygiene facilities** to women in vulnerable sectors such as agriculture, construction, and informal labour.

Across states like Maharashtra, Chhattisgarh, Bihar, and Andhra Pradesh, there has been an alarming increase in the number of young, menstruating women undergoing unnecessary hysterectomies—often without proper medical indication or informed consent. These procedures are frequently performed by private healthcare providers driven by profit or by employers seeking to eliminate the "inconvenience" of menstruation in manual labour environments. The fact that women as young as 20–30 are being sterilized reflects a deep erosion of reproductive autonomy and an economic logic that treats female bodies as machines of labour.

Simultaneously, sanitation neglect—manifested in the lack of clean toilets, water facilities, and menstrual products—continues to be a silent but pervasive crisis for rural women. The **taboo around menstruation**, combined with infrastructural gaps and poor state accountability, creates a hostile environment in which many women are forced to choose between illness, shame, or surgical sterilization. The absence of dignified sanitation infrastructure not only violates public health norms but also reinforces gender-based discrimination.

Despite constitutional guarantees under Articles 14, 15, and 21, and India's obligations under international conventions such as **CEDAW** and the **ICESCR**, the lived realities of these women reflect a clear disconnect between legal ideals and ground-level enforcement. Legal protections concerning informed consent, reproductive health, and labour dignity remain either under-implemented or completely absent when it comes to women at the intersections of caste, class, and geographical marginality.

This research seeks to critically examine the interconnected nature of these violations through a socio-legal and feminist lens. It argues that the **forced hysterectomies and sanitation neglect are not isolated health issues**, but rather **structural human rights violations** that stem from a larger patriarchal and economic framework which devalues the reproductive labour and bodily autonomy of women in the margins.

1. The Phenomenon of Forced Hysterectomies: Causes and Consequences

Forced or non-consensual hysterectomies have emerged as a grave public health and human rights concern in India, particularly among rural and migrant women workers. The procedure involves the surgical removal of the uterus, which results in irreversible infertility and significant physical and psychological consequences.

Causes

One primary driver behind the rising incidences of forced hysterectomies is the economic imperative placed on women's bodies in sectors like agriculture and manual labour. Employers and healthcare providers often view menstruation as a liability that hampers productivity during peak labour seasons, such as the sugarcane harvest.[1] Reports from NGOs and investigative journalism have uncovered that some employers encourage women to undergo hysterectomy under the guise of "health benefits" or as a prerequisite for employment.[2]

In addition, the widespread **lack of menstrual hygiene facilities** and the social stigma around menstruation exacerbate the issue. Women, deprived of access to clean toilets, water, and

[1] International Center for Research on Women (ICRW), *Hysterectomy in India: An Indicator of Gender Inequality and Health Injustice* (2019)
[2] MASUM, 'Forced Hysterectomies among Sugarcane Women: A Field Report' (2021)

sanitary products, often face severe discomfort and health risks during menstruation, leading them to accept or be coerced into sterilization as a solution to avoid "monthly problems."[3]

Consequences

The forced removal of the uterus has far-reaching implications beyond infertility. It exposes women to risks of surgical complications, hormonal imbalances, and mental health issues such as anxiety, depression, and trauma.[4] The psychological impact is intensified by the violation of bodily autonomy and the lack of adequate counselling or post-operative care.

Furthermore, forced hysterectomies reflect and reinforce broader societal inequalities. Women subjected to these procedures are disproportionately from marginalized groups — Dalits, Adivasis, and economically disadvantaged communities — underscoring the intersection of caste, class, and gender oppression.[5]

The practice constitutes a blatant violation of constitutional rights under Article 21 (right to life and personal liberty) and international human rights obligations, including the right to health, dignity, and informed consent.

2. Sanitation Neglect and Menstrual Hygiene Management

Sanitation neglect remains a critical but often overlooked dimension of women's health, particularly in rural and informal labour settings. The absence of adequate sanitation facilities, clean water, and access to menstrual hygiene products significantly impairs women's health, dignity, and productivity.

Infrastructure Deficit and Social Stigma

In many parts of rural India, access to toilets remains alarmingly low. According to the *National Family Health Survey (NFHS-5),* approximately 40% of rural households still lack basic sanitation facilities.[6] The situation is compounded in migratory labour camps and agricultural fields, where temporary and overcrowded living conditions prevent the establishment of proper

[3] WaterAid India, *Menstrual Hygiene in Rural India: Access and Equity* (2022)
[4] Indian Journal of Medical Ethics, 'Psychological Impact of Non-consensual Hysterectomies in Rural Women' (2020) 6(3) *IJME* 120.
[5] Flavia Agnes, *Law and Gender Inequality: The Politics of Women's Rights in India* (OUP 2001).
[6] Ministry of Health and Family Welfare, *National Family Health Survey (NFHS-5)* (2021)

toilets and clean water access. This infrastructural deficit forces women to resort to open defecation or makeshift arrangements, exposing them to health risks and violence.

Moreover, menstruation is shrouded in deep social stigma and taboos, which discourage open discussion and public investment in menstrual hygiene management (MHM).[7] Women often lack awareness and access to affordable sanitary products, and many rely on unhygienic materials like old cloth, which heightens the risk of infections and reproductive tract diseases.

Health Implications and Link to Forced Hysterectomies

Poor menstrual hygiene and sanitation conditions have direct and indirect health implications. Women suffer from urinary tract infections, reproductive tract infections, and other complications linked to poor hygiene.[8] This chronic health burden, coupled with the social stigma of menstruation, often leads to psychological distress and exclusion.

Crucially, the absence of dignified MHM facilities is one of the factors that drives women to accept or are coerced into forced hysterectomies. Without proper toilets or menstrual products, hysterectomy is perceived—wrongly—as a permanent solution to menstrual suffering and related social shame.[9] This creates a vicious cycle where sanitation neglect fuels reproductive rights violations.

Policy and Governance Challenges

While schemes like the *Swachh Bharat Mission* have improved sanitation infrastructure nationally, gaps remain, especially in addressing women's specific needs around menstrual hygiene. The lack of gender-sensitive planning, monitoring, and accountability has resulted in inadequate implementation in rural and migratory contexts.[10] Additionally, health policies often fail to integrate sanitation and reproductive health holistically, leading to fragmented and ineffective responses.

[7] Gita Sen and Nitya Rao, *Gender, Health and Development: Reimagining Justice for Women in India* (Zubaan 2021).
[8] World Health Organization, 'Reproductive Tract Infections and Poor Sanitation: A Public Health Perspective' (2019)
[9] MASUM, 'Forced Hysterectomies among Sugarcane Women: A Field Report' (2021)
[10] Ministry of Jal Shakti, *Swachh Bharat Mission (Gramin) Progress Report* (2023)

3. Legal and Policy Framework Addressing Reproductive Rights and Sanitation

India possesses a range of constitutional provisions, statutes, and policies aimed at protecting reproductive rights and ensuring access to sanitation; however, significant gaps persist in their implementation and enforcement, especially concerning marginalized women.

Constitutional and Statutory Provisions

The Indian Constitution guarantees the right to life and personal liberty under Article 21, which courts have interpreted to include the right to health and bodily autonomy. Article 15 prohibits discrimination on grounds of sex, while Article 42 mandates just and humane conditions of work, including health provisions. Despite these guarantees, forced hysterectomies represent a direct violation of these fundamental rights.

Statutory protections include the Clinical Establishments (Registration and Regulation) Act, 2010, which seeks to regulate health care providers and ensure minimum standards of care.[11] The Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994, aims to prevent sex-selective practices but does not address coercive reproductive surgeries directly. Meanwhile, the National Rural Health Mission (NRHM) and National Health Policy have provisions for maternal health but lack explicit guidelines on informed consent for sterilization procedures.[12]

Sanitation Policies

The Government's flagship *Swachh Bharat Mission (SBM)* has significantly increased toilet coverage in rural areas.[13] However, sanitation policies often overlook menstrual hygiene management (MHM) as a critical component, resulting in insufficient provision of sanitary products, education, and disposal mechanisms. The *Menstrual Hygiene Scheme* under the Ministry of Health aims to distribute sanitary napkins, but its reach remains limited, particularly in migrant and remote communities.[14]

[11] Clinical Establishments (Registration and Regulation) Act 2010.
[12] Ministry of Health and Family Welfare, *National Health Policy* (2017)
[13] Ministry of Jal Shakti, *Swachh Bharat Mission (Gramin) Progress Report* (2023)
[14] Ministry of Health and Family Welfare, *Menstrual Hygiene Scheme* (2019)

Judicial Interventions and Challenges

The judiciary has played a proactive role in affirming reproductive rights and health as part of the right to life. Landmark cases such as *Laxmi Mandal v Deen Dayal Harinagar Hospital* have stressed informed consent and dignity in medical procedures. However, courts have rarely addressed forced hysterectomies explicitly, and access to justice remains hindered by socio-economic barriers and lack of awareness among affected women.

Gaps and Recommendations

Legal scholars and rights activists highlight the need for:

- Explicit laws criminalizing forced hysterectomy and coercive reproductive surgeries,
- Stronger regulation and accountability mechanisms for private healthcare providers,
- Integration of menstrual hygiene management into sanitation and health policies,
- Comprehensive awareness campaigns to dismantle menstrual stigma,
- Enhanced legal aid and support services for affected women.[15]

Without these reforms, the structural neglect and violations faced by vulnerable women will continue unabated.

4. Socio-Economic and Gendered Dimensions of Forced Hysterectomies and Sanitation Neglect

The health and sanitation crises faced by women subjected to forced hysterectomies cannot be fully understood without examining the socio-economic and gendered contexts that perpetuate these violations.

Intersection of Caste, Class, and Gender

Marginalized women—especially those belonging to Dalit, Adivasi, and lower socio-economic backgrounds—are disproportionately affected by forced hysterectomies and inadequate sanitation.[16] These groups face entrenched social discrimination that limits their access to healthcare, education, and social services, creating conditions ripe for exploitation.

In rural agricultural economies, women often constitute the bulk of the labour force yet remain invisible in labour protections and health policies. Their bodies become sites for economic

[15] Flavia Agnes, *Law and Gender Inequality: The Politics of Women's Rights in India* (OUP 2001)
[16] MASUM, 'Forced Hysterectomies among Sugarcane Women: A Field Report' (2021)

calculation rather than respect for autonomy.[17] This intersectional marginalization exacerbates vulnerability to coercive medical procedures and neglect.

Patriarchy and Control Over Female Bodies

Patriarchal norms that stigmatize menstruation and view women's reproductive capacity as a social burden reinforce the acceptability of forced sterilization.[18] Control over women's reproductive choices is also a mechanism for maintaining traditional family and community structures, especially in contexts where women's economic independence challenges gender hierarchies.

Sanitation neglect further reflects gender bias, as infrastructural planning often ignores women's specific needs, perpetuating their invisibility in public policy.[19]

Economic Pressures and Labour Exploitation

Economic necessity drives many women into informal and migratory labour markets where health and safety regulations are weak or non-existent. Employers may covertly or overtly encourage hysterectomies as a way to reduce absenteeism linked to menstruation or pregnancy, treating women's reproductive systems as obstacles to productivity.

The lack of alternative employment, social security, or health insurance forces women to comply with such coercion, highlighting the role of economic precarity in reproductive injustice.

5. Recommendations and the Way Forward

Addressing the intertwined crises of forced hysterectomies and sanitation neglect requires a multi-dimensional approach that centers the rights, dignity, and agency of marginalized women.

[17] Devaki Jain, *Women, Development, and the UN: A Sixty-Year Quest for Equality and Justice* (Indiana University Press 2005).
[18] Leela Fernandes, *India's New Middle Class: Democratic Politics in an Era of Economic Reform* (University of Minnesota Press 2006).
[19] Ministry of Jal Shakti, *Swachh Bharat Mission (Gramin) Progress Report* (2023)

Strengthening Legal Protections and Accountability

First, the legal framework must explicitly criminalize forced hysterectomies and other coercive reproductive procedures, with stringent penalties for violators, including healthcare providers and employers complicit in such practices.[20] Mechanisms for monitoring and enforcing standards in both public and private healthcare sectors need urgent reinforcement, alongside accessible complaint and redressal systems for victims.

Enhancing Access to Menstrual Hygiene and Sanitation

Public policies must prioritize menstrual hygiene management (MHM) as an essential component of sanitation programs. This includes:

- Provision of affordable and eco-friendly sanitary products,
- Construction of gender-sensitive toilets with privacy and water access in rural and labour settings,
- Awareness campaigns to destigmatize menstruation and promote health education.[21]

Empowering Women Through Education and Economic Security

Empowerment initiatives must focus on educating women about their reproductive rights and health, alongside expanding access to economic opportunities that provide social security and reduce vulnerability to coercion. Labour laws should be extended and enforced to protect women workers' health and dignity, including menstrual leave and workplace sanitation norms.[22]

Fostering Intersectional and Community-Based Approaches

Community participation, especially involving women from marginalized groups, is vital for designing culturally sensitive and effective interventions. Intersectional approaches that recognize the roles of caste, class, and gender will ensure that policies do not reproduce existing inequities.[23]

[20] MASUM, 'Forced Hysterectomies among Sugarcane Women: A Field Report' (2021)
[21] Ministry of Health and Family Welfare, *Menstrual Hygiene Scheme* (2019)
[22] International Labour Organization, 'Women at Work: Trends 2016' (2016)
[23] Anupama Roy, *Social Exclusion: Essays in Honour of Dr. Bindheshwari Prasad Mandal* (Sage 2008).

Strengthening Research and Data Collection

Ongoing research, including disaggregated data on forced hysterectomies and sanitation access, will improve understanding and policy responses. Collaboration between government, academia, and civil society is essential for evidence-based advocacy and reform.[24]

Conclusion

The crises of forced hysterectomies and sanitation neglect represent a profound violation of women's fundamental rights and dignity, disproportionately affecting marginalized and economically vulnerable groups. These practices reflect deep-rooted structural inequalities fueled by patriarchy, caste discrimination, and socio-economic marginalization. The physical and psychological consequences of forced hysterectomies, compounded by inadequate menstrual hygiene management and sanitation infrastructure, highlight the urgent need for a holistic and intersectional approach to women's health and rights.

Legal frameworks, while offering a basis for protection, remain inadequate without robust enforcement, clear criminalization of coercive reproductive procedures, and gender-sensitive sanitation policies. Addressing these issues demands coordinated action from the government, civil society, and the healthcare sector to ensure access to dignified healthcare, education, and economic empowerment for women.

Ultimately, safeguarding the "bleeding rights" of women—recognizing menstruation as a natural and dignified aspect of life—is essential to dismantling the systemic neglect and exploitation that perpetuate forced hysterectomies and poor sanitation. Empowering women with autonomy over their bodies, improving sanitation infrastructure, and fostering societal change to challenge stigma are critical steps toward health justice and gender equality.

[24] Indian Council of Social Science Research, 'Research on Women's Health and Sanitation' (2023)