

The Woman's Body in Midlife: Socio-Cultural and Medical Perspectives from South Asia

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パトリシア・ウベロイ教授は、オーストラリア国立大学で東洋学の修士号を取得後、デリー大学で社会学を専攻し博士号を取得。その後、オーストラリア国立大学アジア文化研究所講師、ジャワハルラル・ネルー大学助教授等を経て、1993年よりデリー大学経済開発研究所「社会変動と開発」部門の教授を務めている。

女性学と東洋学、社会学を専門とし、中国や南アジアにおける家族・親族、ジェンダー、象徴および言説分析、大衆文化分析について、幅広く研究活動している。1991年には、女性学分野での教育が評価され、インドのサヘリ・マヒラ・カリヤン・サミティ賞を受賞した。

著書には*Family, Kinship and Marriage in India* (1993) や*Social Reform, Sexuality and the State* (1996)、*Tradition, Pluralism and Identity* (1999) がある。

ウベロイ教授は、1999年11月8日から2000年3月31日まで、ジェンダー研究センターに外国人客員教授として赴任した。本稿はその間行われた公開講演会の発表をもとに作成され、ご寄稿いただいたものである。

[要旨]

中年期の女性の身体（からだ）——南アジアからの社会文化的・医学的見方——

パトリシア・ウベロイ、タリーニ・バハドゥール

南アジアにおける中年期の変化に関するこの論文は、アジアと西洋の諸社会における閉経に関する経験を比較する広範な研究プロジェクトの一部であり、日本と北アメリカの現象を扱ったマーガレット・ロック (1993) の先駆的な研究に啓発されたものである。この論文は大衆的な出版物だけでなく人類学・社会学、公衆衛生・女性の健康、フェミニズムと医学（産婦人科、内分泌学、老年学、精神医学）の各学問分野における文献の再検討と解釈に主に基づいているが、われわれはさらにこの問題について衛生学の研究者や女性の健康に関する活動家、社会学者や様々な職業を持つ中年期の女性に多くのインタビューを行った。概して閉経はこの分野の研究文献においてほとんど注目されていない。南アジアの女性の多くが間違いなく現代生理学のなかで閉経不安症と見なされる症状を経験し、それを和らげる方法を模索しているが、通常これらの問題は老化の自然的過程と区別される医療上の状態とは見なされていない。

ほとんどのインドの言語は「閉経」に該当する言葉をもたず、閉経という変化を単に月経の停止と呼んでいるように見える。この事実は、その地域における初潮と月経——変化、あるいは顕著に目立つ繰り返し起こる状態——の文化的意味にわれわれを注目させる。初潮の儀式は思春期の少女の受胎能力を祝福するだけで

なく、不浄、羞恥と危険というテーマを劇的な方法で表現し、初潮後、毎月、周期的に作動し始める多くのタブーや規制を制度化する。しかし、閉経はこれらのタブーや規制を取り去り、女性を再び儀式的に浄化して、男性と同様に清い存在とすることができる。同時に、通常のライフコースにおいては、女性は閉経を迎えるとき、家族と社会のなかでの地位が頂点に到達する。もしその女性が母親としての社会＝生物学的役割を果たし（ただし息子を産んでいるほうが望ましい）、未亡人になっていなければ。こうした状況下では、受胎能力と性的魅力とその欲望の喪失はあまり悔やまれない。まさに、閉経は妊娠の危険と月経によって反復的に引き起こされる屈辱からの救済として広く歓迎されているようである。

とはいえ、今日、この事態をいよいよ修正するかもしれない力が、少なくとも都市部の富裕な上流階級の、そして国際的な背景と生活様式をもつ女性たちのあいだに及びつつあるように見える。この上流階級のインド人女性たちは、いまや女性のライフサイクルのすべての段階——閉経を含む——における身体意識ということにおいて、グローバルな動向のなかに統合されている。そしてこうした事柄について、大衆的な出版物や医学団体のあいだで急速に情報が流通している。このことは、一方で閉経をホルモン補充治療が必要とされるホルモン欠乏としてこれを「異常視」する傾向を生みだしているが、同時に他方では、顧客を「何歳も若返らせる」という触れ込みで急成長する美容ビジネスの利益をも生み出しているのである。現在強調されているのは、老化と疾病の自然の力への屈服などではなく、それらの過程をできるだけ長く遅らせ阻止できるような活動的で生産的で審美的な身体なのである。

医学関係者の中で閉経への意識を高めるために重要な役割を果たしている機関に、インド閉経協会がある。同協会は、特定のホルモン欠乏症の治療として、そして骨粗鬆症と心臓病（年配の女性には特にかかりやすい）に対する予防としてホルモン補充治療（HRT）の容認を促進するという特定の目的のために1995年に設立された。しかし、いまの見通しとしては、HRTの容認とその長期的な予防としての使用には抵抗があるようである。治療が大多数のインド人女性には手の届かない高額なものであるということ以外に、（月経の継続を含む）不快な副作用の報告、そしてHRTと癌の関連についての指摘があることから、多くの医者と患者は躊躇している。さらに、南アジアでは、「西洋的」「逆症療法的」生理学と並んで代替的な土着医療システムも盛んであり、多くの場合、こうした土着医療システムのほうが、長期的にはより自然でより害のない治療を用いるため、慢性的で生活様式に関係する疾患の治療に特に適していると信じられている。同様に、美容ビジネスは、老化に関する問題がホルモン欠乏の身体の状態に関わるとは同定せずに、老化防止のための治療を提供する。今後ますますインド中流階級の女性は、おそらくHRTよりも強壮剤や美容治療といった養生法に頼り続けて閉経を乗り越えようとするだろう。そして、その一方で、大多数のインド人女性は、閉経に関わるこれらの商品のグローバルな「市場」のいずれからも、否応なく遠ざけられることになるだろう。

（訳 山腰京子 お茶の水女子大学ジェンダー研究センター研究機関研究員）

1. Introduction

This paper is a preliminary and exploratory study of the way in which the midlife transition is experienced in South Asia, India in particular, and the cultural meanings attached to the physiological event of menopause in that region. Our study involved, primarily, a survey of literature in the several academic disciplines of Anthropology/Sociology, Public/Women's Health, Feminism and Medicine (Obstetrics/Gynaecology, Endocrinology, Gerontology, Psychiatry). Additionally, we surveyed articles in the popular press,² and talked to health professionals, women's health activists and women in various walks of life in order to obtain individual and more personal accounts on the subject of midlife and menopause.

As it turned out, the task was a challenging one, for in none of the fields that we surveyed was the subject of midlife or menopause given anything but the briefest mention. For the most part, it was not "named"; it was not (until very recently, as we later point out) the subject of much attention in the popular media, despite increasing public focus on the problems of an aging population;³ it was of minimal concern to health activists, including women's health activists;⁴ and it had received almost no recognition from health professionals in research or in practice.⁵ Indeed, there is a widespread perception, sometimes quite forcefully articulated, that menopause is a physiological transition that is of medical, social and cultural significance only in the West — that this is a "problem" that a poor, developing country like India does not have, should not have, and cannot afford to have: a disease of affluence and self-indulgence, created by pharmaceutical companies for their own profit.

Our challenge, in other words, was to study a "non-event," to map an absence, and this in itself raises a number of conceptual, hermeneutic and ethical problems. Is focusing on a non-event like menopause not creating and simultaneously problematizing the object of study itself?⁶ What is its justification in the light of concern for women's health and well-being in India, when so many other problems are conspicuously more urgent and pressing? Might not the problematization of the issue actually work to reinforce the agendas of the multinational pharmaceutical companies for whom South Asia is as yet virgin territory, awaiting conquest? Or, again, might it not serve to augment the power of the medical profession over women's bodies, lives and self-images?

One answer to this dilemma, which our preliminary inquiry has endorsed, is that problematization of menopause as a women's health issue is an anticipation of things to come, especially for the urban upper and middle classes. If the pharmaceutical companies are already in the act, feeling their way into a new — and potentially huge — market, should not social scientists and women's health activists be out there too? Why should the researcher feel so obligated to defend and justify a focus on the health status of the most privileged among Indian women?⁷ True, their "problems" are of quite a different order to those of the vast majority, but this class is surely an important reference group for those immediately below them in the social pyramid. Upper and middle class women are highly visible in the media and, if the recent history of the proliferation of the New Reproductive Technologies in India is anything to go by, the percolation of new medical ideas, technologies and therapies from the upper crust of society to a much broader class of women can be remarkably swift (see Gupta 2000).

Secondly, one of the purposes of cross-cultural research is to highlight asymmetries in the perception of supposedly universal and “natural” human phenomena. A pioneering example was Margaret Mead’s (now contested) *Coming of Age in Samoa* (1928 [1962]) on the construction of the physiological event of puberty and the social transition of adolescence in a primitive society: it is a study that surely deserves re-reading in the present context. A more contemporary (and certainly more nuanced) example is Margaret Lock’s remarkable *Encounters with Aging* (1993; see also Lock 1986), an ethnography of “mythologies of aging” in Japan and North America. Against the background of the “pathologization” and “medicalization” of the aging female body in North America, Lock described a rather different symptomatology and social perception of menopause and midlife in Japan. At the time when she did her fieldwork (1983 – 84), Lock found menopause to be a medically relatively “unmarked” condition in Japan, presenting a rather different package and hierarchy of symptoms to those found in North American studies (see Table 1).

Table 1. Rates of Reporting Core Symptoms in Previous Two Weeks, by Study

Symptom	Percentage			Chi-square (2df)
	Japan	Manitoba	Massachusetts	
Diarrhoea or constipation	24.5	12.8	21.4	62.8*
Persistent cough	4.2	5.2	10.1	68.4*
Upset stomach	6.3	12.9	16.1	85.1*
Shortness of breath	3.1	8.2	15.6	177.6*
Sore throat	10.5	9.1	10.7	2.9*
Backache (lumbago; pain in the spine)	24.2	26.8	29.6	17.7*
Headache	27.5	33.8	37.2	45.2*
Aches or stiffness (aches and pains in the joints)	14.5	31.4	38.6	279.1*
Dizzy spells (dizziness)	7.1	12.3	11.1	21.4*
Tiredness (lack of energy; exhaustion)	6.0	39.8	38.1	503.3*
Irritability	11.5	17.1	29.9	246.6*
Feeling blue or depressed (depression; melancholy)	10.3	23.4	35.9	365.1*
Trouble sleeping (insomnia)	11.7	30.4	30.6	189.8*
Hot flashes or flushes and/or sudden perspiration	12.3	31.0	34.8	246.6*
Cold sweats and/or night sweats	3.8	19.8	11.4	158.2*

*p=0.00 and 0.68

Note: The Japanese categories appear in parentheses where they differ from the North American categories. Cases of surgical menopause are included.

Source: Lock (1993, p. 35), comparing her own data on Japan with earlier studies in Manitoba, Canada, and Massachusetts, USA (see Avis and McKinlay 1990; McKinlay et al. 1987; and Kaufert 1984).

In particular, “hot flashes” and night sweats were not as prominently reported in Japan as in North America, though they were indeed experienced by some informants; neither were fatigue, depression, irritability, body ache or insomnia. There was also a marked difference in the incidence of gynaecological surgery (only 11.7% in Japan, against 22.9% in Manitoba, Canada, and 31.2% in Massachusetts, USA [Lock 1993, p. 260, see Table 2]), and in the quantum and nature of the medication taken (see Table 3).

Table 2. Gynaecological Surgery, by Study

	Japan		Manitoba		Massachusetts	
	%	N	%	N	%	N
No hysterectomy	88.3	1162	77.1	1010	68.8	5371
Hysterectomy only	2.3	30	12.1	159	8.4	656
Hysterectomy and unilateral oophorectomy	3.0	39	3.6	47	4.1	323
Hysterectomy and bilateral oophorectomy	3.4	45	5.0	66	15.6	1220
Unilateral oophorectomy only	2.6	35	2.2	28	2.5	197
Bilateral oophorectomy only	0.4	5	0.0	0	0.6	35
Total	100.0	1316	100.0	1310	100.0	7802

Source: Lock (1993, p. 260), comparing her own data on Japan with earlier studies in Manitoba, Canada, and Massachusetts, USA (see Avis and McKinlay 1990; McKinlay et al. 1987; and Kaufert 1984).

Table 3. Percentage of Women Using Medication in Previous Two Weeks, by Study

Medication	Percentage			Chi-square (2df)
	Japan (N=1,225)	Manitoba (N=1,224)	Massachusetts (N=7,746)	
Nonprescription pain reliever	13.8	45.3	62.6	1065.1*
Prescription tranquilizers	3.5	12.5	9.8	62.2*
Vitamins or minerals	20.1	29.7	38.4	174.8*
Hormones	2.7	6.4	8.1	46.8*
Sleeping pills	1.6	7.1	4.3	46.0*
Herbal medication or teas	16.0	4.0	3.2	385.3*
Stomach remedies	22.0	8.6	11.0	137.9*

*p=0.01

Source: Lock (1993, p. 261), comparing her own data on Japan with earlier studies in Manitoba, Canada, and Massachusetts, USA (see Avis and McKinlay 1990; McKinlay et al. 1987; and Kaufert 1984).

Lock was willing to concede that such differences in the epidemiological incidence and symptomatology of menopause might reflect biological differences between populations, as well as the influence of diet, environment, work and gendered life-styles. At the same time she emphasized that the social construction and self-perception of the female body through the life-cycle is significantly mediated by the wider social and cultural environment. Reviewing her Japanese informants' self-perceptions of bodily states in relation to their objective menstrual status (pre-, peri-, or post-menstrual), she concluded that:

[D]espite the negative myths about *konenki*,⁸ most [Japanese] women suffer no disabling symptoms and apparently feel no deep sense of loss at this time of life. When encouraged to create their own stories about middle age and aging, as opposed to answers for an interviewer's questions, relatively few Japanese women give much weight to either the end of menstruation or *konenki*. Instead, they choose to focus much more on human relationships and the way in which in middle age a woman turns from being concerned primarily with children and their care to enjoy a brief spell of relative freedom ("mother's time of rebellion"), before she becomes fully occupied with the care of aged

people for a good number of years. It is change in gendered activities, the social rather than the physical consequences of aging, that are usually uppermost in women's minds when discussing middle age. *Konenki* is peripheral to most discourse, although it acts as a portent of things to come (1993, p. 45).

Importantly, the women surveyed in Lock's study belonged to a generation who, almost without exception, had undergone hardship, even severe deprivation, in childhood and young adulthood, but who in their middle age had come to enjoy the fruits of Japan's post-War economic prosperity. In other words, they had good reason to believe that their lives had become much easier in the course of their life-time. They also belonged to a generation in which women's roles were determined by their domestic roles and family relationships, women being the primary care-givers for the young, as well as for the aged in an increasingly long-lived society. Fifteen years on from the time of Lock's original ethnography, life-styles and family relationships may be changing, and certainly Japanese middle-aged women at the turn of the millennium would not have experienced the same levels of deprivation and poverty, discipline and self-discipline, as did the women in Lock's study sample. All the same, Lock asserted — and I think rightly — that Japanese family and gender roles and wider cultural values had still not changed to an extent that would dramatically “westernize” (“pathologize” / “medicalize”) women's psycho-somatic experience of midlife (*ibid.*, Epilogue). To the contrary she believed that the political economy of an aging society would continue to reproduce women's burden as primary care-givers for the aged, while enhancing their anxiety regarding their own eventual progress to old age, sickness and death.

II . The “Unnamed” Phenomenon: Menopause as the Inverse of Menstruation

Beginning her study, Lock had dwelt at some length on the semantic range of the Japanese terms used for “menopause” (or “climacteric”): the little used *heikei* (the end of the menses), the old-fashioned *chi no michi* (path of blood, derived from Sino-Japanese medicine), and the now more acceptable *konenki*, a term widely used in both medical and popular discourse (Lock 1993, Ch. 1). Focussing on *konenki* as the nearest Japanese equivalent, she pointed nonetheless to discrepancies in the meanings attached to *konenki* and “menopause” in Japan and North America respectively that suggested significant differences in women's perceptions of their bodies in relation to life-course events.

Turning now to the Indian context, there appears to be no accepted term for “menopause” (as such) in most of the major Indian vernacular languages. In general, the vernacular terms used to refer to menopause in India, when translated into English, simply mean “the cessation of menstruation”: for instance, Hindi: *mahina band hona*⁹ (the stopping of the monthly period); *mahabari band hona* (the stopping of the big turns, i.e., the monthly menstrual cycle that befalls each woman in turn); *kapde se* or *latta se band hona* (stoppage of the use of the menstrual cloth); Marathi: *mahina band hone* (the stoppage of the monthly period); *pali thambne* (the stopping of the turns); Bengali: *mashik bondo hoe gache* (the monthly period has stopped), *ar hoe na* (there is no more) (cf. Lamb 1999, p. 555); Gujarati: *mashik bandh thai jaye* (the monthly period has stopped); and so on. Thus, as a physiological event, menopause is not linguistically

“marked,” and its semantic range is specifically linked to the absence or cessation of menstruation. This surely suggests that attempting a cultural understanding of menopause in South Asia should entail a consideration of the *whole series* of socio-somatic processes through which notions of femininity and female sexuality are constituted over the individual life-cycle, menarche/menstruation in particular.

An influential article which traces the development of the female persona from the first manifestation of the “signs” of its sexual identity, through puberty and motherhood, to death, is Veena Das’s “Femininity and the orientation to the body” (1988). Strangely, there is no mention in this article of the bodily transition of menopause in the interstices between the “maternal body” and the “female corpse.” To the contrary, and equally strangely when one thinks of it, the comparative Western literature on menopause tends to read the menopausal transition relatively independently of all other female bodily states and statuses — except “aging,” of which this is a first and doleful reminder.¹⁰

Given the linguistic construction of menopause in South Asia as the cessation or inverse of menstruation, one’s attention is turned to the specific connotations of menarche and menstruation in South Asian culture and society. What is it, exactly, that *terminates* with the onset of menopause? Why is menopause — “unsurprisingly,” in some renditions — construed as a “point of liberation” in the Indian woman’s life-cycle (Dube 1997, p. 76; also Desai 1999, WS p. 58; Geetha 1999, WS p. 63), rather than as a potential social, psychological or medical crisis, as it is elsewhere?

Before developing this line of approach, a note of caution is necessary on account of the extraordinary heterogeneity of Indian society. As is well known, Indian family and kinship systems vary markedly by descent and residence rules (patrilineal, matrilineal and bilateral types [see Dube 1997]), by region (especially the North Indian, “Aryan” type, opposed to the South Indian, “Dravidian” type [see Karve 1953]), by caste affiliation (with important differences between high, middle and “untouchable” castes), between communities (Hindus, Muslims, Christians, Sikhs, Buddhists, tribals), and by class status and urban or rural residence (see Uberoi 1993, Introduction). Since the concept of “midlife” as a cultural, social and physiological transition is related to the female life-course, its experience is likely to vary widely through different communities, strata and regions of Indian society — as well as between individuals. It will be our argument here, however, that the experience of menopause in contemporary India is becoming increasingly *class*-differentiated, as is also, now, the experience of menstruation, childbirth and infertility treatment (see Gupta 2000). We will suggest, in sum, that there are major differences developing between the body-perceptions of cosmopolitan and more “westernized” middle and upper middle class women, *whatever* their regional origins and caste and community affiliations, and the great majority of Indian women. While the former are especially vulnerable to the idiom of “medicalization,” a fragment of this class is also familiar with and sympathetic to Western alternativist approaches to illness (see Section III below). Indeed, it is one of the paradoxes of our times that global cultural (and capital) flows are bringing the issue of menopause into the body perceptions of some non-Western women even as some women in the West are looking eagerly towards Asian and other non-Western dietary and therapeutic practices for alternative modes of conceiving and handling the midlife transition.¹¹

While menopause is scarcely mentioned in ethnographic accounts of the female life-course in India, the

literature on both maternity and on menstruation (puberty, especially) is voluminous. There is also, as already noted, a burgeoning literature on “women of age,” as it becomes recognized in public discourse and policy formation that “morbid” women will increasingly outlive men in the older age groups. For the most part, however, this literature ignores the menopausal years except insofar as they prefigure the diseases and disabilities of old age.

The Meaning of Menarche

In general, menarche is a transition which is conspicuously ritualized through much of South Asia, particularly among the majority Hindu population. Even when the actual event of menarche is not strongly or publicly “marked,” as it often is not, the monthly course usually brings into play a number of taboos and restrictions which epitomize the female condition through the reproductive years. In an important early article “On the purity and sexuality of women in the castes of Malabar [Kerala] and Ceylon,” Nur Yalman had shown how puberty rituals in this region give expression simultaneously to several different, almost contradictory, themes: impurity, danger and shame, but also — importantly — auspiciousness, as the pubescent girl's fecundity and readiness for marriage are advertised to the community at large (see Yalman 1963; also Bennett 1983; Dube 1986, 1988, 1997, Ch. 6; Ferro-Luzzi 1974; Good 1991, Ch. 7; Kapadia 1995, Ch. 5; McGilvray 1982; Rajadhyaksha 1995; Ram 1992, Ch. 4, 1998; Winslow 1980). These rituals mark an immediate change not only in the pubescent girl's physiological status but also in her social persona.

On the one hand, menstruation is marked by massive impurity, as is every monthly course thereafter. Until menarche, the young girl (*kanya*) is likened to the goddess as the repository of purity and ritual power (see Bennett 1983; also Hershman 1977), but the moment she menstruates, her life is radically changed. In many Hindu communities, the pubescent girl will be immediately isolated from her family and confined to a special room or hut. Everything she touches, her menstrual blood and soiled clothes, are deemed to be sources of impurity and contamination, and must be ritually purified or disposed of. (A similar impurity attaches to the products of childbirth [see Chawla 1994; Jeffery 1989, esp. Ch. 5; Jeffery, Jeffery and Lyon 1985].) She may not bathe, cook or worship until purificatory procedures have released her from defilement.¹²

The menstruating girl is also both vulnerable to danger (possession by evil spirits), as well as dangerous to others, particularly to the menfolk of her natal family (see Bennett 1983; Yalman 1963), as well as to cows, crops and rivers (Dube 1997, Ch. 6). Menarche heralds the young woman's sexual maturity in a cultural context in which female sexuality is conceived as highly dangerous, unless harnessed within the institution of marriage. In the past, widespread practices of child marriage and post-pubertal consummation ensured that a girl's reproductive powers were early consigned to the hands of her husband and his family.¹³ But, while child or young adolescent marriage continues to be customary in many communities (despite the legal age of marriage being now 18 for girls, and 21 for boys), for most girls nowadays, and increasingly as the years go by, there will be a gap of a few years intervening between sexual maturity and marriage. With brides expected to be virgins at marriage, safeguarding the sexually mature daughter's

purity until she can be committed in marriage becomes a source of immense anxiety for all concerned. A friend confided:

I was so shocked when I first noticed the blood. And all that my mother could say to me was: “Now the trouble (*museebat*) begins!”

The advent of menarche therefore institutes or reinforces immediate restrictions on an adolescent girl’s deportment and behaviour. By many personal accounts, these restrictions are very deeply resented as girls compare themselves with their brothers and male cousins (*Report* 1990; van Woerkens 1990).

Along with the trauma of immediate and drastic behavioural modifications, women also experience intense feelings of “shame” (*sharam*) — a shame associated with female bodily functions in general, and sexuality in particular (e.g. Chawla 1994, esp. pp. 37 – 43; Gupte 1990; Jeffery 1989; Jeffery, Jeffery and Lyon 1985). Every monthly course brings recurrent embarrassment. Firstly, as mentioned, menstruation is in many Indian communities surrounded by severe taboos, which make the women’s bodily status public knowledge within the household and the immediate kin group, if not beyond — for instance, if she is not permitted to cook or to perform domestic rituals or to visit temples. Even her non-availability for conjugal sex may be publicly noted. Within a joint family set-up, other women may take over the cooking, but stories are many of the phenomenon of synchronous menstruation whereby all women in the household menstruate simultaneously, throwing the domestic routine completely out of gear and embarrassing (or amusing) all concerned!

There is also the awkward problem, a very real one through much of India, of disposing of menstrual waste, for sewerage is not at all universal. Even in urban areas, domestic waste is not directly collected by garbage disposal, but is carried in baskets by domestic sweepers (whose low-caste status derives from the polluting work they do) to nearby, open municipal dumps. Though the market for disposable sanitary napkins and tampons has been rapidly growing, especially — presumably — in the post-liberalisation period, these are still a relative luxury that only a fraction of the people can afford. In any case, their disposal remains a cause for anxiety and embarrassment. For the rest, in most parts of the country, cloth pads made from old clothes are used as menstrual protection, and the pads washed, as discreetly as possible, and reused. Sometimes, menstrual waste is burnt or buried, but this again may invite public gaze and speculation.

However, it should be recorded here that menstruation is *not* seen as an illness or pathology, even though it places women in a ritually inferior position to men and causes shame and embarrassment. To the contrary, so long as it occurs *at the proper time* in life and *regularly* — which are regarded as most important (cf. George 1988b) — menstruation is conceived as a link between the human world and the cosmic order: a witness to the cycle of regeneration of the cosmic and natural order, like the phases of the moon or the passage of the seasons (see Das 1988). (One of the terms sometimes used for menstruation, *rtu*, also means “season.”) Correspondingly, undue delay in the onset of menarche and irregular menses are viewed with concern, as many women recall, and as the medical advice columns and instructional articles in women’s magazines attest (see e.g. Goel 1999, p. 42). Contrariwise, the unusually early onset

of puberty is also a cause for dismay and apprehension. Mothers of daughters who have reached menarche at a relatively young age (age 10) have often confided in whispered tones how worried they are about their daughters on this account. They fret about the depleting and “weakening” effects of blood loss on the immature girl’s body, as well as the pains and stomach cramps that they feel could interfere with their daughters’ school performance. There is also a concern that premature menarche may signal precocious sexuality — and all the dangers that this implies.¹⁴

Though the loss of blood is generally viewed with alarm in South Asia, “normal” and “timely” menstruation is seen as a healthy, necessary and cyclical process of ridding the body of accumulated impurities (see Ram 1998, pp. 279 – 80). This is not to say that women do not experience physical discomfort with menstruation, to the point of being, sometimes, quite physically incapacitated and desperate for “quick-fix” pain-relievers to help them carry on with their normal activities (Rajadhyaksha 1995). Several studies that have looked closely at aspects of Indian women’s reproductive health have drawn attention to problems of irregular bleeding, anaemia, amenorrhoea, dysmenorrhoea, scanty menstrual flow, vaginal discharge and profuse bleeding, along with other gynaecological morbidities (see Bang et al. 1990; Gupte 1990; Soman 1997; Tripathi 1998). But overall the understanding is that menstruation ensures the regular removal of bodily impurities and, through this, the reestablishment of somatic balance. Some Ayurvedic, Unani and homeopathic medicines are believed to be useful in ensuring menstrual regularity (see Bode n.d.; Waghalkar 1998), as are numerous ingredients in the pharmacopoeia of women’s traditional herbal remedies (see Shodhini 1997).

The Meaning of Menopause

Now, if menopause is defined in South Asia as the inverse of menarche or menstruation, whether as “event” or as “process,” what does this entail?

Firstly, for women who have fulfilled their socio-biological obligation to produce and rear at least one son, the monthly flow is seen as serving no further useful purpose. (This is the more so if the woman has already undergone a tubal sterilization — a common method of fertility limitation.) The cessation of menstruation then comes as a great relief. Now the woman is not only freed of the menstrual taboos and restrictions and the embarrassment of managing the flow, but is also no longer in danger of pregnancy (Geetha 1999, WS p. 63).

There is a widespread social expectation in India, based on the Hindu rules of conduct, that sexual relations between husband and wife should properly cease once a son or daughter has been married (see esp. Vatuk 1980a, pp. 306 – 09, 1980b; also Lamb 1999, pp. 553 – 56). Given the young age of marriage and reproduction, the wife might be only in her late 30s at this stage.¹⁵ If a woman produces a child after her son or daughter have been married or — worse still — after her own children have themselves begun their reproductive careers, this is regarded, especially among upper status groups, as a matter of great shame for both husband and wife (see Patel 1994, pp. 165 – 67; also Jeffery 1989, p. 158 n12, 179, 181). As ethnographies and popular lore testify, however, the “pregnant grandmother” is by no means a rarity, social norms and public ridicule notwithstanding (Patel 1994, p. 73). The onset of menopause (in India

usually between 42 and 47 years of age, with 44 as the mean age)¹⁶ removes the danger of unwantedregnancy, even if sexual relations continue, as no doubt they often would, regardless of taboos and public disapproval.

Interviews and ethnographies yield no sense of regret over the expected cessation of conjugal sexual relations at such a relatively early age. To the contrary, relief is often expressed that a woman may now legitimately and decently refuse her husband sex — perhaps enabled by the frequent practice of having the grandchild sleep alongside her. Sylvia Vatuk’s informants candidly stated that they saw no reason to continue to make themselves desirable to men who are themselves aged: “Well, he certainly isn’t going to go off and get somebody else at this age, is he?” (1980a, p. 308). Of course, the idea that conjugal sexuality should be geared to dutiful reproduction, rather than to pleasure, might make it difficult for informants to admit regret at the cessation of sexual relations, or to construe menopause negatively on account of a diminishing of their sexual desire or appeal (*ibid.*), but on the whole there is a generalized acceptance that the waning of sexual desire in old age is to be expected. Menopause is therefore taken as an indication of the gradual “cooling” of the body, which no longer needs to release the excess of sexual-reproductive heat formerly drained away through periodic menstruation (see Lamb 1999, pp. 555 – 557).

Again, menopause puts an end to the monthly impurity which, as noted, renders all women of reproductive age physically and spiritually inferior to men. This is an age when many women feel that they can devote themselves to spiritual pursuits with greater credibility than at any other time of life (Vatuk 1980a, esp. pp. 304 – 05). Some of them, now relieved of the burdensome signs of sexuality and reproduction, can be revered as spiritual leaders — the “*matajis*” who head religious orders and institutions. They revert, as it were, to the state of bodily purity that they enjoyed as pre-menstrual girls.

Similarly, the advent of menopause frees women from many of the restrictions to which they had been subject since menarche. They are now more free to move outside the confines of the house, to visit family and friends, to shop and attend weddings, fairs, celebrations, festivals and rituals: even, perhaps, to smoke and drink in public (see Vatuk 1980a). Women themselves often express a sense of liberation at being “no longer a woman,” more “like a man.” “See, I’ve got a beard,” said one old lady pointing to the growth of hair on her chin. “Now I’m a man. I can go anywhere now that I don’t have ‘menses’ [English term] any more, just like a man!” In other words, the post-menopausal woman no longer counts as a “sexual” being, with all the negative connotations of shame and evil that female sexuality implies in this culture (see Vatuk 1980a, p. 307; also Jacobson 1977; Lamb 1999, pp. 553 – 556). This may more than compensate for the termination of her capacity for reproduction.

More importantly, midlife marks a phase in a woman’s life-cycle when, so long as she is the mother of sons, she is likely to be at the height of her power in the domestic sphere (see Das Gupta 1995). As a young wife in her husband’s extended family, the new bride occupies the lowest rung in the family hierarchy. She is expected to be ever-obedient to the wishes of the senior women of the family, especially of her mother-in-law, but also her husband’s sisters. She is required to perform correctly and without complaint some of the heaviest household chores, which may mean getting up well before dawn and working till

late at night. Any mistakes or omissions on her part are likely to evoke pointed remarks regarding her abilities, her upbringing and her looks. But when a woman becomes a mother (a mother of sons, especially), her status undergoes a change for the better, and ultimately she can look forward to the time when she will exert authority over her daughters-in-law, and extract reverential obedience from her sons and grandchildren. Of course, not every woman has an obedient son or a docile daughter-in-law, but the fact remains that, in the female life-cycle, middle age is the stage of life when a woman may look forward — relatively speaking — to status, power and a modicum of comfort.

There are some qualifications to be made to this picture, however. The first is that menopause, particularly *premature* menopause, is a source of great unhappiness if a woman is barren or if she has not been able to produce a son, or if her children have failed to survive (see George 1988b). Failure on these accounts may result in her abandonment; or her husband may feel justified in taking a second wife. Secondly, her power in middle age depends on the filial obedience of her son or sons, and her ability to discipline her daughters-in-law; these are not things that can be taken for granted. In due course, as her own children grow up and her relationship with her husband stabilizes, the daughter-in-law is likely to win out, and the mother-in-law may have to take a back seat. Indeed, it is this domestic power struggle over the figure of the son/husband, rather than the actual physiological transition through menopause, that tends to dominate the personal narratives of middle-aged women, as they take over from their mothers-in-law, or as they seek to delay the usually inevitable victory of the daughter-in-law (Vatuk 1980a; 1980b; 1995).

Even more importantly, a mature woman's self-esteem, public standing and material well-being are connected to her status as an auspicious married woman (*suhagin*). Once widowed, her circumstances may change drastically for the worse. Her source of authority is removed when her husband dies, and she is now dependent on the goodwill of her son, her daughter-in-law, or other kin. Women do not customarily inherit major property in South Asia, either as daughters or as daughters-in-law, and for the most part are entitled only to maintenance from the husband's estate (see Agarwal 1994; Agnes 1999).¹⁷ Given the demographic profile in India, where women are younger and more long-lived than their husbands, and where widow-remarriage is socially stigmatized, the prospect of widowhood is a spectre that looms large on the horizon of every married woman; understandably so, since many studies have disclosed the drastically increased morbidity and impaired life-chances of widows compared to married women — particularly for widows without sons (see Bali 1997a; Chen 1998; Drèze 1990; Lamb 1999). It is little wonder, then, that questions of sheer material survival and the maintenance of social dignity dominate the self-image of many mature women, and shape their fears and hopes as they proceed towards old age (Vatuk 1980a; 1990).

As to the physical implications of menopause, the only major, permanent ill-effect of the cessation of menstruation is believed to be weakened eyesight. Even this, however, is no special cause for alarm, being considered a normal and natural consequence of aging. The explanation given is that the heat of the body that is concentrated in the womb and that escapes every month through the menstrual flow, now has no outlet and accumulates in the head until somatic balance can be successfully reestablished. It is this "heat (*garmi*) inside the head" which causes the eyesight to fail and which is also believed to be at the root of certain other typically menopausal symptoms, such as dizziness, headache and irritability (see

Rajadhyaksha 1995; Vatak 1980a, p. 307).

Other menopausal symptoms, as experienced and labelled in the West, are not entirely absent in the physiological experiences of Indian women as they transit this stage of their lives. The notion of *garmi* or heat may also be used to describe what in the West are known as “hot flashes”;¹⁸ and *ghabrahat*, a symptom commonly reported by menopausal women, is the colloquial term for depression, palpitations and panic attacks. But in any case, such symptoms are not usually linked specifically to the cessation of menstruation. Nor are they seen as forming a complex of inter-related experiences or symptoms, supposedly typical of the midlife years (cf. Vatak 1980a, p. 308). They are just general signs of aging, to be taken more or less for granted.

It is only when menopause occurs unduly early that a problem is seen to arise. This is particularly the case, as already mentioned, when a woman has not yet fulfilled her maternal role. A woman may also feel that she is suffering prematurely the failing eyesight and fatigue associated with old age. On the other hand, if she menstruates beyond the expected span (which is 5 or more years younger than for Western populations), this might also be construed as unhealthy and physically “weakening” (cf. George 1988b, pp. 303–04) — like a man’s excessive expenditure of semen in old age (e.g. Cohen 1999, pp. 132–3). No purpose is seen to be served by her menstruation at this age, the more so if she has already undergone tubectomy or hysterectomy, and her continued menstruation is almost indecent. Patel (1994) reports village women’s recourse to various herbal medicines to induce menopause, as do some personal accounts:

I always used to have a lot of trouble with my periods. I had very heavy flow, and a lot of pain. Sometimes my periods used to come after every 20 days or so. I felt constantly weak and tired. One day my sister-in-law asked me what was wrong with me, and I told her. She told me she had had the same problem, but it had been cured by this swami — just one pill and it’s over. Well, I don’t believe in all these things, but I was desperate. I thought, “why not?” So I went to the swami and took his pill. I bled and bled. And then it stopped. And never again! I was only in my early forties, but I didn’t care. I just wanted an end to it all.

Other informants see the allopathic medical system as offering similar instantaneous relief. One elderly woman said:

By 50, that should all have stopped. It’s too weakening. My daughter in America was still going. She just took some pills, and it all stopped for good.

In sum, as the paucity of literature on menopause suggests, a South Asian woman is somatically defined primarily in terms of her reproductive capacity and as a source of male sexual pleasure. Beyond reproduction and beyond pleasure, menopausal symptoms such as vaginal dryness are deemed of little account — indeed, scarcely speakable.

There are, of course, some negative consequences of this cultural failure to recognize and pathologize menopause as a socio-somatic life-course event. There is, firstly, the perspective of women’s overall reproductive health. Though women in later life continue to suffer health problems in the form of

gynaecological disorders and urinary tract infections, deficiency diseases due to cumulative malnourishment and overwork, malignancies of the reproductive system, muscular and skeletal problems, fatigue, and so on, health workers report an uphill task convincing post-menopausal Indian women, and more so their families, that they need to report gynaecological symptoms and undergo routine medical examinations. By the time they are forced to seek medical attention, their problems have often become extremely serious (see Bang & Bang 1989; Bang et al. 1990).

Secondly, menopause is another context which denies the legitimacy of the *desiring* woman subject (see essays in John and Nair 1998; also Uberoi 1997).¹⁹ This is clearly a point of marked difference with contemporary Western constructions of the feminine body in which sexuality is a key component — *even in middle age*. Indeed, it is the expectation of continued pleasurable sex in post-menopausal years that has provided a major impetus for the development of Hormone Replacement Therapy for menopausal “management” in the West,²⁰ and the most convincing argument for its short-term efficacy.

III. Naming the Phenomenon: Menopause Medicalized

In the previous section, we considered the cultural construction of menopause as the inverse of the body-status that menarche institutes in adolescence: that is, for the most part, as a liberation from the constraints associated with the beginning of the reproductive stage of a woman's typical socio-somatic life course. We noted that in India menopause is not conspicuously pathologized, unless very severe problems bring the woman forcibly into contact with the medical system; and, even then, her specific symptoms may be treated individually without identifying them as part of a “menopausal” complex.²¹ By all accounts, a woman's own self-perception of the midlife phase tends to be dominated by the social dynamics of family relations, good or bad (Vatuk 1980a; 1980b). Her anxieties regarding her old age are also framed by such preoccupations and, for many, by the sheer struggle for day to day survival.

This said, however, it is important to record that social forces are presently at work which may increasingly modify this picture, at least for the urban, affluent, upper-class woman with a cosmopolitan background and lifestyle.

These changes have been under way for some time — indeed, they are implicated in the whole project of Indian “modernity.” But the transformation has undoubtedly quickened in the decade of the 1990s, coinciding with the process of economic “liberalization” and structural adjustment (dated from 1991), the consequent opening up of the media, the rapid growth of consumerism, and the much-vaunted expansion of the “new middle class” (see Rajagopal 1999). Indian women of the upper middle classes are now integrated into the global scene in terms of their body-consciousness through all stages of the female life cycle, including menopause. As one informant, herself a social scientist working in the area of women's health, said, talking of her experience of menopause:

I had this very heavy bleeding, and went to see my gynae. She was surprised. She said: “But you've been living abroad! I'm surprised you weren't put on to HRT (hormone replacement therapy). It's easily available over there, and everyone gets it.”

This globalization of body-imagery in the 1990s is expressed in two main domains. The first is in the process of the “medicalization” of women’s bodies under the joint aegis of the State, the medical profession, and the pharmaceutical lobbies, which has become a matter of much concern for women’s health activists in India and around the world (see e.g. Gupta 2000). For the Indian middle classes, this increasing medicalization has found expression particularly in technologies of childbirth (with a rapidly growing incidence of caesarian section for those who have the means to pay [see *Manushi* 1999]), in sex-selective family building strategies enabled by the New Reproductive Technologies (NRTs), and in the promotion of Assisted Reproduction in high-tech fertility clinics.²² As we shall see, it now frames the understanding of menopause as well, being articulated, chiefly, through efforts to promote the acceptance of Hormone Replacement Therapy both for the treatment of menopausal symptoms and as a prophylactic against osteoporosis and cardiovascular disease (and possibly Alzheimer’s disease as well).

Secondly, is the booming beauty business, promoted by the contemporary mass media and linked to the international fashion scene, in which Indian women have been so conspicuously successful (once they got over their inhibitions about appearing publicly in bathing suits). In its own way and its own idiom, promising to make the client look “years younger,”²³ the beauty business offers treatment for menopausal symptoms, although, again, they are not usually identified as such. The two developments are not necessarily incompatible — it is likely that the women who undergo HRT will also patronize up-market beauty parlours — but they also represent competitive alternative approaches to dealing with the same problems of the peri- and post-menopausal years. Speaking of a very active “socialite” relative, a friend remarked enviously:

She’s over 65, but you’d never guess it. It’s no wonder. She has a full herbal body massage every day for two hours!

In what follows, we will focus primarily on the experience of menopause in reference to the medical system, returning first to the template we had initially formulated — namely, the conceptual link between menarche/menstruation and menopause. There are some interesting transformations suggested here. That is, where earlier menarche and menstruation had been strongly “marked,” at least in terms of rituals and taboos, and menopause “unmarked” by comparison, both body-states are now conceived — *similarly* — as different phases of a medicalized female physiology.

To begin with, there has been a “de-problematization” of menarche/menstruation for middle class girls, partially delinking it from ritual practices and religious belief in the name of scientific rationality and secular life-styles.²⁴ Articles in women’s magazines and the popular press give a good indication of this (see e.g. Goel 1999). In urban and cosmopolitan settings, traditional puberty ceremonies may be discontinued or attenuated, or held only in the privacy of the home — not as a public event (cf. Ram 1998, pp. 287–88). Certainly, middle-class parents try to ensure that menstrual taboos and restrictions do not interfere with their daughters’ schooling. Conversely, however, “premenstrual tension” (PMT) is gaining recognition as a “medical” problem, in line with post-natal and menopausal “blues,” and amenable to medical solutions (see Markande 1996; also Zutshi 1997).²⁵

Similarly for this same class of Indian women, menopause, which was earlier almost a “non-event,” both

socially and medically, has become increasingly problematized and brought to public attention as a *medical* and potential *public health* issue. This problematization begins with the “naming” of the phenomenon — particularly the use of the English term, “menopause”:

I never knew anything about “menopause,” as such. My mother and grandmother, if they had any trouble with it, they never said anything about it and we never knew. I read about it first in the *Readers' Digest*.²⁶

Now named, the phenomenon of menopause is simultaneously presented as a pathology demanding treatment, if only the client can be adequately “informed” and “educated” about her needs at this time of life and made to recognize her “symptoms” for what they are.

The dissemination of information on menopause as a medical condition or pathology takes place at several levels, which one may briefly refer to: the professional and the popular. In the first instance, is the education of members of the medical profession, something rather easier said than done, apparently (cf. Kaufert and Gilbert 1986). Until just a few years ago, awareness about menopause and its management was virtually non-existent among the medical profession, and never featured at the annual meetings of the Obstetrics and Gynaecology Society of India.²⁷ In fact, the initial resistance to HRT came from General Physicians (GPs) and other community doctors, on whose advice women either refused HRT outright or abandoned it. GPs and gynaecologists advised their clients to accept menopause as a natural sign of aging, provided them symptomatic relief, and warned them against the dangers of cancer associated with HRT use.

Educating the medical profession has therefore been the priority task taken up by the Indian Menopause Society (IMS), a society launched in 1995 by a group of medical practitioners belonging to various areas of specialisation from all the major cities in the country. The goals of this Society, as proclaimed in its annual bulletin, include: (i) to provide a forum for the scientific discussion of all aspects of menopause and Hormone Replacement Therapy (HRT); (ii) to promote awareness of menopause and HRT; (iii) to foster a multi-disciplinary approach to all matters regarding menopause; (iv) to undertake research on relevant aspects concerning menopause, especially in the Indian context; as well as (v) to conduct educational programmes for underprivileged menopausal women through multidisciplinary menopausal clinics. On the basis of articles contributed to the *IMS Bulletin*, and interviews conducted with office-bearers of the IMS, it is clear there is virtually no problem associated with menopause or female aging that does not require HRT, be it recurrent urinary tract infections (Garje and Bharucha, *IMS Bulletin*, 1998), common urinary problems such as dysuria, and stress and urge incontinence (Subramaniun, *IMS Bulletin*, 1998), existing ischaemic heart disease, and established osteoporosis (Wangnoo, *IMS Bulletin*, 1998; Ravishankar, *IMS Bulletin*, 1998; Marya, *IMS Bulletin*, 1998), cervical, ovarian, colonic and other non-oestrogen dependent cancers, and the exacerbation of mental and emotional problems following menopause (Jha, *IMS Bulletin*, 1998).²⁸ According to the woman doctor who is the Secretary of the IMS, HRT can be started for all menopausal women irrespective of presenting problems, unless specifically contra-indicated. In her words,

investing in old age health by starting HRT early in menopause, can add both quality and quantity to the last three decades in the lives of women. Even in those where it is started late, it gives them quality years.

Apart from their address to doctors, the IMS also seeks to address government and policy makers to persuade them that menopause is a public health issue of grave dimensions, given the huge numbers of Indian women who will live decades of life under conditions of increasing “morbidity” unless protected by HRT. Typical of this rhetoric, is the following statement from the Summary Report of the First National Consensus on HRT (December 1998):

The population of India has grown considerably in the last century. The estimated population in 1998 was believed to be 965.6 million, of which 465.2 million were females. Approximately 84 million women were above the age of 45 years and possibly post-menopausal. The life expectancy for a female in 1994 was 64.8 years. . . . Increase in life expectancy will cause an increase in the problems of advancing age amongst these women. Increased morbidity and mortality from vasomotor, urogenital, osteoporotic, cardiovascular, psychological and neurological diseases will be a consequence of their living longer in the oestrogen deficient state of menopause. About 35% of post menopausal women in India are estimated to have osteoporosis, *which in real terms means approximately 30 million women in India have osteoporosis or are potentially osteoporotic* (Indian Menopause Society 1998, emphasis added).²⁹

Despite the stated concern of the IMS for the needs of the mass of menopausal women, the high cost of HRT in fact restricts this course of menopause management to only the very wealthy upper crust of society. The expensive screening and measuring tests, the need for regular consultations and visits to ensure proper monitoring of the dosage and its side-effects, and the treatment itself — HRT patches or pills — place it well beyond the reach of the majority of Indian women.³⁰ Significantly, the IMS recommends that poorer women could be given counselling regarding vegetable sources of estrogen, such as soya flour, as well as on the use of herbal and indigenous medicines, lubricants to ease vaginal pain during intercourse, and so on.

The activities of the Indian Menopause Society and the promotional efforts of the multinational pharmaceutical giants (often working in conjunction) appear to have borne fruit, for the dissemination of information on menopause as a medical condition, and on HRT as the major mode of menopause “management,” has increased remarkably in the latter half of the 1990s.³¹ The Voluntary Health Association of India, a major NGO in the health field, has recently produced an informational pamphlet on *Menopause* (see Nath 1999),³² while articles on menopause, osteoporosis, HRT, etc., have begun to appear with increased frequency in the popular press — in newspapers and women’s magazines and in life-style magazines with a readership among the intelligentsia (see e.g. Bajaj 1999; Bansal 1995). The VHAI pamphlet, and several of these articles as well, purport simply to offer the menopausal woman the information necessary to help her to make a mature “choice” among the options now available for the treatment of menopause, that is, effectively, a choice for or against HRT, in one or another of its forms.

Other articles, rather more dramatically, present HRT as the “boon” that post-menopausal women have been looking for:

Fed-up of being closeted and learning to adjust [to] menopause without any help, more and more women are going in for Hormone Replacement Therapy (HRT), and many other forms of treatment which makes it much easier for them to cope with these difficult times (Prakash 1998).

Notwithstanding this unprecedented avalanche of “information” on menopause management, however, there is certainly no unanimity of opinion that HRT therapy is the answer to every aging woman's prayers. In fact, even while presenting information on HRT and its benefits in both the short and the long term, these articles and advice books often simultaneously seek to reassure readers that menopause is a “natural” process of aging which can be taken in good spirit, made the most of, and even enjoyed for the freedoms it brings. They may suggest that a healthy diet, adequate exercise and cultivating a “positive” state of mind should be sufficient to assist the menopausal woman comfortably through her change of life (Nath 1999, Ch. 5).

All the same, there is no doubt that middle class Indian women have become increasingly familiar with the term “menopause,” and the symptoms typically associated with it in the popular bio-medical literature (night sweats, hot flashes, hormonal imbalances, mood changes, etc.), and with the link between oestrogen deficiency and osteoporosis and cardiovascular disorders. Many peri-menopausal and post-menopausal women of this segment claim to have experienced these “menopausal” symptoms, and to have had them diagnosed as such in medical consultations. A female homoeopathic doctor informed us that more and more middle and upper class women, even those from more conservative backgrounds, were confiding problems of declining libido and sexual pleasure, as well as anxieties that, with menopause, they had lost an intrinsic aspect of their femininity and were no longer sexually desirable to their husbands. A leading endocrinologist in a large private hospital in New Delhi also reported that declining libido and vaginal dryness were complaints he regularly received from his menopausal patients, and that often it was the husbands, accompanying their wives for consultations, who voiced the complaint and sought treatment for their wives.

All this suggests the advent of new attitudes to the female body and female sexuality. In the past — at least by brahmanical standards — a woman seen to enjoy or demand sexual activity would be judged morally suspect and dangerous to her husband's physical and spiritual well-being; today, at least in *some* social circles, the female body is more accepted as a repository of sexual pleasure and as inviting general appreciation and scrutiny (see Thapan 1997). It is now considered appropriate for women to have sexual needs, to expect sexual gratification and to cultivate sexual appeal (see also Agnes 1999). Also, as couples break free of traditional norms and constraints and live separately from their extended families — as is increasingly the case for the professional, urban, upper middle classes — the earlier restrictions on sexual intercourse beyond a certain age or stage in the life cycle can no longer be monitored and enforced. For these sections of Indian society, the post-reproductive years are no longer considered a time of rest and gradual retirement (see Vatuk 1980b). Rather, demanding working careers, a busy social life and aspirations

towards improving the overall quality of life have led to a new conception of the female body and female sexuality. The emphasis now is on an active, productive and aesthetic body that, far from succumbing to the natural forces of aging and disease, succeeds in delaying and countering these processes as long as possible. According to a well-known gynaecologist who has pioneered HRT in India, Indian women are demanding to lead better lives, and believe that the risks entailed in ensuring a better a quality of life in their later years are well worth it.

But she may be over-optimistic here. Doctors advocating HRT realize that their major problem, after convincing their fellow doctors, is the problem of patient “compliance.”³³ Though attracted to the thought of symptomless menopause and a wrinkle-free transition to old age, many women are deterred from HRT by reports of the resumption of menstruation or spot-bleeding (“I can’t go through all that again!”). They may also be aware of suggested links between carcinomas and HRT use. More to the point, the idea of a prolonged and relatively expensive treatment is also a serious deterrent to beginning, or pursuing, HRT.

Advice articles admit, somewhat inexplicitly, that there may be side-effects from the use of HRT, “as with any drug,” which “usually disappear after some time” (Bajaj 1999, p. 23). At the same time, they also caution that HRT is “like a knife,” to be used judiciously lest one cut a finger. In a situation where so-called prescription drugs are routinely dispensed by chemists without prescription, they warn that these are not drugs which should be “bought over the counter.” They must be used under strict medical supervision, implemented only after a battery of tests have established the client’s suitability for this regimen, and followed up by routine medical examinations, initially every month, then every three months, and finally every six months (*ibid.*). They should not be stopped without consultation with a doctor. If used for treatment of immediate menopausal symptoms like hot flushes, cold sweats and vaginal soreness, they may be discontinued “after some time”; but if used to prevent or stem severe bone loss or as a prophylactic against heart disease, HRT would need to be taken for “at least 5 years” (*ibid.*), if not for a lifetime.³⁴ Disconcertingly, they conclude that, having once provided comprehensive information on menopause and HRT, “the decision on whether to start HRT or not is entirely yours” (*ibid.*; cf. Lock 1993, p. 363). In the last analysis, that is, the menopausal woman’s exercise of “choice” becomes merely her own, rather than the physician’s, responsibility.

In fact, Indian women do have other “choices” than those that are laid out for them in the burgeoning menopause literature directed to promoting HRT. These may or may not be expressly “medical” technologies and products; and they may or may not require the recognition and “naming” of a menopausal complex as a disease category. Increasingly, however, they will be technologies and products of the global market-place, in competition with HRT for the disposable resources of India’s growing middle classes.

In India, as is well-known, alternative medical systems, including several systems of “indigenous” medicine, flourish alongside “western” or “allopathic” bio-medicine (see e.g. Leslie 1992; Minocha 1982). From the end of the nineteenth century, a number of Indian companies have initiated the industrial manufacture of indigenous medical products (Bode n.d.). These pharmaceuticals are not usually dispensed by a traditional practitioner of one of these medical systems, but are largely bought “over-the-counter” and self-administered (Cohen 1999, pp. 132 – 33). Their promotion in the pharmaceutical market relies heavily

on product advertising in which they are positioned as “natural” products, based on several millennia of medical knowledge and experience but validated by laboratory testing according to the categories and specifications of modern biomedicine. The herbal medicines which comprise the traditional women's lore of home remedies — if their knowledge survives at all — may well become packaged and marketed in the same way for the same middle class market, as have a range of traditionally used “natural” beauty products. Significantly, in the course of their work of documenting women's knowledge of herbal medicines, the Shodhini Collective noted that

the interests of urban and rural women were substantially different. Urban women were keen to learn about the use of traditional remedies and plants in women's health from rural women. Rural women, on the other hand, wanted to learn about modern developments in health, [and] wanted [bio-medical] information to which they had no access (Shodhini 1997, p. 1, emphasis added).

Indian indigenous medicines expressly offer themselves as solutions to the well-recognized “toxicities” of modern life-styles — the stresses and strains of urban bourgeois life (Bode n.d.). They are believed to be especially suitable for the long-term treatment of “chronic” ailments, for which allopathic medicine has no treatment or produces undesirable side effects, and for the treatment of ailments of women, children and the aged who cannot withstand the side-effects of “strong” or “hot” allopathic medicine (ibid.). Tonics (*rasayanas*) — for enhancing memory (for school-children and the aged), for waning sexual virility and performance, for sagging breasts and wrinkling skin, for fatigue and depression, etc. — are a major segment of the market for mass-produced, indigenous pharmaceutical products, as well as an important component in the personal hygiene and beauty products that these companies also simultaneously market (ibid.; Cohen 1999, pp. 127–33). In fact, these “medicines” are presented as at once food or nutrition, beauty treatments and medicines (Bode n.d.). This combination of qualities commends them for the treatment of “female complaints” like dysmenorrhea (painful periods, for which the very successful firm, Dabur, has produced a specific and well-publicized treatment [ibid.]). And, while such products may not be marketed for the treatment of menopausal problems *under that name* (indeed, we have found none such), they cater to many of the supposed symptoms of menopause (headaches, dizziness, “weakness,” fatigue, mood changes, excessive blood loss, frequent urination, weight gain, memory loss, etc.) and appear generally suitable for the toning up and revitalisation that the change of life is deemed to require.

Similarly, there is now a rapidly expanding market at home and abroad for indigenous beauty preparations, which are positioned as high-quality consumer products for the sophisticated upper middle classes. (These products overlap with the indigenous pharmaceuticals to some extent, being at once beauty and medicinal products.) The beauticians and stockists of “natural” beauty products whom we interviewed recognized and self-consciously addressed themselves to treating the specific beauty problems of the middle-aged, middle-class women who constitute an important and moneyed segment of their clientele. They offer treatments for weight loss, for drying and wrinkled skin and sagging breasts, for hair loss, hirsuteness and greying. They did not identify these age-related problems as “menopausal” or hormone deficiency problems, though most of them were familiar with the (English) term “menopause.” In any case, by the

beauticians' account, the sign of aging about which their clients were most concerned was greying hair: at a certain point in the middle class woman's life (and that of her husband as well, for that matter), the question "To dye, or not to dye?" becomes a matter of some importance.³⁵

Aware of the cachet that non-biomedical products and treatments have attained in the global context (Cohen 1999, Ch. 4), the Indian middle classes can now confidently pride themselves on having "traditional" medical and personal care systems whose pharmaceutical and beauty products are tested by time, natural, and effective in the long run, and without the severe side-effects of western products. As time goes on, there is every likelihood that Indian middle class women will resort to such regimens, tonics and beauty treatments, rather than to HRT and hormone treatments, for managing menopause.

IV. Conclusion

In a very short space of time, perhaps just the last half decade of the twentieth century, one has witnessed a complete polarization of attitudes to menopause in India. For the vast majority of Indian women, midlife may continue to be a scarcely regretted — even welcome — phase of their life-cycle when they are liberated from the taboos and restrictions that had characterized their lives as reproductive agents. Hopefully, if all goes well, this is the time of life when they reach the pinnacle of their social power and prestige. Conversely, their anxieties about aging are likely to be focussed on the dynamics of familial relations, and — for many — on the sheer struggle for material well-being and social dignity. The fear of incapacitation and consequent dependence may loom large, but this is not associated particularly with the end of menstruation or a decline in sexual desire and appeal.

On the other side is a class of women, admittedly a very small, elite section of Indian women, whose attitudes towards the female body, sexuality and menopause, have become qualitatively different. Some of them will be persuaded (whether by their doctors or the popular media) to seek an enhanced quality of life in their older years through the new techniques of menopause "management" that are now, increasingly, on offer. For the medical profession and the pharmaceutical industry, this change presents a lucrative future which they are bent on exploiting.

Given the larger and abysmal picture of women's health in India, the ethical question that must confront policy makers regarding this new trend in menopause management is whether or not the concerns that motivate and support it belong less to the domain of individual or public "health" *per se*, and more to the domain of lifestyle aspirations and aesthetics. In public discourse, the question is often put in terms of issues of social justice and priorities: Whom are the new medical technologies benefiting? And the expected answer is: the rich, not the poor. The irony is that, in the case of contemporary interventions in the labelling, pathologizing and medicalizing of menopause, like the ongoing pathologizing of menstruation, of fertility and of childbirth, it may be the relatively well off and educated, not the poor and illiterate, who will become the victims of their own false consciousness.

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Notes

1. Dr. Tarini Bahadur is an independent researcher, located in Delhi. Her Ph. D. dissertation was on *The Female Life-Cycle with Special Reference to the Female Body in Everyday Life* (University of Delhi, 1995).
2. In particular, we looked at issues of the fortnightly English-language women's magazine, *Woman's Era*, said to be the largest-selling English language women's magazine in India, which is targeted to the educated middle classes. The Delhi Press group, which publishes *Woman's Era*, also brings out several very popular women's magazines in Hindi and other Indian vernacular languages.
3. For concise reviews of the state-of-the-art of Indian gerontology, see especially Cohen 1999, Ch. 3; and Vatuk 1991. As Cohen and Vatuk both confirm, the gerontological object, at least until quite recently, was assumed to be male and, in effect, middle-class, though the justification for gerontology was conventionally sought in the idiom of deprivation, discrimination, and destitution. The recent "gendering" of discussion of aging is reflected in the special feature no "Women and Aging" carried in the one of the biannual reviews of Women's Studies in the *Economic and Political Weekly* (Vol. 33, No. 44, 1999). Articles in this issue focus mainly on the demographic and health profile of the aged, and on systematic discrimination against the female aged, especially widows. Murli Desai's contribution, titled "Aging of Women in Post-menopausal Stage: Need for Intervention," is one of the few articles in which "menopause" finds explicit mention (Desai 1999). Though old age is usually calculated from age 60, Desai regards menopause (age 45–55) as "the beginning of old age for women" (1999, WS p. 58). She argues that the loss of her reproductive and productive capacities stigmatizes a post-menopausal woman in a patriarchal society, even though she is no longer subject to the same degree of patriarchal control as she was earlier in her life-cycle. See also Bagchi 1997, especially Bali (1997a) therein; Bali 1997b; and Jamuna and Ramamurti 1994.
4. For instance, Jyotsna Gupta's voluminously detailed *New Reproductive Technologies, Women's Health and Autonomy* (2000) has only very incidental mention of menopause, chiefly in the context of debates on technologies of Assisted Reproduction. Similarly, Lakshmi Lingam's *Understanding Women's Health Issues* (1998) barely mentions menopause, except in the course of making the now routine criticism that state health policies and services are excessively focussed on monitoring the maternal body and controlling fertility, while "the health problems of single or aged women, problems of menopausal [women], reproductive tract infections, sexually transmitted diseases, urinary infections, cancer of the cervix and issues of mental health are not addressed" (1998, p. 120). Articles occasionally remark that the new concepts of "Reproductive Health" and women's "Reproductive Rights," now incorporated into the policy-makers' rhetoric on

women's health issues, should "adopt a life cycle approach to reproductive health needs, starting from before menarche and continuing post-menopause, instead of being narrowly focussed on the pregnant woman and the family planning adoptee" (Ravindran 1998, p. 28). A contemporary context for the more holistic emphasis on reproductive health is the link between Reproductive Tract Infections (RTIs) and HIV/AIDS (see Tripathi 1998). Cynics note, however, that the concept of reproductive health had originally emerged from the "concrete situation and genuine needs" of women in Europe and the US, and was not designed to be "transplanted under totally different circumstances... to further the agenda of population control in demographic terms," which has been its fate in some developing countries like India (see Sen Gupta 1998, p. 31; also Centre of Social Medicine and Community Health, JNU 1998, pp. v – vi). The Shodhini Collective's fascinating manual, *Touch Me, Touch-me-not: Women, Plants and Healing* (1997), looks at women's health issues in a more holistic manner, seeking to identify the most common problems of women's health and to document women's traditional healing practices in several parts of the country. "Menopause" as such finds little direct mention in the manual (but see p. 132, 157), though it lists many remedies for symptoms directly and indirectly associated with menopause in the allopathic medical system.

5. A much-cited article on the experience of menopause of over 400 women in a colony of Varanasi (Benaras) city was published in an early issue of the journal *Maturitas* (see Sharma and Saxena 1981). This study, which revealed a remarkably florid pathology of menopausal symptomatology in the sample (see also du Toit 1990), has been criticized by Lawrence Cohen on methodological grounds (1999, pp. 208 – 09). Cohen's own cautiously proffered impressions, gathered in the course of a study of aging in the same city, endorsed Theresa George's study of Sikh women in Canada (1988a; see also George 1988b). George had found the traditional psychological and psychosomatic symptoms ascribed to menopause in the western literature largely absent in her sample.

For the most part, as Cohen has also noted, the Indian medical literature on menopause appears to be heavily biased towards clinical psychology and psychiatry (see Indira and Murthy 1980; Jai Prakash and Murthy 1981; Jamuna 1987; Jamuna and Ramamurti 1994; Rao and Madhavan 1982; cf. Cohen 1999, p. 208). Other medical writings include Debnath (1997) and Kaw (1994), and the recent Voluntary Health Association of India pamphlet (Nath 1999), referred to in Section III of this paper.

6. Kaufert (1996) is one of the few papers to question the relevance and appropriateness of the replication in developing societies of the research studies carried out in the West, and of the recommendations deriving therefrom, without a fuller understanding of women's lives and health risks in these contexts.
7. See in this regard Meenakshi Thapan's rather defensive justification of her project to study violence and conflict in the everyday lives of Indian upper class women — "a neglected research category in women's studies in India" (1997, p. 191 n6). Interestingly, Lakshmi Lingam's *Understanding Women's Health Issues* (1998), referred to above, deliberately evades address to the health problems of middle class women, stating that "unless otherwise specified, 'women' refers to the poor classes of the rural, tribal and urban areas of India" (1998, p. viii).
8. The most commonly used Japanese term for "menopause."
9. In Hindi and Panjabi, and probably in other vernaculars as well, women also commonly use the English term "menses," as in "*menses band hona*."
10. A notable exception to this statement is Emily Martin's *The Woman in the Body* (1987), which links the cultural interpretation of the functioning of the female reproductive system in the modern West with metaphors of industrial production (see also Martin 1988). Golub (1992, Ch. 9 and pp. 249 – 54) adds a brief discussion of menopause to an extensive discussion of menarche and menstruation. See also Zutshi (1997) who draws attention to commonalities in the biomedical categorization of premenstrual tension and menopause, linked to the figure of the "witch" — the dangerously disordered and disruptive woman — in early modern Europe.
11. See for instance Guillemain's discussion (n.d.) of the use of "complementary therapies" for menopausal management in Australian menopause clinics. (Complementary therapies are of course not restricted to menopause management.) See also Bulbeck (n.d.[a] and n.d.[b]), and Farquhar and Morris (n.d.). Alternative understandings of menopause can

be accessed through the voluminous "New Age" and "Self-Help" popular literature (cf. Cohen 1999, p. 128).

12. A survey a few years ago of women students residing in a university hostel in Delhi confirmed the reluctance of girls to visit a temple during "that time" (see also Dube 1997, pp. 74–75). Some of the more radical among them hotly disputed the injunction against performing rituals and visiting temples during menstruation, insisting that such "superstitions" should not attach to a "natural" physical event. All the same, most of them were unwilling to risk metaphysical retribution on that account.

The fact that a woman menstruates is also cited to justify the exclusion of Muslim women from worship in a mosque (Jeffery 1979, pp. 110–114). Jewish women are customarily subject to similar restrictions, as were menstruating women in the early Christian church (see Ballinger and Walker 1987, p. 40).

13. When widowed, numerous taboos and restrictions were enforced by community and state to contain and control the pre-menopausal widow's sexuality (see Chakravarti 1998; Lamb 1999, pp. 543–52).
14. Since the consumption of "heating" foods is believed to contribute to early menstruation and to enhance the sexual appetite, the mother tends to be blamed for not exercising proper control over her adolescent daughter's diet. On this matter, "traditional" grandmothers are often at odds with their "modern," diet-conscious daughters-in-law: "You shouldn't have given her so many eggs to eat. That's the reason why she has 'flowered' so early!"
15. In Tulsi Patel's ethnography of fertility in a Rajasthan village, the average age of mother-in-lawhood was 35 (Patel 1994).
16. See Debnath et al. 1997; Jai Prakash and Murthy 1981; and Karkal 1999, who gives 44.3 years, and 4 years earlier on average for under-nourished women. Kaw et al. (1994) gives a slightly higher average age of menopause — 47.5 years, but this study was conducted in an atypical environment, Chandigarh. Wasti et al. (1993) report a mean age of 47 in Karachi, Pakistan, unexpectedly uniform across social strata.
17. The passage of the Hindu Succession Act of 1956, giving daughters equal rights with sons in parental property, is routinely evaded.
18. Said to be less common among Indians and other Asians than among Caucasians (see Indian Menopause Society *Newsletter* 3 [1998]). On the other hand, an earlier study of the symptomatology of menopause in the Indian context, already referred to, suggested an unusually florid pathology. See Sharma and Saxena (1981), and Cohen's critical comments thereon (1999, pp. 206–08). Problems in the methodology of such studies are addressed in Kaufert (1996).
19. For various reasons, the area of Indian sexuality has not been well-covered in the sociology of India, and ethnographies have tended to be biased in favour of a "brahmanical" or sanskritic interpretation of sexuality (see Allen 1982). This is clearly a subject that requires further investigation (see John and Nair 1998). V. Geetha, writing of poor, rural women's personal testimonies regarding domestic and sexual violence, notes varying reactions by older women to the onset of menopause. Several of them "spoke movingly of the feeling of gratuitousness and uselessness which beset them, once they could not bear children or work hard as before," but others "welcomed old age as a liberating time" when they were no longer expected to be sexually active (1999, WS p. 63). Geetha nonetheless cautioned that the older woman's release from sexuality and her denial of desire were not necessarily unproblematic (ibid., WS p. 63). The Context of Geetha's reflection was her reading of three Western works on the older woman — Germaine Greer's *The Change*; Doris Lessing's *Love Again*; and Kate Millet's *The Politics of Cruelty* — writings which prompted her to ask

whether we in India value, deride or overlook wilfully the experience of older women in love. . . . [H]ow do we imagine sensuality in our cultures? Does the experience of ageing suggest modes of being sensual that are not merely erotic? Or is the erotic itself transformed in the cultural experience of ageing and made to represent another emotion, for instance, spiritual devotion?

One might well agree with her that "these are questions which the ethnography of aging in India has yet to confront."

20. It is significant, we think, that the Shodhini Collective's compilation of medicinal herbal remedies for women's complaints (1997) focuses on their "healing" properties, and not on their capacity to stimulate sexual pleasure. Obviously,

the two foci are not mutually exclusive (for instance, dealing with Reproductive Tract Infections and complaints of vaginal dryness would surely enhance sexual enjoyment), but the difference in emphasis remains. For this paper, we have not attempted to access the indigenous pharmacopoeia of stimulants, lubricants and aphrodisiacs, nor the no doubt considerable literature of Indian sexology, some of which seriously addresses female sexual desire and response (e.g. Thirleby 1982, pp. 29–49).

21. This is clear from the wide range of herbal medicines that were traditionally used for the treatment of women's complaints (see Shodhini 1997).
22. Understandably, feminist critiques of these developments have concentrated primarily on the State's coercive exercise of power in the context of fertility control, the medicalization of childbirth, the delegitimization of traditional birth attendants and the discrediting of their "knowledge" (see Chawla 1994), and the use of techniques of sex pre-selection (amniocentesis, ultra-sound, etc.) to identify (and thereafter abort) female foetuses. As noted, Jyotsna Gupta's recent book on New Reproductive Technologies contains only passing brief references to the medicalization of menopause (Gupta 2000, p. 394ff. and pp. 408–09), in the context of discussion of late motherhood via Assisted Reproduction. In this connection, it is important to be reminded of Kaufert and Gilbert's article (1986), which warns against the generalization of the "medicalization" model from the domain of childbirth to that of menopause. They argue that the childbirth medicalization model has two dimensions: the first, the pathologization of the process (specifically, nowadays, the hormone-deficiency definition of menopause); the second, the doctors' and patients' practical conformity with this logic (i.e. the universal prescription of HRT). In fact, the Canadian doctors and patients they studied followed various courses of menopause management.
23. See Thapan (1997) for an attempt to link upper middle class Indian women's experience of their bodies in intimate relationships with the ideal feminine body imagery promoted by the modern media and by the fashion / beauty industry.
24. Kalpana Ram (1998) demonstrates that the "enlightenment" discourse on sexuality and the female body may penetrate even deeper in the social hierarchy. The case she refers to is that of Catholic fisher-folk in South India.
25. While secularization and medicalization appear to be two sides of the same coin, some of the old ideas have a way of reappearing in new guise (see also Ram 1998, pp. 290–94). For instance, a rather clinical article on "Menstruation, Menstrual Cycle and Absence of Menstrual Periods" published recently in the *Woman's Era* (see Goel 1999), concludes its presentation of the scientific "facts" and unscientific "myths" about menstruation with the suggestion that "elderly ladies" have an important social role to play in taking proper care of menstruating girls, and in helping them overcome their "shame" on this account. The pubescent girl, the article advises, should be counselled

that it is a great pleasure to become a woman, that it will in no way disturb her studies, swimming, dance classes or parties, that she will be a mother after marriage, that she can freely meet boys and male teachers, etc.

But simultaneously she should be mildly warned that since she was growing up, she must take certain precautions of time, place, person and occasion when meeting members of the opposite sex and that the normal male tendency is to be carelessly harmful to innocent girls. Remember, menstruation is bliss and the beginning of motherhood, which is the ultimate aim of womanhood (Goel 1999, p. 43).

26. This informant then went on to describe how a doctor's consultation over symptoms of fatigue and irritability had resulted in a diagnosis of "menopause." The larger context in which she discussed this suggested that she was undergoing a number of family problems at the time, as well as a midlife crisis in her professional career. Indeed, the doctor had called in her husband, a busy lawyer who relied on his wife totally for the management of the house and the promotion of his social life, and "counselled" him that he should be more "sympathetic" to her at this time of life.
27. Interview with an office-bearer of the Indian Menopause Society, September 1999.
28. Herbal medicines have been in use for all these symptoms, though the symptoms are not necessarily identified as part of a "menopausal" complex. See Shodhini 1998.

29. The rhetoric of numbers and the rhetoric of “morbidity” are not confined to the publications of the IMS, but in fact pervade the literature on women of age. For instance, Bali (1997a, p. 357) writes:

In terms of health status, differences between the male and female are clearly explicit in that females have a higher rate of morbidity. The higher prevalence rates for fatal conditions in males helps explain why population surveys consistently show that females have higher rates of morbidity than males. Females have higher rates of chronic conditions that cause suffering but not to kill. [T]hese account for much of the higher levels of morbidity and disability for females throughout life.

30. An estimated Rs.600 to Rs.1200 per month in 1998 (Chopra 1998).

31. Similar findings are reported elsewhere. See e.g. Bulbeck (n.d.[b]); Chang (n.d.); Chirawatkul (n.d.) Our local general practitioner admitted that earlier he had not been aware of the advantages of HRT for the prevention of osteoporosis, and that there had been a “scare” about cancer associated with this, but that he now advised some patients to seek consultation with a gynaecologist and take prophylactic treatment.

32. Others booklets in the English language series are on Cancer, Diabetes, Heart Disease, and Arthritis and Joint Pain, suggesting a middle class target group for these publications.

33. This is also a problem on which the international literature on menopause focuses. See e.g. Bulbeck (n.d. [a]) and Guillemin (n.d.) Lock (1993) concludes that Japanese women have succeeded in “resisting” the medicalization of menopause.

34. Information such as this aligns HRT with familiar treatments for diseases like leprosy and TB, for which long term patient compliance is notoriously problematic.

35. Indian feminists also occasionally debate this issue — in privacy, of course. Is dyeing one's hair politically incorrect from a feminist position, a giving in to the “beauty myth”? Some stoutly insist that there is nothing wrong with wanting to look and feel younger than their years. Others feel that they are “making a statement” by allowing themselves to go grey “naturally”: “Dye till you're sixty,” is one formula we heard. Other middle class women clearly feel it is appropriate to allow themselves to grey once they become grandmothers, if not before. A newspaper article recently articulated the debate on HRT in similar terms. Some feminists thought that HRT was an unethical attempt to “mimic nature” by introducing oestrogen and progesterone: “To grow old with an artificially induced support system is not acceptable.” On the other hand, Madhu Kishwar, the editor of the feminist magazine *Manushi*, asserted equally strongly:

I don't buy the feminist argument that it [HRT] interferes with the laws of nature. When water which flows downstream is harnessed for power, does that not interfere with the natural order? Nature has been unkind to women for years. They are just [baby] rearing machines. Once they have finished they are to be dispensed with. If HRT gives a better and longer life span for women, then I am all for it (Chopra 1998).

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