REVIEW OF RESEARCH

"UNVEILING MENSTRUAL JUSTICE: BRIDGING GAPS IN INDIA'S HEALTH POLICIES FOR HOLISTIC MENSTRUAL WELL-BEING"

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INTRODUCTION :

Introducing an innovative framework for menstrual justice, this chapter contends that comprehending women's health necessitates recognizing the intricate interplay between their daily gendered experiences, biological factors, and medical conditions. The inadequacy of India's state health policies in addressing women's health stems from a failure to acknowledge the societal marking of women as impure menstruating bodies, contributing to health inequities throughout their life span. This omission by state policies to recognize women's gendered health experiences constitutes menstrual injustice. The chapter elucidates this concept by establishing connections between women's stigmatization during menstruation, their lack of bodily autonomy, and various menstrual health issues encountered in pre-menarche, menstruation, perimenopause, and postmenopause. It further delineates gender-specific biases, blind spots, gaps, and barriers within state policies that hinder the overall well-being of women throughout their life cycles.

A Menstrual Justice Framework

Menstruation, a pivotal biological process in a woman's life, plays a crucial role in her overall well-being and serves as a key indicator of fertility. One would anticipate that the significance of menstruation in contributing to the continuity of the species would result in the appreciation and acknowledgment of both the process and the individuals undergoing it – namely, menstruation and women. However, on a global scale, and particularly in India, our focal point of research, menstruation is predominantly met with shame and silence. In the Indian context, the categorization of female bodies as menstruating bodies is deeply ingrained in religious, social, cultural, and political contexts, often leading to customary stigmatization (Outlook 2018; Bhartiya 2013; Johnston-Robledo and Chrisler 2011). In light of this backdrop, our paper endeavors to scrutinize how Indian health and related policies address the nuanced aspects of menstruation and menstrual health.

Within Hinduism, two conflicting perspectives exist regarding menstruation. The prevalent view deems menstrual blood and menstruating women as 'polluting,' grounded in the belief that all bodily excretions are deemed "ritually impure" (Bhartiya 2013, 524–25; Eichinger Ferro-Luzzi 1974; Garg and Anand 2015, 184–86). In contrast, the alternative 'tantric' perspective posits that menstruating women, through their menses, embody boundless creative power and immense energy (Chawla 2002; Zsigmond 2012). The onset of menarche, symbolizing fertility, is ceremoniously celebrated in numerous Hindu households (Bhartiya 2013, 525; Eichinger Ferro-Luzzi 1974). For girls themselves, menarche marks the

transition from childhood to the gendered construct of 'womanhood' (Manorama and Hora 2002). Girls acknowledge that the imposition of cultural and social controls over their pubescent bodies, coupled with increased restrictions on their physical mobility, ensures they conform to societal expectations as 'women of a specific deportment' (Kågesten et al. 2016, 2; Manorama and Hora 2002).

We contend that instead of confronting the intricate network of beliefs and practices surrounding menstruation, the state opts to endorse it. A recent glaring example of this endorsement is the state's support for the continued exclusion of women of menstruating age from the Sabarimala temple (Outlook 2018), epitomizing the state's role in perpetuating menstrual stigma. In emphasizing the pivotal role of menstruation in the denial of gender justice, we propose adopting a 'menstrual justice' approach. Originating from India's women's health and people's health movements (Manorama and Shah 1996; Saheli Women's Resource Centre 2001), this approach is founded on an alternative understanding of women's biology and health. 'Menstrual justice' constitutes a comprehensive approach that involves listening with sensitivity and respect to the menstrual health needs of girls and women, shaped by their sociocultural context and gendered everyday experiences (SAMA Team 2005; Rishyasyringa 2000).

The foundational principle of the menstrual justice approach asserts that menstruation is a physiological process intricately linked to psychosocial and cultural-religious dimensions. Its dual purpose is as follows: firstly, to explicitly uncover all facets of women's lives connected to menstruation beyond matters of fertility and reproduction, and secondly, to elucidate the intricate connections between this complex web of beliefs and practices and women's experiences of indignity, discrimination, inequality, and injustice. The approach meticulously examines how the sociocultural-religious discourse surrounding menstruation and its associated practices manifest in national policies, leading to violations of women's human rights, discrimination, and inequality. In undertaking this analysis, the approach brings into focus the role played by political institutions and state policies in shaping these dynamics. After providing an overview of the interconnections between menstruation and women's health, this study scrutinizes state policies concerning women's basic, psychosocial, gynaecological, reproductive, and menopausal health within the menstrual justice framework.

Primary Healthcare

Prior to the formulation of India's National Health Policy (NHP) in 1983, healthcare considerations were addressed within the framework of Five-Year Plans. The NHP of 1983 endorsed the concept of "universal primary healthcare services" but rejected the accompanying goal of "free healthcare provision" due to perceived unaffordability (Ministry of Health and Family Welfare, Government of India (MoHFWGOI) 1983). Notably, the NHP of 1983 prioritized a curative approach over preventive, promotive public health, and rehabilitative aspects of healthcare, leading to an expansion of health infrastructure without realizing anticipated benefits for women's health. Unfortunately, health workers were not adequately trained to address women's needs, and their focus on family planning and immunization disproportionately consumed their time.

The subsequent NHP in 2002 (MoHFWGOI 2002) departed from the pursuit of universal comprehensive primary healthcare, adopting a public health regime characterized by selective care targeting specific groups (Duggal 2005, 35). Acknowledging women's subpar health status and the decline in rural health capacity except for "family welfare activities," the NHP of 2002 pledged "top funding priority to programs related to women's health." However, the envisioned health benefits did not materialize as the policy's approach to women's health lacked specificity. While recognizing the need to "address the specific requirements of women in a more comprehensive manner," it failed to identify any singular women's health issue. The sole women-specific goal it outlined was the reduction of the Maternal Mortality Rate (MMR), reflecting a limited understanding of women's health solely as maternal health (MoHFWGOI 2002, 21).

The policy directives outlined in the NHP 2002, focusing on enhancing the availability and access to quality healthcare for rural populations, especially women and children, found manifestation in the National Rural Health Mission (NRHM) of 2005 (MoHFWGOI 2015). However, the reality revealed

a funding bias towards programs related to reproductive and child health and HIV/AIDS within NRHM 2005, overshadowing primary healthcare initiatives (Duggal and Gangolli 2005, 11). The introduction of Accredited Social Health Activists (ASHA) as intermediaries between the village and the public health system lacked adequate training for primary and menstrual healthcare functions. Moreover, their incentive structure was primarily geared towards promoting reproductive health and family planning (Sarin et al. 2016; Hussain 2011, 56).

National nutrition interventions purportedly aimed at women's health, including the Integrated Child Development Services Scheme introduced in 1975 and the Nutrition Policy of 1993, were also implemented. While the scheme initially provided nutrition supplements exclusively to undernourished pregnant women, lactating mothers, and children under age six (Ministry of Women and Child Development, Government of India (MoWCDGOI) 1975), the Nutrition Policy of 1993 (MoWCDGOI 1993) extended nutritional support to malnourished adolescent girls to address high levels of undernourishment (Kanani 2002). However, the policy failed to propose strategies to tackle intrahousehold gender discrimination toward girl children, such as underfeeding and denial of medical treatment for ill-health, the primary causes of malnourishment. Lacking a perspective of "women's nutrition for its own sake" (Kanani 2002), the policy continued to adopt a narrow view equating women's health solely with reproduction. It overlooked measures to address specific nutritional needs of menstruating or menopausal women and failed to institute a research program examining the impact of malnourishment on women's menstrual health across the life cycle (Jeejebhoy 2000, 145; Oomman 2000, 260; Sandoiu 2017).

The National Health Policy (2017) fails to address the existing gaps in healthcare provision for women (MoHFWGOI 2017), despite sporadic mentions of 'women's health issues' scattered throughout its approximately 30 pages. The policy touches upon women's health needs in sections related to reproductive health, maternal health, child and adolescent health (RMNCH+A), malnutrition, population stabilization, gender-based violence (GBV), and women's health and gender mainstreaming. Under the subheading of "Women's Health & Gender mainstreaming," it acknowledges the need for "enhanced provisioning for reproductive morbidities and health needs of women beyond the reproductive age group (40+)" (MoHFWGOI 2017, 14); however, it fails to provide details on how this enhancement will be achieved through changes in existing health programs.

While India's national health and nutrition policies have shown positive growth in recognizing the necessity to address gender imbalances and allocate more resources to enhance women's health, there is a notable absence of substantive programmatic changes to effectively implement these policies.

Psychosocial Health

India's inaugural National Mental Health Policy, instituted in 2014, acknowledges in its preamble the need to address vulnerable groups (MoHFWGOI 2014). However, it falls short in recognizing and addressing the mental health repercussions arising from elevated stress levels experienced by women due to gender discriminatory practices like neglect, child marriage, infertility, pressure to bear sons, witch-hunting, and marital sexual assault (Ramasubban and Jeejebhoy 2000a, 34; Sarojini et al. 2006, 41). The policy also appears oblivious to the emotional distress women endure concerning persistent menstrual issues and the impact of various diseases on menstruation (Oomman 2000, 253–55; Alvergne, Wheeler, and Tabor 2018). Notably, it fails to acknowledge the adverse psychosocial health effects of the perception that girls and women are considered 'polluting' during menstruation (FSG 2016). Rather than mandating access to counselors and health workers equipped with gender-sensitive training on menstrual health, as advocated by women's health activists (Oomman 2000, 257–58), the policy adopts a psychiatric approach to mental health conditions and employs a 'special case' strategy that neglects the mental health needs of menstruating women (Varma 2014, 45).

Menopause

The NHP 2017 acknowledges the health requirements of women beyond the reproductive age of 40+ (MoHFWGOI 2017), marking an initial stride towards responding to the calls from women's health

activists for policies that comprehensively address women's health throughout their life cycle, rather than solely during their reproductive years (SAMA Team 2005). However, the policy tends to lump together older women, encompassing those in late reproductive age, perimenopausal, recently postmenopausal, and beyond age 60, without delineating a strategy to address the health issues specific to this 40+ age group. The health needs of this demographic are also addressed in the 1999 National Policy on Older Persons, significantly revised in 2011. Similar to the NHP 2017, it demonstrates an awareness of the necessity for heightened attention to older women, yet its approach to aging issues remains gender-neutral (Ministry of Social Justice, Government of India 2011).

Neither policy recognizes the implications of menstrual conditions experienced before menopause and the impacts of menopause on both physical and mental health. They fail to articulate specific treatments or procedures within the existing infrastructure that can be utilized to address postmenopausal morbidities. Furthermore, there is an absence of acknowledgment of the need for gender-specific research on issues such as detriments to women's postmenopausal longevity and the long-term consequences of gynecological morbidities (ibid.; Syamala 2010; Jani and Manorama 2007)

Swachh Bharat Abhiyaan (SBA):

The SBA represents the inaugural large-scale government initiative incorporating a strategy to address the previously taboo subject of menstruation (Swachh Bharat Mission 2019). This section briefly scrutinizes the menstrual hygiene management (MHM) component within the SBA framework through the lens of menstrual justice (refer also to Patkar [Chapter 38] in this volume). The SBA aims to achieve (1) dignity for adolescent girls and women and (2) the retention of adolescent girls in school (FSG 2016). This is pursued through a multifaceted strategy involving the provision of sanitation infrastructure, access to menstrual products, and the dissemination of information, education, and communication (IEC) to raise awareness about MHM among adolescent school-going girls, boys, and the community.

The objective of IEC, as outlined in its technical guidelines, is "to create awareness in order to overcome the silence around MHM and break the taboos within the broader society, communities, and also among family members" (Ministry of Drinking Water and Sanitation, Government of India, n.d., 1). The mandated IEC material includes:

- Facts about menstruation, biology, and the process;
- Frequently-asked questions and answers;
- Dispelling myths about menstruation with factual information;
- Case studies/experiences from girls—Guidance on staying healthy during menstruation, including what protection to wear, what to eat, what exercises to undertake, how to maintain cleanliness, and how to manage cramps, as well as proper cleaning, drying, or disposal of sanitary materials, etc. (Ministry of Drinking Water and Sanitation, Government of India 2015, 13).

CONCLUSION

India's health policies spanning 1983, 2002, and 2017, along with related policies on nutrition, mental health, older persons, population, and rural health, have consistently overlooked the intricate connection between menstrual stigma and women's fundamental health. Even the recent SBA falls into this pattern, as it confines its intervention to menstrual hygiene management (MHM) without extending its scope to address broader menstrual health.

To address this gap, we introduce a novel concept: 'menstrual justice.' This framework aims to explicitly highlight the links between the societal marking of women's bodies as inferior and the resulting discrimination, inequality, and injustice they endure. Specifically, we oppose the utilization of menstruation as a means of controlling women and their bodies, rejecting the compartmentalization of women and girls into categories such as preadolescents, adolescents, women of reproductive age, and postmenopausal women. These artificial divisions neglect the underlying continuities in the causes of women's health challenges throughout their life cycles.

We argue that the health effects of designating women's bodies as 'impure' are experienced both physically and psychosocially well before and after menstruation. Therefore, we advocate for a comprehensive approach to women's health that transcends the narrow confines of fertility and menstrual health: menstrual justice in health.

The menstrual justice framework serves as a valuable perspective to comprehend the discrimination and human rights violations endured by women, arising from the designation of Indian women's bodies as 'menstruating bodies' within specific sociocultural and religious contexts. Rooted in women's rights and gender equality, this framework can act as a foundation for urging the state to dismantle structures built upon the classification of menstruating Indian women's bodies as 'impure.'

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