INTERNATIONAL JOURNAL OF NOVEL RESEARCH AND DEVELOPMENT (IJNRD)
© 2026 IJNRD | Volume 11, Issue 3, March 2026 | ISSN: 2456-4184 | IJNRD.ORG

INTEGRATING WELL BEING AND HEALTH OF WOMEN IN INDIA FOR SUSTAINABLE EMPOWERMENT: AN OVERVIEW ON LIMITED RESEARCH ON FEMALE REPRODUCTIVE HEALTH

Author & Co-Author:
Dr Anjali Parmar[1] & Dr. Arpita Parmar[2]

Abstract:
According to our world in Data census in 2021, the female share of the global population was under 50%. Throughout history, doctors have considered women’s bodies atypical and men’s bodies the “norm,” despite women accounting for under 50%. Though policy and social changes in the 1990s have helped turn the tide, women remain underrepresented in research, sometimes grossly so. Generally, women’s health receives attention only during pregnancy and the immediate post-partum period. The goal of this paper is to record the myths that are currently in circulation concerning menstruation, menarche, and other understudied menstrual constraints and how the taboos regarding female reproductive health is leading to limited research, accounting to women being affected by more non-communicable diseases and issues. To empower women, we must transform the societal beliefs that we carry and promote the notion that women deserve to be treated equally as men in all fields.

Keywords: Data Census, Population Pregnancy, Taboos

1.1. Introduction:

This paper will document the myths that circulate about menstruation, menarche, and other, lesser-studied menstrual prohibitions and how this taboo is preventing research about female reproductive health, resulting in women suffering from more non-communicable diseases and problems. The solution to empower women is to challenge the cultural values that we hold and to advocate for the equal treatment of women in all areas.

Menstruation, a universal experience for half the world's population, persists as one of society's most enduring taboos. This paper contends that the cultural narrative of impurity surrounding menarche and menstruation has resulted in socio-medical marginalization. By framing female reproductive health as a private or shameful issue, the scientific community has historically underfunded and under-researched menstrual challenges, directly contributing to the increased prevalence of non-communicable diseases (NCDs) and delayed diagnoses in women.

The incorporation of women’s health and well-being into medical research is a critical area that has historically received insufficient attention, particularly in the realm of female reproductive health. A woman's life is bound to involve maintaining good hygiene throughout her period. The relationship between women's health and well-being and several factors, including the physiology, psychology and pathology of menstruation, makes this a significant problem in terms of the morbidity and mortality rate among the female population. It is believed that

[1] Assistant Professor, Anand Law College, Sardar Patel University, Vallabh Vidhyanagar

[2] Assistant Professor, Anand Commerce College, Sardar Patel University, Vallabh Vidhyanagar

a woman is most susceptible to contracting urinary tract infections, sexually transmitted diseases (STDs), also reproductive tract infections (RTIs) at this time.

The menstrual cycle, often known as the period/monthly cycle, is a special phenomenon that is exclusive to women. It is more than just a term; it refers to a crucial time during which a woman goes through several reproductive changes, beginning with menarche and concluding with menopause. Adolescence is a period of physical, female reproductive, as well as psychological development that normally lasts from puberty until the achievement of legally recognized adulthood.

The issues affecting women's health have undergone a drastic change, and currently NCDs, such as cardiovascular disease, stroke, kidney disease, respiratory diseases and trauma are the leading causes of death for women worldwide – in high as well as low-income countries. Social constructs and biases also leave girls and women more disadvantaged, as evidenced by high rates of sexual violence. The advancement of gender equality and equity, empowerment and elimination of discrimination, are critical to women's health and well-being. This can only be achieved by including the gender dimension in planning health programs and research.

1.2. Literature Review

Gender gap in research historically, medical research has used the male body as the default (70 kg male). Hormonal changes were often considered as a `noise' that would complicate data, and, until the end of the 20th century, women were excluded from many clinical trials.

1.2.1. Cultural Myths and Their Psychological Impact

Research by Sommer et al. (2015) indicates that in numerous cultures, menarche is often accompanied by restrictive practices, such as isolation or dietary restrictions. These cultural myths can lead to young women developing a sense of being "broken" or "unclean." This, in turn, can discourage them from seeking medical attention for concerning symptoms like severe pain or excessive bleeding.

1.2.2. The Menstrual-NCD Connection

Recent studies suggest that menstrual irregularities can serve as early biomarkers for systemic health issues. For instance:
PCOS (polycystic ovarian syndrome): strongly associated with type 2 diabetes and cardiovascular disease. Endometriosis: often takes 7-10 years to diagnose because of the 'normalization' of menstrual pain, leading to chronic inflammatory conditions. Early or late menarche: correlated with an increased risk of breast cancer and heart disease.

1.2.3. The Pathological Consequence of Silence

1. The Diagnostic Gap and "Normalization"

Research indicates a global average of **7 to 10 years** between the onset of symptoms and a definitive diagnosis (Zondervan et al.). During this decade, the patient is often told by family, peers, and even some medical professionals that their "cramps are normal." This is not merely a social failure; it is a clinical one. When a disease is left untreated for a decade, it transitions from a localized reproductive issue to a systemic inflammatory condition.

2. From Localized Pain to Systemic NCDs

The findings suggest that the prolonged presence of ectopic endometrial tissue triggers a continuous immune

response. This leads to **Chronic Systemic Inflammation**, which is a known precursor to several non-communicable diseases:

- **Autoimmune Disorders:** Women with endometriosis are at a significantly higher risk for Lupus (SLE), Rheumatoid Arthritis, and Multiple Sclerosis. The body's immune system, exhausted by the chronic inflammation in the pelvic cavity, begins to misfire globally.
- **Cardiovascular Disease:** Chronic inflammation can lead to atherosclerosis (hardening of the arteries). Recent longitudinal studies show that women diagnosed with endometriosis under the age of 40 have a **3-fold higher risk** of heart attacks and angina.
- **Central Sensitization:** Long-term untreated pain literally "rewires" the nervous system. The brain becomes hyper-reactive to pain signals, leading to **Fibromyalgia** and chronic pelvic pain syndromes that persist even if the initial lesions are surgically removed.

Findings: The Cycle of Marginalization

Through an analysis of current socio-medical trends, three primary findings emerge:

Constraint	Societal Belief	Medical Consequence
Symptom Normalization	"Pain is just part of being a woman."	Delayed diagnosis of endometriosis and fibroids.
Funding Disparity	Menstrual health is a "lifestyle" or "niche" issue.	Lack of innovative treatments for dysmenorrhea compared to erectile dysfunction.
The "Impurity" Myth	Menstruating women are "unclean" or should be silent.	Low health literacy and reduced preventative screenings for reproductive cancers.

The stigma surrounding menstruation creates a data gap, because women are conditioned not to report their menstrual cycle, and the medical profession lacks the longitudinal data needed to understand how menstrual health affects NCDs such as metabolic syndrome and autoimmune diseases.

1.3. Conclusion

Women's empowerment is inseparably linked to the de-stigmatisation of their biology. As long as menstruation is seen more through the lens of superstition than medicine, women will continue to suffer from a higher incidence of preventable communicable diseases. To achieve true equality, we need to move from the model of menstruation management to the model of menstruation health as a vital sign.

Recommendations Integrative medical education: Medical curricula should be updated to consider the menstrual cycle as a fifth vital sign of health, not just fertility. Corporate policy reform: Implement a policy of `menstrual equity' and provide sanitary products and flexible working conditions to normalize the menstrual cycle, and direct public funding to debunk myths (e.g. the `impurity story').

You can argue that **equality in research** isn't just about "fairness"—it's about **preventative medicine**. If we treated the first sign of menstrual pain with the same clinical urgency as a high blood pressure reading, we could potentially prevent a significant percentage of female- prevalent autoimmune and cardiovascular NCDs.

Gender equality in biomedical research should not be understood solely as an ethical demand for fairness. Rather, it is fundamentally a question of **preventative medicine and long-term public health strategy**.

Menstrual pain (dysmenorrhea) is frequently normalized, dismissed, or under-investigated. In contrast, clinical signs such as elevated blood pressure are treated as early warning indicators requiring monitoring, intervention, and systemic risk assessment. This discrepancy reflects a gendered hierarchy of symptoms in medicine

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