



# The Power of Integration

Integrating menstrual health and hygiene, and sexual and reproductive health and rights is a pathway for gender equality



Global  
Menstrual  
Collective

## The intimate linkage between menstrual health and hygiene (MHH), and sexual and reproductive health and rights (SRHR)

*When Eunice was 15 years old, she woke up with blood on her night dress. Shocked, she called for her mother and told her of the strange occurrence. Eunice's mother told her this bleeding would happen, "the rest of her life." A few months later, Eunice was raped by a neighbour and didn't know she had become pregnant by the rape, until the fourth month of pregnancy. She said, "I was still puzzled about menstruation, and the trauma of rape and consequent pregnancy added to my misery!" She dropped out of school and suffered severe anxiety for years.<sup>1</sup>*

Eunice's experience of her first period is not unique. Research from low and middle-income countries found that the proportion of adolescents aware of periods before they first experienced them was abysmally low. Girls and women also have poor knowledge of the menstrual cycle and when they are most likely to conceive (the fertile period).



44% of the adolescent girls in Southeast Nigeria had premenarcheal education
18% of girls in Malawi were aware of menses before their first period, and 30% were scared when they experienced menarche
35% of girls from Bangladesh knew about periods before menarche
16% of women of reproductive age in Angola, 20% of women in Niger, 29% of women in Senegal, and 17% of women from India were aware of the fertile period during their menstrual cycle (DHS, NFHS-4)
90037 girls aged 10-19 years in South Africa gave birth during 2021-2022
Globally, half of all pregnancies are unintended, with an estimated 331,000 unintended pregnancies occurring every day

Owing to deep set socio-cultural and gender norms, a culture of silence, shame and stigma engulfs the female body, and sexual and reproductive experiences. A striking majority of girls and women worldwide are poorly prepared for their first period (menarche) and face significant challenges when it comes to their menstrual health, lacking the necessary preparation and information to effectively manage their periods (and other forms of uterine bleeding) throughout their lives. These challenges are often exacerbated by pervasive stigmas surrounding the topic and the lack of knowledge among parents and teachers, further hindering their access to proper support and resources

Christine used to use leaves and rags during her period, and often stained her clothes as she could not afford menstrual products. When a teacher offered her menstrual pads in exchange for sex, she felt like she had no choice but to agree. At age 14, she found herself pregnant and homeless on the streets of Nairobi, Kenya, due to a lack of support for her menstrual health.

Like Christine, millions of people who menstruate face challenges in accessing affordable and quality menstrual products. The health consequences of such constrained access are many. Some people may be driven to use unsafe materials to manage menses, or use materials for longer than considered hygienic. Such practices cause discomfort and may lead to reproductive tract infections (RTIs), which, if untreated, can have long term negative consequences such as infertility. Others may engage in risky sexual practices (including transactional sex to buy menstrual products), or be vulnerable to sexual exploitation, all of which cause anxiety, trauma, and unintended pregnancies and associated negative outcomes (e.g., early pregnancy, unsafe abortions, sexually transmitted infections).



Two out of three pad users in rural Kenya received their menstrual products from sexual partners

Seven million girls (approximately) from South Africa cannot afford to buy safe menstrual products

2-4 days of daily income may be spent by Nigerian girls and women on menstrual products. In Nigeria, 44% of the population live on less than USD 1.90 per day; the smallest packet of sanitary pads costs USD 1.30

Eunice and Christine's stories powerfully highlight the fundamental links between MHH and SRHR. These interlinkages are biological and social, persist across the life span, and are particularly prominent during adolescence and the reproductive years. For example, the first period, menarche, is a definitive sign of puberty; the menstrual cycle is key to ovulation and the fertile period; and menopause signals the end of the reproductive years. Further, certain MHH concerns can affect SRHR, and vice versa. The unhygienic use of menstrual products or poor menstrual hygiene, for instance, can enhance susceptibility to RTIs. The use of certain hormonal contraceptives may affect changes in the menstrual cycle and bleeding patterns, which, in some cases may lead a woman to discontinue the contraceptive.<sup>9,10,4</sup>



Most striking is how MHH and SRHR are profoundly influenced by the same pervasive socio-cultural norms and structural inequalities. Discriminatory gender norms are significant hurdles that challenge girls and women's access to information, social support, health services and products needed for menstruation, family planning, abortion, menstrual concerns and disorders, and menopause symptoms, among others. These very gender norms and other structural barriers such as poverty, adversely affect girls' participation in school after puberty, women's participation in the workforce (during menstruation, after childbirth), and their mobility and engagement in aspects of daily life. People with gender diverse identities, persons with disabilities, and others who face acute marginalization (e.g., people in sex work, manual scavengers) face additional burdens of stigma and discrimination, owing to their sexual identity or orientation, their cognitive and/or physical impairments, or social status. For communities in humanitarian settings (natural disasters, conflict or displacement), their severely constrained and volatile living situations compromises very basic MHH and SRHR needs. <sup>9,10,11</sup>



Figure 1 shows all the phases of life that are relevant for MHH and SRHR, and striking commonalities: the shared biological underpinnings, the key social determinants affecting both MHH and SRHR, the common programmatic approaches from MHH and SRHR that can be leveraged to strengthen integration action across the life course, with the ultimate goal being integration of MHH and SRHR to accomplish health, wellbeing and gender equality. This figure draws from existing guidance on the integration of MHH and SRH.<sup>9,10,11</sup>

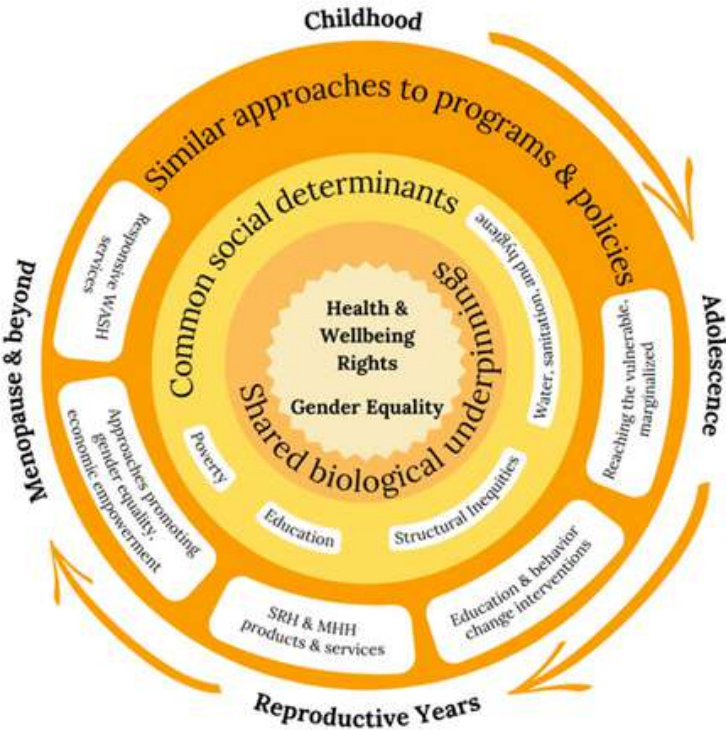


Figure 1: The foundations for integrating MHH and SRHR, forming a pathway for health, wellbeing and gender equality

# The potential benefits of integrating MHH and SRHR

Action on MHH and SRHR, while often implemented as separate or distinct initiatives, need to be integrated, as this can be a compelling pathway towards gender equality. Integrating MHH and SRHR can:

- strengthen understanding of shared biological processes, sexual and reproductive health events across the life course
- harness efforts to address shared social determinants that adversely affect outcomes, and amplify beneficial multi-sectoral actions
- leverage programmatic similarities to enable positive outcomes for all, across the life course, and at scale
- advance achievement of common goals related to health and wellbeing, education, water and sanitation, and gender equality and rights

These benefits of integration are represented in Figure 2.

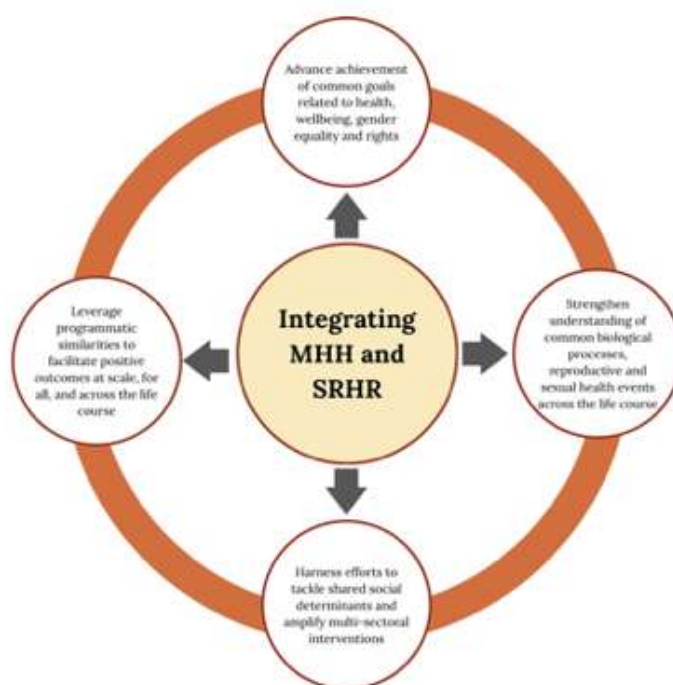


Figure 2: Integrating MHH and SRHR is a pathway for health, wellbeing and gender equality.



## **01. Integration of MHH and SRHR can strengthen understanding of common biological processes, sexual and reproductive events across the life course**

The female reproductive system, and essential processes such as the menstrual cycle and menstruation are fundamental to sexual and reproductive health, from puberty to menopause. Timely, accurate, age- appropriate, education on these topics, and related matters such as healthy timing and spacing of pregnancy, other forms of uterine bleeding, menstrual disorders, and menopause, can better prepare girls and women for reproductive and sexual life events, identify any abnormality or health concern in a timely manner, seek appropriate health care, and have greater bodily autonomy.



A systematic review on educational interventions for MHH among young adolescents reported that a vast majority of these interventions brought improvements in MHH related knowledge, attitudes and practices.<sup>5</sup> Recent research from India found a significant negative association between ovulatory cycle knowledge (fertile period during the menstrual cycle) and the number of children a woman has – poor ovulatory cycle knowledge was correlated with a greater number of children.<sup>6</sup> A scoping review found that contraceptive induced menstrual bleeding changes (CIMBC) may lead to non-use, dissatisfaction and discontinuation of these methods, which in turn, places women at risk for unintended pregnancies and related negative health and social outcomes.<sup>7</sup> Appropriate education of the effects of contraceptives on the menstrual cycle and bleeding patterns can support girls and women to identify suitable methods as per their contexts, and adhere to the selected method to plan their children in a healthy way. The review also noted that in some contexts, CIMBCs may have a positive effect on MHH, especially among those suffering from menstrual problems and disorders such as menstrual pain, heavy bleeding, and polycystic ovarian syndrome (PCOS).<sup>14</sup>



## 02. Integration of MHH and SRHR can harness efforts to tackle shared social determinants and amplify multi-sectoral interventions

Inequitable gender norms, structural inequalities (associated with poverty, ethnic or caste status, gender and sexual orientation etc.), and other social determinants of health like water, sanitation and hygiene (WASH) and education, affect sexual and reproductive health events and processes, including menstruation. Consequently, both MHH and SRHR require multi-sectoral interventions related to health, education, gender equality and empowerment, and WASH.

WASH interventions that enable access to safe, private, functional facilities for girls, women, and people with gender diverse identities in different settings (e.g., educational institutions, worksites, public spaces, health facilities, humanitarian settings) can support menstrual health needs for all ages, as well as WASH needs associated with pregnancy, postpartum period, perimenopause, and even incontinence (amongst others).<sup>8,9,10</sup>

Research and interventions on women's reproductive health and economic empowerment find that improvements in reproductive health leads to improvements in women's economic empowerment; contraceptive use enables women's agency, education and labour force participation; and having fewer children and greater spacing between births also facilitates workforce participation.<sup>11</sup> Evidence on MHH focused workplace interventions highlights positive effects on health as well as workforce participation in terms of decreased menstruation related health care costs and reduced absenteeism respectively. Provision of menstrual materials at work, and separate toilets for women were found to be particularly beneficial.<sup>12</sup>

### **03. Integration of MHH and SRHR can leverage programmatic similarities to facilitate positive outcomes at scale, for all, and across the life course**

MHH and SRHR interventions share programmatic similarities, including but not limited to the provision of information or health education and behavior change communication; provision of products (e.g., menstrual products, contraceptives) and services (health care services related to diagnosis, treatment; nutrition supplements, and WASH); addressing social norms and creating an enabling supportive environment (e.g., working with community influencers, policy change). Integration can potentially extend impactful programmatic strategies in one area to the benefit of the other, and can further support outreach to groups or populations who are overlooked or left behind. For instance, in some LMICs, MHH interventions may be perceived as less threatening or controversial than SRHR programs. Here, the MHH intervention can potentially communicate and reiterate relevant SRHR messages that are culturally acceptable. For example, when sharing information about the menstrual cycle, girls may be told about the fertile period, pregnancy, and even contraceptives.

A global review on comprehensive sexuality education (CSE) provided compelling evidence that CSE leads to improved SRHR, with positive outcomes related to safer sexual practices, delaying sexual debut, and increasing condom use. Further, CSE can also promote equitable social norms among adolescents, youth, and their influencers.<sup>13</sup> Some aspects of MHH are included in CSE, and can be expanded to provide required information and support, particularly for safe menstrual product use, including associated hygiene practices and disposal, as well as menstrual problems, including pain management.

SRHR services for adolescents and adult women may be better established than health services for menstrual problems and disorders in many countries, and may be expanded to provide information, diagnosis and treatment of menstrual conditions, as well as provide information and support for the hygienic management of other forms of uterine bleeding (e.g., postpartum bleeding)<sup>14</sup>. Women in mid-life (aged 40 years onwards) do not come under the purview of mainstream SRHR and MHH interventions. Health services promoting breast and cervical cancer screenings and non-communicable diseases for adults can also provide information on perimenopause and the management of symptoms.

Hard to reach populations, groups or communities facing marginalization, and humanitarian settings present compelling contexts for integration as service delivery can be complex and challenging under these conditions. Separate guidance for SRHR and MHH exists for humanitarian settings, and can be reviewed to bring together essential elements. For example, the minimal essential service package for SRHR can include provision of menstrual materials and essential information.<sup>15</sup> In the same vein, guidance on MHM in emergencies and on menstrual disposal and waste management, and laundering in emergencies can be incorporated into the larger package of SRHR services and response actions.<sup>16</sup>



## 04. Integration of MHH and SRHR can advance achievement of common goals related to health, wellbeing, gender equality and rights

17,18,19

SRHR and MHH are a matter of health, wellbeing and human rights. The conceptualizations of both SRHR and MH underscore bodily autonomy, self-esteem, decision making, and the need for services and products that are appropriate and responsive from a public health and human rights perspective.

SRHR is “a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity” ([Starrs et al, 2018](#))

Menstrual health (MH) is a “state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity, in relation to the menstrual cycle” ([Hennegan et al, 2021](#))

WHO calls for menstrual health to be recognized, framed and addressed as a health and human rights issue, not a hygiene issue ([50 Session of the Human Rights Council, 2022](#))

The Sustainable Development Goals (SDGs) do not explicitly reference menstrual health or menstrual hygiene, while two SDGs explicitly note SRHR (SDG 3, target 3.7; and SDG 5, target 5.6), and are relevant for MHH as well. Strong and positive associations exist between the SDGs, and MHH and SRHR, particularly for SDGs 3 (good health and wellbeing), 4 (quality education), 5 (gender equality) and 6 (clean water and sanitation).<sup>20</sup> Concerted actions on these SDGs can accelerate progress to meet targets that are critical for both MHH and SRHR, and vice versa.<sup>21</sup>

For instance, gender responsive sanitation facilities in homes, schools, worksites and other relevant settings, may reduce the risk of gender-based violence and RTIs associated with inadequate sanitation.<sup>22,23,24,25</sup> Child marriage, female genital mutilation (FGM), discontinuation of girls' education around puberty are some manifestations of gender discrimination that profoundly affect MHH and SRHR during adolescence, with negative impacts continuing through the life course. A young girl who undergoes FGM may experience both short term and long-term MHH and SRHR issues, such as difficulty passing menstrual discharge, birth complications, and chronic RTIs.<sup>26</sup> Therefore, interventions that tackle FGM and associated discriminatory gender norms, may serve as an important safeguard for a young girl's MHH and SRHR through her life.



<b>Relevant SDGs and associated targets for MHH and SRHR</b>	
SDG 3: Ensure healthy lives and promote well-being for all at all ages	SDG 3.7 - ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs.
SDG 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all	SDG 4.1: By 2030, ensure that all girls and boys complete free, equitable, and quality primary and secondary education leading to relevant and effective learning outcomes  SDG 4.a: Build and upgrade educational facilities that are child, disability, gender sensitive, and provide safe, non-violent, inclusive, and effective learning environments for all
SDG 5: Achieve gender equality and empower all women and girls	SDG 5.1: End all forms of discrimination against all women and girls everywhere  SDG 5.6: Ensure universal access to sexual and reproductive health and rights in accordance with the Program of Action of the International Conference on Population and Development, and the Beijing Platform for Action, and the outcome documents of their review conferences
SDG 6: Ensure availability and sustainable management of water and sanitation for all	SDG 6.2: By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations



## Calls to action

### **For practitioners/implementers:**

- Identify opportunities for integration in existing MHH or SRHR programs, and develop a plan of action for integration that can bolster efforts to achieve programmatic goals related to health and wellbeing, as well as gender equality across the life course
- Share good practices of integration with the wider MHH and SRHR community of practice
- Share programmatic insights and research evidence on the positive outcomes from integrating MHH and SRHR to support greater investment in this area of work

### **For researchers:**

- Study approaches to MHH-SRHR integration and identify pathways for scale
- Study the impact of MHH-SRHR integration to make the case for integrated action and to drive investment to support integrated programs
- Establish the linkage between interventions, outputs and outcomes related to MHH and priority outcomes of interest in SRHR.

### **For donors:**

- Support investments in integrated MHH-SRHR programs, that supports implementation and evidence generation, and sharing of good practices across multi-sector stakeholders, and policy advocacy

## Calls to action

### **For policy makers:**

- Draw on the evidence base and programmatic insights to frame policies and operational guidelines that support MHH-SRHR integration across the life course
- Support integrated programs for hard to reach, marginalized and vulnerable groups
- Ensure budgetary allocations for integrated programs

### **For advocates**

- Mobilize grassroots advocacy by activating community-based organizations, youth groups, and stakeholders to raise awareness and advocate for MHH-SRHR integration in their communities
- Influence policy and decision-making by engaging with policymakers and influencers to prioritize MHH-SRHR integration in agendas and advocate for policies that support comprehensive services based on MHH-SRHR integration research
- Foster collaboration and coalition-building by facilitating collaborations between advocacy groups, NGOs, and organizations to amplify the collective voice and advocate for increased funding and resources.

### **For all:**

- Identify and include attention to hard to reach, marginalized and vulnerable groups
- Foster collaborations with other sectors addressing WASH, education, gender equality (e.g., gender-based violence, child marriage, FGM) to promote MHH-SRHR integration

## References

- <sup>1</sup> This case study was shared by Days for Girls
- <sup>2</sup> Population Services International (2018). Technical Brief for the Integration of Menstrual Health in SRHR. Available at: <https://www.psi.org/publication/technical-brief-for-the-integration-of-menstrual-health-in-srhr>
- <sup>3</sup> UNFPA (2021). Technical Brief on the integration of menstrual health into sexual and reproductive health and rights policies and programs. Available at: [https://esaro.unfpa.org/sites/default/files/pub-pdf/mhm-srhr\\_integration\\_digital.pdf](https://esaro.unfpa.org/sites/default/files/pub-pdf/mhm-srhr_integration_digital.pdf)
- <sup>4</sup> Wilson LC, Rademacher KH, Rosenbaum J, Callahan RL, Nanda G, Fry S, Mackenzie ACL. Seeking synergies: understanding the evidence that links menstrual health and sexual and reproductive health and rights. *Sex Reprod Health Matters*. 2021 Dec;29(1):1882791. doi: 10.1080/26410397.2021.1882791. PMID: 33599162; PMCID: PMC8009024. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8009024/>
- <sup>5</sup> Evans RL, Harris B, Onuegbu C, Griffiths F. Systematic review of educational interventions to improve the menstrual health of young adolescent girls. *BMJ Open*. 2022 Jun 8;12(6):e057204. doi: 10.1136/bmjopen-2021-057204. PMID: 35676001; PMCID: PMC9185475.
- <sup>6</sup> Babbar, K., & Dev, P. 'Knowledge is Power': Does Ovulatory Cycle Knowledge helps in improving reproductive health and empowerment-related outcomes? Link: <https://iima.ac.in/sites/default/files/rnpfiles/16572020502021-11-04.pdf>
- <sup>7</sup> Polis, C.B., Hussain, R. & Berry, A. There might be blood: a scoping review on women's responses to contraceptive-induced menstrual bleeding changes. *Reprod Health* 15, 114 (2018). <https://doi.org/10.1186/s12978-018-0561-0>
- <sup>8</sup> <https://washmatters.wateraid.org/sites/g/files/jkxoof256/files/le-rle-de-leau-de-lassainissement-et-de-lhygiene-dans-les-droits-en-matiere-de-sant-sexuelle-et-reproductive.pdf>
- <sup>9</sup> <https://washmatters.wateraid.org/sites/g/files/jkxoof256/files/2019-08/a-shared-agenda-exploring-links-between-water-sanitation-hygiene-and-sexual-and-reproductive-health-and-rights-in-sustainable-development.pdf>

## References

- 10 <https://iwaponline.com/washdev/article/11/6/1016/84510/The-hidden-WASH-needs-of-perimenopausal-women>
- 11 [https://www.prb.org/wp-content/uploads/2017/09/17-246\\_POPPOV\\_Women\\_Empower.pdf](https://www.prb.org/wp-content/uploads/2017/09/17-246_POPPOV_Women_Empower.pdf)
- 12 [https://www.irisgroupinternational.com/\\_files/ugd/979110\\_574073dbba014bc795cf313f9d5c5599.pdf](https://www.irisgroupinternational.com/_files/ugd/979110_574073dbba014bc795cf313f9d5c5599.pdf)
- 13 <https://unesdoc.unesco.org/ark:/48223/pf0000243106>
- 14 <https://esaro.unfpa.org/en/publications/technical-brief-integration-menstrual-health-sexual-and-reproductive-health-and-right-0>
- 15 <https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations>
- 16 <https://www.publichealth.columbia.edu/research/programs/gate/our-work/menstruation-emergencies>
- 17 [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(18\)30293-9.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(18)30293-9.pdf)
- 18 Hennegan J, Winkler IT, Bobel C, Keiser D, Hampton J, Larsson G, Chandra-Mouli V, Plesons M, Mahon T. Menstrual health: a definition for policy, practice, and research. *Sex Reprod Health Matters*. 2021 Dec;29(1):1911618. doi: 10.1080/26410397.2021.1911618. PMID: 33910492; PMCID: PMC8098749.
- 19 <https://www.who.int/news/item/22-06-2022-who-statement-on-menstrual-health-and-rights>
- 20 Linkages exist between the other SDGs and MH and SRHR, however, these may be more indirect, or address larger structural issues such as poverty.

## References

21

Sommer M, Torondel B, Hennegan J, Phillips-Howard PA, Mahon T, Motivans A, Zulaika G, Gruer C, Haver J, Caruso BA; Monitoring Menstrual Health and Hygiene Group. How addressing menstrual health and hygiene may enable progress across the Sustainable Development Goals. *Glob Health Action*. 2021 Jan 1;14(1):1920315. doi: 10.1080/16549716.2021.1920315. PMID: 34190034; PMCID: PMC8253211.

22

<https://www.unicef.org/eap/media/10921/file/Briefing%20Note.pdf>

23

Pommells, Morgan & Wallace, Corinne & Watt, Susan & Mulawa, Zachariah. (2018). Gender Violence as a Water, Sanitation, and Hygiene Risk: Uncovering Violence Against Women and Girls as It Pertains to Poor WaSH Access. *Violence Against Women*. 24. 107780121875441. doi: 10.1177/1077801218754410.

24

Ademas A, Adane M, Sisay T, Kloos H, Eneyew B, Keleb A, Lingerew M, Derso A, Alemu K. Does menstrual hygiene management and water, sanitation, and hygiene predict reproductive tract infections among reproductive women in urban areas in Ethiopia? *PLoS One*. 2020 Aug 21;15(8):e0237696. doi: 10.1371/journal.pone.0237696. PMID: 32822377; PMCID: PMC7444535.

25

Das P, Baker KK, Dutta A, Swain T, Sahoo S, Das BS, Panda B, Nayak A, Bara M, Bilung B, Mishra PR, Panigrahi P, Cairncross S, Torondel B. Menstrual Hygiene Practices, WASH Access and the Risk of Urogenital Infection in Women from Odisha, India. *PLoS One*. 2015 Jun 30;10(6):e0130777. doi: 10.1371/journal.pone.0130777. PMID: 26125184; PMCID: PMC4488331.

26

WHO: [https://www.who.int/teams/sexual-and-reproductive-health-and-research-\(srh\)/areas-of-work/female-genital-mutilation/health-risks-of-female-genital-mutilation](https://www.who.int/teams/sexual-and-reproductive-health-and-research-(srh)/areas-of-work/female-genital-mutilation/health-risks-of-female-genital-mutilation)

## Acknowledgements

This brief was prepared by the Global Menstrual Collective (GMC)  
We acknowledge the contributions of the following people (organizations in alphabetical order): Diana Nelson, Jess Strait & Jessica Williams (Days for Girls); Arundati Muralidharan (GMC); Renjini Devaki (MIET AFRICA); Mascha Singeling & Margot Bolwerk (PLAN International - Netherlands); Odette Hekster & Deborah Maufi (Population Services International-Europe); Femke van Heun (Simavi); Tanya Mahajan (The Pad Project); Halima Lila, Renata Tallarico & Meron Negussie (UNFPA, ESARO); Anagha Nair and Shilpa Nair (Uninhibited); Ina Jurga (WASH United); Therese Mahon (WaterAid)  
June 2023



[globalmenstrualcollective@gmail.com](mailto:globalmenstrualcollective@gmail.com)

[LinkedIn](#)

[globalmenstrualcollective.org](http://globalmenstrualcollective.org)

