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A Global Review of Gender-Integrated Menstrual Health Advocacy

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ABSTRACT

Menstrual health continues to be a lower and often neglected global public health priority, which disproportionately affects females across all income settings. Despite growing investment in education programs targeting menstrual health, the programs have a critical design gap in that men and boys, who are primary drivers of menstrual stigma, are systematically excluded from advocacy efforts. This literature review examines published evidence across four gender-integrated advocacy model types, namely school-based programs, community engagement, peer-led initiatives, and policy reform, spanning diverse geographic and economic settings. The findings indicate that advocacy programs that include males as learners, peer educators, and household allies more strongly reduce stigma and more durably change behavior than female-only approaches. Despite evolution of such programs, there are still significant gaps in evidence quality, measurement frameworks, digital health application, and policy mandates for male inclusion. This review presents an argument for gender-integrated menstrual health advocacy as a necessary component of approaches to achieve menstrual equity.

INTRODUCTION

Menstruation, also referred to as ‘period’ is defined as ‘the monthly shedding of the uterine lining that occurs in individuals of reproductive age when a released egg is not fertilized, resulting in cyclical blood flow’. Menstrual health, is defined as "a state of complete physical, mental, and social well-being, in context of the menstrual cycle," and is now understood to extend far beyond biology to also include education, dignity, and social participation (Hennegan et al., 2021). Despite this progress, this standard is not met for hundreds of millions of people globally. Per recent literature (The Lancet Regional Health-Americas, 2022), more than 500 million women and girls currently lack adequate access to menstrual hygiene management. Globally, this gap was worsened by pandemics such as SARS-Cov 2 (Anand et al., 2022) and COVID-19 (Poague et al., 2022) and the resulting economic pressures. The consequences of this are significant because school absenteeism among adolescent girls across low- and middle-income countries (LMICs) is a direct outcome of menstrual stigma and inadequate sanitation facilities; this has been linked to reduced educational development and long-term opportunities (Baleke et al., 2025). Studies have shown that educational interventions have promise, but actively combining knowledge with enabling environments appears to have the strongest effects on menstrual health outcomes (Evans et al., 2022). The measurable clinical (e.g., endocrine disorder detection from menstrual

cycles) and socio-economic (e.g., improved productivity and mental health) benefits of women's health outcomes have been shown to be limited by the exclusion, or poor engagement of men and boys from sexual and reproductive health programming in LMICs (Gottert et al., 2025). Including both men alongside women in the menstrual health education programs is now an evidence-supported strategy to reduce menstrual stigma (Ruane-McAteer et al., 2020) and promote gender equity.

METHODOLOGY FOR LITERATURE SEARCH

A systematic search of peer-reviewed literature was conducted using PubMed and Google Scholar. This was supplemented by targeted searches of websites of peer reviewed journals such as PLOS ONE, BMJ Open, BMJ Global Health, The Lancet Regional Health, and Frontiers in Public Health. The article search was conducted between July and September 2026. Search terms included the following, individually or in combination using Boolean operators (and, or): menstrual health, menstrual hygiene management, menstrual stigma, gender-integrated menstrual advocacy, male engagement, boys and menstrual health, menstrual peer education, menstrual health policy, school menstrual hygiene, community menstrual advocacy, menstrual health advocacy global, menstrual health education and income, and menstrual education intervention.

The following inclusion criteria were applied to the search: (1) peer-reviewed journal articles or primary legislative/policy documents, (2) articles published between January 2020 and September 2026, (3) literature focused specifically on menstrual health education, advocacy, or stigma, (4) literature reporting outcomes related to knowledge, attitudes, or behaviors concerning menstruation, and (5) literature specifically addressing school-based programs, community engagement, peer-led models, or policy reform. The following exclusion criteria were also applied to the literature search: (1) articles focused only on menstrual products or product access with no particular educational or advocacy component, (2) non-peer-reviewed sources (except legislative/policy documents), and (3) studies involving only female participants with no engagement or inclusion of male stakeholders.

A total of 34 primary references were included in the final review. Studies were not pooled statistically; this review is a narrative synthesis organized by intervention model type and income-level setting.

MESTRUAL STIGMA ACROSS BORDERS

Menstrual stigma, the perception of menstruation as impure, shameful, or taboo, persists globally across income settings, and generates inequalities in education, health, and social participation (Selva et al., 2026). A synthesis of 104 studies across 16 high-income countries (HIC) showed that social norms causing menstruators to conceal their periods produced shame, reduced academic participation, and increased mental burden, similar to findings in LMICs (Barrington et al., 2021). In HIC schools, shame is driven from the implicit message to girls that they primarily bear the responsibility of hiding menstruation from boys (Thomas et al., 2024). In LMICs, such as in South Asia, the stigma is more acute, with menstruating girls facing active behavioral restrictions based on cultural narratives framing menstruation

as impure (Mehjabeen et al., 2024); in sub-Saharan Africa, fear of ridicule from male peers forces school absenteeism (Shah et al., 2022). Globally, across 44 countries, menstruation-related absence from school, work, and social life was found to be widespread and directly linked to inadequate access to products and information (Crankshaw et al., 2025). A national survey in Spain indicated that comfort discussing menstruation with men was a very strong predictor of reduced menstrual stigma (Zanini et al., 2025); such outcomes have also been observed in sub-Saharan Africa (Smith et al., 2026). Thus, male engagement is critical.

GLOBAL GAP AND SOLUTIONS FOR GENDER-INTEGRATED MENSTRUAL HEALTH ADVOCACY

There is growing evidence for gender-integrated menstrual health advocacy across four different models: school education, community engagement, peer-led programs, and policy reform. A core and consistent finding across HICs and LMICs is that when programs actively include men and boys as informed participants, outcomes improve for everyone (Figure 1), even if the mechanisms differ by context and resource level.

Based on the reviewed literature, evidence for gender-integrated menstrual health advocacy can be organized into four model types, namely school-based education, community engagement, peer-led programs, and policy reform. This organizational framework developed by the author is evidence informed and is not based on formal definitions in the field.

School Programs

Across social and economic settings, boys receive less menstrual health education than girls and this exclusion itself promotes stigma. In rural Kenya, male teachers were sensitized with female staff and this led to more supportive school environments, significantly increasing classroom confidence among girls during menstruation (Shenkman et al., 2023). In Bangladesh, structured puberty education for schoolboys significantly increased their menstrual knowledge and peer-to-peer comfort (Khan et al., 2023), and their own buy-in into engagement. The dynamic is identical in HICs; in England, Taylor and Greig (2024), concluded that eliminating stigma requires including male peers, who were found to receive less than half of the menstrual health education as their female peers, and policymakers in the conversation. In France, a randomized intervention delivering menstrual health sessions to mixed-gender classes was found to significantly decrease stigmatizing behavior among boys (Bollinger et al., 2026). Thus, the common thread of learning is that excluding boys from menstrual education does not protect them from discomfort and instead fosters ignorance that places the burden on girls.

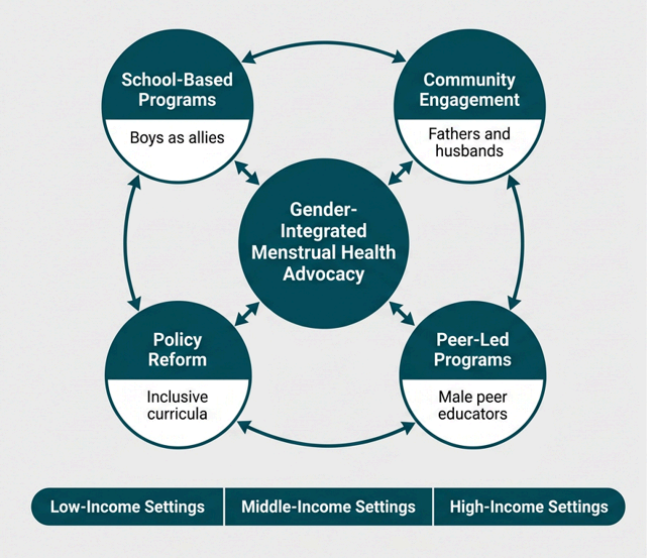

Figure 1. Gender-integrated menstrual health advocacy framework representing a conceptual synthesis of intervention models operating across global income settings. Arrows indicate cross-model reinforcement.

Engaging Men in the Community

Across income settings, there is evidence that men as fathers, husbands, and community leaders closely influence menstrual norms, although in different forms, based on context. In India, an MIC, programs including male family members alongside girls produced durable attitude changes that led to more supportive home environments and reduced behavioral restrictions on menstruating women, than interventions targeting girls alone (Ottsen et al., 2026) or based on menstrual health product access (Dubey and Sivakami, 2024). In HIC settings, workplace policies and media campaigns are beginning to actively target men for menstrual health messaging, but there has been only limited rigorous assessment of these approaches relative to the LMIC evidence base (Selva et al., 2026).

Peer Led Programs

Peer-led models of menstrual health education tend to be particularly strong in low-resource and healthcare access settings. The *Act With Her* life-skills program included teenage boys in menstrual health literacy programs alongside girls, with the goal of effecting community-level norm change rather than solely educating the individual. Such an approach is critical in settings where structural stigma, more than information gaps, is the primary barrier (Baird et al., 2022). The evidence of impact is strong; in Rwanda, training adolescent boys as peer educators in sexual and reproductive health (SRH) produced significant

attitude improvements among both girls and boys (Nkurunziza et al., 2025). To be noted though, this work addressed broader SRH peer education, and not menstrual health specifically. It is relevant to cite it because it provides more broad evidence for effectiveness of peer-led models as an advocacy approach. Rigorous peer-led evaluations specific to menstrual health remain very limited in high-income settings. This is a gap that itself represents a research priority that must be addressed. A key reason for the effectiveness of peer-led models is that knowledge is a vital mediating factor in determining male attitudes toward menstruation. In this context, a cross-sectional study of adolescent boys conducted across high schools in Ghana determined that more than 50% of respondents had negative sociocultural beliefs about menstruation and an equal number exhibited poor attitudes. However, these figures were significantly decreased by increased knowledge, confirming that there is no inherent resistance to change among boys, but rather they simply have not been educated (Wuresah et al., 2025). This finding in particular, directly influences peer-led program design in that peer educators trained to deliver accurate menstrual health knowledge to male classmates can evoke greater engagement and buy-in than through adult-led classroom instruction, because the instructor is perceived as a credible social equal. Similarly, a peer-led intervention study with boarding school students in Indonesia found that peer education significantly improved both knowledge and attitudes to menstrual hygiene management among all participants. This study concluded that programs targeted at mixed-gender groups were better equipped to address the social manifestations of stigma than delivery to a single-gender audience (Berliana et al., 2025). Collectively, published evidence suggests that scaling peer-led models are both cost-effective approaches that can be adopted in resource-constrained settings, but more importantly, pedagogically superior methods to effect change in norms. Certainly, there is a strong argument for these approaches to be piloted and rigorously evaluated in HIC schools.

Policy Reform: The Missing Mandate

Across all three income-level settings, the prevailing finding is that there are no policy mandates for gender-inclusive menstrual health education. To illustrate, in sub-Saharan Africa, Kenya and Rwanda both have successfully inserted menstrual health into school curricula, but in neither country are boys required to receive that education (Dodroe et al., 2025). In the USA, an analysis of K–12 education standards conducted across all the states showed comprehensive gender-inclusive menstrual health education was implemented in just one jurisdiction, Washington DC (Richardson et al., 2025). Across LMICs and HICs, the persistent gap appears to be the same in that the policies address access to products, but not attitudes, and rarely require the male gender to be part of the dialogue (**Figure 1**). In Europe, despite passing two progressive pieces of menstrual legislation, namely the Period Products Act (2021) in Scotland and the comprehensive menstrual health law (2023) in Spain (Brassart Olsen and Rothmar Hermann, 2025) the advances are limited to product access and workplace rights. Neither legislation provides a directive for gender-inclusive menstrual education in schools or mandates boys to participate in menstrual health education programs (Brassart Olsen and Rothmar Hermann, 2025). Of the two legislations, the law in Spain is the further reaching and presumably more impactful in mandating menstrual health education, healthcare access, and research on menstruation, but the social norm component, represented by the gender-inclusivity requirement, is noticeably absent. This, arguably the most powerful driver of behavior change, thus remains unaddressed by law. A recent report of the Women

and Equalities Committee (2024) specifically acknowledged this gap, stating that current policy "fails to recognize the importance of boys and men understanding reproductive health conditions" and recommended that the guidance be revised to include boys in reproductive health education, including menstruation, as part of their role in changing the culture and stigma faced by young women. The fact that this recommendation by a high-level parliamentary committee in a HIC, which has stayed as such rather evoke a policy change, emphasizes how far even the world's most progressive societies remain from treating gender-integrated menstrual education as a requirement that the available evidence strongly supports.

GAPS, CHALLENGES, AND OPPORTUNITIES

Despite the promising evidence there are still several vital gaps that must be addressed: 1) Scalability is limited since the body of evidence is drawn from studies that are either small-scale, short-term, or highly region-specific. Follow-up data over longer terms are rare in available literature (Gottert et al., 2025); 2) Assessments of the impact of male engagement are consistently overlooked in program design and evaluation, which implies that where inclusive education programs do exist, their impact on the male gender go unmeasured (Betsu et al., 2024); 3) In some societies/countries, male involvement in menstrual health meets cultural resistance as socially inappropriate. In such regions, there is a critical need for context-sensitive implementation prior to adopting gender-integrated models at scale (Ottsen et al., 2026); 4) there are issues with the way program evaluations are performed. Most studies consider self-reported knowledge scores as their primary outcome, without taking into consideration downstream evidence of improvements in terms of behavioral and household decision-making changes, and school attendance rates of girls. In the absence of these standardized outcome frameworks that capture both change in male attitudes and behavior, it is difficult to make outcome comparisons across studies and meaningfully interpret the study findings (Gottert et al., 2025). Here too, peer-led models suggest that boys themselves can be the most credible messengers for norm change among their peers, more effectively using digital platforms, from community radio to mobile health applications. These platforms offer scalable, low-cost paths to connect with males in settings where in-person programming is difficult to implement.

Despite their promise, adoption of mobile health approaches to advance menstrual health education remains far below its potential. A recent literature review by Aminu et al. (2026) failed to identify even one eligible, empirical study that reported on mHealth interventions for menstrual hygiene in Africa, a region with the highest burden, despite advances being made in other areas of reproductive health across the continent. While this is a stark gap, it also offers a prime opportunity for future investment. In their review of digital interventions for sexual and reproductive health across LMICs, Dowling et al. (2025) identified two broad implementation approaches based on pushing out information to adolescents and pulling in these individuals to engage through mobile platforms. Both approaches were found to be effective in increasing menstrual knowledge and behavioral change around health and support to females. The authors concluded that the infrastructure for digital menstrual health education already exists but needs to be built upon with concerted effort.

Moving forward, aligning gender-integrated menstrual health advocacy with social development goals (SDGs) such as SDG 3 (Good Health), SDG 4 (Quality Education), and SDG 5 (Gender Equality) would

create a policy lever. This would be critical to creating a framework for governments to act and for advocates to hold them accountable. Translating such SDG alignment into concrete policy action however mandate perusal of two actions that have not been implemented at scale, including a) standardization of menstrual health education nationwide to explicitly require boys to be included as learners, together with girls, and b) demarcation of dedicated funding streams within national education and health budgets to promote gender-integrated programs. These structural enablers will be vital to advance advocacy models beyond small-scale pilot initiatives to be able to develop interventions that are effective at the population-level.

CONCLUSION

The evidence presented through this literature is transformative in implying that menstrual health can be achieved only by reaching beyond the girls and women who menstruate. Across all income milieus, gender-integrated advocacy programs that include men and boys as learners, peer educators, household allies, and policy advocates consistently generate stronger and more long-lasting outcomes than single-gender approaches can alone. Crucially, this is not a zero-sum proposition. Drawing on broader sexual and reproductive health evidence, Gottert et al., 2025 performed a systematic review of 35 review articles to find that male engagement interventions across HIV prevention, family planning, and maternal health consistently benefit both women and men, with no apparent adverse effects. While this article does not address menstrual health specifically, it does emphasize the tenet that engaging men is a safe and effective health strategy. In fact, the evidence reviewed by Gottert at al. suggests that the principle applies equally to menstrual health advocacy.

This literature review indicates that significant gaps remain in menstrual health advocacy including 1) narrow regional base for the evidence on gender-inclusive education, 2) lack of standard frameworks to quantitatively track downstream male attitude and behavioral changes, 3) limited adoption of digital tools for menstrual health advocacy even in the highest-burden settings, and 4) absence of policy mandates globally, for male inclusion in menstrual health education. The challenge that now needs to be addressed is how to scale up male inclusion advocacy efforts with cultural sensitivity, rigorous evaluation, and the political will that the evidence indicates as necessary. Perhaps the most important takeaway is that menstrual health is not a women's issue but rather it is a shared human responsibility. The emphasis now and in the future must be on evolving global health policy to meet these goals (Webb et al., 2025; Selva et al., 2026).

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