Cycle Breakers
Reimagining Menstrual Policy Beyond ‘Dignified’ Pads

A Review of MHM Frameworks
Across Civil Society and Public Policy:
Lebanon's Case for Menstrual Justice

A study report by Jeyetna
February 2026

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Introduction

Over the past decade, menstrual policy has been increasingly framed as a technical problem of hygiene and product access, recasting menstruation as an individual management issue rather than a political and structural concern. This framing underpins dominant Menstrual Hygiene Management (MHM) approaches, which prioritise product distribution, infrastructure, and behavioural guidance while presenting themselves as pragmatic solutions. In practice, MHM narrows what menstrual policy is allowed to "see": it privileges cleanliness, discretion, and uninterrupted participation while sidelining pain, disability, menopause, and the structural conditions that shape menstrual life—health systems, labour regimes, social protection, and power relations rooted in gender, class, coloniality, and disability (Bacchi, 2016; Lahiri-Dutt, 2015; Bobel, 2019; McAllister et al., 2025).

This report is written amid Israel's genocidal assault on Gaza and intensified military aggression in Lebanon—conditions that shaped both its urgency and its orientation. During this period, Jeyetna partnered with mutual aid networks for decentralised menstrual responses: migrant domestic workers sleeping on the streets, shelters with severe bathroom shortages that forced health-compromising wait times, and large-scale displacement linked to disrupted cycles and inadequate access to care.

These moments made the limits of product-centred "dignity"[1] interventions impossible to ignore: when toilets are unsafe, clinics are unaffordable, and people are displaced, a pad alone cannot produce dignity. Against this backdrop, the report advances a menstrual justice approach—centering pain and disability justice, labour protections, and community-led resistance—while interrogating how MHM's colonial, capitalist, and patriarchal logics fail under conditions of violence and institutional collapse (Bobel, 2019; McAllister et al., 2025).

Methodologically, the report combines discourse analysis and comparative policy review with primary research in Lebanon: a focus group discussion with six organisations providing period products across peripheral regions and refugee contexts, plus interviews with healthcare providers, a social protection expert, and practitioners working on sexual and reproductive health and rights (SRHR). The analysis is guided by Carol Bacchi's "What's the Problem Represented to be?" (WPR) approach, which examines how policies construct problems—and how those constructions determine what becomes thinkable, fundable, and

1 Throughout this analysis, terms central to MHM discourse—such as dignity, appropriate, hygienic, and proper—are placed in quotation marks at their first occurrence to signal their constructed, contested nature. Subsequent uses appear without quotation marks, not because they have become neutral, but to maintain readability while their problematic framing remains implicit in the critique.

actionable (Bacchi, 2016).
Applied here, WPR reveals how MHM constructs menstruation as a hygiene issue and then treats the resulting interventions as neutral—while excluding pain, disability, labour rights, and lifecycle needs from policy concern.

The report moves from global discourse to policy possibility and then to institutional failure. The first section traces how menstruation became governed as hygiene through MHM and why that framing disciplines policy toward concealment and productivity. The second section briefly examines Scotland and Kenya as partial departures from product-only logics. Third section centres Lebanon as the crucial case: where political capture, policy silence, and collapsing systems force menstruating people to absorb structural failure. The section then turns to grassroots organisations and midwives to analyze counter-frameworks of care despite shrinking civic space. The report ends with recommendations that treat menstrual health as a matter of health rights, labour, education, and social protection—not dignity-through-consumption.

1. How Menstruation Became a Hygiene Problem

Menstrual Hygiene Management (MHM) did not emerge as a neutral framework. It reflects a historical shift in how menstruation entered global policy agendas: from feminist and environmental movements that challenged shame and corporate exploitation, to the WASH sector's technocratic governance model that reframed menstruation as a hygiene problem requiring standardised solutions (Bobel, 2006; Bobel, 2019). This shift changed not only what menstruation "means" in policy, but what counts as an acceptable intervention. Where earlier activism asked why menstruation is treated as dirty or unmentionable, MHM asked how to manage it discreetly through products, toilets, and behavioural advice.

This reframing was consolidated through a widely cited definition of MHM: the use of "clean menstrual management materials" changeable in privacy as often as necessary, with access to soap, water, and disposal facilities (Sommer & Sahin, 2013). The definition appears technical, but it is also disciplinary: it establishes a norm of "proper" menstruation as clean, private, frequently managed, and non-disruptive. It implicitly imagines a menstrual subject who can access toilets on demand, has money or supply chains for products, and can keep bleeding invisible at school, work, or in shelters. Those who cannot meet these conditions—trans and gender non-conforming folk, people

chronic pain, disability, irregular cycles, or displaced—become unintelligible within the policy frame.

Through a WPR lens, MHM is not responding to a pre-existing "menstrual problem"; it constructs the problem as inadequate hygiene practices and insufficient access to products and facilities (Bacchi, 2016). That construction produces a narrow field of legitimate responses—product distribution, infrastructure upgrades, and behaviour change—while foreclosing others such as labour protections, disability accommodations, pain management, social security coverage, or the validation of indigenous and communal practices (Bacchi, 2016; Lahiri-Dutt, 2015; McAllister et al., 2025). The result is a policy world where a school can distribute pads while ignoring the student doubled over in pain in the classroom, or a workplace can install a bathroom while penalising someone who needs breaks or sick leave.

A "good period," in this policy logic, is one nobody notices. Bobel (2019) argues that MHM advances a normative ideal of menstruation that is discreet, managed, and invisible—turning "dignity" into concealment and compliance rather than comfort, autonomy, or care. This shows up in everyday scenes: students enduring lessons through severe cramps; workers timing bathroom breaks to avoid notice;

humanitarian settings distributing “dignity kits”[2] while toilets remain unsafe, overcrowded, or unavailable. Under this model, the price of “dignity” is often endurance: keep bleeding hidden, keep pain silent, keep productivity uninterrupted.

MHM’s universalising language intensifies exclusion. Menstruation is frequently treated as a medically neutral, uniform experience shared by “all women,” abstracted from bodily difference and social context (Lahiri-Dutt, 2015). This erases trans and non-binary people, peri/menopausal people, and those with disabilities, while narrowing attention to adolescent girls in the Global Majority[3] (Sahin et al., 2015; McAllister et al., 2025). What reads as neutrality functions as a sorting mechanism: whose menstruation counts as “normal” enough to be managed through products, and whose menstruation is too complex—too painful, too visible, too disabled, or too politically inconvenient to be addressed.

At the same time, empowerment is increasingly promised through consumption. Menstrual capitalism converts

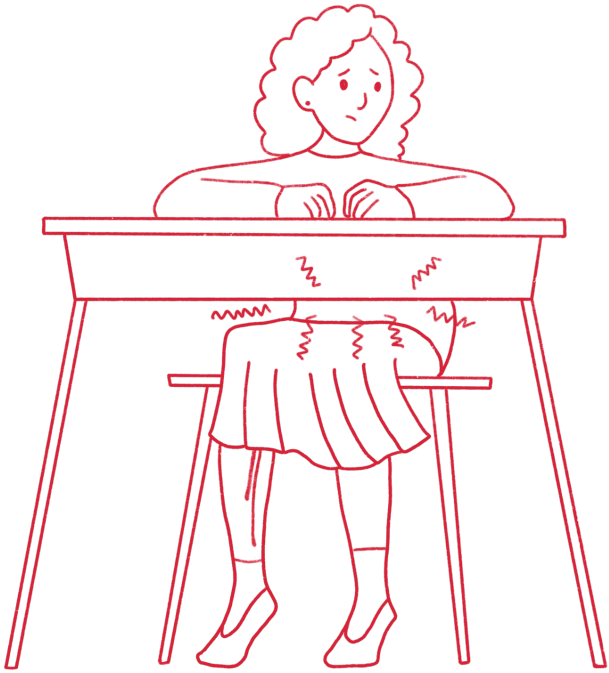
2 United Nations. (2024, June 2). Explainer: What's a dignity kit? UN News. https://news.un.org/en/story/2024/06/1150541

3 The term ‘global majority’ is used to prioritise reference to the demographic majority of the world’s population over the colonial and geographically Eurocentric framing of the ‘Global South’.

stigma into profit while presenting product choice as liberation (Crawford & Waldman, 2022). “Feminine hygiene” campaigns deepen anxieties around smell, leakage, and visibility, pushing self-monitoring rather than structural change (Fahs, 2016). This produces the productivist trap: menstruation is acknowledged only insofar as it threatens school and work attendance, and policy attention centres on keeping participation uninterrupted rather than ensuring wellbeing (Lahiri-Dutt, 2015; Bobel, 2019). The logic is not “your body deserves accommodation,” but “your body must not interrupt institutions.”

Pain is where this framework collapses. Dysmenorrhea affects an estimated 50–90% of people who menstruate and is a leading driver of menstruation-related absenteeism (Li et al., 2020; Amery et al., 2023; Miiro et al., 2018; Shah et al., 2022). Chronic conditions such as endometriosis and polycystic ovary syndrome intensify pain, fatigue, and impairment in ways no pad can solve. Pain cannot be standardised into a kit, nor reconciled with policies built around uninterrupted performance. Taking pain seriously would require healthcare access, labour accommodations, flexible attendance, and disability recognition—structural interventions that challenge the premises of MHM. MHM’s silence on pain is therefore not an oversight: it is a political refusal that

normalises suffering as the cost of participation.



2. What Becomes Possible Beyond Management

Menstrual health is increasingly visible in global health discourse, yet remains marginal in global policy agendas. Major institutions, including the WHO, have not established binding standards, sustained research investment, or coordinated advocacy for a holistic menstrual health approach (McAllister et al., 2025). This marginalisation is sharpened by global funding contractions in SRHR, including a reported drop of 4 billion USD in 2023 compared to the previous year (Deutsche Stiftung Weltbevölkerung, 2025)[4]. National frameworks often follow a similar narrowing: product access schemes, local manufacturing support, limited menstrual leave provisions, and partial integration into education or health services—without consistently addressing labour rights, pain, disability, or social protection.

Still, Scotland and Kenya show that policy can stretch beyond product-only approaches—though unevenly and with gaps.

4 Deutsche Stiftung Weltbevölkerung (DSW). (2025). Donors Delivering for SRHR Report 2025: Tracking OECD DAC Donor Funding for Sexual and Reproductive Health and Rights. https://donorsdelivering.report/wp-content/uploads/2025/06/DDSRHR2025.pdf

2.1 Scotland: Menstrual Health as Public Responsibility

Scotland's menstrual health framework departs from dominant MHM logics by treating access to period products as a legal entitlement rather than a discretionary or charitable intervention.
The Period Products (Free Provision) (Scotland) Act 2021[5] obligates public authorities and education providers to ensure free access, shifting responsibility from individuals to institutions.
This legal framing matters materially: it removes the need for disclosure, means testing, or proof of need, and positions menstruation as a routine concern of public service delivery rather than a private inconvenience.

In practice, this approach embedded menstrual provision within everyday public infrastructure.
Beginning with pilot schemes in schools and community spaces in 2017, provision was scaled through annual budget commitments that required local authorities, colleges, and universities to make products consistently available. To support accessibility beyond formal institutions, the Scottish Government also developed a public-facing national website that maps locations where free period

5 Period Products (Free Provision) (Scotland) Act 2021, asp 1. Available at: https://www.legislation.gov.uk/asp/2021/1/enacted

products are available. This tool translated legal entitlement into practical access, allowing people to locate products without navigating gatekeepers or stigma, and reinforcing the principle that access should be ordinary, visible, and predictable.

Scotland's framework also extends beyond products to recognise menstrual health across the life course. Workforce policies[6] developed through national consultation explicitly include menstruation and menopause, with implementation planned for October 2025. These guidelines require employers to provide accommodations—such as flexible schedules and rest breaks—based on individual need. These measures are framed as health rights rather than productivity tools, centering bodily autonomy and wellbeing over uninterrupted performance.
Scotland thus demonstrates how menstrual policy can move beyond access toward institutionalised accommodation grounded in care.

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6 Scottish Government. (2025, February). *A Consultation on the NHSScotland 'Once for Scotland' Workforce Policies: Managing Health at Work Consultation Document*. Available at: https://www.gov.scot/publications/nhsscotland-once-scotland-workforce-policies-managing-health-work-public-consultation-2/documents/

2.2 Kenya: What Multisectoral Policy Enables and What It Leaves Out

Kenya's menstrual health framework represents a different route beyond narrow product provision, shaped by constitutional commitments to health and education and by decentralised governance. Since the early 2000s, reforms have included removing taxes on menstrual products, introducing state-funded pad distribution in public schools, and adopting the national Menstrual Hygiene Management Policy 2019–2030 (Government of Kenya, 2019).[7] Together, these measures position menstruation as a public issue linked to education outcomes, public health, and gender equality rather than solely a private hygiene concern.

On the ground, schools function as primary sites of intervention. Pad distribution aims to reduce menstruation-related absenteeism, while education components address stigma and misinformation. Implementation is decentralised: county governments adapt budgets and delivery within national coordination structures, including inter-ministerial MHM task forces. Civil society organisations play a central role in distributing products—particularly reusable options—delivering

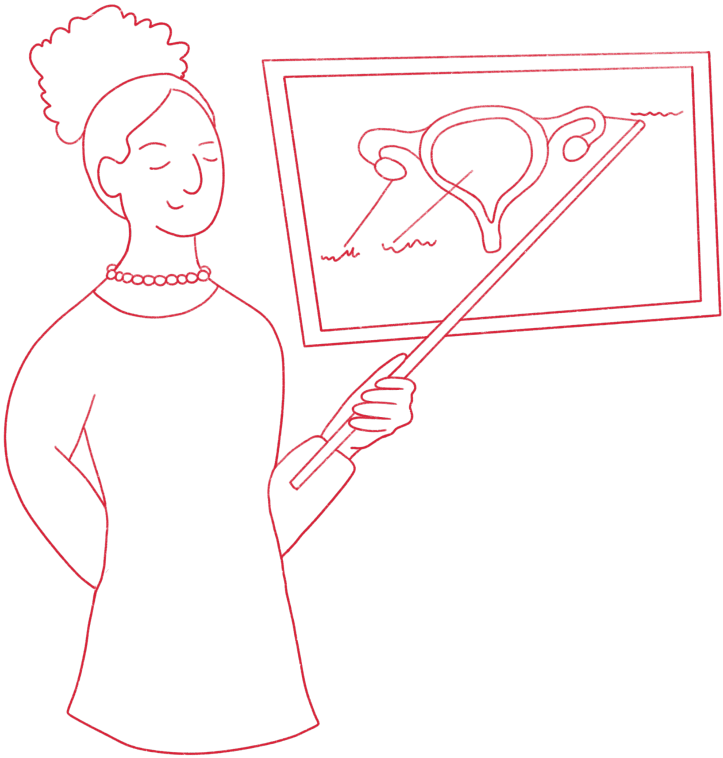
7 Kenya, Ministry of Health, Department of Environmental Health. (2019). Menstrual Hygiene Management Policy
2019-2030. Government of Kenya. Available at:
https://repository.kippra.or.ke/server/api/core/bitstreams/d87754dc-88fc-45ce-943a-5f3526c47480/content

education, and engaging communities, including boys and men.
Environmental considerations such as menstrual waste management are explicitly incorporated, reflecting an attempt to link menstrual health to sustainability as well as access.

At the same time, Kenya's framework reveals persistent constraints. Implementation varies widely across counties due to uneven funding and infrastructure. Labour protections remain weak, especially in the informal sector where most workers are concentrated. As in many national menstrual policies, menstrual pain, chronic gynaecological conditions, and menopausal needs receive limited attention. The policy's focus on school attendance risks reproducing productivist logics, addressing menstruation primarily insofar as it disrupts participation rather than recognising pain and impairment as health and justice concerns.

Kenya thus illustrates both possibility and limitation: multisectoral expansion beyond products is achievable even in resource-constrained settings, yet without enforceable labour protections and explicit attention to pain and lifecycle health, management-oriented frameworks continue to shape outcomes.

Read together, Scotland and Kenya illustrate that policy can move beyond “pads + silence,” but also that depth matters: enforceability, labour protections, lifecycle inclusion, and the willingness to centre pain are what separate meaningful accommodation from upgraded management.



3. Lebanon as Exposure: Menstrual Health Under Institutional Collapse

Lebanon is where the limits of dominant menstrual policy frameworks become unavoidable.
Unlike Scotland and Kenya, Lebanon's prolonged economic collapse, political capture, erosion of public systems, and ongoing Zionist colonial violence expose what happens when social protection, labour law, and health policy fail simultaneously. This chapter traces how political capture hollowed out the National Social Security Fund (NSSF), how labour law governs menstruation through silence, how Vision 2030 institutionalises SRHR and education blind spots, and how period poverty became a moment of political exposure—before turning to grassroots organisations and midwives building counter-frameworks of care amid state retreat.

3.1 The National Social Security Fund: Collapse by Design and Political Capture

The NSSF exemplifies how social protection becomes structurally incapable of responding to menstrual health not only through neglect, but through design and capture. Established in 1965 following Fouad Chehab's 1963 social insurance decree[8], it was envisioned as a welfare pillar covering sickness and maternity care, family allowances, end-of-service indemnity, and work-related injuries.

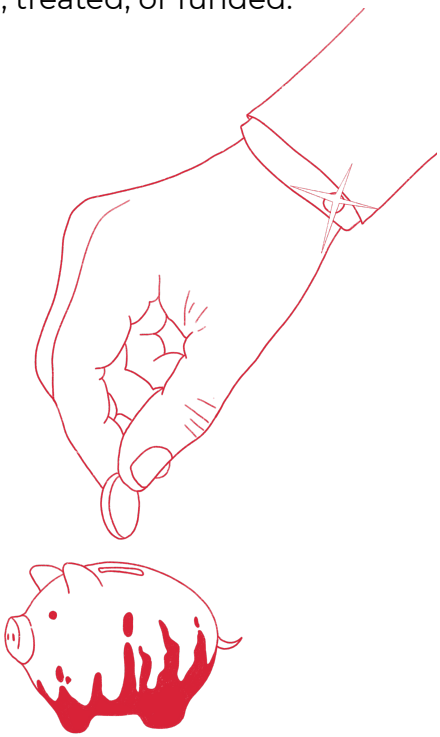
Yet from inception, eligibility excluded large segments of the population, including informal workers and non-Lebanese labourers—people whose contributions often subsidised a system that denied them access.

Political capture then converted imperfection into failure. Despite legal provisions for financial and administrative independence, ruling parties restructured governance to consolidate control: expanding governmental representation on the board diluted labour representation and repurposed the NSSF toward private and partisan interests. This was not incidental. As scholars note, the Fund threatened Lebanon's clientelist order by offering the possibility of rights-based protection outside sectarian mediation; neutralising it preserved dependence on patronage networks (Salloukh et al., 2015; Osmat, 2023).

Since 2019, compounded crises have hollowed out the Fund's practical function. While nominal reserves have been estimated around USD 450 million, benefits became largely symbolic amid exchange rate disparities between contributions, reimbursements, and provider fees in a

8 Social Security Law, Decree No. 13955 Lebanese Official Gazette (1963). Available at: https://natlex.ilo.org/dyn/natlex2/r/natlex/fe/details?p3_isn=20890

dollarised medical system (Osmat, 2023; Proudfoot & Zoughaib, 2025). In concrete terms, this means a worker can be “insured” yet still face unaffordable clinic fees or out-of-pocket medication costs. In such a landscape, menstrual health is not simply absent from the NSSF’s mandate; it becomes institutionally impossible to accommodate. When “sickness and maternity” coverage is unstable, discretionary, and depleted, there is no pathway through which menstrual pain, endometriosis, or lifecycle needs can be reliably recognised, treated, or funded.



3.2 Lebanese Labour Law: Governance of Silence

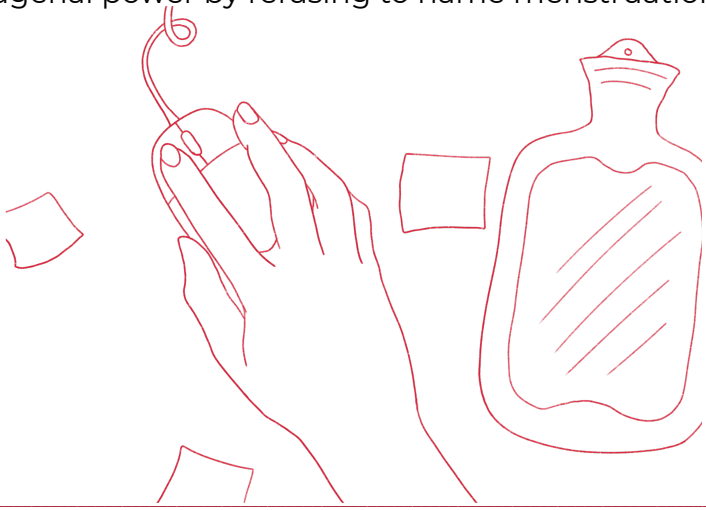
For a worker with severe menstrual pain, the practical dilemma is not whether accommodation exists, but which cost must be paid to secure it. Menstruation is not named anywhere in the Lebanese Labour Code. Workers must navigate indirect provisions: disclose intimate health information, exhaust limited entitlements, or work through pain to avoid penalty. What appears as a gap functions as governance: menstruation is privatised and absorbed by the worker's body rather than treated as a workplace obligation.

Proxy protections exist but are structurally weak. Article 26 prohibits gender-based discrimination, yet invoking it requires proving discriminatory intent and disclosing sensitive health details in a social context saturated with stigma—barriers that make it largely unusable in practice. Articles 62 and 63[9] mandate water and sanitation; for a menstruating worker, a clean bathroom is a health requirement, yet the law treats it as general welfare rather than naming the gendered reality it supports.

Time and leave provisions deepen inequality. Article 36[10]

9 Lebanese Labour Law, Code du Travail Libanais, Legislative Decree No. 340 (16 September 1946), Art. 26.
10 Ibid., Arts. 36.

grants women a break after five consecutive hours of work (men after six), implicitly acknowledging bodily difference without naming its cause. When pain requires absence, workers rely on sick leave under Article 40[11]—conditional on tenure and medical certification. This tiered system means precarious and newer workers have the least paid leave, and those who menstruate must medicalise a cyclical process to justify rest. Otherwise they sacrifice annual leave for a recurring health need—turning leisure into survival. In practice, the framework leaves decision-making in employers' hands, normalising endurance and preserving managerial power by refusing to name menstruation.



11 Ibid., Arts. 40.

3.3 Vision 2030: Institutionalising Blind Spots

Lebanon's National Health Strategy, Vision 2030, was published by the Ministry of Public Health in January 2023, supported by the WHO, and presented as a roadmap to rebuild a system battered by collapse and the emigration of health professionals[12](El Kak et al., 2025).
Three years on, its silences have become structural.

The first critique is its SRHR blind spot. Vision 2030 aligns rhetorically with the UN 2030 Agenda yet lacks a rights-based SRHR approach consistent with WHO and UN mandates.
Reproductive health is narrowed to women's, maternal, and infant health, while core SRHR components—family planning, STI prevention, contraception, and abortion—are absent (El Kak et al., 2025). This is particularly consequential under a legal regime where abortion remains criminalised under Presidential Decree No. 13187 except when pregnancy threatens the woman's life[13].Excluding these domains signals that bodily autonomy and non-maternal sexual health fall outside legitimate state responsibility.

The second critique is the strategy's silence on

12 Ministry of Public Health & World Health Organization Lebanon. (2023). Lebanon National Health Strategy: Vision 2030—Out of the crisis and towards better health for all. Ministry of Health. https://www.moph.gov.lb/userfiles/files/About%20MOPH/StrategicPlans/National-Health-Strategy%E2%80%93Vision2030/LHS_220124.pdf

on comprehensive sexuality education (CSE). Across Lebanon, sexuality education is often limited to narrow biology, omitting social, emotional,relational, and practical dimensions needed for informed SRHR decision-making. Vision 2030 neither acknowledges this gap nor proposes mechanisms to integrate CSE within national health or education strategies (El Kak et al., 2025). This omission perpetuates stigma, misinformation, and fear—particularly around menstruation and menopause—and blocks sustainable menstrual health progress by leaving knowledge production to families, employers, and informal networks.

Together, these omissions institutionalise invisibility: they foreclose funding pathways, provider training, service integration, and accountability for menstrual health and SRHR. Silence becomes policy.

[13]

13 Presidential Decree No. 13187 (20 October 1969), amending the Lebanese Penal Code to permit therapeutic abortion only when necessary to save the pregnant woman's life, subject to consultation with two additional physicians and the woman's consent (or in emergencies where consent cannot be obtained).

3.4 Period Poverty as Political Exposure

In July 2020, as Lebanon's economic collapse accelerated, the government published a list of essential goods eligible for subsidies[14].Menstrual pads were excluded—alongside the inclusion of items such as razors—triggering public outrage and forcing menstruation into national debate. The omission did not merely reflect scarcity; it exposed political judgment: menstruation was treated as non-essential in crisis. In a context of hyperinflation and currency freefall, this decision effectively guaranteed price spikes.

Between 2020 and 2023, menstrual pad costs reportedly rose by as much as 500%[15],pushing many to ration supplies, extend use beyond safe limits, or use makeshift alternatives such as cloth, tissue, or diapers.[16]
"Period poverty" here functioned as political abandonment rather than individual deprivation. As a social protection expert interviewed for this research noted, the outrage produced a brief moment of collective recognition—menstruation as a structural issue—yet it quickly dissipated without reform. Menstrual health remained absent from policy discussions and institutional agendas even as it

14 McLoughlin, S. (2021, June 2). Period Poverty – A Global Crisis—Women In International Security. Women In International Security (WIIS). https://wiisglobal.org/period-poverty-a-global-crisis-2/
15 Maalouf, F., Morse, C., & Soto, S. (2024). Addressing Period Poverty: Challenges and Solutions in Lebanon, Gaza, and Beyond (No. 12; p. 12). Anera. https://www.anera.org/wp-content/uploads/2024/05/OTG-Period-Poverty-Gaza-Lebanon.pdf

it became materially unaffordable for growing numbers of people.

The subsidy episode revealed not only exclusion but institutional incapacity: Lebanon's social protection system has no explicit menstrual health provisions, and existing mechanisms for sickness or income loss are ill-suited to recurring menstrual needs. Even endometriosis remains largely theoretical within social security practice—without clear precedents for coverage inside a system already dysfunctional[17].The political exposure did not become policy change; it became another handoff of responsibility to households and civil society.

16 Fighting period poverty: 3 substitutes for disposable pads and tampons - Beirut Today. (2020, July 20). https://beirut-today.com/2020/07/20/fighting-period-poverty-3-substitutes-for-disposable-pads-and-tampons/

17 The Independent Oversight Board of the Reform Recovery, Reconstruction Framework of Lebanon (3RF). (2023).National Social Protection Strategy for Lebanon: An Overdue Exigency. https://www.lebanon3rf.org/sites/default/files/202311/National%20social%20protection%20staretgy%20IOB%20November%202023%20.pdf

3.5 Grassroots Activism and Midwifery as Counter Frameworks of Care

Where the state retreated, grassroots organisations and primary healthcare providers—especially midwives—reconstituted menstrual health governance from below. Their interventions did not only distribute products; they contested the terms through which menstruation was made invisible, dirty, or unimportant.

Grassroots organisations working in peripheral regions and refugee contexts described a conscious refusal of "sanitary/hygiene" language, choosing "menstrual" or "period" products as a political intervention against medicalised and patriarchal narratives of uncleanliness. Their education sessions often reached whole families—especially mother-daughter pairs—creating space for intergenerational discussion of puberty, reusable products, menopause, pain, postpartum bleeding, incontinence, and bodily autonomy. They emphasised that stigma reduction requires engaging men and boys, even when buy-in is uneven. They also highlighted who gets excluded from many initiatives—people in orphanages, prisons, and some public schools—and named expansion to these groups as a priority.

Midwives emerged as structurally central. Regulated since 2014, midwives remain among the few providers positioned to offer continuity of SRHR care across the life course—

from puberty through menopause. In a privatised system that sidelines preventive community care, midwives are often deeply trusted yet marginalised within policy and funding. Interviews showed midwives frequently serve as the first or only point of contact for those seeking information about menstrual pain, irregular cycles, menopause, or reproductive health as hospitals become unaffordable and SRHR services are deprioritised.

These clinical encounters have intensified political significance amid shrinking civic space and moral panic around gender and sexuality. As organisations reduce visibility or "go underwater" to avoid backlash[18] and protect patients, the consultation room becomes a site of quiet resistance—where care can affirm experience rather than discipline it. Yet midwives remain excluded from national health planning, limiting their capacity to shape systemic change.

Across grassroots and midwifery networks, collaboration—sharing referrals, resources, and practices—countered donor-driven competition. Still, donors often demanded proof in commodities distributed, producing skepticism

18 Nabulsi, M. (2023). Navigating Taboos: Exploring social media policies and SRHR content restrictions in WANA. SMEX. https://smex.org/wp-content/uploads/2023/03/MiraNabulsi-SRHR-Mariam-al-Shafei-Fellowship-2023.pdf

toward reusable products and education-heavy interventions. Even within resistance, productivist funding logics persist.

Recommendations: Beyond Dignified Pads — Toward Menstrual Justice in Lebanon

This report shows how dominant MHM frameworks reduce menstruation to discreet product use, obscuring pain, disability, labour conditions, and lifecycle transitions. Scotland and Kenya demonstrate partial expansions beyond access alone, but Lebanon exposes what happens when political capture, policy silence, and institutional collapse converge: menstruation becomes governed through absence, and costs are absorbed by individuals and communities. Lebanon's grassroots organisations and midwives build counter-frameworks of care, yet cannot substitute for rights-based policy, stable public systems, and enforceable protections. Moving toward menstrual justice in Lebanon requires structural action. Below are policy recommendations for the context of Lebanon:

1. Adopt health-centred menstrual frameworks

Legally recognise menstruation and menopause as health issues requiring enforceable workplace accommodations (paid leave, rest, flexibility) grounded in care and bodily autonomy—not productivity incentives.

2. Democratise menstrual product access

Subsidise a diverse range of products (disposable pads, tampons, cups, reusable pads, period underwear) to

support comfort and choice, and partner with local organisations to strengthen ethical, local manufacturing.

3. Mandate lifecycle-inclusive education
Integrate comprehensive menstrual health education—pain, stigma, disability, menopause—into national curricula through the Ministry of Education, moving beyond narrow biological instruction.

4. Centre marginalised expertise in policy design
Fund and formally include community-led initiatives, midwife networks, and indigenous/communal knowledge systems in policy development, ensuring meaningful participation of those marginalised by gender norms, disability, migration status, and poverty.

5. Diversify crisis and humanitarian responses
Replace single-product models with multi-option menstrual kits delivered through mutual aid and community networks, prioritising comfort, safety, and context over standardisation.

6. Advance research and advocacy on pain and labour
Document links between menstrual pain/chronic conditions and labour/education exclusion to support policy reform demands, and expand research across the full life course—from menarche to menopause.

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