STRENGTHENING HEALTH SYSTEMS FOR MENSTRUAL HEALTH IN LOW- AND MIDDLE-INCOME COUNTRIES

BRIEF 2: HEALTH SYSTEMS RESPONSE

Menstrual Health Action for impact

psi Europe

HEALTH SYSTEMS RESPONSE TO MENSTRUAL HEALTH IN LOW- AND MIDDLE-INCOME COUNTRIES

Health systems in low- and middle-income countries (LMICs) are failing the millions of people who menstruate — offering little beyond awareness campaigns and product distribution, while neglecting critical menstrual health concerns and disorders. Many girls, women, and others who menstruate do not receive the care that they need because of underutilized and poorly resourced primary healthcare, undertrained healthcare workers, poorly disseminated medical guidelines and practices, and lack of life-long support for their menstrual health. This is a glaring gap - and an urgent call to action. Strategic investment to strengthen health systems for menstrual health can transform healthcare delivery, reduce long-term health and economic burdens, and drive progress on universal health coverage, adolescent and reproductive health, and gender equity.

This brief - the second in a three-part series - calls for urgent, strategic investment to remiagine and build responsive, integrated, and equitable health systems that recognize menstrual health as a fundamental component of women's health and rights.

KEY MESSAGES

MENSTRUAL HEALTH IS LARGELY ABSENT FROM LMIC HEALTH SYSTEMS. Despite the high burden and widespread impact of menstrual concerns and disorders, most health systems offer little more than awareness campaigns and product distribution — falling short in providing comprehensive information on health aspects, diagnosis, treatment, or long-term management of these conditions.

HEALTH-SEEKING FOR MENSTRUAL HEALTH IS LIMITED BY STIGMA, GAPS IN SERVICES, AND SYSTEMIC NEGLECT. Cultural norms, poor health literacy, normalization of symptoms, and inaccessible or under-equipped services prevent millions of people from seeking and receiving the care they need.

EVERY PILLAR OF THE HEALTH SYSTEM FALLS SHORT IN ADDRESSING MENSTRUAL HEALTH. From governance and financing to data systems and service delivery, menstrual health is excluded from core health functions - resulting in underdiagnosis, fragmented care, and high out-of-pocket costs.

PRIMARY CARE IS A MISSED OPPORTUNITY. Menstrual health can and should be integrated into primary healthcare through awareness and body literacy, screening, early diagnosis, and referrals; but services remain siloed and underutilized.

STRATEGIC INVESTMENT IN MENSTRUAL HEALTH SYSTEMS WILL YIELD CROSS-SECTORAL BENEFITS. Strengthening menstrual health responses will improve gender equity, reduce long-term health burdens, and advance universal health coverage and reproductive health goals.

Health-seeking for menstrual health concerns and disorders is alarmingly low.

> **Unless and until a woman is married, and is either having a child or has had a child, it is considered a taboo to visit a gynaecologist, whether this is in the government system or in the private system.**
>
> *- Public health expert from India*

In spite of the prevalence and disruptive, pervasive nature of menstrual concerns and disorders, girls and women's healthcare seeking behaviours are limited by the complex interplay of individual, interpersonal, socio-cultural, economic and health systems factors (table 1). These barriers normalize and stigmatize atypical menstrual experiences, placing girls and women at risk of long-term discomfort and pain, with associated physical and mental health implications, as well as social and economic costs (refer to Brief 1 in this series).[3]

Healthcare seeking for abnormal uterine bleeding (AUB) and heavy menstrual bleeding (HMB), both common gynaecological concerns, is limited, even when women have access to healthcare.[4] Key barriers are insufficient knowledge of irregularities associated with the menstrual cycle, normalization of symptoms, and stigma associated with seeking care for bleeding irregularities.[5,6,7]

People with dysmenorrhea (painful menses) often normalize or manage symptoms themselves, and may often avoid seeking healthcare altogether due to limited resources, poor healthcare access, compounded by the stigma associated with the "inability" to manage this pain.[8] A natural transition like menopause is not spared, with women unaware of symptoms, normalizing their discomfort, and acutely experiencing shame associated with the end of the reproductive years.[9]

TABLE 1: BARRIERS TO CARE FOR MENSTRUAL HEALTH CONCERNS AND DISORDERS

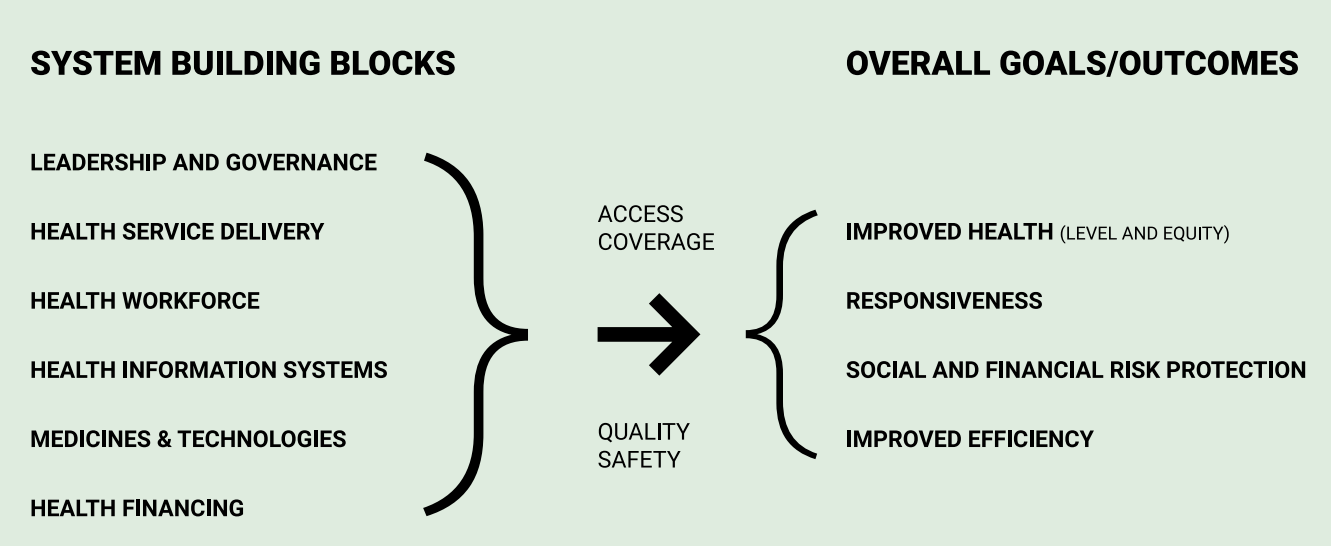
INDIVIDUAL & INTERPERSONAL	• Poor body and health literacy of conditions and linkages with other health conditions, and long term health implications
	• Normalization of symptoms (pain and heavy bleeding)
	• Perceptions of risk and severity of symptoms
	• De-prioritization of concerns and disorders in lieu of other pressing health conditions/ needs (often associated with fertility)
HEALTH SYSTEMS - PUBLIC AND PRIVATE HEALTHCARE	• Limited availability of health services for menstrual health (MH) concerns and disorders
	• Accessibility challenges related to distance to health facility, need for male chaperons
	• Limited acceptability (e.g., presence of female doctors, gynaecologists, experience with health providers)
	• Constrained capabilities/capacities of the health service to address MH concerns and disorders, or for referral
	• Limited affordability including incentives to seek treatment, financing schemes for conditions requiring long-term care
SOCIO-ECONOMIC	• Socio-cultural norms enhance and reinforce stigma associated with: ◦ Menstrual concerns and health seeking behaviour for information, services ◦ Life stage (e.g., menopause) ◦ Infertility ◦ Capabilities/capacities to carry out household and work responsibilities
	• Economic costs of care seeking for individuals and families

HEALTH SYSTEMS FAIL TO RESPOND TO MENSTRUAL CONCERNS AND DISORDERS

Health systems in LMICs, both public and private, are oftentimes not structured and capacitated to manage menstrual concerns and disorders - from prevention to treatment or long-term management of conditions.

Gaps exist across essential building blocks of the health system (figure 1), interacting to present significant barriers to care.[10]

FIGURE 1: WORLD HEALTH ORGANIZATION'S HEALTH SYSTEMS BUILDING BLOCKS



Drawing on expert insights,[a] this brief highlights the barriers to menstrual healthcare present in each of these health systems building blocks.

1. LEADERSHIP AND GOVERNANCE

Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability.

BARRIERS TO MENSTRUAL HEALTHCARE:

Low prioritization of menstrual health concerns due to their low direct risk for mortality, as well as limited understanding among decision makers about their prevalence, implications on health (including other health conditions) and overall wellbeing. Relatedly, governments and funders have traditionally focused on reproductive and maternal health issues that cause significant mortality in LMICs and population growth concerns.

Fragmented policymaking as menstrual health is siloed from other health areas relevant for girls and women, especially anaemia, family planning and contraceptive use, maternal health, and even non-communicable/chronic diseases despite strong interlinkages.

Lack of a unified framework that presents a comprehensive, cross-condition foundation to define, classify, or guide health systems responses to menstrual health concerns and disorders.

Weak accountability with few mechanisms, if any, exist to survey, track and report menstrual health conditions and health service responses.

2. HEALTH SERVICE DELIVERY

Good **health services** are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.

BARRIERS TO MENSTRUAL HEALTHCARE:

Narrow scope to address menstrual health in primary healthcare despite tremendous potential to do so, especially from a health promotion and disease prevention perspective (screening, basic diagnosis and referral). Primary healthcare for menstrual health has been restricted to awareness and product distribution.

Poor coordination across care levels with weak referral systems, and fragmentation within health systems, and between public and private providers. This limits the ability to increase awareness, screen and address issues at the primary care level, and provide continuity of care for chronic conditions (like PCOS, endometriosis) and associated health concerns.

Siloed implementation as health services for linked health needs (e.g., family planning, anaemia, adolescent health, chronic diseases) miss opportunities to integrate menstrual healthcare.

Lack of life-course approach in health services, using menstrual health as a lever to understand and support health needs comprehensively across adolescence, the reproductive years, and menopause.[11,12]

Lack of consensus on diagnostic criteria for disorders like PCOS and endometriosis. This can lead to different diagnostic tools being used in healthcare settings, affecting identification and consistent reporting of these conditions.

Targets and incentives lead to health programs addressing certain priority health issues, often in silo, potentially influencing if and how menstrual health concerns are addressed.

Limited management options for menstrual health disorders arising from the paucity of health promotion and disease prevention efforts combined with greater investment in tertiary care. This can lead to surgical procedures being conducted for certain menstrual health conditions (like heavy menstrual bleeding) that may be managed through other, less invasive means.

3. HEALTH WORKFORCE

A well-performing **health workforce** is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).

BARRIERS TO MENSTRUAL HEALTHCARE:

Inadequate pre-service and in-service training for all cadres of healthcare providers on menstrual health concerns and disorders, and their linkages with other health conditions. Further, training on accepted protocol to diagnose conditions may be limited, or providers may use outdated protocol.

Normalization and dismissal of symptoms by healthcare providers leading to misdiagnosis, delayed treatment, or even lack of treatment.

Human resource challenges include the lack of specialists (e.g., gynaecologists), female doctors, and doctors trained on menstrual disorders. These lacunae can preclude timely identification, diagnosis and treatment, and may also hinder healthcare seeking by girls and women in more traditional and conservative societies.

4. HEALTH INFORMATION SYSTEMS

A well-functioning **health information system** is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.

BARRIERS TO MENSTRUAL HEALTHCARE:

Scarce data from national surveys and health monitoring information systems that rarely collect data on menstrual concerns and disorders.

Limited implementation of standardized indicators or criteria as existing clinical criteria may not be widely communicated, known, and adopted across public and private healthcare settings making prevalence and burden hard to track within and across countries.

Underuse of digital tools to enhance efficiencies in identification of symptoms, co-morbid conditions, treatment options, and referrals.

5. MEDICINES AND TECHNOLOGIES

A well-functioning health system ensures equitable access to **essential medical products, vaccines and technologies** of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.

BARRIERS TO MENSTRUAL HEALTHCARE:

Inadequate access to more efficient and/or advanced diagnostic tools (e.g., AI-based or non-invasive diagnostic tools, ultrasounds, MRIs) at primary or secondary healthcare facilities in LMICs challenges timely screening, diagnosis, and appropriate referrals.

Limited management options for symptoms and conditions as essential medicines and technologies (e.g., hormonal therapies, nonsteroidal anti-inflammatory drugs) at the primary health care level are often unavailable, inaccessible or unaffordable.

Technology innovations exist, but are limited, undermining care pathways. Digital technologies and platforms can support awareness generation, nudge people towards timely healthcare, enable follow-ups and link health services, but are not well established in LMICs. Where digital health technologies do exist (like in India), they may face hurdles to scale due to infrastructure and technical barriers (e.g., electricity supply), personal barriers (e.g., comfort with technology innovations, education levels, access to smart phones), and concerns regarding increased workload.[13]

6. HEALTH FINANCING

A good **health financing system** raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.

BARRIERS TO MENSTRUAL HEALTHCARE:

High out-of-pocket expenditures are incurred especially for chronic or complex conditions like PCOS or endometriosis, amounting from diagnostic procedures, treatment, other related needs (e.g., nutritional supplements) as well as repeated visits to health facilities (which further leads to work absenteeism, and reduced or lost wages).

Limited and skewed insurance coverage as publicly funded schemes may not cover comprehensive care, private healthcare services, and sometimes incentivize inappropriate treatments (e.g., unnecessary hysterectomies in India).

Reliance on private healthcare as public healthcare services may be unavailable, unable to meet menstrual health needs or are not trusted. Patients in LMICs often turn to private health care, which has cost implications, and may not be supported by public health insurance schemes.

CONCLUSION

Menstrual health concerns and disorders remain poorly understood, normalized, and largely invisible in health systems. Health-seeking is limited due to stigma, lack of awareness, and systemic barriers across all building blocks of public and private health systems - from leadership and financing to service delivery and data. Current health systems are neither designed nor equipped to diagnose, treat, or manage menstrual health conditions

across the life course. Addressing these gaps requires urgent, strategic investment to build responsive, integrated, and equitable health systems that can recognize, reimagine, and respond to menstrual health as a critical component of girls and women's health and well-being.

WHAT COMES NEXT

This brief is the second in a three-part series designed to support strategic, evidence-based investment in menstrual health. The next and last brief will present the investment case to strengthen health systems to address menstrual health.

CONTRIBUTORS

This brief was authored by Arundati Muralidharan and Tanya Mahajan (Menstrual Health Action for Impact) in collaboration with Odette Hekster (PSI Europe), Caroline Bakasa (PSI Malawi) and Rhona MacGuire (PSI Europe).

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NOTES

a. Insights on barriers posed by health system building blocks to menstrual health were shared by 20 key informants across India, Malawi and globally.

SUGGESTED CITATION

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