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Global Health Priorities and the Neglect of Menstrual Health and Hygiene

The Role of Issue Attributes

ABSTRACT Comfortable management of menstruation is a fundamental need for all women of reproductive age, and its absence is a denial of their basic rights. Yet millions of women and girls do not have access to menstrual hygiene facilities. Through archival research and qualitative document analysis of reports from several multilateral organizations, this paper shows that the issue of menstrual health and hygiene (MHH) has been largely absent from the global development agenda, despite its significant impact on women's health, education, income, and well-being. It argues that three issue attributes—measurability, cultural sensitivity, and background characteristics of the affected population—have hindered the recognition and prioritization of MHH. The paper contributes to the interdisciplinary literature on agenda-setting, global health, and social movements, and to development studies more broadly. It draws attention to an under-researched subject and is the first, to my knowledge, to examine why MHH was not adopted as an issue of significance within global health. By doing so, this paper offers valuable insights for scholars and practitioners interested in advancing women's reproductive health and rights and gender equality. KEYWORDS Global health priorities, Menstrual health and hygiene, Gender and development, Agenda setting

Comfortable management of menstruation is a fundamental need for all women of reproductive age, and its absence is a denial of their basic rights. Yet millions of women and girls do not have access to menstrual hygiene facilities (WHO/UNICEF JMP 2021). In many parts of the world women and girls are known to engage in unhygienic menstrual practices—from reusing menstrual absorbents to washing and drying them under unsanitary conditions (Hennegan et al. 2016; Jalali 2020; Kuhlmann et al. 2019; Sommer et al. 2015; Tamiru et al. 2015; van Eijk et al. 2016)—because they lack access to basic facilities for menstrual hygiene management, including sanitary absorbent material, soap and water for washing, and toilets that are accessible, safe, and private.[1]

Women and girls in wealthier countries such as the United Kingdom and United States also struggle with period poverty, especially low-income and homeless women and girls, transgender and nonbinary individuals, and prisoners (Bozelko 2015; Kuhlman et al. 2019; *Lancet* 2018; Sommer et al. 2020; Weiss-Wolf 2020).

As this paper will document, until very recently menstrual health and hygiene (MHH) issues were unrecognized within development and even now remain marginalized in the global development agenda. In the field of development, menstrual hygiene is embedded

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within the water, sanitation, and hygiene (WASH) sector, and bundled with food and hand hygiene in the latter category. Much of the focus globally has been on tracking the health benefits of water and sanitation. Hygiene tends to be neglected. When issues of hygiene are addressed, the focus is on handwashing behavior (WHO/UNICEF JMP 2018); less attention is paid to the MHH needs of women and girls (Mahon and Fernandes 2010; Patkar 2020), even though it is integral to the achievement of many development goals (Sommer et al. 2021). As a recent editorial in *The Lancet* (2018:379) noted, "The needs of the 300 million women and girls menstruating on any given day remain buried low on the global health agenda."

What accounts for the absence of MHH from the global health agenda? Why was it omitted from the Millennium Development Goals (MDGs) *and* the Sustainable Development Goals (SDGs)—landmarks of development commitments that have shaped global and national level policies for several decades?

Research in the fields of domestic and transnational social movements (Bob 2005; Carpenter et al. 2014; Joachim 2007; Keck and Sikkink 1999), agenda setting (Annesley et al. 2015; Cobb and Elder 1971; Peake 2016), policy diffusion (Makse and Volden 2011; Nicholson-Crotty 2009), and global health (Benzian et al. 2011; Campbell 2020; Koivusalo and Mackintosh 2011; Maher and Sridhar 2012; Shiffman et al. 2016; Stuckler et al. 2011) has found that networks and alliances, framing of ideas, and issue characteristics often explain the adoption and diffusion of policies, global health agendas, and movement claims. Here I examine the role of issue characteristics. I believe these are important because not only do they influence the agenda-setting process, but as some scholars have said, contestation over framing and network types is often shaped by issue properties (Htun and Weldon 2010; Peake 2016).

The issue attributes identified by sociologists and political scientists fall into five categories: high saliency (Nicholson-Crotty 2009; Peake 2016; Shiffman et al. 2016); amenability to solutions (Carpenter et al. 2014; Gormley 1986; Nicholson-Crotty 2009; Shiffman 2016; Swidler 2010); measurability (Carpenter et al. 2014; Joachim 2007; Shiffman 2016); cultural sensitivity (Carpenter 2007; Htun and Weldon 2010; Onono et al. 2019; Swidler 2010); and the background of the affected population (Cobb and Elder 1971; Shiffman 2014; Waage et al. 2010). This paper examines whether the properties intrinsic to the MHH issue prevented its adoption.

While many studies explain why some health issues have become global health priorities and others have not, this is the first paper, to my knowledge, that examines the issue of MHH. Exploring a case that failed to attract global attention can improve our knowledge of even the successful cases that do and the importance of certain issue attributes which typically receive less attention.

I have adopted Carpenter's (2007) and Bob's (2005) measure of issue adoption: an issue has become a global priority when gatekeeping organizations within a network champion it by devoting financial, technical, and human resources to it. This understanding of global priority is close to that used by others in the field of global health (Maher and Sridhar 2012; Shiffman and Smith 2007), but I differ from the work of these scholars by focusing here on international organizations as gatekeepers, not on

individual leaders or countries. I use three primary indicators to measure MHH priority: mentions and discussions in 114 flagship reports from four multilateral organizations; goals and targets in the MDGs and SDGs; and global aid allocation.

The analysis suggests that three of the five features of the issue—measurability, cultural sensitivity, and the background of the affected group—do provide satisfactory explanations, while the other two—saliency and amenability to solutions—fail to predict issue adoption. Issue attributes that affect issue adoption are also shown to influence advocacy of the MHH issue.

The paper thus has two objectives: to demonstrate the low priority given to this issue in global health and development, and to explain the reasons for this silence. The first section relies on analysis of primary documents. The second section relies on secondary sources except for one explanatory factor (measurability), which relies on primary analysis of data.

After a section on data and methodology, I provide evidence of the neglect of MHH issues in various multilateral organizations; in the second part, I examine whether the various issue attributes explain this neglect.

DATA AND METHODOLOGY

The research primarily uses organizational documents and secondary research material as data sources. By examining 114 reports from four multilateral organizations over nearly a 40-year period and a variety of other research material (Table 1), I track the inclusion and exclusion of the MHH issue over time and then trace whether issue attributes affect adoption success.

Data Sources

I used four kinds of data for this work. The first three were used to measure the priority of MHH in the global health agenda (Table 1) and the last one to examine if the issue property of measurability explained the silence on this issue (not shown in the table).

1. *Annual/flagship themed reports from multinational organizations*. I examined 114 flagship annual reports published over 38 years (1978 to 2015) by four multilateral organizations (World Bank, UNDP, UNICEF, and WHO). These themed reports, published annually, provide an in-depth analysis of a specific issue in development. Such organizations publish many reports, but these are considered flagship publications because they convey what each organization believes is central to development.[2] I recognize that these organizations are not the only actors in global health and development, but they play a dominant role in shaping and implementing the global development agenda, including for health. The Bill and Melinda Gates Foundation, another major actor in the field of global health, is here examined only for its funding support for MHH. Until very recently the foundation was absent from this area, as we will see later on.
   Data were collected through 2015 because the MDGs were meant to be achieved by 2015, with the UN adopting the 2030 Agenda for Sustainable Development that year.

TABLE 1. Measures of the Priority of Menstrual Health and Hygiene in the Global Health Agenda

Measures of Priority		
	Data Source	Method & Measures Used in Coding
1. Multilateral Agencies		
World Bank (1978–2015)	World Development Report (1978-2015)	QDA of 38 reports for MHH, Hygiene & Family Planning (FP)
UNICEF (1980–81–2015)	The State of the World's Children (1980–81–2015)	QDA of 35 Reports for MHH, Hygiene & FP
UNDP (1990–2015)	Human Development Report 1990–2015 (2007 & 2012 not available)	QDA of 24 reports for MHH, Hygiene & FP
WHO (1995–2013)	World Health Report - 1995–2013 (2009, 2011, 2014, 2015 not published; 1996, 2005, 2012 not available)	QDA of 14 Reports for WASH, MHH & FP
2. Funding for MHH		
Official Development Assistance	OECD Query Wizard for International Development Assistance (QWIDS); author calculations	WASH & MHH, Health, Population & Reproductive Health (PPRH)
The Bill & Melinda Gates Foundation	OECD QWIDS (author calculations); Water, Sanitation, and Hygiene Overview: Strategy Overview. Bill and Melinda Gates Foundation	WASH & MHH, Health & PPRH
UN Sanitation & Hygiene Fund	Investing in Sanitation, Hygiene & Menstrual Health The SHF strategy 2022–2025	WASH & MHH
3. Selected Reports pertinent to WASH and Women		
WHO	The Global Strategy for Women's, Children's, & Adolescents' Health (2016–2030)	QDA for MHH
UN-Water	The 2019 UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) Report	QDA for MHH
UN General Secretary	UN General Secretary 2019 Beijing Review	QDA for MHH
UN	Millennium Development Goals	mention of WASH & MHH
UN	Sustainable Development Goals & targets	mention of WASH & MHH

2. *Global aid allocations for the WASH sector*, since MHH is embedded in this sector.
3. *Selected recent reports from multilateral organizations connected with WASH and women's issues*.
4. *Annual data on WASH and MHH indicators*. To examine whether the property of measurability explains the silence on this issue, development indicators published by several multilateral organizations over nearly a 40-year period were also analyzed for data on access to water, sanitation, and menstrual hygiene facilities.

Methodology

The primary research method used was qualitative document analysis (QDA), applied to publicly available reports from four multilateral organizations covering nearly four decades. Content analysis is an import tool in document analysis, organizing information into categories that can be analyzed to provide answers to the central research questions (Bowen 2009; Fereday and Muir-Cochrane 2006). According to Atkinson and Coffey (1997:33), documents are a means of tracking change and development, noting that "the absence, sparseness, or incompleteness of documents should suggest something about the object of the investigation, or the people involved. What it might suggest, for example, is that certain matters have been given little attention or that certain voices have not been heard." QDA of all the reports was done using NVivo software (three reports were hand searched as the electronic version was not available).

Data analyses combined content and thematic analysis for these purposes:

- To see whether MHH was *the primary theme* of any of the 114 annual reports.
- To trace these reports' inclusion or exclusion of MHH and the context in which the term is used (such as in relation to health, education, gender equality, human rights, or quality of life issues). The primary search terms for NVivo coding were "menstrual hygiene," "menstruation," and "menstrual health."
- For reference, data on hygiene and family planning (including contraceptive prevalence, contraception, and fertility) were also collected to examine the prominence of these issues in development *vis-à-vis* MHH.
- Data on WASH and MHH indicators were analyzed to assess the availability of MHH data and its measurability and whether it affected the emergence of the issue at the global level. For comparison, data on contraception were also collected to highlight the historical prominence of some issues in development.

THE ABSENCE OF MENSTRUAL HEALTH AND HYGIENE FROM THE GLOBAL HEALTH AGENDA

The neglect of MHH issues can be observed in the annual flagship reports from various multilateral organizations, in the issues focused on in the seminal MDGs and SDGs, in bilateral and multilateral funding support, and in various other reports from UN bodies.

Themes of Flagship Reports

Of the 114 flagship reports published by the four multilateral organizations over 38 years (between 1978 and 2015), not one focused on MHH. In fact, only one was dedicated to the role of WASH in development (the UNDP's *Human Development Report 2006: Beyond Scarcity: Power, Poverty, and the Global Water Crisis*), and even that report did not mention menstrual hygiene even once. Yet the World Bank has published on topics such as mind, society, and behavior (*World Development Report 2015*) and the internet and development (*World Development Report 2016*), and UNICEF has reported on leadership (*State of the World's Children 2002*) and child participation (*State of the World's Children 2003*), topics less relevant than MHH to the health and well-being of millions of women and adolescent girls.

QDA of All Reports

QDA reveals that MHH is never even mentioned in any of these 114 flagship reports. In contrast, "family planning" and its equivalent terms (contraceptive prevalence, contraception, fertility) were mentioned and discussed often (Figure 1). Although "hygiene" appears far less frequently than "family planning," it is mentioned in themed reports from all four organizations.

MHH is not mentioned even in flagship reports pertinent to gender issues in development, such as the *World Development Report 2012* on gender equality and development; the *Human Development Report 1995* with a focus on gender and human

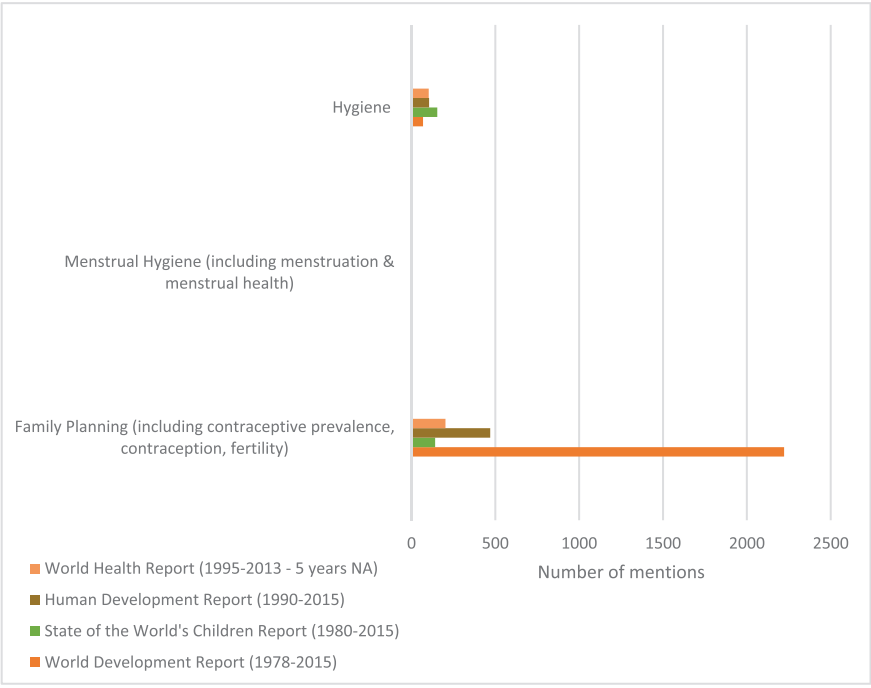

FIGURE 1. Number of mentions of "menstrual hygiene," "hygiene," and "family planning" in flagship reports of the UNDP, UNICEF, World Bank, and WHO, 1978–2015. Source: Qualitative data analysis using NVivo matrix coding; hand search of three reports.

development; the *State of the World's Children 2004* on girls, education, and development; or any of the *World Health Reports*. Nor is it mentioned in the many other annual themed reports where MHH would be a relevant topic—at least 13 such *World Development Reports*, 13 *Human Development Reports*, 17 *State of the World's Children* reports, and 10 *World Health Reports*. In comparison, as the figure reveals, family planning is mentioned frequently (the *World Development Report 1984* was dedicated to the theme of population and development), even in reports not relevant to the issue, such as the *Human Development Reports*—2001 on technology, 2002 on democracy, 2004 on cultural liberty, and 2005 on aid, trade, and security (not shown in the figure).

Millennium Development Goals

In the MDGs (UN 2000), the mechanisms outlined for women's empowerment focused on improving access to education, employment, and political representation but not water, sanitation, or menstrual hygiene facilities. WASH remained buried inside the seventh goal, on environment. Even the UN Task Force on Education and Gender Equality failed to address the MHH issue (UN Millennium Project 2005).

Sustainable Development Goals

In the SDGs for 2030 (UN 2015), WASH finally has a dedicated goal (number 6, and eight target measures), but menstrual hygiene is never explicitly mentioned. Goal 6 is "to ensure availability and sustainable management of water and sanitation for all." Target 6.2 is to "achieve access to adequate and equitable sanitation and hygiene for all,... paying special attention to the needs of women and girls." Yet indicators 6.2.1a and 6.2.1b, which focus on safely managed sanitation services and handwashing facilities at home, also fail to address menstrual hygiene directly (Loughnan et al. 2020). In addition, although several SDGs—including Goal 3 on health, Goal 4 on education, Goal 5 on gender equality, and Goal 10 on reducing inequality—have close links with MHH, these links were never acknowledged (see Sommer et al. 2021 for links to other SDGs).

Aid Allocation for WASH and MHH

In this paper, aid allocation is used as a measure of global commitment and priority (Bump, Reich, and Johnson 2013; Stuckler et al. 2011). As mentioned, in the field of development, menstrual hygiene is embedded in the WASH sector. Aid commitments to this sector have historically been very low. Between 1980 and 2020, aid commitments to water supply and sanitation as a proportion of all aid never rose above the 6 percent reached in 1996 (see Figure 2), with no funding for hygiene. In fact, in the last 20 years aid committed to health, population, and reproductive health (including HIV/AIDS) has far outpaced aid to WASH. By 2020, aid to water and sanitation was only 3.6% of total aid commitments (OECD n.d.a, author calculations),[3] and none was dedicated to hygiene.

According to recent estimates by the World Bank (Hutton and Varughese 2016:3), the total annual capital cost of meeting the SDG WASH targets (6.1 and 6.2) is USD 114 billion per year (range: USD 74 to 166 billion). This includes hygiene, at USD 2 billion. In 2020, commitments of development assistance to the WASH sector through external

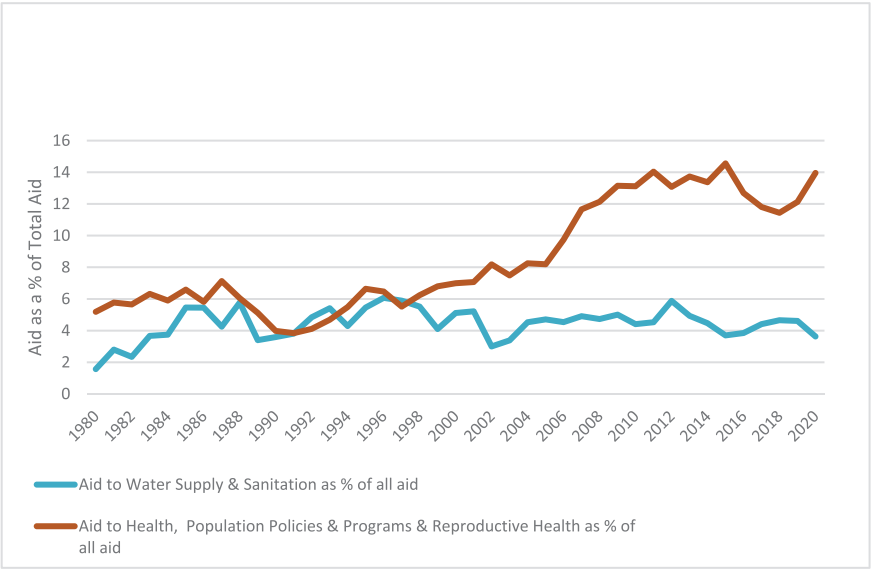

FIGURE 2. Aid commitments as a percentage of total aid (constant prices, millions of 2020 USD) for water supply and sanitation versus health, population policies and programs, and reproductive health, 1980–2020.
Source: OECD QWIDS data, author's calculations. Includes aid from all official donors plus the Gates Foundation.

support agencies such as bilateral donors, multilateral development banks, and the Gates Foundation added up to about USD 9 billion (OECD n.d.a), far below the global need.

Historically, WASH but especially MHH has not been a priority of the Gates Foundation (Gates Foundation 2012; UN-Water 2014). The foundation's aid to water and sanitation sector is far smaller than its aid to health and to population policies, programs, and reproductive health (PPRH-including HIV/AIDS) (Figure 3). In 2020, of total aid commitments by the Gates Foundation, 63% went to health and nearly 14% to PPRH, but only 1.6% to the water and sanitation sector. This was less than 1% of all official aid to the WASH sector (OECD n.d.a, author calculations).

Funding for MHH is integrated into programs for water and sanitation, so it is difficult to track accurately. However, donors report no dedicated funding for MHH within WASH (OECD n.d.b) (Figure 4).

Most recently, a new multilateral mechanism has developed with the purpose of investing in MHH. The UN's Sanitation and Hygiene Fund (2022) aims to prioritize global support for sanitation, hygiene, and menstrual health for the world's poorest. It plans to leverage up to USD 2 billion of additional investment in the sanitation economy and is developing performance indicators that can be monitored and evaluated so funders will know the impact of their investments. While private institutions such as the Gates and Kulczyk Foundations, and a few bilateral and multilateral organizations and countries, provide support for MHH programs, it is still far less than what is required to meet the needs of millions of poor women and girls. By one rough estimate, funding for MHH

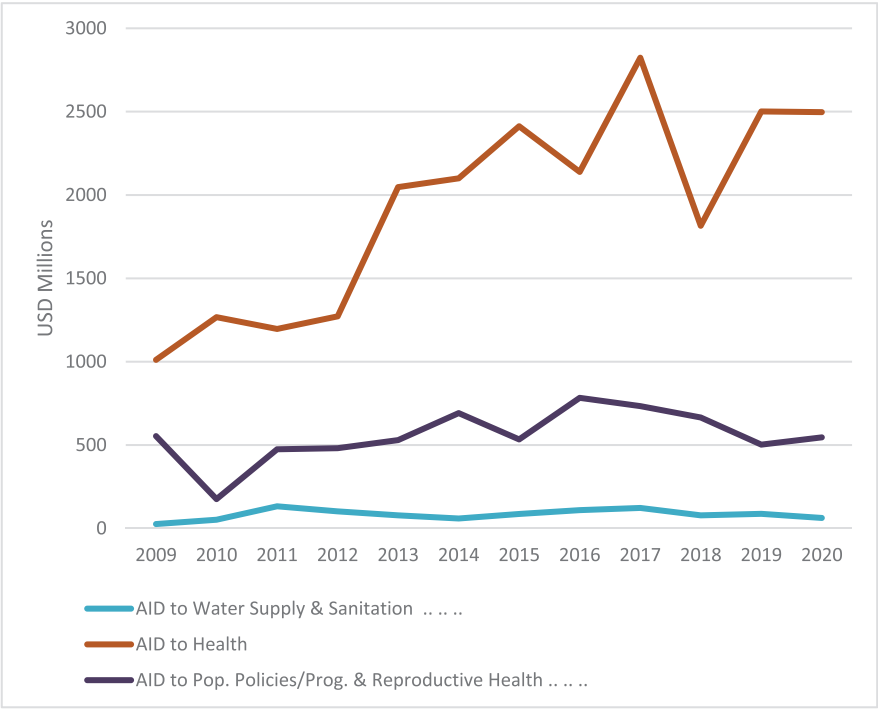

FIGURE 3. Gates Foundation aid commitments to water supply and sanitation; health; and population policies and programs and reproductive health (constant prices, millions of 2020 USD), 2009–2020.
Source: OECD QWIDS data, author's calculations.

ranges from USD 10 million to USD 100 million per year (this includes government spending in high income-countries—Kulczyk Foundation 2020), indicating the low priority given to this issue within the global development agenda (Global Menstrual Health and Hygiene Collective 2019).

Menstruation has huge implications for gender equality, yet, as I have shown, major international development organizations and even private foundations have remained silent on this issue. The historical silence of these major actors shaped the goals and targets prioritized in the MDGs, which were based on the development ideas and campaigns of the 1980s and 1990s (Waage et al. 2010). The omission of MHH from the SDGs has prolonged inaction in this area. In contrast, issues such as family planning, and other areas of health that were discussed in the flagship reports of multilateral organizations or already received funding (Figures 1 and 2), were eventually prioritized in the MDGs and the SDGs. As Waage et al. (2010) note, goals and targets that had stronger ownership by international or national institutions were more likely to be adopted in the MDGs.

More recent UN reports continue to remain silent on this issue. For example, the UN's *Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030)* envisions for 2030 "a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable

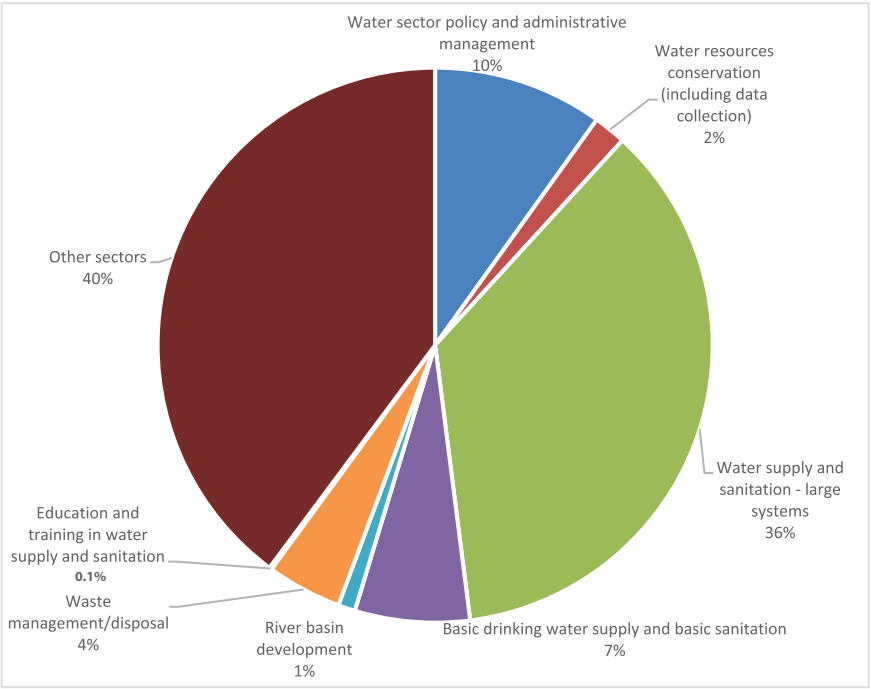

FIGURE 4. Proportions of total official aid commitments to WASH subsectors, 2017. Source: OECD QWIDS data, author's calculations.

societies." Yet the 108-page report makes no mention of MHH. Similarly, when UN-Water's Global Analysis and Assessment of Sanitation and Drinking-Water (GLASS) surveyed 16 external support agencies (bilateral donors, multilateral organizations, foundations, financing institutions, and external agencies that support countries' work toward sanitation and water for all) on their 2021 target for new or improved drinking water and sanitation, none reported planning to target menstrual hygiene management, although a few included hand hygiene as a target area (UN-Water 2019). In another GLAAS survey of 25 external support agencies, the combined list of their 33 priority areas of action within WASH did not include MHH—although it may have been included within WASH in schools and health care facilities, while at least 10 agencies did list hygiene promotion (which is a separate area within WASH) as a priority area (UN-Water 2019). Finally, the UN Secretary-General's 2019 review of the Beijing Declaration, prepared for the 23 rd special session of the General Assembly, mentioned MHH only once, with respect to access in schools.

The low priority given to menstruation issues can also be seen in academic research. For example, a PubMed search on the term "menstruation" by Critchley et al. (2020) yielded less than 4,000 publications per decade over the three decades spanning 1991 through 2019. "Menstrual blood" yielded around 200 to 400 publications per decade in the same period. In comparison, "searches of 'peripheral blood' and 'semen' yielded almost 100,000 and 15,000 publications, respectively, over the past decade" (624).

CAN ISSUE ATTRIBUTES EXPLAIN THE ABSENCE OF MHH FROM THE GLOBAL HEALTH AGENDA?

This section examines whether the properties intrinsic to the issue prevented its adoption. Properties examined include salience, amenability to solutions, measurability, cultural sensitivity, and background of the affected population.

Salience

Issues that are important to a large portion of the population or are perceived as having high mortality, morbidity, or socioeconomic costs are more likely to be adopted by advocates and gatekeepers (Bob 2005; Cobb and Elder 1971; Cooley and Ron 2002; Nicholson-Crotty 2009; Peake 2016; Shiffman 2016; Smith and Gorantla 2021). For example, Shiffman (2016) notes that data on the severity of the neonatal health issue facilitated the rise of leadership and a governance structure to address the issue, along with funding and favorable norms.

Nearly 500 million people around the world still practice open defecation, and 2.3 billion lack basic hygiene services (a handwashing facility with soap and water) at home (WHO/UNICEF JMP 2021). Millions of women and adolescent girls thus lack access to period-friendly toilets. Although global data on lack of access to sanitary menstrual material are not available, studies have shown that access is a problem for many women and girls. Such deprivation, together with the burden of managing menstrual taboos, exacts a heavy toll on education, income (Alam et al. 2017; Hennegan et al. 2020b; Schoep et al. 2019; Sommer and Sahin 2013), and physical and mental health (Das et al. 2015; Hennegan et al. 2016; Hulland et al. 2015; Jalali 2021; Oruko et al. 2015).

Thus, despite the huge population affected by lack of access to menstrual hygiene facilities and its centrality to women's health and well-being, this issue has failed to emerge as a global priority.

Amenability to Solutions

Problems and grievances which can be addressed via solutions that are not highly technical or complex are more likely to gain priority (Campbell 2020; Gormley 1986; Makse and Volden 2011; Nicholson-Crotty 2009; Shiffman 2016; Stone 2006). Carpenter et al. (2014:461) found that that within human rights transnational advocacy networks, "issues that are 'too complex' or seem to have impossible or unachievable solutions are less likely to gain advocacy attention." Similarly, Campbell (2020:6) notes that the Treatment Action Campaign in South Africa was successful because "it had a clearly definable, single endpoint (access to life-saving treatment by people with AIDS) associated with implementable strategies. The uncontroversial nature of this goal was capable of uniting diverse movement participants at every level from microlocal to global." Shiffman (2016) found that the global health chief of the Gates Foundation was willing to support the issue of newborn survival because it could be addressed immediately at low cost and with existing, easy-to-use technologies.

But the issue of MHH contradicts these studies. That women and girls require access to water, sanitary absorbent material, and a private, safe space to manage menstruation is

not news; nor is any new technology needed to address these needs. In fact, as Farrell-Beck and Kidd (1996) show, since the late nineteenth century medical health professionals in the United States (physicians and obstetric nurses) have emphasized the importance of menstrual and perineum hygiene for women's health and, together with pharmacists, spread the benefits of napkins and tampons to women in the US (also see Freidenfelds 2009). In resource-poor countries such as India, although most women and girls did not use commercially produced napkins until very recently, sanitary napkins have been widely available for many decades and are used by most middle-class women. In fact, by 1954 foreign manufacturers such as Kotex were marketing the product to the wider Indian population of "modern women." Local manufacturers entered the sector by 1975 (Chattopadhyay 2016). Thus, the means to address menstrual hygiene needs (including safe, private, functioning toilets) have long been known, yet this has not facilitated issue adoption. Similarly, Swidler's (2010) work on the global response to AIDS shows that the availability of simple, less technical solutions (such as male circumcision) to prevent AIDS did not ensure adoption of this issue by health advocates in the early stages. Others in the field of global health have also found that the availability of cost-effective interventions to prevent or cure diseases does not guarantee adoption by gatekeepers (Buse and Hawkes 2014; Koivusalo and Mackintosh 2011; Maher and Sridhar 2012; Stuckler et al. 2011).

Measurability

Measurable evidence of a problem and its solution facilitates wider acceptance by key actors (Benzian et al. 2011; Carpenter 2014; Joachim 2007; Makse and Volden 2014; Shiffman et al. 2016). It aids in conceptualization of the problem and in governance. As Fukuda-Parr and McNeill (2019:6) note, numeric indicators of poverty in the MDGs raised "awareness about global poverty as an urgent moral imperative of the world as a whole. They gained traction and became widely accepted by the main stakeholders—national governments, international agencies, activists, journalists, politicians and others—as the consensus agenda for development, regardless of whether they fully agreed with it." Data on public problems are used strategically in "information politics" by grassroots groups and social movements (Keck and Sikkink 1999). For example, in the promotion of gender-equality policies, gender statistics became a critical tool in issue framing, policy analysis, policy design, and policy implementation, as well as campaigning, lobbying, and advocacy (De Rosa 2014). Joachim (2007) found that the technical knowledge provided by social scientists about the prevalence and consequences of domestic violence helped legitimize the issue of gender violence within the criminal justice system and increase recognition of the issue in various international bodies. Carpenter et al. (2014:461) found that advocates for human rights "emphasized the problem's inherent measurability—a function of the issue itself as well as the tools available to advocates"—as a reason why the issue holds their attention.

By the same token, lack of measurable evidence can hurt advocacy. Benzian et al. (2011) found that global oral health has not gained the political attention it deserves

partly because of disagreement over its definition and the appropriate data to collect. The dearth of global data on MHH issues has impeded advocacy efforts.

Since menstrual hygiene is part of the WASH sector and because it requires access to water and toilets, I examine global data published by multilateral development agencies on water and sanitation and on four indicators of MHH developed recently by the WHO/UNICEF Joint Monitoring Program (JMP) (2021).

Historically, WASH measures were absent from the development indicators published annually by the major multilateral organizations. My research shows that World Bank's World Development Indicators included WASH only infrequently, and until recently only for some measures. For example, water access data were published from 1978 through 1982 and then from 1993 through 2001, but not for the 10 years from 1983 through 1992. Sanitation access data were only available beginning with 1980 (published in the 1996 *World Development Report*); the 18 reports from 1978 through 1995 had no data on sanitation. Similarly, the UNDP's *Human Development Report* first offered global data on water access in 1990, and for sanitation access 10 years later, in 2000. Neither organization has published any global data on MHH. For comparison, both have reported data on contraceptive prevalence—the World Bank as early as 1979 and the UNDP in 1995 and every year since. The WHO/UNICEF JMP, tasked by the UN with monitoring progress on water and sanitation, did not provide any data on menstrual hygiene until 2021. In fact, only in 2016 did the JMP rebrand itself as the Joint Monitoring Program for Water Supply, Sanitation and Hygiene (from just drinking water and sanitation), as it underwent a major transition from MDG to SDG reporting. Its annual reports and updates started including data on hand hygiene in 2017, and added MHH only in 2021.

Even now, no global data are available on the number of women and girls lacking access to menstrual hygiene facilities. Measurement targets for post-2015 were first proposed in 2012 by the Global Monitoring Working Group on Hygiene (London School of Hygiene and Tropical Medicine 2012), but they were not adopted, probably because of lack of ownership by major international organizations. As mentioned, data on menstrual hygiene were first published by the JMP in 2021 (data for 2017 to 2019), but only for 42 countries and not for all four indicators (awareness, use of menstrual materials, access to a private place to wash and change, participation in activities).

Lack of reliable measurement indicators has been a major problem in this area. As observed by the Global Advisory Group Monitoring Menstrual Health and Hygiene (Sommer et al. 2019:2), "a critical barrier to making progress on addressing menstruation and the range of girls' needs around this issue, is the lack of adequate validated measures related to measuring menstruation within global health and development." Part of the problem is that the definition of menstrual health and hygiene is evolving. Earlier definitions put greater emphasis on hygiene management (access to materials, facilities, and information) and referred to the issue as "menstrual hygiene" (London School of Hygiene and Tropical Medicine 2012) or "menstrual hygiene management" (Sommer et al. 2015). More recent definitions have moved away from a focus on "hygiene," which signified menstruation as dirty or impure, and toward a WHO-inspired definition of

health with attention to mental, social, and physical well-being and conveyed by the term "menstrual health and hygiene" (the term preferred here). Using this definition also stresses that menstruation is a critical indicator of female health, and a healthy menstrual cycle should be used as a measure of over well-being (Bobel and Fahs 2020). The use of the term also emphasizes the importance of dismantling harmful stigmas and norms, focusing on social and psychological well-being, and the inclusion of gender-diverse populations (Hennegan et al. 2021). Poverty, equity, and human rights issues have also been captured by terms such as "period poverty," "menstrual equity," and "menstrual justice" (Manorama and Desai 2020; Weiss-Wolf 2020).

A systematic review (Hennegan et al. 2020a) of studies on menstrual knowledge, attitudes, beliefs, and restrictions and on menstrual hygiene practices found that no two studies measured menstrual hygiene practice the same way. Several organizations working in the field of MHH lament that the dearth of data has hindered their work (Miller and Winkler 2020) and, together with definitional problems, has fragmented action and funding for menstrual health (Hennegan et al. 2021).

Recently, several attempts have been made to develop reliable measures for MHH and collect data through large-scale demographic surveys (Case for Her et al. 2021; Hennegan 2020; PMA 2020; USAID 2019). Advocates emphasize the urgent need to develop standardized measurement indicators to attract investment, advance advocacy and policy, and achieve results (Ljungberg and Coates 2020; Loughnan et al. 2020; Miller and Winkler 2020; Wilson et al. 2021).

Cultural Sensitivity

Issues that are culturally sensitive may receive less public attention (Allwood 2018; Carpenter 2007; Htun and Weldon 2010; Onono et al. 2019; Swidler 2010). Onono et al. (2019) found that cultural sensitivity regarding sexuality education for adolescents in Kenya made it harder for advocates of sexual and reproductive health to convince policymakers to prioritize this issue. In the early years of the HIV-AIDS epidemic, the stigma related to the disease hindered society's response, and it continues to interfere with research, prevention, treatment, care, and support efforts (Herek 1999; Mahajan et al. 2008). Htun and Weldon (2010) argue that sex equality policies (such as those on abortion and contraception) that challenge religious doctrines or codified cultural traditions may provoke more opposition from religious and traditional authorities (compared to non-doctrinal policies such as gender quotas in politics) and thus affect gender policy adoption.

Menstrual advocacy challenges traditional gender norms about embodiment that shame menstruating bodies (Bobel and Fahs 2020). In most parts of the world, menstruation is considered a taboo subject and managed in secrecy. Menstruators do not talk about their monthly bleeding; they feel impure, and they experience shame and fear if caught with a blood stain (Bobel and Fahs 2020; Caruso et al. 2017; Jalali 2020; Johnson 2021; O'Flynn 2006; Sahoo et al. 2015). And when they suffer from menstrual morbidities they hesitate to seek treatment, because "disclosure renders women

vulnerable to stigmatization" (Seear 2009:1220; also see Harlow and Campbell 2004; O'Flynn 2006).

The issue of MHH may thus have low priority because menstruators, but more especially men, are reluctant to discuss the issue where it matters, in policy circles and strategizing sessions. In fact, Target 6.2 of the SDGs does not even use the word "menstruation" but delicately refers to "the needs of women and girls." As Winkler and Roaf (2014:1) have noted, "The taboo and silence around menstruation makes menstruation a non-issue." Senior government officials in Uganda objected to the public discussion of menstruation because it broke taboo and secrecy. The Ugandan activist Stella Nyanzi (2020) was jailed for publicly teaching boys and girls about menstruation. Over more than a decade of working in this field, Patkar (2020) recalls "being shushed at any mention of menstruation." The topic was considered unmentionable, and anyone articulating it was politely ignored. This silence and opposition persisted for many years in the fields of reproductive health, education, and WASH (Bharadwaj and Patkar 2004; also see Sommer et al. 2015). The UN Special Rapporteur on the Human Rights to Safe Drinking Water and Sanitation has noted that the silence and stigma surrounding menstruation made finding solutions for MHH a low priority within the Human Rights Council (Roaf and Albuquerque 2020). Even gathering information on these issues can be difficult, as the Global Advisory Group on Menstrual Health and Hygiene has noted: "Overall findings highlight the complexity of addressing menstruation in societies around the world that have ongoing menstrual restrictions and taboos that are relevant for the design of interventions" (Sommer et al. 2019:1). Within the field of women's health, endometriosis, which is often painful and chronic and affects about 10% of reproductive-age women, receives little attention among health care providers, and the public, and is even ignored by patients (As-Saine et al. 2019). Part of the reason is the societal normalization of women's pain and stigma around menstrual issues. This is also one reason why the disease has remained under-researched and underfunded, according to a broad-based review by the Society for Women's Health Research (As-Saine et al. 2019; Guidone 2020).

To make substantial progress on this issue, menstrual advocates need to challenge the social construction of the body as dirty and in need of concealment (Bobel and Fahs 2020; Johnson 2021).

Background of the Affected Population

Some scholars have argued that the issues that show up on the public agenda are those that motivate the powerful. "Some groups have a greater ease of access than others and are thus more likely to get their demands placed on an agenda than others," either because they have greater access, are better able to mobilize resources, are in advantaged socioeconomic positions, or because they are held in high esteem (Cobb and Elder 1971:908). Similarly, Shiffman (2014) notes that "the United Nations post-2015 health development goal-setting process may be privileging some issues whose backers are particularly adept at global lobbying and advocacy, while sidelining other issues whose backers lack such access or capacity."

As Gloria Steinem (1983) wrote, if men could menstruate, Congress would fund a National Institute of Dysmenorrhea to prevent monthly work loss. While the global silence on MHH underscores the entrenched role of unequal gender norms and power structures that perpetuate gender inequalities, it also highlights the role of poverty in determining access. Menstrual hygiene issues primarily impact women and girls from poorer sections of society (in both high- and low-income countries), for they cannot afford to buy sanitary absorbents and do not have access to period-friendly toilets (Jalali 2020; Kuhlman et al. 2019; Tamiru et al. 2015; Tegegne and Sisay 2014; Weiss-Wolf 2020). Rossouw and Ross (2021) found evidence of inequality in menstrual hygiene management in Kinshasa (DRC), Ethiopia, Ghana, Kenya, Rajasthan (India), Indonesia, Nigeria, and Uganda. Wealth, education, the rural–urban divide, and infrastructural limitations of the household were major contributors to these inequalities. Menstrual poverty and taboos even compel poor young women to undergo hysterectomies. A rural Indian woman interviewed by Desai (2016:14) said, "Out of frustration of cleaning everything related to menstruation [cotton cloths and towels used], some women just get the operation. Where they may not have years ago, today they have an easy option to stop periods."

MHH is thus an issue borne by a constituency with limited power to influence global or national priorities (although the burden of menstrual etiquette is borne by all menstruators). This may be another reason why the issue of MHH has been historically overlooked.

For many decades women's organizations and networks remained silent on this subject. The action documents of the International Conference on Population and Development (ICPD), in Cairo in 1994, and the UN's Fourth World Conference on Women, in Beijing in 1995, were both shaped by feminists and hundreds of women's organizations yet were strikingly silent on the issue of menstruation. The International Women's Health Coalition, which played a central role in both conferences to ensure that sexual and reproductive rights and health are at the center of international and national population and health policies and programs, ignored MHH issues (Germain 2016).

Nearly 20 years later, even the groundbreaking Montevideo Consensus adopted by 33 countries in 2013 and designed to guide the achievement of ICPD goals through the SDGs remained silent on MHH issues (ECLAC 2013). ICPD25, held in Nairobi in 2019 attended by 8,000 delegates from 170 countries, failed to include MHH as part of the summit theme, though several included themes were compatible with MHH (UNFPA 2019).[4] Other reports by advocates of sexual and reproductive health rights also often continue to ignore the issue (UNFPA 2014; also see Germain 2016). As Sommer et al. (2015:1307) note, "The sexual and reproductive health community continues to largely refrain from exerting any ownership (or responsibility) for addressing menarche and MHM [menstrual hygiene management] in their programming and policy."

The continuing silence of some feminist and women's advocacy groups on this issue is also very notable. For example, a 32-page report by the Consortium on Gender, Security

and Human Rights (2017) critiqued the SDGs yet made no mention of their glaring omission of MHH. Until recently, even women's health advocates remained silent on this issue—from international nonprofit organizations such as International Council on Women's Health Issues (Davidson et al. 2011), to southern grass-roots organizations that work on women's health. For example, the report from a 2006 national dialogue event on women's health in India, organized by the Indian women's health movement and attended by 280 participants from many parts of the country, mentions MHH only once, in the context of women in prisons (People's Health Movement–India 2015). Similarly, the 10th International Women and Health Meeting (in 2005 in India) did not have a session on this issue (*Saheli* 2005).

Historically, the global women's health movement focused on reproductive self-determination, affordable medical care, satisfaction of basic needs, a safe workplace, and freedom from violence (Doyal 1996; also see the 1997 special issue of *Reproductive Health Matters,* written by activists and scholars and published soon after the ICPD conference on the International Women's Health Movement)—but did not address MHH issues. Why the silence?

Examining this issue through an intersectional lens provides some possible reasons. An intersectional framework (first introduced by Kimberlé Crenshaw in a 1989 paper) highlights that because there are intra-group differences in marginalized groups, people's lives cannot be understood only with reference to single categories, such as race, gender, religion, disability, or socioeconomic status (Hankivsky and Jordan-Zachery 2019). The lived experiences of women will vary across intersectional lines based on the axes of class, race, caste, and other social locations. An intersectional approach thus avoids the assumption that all women will be equally burdened with menstrual management.

The monthly management of menstrual hygiene is a burdensome experience for poor women and girls but a mere inconvenience for the educated, middle-class women who inhabit global development circles and local advocacy organizations (Boosey and Wilson 2014). The feminist drivers of the Cairo and Beijing conferences were college-educated, middle-class women (Joachim 1999), who by the 1980s did not suffer much from the burden of managing menstrual hygiene. The central belief of the women's liberation movement is that the personal is political. The feminists shaping global agendas did not have any personal experience with menstrual poverty, as they did with other issues such as unsafe abortions, domestic abuse, and sexual harassment. These latter issues became the subject of public campaigns and policy interventions, while menstrual issues remained largely invisible and neglected.

In other instances, women's health movements have also ignored the lived realities of minorities and poor women. In the 1970s and 1980s, the U.S. women's health movement's "emphasis on abortion rights and choice failed to address the linked socioeconomic and community health issues confronted by many women of color and poor women," such as forced sterilization (Nelson 2010:136). Other research also shows how interest groups representing the marginalized ignore the interests of other intersectionalities (Bolt 2004; Spieldenner et al. 2022; Strolovitch 2006).

BREAKING THE SILENCE

In the last several years, there has been some progress in taking the issue of MHH more seriously. There are now many advocacy organizations at the local, regional, and global levels (Crawford et al. 2019; Miller and Winkler 2020; Nyanzi 2020; Patkar 2020; Sommer and Clark 2020; Sommer et al. 2015). More than half of the World Bank's water supply and sanitation projects now include an MHH component (World Bank 2022). The Gates Foundation is investing in the design and development of new menstrual hygiene products and better monitoring of menstrual hygiene practices (PMA 2020). Development agencies, together with women's advocacy groups (Global Menstrual Collective, https://www.globalmenstrualcollective.org; WHO/UNICEF JMP 2021), have begun to create new measures and collect global data on MHH. And, as mentioned, a new Sanitation and Hygiene Fund has emerged which aims to raise global funds for menstrual hygiene.

The issue began to draw global attention only around 2010. In May 2012, the Global Monitoring Working Group on Hygiene, organized by the WHO/UNICEF JMP, met to propose post-2015 global goals, with corresponding targets and indicators, for access to safe drinking water, sanitation, and hygiene, including menstrual, hand, and food hygiene.[5] Menstrual hygiene management was formally defined for the first time by this working group. At the 2012 World Water Forum in Marseille, menstruation had a dedicated session. May 28 as Menstrual Hygiene Day began to be observed in 2013, thanks to the organizing efforts of an international NGO, WASH United. In 2019, the UN General Assembly adopted a resolution calling on states to address menstruation stigma and stereotypes as well as to ensure access to equitable sanitation and hygiene for all women and girls (UN 2019). Media attention to this issue also increased in the 2010s: *Cosmopolitan* dubbed 2015 "the year the period went public" (Bobel and Fahs 2020; Winkler 2020), and several TED Talks were held on the subject of menstruation.

Three factors explain why the issue finally began to gain global attention: the addition of the WASH sector to the SDGs; the voices of poor women and girls, which were heard by the gatekeepers; and scholarly and action research by scholars and NGOs that heard these voices, brought them to the attention of gatekeepers, and fueled menstrual activism in both the global North and the global South.

First, MHH entered the global sphere through being a part, although a small subsidiary part, of the WASH sector—not as a stand-alone issue or even as a part of reproductive health and rights. Although the UN recognized the right to water and sanitation in 2010, they did not have a dedicated goal in the MDGs but, as mentioned, remained obscured within Goal 7, on the environment. There was no target for hygiene (food, hand, or menstrual hygiene). Water and sanitation were finally recognized as critical development issues in the SDGs. In the preparations for the SDGs, measurement indicators were discussed for all the areas within WASH, including (finally) menstrual hygiene. The 2012 Global Monitoring Working Group on Hygiene (organized by the WHO/UNICEF JMP) was tasked with developing globally relevant goals, targets, and indicators for MHH.[6] The targets for menstrual hygiene management in schools and

health facilities were used in the lobbying effort for the post-2015 sustainability goals (Thomson et al. 2019).

It can be argued that this is how the issue finally gained global attention: by piggybacking on the WASH sector. Some UN bureaucrats, WASH advisers, and practitioners with years of experience on the ground have argued that this was an ideal entry point for starting the conversation on a taboo subject like menstruation. Since the WASH sector "is perceived as rather technical, it provided an 'innocuous cover' to start addressing issues that are ultimately about deeply entrenched gender norms" (Roaf and Albuquerque 2020). Patkar (2020:492), a WASH practitioner, notes: "Working with policy makers, it was prudent to couch activist actions—for example, breaking the silence on menarche and menstruation—within the instrumentalist language linked to budgets and measurable outputs. The water and sanitation sector, ever pragmatic and action oriented, offered the ideal launch pad." Sanitation policies focused on infrastructure and designed to improve toilet access led inadvertently to awareness of the challenges schoolgirls faced in managing menstruation where period-friendly toilets did not exist (Patkar 2020; Sommer et al. 2015). In addition, the use of the term "hygiene" with menstruation "reflected the power of the word 'hygiene' to neutralise the otherwise alarming reference to menstruation" (Thomson et al. 2019:1305). In fact, Boosey and Wilson (2014) found that most clear references to menstruation in the UN reports resulting from the special procedures mandates of the right to education, the right to health, and the right to water and sanitation were made in the context of the latter; the right to education and the right to health generated only one clear reference each, though they were established 10 years earlier.

However, the submergence of the issue within WASH also had negative consequences. For one, MHH continued to be ignored within WASH and was never explicitly mentioned in the SDGs. Within the WASH sector, as mentioned, much of the focus globally has been on funding water and sanitation and on tracking its health benefits (WHO/UNICEF JMP 2017), not on MHH. Also, because the issue was submerged within the WASH sector, the development discourse around menstruation dominated—that is, a focus on hygiene, product provision, and period-friendly toilets, especially in schools and health facilities—to the neglect of the rights discourse, which emphasizes factors such as pain management, menstrual dysfunction, and the burden of taboos and stigma (Bobel and Fahs 2020; Gaybor and Harcourt 2022; Harlow and Campbell 2000; McLaren and Padhee 2021; Patkar 2020; Thomson et al. 2019).

The second factor that helps explain why MHH finally began to gain global attention is the voices of poor menstruators, especially from southern countries. They helped transform this issue from an unmentionable, untreatable, private problem to a treatable public problem. Changemakers, practitioners, and advocates began to hear about the challenges women and girls faced in relation to water and sanitation, especially when menstruating or pregnant (MacArthur, Carrard, and Willetts 2020). Catarina de Albuquerque, the UN Special Rapporteur on the Human Rights to Water and Sanitation, recalls that what prompted her to consider menstruation as part of her mandate on water and sanitation were the stories women and girls told her about their needs in terms of

access to facilities and materials (Roaf and Albuquerque 2020). Similarly, Patkar (2020), a practitioner with years of experience in the WASH sector in Africa and Asia, says that the silence on MHH was broken because of trainings and dialogues conducted in many countries in Asia and Africa which relied on making the voices of thousands of women and girls heard. Through multi-country training workshops and regional sanitation conferences organized by UN agencies (such as UN Women, the Water Supply and Sanitation Collaborative Council, and UNICEF) and local ministries with the aid of international NGOs (such as WaterAid) and researchers, "these voices rang clear and true; they changed the perceptions, understanding, attitudes, and openness of diverse populations and their policy makers, who cast away age-old taboos to ask questions, learn, and embrace the universal truth of menstruation" (486). "The interaction, role plays, honest voices, and tough talk by many who had suffered ultimately produced change-makers, champions, movers, and shakers" at the national, regional, and global levels (499) and led to menstrual policies in several countries, including India, Senegal, and Kenya. In northern countries, such as the US, lawyers and advocates heard "the personal testimony of school-age girls, formerly incarcerated women, teachers, and shelter administrators about their lived experiences with menstrual inequity" (Crawford et al. 2019:356) and persuaded state and city lawmakers to make tampons more affordable and accessible.

The third factor was academic scholars and researchers working for NGOs, who played a part through their fieldwork, bringing the voices of poor menstruators to the global community. There was a steady increase in academic research by scholars[7] and action research by various international NGOs (such as WaterAid, Wash United, Oxfam, SIMAVI, World Vision International, and Save the Children—see Bhardwaj and Patkar 2004; McArthur et al. 2020; McLaren and Phadee 2021; Patkar 2020) and social enterprises (Goonj, EcoFemme, Afripads, and Zana Africa—see Gaybor and Harcourt 2022). Some of this work was funded by UN agencies, donor countries such as Canada and UK, or private foundations (Sommer and Clark 2020).

This body of empirical research helped document the experience of poor women and adolescent girls in many parts of the world and turn a private concern, shrouded in secrecy and shame, into a global problem requiring a global response. It also led to early discussions on developing measurement indicators for MHH in the SDGs (London School of Hygiene and Tropical Medicine 2012). Some of those involved in the initiative were scholars and practitioners of MHH. These and other scholars (Hennegan et al. 2020a, 2021) and practitioners later emerged to form the Global Advisory Group on Monitoring Menstrual Health and Hygiene. This group has been advising the WHO/UNICEF JMP on developing measurement indicators (Sommer et al. 2019).

In northern countries, such as the United States, the experiences of the poor menstruators were heard by academic scholars doing field research and running legal clinics, who documented period poverty in many states (Crawford et al. 2019; Sommer et al. 2020). Activists demanded the removal of taxes on sanitary products and better access to affordable menstrual hygiene products in homeless shelters and prisons (Crawford et al. 2019). Another strand of menstrual activism emerged through the voices of the more

educated, well-off sisters who have focused on challenging the norms of menstrual etiquette (artists who celebrate menstrual blood in their art; an athlete who bleeds in public; a proposal for workshops on "free bleeding" in Canadian schools and elsewhere; the viral #HappyToBleed campaign in India—see Bobel and Fahs 2020; Gaybor and Harcourt 2022; Moraes and Sahasranaman 2018).

While the WASH sector created a small gateway to bring this issue to global attention, it was the firsthand knowledge that educated, middle-class researchers (primarily women) gained from the menstrual experiences of the poor that brought momentum to this issue. As Sommer et al. (2015:1306) also noted, "These first-person narratives generated through participatory methods . . . provided the key evidence at the moment that a global movement began to coalesce." Biographical testimony was thus an important instrument researchers used to connect menstruators to the development community. Such testimony has also been effective in raising awareness and mobilizing resources for other global issues: HIV/AIDS, women's rights, and other human rights in general (Burchardt 2016; Joachim 1999; Keck and Sikkink 1999; Merry 2009).

CONCLUSION

Women's bodies are critically dependent on access to menstrual hygiene facilities, yet until very recently such needs have remained unrecognized by development agencies, as my work here has documented. And while the gendered nature of development has been the focus of extensive research, showing how gender inequalities in society, including within the family, lead to gendered development outcomes, MHH has remained surprisingly absent from the work of development scholars, including gender and development scholars, even though it is integral to the achievement of many development goals (such as poverty removal, education, health, and gender equality). These links are rarely acknowledged by scholars. For example, the journal *Gender and Development* has published only five research articles which focused on MHH in a 25-year period (1998 to 2023), and *World Development* published no research article on this topic between 1975 and 2023. This paper fills the gap by addressing an issue that is critical for women's health and dignity and documents decades of silence on it from multiple international agencies.

In addition, this paper makes several contributions to the literature on social movements, agenda-setting, and global health, which also has not addressed this issue before, to my knowledge. The paper also sheds light on the factors that hinder policy adoption and movement success, which have been under-studied compared to the factors that promote them. And by focusing on issue properties as important explanatory factors, it shows the importance of intersectional marginalization in understanding why particular issues are neglected by the global health community, a factor that has received less attention in the literature. My research has shown that issue properties may even affect activism: lack of data led to efforts to collect evidence; the stigma surrounding menstruation led to public displays of bleeding and collection of biographical testimony with which to lobby the

gatekeepers; and the low status of menstruators affected the failure of women's rights activists to adopt this issue as part of the fight for reproductive rights and health.

The evidence presented here does not constitute a definite test of the issue properties that are predictive of issue adoption by gatekeepers. But it does suggest that obstacles to issue adoption may emerge as much from the attributes of an issue as from external factors such as political opportunity structures, networks, and allies, which have been the subject of much study. I did not examine the role of these factors, including the impact of resonant frames, which are known to be significant in determining the success of movement claims and global health agendas. I plan to study these determinants in the future to see whether the insights of this body of literature are generalizable to a broader set of issues such as MHH. Another limitation of this study is the lack of interview data from key actors in multilateral organizations, which might have provided more insights into why MHH did not become a global health priority. I hope the analysis of many documents from a variety of different organizations over a long period has helped overcome this data gap to some extent. ■

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NOTES

1. The definition of menstrual health and hygiene followed here adopts the following understanding of the issue: "Menstrual health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in relation to the menstrual cycle" (Hennegan et al. 2021:32). Hence MHH services should include "information about the menstrual cycle and self-care; materials, facilities and services to care for the body during menstruation; diagnosis, care, and treatment for menstrual discomforts and disorders; a positive and respectful environment which minimizes psychological distress; and freedom to participate in all spheres of life" (Hennegan et al. 2021:32). Occasionally I will also use the term "menstrual hygiene," but this term includes health concerns associated with menstruation.

2. For example, *The State of The World's Children 1982–83* launched the child survival revolution and the GOBI strategy (growth monitoring, oral rehydration therapy, breastfeeding, and immunization). The seminal 1993 *World Development Report on Investing in Health* broke ground in inventing a new measure of ill health, the DALY (disability-adjusted life year), and providing the global burden of disease analysis, which has been widely adopted in the health sector. The UNDP's first report, the *Human Development Report 1990*, was a landmark publication which introduced the Human Development Index, which attempts to measure progress on issues such as education and health, not just income. WHO considers the *World Health Report* its leading publication, with its main purpose being to help policymakers, donor agencies, and international organizations make appropriate health policy and funding decisions.

3. This includes all aid commitments from official donors and the Gates Foundation.

4. The entire report mentions menstrual hygiene just twice: once with respect to modern technologies for menstrual management and a second time with respect to availability of sanitary material during humanitarian crises.

5. Very few of the working group's suggestions made it into the SDGs, although the report suggested several measurement indicators for menstrual hygiene.

6. Since the report addressed all three types of hygiene (hand, food, and menstrual hygiene), the participants were concerned that if "good hygiene" was presented as one overarching goal people would understand it to mean handwashing only and both menstrual and food hygiene would be totally "lost," since they were newer focus areas.

7. Search of the terms menstrual hygiene (MHY), menstrual health (MHE), and family planning (FP) on PubMed (March 30, 2023) returned 106 references to MHY, 1,921 to MHE, and 3,505 to FP in the 15-year period from 2008 to 2022, compared to 24 references to MHY, 853 to MHE, and 1,858 to FP in the previous 15 years (excluding references to clinical trials and randomized controlled trials). Thus there were more than four times the hits for MHY, more than twice the hits for MHE, and almost twice the hits for FP, compared to the earlier period.

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