RESEARCH REPORT · NIGERIA · 2026

Designing for Dignity

Evidence for Inclusive Menstrual Health and Digital Solutions for Queer and Gender Diverse Nigerians

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149
queer menstruators surveyed across Nigeria

15
key informant interviews with providers & advocates

83.9%
willing to use a private digital health tool

COMMISSIONED BY	FOCUS	METHOD	FUNDED BY
Initiative for Gender Equality and Sexual Reproductive Health (IGE-SRH)	Menstrual health, SRHR & digital innovation	Mixed-methods, rights-based study	FOS FEMINISTA

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FOREWORD

A matter of dignity

Menstrual health is not just a public health issue; it is a matter of dignity, equity, and human rights. Yet for many queer and genderdiverse individuals in Nigeria, menstruation is experienced at the intersection of stigma, invisibility, and systemic exclusion.

This research, *“Designing for Dignity: Evidence for Inclusive Menstrual Health and Digital Solutions in Nigeria,”* comes at a critical time when conversations around menstrual health are gaining global momentum, but still largely exclude marginalized populations. By centering the lived realities of queer menstruators, this study challenges dominant narratives and expands our understanding of what inclusive menstrual health dignity truly means.

The findings presented in this report are both compelling and urgent. They reveal not only the physical and emotional burdens of menstruation but also the structural barriers; ranging from discriminatory healthcare practices to policy gaps, that continue to deny many individuals their right to safe, respectful, and inclusive care.

> *This report is a call to action: to listen, to include, and to design systems that affirm the dignity and humanity of all individuals, regardless of gender identity or sexual orientation.*
>
> IGE - SR H

Importantly, this research does more than highlight challenges; it offers a pathway forward. Through evidence-based recommendations and innovative solutions such as digital health platforms, it provides actionable strategies for policymakers, healthcare providers, and development partners. As we move toward achieving equitable SRHR outcomes and the Sustainable Development Goals (SDGs), it is imperative that no one is left behind.

WITH GRATITUDE

Acknowledgements

The successful completion of this research study would not have been possible without the contributions, support, and commitment of numerous individuals and organizations.

We extend our deepest appreciation to the Initiative for Gender Equality and Sexual Reproductive Health (IGE-SRH) for commissioning this study and for their unwavering commitment to advancing inclusive Sexual and Reproductive Health and Rights (SRHR) in Nigeria. Their leadership in centering marginalized voices, particularly queer and gender-diverse individuals, continues to shape transformative and rights-based interventions.

To the participants

We sincerely thank all study participants—particularly the queer menstruators who courageously shared their lived experiences. Your voices, stories, and insights are the foundation of this research and a powerful call to action for more inclusive systems and policies.

We also acknowledge the contributions of key informants, including healthcare providers, civil society organizations (CSOs), and community leaders, whose expertise and perspectives enriched the depth and relevance of this study.

Special recognition goes to the research team for their dedication, professionalism, and sensitivity in conducting this work, especially within a complex socio-legal context. Your commitment to ethical, inclusive, and high-quality research is commendable.

Finally, we appreciate all partners, advocates, and allies working to advance menstrual health, gender justice, and human rights in Nigeria. This research is a collective step toward ensuring dignity, equity, and inclusion for all.

REFERENCE

Acronyms

IGE-SRH	Initiative for Gender Equality and Sexual Reproductive Health	**SRHR**	Sexual and Reproductive Health and Rights
KII	Key Informant Interview	**CSO**	Civil Society Organisation
MHHM	Menstrual Health and Hygiene Management	**VAT**	Value Added Tax
PCOS	Polycystic Ovary Syndrome	**LGBTQ+**	Lesbian, Bisexual, Transgender, Queer and other Diverse Identities
LBQ	Lesbian, Bisexual and Queer	**TGD**	Transgender and Gender Diverse
MEL	Monitoring, Evaluation and Learning	**WASH**	Water, Sanitation and Hygiene
SDGs	Sustainable Development Goals	**SSMPA**	Same-Sex Marriage Prohibition Act, 2014
mHeal th	Mobile Health	**UNICEF**	United Nations Children’s Fund
UNFPA	United Nations Population Fund	**NPJ**	Nature Partner Journals (npj Digital Medicine)

A note on language

This report intentionally uses context-specific language—such as “transgender men,” “non-binary,” “intersex,” and “queer women”—to reflect the lived experiences of menstruating populations in Nigeria. Terminology around gender and sexuality is politically sensitive and culturally variable; careful selection ensures inclusivity while maintaining clarity and safety for the communities discussed.

EXECUTIVE SUMMARY

The evidence, in brief

Menstrual health is a fundamental human right and a critical component of sexual and reproductive health and rights (SRHR). However, for queer individuals who menstruate in Nigeria, this right remains significantly undermined by stigma, discrimination, economic barriers, and systemic exclusion.

This report presents the findings of a groundbreaking, queer-inclusive menstrual health study conducted by IGE-SRH, aimed at generating evidence to inform inclusive policy, programming, and digital health innovation. Using a mixed-methods approach, the study engaged **149 queer menstruators** across Nigeria through surveys and conducted **15 Key Informant Interviews** with healthcare providers, civil society actors, and community leaders. The findings reveal a deeply concerning landscape.

53.7%

report that menstruation is difficult—rising to 91.7%among adolescents

62.4%

experience emotional distress, the most common menstrual challenge

40.3%

faced discrimination in healthcare settings because of their identity

16.1%

face challenges accessing menstrual products, highligh period poverty

67.8%

rely on the internet for menstrual health information

These findings underscore three critical realities. First, queer menstruators face a compounded burden where physical, emotional, and identity-based challenges intersect. Second, the healthcare system remains largely unprepared and, in many cases, unsafe for queer individuals. Third, digital health solutions present a powerful and immediate opportunity to bridge gaps in access, information, and support.

Five strategic responses

In response to the evidence, this report outlines strategic recommendations across five key areas:

● 1 Policy Reform

Expanding Nigeria’s menstrual health framework to explicitly include gender-diverse populations and ensuring equitable access to menstrual products.

● 2 Healthcare System Strengthening

Institutionalizing gender-affirming care, training providers, and enforcing non-discrimination policies.

● 3 Digital Innovation

Developing the *RainbowCare App*, a secure, inclusive platform offering menstrual tracking, mental health support, and access to queer-friendly services.

● 4 Community Action

Leveraging civil society and community networks to provide safe spaces, education, and grassroots support.

● 5 Research Advancement

Building a sustained evidence base on queer menstrual health through inclusive and longitudinal studies.

At IGE-SRH, we believe that menstrual health dignity must be inclusive, intersectional, and rights-based. This research is not only a documentation of challenges but a call to action for governments, development partners, healthcare systems, and communities to recognize and respond to the needs of all people who menstruate.

We remain committed to advancing equity, amplifying marginalized voices, and driving innovative solutions that ensure dignity, safety, and access for queer menstruators across Nigeria.

01

Key Findings

Seven intersecting dimensions of the queer menstrual experience—from symptom burden and health care discrimination to economic barriers and digital opportunity.

Menstrual health experiences & needs
Emotional & psychological experiences
Healthcare access & utilization
Economic barriers & period poverty
Social norms, stigma & identity
Digital health use & preferences
Intersectionality of experiences

1 Menstrual health experiences and needs

Examined lived menstrual health experiences and menstrual health needs of queer individuals.

The findings reveal that menstrual health experiences among respondents are characterized by a high prevalence of physical discomfort and unmet health needs. A majority (53.7%) of respondents reported experiencing difficult menstruation, including symptoms such as severe cramps, irregular cycles, fatigue, and general discomfort.

Qualitative insights further indicate that many participants lack access to appropriate menstrual health management resources, including accurate information, pain management options, and supportive healthcare services. Respondents described relying on informal coping mechanisms, such as self-medication or advice from peers, due to limited access to professional guidance.

In addition, menstrual needs extend beyond physical management to include the need for privacy, dignity, and access to safe and hygienic facilities. These needs are often unmet, particularly in environments where menstrual health is stigmatized or inadequately supported.

Overall, the findings suggest that menstrual health needs among queer individuals are multifaceted, encompassing physical, informational, and environmental dimensions.

2 Emotional and psychological experiences

Assessing psychosocial and identity-related challenges and how stigma, identity, and access affect their experiences.

A significant proportion of respondents (62.4%) reported experiencing emotional and psychological distress related to menstruation. These experiences include anxiety, embarrassment, mood fluctuations, and discomfort.

The data indicate that emotional distress is not solely linked to physical symptoms but is also influenced by identity-related factors. For many participants, menstruation is associated with gender dysphoria or discomfort due to the alignment of menstruation with socially constructed notions of femininity. This creates an additional layer of psychological burden for individuals whose gender identity does not align with these norms.

Qualitative responses highlight feelings of isolation and internal conflict, particularly in contexts where individuals are unable to openly discuss their experiences or access supportive networks. The lack of inclusive language and representation in menstrual health discourse further exacerbates these challenges.

These findings demonstrate that menstrual health is closely linked to mental and emotional well-being, particularly within socially restrictive environments.

3 Healthcare access, utilization, and experiences

Identified barriers to healthcare and services and how stigma, identity, and access affect their experiences?

The study identifies significant barriers to accessing healthcare services. Approximately 40.3% of respondents reported experiencing discrimination or stigma in healthcare settings. These experiences include misgendering, lack of provider sensitivity, and negative attitudes from healthcare personnel.

As a result of these experiences, 22.1% of respondents reported avoiding healthcare services altogether due to fear of mistreatment or discrimination. This avoidance behavior has implications for both menstrual health and broader health outcomes, as it limits access to diagnosis, treatment, and preventive care.

Qualitative findings indicate that healthcare environments are often perceived as non-inclusive and unresponsive to the needs of queer individuals. Participants reported a lack of trust in healthcare providers and expressed concerns about confidentiality, respect, and safety.

These findings suggest that both structural and interpersonal factors within healthcare systems contribute to reduced service utilization and unmet health needs.

4 Economic Barriers and Access to Menstrual Products

Identified barriers to services and how access and socio-economic factors affect experiences

Economic constraints emerged as a key factor affecting menstrual health management. Respondents reported difficulties in accessing affordable menstrual products, indicating the presence of period poverty within the study population.

Limited financial resources, coupled with broader socio-economic marginalization, restrict the ability of individuals to consistently purchase menstrual products. In some cases, participants reported resorting to alternative or less hygienic materials, which may increase the risk of health complications.

The findings also suggest that economic barriers intersect with other forms of exclusion, further limiting access to both products and healthcare services. This highlights the importance of considering affordability as a central component of menstrual health interventions.

5 Social Norms, Stigma, and Identity-Related Barriers

Assess psychosocial and identity-related challenges and how stigma and identity affect experiences?

Social and cultural norms surrounding menstruation play a significant role in shaping participants' experiences. Menstruation is often framed within rigid, gendered expectations, which do not account for the experiences of queer and gender-diverse individuals.

40.3% of respondents said they have experienced discrimination in healthcare settings, showing that stigma exists in health services. These participants reported experiencing stigma, silence, and exclusion in both community and institutional settings. These experiences are compounded by broader societal attitudes toward sexual orientation and gender identity, creating an environment in which individuals may feel marginalized or invisible.

Qualitative data highlight that stigma operates at multiple levels, including interpersonal interactions, community norms, and institutional practices. This contributes to reduced openness, limited access to support, and increased psychological distress.

The findings underscore the role of social context in shaping menstrual health experiences and outcomes.

6 Digital Health Use and Preferences

Explore digital health opportunities and solutions that improve inclusive menstrual health services

The study found a high level of openness to digital health solutions, with 83.9% of respondents indicating willingness to use digital platforms for menstrual health information and support.

Participants identified digital platforms as accessible and private alternatives to traditional healthcare services. These platforms are perceived as particularly useful in contexts where stigma and discrimination limit access to in-person care.

Qualitative insights suggest that preferred features include accurate health information, anonymity, peer support, and mental health resources. However, concerns were also raised regarding data privacy, misinformation, and the need for culturally relevant and inclusive content.

These findings indicate that digital health solutions may serve as complementary tools for addressing gaps in menstrual health information and support.

7 Intersectionality of experiences

Across all findings, it is evident that menstrual health experiences are shaped by the interaction of multiple factors, including physical health, emotional well-being, healthcare access, economic status, and social identity.

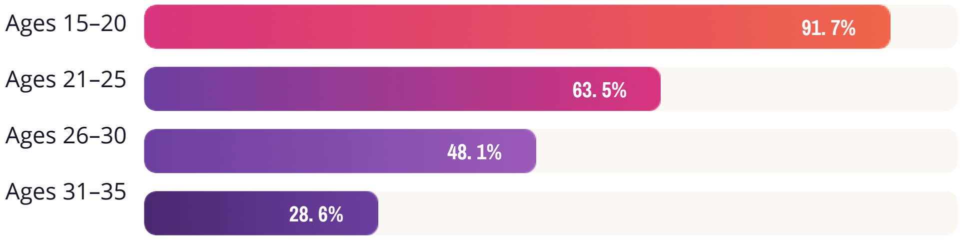
These factors do not operate in isolation but intersect to produce varied and complex experiences. For example, individuals experiencing economic hardship may also face greater barriers to healthcare access, while those experiencing stigma may be more likely to avoid seeking care.

The intersectional nature of these experiences highlights the need for comprehensive approaches that address multiple dimensions of menstrual health simultaneously.

01 · AT A GLANCE

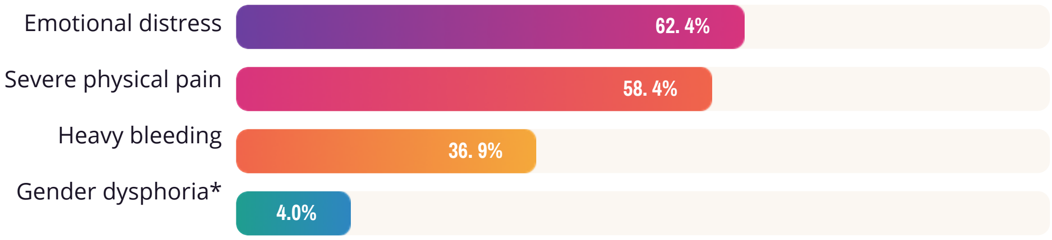
The burden, in numbers

Reported menstrual difficulty rises sharply among the youngest menstruators



Share reporting their menstrual experience as “sometimes” or “very” difficult, by age group (survey, N=149).

Emotional distress outranks physical pain as the leading symptom



*Symptoms experienced during menstruation; multiple responses permitted (N=148). *Likely under-reported—many participants described dysphoric experiences in non-clinical language.*

22.1%

avoided a health facility because oftheir identity

67.8%

relyontheinternet as their mainhealthinformation source

16.1%

face difficultyobtaining menstrualproducts

02

Recommendations

A phased, actorspecificroadmap—structured across immediate, mediumterm, and longtermhorizons—reflectingboththe urgency of identified gapsandthe need for sustained structural transformation.

Immediate · Urgent gaps in safety, access & inclusion

Medium-term · Institutionalising inclusion & service delivery

Long-term · Structural equity & evidence-based practice

Drawing on triangulated evidence from the survey and Key Informant Interviews (KIIs), these recommendations are structured across immediate, medium-term, and long-term time horizons. This phased approach reflects both the urgency of identified gaps and the need for sustained structural transformation. Responsibilities are distributed across key institutional actors to ensure accountability and feasibility.

1

IMMEDIATE ACTION

Addressing urgent gaps in safety, access, and inclusion

Federal Ministry of Health (FMoH)

should strengthen existing patient rights and quality of care frameworks by reinforcing non-discrimination principles in the delivery of menstrual health and broader SRHR services, in line with the National Health Act (2014). As part of ongoing sector reforms, the Ministry should initiate a technical review of the National Menstrual Health and Hygiene Management (MHHM) Policy to improve inclusiveness, clarity of language, and responsiveness to the needs of underserved and vulnerable populations.

In collaboration with relevant stakeholders, including professional councils and civil society organisations, the Ministry may also support the development of a confidential and voluntary referral network of trained and sensitised healthcare providers to improve access to respectful and client-centred services, particularly for populations who experience barriers within conventional service settings.

Civil society organisations (CSOs)

particularly queer-led groups, should prioritise the integration of menstrual health education into existing peer support and community outreach programmes, ensuring that content is gender-affirming and trauma-informed. In parallel, CSOs should expand community-based menstrual product distribution initiatives to address immediate period poverty, while initiating structured engagement with faith and traditional leaders to begin dismantling entrenched menstrual stigma.

Health training institutions should deploy short-term, in-service training programmes focused on gender-affirming, trauma-informed care. Given that current provider competence is largely informal, these rapid capacity-building interventions are critical transitional measures while curriculum reform is underway.

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Digital health developers

should prioritise the co-design and development of a minimum viable version of the RainbowCare App, ensuring that core functionalities—such as anonymous access, menstrual tracking, and basic mental health support—are available. Given the high-risk legal and social context, privacy-by-design principles (including encryption, anonymity, and discreet interfaces) must be treated as essential safety features rather than optional enhancements.

Donors and development partners

should provide catalytic funding to support pilot interventions, including digital innovation, community outreach, and provider training. Flexible, rapid-response funding mechanisms will be essential to enable queer-led organisations to respond effectively to urgent needs.

2

MEDIUM-TERM SYSTEMS REFORM

Institutionalising Inclusion and Strengthening Service Delivery Systems

Federal Ministry of Health (FMoH)

should complete and operationalise a revised, inclusive National MHHM Policy, ensuring that gender-diverse populations are explicitly reflected in definitions, service standards, and monitoring frameworks. The establishment of a National Queer and Intersex Menstrual Health Task Force will be critical to guide implementation, coordinate stakeholders, and institutionalise inclusive data standards. Additionally, the Ministry should implement fiscal measures, including the removal of VAT on menstrual products and the introduction of subsidised or free distribution schemes within public institutions.

Civil society organisations (CSOs)

should transition from pilot interventions to scaled programming, including the formalisation of safe clinic networks in partnership with government actors. Evidence-based community engagement strategies should be expanded to shift harmful social norms, particularly through collaboration with religious and traditional leaders who hold significant influence over community perceptions.

Health training institutions

must embed gender-affirming and queer-inclusive care into pre-service curricula for all health professionals, while institutionalising continuous professional development (CPD) requirements. This reform is essential to move from ad hoc sensitisation to sustained professional competence.

Digital health developers

should scale the RainbowCare App nationally, integrating advanced features such as clinic navigation, peer support systems, and referral pathways. Ensuring accessibility through low-bandwidth optimisation and offline functionality will be critical to equitable reach. Robust data governance frameworks must be established to safeguard user privacy and build trust.

Donors and development partners

should invest in the scale-up of inclusive service delivery models, digital health innovations, and institutional capacity strengthening. Funding should also support rigorous implementation research to evaluate effectiveness and inform adaptive programming.

3 LONG-TERM POLICY AND RESEARCH PRIORITIES

Advancing Structural Equity and Sustaining Evidence-Based Practice

Federal Ministry of Health (FMoH)

should institutionalise inclusive data collection systems by integrating gender identity and sexual orientation variables into national health surveys, including the Demographic and Health Survey. Sustained public financing mechanisms must be established to ensure equitable access to menstrual products and services, aligned with broader universal health coverage (UHC) commitments.

Civil society organisations (CSOs)

should continue to play a critical advocacy role, leveraging emerging evidence to advance legal and policy reforms that address structural discrimination. Long-term investment in community-led systems will be essential to sustain trust and accessibility.

Health training institutions

should establish specialised centres of excellence focused on gender-inclusive SRHR research, training, and clinical guideline development. These institutions will be central to generating locally relevant evidence and sustaining professional capacity.

Digital health developers

should evolve the RainbowCare platform into a comprehensive digital SRHR ecosystem, incorporating telehealth, referral systems, and integrated service delivery. Continuous user-centred evaluation and iterative design will be essential to maintain relevance and effectiveness.

Donors and development partners

should prioritise longitudinal and large-scale studies to track changes in menstrual health outcomes among queer populations over time. Investment in locally led research will be critical to ensuring contextual relevance and sustainability of evidence generation.

The evidence presented in this study underscores that menstrual health inequities among queer and gender-diverse populations in Nigeria are systemic, intersectional, and deeply embedded within policy, healthcare, and social structures.

> *“Addressing these inequities requires a coordinated, multilevel response that combines immediate protective measures with longterm structural reform.*
>
> SYNTHESIS OF RECOMMENDATIONS

The phased and actor-specific recommendations outlined above provide a practical and evidence-based roadmap for advancing inclusive menstrual health and ensuring that dignity, safety, and access are realised for all.

03

Introduction

Why menstrual health for queer and gender diverse Nigerians demands urgent, context specific evidence—and why existing research has left them invisible.

- 3.1 · Queer-inclusive menstrual health context
- 3.2 · Menstrual issues & traditional beliefs in Nigeria & West Africa
- 3.3 · Queer & gender-diverse menstruators in the region

Menstrual health is a fundamental component of SRHR; however, it remains inadequately addressed for populations whose identities fall outside dominant gender frameworks.

Queer and gender-diverse individuals who menstruate experience compounded vulnerabilities driven by stigma, discrimination, and limited access to safe, affirming, and confidential healthcare services, which collectively undermine health outcomes and dignity (Hennegan et al., 2019).

Despite growing global attention to menstrual health, a significant evidence gap persists regarding the experiences of queer menstruators. Existing research has largely focused on cisgender women and girls, leaving transgender men, non-binary, and intersex individuals underrepresented in data, policy, and service design (Pate, 2020). Consequently, there is limited understanding of their specific needs, barriers to care, and health-seeking behaviours, particularly in low- and middle-income contexts.

Nigeria presents a critical context for this inquiry due to the widespread prevalence of period poverty, systemic gaps in menstrual health infrastructure, and socio-legal environments that further marginalise queer populations. National data indicate that a substantial proportion of menstruators lack access to affordable products, safe sanitation, and accurate information, with these challenges intensified by stigma and restrictive social norms (Hennegan et al., 2019). These structural constraints intersect with identity-based exclusion, amplifying health inequities for queer individuals.

In response to these gaps, this study aims to generate context-specific, empirical evidence on the menstrual health experiences of queer and gender-diverse individuals in Nigeria. The research seeks to inform inclusive policy development, strengthen service delivery systems, and support the design of innovative, rights-based interventions, including digital health solutions, that advance menstrual dignity for all.

3.1 Queer-inclusive menstrual health context

An estimated 1.8 billion people worldwide experience menstruation, including cisgender women, transgender men, non-binary individuals, intersex persons, and queer women (UNICEF, 2018; Hennegan et al., 2019). Despite this, nearly 500 million lack access to adequate menstrual health resources, including clean water, safe sanitation, appropriate products, and reliable information.

For queer women, transgender, and intersex individuals, challenges are compounded by social stigma, discrimination, and exclusion from health systems structured around gender-normative assumptions. Many gender-diverse menstruators experience fear of harassment in public spaces, gender dysphoria, and barriers to respectful healthcare (Pate, 2020; Hennegan et al., 2019).

Intersex individuals may encounter medical stigma and insufficient reproductive health information, while lesbian menstruators are often rendered invisible within sexual and reproductive health and rights (SRHR) policies, limiting access to education and services tailored to their needs. These intersecting barriers reinforce systemic exclusion and constrain equitable access to menstrual health support.

Menstrual health management encompasses not only access to products but also safe and private spaces, inclusive healthcare services, accurate information, and environments free from stigma. Where these elements are absent, period poverty emerges as a multidimensional human rights issue shaped by economic inequality, gender norms, and structural exclusion (Hennegan et al., 2019).

Failure to address these gaps negatively affects education, economic participation, mental health, and overall well-being, perpetuating cycles of inequality among queer and gender-diverse populations (Pate, 2020).

This report intentionally uses context-specific language; such as “transgender men,” “non-binary,” “intersex,” and “queer women” to reflect the lived experiences of menstruating populations in Nigeria. Terminology around gender and sexuality is politically sensitive and culturally variable; therefore, careful selection ensures inclusivity while maintaining clarity and safety for the communities discussed.

3.2 Menstrual Issues and Traditional Beliefs in Nigeria and West Africa

A review of academic and policy literature indicates that menstrual health in Nigeria and West Africa is strongly influenced by cultural beliefs, gender norms, religious practices, poverty, and inadequate health and sanitation systems. Across many communities, menstruation is highly stigmatized and framed as shameful, dirty, or spiritually impure, resulting in silence, misinformation, and restrictive practices (Sommer et al., 2015; UNICEF, 2019).

In Nigeria, traditional and religious beliefs often impose behavioural limitations on menstruators, such as exclusion from places of worship, restrictions on cooking or social interaction, and expectations of secrecy to prevent perceived contamination or misfortune (Adinma & Adinma, 2008; Oche et al., 2012). Menstrual blood may be associated with spiritual danger or supernatural power, reinforcing fear and taboos that hinder open discussion between parents, caregivers, and adolescents. Consequently, many young people experience menarche without adequate preparation or accurate health information, increasing anxiety, shame, and risky coping behaviours (Ameade & Garti, 2016).

● **Period poverty remains a major public health and social challenge.**

Economic constraints, high costs of menstrual products, and limited access to clean water, sanitation, and hygiene (WASH) facilities compel many menstruators to use unsafe or improvised materials, increasing the risk of reproductive and urinary tract infections (Hennegan et al., 2019). School-based studies in Nigeria link inadequate menstrual support to absenteeism, reduced academic participation, and school dropout, particularly among low-income girls and adolescents (Adegoke, 2015; UNICEF, 2021).

Menstruation is also closely tied to gender expectations and control over sexuality. In some communities, the onset of menstruation is perceived as a marker of marriage readiness or sexual maturity, heightening risks of child marriage, early pregnancy, and gender-based violence (Plan International, 2018). Patriarchal norms further limit men's and boys' involvement in menstrual education, reinforcing the perception that menstruation is a private or shameful "women's issue" rather than a shared public health concern.

While government and civil society initiatives in Nigeria increasingly recognize menstrual health as a human rights and development issue, national policy responses remain fragmented, underfunded, and predominantly focused on cisgender women and girls, with limited attention to marginalized or gender-diverse populations (Federal Ministry of Health Nigeria, 2020; UNFPA, 2022).

Mainstream menstrual stigma in Nigeria does not affect all menstruators equally. Queer women, transgender men, non-binary, and intersex individuals face heightened vulnerability due to exclusion from health systems, invisibility in policy, and discrimination in communities already governed by restrictive norms. Cultural taboos around menstruation intersect with gender and sexual marginalization, amplifying shame, fear, and barriers to safe and dignified menstrual management. Understanding these compounded challenges is critical for developing inclusive menstrual health strategies that address the needs of all menstruating populations in Nigeria

3.3 Queer and Gender-Diverse Menstruators in Nigeria and West Africa

International literature highlights that menstrual health challenges extend beyond cisgender women to include transgender men, non-binary individuals, intersex persons, and queer women. Gender-diverse menstruators frequently face stigma, discrimination, and exclusion from health systems designed around gender norms, which limits safe and dignified menstrual management (Pate, 2020; Scheim & Bauer, 2015; Chrisler et al., 2016). Many rely on informal peer networks or online platforms for information, which can provide critical support but also risk misinformation and restricted access to professional care (Poteat et al., 2013). Intersex individuals often encounter medical stigma and non-consensual clinical interventions, further constraining autonomy and access to reproductive health knowledge (Carpenter, 2016).

African studies indicate that menstrual health challenges are shaped by intersecting factors including poverty, gender norms, cultural taboos, and inadequate WASH (water, sanitation, and hygiene) infrastructure (Sommer et al., 2015; Hennegan et al., 2019). However, research on queer and gender-diverse menstruators remains extremely limited. Available evidence suggests that stigma, discrimination, and exclusion in health and education systems are heightened in restrictive legal and social contexts, mirroring global findings (Pate, 2020).

The Nigerian legal context

Nigeria's Same-Sex Marriage (Prohibition) Act, 2014 (SSMPA) shapes a socio-legal environment in which queer individuals face criminalization, offering no formal protection for queer patients within the health system. This context makes confidentiality, anonymity, and discreet design not merely preferences but physical safety requirements for any intervention.

In Nigeria specifically, the criminalization of LGBTQ+ identities and widespread social stigma exacerbate barriers for queer menstruators. Gendered health facilities and "women-only" menstrual programs may intensify gender dysphoria, emotional distress, and avoidance of care among transgender and non-binary menstruators (Human Rights Watch, 2016; Chrisler et al., 2016). Peer and digital networks are often critical for accessing information, but structural exclusion and fear of disclosure limit engagement with formal health services. Intersex menstruators face compounded medical and educational marginalization, highlighting gaps in bodily autonomy and inclusive reproductive health education (Carpenter, 2016).

Despite growing international and regional literature, there is little context-specific empirical evidence on the menstrual health experiences of queer and gender-diverse populations in Nigeria. Most programs and research continue to assume that all menstruators are cisgender women, leaving critical questions about lived experiences, coping strategies, and service needs of queer menstruators unanswered.

Addressing menstrual health for queer and gender-diverse populations in Nigeria requires culturally responsive education, inclusive SRHR policies, multi-sectoral investment, and intentional integration of marginalized voices into research, programming, and digital health innovations. This study directly addresses the identified evidence gap by documenting the menstrual health experiences of queer menstruators in Nigeria.

3.4 Research Purpose and Objective

The primary aim of this study is to generate context-specific evidence on the menstrual health experiences, challenges, and service needs of queer and gender-diverse individuals in Nigeria, with a view to informing inclusive menstrual health programming, policy development, and digital health interventions.

Research Specific Objectives:

1. To document the lived experiences of queer menstruators in Nigeria, including social, cultural, and health-related barriers to safe and dignified menstrual management.
2. To examine the impact of stigma, discrimination, and gender norms on access to menstrual health information, products, and services among queer and gender-diverse populations.
3. To identify existing coping strategies, support networks, and digital or community-based resources used by queer menstruators to manage menstrual health challenges.
4. To assess gaps in formal health, education, and policy systems in meeting the menstrual health needs of queer populations, with attention to inclusivity and accessibility.
5. To provide actionable recommendations for culturally responsive programming, inclusive policies, and digital health innovations that address the menstrual health needs of queer and gender-diverse individuals in Nigeria.

3.4 Research Questions

- What are the menstrual health experiences and needs of queer individuals who menstruate in Nigeria?
- What barriers do they face in access to products, information, and healthcare?
- How do stigma, identity, and psychosocial factors shape menstrual experience?
- What community and digital health solutions do participants prioritize?

3.6 Significance of the Study

This study provides critical, context-specific evidence on the menstrual health experiences of queer and gender-diverse individuals in Nigeria, addressing a major gap in research, policy, and programming. Its significance spans multiple domains such as documenting the lived experiences and service barriers faced by queer menstruators, the study informs inclusive sexual and reproductive health and rights (SRHR) policies that move beyond cis-normative assumptions. Evidence from this research can guide policymakers in integrating gender-diverse needs into national and subnational menstrual health strategies.

The Findings offer actionable insights for NGOs and community-based organizations to design programs that are culturally sensitive, stigma-informed, and inclusive of queer and gender-diverse populations. Programs can better address both the material and psychosocial dimensions of menstrual health.

The study highlights barriers in health facilities, including gendered service models and discriminatory practices. This knowledge can help healthcare providers implement inclusive clinical protocols, improve provider training, and ensure safe, respectful, and dignified care for queer menstruators.

The research informs the design of digital health platforms, such as the RainbowCare App, by identifying information needs, preferred communication channels, and privacy considerations specific to queer and gender-diverse users. Digital solutions can therefore be tailored to improve accessibility, accuracy, and user engagement.

By centering the voices of queer menstruators, the study strengthens community-led advocacy efforts, amplifying marginalized perspectives and supporting campaigns for menstrual equity, social acceptance, and policy change.

The findings highlight evidence gaps and methodological considerations for future studies on menstrual health in marginalized populations. This includes understanding intersecting vulnerabilities, measuring psychosocial impacts, and evaluating interventions designed for queer and gender-diverse communities.

By addressing these domains, this study moves beyond general menstrual health discourse, foregrounding the specific challenges and priorities of queer and gender-diverse populations in Nigeria.

04

Research Methodology

A mixed-methods, rights-based design anchored in feminist, queer, participatory, and human rights frameworks—centering the voices of queer menstruators throughout.

The study employed a mixed-methods, exploratory, and rights-based design, integrating qualitative and quantitative approaches to capture both personal experiences and systemic factors shaping menstrual health. The research was anchored in feminist, queer, participatory, and human rights frameworks to ensure that the voices of queer menstruators were central, structural inequities were addressed, and ethical research practices were maintained throughout.

149
surveyrespondents (target was150;one removed in data cleaning)

15
KeyInformant Interviews, conducted February 2026

~43
averageKIIduration, primarily viavirtual platforms

Data collection was conducted across multiple urban and peri-urban locations in Nigeria, selected to reflect diverse socio-cultural, legal, and geographic contexts and to include areas with active queer networks and community-based organizations. Participants were recruited through purposive sampling, using community networks, LGBTQ+ organizations, and digital platforms, and supplemented by snowball recruitment to reach additional participants. Recruitment materials emphasized confidentiality, voluntary participation, and the study's focus on menstrual health experiences.

Eligible participants were individuals aged sixteen years or older who experienced menstruation, self-identified as queer, including transgender men, non-binary individuals, intersex persons, or queer women, and were willing and able to provide informed consent. Individuals were excluded if they were not residing in Nigeria at the time of the study, did not menstruate, or were unable or unwilling to provide informed consent.

The quantitative component involved surveys administered to 150 participants. Surveys were conducted primarily online via secure, encrypted forms to ensure privacy and accessibility. The qualitative component involved fifteen semi-structured Key Informant Interviews (KIIs), purposely selected to ensure diversity in identity, sexuality and sectors they operate. KIIs were conducted virtually through secure phone calls and in confidential community spaces.

The KII guide was co-developed with queer community stakeholders and reviewed by subject-matter experts to ensure cultural relevance, sensitivity, and alignment with study objectives. The guide included open-ended questions exploring menstrual experiences, access to services, stigma, coping strategies, and policy or programmatic needs.

Quantitative survey data were cleaned, coded, and analyzed using SPSS version 28, employing descriptive statistics and cross-tabulations to identify patterns in menstrual health access, stigma, and service utilization. Qualitative data were transcribed verbatim and analyzed using thematic analysis in NVivo version 14, combining inductive and deductive coding to capture emergent themes related to stigma, service barriers, coping strategies, and recommendations.

Quality assurance measures included training of enumerators and interviewers in ethical engagement, trauma-informed approaches, and accurate data recording. Pilot testing of survey instruments and KII guides ensured clarity, cultural appropriateness, and consistency. Triangulation of qualitative and quantitative findings strengthened validity and reliability.

Data protection procedures were rigorously followed. All participant data were anonymized using unique identifiers. Ethical approval was obtained from all participants of the research, and participants were informed of their right to withdraw at any point.

This methodology enabled the study to generate holistic and actionable insights into the menstrual health experiences of queer and gender-diverse populations in Nigeria, integrating individual lived experiences with broader systemic, cultural, and policy-level factors.

4.1 Study design and approach

This study employed a mixed-methods, exploratory, and rights-based design to generate a comprehensive understanding of menstrual health experiences among queer and gender-diverse individuals in Nigeria. The research combined three complementary components: a desk review, a quantitative survey, and qualitative Key Informant Interviews (KIIs). Each component contributed uniquely to understanding the challenges, coping strategies, and service needs of queer menstruators, while their integration enabled a holistic analysis linking personal experiences with systemic, cultural, and policy factors.

The desk review involved a systematic examination of existing literature, national and regional policies, program reports, and advocacy documents related to menstrual health, SRHR, and queer populations. This review identified key trends, knowledge gaps, and best practices, and provided the contextual foundation for the survey and interview instruments. By highlighting the absence of data on queer menstruators, it informed the design of inclusive research tools and guided the focus of both qualitative and quantitative components.

The quantitative survey captured broader patterns and trends in menstrual health experiences, stigma, access to services, and coping strategies among queer menstruators. Surveys were administered primarily online through Google Forms, with paper questionnaires used where digital access was limited. The survey was designed to reach a diverse sample in terms of gender identity, age, and geographic location. Analysis of survey data using SPSS version 28 provided descriptive statistics and cross-tabulations that quantified experiences and service barriers, enabling the research team to identify priority areas for intervention.

Qualitative inquiry was conducted through semi-structured KIIs using an interview model developed with input from queer community stakeholders and reviewed by subject-matter experts. Fifteen participants were purposely selected. The KIIs explored personal experiences with menstruation, stigma, service access, coping mechanisms, and policy or programmatic needs. Transcripts were analyzed using thematic analysis in NVivo version 14, combining inductive and deductive coding to generate rich, context-specific insights that complemented and explained quantitative trends.

By integrating these three methods, the study produced a nuanced understanding of menstrual health among queer populations in Nigeria. The desk review provided context, the survey quantified patterns across a broader population, and the KIIs provided depth and nuance, with triangulation strengthening the validity of findings and supporting actionable recommendations for policy, programming, service delivery, and digital health innovations.

4.2 Study population

The study was designed to target 150 queer individuals in Nigeria who menstruate, with purposive attention to diversity across gender identities, age, geographic location, and socio-economic background. The intended participants included transgender men, non-binary individuals, intersex persons, and queer women, including lesbians and bisexual women. The target age range focused on individuals aged 18 years and older, with attention to younger adults aged 15–20, acknowledging that while some participants fall within a younger age range, all were legally adults capable of providing informed consent. No participants under the age of 18 participated in this research, ensuring compliance with ethical guidelines regarding minors.

The study ultimately achieved a sample size of 149 participants for the quantitative survey. The difference of one participant from the intended sample size was due to data cleaning, which removed responses that were incomplete or did not meet eligibility criteria. Participants were drawn from diverse urban and semi-urban communities in Abuja, with deliberate efforts to include individuals from marginalized and low-income or low-literacy backgrounds.

● Eligibility criteria

- Menstruate, either currently or within the past 12 months.
- Self-identify as queer, including transgender men, non-binary individuals, intersex persons, or queer women.
- Be at least 18 years old at the time of participation.
- Be residents of Abuja.
- Be willing and able to provide informed consent.

In addition to community participants, 15 Key Informants (KIs) were engaged to provide contextual and institutional perspectives. These included healthcare providers involved in sexual and reproductive health services, SRHR advocates and feminist organizers working with queer populations, queer menstruators with leadership or peer-support experience, and leaders of community-based or queer-led organizations involved in advocacy, education, and service delivery. This combination of community voices and institutional expertise ensured that the research captured both lived realities and systemic enablers or barriers to menstrual health, dignity, and access to inclusive services.

The final age range of survey participants was 18–55 years, with the 15–20 age group representing young adults. This clarifies that no minors were included, while still capturing the experiences of younger adult menstruators who are legally capable of consenting to participate.

4.3 Ethical considerations

Given the nature of this study as a community-led, low-risk, non-clinical research activity focused on lived experiences and service access, formal institutional ethical approval was not required. The research did not involve clinical interventions, biomedical procedures, or the collection of highly sensitive personally identifiable data that would warrant review by a formal ethics board. Instead, it followed established community-based participatory research and safeguarding standards, ensuring that all ethical considerations were rigorously applied in practice.

Despite the absence of formal ethics board approval, the study fully adhered to ethical best practices throughout implementation. Participation was strictly voluntary, and informed consent was obtained from all participants using approaches tailored to their literacy levels, safety, and comfort, including written, verbal, and digital formats. Participants were clearly informed about the purpose of the study, how the data would be used (including for advocacy, policy engagement, and digital health innovation such as the RainbowCare App), potential risks and benefits, and their right to withdraw at any stage without consequence.

To ensure participant safety, no personally identifiable information was collected or published, and all data were anonymized, securely stored, and accessible only to authorized research personnel. The research team implemented a trauma-informed, do-no-harm approach during all engagements. Participants were not pressured to share sensitive experiences and were given the option to pause, skip questions, or withdraw entirely at any point. Emotional well-being was actively prioritized, and referrals to appropriate psychosocial and SRHR support services were provided where necessary.

Importantly, the study did not include participants under the age of 18, thereby eliminating the need for assent procedures or parental/guardian consent. All participants were consenting adults.

Ethical accountability was further strengthened through active engagement with queer-led organizations, SRHR advocates, and trusted community stakeholders, ensuring that the research remained respectful, context-sensitive, non-extractive, and directly beneficial to the communities involved.

Overall, while formal ethical approval was not required, the study was conducted in full alignment with international ethical principles for social research, prioritizing participant dignity, confidentiality, safety, and community ownership at every stage.

4.4 Limitations

This research faced several methodological and contextual limitations inherent in working with queer menstruators in Nigeria. Recruitment proved challenging due to the hidden and stigmatized nature of the population. Concerns about stigma, legal risks, and social exposure influenced some participants' willingness to participate or share openly, which may have introduced response bias. The study relied on purposive and snowball sampling, which, while effective for reaching a hard-to-access population, limited statistical generalizability and representativeness.

Geographic coverage was constrained by logistical, safety, and funding considerations, which meant that some regions were more accessible than others. Additionally, Nigeria's legal and political climate toward LGBTQ+ communities required careful attention to confidentiality and framing, to ensure participant safety and avoid unintended harm. Discussions of menstruation, stigma, and prior experiences occasionally elicited emotional distress, potentially affecting the depth of responses.

● How these challenges were mitigated

The study worked closely with trusted community networks for recruitment, implemented anonymous and confidential data collection through online surveys and secure virtual interviews, and adopted trauma-informed facilitation during qualitative sessions. A hybrid approach, combining online and limited in-person engagement, was used to balance accessibility with safety.

Despite these limitations, the study generated rich, context-specific insights into the menstrual health experiences of queer populations. While the findings cannot be interpreted as nationally representative prevalence estimates, they provide credible, community-informed, and policy-relevant evidence. Readers are encouraged to consider the results as reflective of the experiences of the study population and contexts, rather than as generalizable across all queer menstruators in Nigeria.

05

Result & Discussion

A triangulated, multiperspective evidence base—survey data from 149 queer menstruators woven together with the lived expertise of 15 key informants.

5.1 · Demographic profile
5.2 · Menstrual health experiences & the compounded burden
5.3 · Access to products, economic barriers & period poverty
5.4 · Healthcare access, discrimination & structural barriers
5.5 · Stigma, identity, community & psychosocial well-being
5.6 · Digital health: acceptability, design & trust
5.7 · Key informant stakeholder profile

This section presents a comprehensive analysis and discussion of findings from two complementary data sources: a quantitative and qualitative survey administered to 149 queer individuals who menstruate across Nigeria, and in-depth Key Informant Interviews (KIIs) conducted with 15 stakeholders representing healthcare providers, civil society leaders, community advocates, SRHR experts, and LBQ individuals with direct lived experience. Together, these sources provide a triangulated, multi-perspective evidence base that simultaneously captures the lived realities of queer menstruators and the systemic, institutional, and community forces that shape those realities. Findings are discussed thematically, addressing the study's three core research questions, with KII insights integrated throughout to deepen and contextualize the survey data.

5.1 Demographic profile

5.1.1 Survey sample

Of the 149 survey respondents, 148 (99.3%) confirmed voluntary participation, all (100%) were aged 18 years or older, and 148 (99.3%) reported active menstruation within the past six months. The age distribution was heavily concentrated among young adults: those aged 21–25 and 26–30 each comprised 34.9% of the sample (n = 52), making the 21–30 cohort 69.8% of respondents. Adolescents (15–20) represented 8.1% (n = 12), while respondents aged 31 and above accounted for 22.1%.

Cross-tabulation of age with menstrual difficulty indicates a clear age gradient: 91.7% of the 15–20 age group reported their menstrual experience as sometimes or very difficult, compared with 63.5% of 21–25-year-olds, 48.1% of 26–30-year-olds, and 28.6% of those aged 31–35. This pattern suggests that younger menstruators, who may be navigating puberty alongside emerging queer identities, experience higher physical and emotional burden.

Age group	% reporting difficult experience	n
15 – 20	**91.7%**	12
21 – 25	63.5%	52
26 – 30	48.1%	52
31 – 35	28.6%	21
36 – 40	50.0%	8
41 – 45	50.0%	2

Table 1 · Menstrual difficulty by age group — cross-tabulation.

These quantitative findings are supported by qualitative evidence. Intersex and LBQ participants described irregular cycles, severe pain, fatigue, and anxiety as particularly challenging in early adulthood. For example, an intersex participant explained that unpredictable menstruation "makes me confused and worried," while a queer woman reported needing to constantly plan her daily activities around heavy flow and pain. Community leaders also observed that adolescents face compounded vulnerability due to stigma, lack of privacy, and limited access to menstrual products.

While these results align with literature suggesting heightened menstrual distress among younger gender-diverse individuals (Arshed et al., 2024), interpretation should be cautious. The sample is purposely recruited and may overrepresent those already engaged with queer or SRHR networks. The cross-sectional survey captures self-reported experiences, which may be influenced by recall bias or social desirability. Nonetheless, the convergence of quantitative trends and KII narratives provides credible insight into age-related patterns of menstrual difficulty among queer menstruators in Nigeria.

5.1.2 Gender identity and sexual orientation

The survey captured a heterogeneous queer population: 40.9% (n=61) identified as cisgender women, 33.6% (n=50) as genderqueer, 11.4% (n=17) as non-binary, and 14.8% (n=22) as another identity. In terms of sexual orientation, lesbians were the largest group (57.0%, n=85), followed by queer (16.1%, n=24), bisexual (14.1%, n=21), pansexual (5.4%, n=8), and those preferring not to disclose (6.7%, n=10).

Cross-tabulation of gender identity with reported identity-related shame or anxiety during menstruation indicated a gradient: non-binary respondents experienced the highest level of shame (50.0%), followed by genderqueer (30.6%), cisgender women (23.0%), and participants with other identities (10.0%).

Identity-related shame and anxiety follows a clear gradient by gender identity

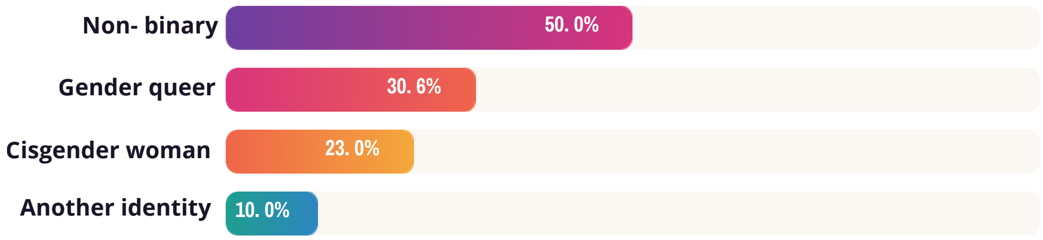


Table 2 · Share reporting identity-related shame or anxiety during menstruation (yes/sometimes), by gender identity.

These quantitative trends are supported by qualitative interviews: healthcare providers noted that non-binary and genderqueer menstruators often face misunderstanding or judgment in clinical settings, while community leaders described social pressures and stigma that intensify anxiety for those whose bodies and identities fall outside normative gender expectations. For instance, one intersex participant reported feeling "ashamed sometimes because people expect all women to be the same," reflecting how social and institutional cues reinforce internalized stress.

While these findings suggest a pattern of greater identity-related anxiety among non-binary and genderqueer menstruators, interpretation should be cautious. The sample was purposively recruited from networks engaged with queer and SRHR initiatives, which may limit generalizability. Self-reported measures of shame may also be influenced by social desirability or recall bias. Nevertheless, the convergence of survey and KII data aligns with literature indicating that gender-diverse menstruators face higher psychosocial burden, stigma, and barriers to supportive care (e.g., Jones et al., 2022; Arshed et al., 2024).

5.2 Menstrual health experiences: the compounded burden

5.2.1 Overall menstrual experience

Among survey respondents, 45.6% (n=68) described their menstrual experience as mostly manageable, 40.3% (n=60) as sometimes difficult, and 13.4% (n=20) as very difficult, resulting in an aggregate reported difficulty rate of 53.7%. This proportion is higher than population-level estimates for cisgender Nigerian women (Shomuyiwa et al., 2024), indicating that queer menstruators may experience a comparatively greater burden of menstrual distress.

KII testimony corroborated these patterns and provided deeper insight into lived experiences. One LBQ participant described her menstrual experience as physically debilitating, noting that on the worst days she could not get out of bed, could not complete basic household chores, and performed only minimal tasks at work due to pain and fatigue. Another informant reflected on the compounded challenges of previous hormonal dysfunction, which had previously prevented regular menstruation; she now experiences excruciating pain, mood swings, and cravings, but moderates her complaints consciously, aware of what it means not to menstruate at all. A third participant highlighted the physically draining nature of her cycles, citing fatigue, body aches, migraines, and mood disruption that interfere with daily productivity and professional responsibilities. These experiences align with Favour Chinedu's KII account, where prescribed hormonal interventions were required to induce menstruation, highlighting structural gaps in the Nigerian health system's capacity to provide queer-affirming menstrual care.

The convergence of survey and KII findings suggests that queer menstruators in Nigeria face multi-layered challenges, including physical, emotional, and occupational impacts. While these data indicate elevated menstrual difficulty, caution is warranted: the sample was purposively recruited and may over-represent those experiencing significant menstrual distress. Nonetheless, the pattern resonates with existing literature showing that gender-diverse adolescents and adults often report intensified menstrual symptoms and barriers to care (Arshed et al., 2024; Jones et al., 2022). These findings underscore the need for responsive, inclusive, and accessible menstrual health services that account for the unique physiology and social realities of queer populations.

> *"On the worst days she could not get out of bed, could not complete basic chores, and performed only minimal tasks at work due to pain and fatigue.*
>
> LBQ KEY INFORMANT · LIVED EXPERIENCE

5.2.2 Symptom burden: the primacy of emotional distress

Survey results indicate that emotional distress was the most frequently reported menstrual symptom, affecting 62.4% of respondents (n=93). This was followed by severe physical pain (58.4%, n=87), heavy bleeding (36.9%, n=55), and gender dysphoria (4.0%, n=6). Only 8.7% (n=13) reported no symptoms. The prominence of emotional distress over physical symptoms highlights the psychosocial dimension of menstruation for queer populations.

Symptom	n	%	Rank
Emotional distress	93	**62.4%**	1st
Severe pain	87	58.4%	2nd
Heavy bleeding	55	36.9%	3rd
All of the above	10	6.7%	—
Gender dysphoria	6	4.0%	4th
None of the above	13	8.7%	—

Table 3 · Symptoms experienced during menstruation (multiple responses permitted, N=148).

KII findings provide rich context for these patterns. The CSO Executive Director described how community dialogues created safe spaces in which women and young people revealed years of emotional suffering previously endured in silence, reflecting the structural pressures that exacerbate distress. The senior nurse/matron recounted a case where a young woman's irregular periods provoked family blame; the greatest relief for the patient was relational—being believed and not judged—emphasizing that emotional support is a critical component of menstrual care.

LBQ participants consistently described the dual burden of physical discomfort and emotional strain. One participant detailed how she endured severe pain while concealing her distress at work to avoid drawing attention, experiencing this as both exhausting and dehumanising. Another noted that menstrual-related mood shifts were intensified when combined with other life stressors, aligning with Arshed et al.'s (2024) findings that gender-minority stress amplifies psychosocial menstrual impacts. The intersex informant highlighted the emotional toll of unpredictable menstruation, expressing fear and confusion due to irregular cycles and a lack of reference points in social or health narratives.

These findings are consistent with Minority Stress Theory (Meyer, 2003; Logie et al., 2018), which posits that LGBTQ+ individuals experience chronic psychosocial stress from stigma and discrimination, stress that compounds biological processes such as menstruation. The integration of survey and KII data suggests that for queer and intersex menstruators in Nigeria, emotional distress is not merely a symptom but an emergent consequence of intersecting social, familial, and institutional pressures. Caution is warranted in generalizing these results beyond the study sample, which is purposively recruited; however, the findings align with international evidence that psychosocial dimensions of menstruation are heightened for gender-diverse populations (Arshed et al., 2024; Jones et al., 2022).

5.2.3 Physical symptom burden and functional impairment

Quantitative data from the survey indicate that physical symptoms are highly prevalent among queer menstruators in this sample: 58.4% (n=87) reported severe pain, and 36.9% (n=55) reported heavy bleeding. These findings suggest that functional impairment due to menstrual biology is a common experience, potentially affecting daily activities and productivity.

KII data provide concrete illustrations of these physical challenges. One LBQ participant described menstrual flow so heavy that it caused brain fog and made it difficult to concentrate at work, while also requiring constant vigilance over clothing choices to avoid public soiling—an exhausting compromise of professional functioning and personal dignity. Another participant detailed cramps so severe they radiated through her legs, leaving her homebound on certain days.

From a clinical perspective, the medical doctor KII participant corroborated these patterns, noting that menorrhagia, dysmenorrhea, and stress-related menstrual disruption are the most frequent presentations among queer women seeking care. He highlighted the structural and institutional dimensions of these impairments: in one case, a queer woman in her early thirties who had not menstruated for over six months was misdiagnosed at a prior facility as having a “spiritual” condition, delaying appropriate hormonal and psychological intervention, exacerbating anxiety, and reinforcing distrust of the health system.

These qualitative accounts contextualize the survey findings, illustrating how physical symptoms translate into functional impairment and compounding psychosocial stress. The results align with prior research showing that dysmenorrhea, menorrhagia, and cycle irregularities are major contributors to activity limitation among adolescent and adult menstruators (Shomuyiwa et al., 2024; Arshed et al., 2024). In queer populations, these impairments are further complicated by social stigma and prior negative healthcare experiences, consistent with Minority Stress Theory (Meyer, 2003; Logie et al., 2018).

5.2.4 Gender dysphoria and the body-identity conflict

Quantitative findings show that 4.0% (n=6) of survey respondents explicitly reported gender dysphoria as a menstrual symptom. However, this figure likely underestimates the true prevalence, as many participants expressed dysphoric experiences in non-clinical language—for example, stating “I wish it didn’t exist,” “I don’t want it at all,” or “I bleed every month just because I refuse to get pregnant.” These expressions reflect significant distress and disconnection from their menstrual experiences that may not be captured in formal survey coding.

KII data provide deeper insight into this dysphoric dimension. The intersex informant described her body as fundamentally alien to existing menstrual health frameworks, producing a sense of menstruation as socially unrecognised and institutionally invisible. She articulated that her bodily experience did not fit any known clinical or educational narrative, highlighting structural gaps in menstrual health provision. The CSO Executive Director described a trans man in her network who found it profoundly distressing to purchase sanitary pads because social assumptions about gender identity made a routine task a source of anxiety—a small but illustrative example of how everyday environments can amplify menstrual-related dysphoria.

These qualitative accounts suggest that dysphoria during menstruation is broader and more pervasive than the 4.0% quantitative figure indicates. This aligns with research by Schwartz et al. (2023, cited in Arshed et al., 2024), who reported that 93% of transgender adolescents experienced menstrual-related dysphoria. While caution is needed in extrapolating these findings to all queer populations in Nigeria, the combined survey and KII data suggest that gendered distress linked to menstruation is a salient component of the queer menstrual experience and interacts closely with social stigma, institutional invisibility, and bodily nonconformity.

5.2.5 Comfort in public and shared spaces

Survey results indicate that 48.3% (n≈72) of respondents reported feeling only sometimes comfortable managing menstruation in public or shared spaces, 30.2% (n≈45) felt comfortable, and 20.8% (n≈31) reported being uncomfortable. Disaggregating by gender identity, 73.1% of genderqueer and non-binary respondents reported at least intermittent discomfort, highlighting a heightened vulnerability within gender-nonconforming populations.

KII data help contextualize these findings. LBQ informant Bogofanyo Jonah described avoiding leaving the house on her heaviest days, citing both pain and anxiety over checking herself, compounded by inadequate public facilities. A community leader recounted that in a 2022 project in Kaduna, over 30% of schoolgirls missed classes due to menstruation and poor facilities—a pattern mirrored in the survey's adolescent respondents. The senior nurse/matron emphasised that poor maintenance of public sanitation infrastructure is a systemic issue affecting all menstruators, but queer individuals face additional risks due to exposure in gendered washroom spaces.

These findings suggest that discomfort in public menstrual management is not only a matter of individual coping but also a structural issue, intensified for gender-nonconforming individuals. The binary design of Nigerian public sanitation facilities and social surveillance mechanisms renders safe and dignified menstrual management particularly challenging for queer people. This aligns with Rowan et al. (2023), who found that transgender and non-binary individuals face systematic exclusion from mainstream WASH infrastructure. While these data provide strong indications of structural barriers, interpretation should remain cautious given the limited sample size and potential variation across regions.

5.3 Access to products, economic barriers, and period poverty

5.3.1 Product use and affordability

Survey data indicate that sanitary pads were the predominant menstrual product, used by 92.6% (n=138) of respondents. Despite this high uptake, 16.1% (n=24) reported difficulty obtaining products, revealing that product availability does not fully translate into reliable access. Qualitative survey responses highlighted coping strategies such as using baby diapers on heavy-flow days or prioritising pads over other essentials like food or pain relief, underscoring the economic trade-offs faced by menstruators.

Menstrual product	n	%
Pads	138	**92.6%**
Tampons	17	11. 4 %
Combination	5	3.4%
Cloth	4	2.7%
Menstrual cup	1	0.7%

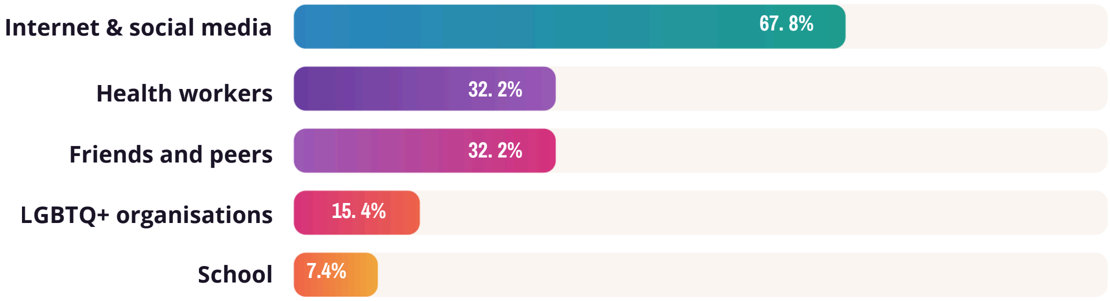
Table 4 · Menstrual products used by respondents (multiple responses permitted, N=148).

KII data provide deeper context to these challenges. One of the CSO Executive Directors described young women forced to choose between purchasing food or sanitary pads, illustrating the dignity costs imposed by economic precarity. A community leader shared a 2023 programme in Kano State that provided affordable reusable pads to over 400 adolescent girls, showing how targeted interventions can partially mitigate access barriers. LBQ informant Bogofanyo Jonah emphasized that even when products are technically available, quality and affordability remain limiting factors, particularly for those with sensitivities or preferences for specific brands.

These findings suggest that while sanitary pads are widely used, consistent and affordable access remains constrained for a meaningful minority, with economic, quality, and supply factors interacting to limit effective menstrual management. KII testimonies underscore that product access is both a material and a structural issue, shaped by pricing, policy, and social inequities. This aligns with Shomuyiwa et al. (2024), who identified fiscal interventions—such as VAT reduction and subsidised distribution—as effective strategies to improve menstrual product access in low- and middle-income country contexts. Caution is warranted in generalising these findings nationally, given the purposive sampling and localized qualitative insights.

5.3.2 Information-seeking and digital health behaviour

The Internet and social media were the dominant source of menstrual health information for 67.8% of survey respondents (n=101), followed by health workers (32.2%), friends and peers (32.2%), LGBTQ+ organisations (15.4%), and school (7.4%). This digital information-seeking dominance reflects a rational adaptive strategy within a healthcare system broadly hostile to queer identities. The medical doctor KII informant acknowledged this dynamic explicitly, noting that many queer women he works with report years of previously ignored or mismanaged menstrual conditions, conditions that had been self-managed largely through online information because formal care had failed them. The senior nurse observed that digital tools offering early information access could help queer women recognise when symptoms warrant clinical attention and seek care earlier than they would without such guidance, reducing the escalation of untreated conditions.



Primary sources of menstrual health information (multiple responses permitted, N=149).

Reproductive rights and mental health practitioners among the KII informants highlighted that online information ecosystems for queer health in Nigeria are simultaneously life-saving and unreliable: while they provide a confidential space for identity-affirming health seeking, they are unregulated, algorithmically shaped, and frequently populated with content oriented toward heterosexual cisgender audiences that does not address the specific physiological and psychosocial dimensions of queer menstrual experience. This reinforces the case for purpose-built, evidence-based, queer-inclusive digital health tools, an argument that the 83.9% of survey respondents willing to use a private digital health tool makes resoundingly empirical.

5.4 Healthcare access, discrimination, and structural barriers

5.4.1 Healthcare avoidance: a rational response to structural hostility

Quantitative survey data indicate that 22.1% (n=33) of respondents reported having avoided a health facility because of their queer or non-binary identity. While this represents roughly one in five participants, the figure gains further significance when interpreted alongside qualitative evidence, which highlights the concrete experiences driving such avoidance.

KII participants provided detailed accounts illustrating the rationale behind facility avoidance. The intersex informant described a formative encounter in her early twenties in which a clinic staff questioned her mother judgmentally about her irregular menstruation, prompting her permanent withdrawal from care. A medical doctor corroborated this pattern, recounting that a queer patient with irregular bleeding was mocked by lab personnel regarding her sexual orientation, discouraging her from follow-up care despite ongoing symptoms. Similarly, a senior nurse recounted intervening when a junior staff member laughed at a patient for not conforming to feminine expectations, highlighting that breaches of dignity can occur at multiple levels of clinical interaction and that institutional safeguards are often absent.

These findings suggest that healthcare avoidance among queer menstruators is not random but reflects anticipated or previously experienced stigma, misgendering, and confidentiality breaches. The pattern aligns with Jessani et al. (2024), who found that fear of provider discrimination is a leading cause of healthcare avoidance among transgender and gender-diverse individuals in Africa. In Nigeria, legal and policy contexts—such as the SSMPA—further compound this risk by offering no formal protection for queer patients, a reality echoed by TIERS' (2024) documentation of 556 reported rights violations in a single reporting period. While the survey quantifies avoidance, KII narratives reveal its deep psychosocial and clinical consequences, underscoring the need for structural interventions rather than solely individual-level education or sensitisation programs.

5.4.2 Discrimination within healthcare facilities

Survey data indicate that among respondents who attended health facilities, 40.3% reported experiencing at least one form of discrimination. Specific experiences included judgmental comments (29.5%, n=44), misgendering (12.1%, n=18), breaches of confidentiality (4.7%, n=7), and refusal of care (2.0%, n=3). Cross-tabulation suggests a directional relationship: among the 33 respondents who had previously avoided facilities, 72.7% reported having encountered discrimination during prior visits, highlighting a likely feedback loop between exposure to stigma and avoidance behavior.

Experience in health facility	n	%	Also avoided facility
None	89	59.7%	9 (10.1%)
Judgmental comments	44	29.5%	15 (34.1%)
Misgendering	18	12.1%	7 (38.9%)
Breach of confidentiality	7	4.7%	4 (57.1%)
Refusal of care	3	2.0%	**3 (100%)**

Table 5 · Healthcare discrimination experiences and facility avoidance — cross-tabulation (N=148).

Key Informant Interviews provide critical context for these quantitative patterns. The medical doctor highlighted that formal medical training in Nigeria rarely includes LGBTQ+ or intersex health content, a gap echoed by a 2024 national assessment of psychology curricula (Springer, 2024) showing that sexual and gender diversity is primarily addressed pathologically rather than affirmatively. The senior nurse identified structural enablers of discrimination, including staff bias, absence of institutional guidelines, and fear of management repercussions. Both healthcare provider informants emphasised that despite personal motivation to provide affirming care, systemic constraints—binary intake forms, gendered ward layouts, and overcrowded public facilities—limited their ability to deliver culturally competent services.

The LBQ KII participant, Bogofanyo Jonah, offered a first-person account of structural harm even in the absence of overt discrimination. She described clinical encounters where heteronormative assumptions dominated care: questions, tests, and procedures were framed exclusively for heterosexual women, with no attention to her sexual or reproductive context. To access services, she reported needing to "pocket" her LGBTQIA identity entirely—a form of institutionalised self-erasure that compounds emotional and psychosocial harm.

These findings suggest that discrimination in health facilities is both overt (judgmental comments, misgendering) and subtle (heteronormative structuring of care), consistent with minority stress frameworks (Meyer, 2003; Logie et al., 2018), which link chronic exposure to stigma and microaggressions with adverse psychosocial outcomes. This aligns with Jessani et al. (2024), who reported that provider bias and institutional gaps are primary barriers to care for transgender and gender-diverse populations in Africa. While the survey quantifies exposure to discrimination, KII narratives illuminate its structural and relational roots, underscoring that interventions must address systemic reform in addition to individual training.

> *"To access services, she reported needing to "pocket" her LGBTQIA identity entirely—a form of institutionalised selferasure that compounds emotional and psychosocial harm.*
>
> BOGOFANYO JONAH · LBQ KEY INFORMANT

5.4.3 Safety in clinical communication

Survey results indicate that 63.8% of respondents felt safe discussing menstruation with a healthcare provider, while 35.6% reported experiencing at best conditional safety, suggesting that over one-third of the sample navigate environments where disclosure is context-dependent.

Key Informant Interviews provide insight into the structural roots of this conditionality. The LBQ informant Azeezat Abdulsalam described encounters in which heteronormative questioning—assumptions about sexual activity, reproductive goals, and relationship structures—felt invalidating, discouraging full openness. She noted that fear of discrimination or breaches of confidentiality made her cautious, particularly in facilities lacking LGBTQ+ knowledge. The medical doctor corroborated that while his facility strives for inclusion through practices like using chosen names and focusing on anatomy rather than gender assumptions, institutional systems—including gendered intake forms and ward structures—remain rigidly binary. As a result, inclusive practice is often dependent on individual providers rather than embedded in organizational structures.

A mental health practitioner KII participant further highlighted the clinical implications: patients who manage disclosure strategically often share filtered narratives, limiting the provider's understanding of psychosocial contexts essential for accurate diagnosis and effective treatment. This is particularly consequential for conditions such as stress-related menstrual disruption, which the medical doctor identified as common among queer patients.

These findings suggest that perceived safety in healthcare interactions is structurally mediated rather than solely individual. Conditional safety may result in incomplete clinical disclosure, diagnostic gaps, and suboptimal care—outcomes consistent with Minority Stress Theory (Meyer, 2003; Logie et al., 2018), which links structural stigma and psychosocial stress to health inequities. This echoes patterns observed in African contexts, where institutional rigidity and provider bias constrain affirming care for gender-diverse populations (Jessani et al., 2024). While a majority report feeling safe, the significant minority experiencing conditional safety underscores the need for systemic reforms rather than reliance on individual provider discretion.

5.5 Stigma, identity, community, and psychosocial wellbeing

5.5.1 Cultural and religious stigma

Survey results indicated that 26.9% of respondents experienced at least some identity-related shame or anxiety about menstruation, highlighting a substantial minority for whom menstrual management is emotionally and socially burdensome.

Key Informant Interviews contextualize the cultural and institutional roots of this shame. A community leader working across northern Nigerian states described menstruation as largely shrouded in secrecy and tied to notions of purity and morality, often discussed only privately among women and girls. In many households, menstruating girls are instructed to avoid cooking, praying, or participating in social activities. Certain traditional beliefs, such as prohibiting menstruating women from touching water sources, directly impede daily functioning and dignified menstrual management.

The CSO Executive Director provided a complementary perspective, noting that menstrual stigma is reinforced institutionally through gaps in education: many students first learn about menstruation only when they experience it, as teachers often avoid comprehensive menstrual health education due to personal discomfort. Religious and traditional authorities further shape menstrual norms; however, the same actors can act as allies—she cited a case in Kano where imams encouraged parents to allow menstruating girls to attend school, improving attendance by an estimated 20%.

These findings suggest that identity-related shame is not solely an individual psychological experience but is socially and culturally produced through secrecy, misinformation, and gendered moral codes. This aligns with existing literature on menstrual stigma in conservative contexts (Chandra-Mouli et al., 2019; Sommer et al., 2021), which identifies structural, educational, and religious influences as key determinants of shame and anxiety. While only about one-quarter of survey respondents reported shame, qualitative evidence indicates that this figure may underrepresent the subtle, socially mediated pressure experienced by many queer menstruators, for whom cultural and familial norms amplify both psychological and practical challenges in managing menstruation.

5.5.2 Identity-related shame: the queer dimension

Quantitative survey data indicate that identity-related shame is unevenly distributed across gender identities. Non-binary respondents reported the highest rate of shame (50.0%), followed by genderqueer respondents (30.6%) and cisgender women (23.0%). This gradient suggests that gender-nonconforming individuals experience a disproportionate burden of menstrual-related identity stress.

Key Informant Interviews provide nuanced understanding of the mechanisms producing this shame. The LBQ informant Bogofanyo Jonah recounted a colleague who, upon learning her sexual orientation, remarked, “What do I need a period for if I know I am going to end up with a woman?” and asked intrusive questions. This illustrates a social logic that frames menstruation and lesbian identity as incompatible, producing both identity invalidation and biological erasure. Similarly, the LBQ informant Azeezat Abdulsalam described recurrent assumptions that menstrual health is irrelevant to her because she does not have relationships with men, a form of social invalidation that renders queer menstrual healthcare needs invisible.

The intersex KII participant highlighted an additional, medically produced dimension of shame. Subjected to non-consensual medical interventions in childhood, she was left with enduring distrust of healthcare systems and a sense of disempowerment over her own body. This aligns with literature documenting intersex individuals’ heightened vulnerability to human rights violations and lifelong medical trauma (Carpenter, 2016), demonstrating that identity-specific shame can be socially and institutionally mediated.

> *“Subjected to nonconsensual medical interventions in childhood, she was left with enduring distrust of healthcare systems and a sense of disempowerment over her own body.*
>
> INTERSEX KEY INFORMANT

These findings suggest that identity-related shame for queer menstruators is not merely a product of cultural stigma but operates through intersecting social and medical mechanisms. The quantitative patterns observed are reinforced by qualitative accounts, which illustrate how heteronormative assumptions, social invalidation, and medicalized interventions collectively shape lived experiences of shame. Caution is warranted in generalizing these findings to all queer menstruators in Nigeria, but they are consistent with literature highlighting that non-binary, genderqueer, and intersex individuals face compounded psychosocial and institutional pressures around menstruation (Schwartz et al., 2023; Carpenter, 2016).

5.5.3 Community support: protective but fragile

Quantitative survey results indicate that just over half of respondents (51.7%) felt consistently supported by their communities during menstruation, while 47.6% experienced at least intermittent lack of support. This suggests that community support for queer menstruators is uneven and often conditional.

Key Informant Interviews add depth to this quantitative finding. The CSO Executive Director highlighted that queer community networks function as crucial support systems for those unable to access formal care, offering both emotional reassurance and practical health information.

However, these networks are fragile, operating largely online, informally, and under persistent legal and social threat, which limits their reach and sustainability. The community leader described safe dialogue spaces that have enhanced young people's willingness to seek support, but also noted that in more conservative areas, even establishing such spaces is contested.

Among LBQ informants, support was contingent on disclosure and social context. Ellen Igewemba noted that while she now feels relatively comfortable managing menstruation, broader social attitudes outside her immediate family environment remain judgmental or uncomfortable. Favour Chinedu articulated a preference for queer-specific healthcare spaces, staffed by queer-aware personnel or dedicated clinics, where she could fully express her health needs without fear—an aspiration echoed by multiple KII participants. This aligns with survey data showing that 83.9% of respondents expressed willingness to use private digital health tools, suggesting strong demand for identity-affirming health infrastructure.

These findings suggest that while community networks can buffer queer menstruators from social and health-related marginalization, support remains inconsistent and context-dependent. Conditional or fragile support networks, especially in legal and social environments hostile to LGBTQ+ identities, can leave gaps in care and exacerbate isolation. This observation is consistent with Minority Stress Theory (Meyer, 2003; Logie et al., 2018), which emphasizes that psychosocial support moderates the impacts of stigma but cannot fully counter structural stressors. The expressed preference for queer-specific or digital health solutions resonates with emerging literature on identity-affirming health innovations in low-resource and legally restrictive settings (Rowan et al., 2023).

5.6 Digital health: acceptability, design, and trust

5.6.1 The case for digital health tools

Survey data show that a substantial majority of respondents (83.9%, n=125) expressed willingness to use a private digital menstrual health tool. This high level of interest suggests a strong demand for alternative, potentially safer channels of accessing menstrual and broader sexual and reproductive health (SRHR) support.

Key Informant Interviews consistently reinforced this finding across stakeholder groups. The medical doctor described digital tools as offering discreet appointment booking, menstrual tracking—particularly for irregular cycles—SRHR education, referrals to queer-friendly providers, and mental health support, especially for individuals reluctant to seek in-person care. The senior nurse similarly noted that digital platforms could enable users to monitor symptoms, access reliable information, and seek early guidance in a private and reassuring manner, potentially reducing delayed care-seeking and emergency presentations commonly observed in clinical settings.

From a systems perspective, the CSO Executive Director framed digital health tools as critical infrastructure in contexts where formal services remain inaccessible or unsafe for queer populations. She emphasized that for queer and trans menstruators facing layered stigma, a secure digital space may represent one of the few viable entry points into the health system without immediate identity-related risk.

These findings suggest that digital platforms are widely perceived as acceptable and potentially useful among queer menstruators in this sample.

● **A note of caution**

Willingness to use such tools should be interpreted carefully: expressed interest does not necessarily translate into sustained usage or equitable access, particularly in settings shaped by digital divides, data privacy concerns, and varying levels of digital literacy (Agarwal et al., 2015; Rowan et al., 2023).

. Existing literature supports the growing role of digital health interventions in expanding access to SRHR information and services in low-resource and restrictive contexts (Agarwal et al., 2015; Rowan et al., 2023), while also highlighting the importance of trust, confidentiality, and user-centered design.

5.6.2 Feature Priorities: Clinical and Community Evidence

Survey findings identified five priority features for a digital menstrual health tool: period tracking (70.5%), pain management tips (56.4%), mental health support (50.3%), queer-specific information (44.3%), and anonymous chat functionality (31.5%). These preferences indicate a demand for tools that combine clinical utility, psychosocial support, and identity-affirming content.

Desired app features: survey demand, KII validation, and clinical priority

Feature	Survey %	KII validation	Clinical priority
Period tracking	70.5%	All provider & community informants	High — irregular cycles prevalent
Pain management	56.4%	Doctor, nurse informants	High — 58.4% report severe pain
Mental health support	50.3%	MH practitioners, CSO lead	Critical — 62.4% emotional distress
Queer-specific info	44.3%	CSO lead, advocates, LBQ informants	High — content gap in all apps
Anonymous chat	31.5%	All informants cited safety need	High — criminalized context
Emergency support	26.8%	Rights advocates, digital practitioners	High — safety threats documented

Table 6 · Desired app features — survey demand, KII validation, and clinical priority mapping.

Key Informant Interviews provided important context for these preferences. Mental health practitioners and a reproductive rights lawyer emphasized that the demand for mental health support should be understood within the psychosocial complexity of queer menstrual experiences, recommending trauma-informed design and clear referral pathways to queer-affirming counselling services. The medical doctor further highlighted the need for tracking functionality that accommodates complex menstrual conditions such as PCOS and endometriosis, which were frequently referenced in both survey responses and qualitative accounts, yet remain insufficiently addressed within existing care pathways for queer patients.

Civil society and digital health informants underscored the significance of queer-specific information. The CSO Executive Director noted that most menstrual health programming in Nigeria assumes a cisgender female user, effectively excluding trans men, intersex persons, and gender-diverse individuals. Digital health practitioners observed that this exclusion is replicated in existing menstrual tracking applications, which are typically designed around heteronormative and cisnormative assumptions, including language and features oriented toward heterosexual reproduction.

These findings suggest that user preferences extend beyond basic menstrual tracking to encompass integrated, identity-affirming, and psychosocially responsive features. However, the relative prioritization of features should be interpreted cautiously, as expressed preferences may reflect immediate perceived needs rather than long-term usage patterns or feasibility constraints. The observed demand for inclusive design aligns with emerging evidence that mainstream digital health tools often inadequately serve gender-diverse populations (Akbar et al., 2025), highlighting a gap between available technologies and user needs.

5.6.3 Trust architecture: privacy, ownership, and safety by design

Survey respondents provided sophisticated qualitative accounts of trust determinants for digital health tools, coalescing around five themes: data privacy and confidentiality, medical accuracy, queer identity affirmation, anonymity and discreet design, and community or peer credibility. KII informants elaborated on each of these dimensions from their respective professional and experiential positions.

The medical doctor and nurse informants both identified data encryption, anonymous user options, minimal data collection, and clear consent processes as non-negotiable technical safeguards, particularly given the criminalization and stigma around queer identities in Nigeria. The reproductive rights lawyer among the KII informants specifically flagged the legal exposure created by health app data under Nigeria's current legal framework: any personally identifiable data connecting a user to LGBTQ+ identity could potentially be used against them under the SSMPA, making truly anonymous use architecturally essential rather than optional. This contextualises one survey respondent's articulation of a comprehensive safety design, requesting a passcode, neutral app icon, and user-controlled discreet notifications, as not merely a preference but a physical safety requirement in a context where a visible LGBTQ+-branded app on a phone screen may constitute a disclosure risk.

> *"Communities will trust tools built by people who actually understand them—who have lived the experience of navigating queer identity in a hostile health system in Nigeria.*
>
> **CSO EXECUTIVE DIRECTOR**

Community ownership and lived-experience credibility emerged powerfully from KII informants as a trust prerequisite. The CSO Executive Director expressed that communities will trust tools built by people who actually understand them, who have lived the experience of navigating queer identity in a hostile health system in Nigeria. The LBQ informants consistently expressed preference for a tool that was queer-owned, queer-designed, and built with knowledge of their specific context. This community ownership imperative is consistent with the NPJ Digital Medicine (2025) systematic review finding that community co-design is the strongest predictor of mHealth app trust and uptake among transgender and gender-diverse individuals, evidence that directly supports the participatory co-design model proposed for the RainbowCare App.

Mental health practitioners among the KII informants added a clinical dimension to trust architecture: the app's mental health support module must be designed to recognise the limits of digital support and include robust referral pathways to queer-affirming human practitioners. One mental health informant cautioned that digital mental health tools for queer populations in criminalized contexts face a particular challenge, they must be supportive enough to provide genuine assistance while transparent enough about their limitations to prevent users from substituting digital interaction for professional care they urgently need. This balance, affirming, accessible, and appropriately bounded, should guide the mental health design philosophy of the RainbowCare App.

5.7 Key Informant Interview stakeholder profile

A total of 15 Key Informant Interviews (KIIs) were conducted in February 2026, primarily via virtual platforms, with an average duration of approximately 43 minutes. The KIIs were purposively selected to capture diverse perspectives relevant to queer menstrual health in Nigeria, including institutional, advocacy, and lived-experience viewpoints.

Healthcare providers

A medical doctor specializing in SRHR and a senior matron with nearly three decades of experience offered insights on service delivery challenges, gender-inclusive care, and systemic barriers.

Civil society & advocacy

A queer-inclusive CSO Executive Director, a community leader active in northern states, and additional SRHR advocates and queer-led organisation leads contributed perspectives on policy, community mobilisation, and digital health interventions.

Lived experience

Several LBQ individuals, including one intersex participant, provided first-person accounts of navigating menstruation amid social stigma, economic constraints, and gaps in healthcare.

Other professionals

Peer educators, mental health practitioners, reproductive rights lawyers, and digital health practitioners added further context on mental well-being, legal risks, and inclusive platform design.

Key insights across stakeholder groups

- **Menstrual experience and identity:** Many informants described irregular or medically complex menstruation as compounding stress, particularly for intersex and non-binary individuals. One intersex participant reported feeling “ashamed sometimes because people expect all women to be the same,” echoing survey findings that 50% of non-binary respondents reported identity-related shame.
- **Healthcare access and stigma:** Providers highlighted that queer and gender-diverse menstruators often encounter bias, heteronormative assumptions, and lack of privacy, which aligns with survey trends showing higher anxiety among genderqueer and non-binary participants. Several KIIs described experiences where judgmental clinical interactions delayed care, contributing to distrust.
- **Socio-economic constraints:** Informants emphasized that financial barriers to menstrual products and medical care disproportionately affect marginalized queer individuals, reinforcing the survey’s observation that irregular menstruation often entails higher costs.
- **Community and policy gaps:** Advocates noted that social taboos, restrictive cultural norms, and lack of gender-inclusive policies limit access to education, facilities, and supportive services, corroborating both survey and literature evidence on structural barriers to menstrual health for queer populations (Jones et al., 2022; Arshed et al., 2024).
- **Coping and support networks:** Many participants relied on peer groups, queer-friendly CSOs, and digital platforms to navigate menstruation safely, reflecting the importance of community-based support highlighted in both KIIs and survey responses.

Interpretation & caution: The qualitative data enrich the quantitative survey findings, providing explanatory context for patterns observed in shame, menstrual difficulty, and healthcare access. However, the insights should be interpreted cautiously: KIIs were purposely selected and not representative of all queer populations in Nigeria, and responses may reflect recall bias or willingness to disclose sensitive experiences. Despite these limitations, the findings underscore consistent themes reported in the literature: gender-diverse menstruators experience compounded psychosocial and structural challenges, heightened stigma, and gaps in inclusive service provision (Arshed et al., 2024; Jones et al., 2022).

06

Conclusion

Menstrual health for queer Nigerians is not merely a biological concern—it is a multidimensional human rights issue, and its neglect is an ongoing violation that this evidence base is positioned to address.

This study represents the first largescale, multimethod, queerinclusive menstrual health investigation conducted in Nigeria—combining survey data from 149 queer menstruators with indepth interviews from 15 stakeholders spanning healthcare, civil society, advocacy, and lived experience.

Its findings demonstrate with compelling force that menstrual health is not merely a biological or hygiene concern for queer individuals in Nigeria, it is a multidimensional human rights issue constituted by the intersection of identity, stigma, structural exclusion, economic deprivation, and a criminalized social environment.

Three major analytical conclusions emerge from the triangulated data.

First — a compounded health burden

Queer menstruators in Nigeria carry a compounded health burden that is qualitatively and quantitatively distinct from the menstrual health challenges documented in cisgender female populations. Emotional distress (62.4%) emerged as the dominant symptom, exceeding severe physical pain (58.4%), reflecting the psychosocial overlay of minority stress, gender dysphoria, identity-based stigma, and social isolation that characterises the menstrual experience of queer individuals in a criminalized context. KII testimony from healthcare providers, community leaders, CSO workers, and LBQ individuals alike consistently confirmed this primacy of emotional burden, with clinical cases of spiritual misdiagnosis of hormonal conditions, community accounts of silencing and shame, and first-person narratives of debilitating pain managed in isolation and without clinical acknowledgement. The pronounced gradient of identity-related shame between non-binary (50.0%), genderqueer (30.6%), and cisgender (23.0%) respondents confirms that gender nonconformity is independently a risk factor for menstrual health distress, through mechanisms including dysphoria, social alienation, and the absence of body-affirming clinical frameworks (Arshed et al., 2024).

Second — the healthcare system as a barrier

The healthcare system, as currently constituted, functions as a barrier rather than a resource for the majority of queer menstruators. Over one in five respondents (22.1%) had avoided a health facility due to identity; over 40% had experienced discrimination; and 35.6% felt at best conditionally safe in clinical communication. KII data from both provider and patient informants illuminated the institutional roots and human costs of this failure: a single discriminatory clinical encounter producing years of hospital avoidance; queer healthcare professionals erasing their own identities to access routine care; trans men unable to purchase menstrual products without being publicly questioned; and intersex individuals subjected to non-consensual childhood medical interventions that permanently shaped their relationship to healthcare and to their own bodies. The recently validated National Policy on Menstrual Health and Hygiene Management (Nigeria Health Watch, 2025) is a historic development but is silent on gender-diverse menstruators, a critical omission that this study's evidence base is uniquely positioned to address.

Third — digital health as the near-term pathway

Digital health tools represent the most viable near-term pathway to bridging the menstrual health gap for queer individuals in Nigeria. The 83.9% survey demand for a private digital tool, the 67.8% already using the internet as their primary health information source, and the unanimous KII endorsement of digital approaches across all stakeholder categories together constitute one of the study's most policy-actionable findings. The feature demands identified, period tracking, pain management, mental health support, queer-specific content, anonymous chat, and emergency support, form a clinically coherent, rights-based service package that no existing app currently provides. Trust in such a tool is conditioned on privacy, community ownership, medical accuracy, anonymity, and discreet design, requirements that are technically achievable but demand sustained investment in co-design, security architecture, and community accountability.

● Implications for the Sustainable Development Goals

Taken together, these conclusions affirm that menstrual health for queer Nigerians is directly implicated in at least five Sustainable Development Goals, SDGs 1, 3, 4, 5, and 10, and that its continued neglect constitutes not only a public health failure but an ongoing violation of the human rights of one of Nigeria's most systematically excluded populations.

> *"This research is a call to action: to listen, to include, and to design systems that affirm the dignity and humanity of all people who menstruate.*
>
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SOURCES & FURTHER READING

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DESIGNING FOR DIGNITY

Every person who menstruates deserves safety, access, and dignity.

This research is a collective step toward ensuring dignity, equity, and inclusion for all—regardless of gender identity or sexual orientation.

Listen.

Centre the lived realities of queer menstruators in every conversation about menstrual health.

Include.

Build policy, services, and tools that explicitly recognize gender-diverse menstruators.

Design.

Embed dignity, safety, and confidentiality as architecture — not afterthought.

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