



Menstrual Hygiene Management Programming in Maharashtra: The journey of a decade

SUMMARY

In India, the state of Maharashtra has been pioneering innovations on MHM in both policy and practice since 2009. Government bodies, civil society organizations, social enterprises, and academia have collectively been proactive in generating robust evidence and approaches on menstrual hygiene management (MHM) for the past decade. A concerted action led by the state government, enabled systematic coordination between various ministries involved in MHM programming; allocating a generous budget, tracking progress, and leveraging the capacity of development partners to support cross-sectoral convergence and on-ground implementation. The state recognized MHM as a multi-sectoral issue that requires integrated action from the WASH, education, health, adolescents, protection and gender sectors, instead of implementing it as a stand-alone scheme. This field note documents the programmatic progress and the momentum that Maharashtra gained in menstrual hygiene management (MHM) at the state and district level in the last decade (2009-19). It shows how innovations in programming and convergence between all departments promoted menstrual hygiene behaviour change among girls, boys, parents, teachers, and others

Introduction

India is home to the largest number of adolescents in the world, representing one-fourth of the country's 1.38bn population (Census 2011). For the 50 percent of these adolescents who are girls, gender inequalities impact their education, health, and social participation (Free Standards Group 2016). Menarche, a critical marker of adolescence for girls, signifies an abrupt change for girls when they transition from childhood to adulthood (WaterAid, 2017). Lack of guidance on how to navigate the pressures of puberty can leave girls vulnerable to negative outcomes in

their health, education, and overall development. Field studies conducted jointly by UNICEF and the Liverpool School of Tropical Medicine found that barely half of the adolescent girls in India were aware of menarche before their first menstruation (Van Eijk et. al, 2016).

As the body of research on the importance of menstrual hygiene for girls expands, there has been a growing interest in addressing it, especially through water, sanitation, and hygiene (WASH) in schools (WinS) programmes. Several

countries in South Asia have started to integrate menstrual hygiene management (MHM) programming into national norms, standards or guidelines.

The State of Maharashtra, home to 21.3 million adolescents in India (UNFPA, 2011), emerged as the leader in giving policy attention to MHM, and since 2009 has been at the forefront of innovation in policy and practice to ensure that WASH services, including those in schools, address the needs of menstruating girls and women. Government bodies, development agencies, academic institutions, civil society organizations, and social enterprises have all been proactive in generating evidence and pioneering approaches on MHM in the last ten years. The state's WASH programme has been examining sanitation from an all-encompassing gender perspective that

focuses not only on access to toilets but also addresses the lack of appropriate sanitation and MHM mechanisms that hinder adolescent girls in attaining their full potential. MHM has been receiving policy attention from the central government since 2011, with each ministry bringing its unique approach to address this cross-cutting topic. Figure-1 below shows the timeline of initiatives undertaken by the government, on a national-level, to prioritize and create awareness on menstrual health.

Parallel to the national programmes, Maharashtra has been working towards mainstreaming MHM in their state policies since 2009. In this way, the state has emerged as a trailblazer in setting the ground for introducing policies centred around menstrual hygiene, both nationally and for other Indian states, as well.

Figure 1: Genesis of MHM programming in Maharashtra (shown on top) and India (bottom)



Factors enabling Maharashtra's pathway to MHM progress

1. Cross-sectoral collaboration and alignment with national policy framework is vital: full alignment with national strategies in WASH, education, gender, women, youth, health and other relevant sectors, was a key factor that enabled Maharashtra to spearhead, evolve, and transition its efforts in MHM. Nationally, MHM has been receiving policy attention, with each ministry bringing its own unique approach to addressing this cross-cutting topic. Several ministries such as the Ministry of Drinking Water and Sanitation, Human Resource Development (MoHRD), Health and Family Welfare (MoHFW), and Women and Child Development, contributed to the national policy and advocacy efforts in addressing school WASH needs in an equitable and gender-inclusive way by giving special emphasis to MHM.

The nationwide launch of the Swachh Bharat Mission (Clean India Mission) in 2014 elevated the urgency to adopt an integrated approach, on the similar lines of Maharashtra, to improve MHM for adolescent girls and women country-wide. The subsequent release of the National MHM Guidelines by the Ministry of Drinking Water and Sanitation (now renamed as Ministry of Jal Shakti) The year 2015 was a breakthrough in the policy landscape for gender and sanitation in India. A dedicated funding was allocated for MHM within the SBM budget for providing sanitary pads, creating awareness, and managing waste generated.

Figure 2: Disposal mechanism and incinerators in schools



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2. Contextualizing national guidelines to state-specific policies: Maharashtra became the first state in India to prioritize MHM by introducing state-specific guidelines in 2016. The guidelines, framed jointly by the Drinking Water and Sanitation Department and UNICEF, served as a strategic note that establishes a state-level action plan for mainstreaming MHM in ongoing programmes that have been operational for a decade. It indicated a broad framework for convergence and collaboration with various stakeholders for strengthening MHM programming in the state.

3. Roll-out of new schemes and innovative strategies: Maharashtra's government rolled-out *Asmita Yojana*, a scheme to provide sanitary napkins at subsidized rates in all 36 districts (a pack of eight for INR 5 (USD 0.06) each for girls and INR 24 (USD 0.33) for rural women. Under this scheme, women-run self-help groups (SHG) were entrusted with the responsibility of distributing good quality sanitary napkins (procured centrally) and counselling girls about menstruation. Girls were given smart cards, which the SHG members would scan using the *Asmita* mobile app and dispatch a packet of sanitary napkins. With a generous grant of INR 30 million (USD 407,000) from the state government, more than 276, 554 girls were issued smart cards in the first year of its launch. More than 29,568 self-help groups across the state procured sanitary napkins worth INR 3.6 million (USD 478,860)

Apart from this, the Maharashtra government made menstrual hygiene education mandatory in schools, by following a curriculum designed by UNICEF. Representatives from government departments visited schools and *angwanwadis* (pre-schools) located in ten districts twice a month to conduct awareness programmes on menstruation

4. Going beyond the provision of menstrual products- the environmental concerns of disposal: Though an increasing

number of women and girls began using sanitary napkins, in a culture of silence, not many knew about the impact of their disposal on the environment. By taking on the urgent need to tackle the environmental challenges that accompany menstrual waste management, the State Water and Sanitation Department has invested INR 200 million (USD 280,000) to install adequate disposal facilities in the schools of 27,668 villages of the state. (Figure-2).

More than a hundred schools introduced environmentally friendly, culturally-appropriate, and safe waste management approaches by inventing sustainable methods for disposing of sanitary waste— such as a small earthen pot lined with

Figure 3: Low-cost incinerator in an earthen pot



dried leaves that worked as a low-cost incinerator (Figure-3). With the advent of the second phase of SBM in 2019, an increased policy emphasis on menstrual waste management was manifested in the National Rural Sanitation Strategy.

5. Leaving no one behind – reaching out to socially excluded communities: UNICEF programming continued to deliver services and supplies to reach the poorest and most marginalized groups where no one else was able to do so. This included providing access to WASH facilities for children from socially excluded communities and promoting safe and hygienic facilities and practices among adolescent girls, especially from tribal-dominated districts. By conducting regular field studies in Gadchiroli district, UNICEF supported the states’ efforts to strengthen monitoring systems to better identify the most vulnerable and disadvantaged groups and assess the extent to which they can be served

(Figure-4). The Tribal Development Department deployed approximately INR 40 million (USD 54,000) to design and implement inclusive MHM interventions in 778 schools (benefitting 100,000+ girls) for economically marginalized girls living in remote areas.

The key pillars of the MHM programming in

Figure 4: Baseline and endline surveys conducted in Gadchiroli and Sindhudurg



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Maharashtra are listed below:

Enabling and facilitating an MHM friendly environment where girls confidently manage their periods and feel encouraged to enroll and stay



Creating awareness, breaking silence, and debunking myths on social taboos which were replaced with scientific and factual information



Empowering girls with knowledge and skills to manage menstruation, thereby boosting their morale and self-esteem



Encouraging behavioural and attitudinal change to adopt and maintain hygienic practices. This entailed instilling a positive attitude towards menstruation with no fear, embarrassment, and humiliation



Facilitating access to toilets, changing rooms, as well as to appropriate disposal facilities

6. Inter-sectoral convergence and investment in human capital: UNICEF's consistent efforts in supporting the State of Maharashtra demonstrated how ongoing capacity building at the district level could influence wider state-level approaches on MHM. Additionally, gaining the interest of district administrators was vital for bringing together all government departments (with Drinking Water and Sanitation department taking the lead followed by Health, Education, and Rural Development) to execute MHM interventions in all schools. By mobilizing a pool of 643 master trainers, these frontline departments collectively invested INR 5 million (USD 66,539) to mobilize human capital (public representatives such as teachers, SHG members and government staff) whom were equipped with the skills to deliver quality and sustainable services (such as training workshops and sensitization sessions).

7. Drilling down interventions from state to district level: In Maharashtra, UNICEF supported 'area-wide' programming delivered through government-run systems covering several districts. This approach offered an opportunity to test and refine implementation strategies, build local capacity and monitoring systems, and learn lessons from successes and failures before replicating the strategies in other districts. It helped to convince higher-level decision-makers to formulate policies and allocate funds for large-scale implementation. Additionally, gaining the buy-in and interest of the district government through constant advocacy and regular consultations, proved to be instrumental in bringing together the relevant departments that must coordinate to execute an MHM intervention in all schools. UNICEF's work in Maharashtra influenced other state's approaches to MHM; Jharkhand and Madhya Pradesh also developed roadmaps in 2018 and 2019 respectively, to operationalize MHM interventions in their states.

Outcomes

The concerted efforts of the Government of Maharashtra and UNICEF to support the menstrual

hygiene programming in the state was aimed at improving outcomes on education, health, and gender equality for girls and women. By comprehensively addressing a range of factors; such as building self-efficacy, developing a gendered policy, effecting social change and increasing access to facilities, girls gained the confidence, knowledge and skills to manage their menstruation safely (van Eijk AM, et al; 2016). The ultimate outcome of the project was to create a more supportive school environment, resulting in increased attendance rates of girls at primary and secondary levels. Key results are listed below:

Increased leadership by state ministries: The advancement of the MHM component in schools through a comprehensive, evidence-based advocacy platform, brought in participation, action, and funding from all levels of government. A designated MHM Resource Group led by local district functionaries, increased the discourse on MHM among the education, health, and sanitation departments working at the district level.

Increased understanding of MHM practices and barriers faced by girls in schools: Through the strengthening and formation of youth clubs, 40,000 girls studying in district schools were reached. These clubs (named *Meena Raj Manch*) served as pathways to impart knowledge on menstrual hygiene, provision of health, counselling services, and other key support, where needed. More than 650 public representatives from all state ministries were trained to deliver evidence-based information on menstruation and reproductive health in the school setting. They further cascaded the learnings by mobilizing 9,000+ stakeholders (such as teachers, school authorities, municipal bodies, etc.) across the state.

Bespoke communication program development: Individual behaviours are shaped by social, cultural, economic and political contexts, and therefore require interactive approaches and a mix of communication channels in order to encourage and sustain positive and safe behaviours. To affect behaviour change, groups of

individuals (such as girls, teachers, parents, and health workers) were empowered through a participatory consultation process, creating a platform to define their needs and giving them a voice to demand their rights. Behaviour change communication (BCC) activities went beyond imparting biological information by instilling the right knowledge, attitude, and practice to adopt appropriate hygiene practices and coping mechanisms with regards to MHM.

Increased diversity and inclusion in

programming: The reach of the interventions benefitted school-going and out-of-school girls, as well as those enrolled in 45 Kasturba Gandhi Balika Vidyalaya residential schools for girls from tribal and excluded communities. This facilitated opportunities and platforms that brought to the perspectives and voices of girls and women and their experience of menstruation, especially those from traditionally marginalized and excluded groups.

Increased demand for hygiene material: There was a significant surge in demand for sanitary napkins and changing rooms/private spaces in schools. In Sindhudurg district, changing rooms for adolescent girls were installed in more than 600 schools.

Mothers and teachers becoming ‘carriers of knowledge’: A designated MHM educator was appointed in schools in 35 districts. This person played a pivotal role in enhancing knowledge, discussions and planning sessions about MHM. These discussions helped to reduce menstruation-related fear, and absenteeism amongst girls. Outside the school setting, mothers stepped in to empower girls with knowledge about menstruation before getting their first menses. This attitude had also translated to action, as mothers provide their daughters with sanitary napkins at home too. At the household level, these efforts debunked myths and led to the creation of a new social norm of speaking openly about a previously tabooed subject.

Lessons Learned

1. The establishment of working groups within the government ensured the uptake of MHM programming by development partners and civil society organizations.
2. Typically, improving menstrual hygiene is often equated with girls having access to a sanitary napkin. Through the interventions, it was learned that the issues, however, run far deeper. Girls, women, adolescents, mothers, and teachers are often unaware of its impact on reproductive health and best practices to manage it hygienically. Solving this issue is possible, but interventions should encompass both MHM and the broader systemic factors that link menstruation with health, well-being, gender equality, education, equity, empowerment, and rights. It was also observed that sometimes, interventions may be effective on paper, but the ground reality may be quite different. For instance, ensuring the last mile-delivery of sanitary napkins in remote areas may seem to be the solution for the unavailability of sanitary material. However, if this is not accompanied by awareness building and appropriate messaging, the effectiveness of this intervention will be limited and not lead to the desired behaviour change.

Figure 5: School girls learning about menstrual health and hygiene in peer groups



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3. Interventions that involve engagement with school-going students over a time-specific period (the years of adolescence), can have a sustained impact on their lives and situations which is more effective than offering a one-time solution.

4. While improved access to sanitary products could address some significant problems underlying girls' school absenteeism, they are not sufficient to overcome the cultural silence surrounding menstruation, unless they are linked with strong sexual and reproductive health and rights education. As beliefs, taboos, and etiquette are culturally, socio-economically and spatially specific, there can be no 'one size fits all' solution to improving girls' MHM-related experiences. Participatory approaches investigating locally specific MHM preferences, such as for the disabled or marginalized communities, can be helpful in designing MHM infrastructure in schools.

5. For advancing the menstrual hygiene agenda, area-wide implementation of MHM can offer the opportunity to build on the evidence base, and showcase the potential for MHM programming delivered at scale. In this way, it can help to convince higher-level decision makers to develop enabling policies and strategies, and allocate resources and capacity for effective, large-scale implementation through the education or health system.

Figure 6: Mothers discussing MHM in schools



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Next Steps

While significant momentum has been generated in the state of Maharashtra, there remains much to be done, including generating additional evidence of impact, engaging a broader range of stakeholders, and mobilizing resources and stakeholders. Here are a few ways forward:

1. Strengthening partnership with the Chief Minister's Village Social Transformation Foundation, which is expected to promote convergent programming between MHM and other sectors by reaching 1,000 of the state's low human development indexed villages. In the run-up to the global Menstrual Hygiene Day in 2019, seventy-five government representatives became master trainers and conducted sensitization sessions in 150 villages across the state.
2. Ensuring the continuation of the programme in the long run through incentives, continued convergence amongst stakeholders, and a robust monitoring system. Together with practitioners and researchers, operational research can be carried out that monitors not only the outputs and outcomes of the intervention but also whether the intervention is being implemented as planned. This process monitoring is an essential part of adaptive programme management, as the results inform rapid course-correction when the desired outcomes are not being achieved. This also provided UNICEF the opportunity to form new partnerships with academic institutions, to test new indicators under development and contribute to the national evidence base.
3. Putting focus on 'men' in menstruation could foster stronger psycho-social support and create an enabling environment to address the WASH needs of girls and women, especially related to MHM. There is a need to carefully tailor messages and proactively include boys, fathers, and community leaders to address their own barriers to promoting better MHM.

4. Encouraging innovations and a greater role for the private sector in achieving sustainable and quality services at scale such as supporting community entrepreneurs in running manufacturing units. The possibility of collaborating with actors who have the reach and the expertise necessary to share, transfer, and adapt learning within districts, could also be explored.

5. Leveraging investments (both government and private) in adolescent girls' well-being that can yield triple dividends - for girls, for the women they will become, and for the next generation.

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