EMPOWERING ADOLESCENTS: MENSTRUAL HYGIENE MANAGEMENT AS AN ENTRY POINT

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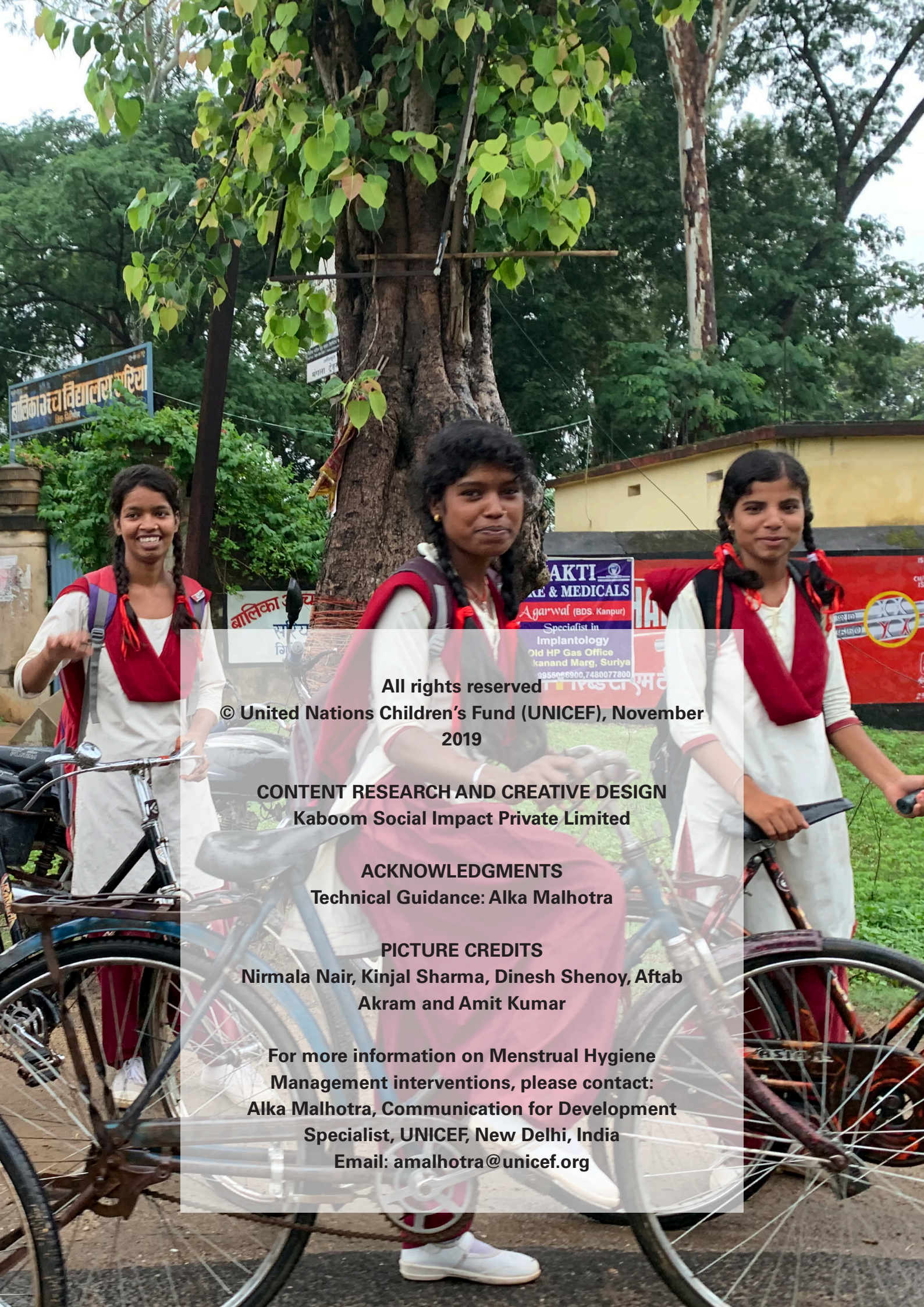
for every child



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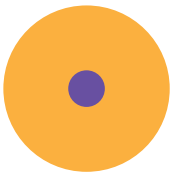
INTRODUCTION

On any given day, more than 800 million women and girls between the ages of 15 and 49 are menstruating.[1] Yet across the world the biological fact of menstruation remains veiled in silence, secrecy, shame, stigma, and indignity. In India, 48% of adolescent girls are unaware of menstruation prior to menarche.[2] 69% girls feel that menstruation-imposed restrictions on mobility are fair,[3] and only around 58% of 15-24-year-old girls and women had access to hygienic menstrual absorbents in the year 2015-16.[4]
Challenges faced in regards to menstrual hygiene management (MHM) underscore the much bigger picture of discriminatory social norms that girls face during puberty. There is evidence to show that gender-discriminatory social norms can become even more pronounced during puberty and can undermine efforts to achieve multiple health and development outcomes.[5]

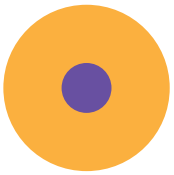
Menarche is often considered to be a liminal phase in a girl's life, one that marks her transition from girlhood to womanhood and therefore significantly changes her image and the role she is expected to play in the community.

This can translate to gender discrimination in the form of unequal chore burdens and caretaking responsibilities; and human rights violations in the form of exclusion from education, employment, and decision making; child marriage; limitations on reproductive control; and violence, sexual abuse, and exploitation.

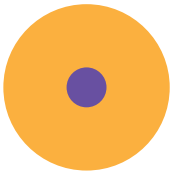
IN THE INDIAN CONTEXT,



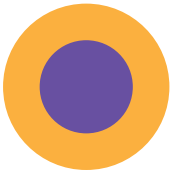
22% OF ADOLESCENT GIRLS HAVE RECEIVED NO EDUCATION



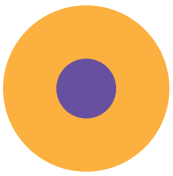
30% ARE ALREADY MARRIED



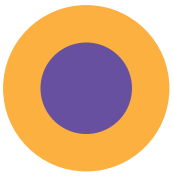
24% HAVE BEGUN CHILD-BEARING



56% ARE ANAEMIC



36% HAVE NEVER HEARD OF HIV/AIDS



55% LIVE IN HOUSEHOLDS WITHOUT TOILETS[6]

MHM THEREFORE IS ULTIMATELY A HUMAN RIGHTS CONCERN AND AN ISSUE PERTAINING TO GENDER EQUALITY.

In India, MHM assumes particular significance as the country is home to the largest population of adolescents in the world. Adolescents represent one fourth of India's population of 1.3 billion out of which about 120 million are adolescent girls of reproductive age. In many states and areas across India, adolescents and women of reproductive age face significant challenges to manage their menstruation including lack of knowledge, access to facilities, shame, stigma and discrimination. Men and women including decision makers, lawmakers, bureaucrats, teachers and even medical practitioners refrain from discussing menstruation in public and even among their own families, leading to further internalization of the taboo and stigma around this natural phenomenon.

Within government structures, MHM as an issue has been scattered across different departments with lack of ownership by any one. Schemes on MHM have lacked cohesiveness and longevity due to lack of specific funds being allocated for MHM interventions.. This has led to menstruation often being ignored and brushed aside in adolescent specific programes.

When UNICEF started focusing on MHM in the year 2012, it committed itself to making menstruation a safe and hygienic experience for millions of girls across India. The idea is that good MHM requires not just access to hygienic products, but as much about access to accurate information and knowledge, confidence to challenge social norms and misconceptions, safe sanitation and disposal facilities, and essentially a sensitized social environment.

[1] https://www.fsg.org/publications/opportunity-address-menstrual-health-and-gender-equity
[2] https://www.dasra.org/news-and-events/only-48-of-the-adolescent-girls-population-in-india-are-aware-about-menstruation-prior-to-the-first-period
[3] https://www.unicef.org/wash/schools/files/MHM_vConf_2014.pdf
[4] National Family Health Survey-4
[5] https://www.tandfonline.com/doi/full/10.1080/02673843.2019.1590852
[6] Ministry of Women and Child Development, Government of 2012; NFHS 2008; SOWC 2011

THE KEY TO FULFILLING GIRLS' AND WOMEN'S RIGHTS

Menstrual Hygiene Management is one of the key focus areas of the United Nation's agenda of fulfilment of girls' and women's rights and is closely linked with several of its Sustainable Development Goals (SDGs), like

SDG2 on 'Good health and well being',

SDG 4 on 'Quality Education,

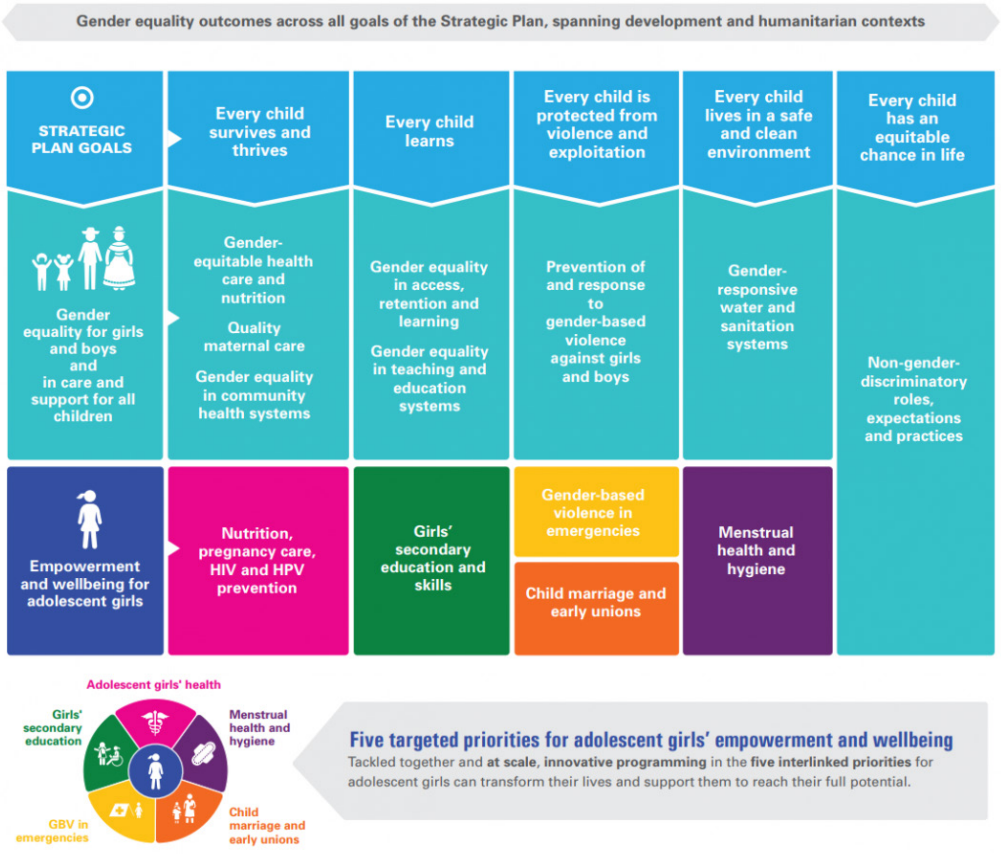
SDG 5 on 'Gender Equality' and,

SDG 6 on 'clean water and sanitation'.

UNICEF's aim is to comprehensively address a range of factors such as building self-efficacy, developing a positive policy and programme environment, effecting social change and increasing access to materials and facilities so as to support girls and women to have the confidence, knowledge, and skills to manage their menstruation in a safe manner, using appropriate materials and facilities both at home and away from the household. The global policy of UNICEF aims to adopt MHM by addressing four interrelated determinants; social support, knowledge and skills, facilities and services, and materials and supplies – along with improvements in the enabling environment through appropriate policies, coordination, financing, capacity building, and monitoring of education, health, and WASH sectors.

Because of its huge transformational potential, MHM is one of UNICEF's interlinked priorities in its Gender Action Plan 2018-2021, which aims at achieving gender equality and girls' empowerment. UNICEF believes that the five priorities of the Gender Action Plan if implemented together and at scale can dismantle some of the most stubborn barriers to gender equality and transform the lives of adolescent girls – supporting them to become healthy, educated and empowered women, able to direct the course of their own lives.

Even though, the government of India did not have any programmes which focused exclusively on MHM, it launched many adolescent centric schemes in which MHM was a component. **The Rashtriya Kishore Swastya Karikram (RKSK)** focused on providing services through Adolescent Friendly Health Clinics. **The Kishori Shakti Yojana (KSY)**, aimed at improving health and nutritional status of adolescent girls. The **Scheme For Empowerment of Adolescent Girls, (SABLA)** aimed to reach out to out of school girls through anganwadi centers. The **Kasturba Gandhi Balika Vidyalayas (KGBVS)** was a residential programme started specifically to provide education to marginalized sections of the society. **The Swachh Bharath Mission (SBM)** national flagship programme on sanitation, which has a focus of providing separate toilet for girls as well as safe disposal of menstrual waste as a part of its second phase of ODF+ program.



EARLY INTERVENTIONS – TOWARDS BREAKING THE SILENCE

Menstrual Hygiene Management (MHM) is intrinsically connected to a host of adolescent issues including health, nutrition, child protection, education and learning, and sanitation and hygiene, and so on. UNICEF started working on MHM in the year 2012. But the focus on institutionalising MHM began only in the year 2014 when the government of India launched a host of adolescent centric interventions like ARSH and RKSK which had an MHM component under it. UNICEF has been focusing on highlighting MHM during advocacy interventions and IEC activities under all adolescent centric initiatives related to nutrition, sanitation, reproductive and sexual health and child protection especially in the six states, namely – Jharkhand, Bihar, Gujarat, Maharashtra, Uttar Pradesh and Rajasthan. The key purpose has been to position menstruation as one issue that has the potential to link all other adolescent-related issues, and highlight that better focus on the area can create an entry point to foster the empowerment of adolescents to become their own catalysts for change.

In 2012 there were only a few organisations actively addressing menstrual hygiene management. In that landscape an intervention with an exclusive focus on MHM was envisioned in 4 states – Jharkhand, Bihar, Maharashtra and Uttar Pradesh. The objective was to break the silence on menstruation, and ensure that girls and women understand hygienic methods of managing menstruation and start to question the stigmas imposed on them.

At the time of the programme's inception, menstruation was considered to be a cultural taboo and none of the stakeholders were comfortable discussing issues around MHM. Even higher level bureaucrats who took policy decisions were reluctant to talk about menstruation on public platforms. In Maharashtra, government officers admitted to feeling uncomfortable when sanitary pads were placed on tables by MHM advocates during discussions, and would often ask for sanitary pads to be removed.

It was at this time in 2012 that two programmes were launched in Bihar and Jharkhand, respectively: **PYARHI (Promoting Young Adolescents Reproductive Health Initiative)**,an SBCC intervention by UNICEF in partnership with Johnson & Johnson, the Government of India and Integrated Development Foundation in two districts of the state of Bihar, and **MAHIMA** 'Breaking the Taboo' intervention by UNICEF, Johnson & Johnson and the Government of Jharkhand in two districts of the state. MHM was starting to be viewed as an entry-point for

a much wider target of fostering adolescent empowerment. The MHM intervention in Bihar launched in 14 blocks of Nalanda and Vaishali districts stressed on improving MHM practices through **community dialogue, capacity development, interpersonal communications, and advocacy initiatives** through a comprehensive communications package. The intervention was executed with the close cooperation and support of various government departments mainly the Departments of Education, Health, and Social Welfare. The MAHIMA intervention in Jharkhand was launched in again two districts, Gumla and East Singhbhum, in close collaboration with the Departments of Social Welfare, WCD, Health and Family Welfare, and the District Education Programme. The key pillars included **inter-personal communication, community dialogue and mass media, and training and capacity building.** The pilot interventions had two definite objectives: to get adolescent girls to talk openly on MHM without any stigma or embarrassment, and to ensure that all government departments realized the importance of MHM and acquired the correct knowledge and skills to integrate it into other interventions.

Simultaneously, UNICEF started another similar intervention of a more comprehensive nature and of a longer duration in the most populous state of India, Uttar Pradesh. Launched with the support of IKEA foundation, project **GARIMA** like the earlier two MHM projects was an SBCC intervention launched in 1974 villages spread across the districts of Jaunpur, Mirzapur and Sonebhadra. While PYARHI, MAHIMA and GARIMA were specific projects in collaboration with external agencies, advocacy efforts were on in other states to enlighten the government to start work on MHM to holistically address issues pertaining to reproductive health, education, nutrition, anaemia, sanitation and overall development of the girl child. While PYARHI, MAHIMA and GARIMA were specific projects in collaboration with external agencies, advocacy efforts were on in other states to enlighten the government to start work on MHM to holistically address issues pertaining to reproductive health, education, nutrition, anaemia, sanitation and overall development and health of the girl child. One of the states in which UNICEF was proactively pursuing this agenda was **Maharashtra**. UNICEF was encouraging a district centric approach where the CEOs of the district where driving the MHM agenda as a larger part of girls and women's empowerment in the state.

Meanwhile the interim reports of the PYARHI and MAHIMA projects clearly indicated that it is possible to engage with girls and their immediate family members, frontline workers, teachers and other stakeholders and bring about a change in attitudes and safe sanitation practices. it was then decided that a phase 2 of the project (May 2016 to April 2019) would be undertaken with the same partners and a new state of **Gujarat** would also be brought under these interventions. It was decided that the focus of phase 2 would be on strengthening government programmes aimed at adolescents like RKSK, ARSH, SBM, and Swachh Vidyalaya Abhiyan and integrating MHM into these programmes and facilitating their roll out.

2012 – 2015 is seen as the first phase of MHM programming with 4 states paving the way. The key learnings from this phase were used in the planning and implementation of Phase 2 of the MHM interventions. The focus of Phase 2 between 2016 - 2019 was to:

1. **Integrate MHM into existing adolescent-centric government programs like RKSK, SABLA, ARSH, SBM, and Swachh Vidyalaya Abhiyan with a clear vision to advocate for the programmes to work in tandem with each other.**
2. **Strengthen convergent implementation of adolescent-centric programmes on health, nutrition, child protection and education. Priority was to be given to strengthen existing institutions and define operational processes and guidelines.**
3. **Stress on building capacities of various influencers and stakeholders including mothers, fathers, teachers, and frontline workers (FLWs) to create a sensitized environment for adolescents. The need was recognized to create appropriate communication materials to bring about a positive behaviour change in communities on safe MHM practices.**
4. **To motivate and create positive social norms regarding adolescent girls' management of menstruation.**

UNDERSTANDING SOCIAL CONNECTIONS TO EMPOWER THE ADOLESCENT GIRL

At the heart of successful promotion of MHM is the understanding that the needs of the adolescent girl must be prioritized first and foremost, and furthermore that the issue cannot be tackled unidimensionally. Improving MHM is interconnected with improving indicators in health, education, sanitation and child protection, therefore impacting larger social issues like child marriage, violence, sexual exploitation and general lack of agency of girls and women.

UNICEF's SBCC framework is based on the Socio-Ecological Model, which represents a social system that places the adolescent girl at the center and maps the levels that form the stakeholders and influencers in her life and how each can be influenced in order to bring about a positive change within the social system. The model displays the intrinsic connection that a girl has with her family, community, institutions, government and finally the physical environment. The Social Ecological Model forms the crux of the scale-up of the interventions in each of the states.

CONVERGENCE OF ADOLESCENT-CENTRIC DEPARTMENTS

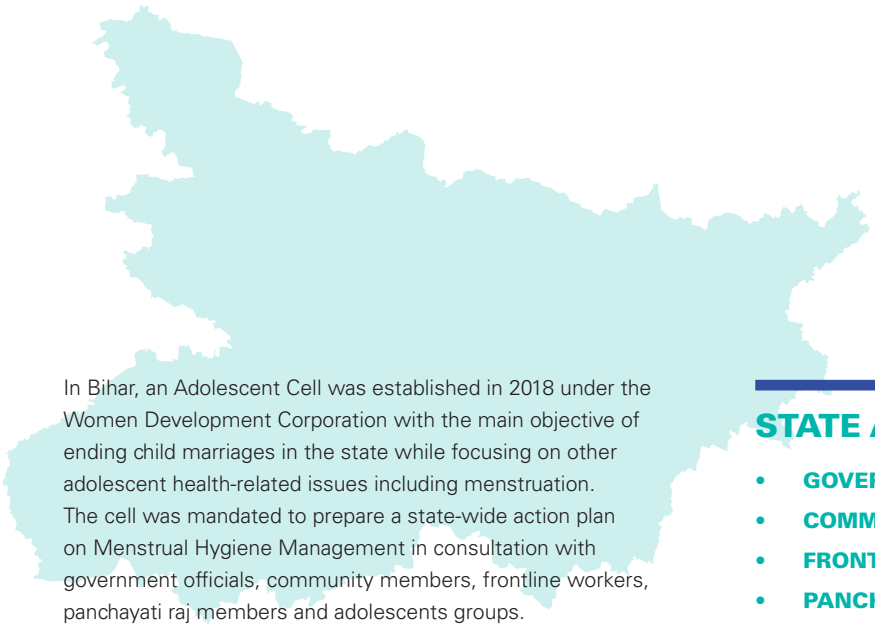
The process to foster convergence was set rolling among the various departments to address MHM issues in a holistic manner from top to the ground level. A series of seminars and meetings were held with government officials and decision makers to ensure that MHM was not perceived in isolation and helped in accelerating the process of inclusion of an MHM component into various existing government programmes. Success stories of GARIMA, MAHIMA, and PYARHI interventions along with the findings of the formative research studies conducted in Phase 1 were presented to various states departments to emphasise the need to include MHM within adolescent-centric programmes. As the UNICEF CFO puts it,

"The key to this was to positioning MHM as a beginning within a continuum. It is a comprehensive approach for adolescents including life skills, nutrition, education, health and many other things to improve their lives. This program was to be looked upon for opening up other possibilities for girls." - Madhulika Jonathan, CFO, Jharkhand.

The intersectoral convergence model differed from state to state. But key departments, especially those implementing adolescent-centric central government schemes like the Department of Health (RKSK/SABLA/ARSH), Women and Child Development (Kishori Shakti Yojana/Integrated Child Development Scheme), Education (SSA) and SBM (ODF Plus) were common in all the states.

ESTABLISHING STRUCTURES TO FACILITATE CONVERGENCE

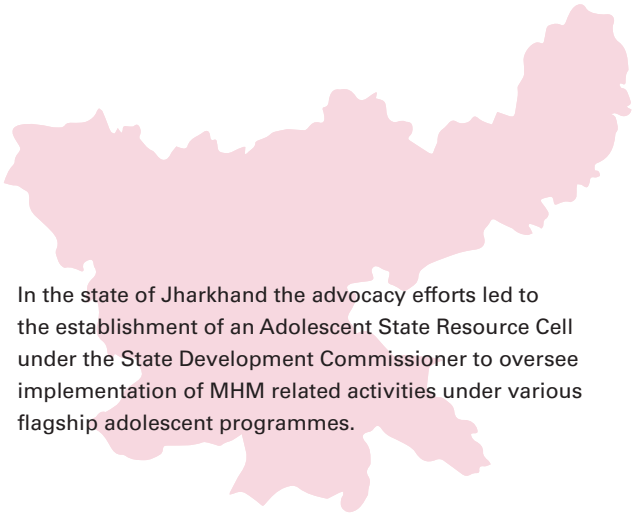
In Gujarat, a state level convergent committee for adolescent programming was set up in the year 2017 under the chair of the Principal Secretary, Health with the mandate of pooling of resources under various line departments and to provide oversight and direction in implementing MHM-related schemes.



In Bihar, an Adolescent Cell was established in 2018 under the Women Development Corporation with the main objective of ending child marriages in the state while focusing on other adolescent health-related issues including menstruation. The cell was mandated to prepare a state-wide action plan on Menstrual Hygiene Management in consultation with government officials, community members, frontline workers, panchayati raj members and adolescents groups.

STATE ACTION PLAN CONSULTED

- GOVERNMENT OFFICIALS
- COMMUNITY MEMBERS
- FRONTLINE WORKERS
- PANCHAYATI RAJ MEMBERS
- ADOLESCENTS GROUPS

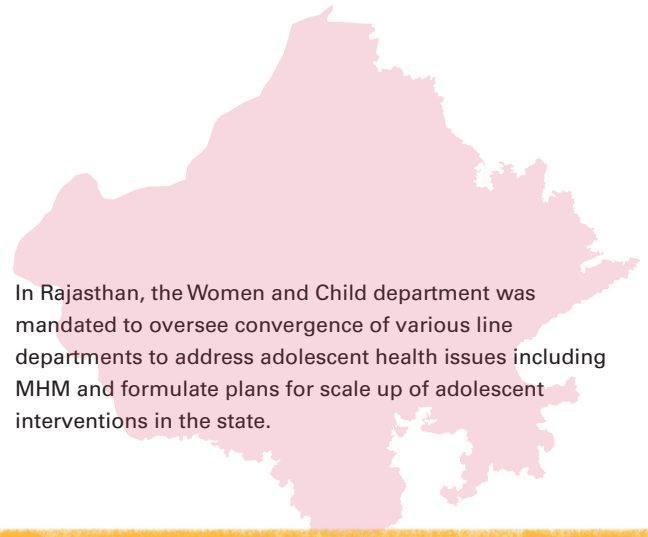


In the state of Jharkhand the advocacy efforts led to the establishment of an Adolescent State Resource Cell under the State Development Commissioner to oversee implementation of MHM related activities under various flagship adolescent programmes.

STATE DEVELOPMENT

ADOLESCENT STATE RESOURCE CELL

OVERSEEING MHM



In Rajasthan, the Women and Child department was mandated to oversee convergence of various line departments to address adolescent health issues including MHM and formulate plans for scale up of adolescent interventions in the state.

WOMEN AND CHILD DEVELOPMENT DEPARTMENT (WCD)

OVERSEE CONVERGENCE OF VARIOUS LINE DEPARTEMENTS TO ADDRESS ADOLESCENT HEALTH ISSUES INCLUDING MHM

In Maharashtra where MHM interventions are driven at the district level, nodal departments for implementing Adolescent/MHM issues differed from district to district as per the vision and focus of the Chief Executive Officer, the administrative head of the Zilla Parishad, of each district. For example, in Sindhudurg, the Assistant Project Officer, Sarva Shiksha Abhiyan is the nodal officer who is incharge of planning, strategizing and implementing MHM interventions, while in Thane and Gadchiroli districts, the Taluka Health Officer (THO) and Additional District Health Officer (ADHO) are the nodal officers. In many other districts, the Deputy CEO of the Department of Water Supply and Sanitation (WATSAN) is the nodal officer Deputy CEO entrusted with MHM interventions.

DISTRICT INTERVENTIONS LED BY CEOS

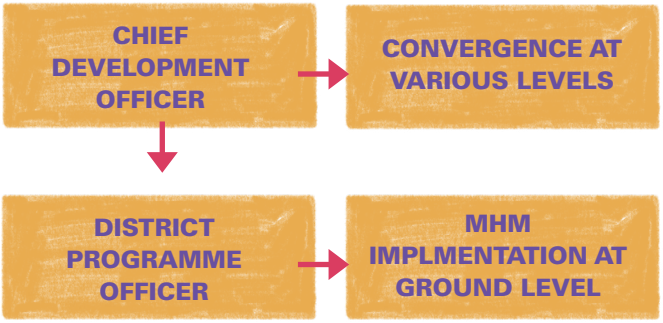
MHM IMPLEMENTATIONS NODAL OFFICERS IN DIFFERENT DISTRICTS

SINDHUDURG- THE ASSISTANT PROJECT OFFICER, SARVA SHIKSHA ABHIYAN

OTHER DISTRICTS- THE DEPUTY CEO OF THE DEPARTMENT OF WATER SUPPLY AND SANITATION (WATSAN)

THANE AND GADCHIROLI DISTRICTS- THE TALUKA HEALTH OFFICER (THO) AND ADDITIONAL DISTRICT HEALTH OFFICER (ADHO)

The same story holds true for Uttar Pradesh where the Chief Development Officers who heads the development wing of the of the district, under the overall supervision of the district magistrate are in charge of the convergence platform while the district programme officers are involved in implementation of interventions at the ground level.



UNICEF played an important role in facilitating the entire convergence process both at state and district levels in all the states often in partnership with NGOs, for example Sewa Rural in Gujarat and SAARTHAK in UP. The process involved included formal deliberation and discussions with various line departments, planning and strategizing the implementation process and providing technical support to capacitate the core team. The convergence of line departments dealing in adolescent health issues has been a major catalyst in streamlining MHM interventions and scaling it up at the state and district levels. Through this process the local partnerships are encouraged to actively take forward the process of convergence to ensure they are empowered to take a lead in the process and ensure sustainability of the process.

SCALE-UP MODELS

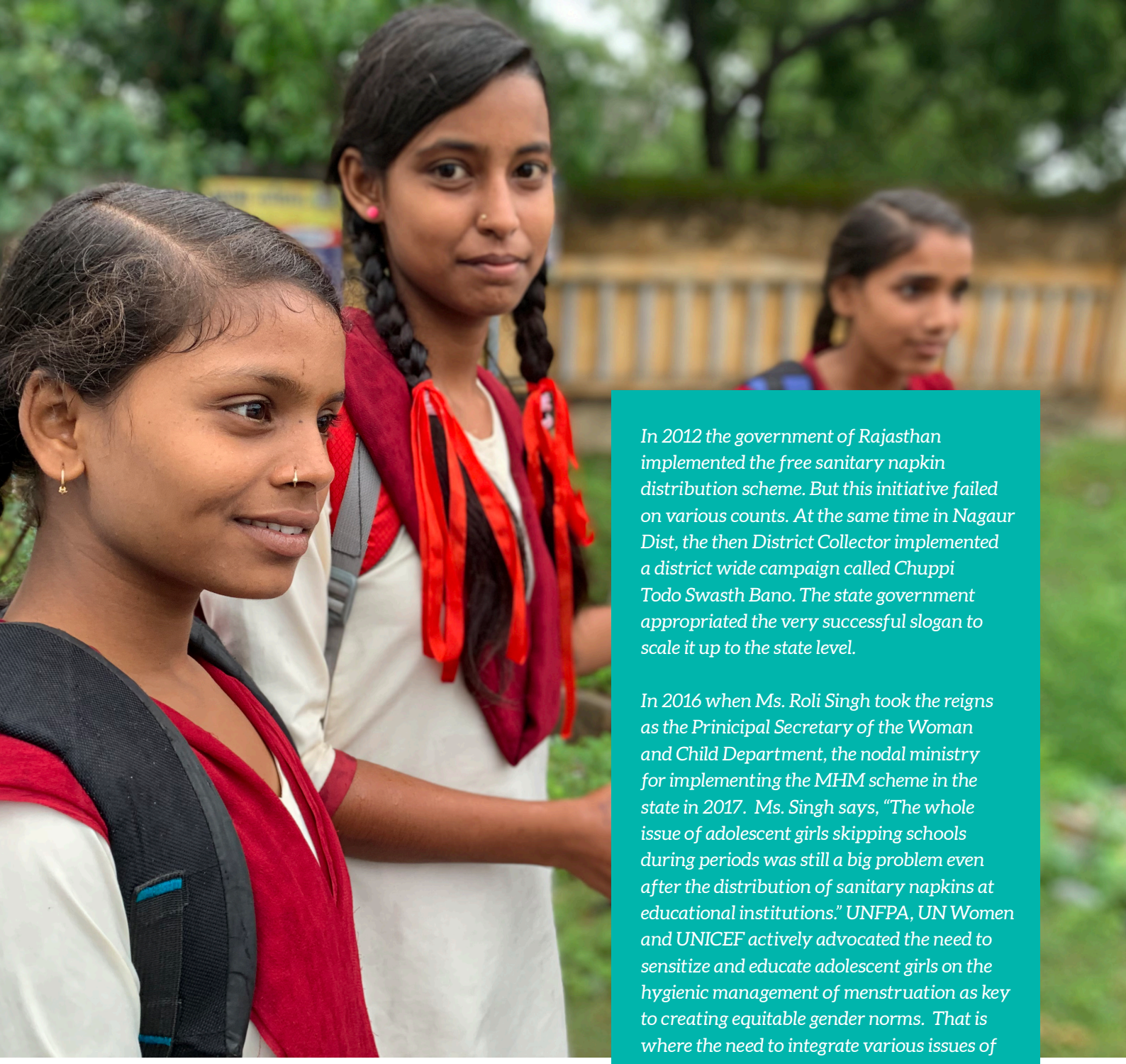
After intense advocacy efforts with state governments, different models were adopted for scaling up adolescent-centric programmes with strong MHM components in the states. Based on the receptivity, co-operation and intent shown by various state governments and district administrations, the approach was either top-to-bottom (state-driven) or bottom-to-top (district-driven). The basic difference is that in the state-centric approach, the state government is guiding the district administration to scale up adolescent interventions by creating structures and models for them through guidelines, fostering convergence at the state level for replication, forging civil society partnerships, making available IEC tools, and addressing supply and disposal aspects in a limited manner. Under the district-centric approach, the district administration is creating processes and structures as per its strength and ground realities and implementing the initiative based on its own belief and commitment for the cause. All the structures and interventions from convergence of departments, to pooling of resources, to capacity building, IEC/BCC and implementation are handled at the district level.

STATE-DRIVEN APPROACH

In the states of **Bihar, Jharkhand and Rajasthan**, the urgency and commitment for prioritizing MHM and implementing the MHM programme has come from the top. The approach ensured that MHM was included in the states' agenda with a definite 'ownership'.

In Bihar, the success of Promoting Young Adolescents Reproductive Health Initiative (PYARHI) between 2012-2014 led to the National Health Mission to ask the state government to include Menstrual Hygiene Scheme in the Annual Programme Implementation Plans (PIPs). This gave rise to the **Adolescent Cell** to be established on Menstrual Hygiene Day, May 28, 2018. While the primary focus of the Cell was to end child marriage, it recognised that empowerment of girls was closely tied to ensuring that menarche was not considered a phase that debilitates a girl and she is empowered to take charge of this phase and adulthood that follows.

In Jharkhand, the formative research showed that a staggering figure of over 70% of women and girls did not have any knowledge of menstruation at menarche. The success of



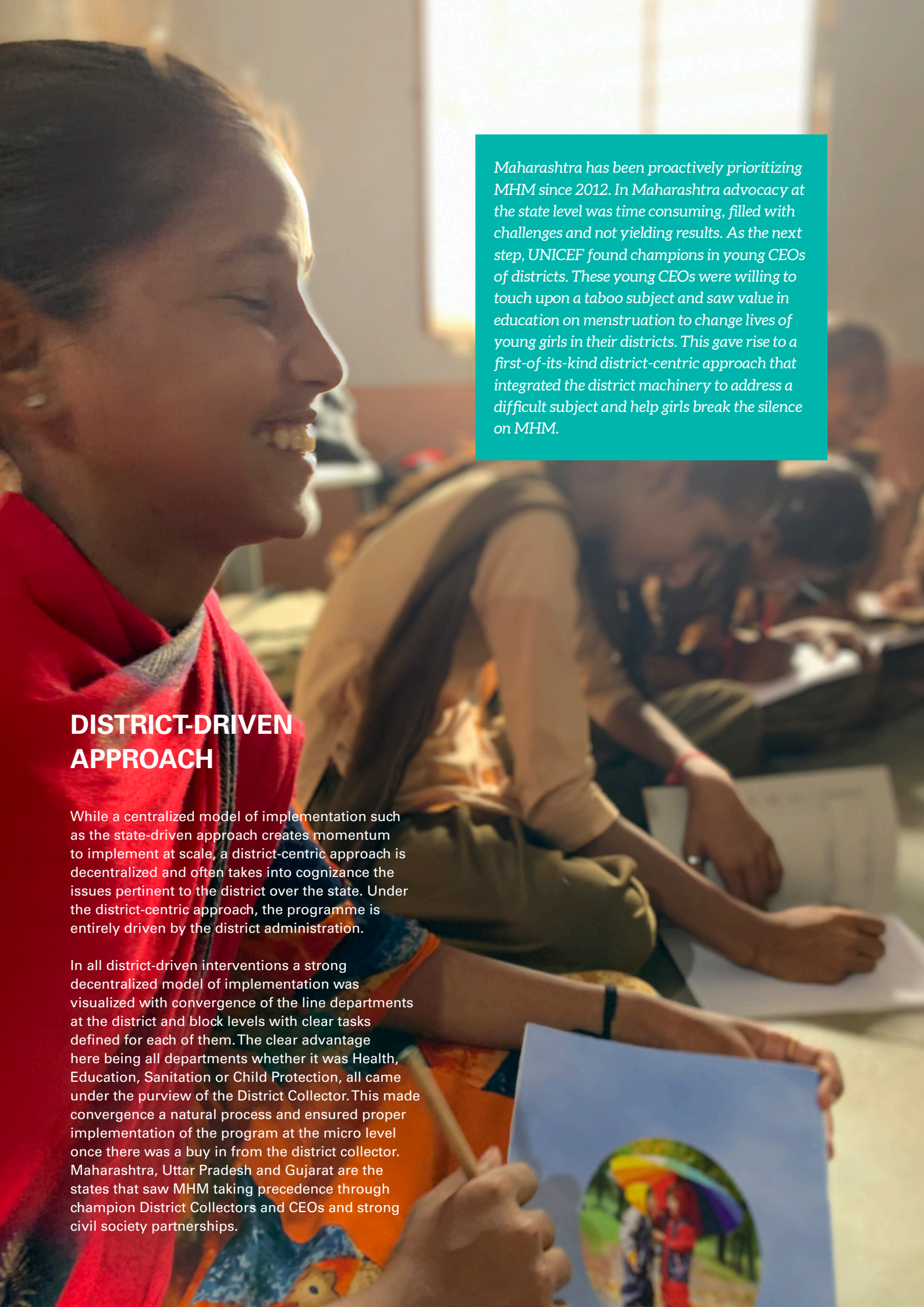
MAHIMA through 2012-2015 gave impetus to UNICEF to advocate for mainstreaming and strengthening the processes, methods and tools developed in pilot intervention through the Health Department's RKSK program. This led to the launch of the State Menstrual Hygiene Management Action Plan (2018 - 2022) published jointly by DWSD and NHM ensuring the entire value chain of MHM was considered and closely linked to the empowerment of adolescent girls. The focus was to ensure the silence, shame and stigma gave way to a confident girl who does not see periods as limiting her in any way.

More recently, in 2018, in Rajasthan, the initiative was taken by the then chief minister where the state government has created strategic frameworks for implementation or scale-up of adolescent programmes inspite of limited prior implementation of MHM-centric programs.

In 2012 the government of Rajasthan implemented the free sanitary napkin distribution scheme. But this initiative failed on various counts. At the same time in Nagaur Dist, the then District Collector implemented a district wide campaign called Chuppi Todo Swasth Bano. The state government appropriated the very successful slogan to scale it up to the state level.

In 2016 when Ms. Roli Singh took the reigns as the Prinicipal Secretary of the Woman and Child Department, the nodal ministry for implementing the MHM scheme in the state in 2017. Ms. Singh says, "The whole issue of adolescent girls skipping schools during periods was still a big problem even after the distribution of sanitary napkins at educational institutions." UNFPA, UN Women and UNICEF actively advocated the need to sensitize and educate adolescent girls on the hygienic management of menstruation as key to creating equitable gender norms. That is where the need to integrate various issues of adolescents including nutrition, reproductive health, and child protection, and bring about an attitudinal change in the MHM intervention in the state took birth. It was recognized that creating demand for hygienic menstrual absorbents lay in education on menstruation.

In February 2018, then CM of Rajasthan, Vasudhara Raje Scindia took cognizance of the issue and prioritized MHM intervention across all adolescent programs in the state and announced a budget of INR 760 million for the upliftment of the MHM scheme in the state in February 2018.



Maharashtra has been proactively prioritizing MHM since 2012. In Maharashtra advocacy at the state level was time consuming, filled with challenges and not yielding results. As the next step, UNICEF found champions in young CEOs of districts. These young CEOs were willing to touch upon a taboo subject and saw value in education on menstruation to change lives of young girls in their districts. This gave rise to a first-of-its-kind district-centric approach that integrated the district machinery to address a difficult subject and help girls break the silence on MHM.

DISTRICT-DRIVEN APPROACH

While a centralized model of implementation such as the state-driven approach creates momentum to implement at scale, a district-centric approach is decentralized and often takes into cognizance the issues pertinent to the district over the state. Under the district-centric approach, the programme is entirely driven by the district administration.

In all district-driven interventions a strong decentralized model of implementation was visualized with convergence of the line departments at the district and block levels with clear tasks defined for each of them. The clear advantage here being all departments whether it was Health, Education, Sanitation or Child Protection, all came under the purview of the District Collector. This made convergence a natural process and ensured proper implementation of the program at the micro level once there was a buy in from the district collector. Maharashtra, Uttar Pradesh and Gujarat are the states that saw MHM taking precedence through champion District Collectors and CEOs and strong civil society partnerships.

In 2014-15, 'District approach to MHM' was introduced for scale, convergence and leveraging government resources. With UNICEF as the technical partner and under the leadership of the CEO, Zilla Parishad, MHM implementation took place in Thane District. Thereon began the journey of district level implementation of MHM programming led by CEOs in 12of the 34 districts, paving the way for state-level implementation.

In 2016, Maharashtra was the first state to have launched the state guidelines for MHM in WASH in Schools (WINs) and till date remains the only state that has a state guideline for implementing MHM programs in schools. The state guideline ensures that all municipal government-run schools in Maharashtra have modules on MHM to train adolescent girls about puberty and menstruation and teach them about the various myths and misconceptions around periods.

Despite no financial assistance the state has implemented a strong MHM program through the will of the District CEOs and strong advocates of MHM within the UNICEF team. In fact the Maharashtra program is responsible for influencing states like Rajasthan to understand the strength of a strong SBCC program to empower adolescent girls.

Many of the districts adopting the district-centric approach followed a model, where a formative research was conducted to understand the menstrual practices and beliefs prevalent locally, access to menstrual absorbents, and disposal mechanisms followed by the community. Based on the results of the research, a district MHM plan of action was formalized by the district administration wherein capacity building, IEC/BCC and monitoring approaches were defined and concrete tasks were underlined for each supporting department right down to the panchayat level to bring about a change in behaviours. Here convergence of departments happened naturally, as the line departments were reporting to the respective heads of district administration, to follow the MHM plans formalised to be implemented at a micro level.

In Gujarat, the MHM intervention was run in the Sabarkantha district under the leadership of the Chief Medical Officer (CMO). In 2017 a state level workshop on MHM titled 'Safer Action for Safer Menstruation', was conducted in partnership with Sarva Shiksha Abhiyan, Gujarat. The workshop was attended by Department of Health, Rural Development Department, Women and Child department, Tribal Development Department and Education Department. The workshop deliberated on creating an enabling environment to facilitate the formation of a state-level MHM policy to step up MHM interventions in the state and a state-level convergent committee for adolescent programme was established. It was decided that a pilot program on MHM will be run in districts of Narmada, Sabarkantha as well as in Surat by civil society partners like Sewa Rural with the technical expertise from UNICEF to inform the scale up of the interventions.

In Uttar Pradesh, the GARIMA project was implemented successfully in 3 districts between 2012-2015. As a result, in 2016 a state roadmap for strengthening menstrual hygiene management in Uttar Pradesh was developed with the active participation of various departments like SSA, SBM, ICDS and other public and private sector partners. This road map paved way for 'Accelerating Menstrual Hygiene Management and WASH in Schools' being implemented with the support of the civil society partner, SARTHAK. Under Accelerating Menstrual Hygiene Management and WASH in Schools separate district specific action plans are developed for each of these nine districts taking into consideration the realities that exist at the ground level. The MHM intervention, focuses on integrating all the four major departments, Education, health, ICDS and Panchayati Raj Institutions through their various interventions under RKSK, SBM SSA with clear tasks laid out for each of them. The stress is to initiate a dialogue among family and then in the community to help adolescent girls and women practice safe MHM with dignity. The district administration also takes the onus of pooling together of resources for MHM and works towards providing access to MHM products to adolescent girls and women within their easy reach.. SARTHAK closely woks with the district administration and oversees the implementation of the MHM programme through capacity building, overseeing IEC/BCC activities and monitoring of the MHM interventions at the ground level.

The success of some of the district-driven programmes in no way undermines the state-centric approach that is being followed in Rajasthan or in Bihar. For adolescent interventions to lead to better health, nutrition, child protection and sanitation indicators and finally overall empowerment of adolescents and women, a synergy has to be achieved between state and district administrations with central assistance, something similar to the Swachh Bharat model which adopted a district-centric approach with clear-cut hand holding under the state government.

At the end, state-centric as well as district-centric approaches have both proven successful through the proactive stance of the district administration, because the key to the success of any program lies in reaching the last mile. Whether the approach is top-to-bottom or bottom-to-top, what is crucial is that the results reach the people it is ultimately intended for, i.e. adolescent girls.

REACHING THE LAST MILE: CASCADING TRAINING MODELS

Menstruation is a normal biological process but the misconceptions and restrictions imposed upon the issue makes it as much a social impediment. Girls are not limited by physical constraints during their periods. What causes a girl to stop participating in normal everyday activities rises from the socially constructed negative associations of the issue. This leads to adolescent girls to often drop out of school, give up participating in physical activities like sports and dance, stop interacting with boys and often not interacting even with their own fathers and facing segregation at home. This segregation is associated with the stigma attached to menstruation that leads to girls losing their confidence, considering themselves to be not at par with the boys and eventually accepting that they are limited in ways that they are actually not.

In the state as well as district level approaches the key was to reach the last mile. This meant paving a path to reach the center of the socio-ecological model – the adolescent girl. For this it was crucial to build capacity of the groups that are the key influencers in a girl's everyday life – the spheres that form the immediate environment of the girl. UNICEF recognized this and advocated for the governments as well. Here arose the need to adopt a cascading model of training. Under this process, all the major line departments are encouraged to create their own pool of Master Trainers who then follow the cascading model and start building capacities of their concerned staff down the line all the way to the panchayat level. The key advantage of the cascading model of training was that it helped to create a robust team of knowledge practitioners and trainers at different levels.[7]

Trainings, whether cascading or not, are as good as the focus of the training itself. UNICEF followed a structured SBCC approach to create content that was innovative, informational, as well as easy to use and disseminate at scale. MHM trainings in states were a success but not the end. While the trainings yielded immediate results, it was clear that long-term impact of the trainings required a model that allowed multiple refresher trainings or continuous hand holding of influencers to ensure menstruation was portrayed positively in a factually correct manner.

FOCUSED SBCC APPROACHES: SHIFTING NARRATIVES FROM PAD-FOCUSED TO 'CHUPPI TODO'

Menstrual Hygiene Management is a focus area under SDG 6 – which is access to safe drinking water and sanitation. This often leads to confusion that menstruation is only about managing periods hygienically. Earliest interventions by governments of all focus states (as well as other states in India) revolved around the supply of free sanitary pads to girls in schools, to ensure that periods are managed hygienically. In 2014, UNICEF and WaterAid conducted a study across countries in South Asia and the results can be clearly seen in the spot analysis. There was a staggering lack of information on psycho-social changes and reproductive health or skills-based hygiene education (FSG 2016) and low capacity among teachers/frontline staff on MHM.

UNICEF has consistently worked towards shifting knowledge, attitudes and practices on MHM and not just dictated the use of particular menstrual absorbents. The key value addition by UNICEF in all the six states was the expertise in planning and developing training and communication packages aimed at different sections of the target audiences. The basic theme of the communication materials were developed centrally and remained the same for all states.[8] To support this, state-specific materials were exclusively developed as per the state's specific needs.

Across the six states, the major approaches adopted under the SBCC model revolved around intense interpersonal communication interventions in schools and communities, fostering community dialogues through creation of peer groups, teachers and frontline workers consisting of ASHAs, Anganwadi workers, Jal Sahiyyas, Swacchagrahis, and other state specific resources, social mobilisation interventions through innovative approaches, and even digital media in the state of Gujarat. The stress was on disseminating information through an edutainment approach.

[7] Details of the Trainings undertaken in states can be found in Annexures

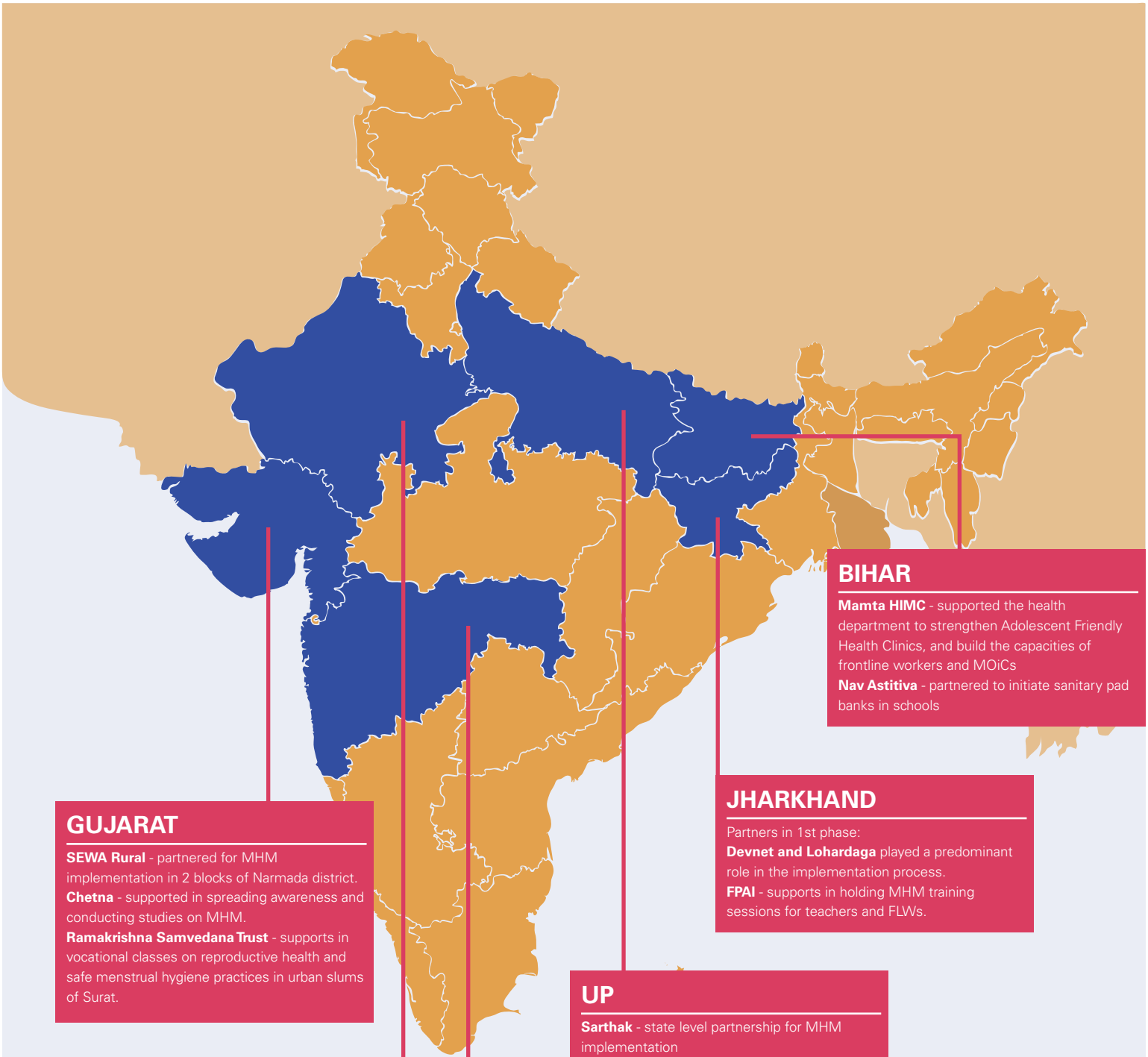
[8] Annexure 2: Details of the SBCC training materials

Thereforethe SBCC approach ensured that positive shift in knowledge and attitude in girls was supported by the increase in knowledge and awareness within her immediate environment as well as within the key influencers in the community, thus following the socio-ecological model. Many states have already started approaching boys and men in the community and all states are working towards a planned approach to introduce MHM to them in the next phase of the intervention.

Partnerships between non-governmental organizations (NGOs) and community-based organizations (CBOs) have been a significant force in efforts to address adolescent issues through collective means. In facing the challenges of scaling up the MHM initiatives, whether in terms of disseminating information, capacity building, creating CSO networks or providing support to the existing government networks, CBOs have played a crucial role.

Both NGOs and CBOs have performed different functions within this partnership. While NGOs have been key in conducting research and endline assessments, supporting capacity building initiatives and supporting government's existing services, CBOs have played an equally important role in bringing in the local perspectives to create champions and innovations within communities.

The network below shows the commitments and contributions of key partners who supported scale-up of the MHM initiatives in the focus states.



BIHAR

Mamta HIMC - supported the health department to strengthen Adolescent Friendly Health Clinics, and build the capacities of frontline workers and MOiCs
Nav Astitiva - partnered to initiate sanitary pad banks in schools

JHARKHAND

Partners in 1st phase:
Devnet and Lohardaga played a predominant role in the implementation process.
FPAI - supports in holding MHM training sessions for teachers and FLWs.

GUJARAT

SEWA Rural - partnered for MHM implementation in 2 blocks of Narmada district.
Chetna - supported in spreading awareness and conducting studies on MHM.
Ramakrishna Samvedana Trust - supports in vocational classes on reproductive health and safe menstrual hygiene practices in urban slums of Surat.

UP

Sarthak - state level partnership for MHM implementation

RAJASTHAN

Insaniyat - engaged with adolescent girls and addressed their queries on key issues regarding health and hygiene and conduct anemia tests for adolescent girls.
JatanSansthan– engages with adolescent girls in and out of schools and provides trainings in anganwadi centres on MHM.

MAHARASHTRA

Lulla Charitable Trust, Sangli - training of the district level Master and Base Trainers.
WIT Foundation, Sangli - partnership for supplying free sanitary absorbents in some schools, and also supply of Master Trainers.
Village Social Transformation Foundation - Implementing MHM Awareness program in 850 villages with the help of Trained resources in 20 districts

EMPOWERING ADOLESCENTS GIRLS AS CHANGE AGENTS

MHM, through the intervention, has served as an entry point to address issues pertinent to adolescents, especially adolescent girls. In the first 2 phases the key point of intervention has been the schools with a lesser focus on out-of-school girls within the community.

The success of any intervention lies in the key participant being empowered to take the intervention forward. Similarly, all 6 states have laid stress on empowering girls within schools to take on the role of Peer Educators.

The Peer Educators as found under RKSK are mandated to create Adolescent Groups both at school and community levels to disseminate messages on safe MHM practices. They also participate in community meetings and other programmes like VHNDs to spread awareness on MHM and adolescent related health issues. The peer educators are equipped with a tool kit to create awareness on puberty, health, nutrition, reproductive health, MHM and other key issues that impact adolescents, freqently asked questions (FAQs) and game-based activity tools like cards to engage with the community.

Peer Educators are girls from within the schools and community making them highly visible and trustworthy. They are very motivated and go out of their way to make sure the information imparted is accurate and entertaining because they believe girls must know all about menstruation prior to menarche.

In states like Jharkhand the Peer Educators are closely linked to the Bal Sansads or Children's Parliament and the Health Minister is often in-charge of creating awareness on MHM. In one such KGBV in Ramgarh district, the Peer Educators have written and created a nukkadnatakas well as a song based on their personal experiences to impart messages on MHM to girls.

In three districts of Mirzapur, Jonepur and Sonbhadra in Uttar Pradesh a team of Peer group volunteers have been handpicked to create a Red Force who have beenexperienced, committed and proven ambassadors of MHM. These RED Force members are mandated to assist the Education, Health, ICDS and Panchayati Raj departments. They have also been mandated to adopt a school in their village/block and disseminate knowledge on safe MHM practices.

Other state-specific innovations like SwacchtaSabhas, Bhaiyya Didi Groups, Maa-BetiSamvad, ChuppiTodoDiwas are being used in different states to reach out to out of school adolescents, mothers, community leaders and male members of the society to ensure girls do not face discrimination based on menstruation.


सफाई मंत्री

‘SAFE SPACES’ TO ENCOURAGE ADOLESCENT-FRIENDLY DIALOGUES

For silence, stigma and shame to end it is important that adolescents have access to a space where their needs and asks are prioritised over others. Innovations have taken place in all the states to facilitate adolescent-friendly spaces where they can initiate dialogue and discussions around adolescent issues, especially MHM.

A key focus of the MHM interventions was to reach out to girls in residential schools of **Kasturba Gandhi Balika Vidyalayas**. A holistic approach to adolescent health issues, especially MHM has evidently been the key focus in KGBVs. Emphasis has been on building capacity of teachers on safe MHM practices. The focus is to provide holistic solutions on adolescent health issues and MHM to girls studying in these schools by creating peer educators, building capacities of teachers on ARSH and MHM, ensuring supply of sanitary pads and providing incinerators in these institutions.

The Rashtriya Kishore Swasthya Karyakram, the flagship programme for implementing Adolescent Health issues across the country have initiated the **Adolescent Friendly Health Clinics (AHFCs)**. Advocacy efforts have focused on making use of this platform to address adolescent health issues of girls in and out of school. These AFHCs are mandated to be equipped with a doctor, a counsellor and two ANMs. These clinics also provide counselling on MHM and store and supply menstrual absorbents.

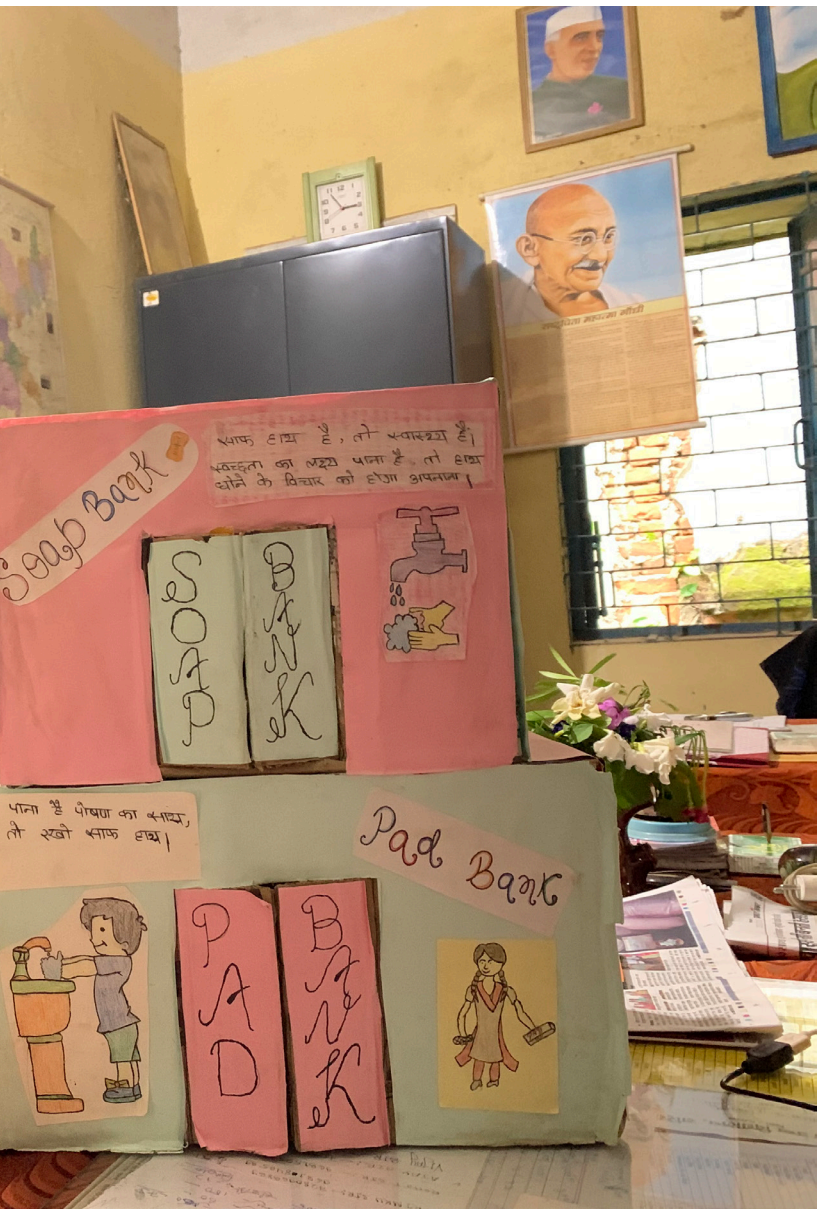
In Bihar, the government activated 206 Adolescent Friendly Health Clinics in ten priority districts and have been working towards creating a strong peer groups mechanism at the village level. Under this intervention it has been planned that a group of two boys and two girls arewill be recruited to assist ASHA workers who have been trained to counsel the community on adolescent issues including safe menstrual hygiene practices.

States have also independently initiated successful innovations that display knowledge materials on menstruation and especially encourage interaction through games and play in schools. The areas often carry drop boxes where girls can ask questions related to menstruation anonymously, creating an informal support system within the school. The spaces provide the platform to help end the shame and stigma around periods, provide counselling services and create a space for managing periods safely, hygienically and with dignity. Some of these include exclusive **MHM Changing Rooms** in Maharashtra, **Adolescent Corners** in Gujarat, **Pad Banks** in Jharkhand, **Sanitary Pad Banks and Trust Boxes** in Bihar, and MHM Learning Labs in Uttar Pradesh. In Uttar Pradesh, these corners are open to parents, women's groups and frontline workers on designated days where they can bring members of the general public and initiate MHM-centered discussions and activities. In communities where girls find it difficult to find physical spaces to discuss menstruation, the above-mentioned areas become a 'safe space' where informal exchange of knowledge can take place. They provide the much needed social engagement as well as support groups for girls.

ACCESS TO MENSTRUAL ABSORBENTS AND DISPOSAL

Positive shifts in knowledge, attitudes and behaviour in the MHM value chain include empowering adolescent girls with the agency to take informed decisions on use of hygienic menstrual absorbents and the knowledge to dispose the used absorbent safely thereafter.

State governments in all the focus states have dedicated schemes to distribute sanitary napkins to girls in schools and communities. The schemes are often plagued with issues of quality, procurement, storage and distribution. There have been cases where sanitary napkins provided free of cost have gone unused by girls because of lack of knowledge to use the product or lack of space to dispose the product after use. SBCC interventions providing knowledge on informed choice and empowering girls to choose the product they find comfortable have been therefore deemed necessary. States like Jharkhand and Rajasthan focused on creating demand for use of hygienic absorbents by enabling girls with information on managing periods as well as disposing products without shame. This has built a mechanism where girls demand absorbents as and when they need them. Parallelly, the state machinery focused on the supply side of the issue by procuring and distributing sanitary pads and the programs ensured that the girls were not just aware but also ready to make use of the systems. Bihar has introduced the MMKUY where direct benefit is transferred to the girls' accounts so they have access to funds and the flexibility to decide how to manage her period hygienically and safely.



Hand-in-hand with any supply of menstrual products lies the need to build knowledge and infrastructure for the disposal of the used products. While myths and taboos around menstruation limit girls and women in their everyday lives, there are similar misconceptions around disposal of used menstrual products. While looking at MHM holistically, disposal is a huge chunk that cannot be ignored. With states continuing to supply free sanitary napkins, the need to build awareness, end misconceptions and set up infrastructure to dispose used materials is imperative.

Infrastructure to tackle disposal at scale, especially in residential schools have been successful. KGBVs have working incinerators that help girls dispose used products. But the same is yet to happen at non-residential schools and at the community level. In Gujarat experiments with locally produced clay incinerators have shown some positive results but there is no evidence of it working at scale.

While supply of sanitary absorbents and disposal have not been UNICEF priorities, the team has been providing technical expertise and hand holding states to find solutions to the issue that is massive in scale.

CHALLENGES AND THE WAY FORWARD

Adolescents girls and women are central to designing a successful MHM intervention. Between 2016-2019 substantial efforts have been put in to pave way for proving a case to consider MHM as an entry point to strengthening adolescent centric programs. This has clearly open doors for further dialogue and advocacy to build robust and continuous MHM focussed programs within the existing government departments and programs.

GOVERNMENT STRUCTURES AND ADVOCACY

One of the key challenges confronting the state governments is the problem of how to scale up adolescent and MHM interventions across the states. An analytical study of all the states show that adolescent interventions are confined to certain parts of the state or in select districts. While the recent UNICEF-supported programmes have been focused in the right direction, emphasizing on creating awareness rather than just promote a particular type of absorbent, it has yet to reach a significant part of the population. One of the biggest stumbling blocks in this regard could be the absence of structures and proper government machinery in many districts across these states. The flagship programmes, like RKSK and SABLA around which adolescent and MHM interventions have been built are non-existent in many districts of Gujarat, Bihar, Uttar Pradesh and Rajasthan. Advocacy with the state governments need to focus on availability of infrastructure before planning to scale up adolescent/MHM interventions across the state.

Even in those areas where adolescent-centric schemes like RKSK, SABLA, SBM (ODF+), and Kishori Shakthi Yojana are active, further push needs to be added for the government to strengthen their reach and power. In many districts, Adolescent Friendly Health Clinics have not been created or are non-active. Institutions like AFHCs which provide counselling services on diverse aspects of health, including menstruation, through medical professionals and trained counsellors need

to be strengthened and made adolescent-friendly. It must be advocated to governments to ensure that proper budgets are allocated for strengthening of these institutions.

Considerable convergence of government departments implementing adolescent issues has happened in many districts across states. This needs to be followed up and emulated in other districts and states. Learnings from the existing states can help states start working on MHM and whether a district centric or a state centric model arises depends on the social, cultural and political conditions present in the states. In case of the district-driven approach, state governments could motivate the DMs to take ownership and to ensure convergence at the district level and implement adolescent-related schemes while the state government takes charge of budgeting, monitoring and evaluating the programme. In case of a state-driven approach the state government should guide the district administration to scale up adolescent interventions by providing appropriate guidelines for replication of state-level convergence models.

There are several good practices adopted by the districts like Giridih in Jharkhand and Narmada in Gujarat that have been documented through this effort. These must be made available for districts that start implementing adolescent centric/ MHM interventions. State-level deliberations and experience sharing workshops should be held to facilitate this process of a more diversified, yet unified MHM implementation process across the state. Along with physical meets webinars could be conducted to share the learnings and challenges to fortify cross leaning.

OPPORTUNITIES

Menstruation has already recognized as much a social construct as it is a biological inevitability. The need of the hour is to change the narratives prevalent around menstruation. For this to happen, the governments, the civil society and the various stakeholders need to take a proactive stand. As the socio-ecological model highlights, to empower the adolescent girl various structures around her need to be strengthened.

It should be advocated that education with a focus on reproductive health and safe menstrual practices should be made a part of the school curriculum to ensure continuous and repetitive sharing of messages. Children studying in schools as well as teachers are overburdened and one way to ensure they do not feel the added pressure of another subject to teach is to include menstruation in existing syllabi.

While cascading training models reaching teachers have been positively received, continuous sessions with the teachers is important to ensure lessons on menstruation and sex education are not skipped. The teachers must feel equipped to handle the subject through continuous refreshers.

The scale of trainings is huge and it is understandable that continuous hand holding of teachers is a dream rather than reality. While a person to person training cannot be replaced by anything technology must be explored to assist in scale up and continuous hand holding of teachers and other stakeholders. Menstruation has always been clouded by silence. There is on-going interpersonal communication work which is without a doubt helping girls come out of the cocoons. Further work could explore possibility of a communication campaign going beyond and involving mass media and direct media. This will contribute to not just help reach out to all sections of the society to normalise menstruation. It is important that menstruations starts getting space in public discourse and discussions therefore end the silence.

Digital Media campaigns such as #KemChoPeriod in Gujarat too must be explored as a possible way to involve different stakeholders as well as adolescent girls to voice their opinions. While a digital campaign may not penetrate deep rural areas, it has the ability to create local influencers who can have cascading effects bringing voice to the issue.

Adolescent girls are the primary targets of MHM interventions and rightly so because they are the most vulnerable to health and social risks. Furthermore, many of them will at some point become mothers and maternal health has profound consequences for subsequent generations. There is a need to reach out to adolescent girls through various platforms by building the capacities of parents, teachers, frontline health workers and all those who interact with them closely. This can only be achieved by building the capacities of these influencers through planned strategic capacity building interventions. To create a constant dialogue on adolescent issues, it would be pragmatic to strengthen existing infrastructure and create more Peer Groups. Along with it, create more safe spaces and platforms like adolescent corners and adolescent friendly health clinics where girls can freely discuss taboos around menstruation and ways to hygienically manage menstruation. The beginning of this can be seen in Bihar, Jharkhand and Gujarat.

It is also vital to sensitise and engage adolescent boys in these deliberations. Male sensitization at the community level will have a very positive effect not only in encouraging safe MHM

practices but will also have a profound impact on various gender inequality issues thereby fostering a supportive attitude in the communities they live in. It will also do good to involve social and religious leaders in the MHM campaign as a lot of stigma revolves around religious issues.

The IEC/ BCC materials which are being used under MHM/ adolescent interventions are already well designed. It could be considered to make the accompanying tools more interactive. Efforts must be made to make the creation and use of these materials co-creative and participatory so that the focus remains on the users and their specific requirements. Modern technology such as mobile phones, the internet, etc. should be used to support the scaling up of these materials to make them more user-friendly – not just for the girls but also the trainers.

PRODUCTS AND INFRASTRUCTURE

Accessibility to hygienic menstrual absorbents at affordable prices is an important determinant of menstrual hygiene management practice. Many state governments have been trying to address this issue through centralized distribution and by encouraging SHGs and local entrepreneurs to manufacture sanitary pads. But these efforts have not succeeded in giving the desired results. If sanitary pads are to be supplied for free then the process must be continuous and modalities must be worked out accordingly.

There is a lot of emphasis on the SHGs and local entrepreneurs to manufacture sanitary pads. Scale up of such models have to be assessed and success stories must be unearthed. And if this model has not been succeeding for all these years, cognizance must be taken to return to the drawing board to create a model that works rather than implementing the same in different places.

There is also a need to create the right spaces for adolescent girls and women to practice safe menstruation practice in schools and in the privacy of their homes. The National Family Health Survey 4 (NFHS 4) shows that about 62% women are using cloth for managing menstruation. It is an accepted fact that girls/women who use cloth as absorbents are not able to follow safe hygiene practices due to lack of space for washing and drying them in sunlight. Even girls/women who use sanitary pads face issues regarding spaces to change and dispose them. In schools, higher educational institutions, hospitals and in public spaces, women's toilets need to made MHM friendly with provisions for changing and disposal of menstrual absorbents along with access to water and soap.

Establishing vending machines and incinerators in schools other than KGBVs need to be assessed for quality of the product disbursed, operation and maintenance of these machine and feasibility of maintaining these machines within schools in a long term. As for incinerators, there must be a study to see the impact of faulty machines with high operational costs and study them for safety standards especially from the perspective of impact on health of girls in case they do not follow stringent safety standards.

Advocate with state governments to have safety and quality standards for the menstrual absorbents distributed at scale.

The sustainable disposal of absorbents is another important issue that governments and policy makers should take note of. Misconceptions regarding the disposal of used absorbents must be tackled, and infrastructure to dispose absorbents at scale must be made available. In most non-residential schools in targeted states, working incinerators continue to be a distant dream. Knowledge and availability of disposal methods in all schools, homes of girls/women, and public spaces is essential. Where possible, the government can promote and make available environment-friendly menstrual absorbents. However, the choice of what product to use must still be left to the individual girl.

CREATION OF NETWORKS

MHM for long has been a lonely process – for girls when on their period, for mothers in their act to talk to their daughters, for boys go spend their lives not knowing what it is and for communities hiding girls and women. There is an opportunity to create networks within the civil society, NGOs and CBOs to pro-actively take up the issue. A platform like a CSO forum created and integrated into to the state structure for effective implementation and monitoring of the MHM programme would be very effective.

Partnership pools for each district to support the district administration, especially in areas like SBCC and capacity building initiatives too will help the scaling up efforts of MHM programmes.

EVALUATION

A model to assess MHM implementation in the context of adolescent centric programs would be helpful to showcase the long and lasting effect of a girl who is aware of menstruation at menarche and one who is not. There is a need to have clear indicators to show the impact from a physical and social perspective along with WASH.

CONCLUSION

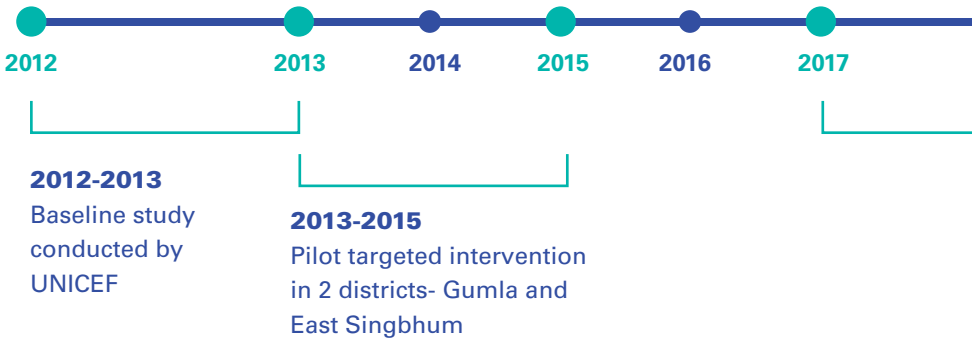
With limited resources available to address adolescent health issues, understanding the links between menstrual health and hygiene and a broader set of norms can help to identify if there is an opportunity to influence a holistic set of outcomes, and set girls on a longer-term path to success. While UNICEF's recent programmes have been evidently successful in making the lives of menstruating girls and women much easier, there is still a long way to go.

As UNICEF's Gender Action Plan states, MHM is a cross cutting issue with inter-linked priorities. It may not suffice to have a single nodal department or a single fund to address MHM because of the multi-faceted nature of the issue. The interventions since 2014 have proven there is a need to talk about MHM in the context of adolescent centric issues and not in isolation to ensure buy in from various stakeholders. And this must continue to be scaled up in the focus states, other states as well as at the centre.

Proper MHM is therefore an important step towards safeguarding the dignity, bodily integrity and overall life opportunities of women and girls. Only when girls and women are emancipated from the stigma attached to their menstruating bodies can they lead healthy, fulfilling, independent lives. Empowerment of girls leads to better futures for women, children, and families, ultimately paving the way for a significant intergenerational impact.

ANNEXURE 1: STATE TIMELINES

JHARKHAND



BIHAR

2012
Menstrual Hygiene Pilot project initiated by the Government of India - Nine districts in Bihar were identified for launching this pilot project wherein a set of six napkins costing six rupees per pack were distributed by ASHA workers among adolescent girls and women of reproductive age in the state.

2014-2016
UNICEF in partnership with the Government of India and Integrated Development Foundation launched a social and behavioral change intervention - called Promoting Young Adolescents Reproductive Health Initiative (PYARHI) in 14 blocks of Nalanda and Vaishali districts.

2013
UNICEF conducted a formative research to determine the existing practices, attitudes, norms and stigmas related to Menstrual Hygiene Management in the state -The survey conducted in two districts of Vaishali and Nalanda indicated very low awareness and hygiene standards among adolescent girls regarding usage and disposal of absorbents.

2017
National Health Mission asked the state governments to include Menstrual Hygiene Schemes in their Annual Programme Implementation Plans (PIPs)

2018-2019 –State Menstrual Hygiene Management Action Plan (2018 - 2022) published jointly by DWSD and NHM.

2018

2019

2017-2018 – UNICEF efforts towards mainstreaming and strengthening the processes, methods and tools developed in pilot intervention through RKSK program

2019 – A state level awareness campaign – Chupi Todo-Swasth Raho conducted across all districts. District and block level program officers and front-line workers from different programs were the fulcrum to reach communities, schools.

The district level action plans for implementing MHM in the respective districts under the leadership of district commissioner is in progress.

2018 – **Adolescent Cell** was established on May 28, 2018 with a brand identity and logo under the Women Development Corporation of the state. It was mandated that the Adolescent cell would act as a convening body for all departments working on women and adolescent empowerment issues in the state. The Focus of the adolescent cell would be geared towards ending child marriages in Bihar. But the cell would also work on other adolescent health related issues including menstruation.

2018

2019

Government Stakeholder Consultation was held with key line department officials from Health, Education, SRLM, ICDS and Women Development Corporation.

CSO Partner State Level Consultation of organisations working on MHM was also organized to further supplement the inputs that would go into the action plan

State government launched the ambitious ***Mukhyamantri Kanya Utthan Yojana***, a scheme of conditional transfer of cash for empowerment of girls in a phased manner from birth till the day she completes her graduation.

2019 – 152 master trainers, four from each of the 38 districts were identified and trained on ARSH issues including menstruation for a period of five days.

UNICEF helped RKSK in reactivating and strengthening 127 Adolescent Friendly Health Clinics in twelve districts.

LAUNCH OF STATE ACTION PLAN - PROPOSED

MAHARASHTRA

IN 2010-2011
within this integrated program, through The Nirmal Gram Puraskar Guidelines (2010) UNICEF envisioned a formative research and a baseline survey on WASH, where one of the hygiene components included menstrual hygiene.

BETWEEN 2009-2011
UNICEF-Maharashtra was advocating for MHM at different meetings and spaces.

2011-2012
A baseline study in 2011-12 was conducted primarily for WASH through an organisation called Innovations, in which MHM as a component was included.

UP

2013
UNICEF with the support of IKEA Foundation initiated a pilot project to create awareness on Menstrual Hygiene Management in three districts of Uttar Pradesh - GARIMA. SBCC intervention focused on enhancing knowledge, positive attitudes and life skills of adolescent girls and women in dealing with Menstrual Hygiene in 1,974 villages spread across the districts of Jaunpur, Mirzapur and Sonebhadra.

2012
GoI sanitary pad distribution scheme launched.

2016
a **state roadmap for strengthening menstrual hygiene management** in Uttar Pradesh was developed with the active participation of various departments like SSA, SBM, ICDS and other public and private sector partners.

IN 2014-2015
'District approach to MHM' was introduced for scale, convergence and leveraging government resources. UNICEF as the technical partner, under the leadership of the CEO, Zilla Parishad, demonstrated MHM implementation in Thane District.

2014

2015

ONWARDS

district level implementation led by CEOs in 12/34 districts paved way for state level implementation

IN 2013-2014
the first WASH intervention with MHM component, the Daily Handwashing for an Ailment-free Life (DHaAL) project was implemented in Jalna district of Maharashtra by UNICEF with support from IDBI.

2017
The project '**Accelerating Menstrual Hygiene Management and WASH in Schools'** is being implemented with the help of SARTHAK , an NGO based in Varanasi which was associated with UNICEF under its GARIMA project in the state.

Separate district specific action plans are developed for each of these nine districts taking into consideration the realities that exist at the ground level.

2017

GUJARAT

2019 onwards
UNICEF with its partners to approach state for scale up of this intervention.

2018
launch of MH programme at the district level (Narmada).

2011 2012 2013 2014 2015 2016 2017 2018 2019

2011
GoI sanitary pad distribution scheme launched

2014 – pilot scheme was then merged with the Rastriya Kishore Swasthya Karikram. The Gujarat government was implementing this intervention in four districts of the state.

2017
UNICEF organized a one day state level workshop on MHM titled 'Safer Action for Safer Menstruation', in partnership with Sarva Shiksha Abhiyan, Gujarat - attended by Health Department, Rural Development Department, Women and Child department, Tribal Development Department and Education Department also deliberated on creating an enabling environment to facilitate formation of a state level MHM policy to step up MHM interventions in the state.

State level convergent committee for adolescent programme was established.

UNICEF - rural (in Narmada district+Sabarkanta) as well as urban (in Surat) interventions.

RAJASTHAN

2012
GoI sanitary pad distribution scheme launched.

2018 – budget of 716 million allocated for the upliftment of the MHM scheme.

state level consultation for MH Scheme.

2012 2013 2014 2015 2016 2017 2018 2019

2014
the scheme got a makeover and was re-named as the UDAAN scheme with the focus on reaching out both to school going and out of school adolescent girls including those staying in urban slums through distribution of sanitary napkins and getting the message of MHM across to adolescents.

2019
MHM intervention in the district (Udaipur).

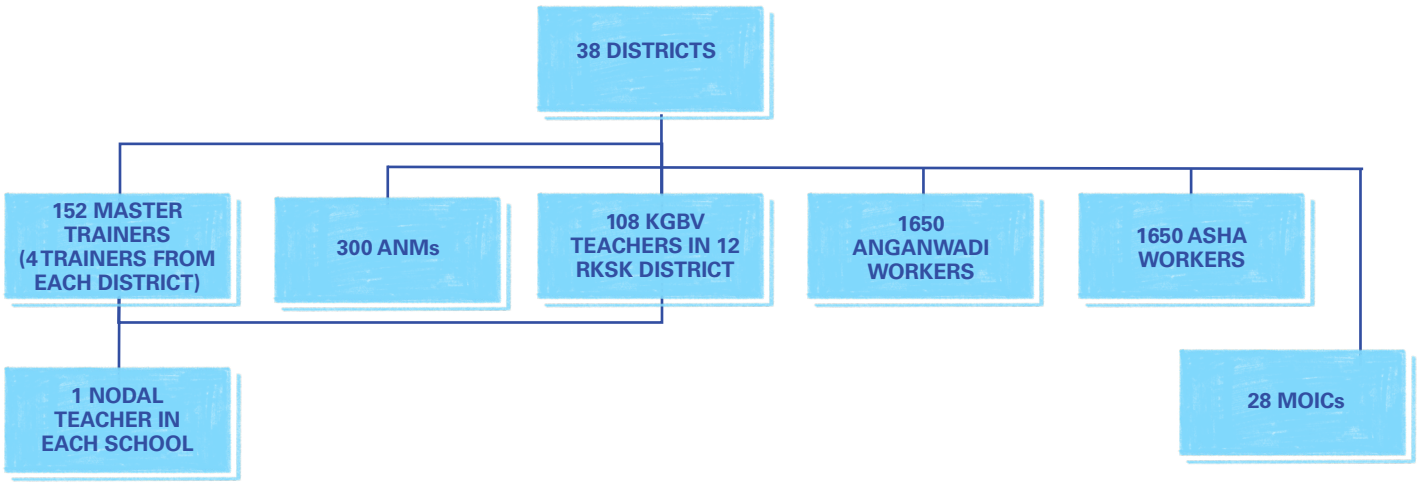
ANNEXURE 2: DETAILS OF THE STATE LEVEL TRAINING PROGRAMS IN A TABULAR FORM

JHARKHAND

PHASE 1	district level capacity building consisted of convergence workshop with all stakeholders
PHASE 2	13 blocks workshops for 11 KGBV, private schools male and female principals, ANMs, anganwadi workers and poshansakhi, active SHGs and Rani Mistris.
PHASE 3	MHM awareness workshop with KGBV students, all upper primary and higher secondary schools
PHASE 4	Gram Panchayat wise MHM awareness was provided to PRIs, anganwadi centre wise meetings with adolescent girls and women and village wise MHM Sabha with (19th of every month during swachhatasabha) youth and communities.

BIHAR

On a state level, 152 master trainers, four from each of the 38 districts were identified and trained on ARSH issues including menstruation for a period of five days. The Life Skill Based Training Module was used to build the capacities of 108 KGBVS teachers who were trained as Master trainers in 12 RKSK focus districts. Moreover, 1650 ASHA workers, 1650 Anganwadi Workers, 330 ANMs and 28 MOICs were trained in the state



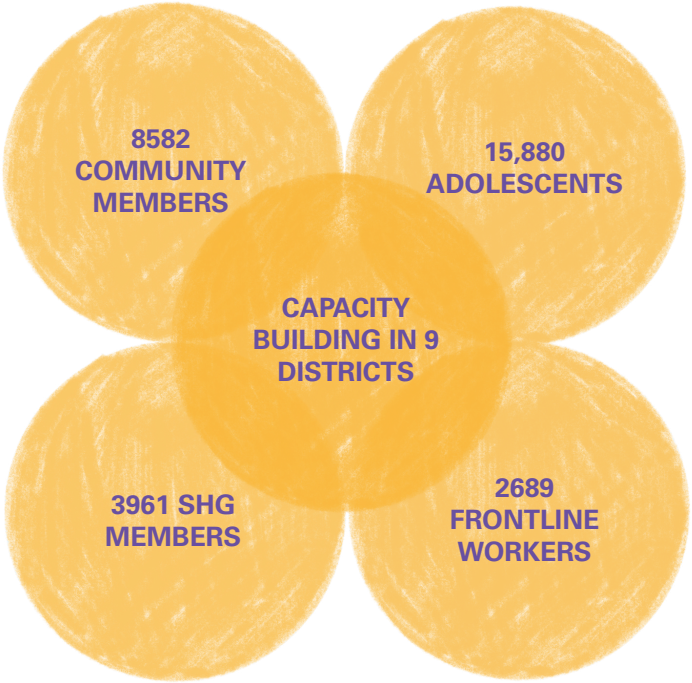
MAHARASHTRA

At present, 667 Master Trainers on MHM have been capacitated at the state level:

- 2 trainers from each district, a pool of 309 Master trainers trained on MHM from all rural districts of Maharashtra from WSSO
- 5 teachers from each district, 195 Master trainers of Education Department from all the 36 districts of Maharashtra.
- 72 master trainers from MSRLM representatives working as either District Managers, Community Cluster Coordinators, Block Managers from 9 saturated blocks of MSRLM in various districts of Maharashtra.

UP

In UP, within a span of one and a half years in nine districts out of which, five districts were added only in 2019, the MHM intervention has managed to orient more than 15,880 adolescents,n2689 frontline workers, 3962 SHG members and 8,582 community members through capacity building initiatives.



GUJARAT

Narmada District -The Intervention was targeted to reach out to more than 2,00,000 girls, both school-going and out-of-school in 260 primary schools and 46 secondary schools of these two blocks. These included Anganwadi workers, Asha workers, ANMs, ICDS supervisors in AFHCs, volunteers and ground level staff at the field level. Apart from FLWs, 193 teachers were trained in 5 batches. The training sessions were conducted in a series of batches of less than 45 participants each.

S.NO.	PARTICIPANT CATEGORY	NO. OF PARTICIPANTS TRAINED
1	AWW	303
2	ASHA / ASHA Facilitator	262
3	ANM / ICDS Supervisor/ AHC	66
4	Teachers	193
5	Remaining	43
6	On site	25
	TOTAL	**900**

Sabarkantha District -The MHM part of the training has been completed in 350 high schools successfully reaching out to more than 30,000 students. The training process has now been expanded to another 650 upper primary schools in the district

MHM TRAINING SESSIONS

350 HIGH SCHOOLS AND 650 UPPER PRIMARY SCHOOLS

30,000 STUDENTS REACHED

Surat x- A group of 30 city level volunteers have been trained as Master trainers and have already sensitized and trained teachers on MHM.

MASTER TRAINERS AT CITY LEVEL = 30

RAJASTHAN

The nodal department of WCD had a pool of 44 Master Trainers consisting of 8 male and 36 female professionals, while PRI department had a pool of 54 trainers, 47 male and 7 female trainers. The Education department currently has a pool of 15 trainers and is in the process of creating a separate pool of 80 Master Trainers who will be involved in creating trainers at district, block and GP levels for the successful scale up of the MH Scheme initiative.

The pool of Master Trainers will in turn train the batch of trainers under each department.

ANNEXURE 3:
HOLISTIC IEC/BCC PACKAGES

The IEC/BCC materials created were meant to supplement the activities of peer groups, mothers, teachers and frontline health workers. This included posters, questions and answers, flip charts and mobisodes. The main communication package that was developed consisted of

(a)Five Facts for Life (FFL3)
(b) IPC videos of Ammaji Kehti Hai series,
(c) Paheli Ki Saheli (Friends of Riddles) Package and
(d) ADHA full TV series episodes essentially an entertainment package on key aspects of menstruation and consists of films, riddles, activity-based games, and other communication tools.

The tools can be broken down as

(1) Paheli Ki Saheli films,
(2) Paheli Ki Saheli Storybook,
(3) Paheliki Sahelipersonal diary
(4) Paheliki Saheli story book and
(5) Paheliki Saheli Poster. These packages were remodeledin each of the states with state-specific context and materials.

Another IEC tool that is being widely used is AmmajiKehti Hain set of five films. This includes Meri Saheli Meri Maa– a film which showcases how to prepare for menarche, Sayani Sudha – which talks about menstruation, Pratiyogita– which highlights hygienic management of menstruation, Bapu– which emphasizes the role of fathers in supporting their daughters during menarche and Hero No 1, which talks about gender sensitivity among adolescent boys.

As far as mass media is concerned, episodes of AdhaFull, a 78 episode TV series which discusses existing social norms and showcases transformation from a culture of silence to a culture of change was screened at community gatherings. These half-hour episodes highlights adolescent issues like child marriage, nutrition, stereotyping of girls and boys, peer pressure, gender-based violence, sexual health, and menstruation through a mix of social drama, action, energy, fun, humour and emotions. The other tool that has been used selectively at schools to create awareness on adolescent issues and child health is the Facts for Life, a global publication that provides information in an easy to understand format to families and communities on how to save and improve the lives of children.

All these communication tools including posters, flip charts, MHM aprons(highlighting the process of menstruation) were used extensively in schools and community gatherings by peer groups, teachers and frontline health workers to create awareness on adolescent issues.

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