

WSSCC review of MHH progress and challenges: *Synthesis Report*



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Acknowledgements

The consultants would like to thank the various interviewees and organisations working on MHM that contributed their time, experience, insights and support to this review and analysis. These include representatives of Parliament, government ministries, departments, agencies and institutes, sub-national government authorities, schools, NGOs, CBOs, UN Agencies, a research institute, the media and the private sector in Tanzania, Kenya and India.

We found the studies in each of the three countries very interesting; and it was inspiring to learn about the progress achieved over the past few years, as well as the level of enthusiasm there is for taking MHH forward and making a difference for women and girls.

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Cover photo: Kenya MHM Training 2017/WSSCC

Dedication - Rehema Darueshi

Mother and Teacher at Toa Ngoma Primary School

MHM and Disability Activist and National MHM Trainer of Trainers, Head of Department for the Women, Children and Youth with Disabilities - Tanzania League of the Blind; and Board Member of SHIVYAWATA, the Association of People with Disabilities in Tanzania



It is with great sadness that we share that Rehema Darueshi, one of the most active MHM Champions and National MHM ToT Trainer in Tanzania, passed away in April 2020. Her views and ideas for what was needed going forward are incorporated into this review document.

Rehema was a very driven and inspirational person. Visually impaired herself she championed and led different initiatives to build the capacity of people with disabilities, especially her students. She pro-actively sought out children with visual impairments to help them attend school and from 2013 to 2018, and she managed to enroll 35 children who were visually impaired in the Toa Ngoma Primary School in Dar es Salaam, initially welcoming them to stay at her home, so they would not need to take the journey every day to and from school. She later lobbied with the Ministry of Science and Technology (MoEST) and was successful to build a dormitory, kitchen, dining hall and classrooms at the school for them to be able to live and study comfortably.

She worked in collaboration with *Hedhi Salama*, to develop and facilitate trainings for teachers and children who are visually impaired and children with other disabilities and she worked to have braille versions of MHM/adolescent books developed. She also had a dream to be able to set up a steering committee for MHM for people with disabilities and to be able to source increased resources and equipment, such as a braille embossing machine, to be able to support much larger numbers of girls and women with sight impairments across the whole of Tanzania.

She will be greatly missed by all of her family, friends, students, peers and colleagues in Tanzania, including in particular, all members of the Menstrual Health and Hygiene Coalition and also colleagues and friends from across the world – but we will continue to be inspired by her drive, commitment and vision for the future.

Acronyms

CHVs	Community Health Volunteers
CLTS	Community-Led Total Sanitation
CoETG	Centre of Excellence in Tactile Graphics (India)
CSR	Corporate Social Responsibility
DDWS	Department of Drinking Water Supply (India)
DPOs	Disabled person's organisation
FANSA	Freshwater Action Network South Asia
FBO	Faith-based organisation
FGM	Female genital mutilation
GBV	Gender-based violence
GIWA	Global Interfaith WASH Alliance (India)
GOI	Government of India
GSF	Global Sanitation Fund
HP-TWG	Hygiene Promotion – Technical Working Group (Kenya)
IIT	Indian Institute of Technology, Delhi
ISU	The India Support Unit
IVDP	Integrated Village Development Program (India)
K-SHIP	Kenya Sanitation and Hygiene Improvement Programme
KEWASNET	Kenya Water and Sanitation Network
LGA	Local government authority
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex and questioning or queer
MDWS	Ministry of Drinking Water and Sanitation (India)
MHAI	Menstrual Health Alliance India
MHH	Menstrual health and hygiene
MHM	Menstrual hygiene management
MHRD	Ministry of Human Resource Development (India)
MoDWS	Ministry of Drinking Water and Sanitation (India)
MoE	Ministry of Education (Kenya)
MoEF	Ministry of Environment and Forestry (Kenya)
MoEST	Ministry of Education, Science and Technology (Tanzania)
MoEVT	Ministry of Education and Vocational Training (previous name of the Education ministry, Tanzania)
MoH	Ministry of Health (Kenya)
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children (Tanzania)
MoHFW	Ministry of Health and Family Welfare (India)
MoHSW	Ministry of Health and Social Welfare (previous name of the Health ministry, Tanzania)
MoPSYGA	Ministry of Public Service, Youth and Gender Affairs (Kenya)
MP	Members of Parliament
NBS	National Bureau of Standards (Tanzania)
NC	National Coordinator
NFHS	National Family Health Survey (India)
NGO	Non-governmental organisation

NITI	National Institute for Transforming India
PO-RALG	President's Office – Regional Administration and Local Government (previously known as the PMO-RALG, Tanzania)
RCH	Reproductive and child health
RKSK	Rashtriya Kishor Swasthya Karyakram (adolescent health programme) (India)
RTE Act	The Right to Education Act (India)
SBM	Swachh Bharat Mission (India)
SBM-G	Swachh Bharat Mission-Gramin (India)
SHF	Sanitation and Hygiene Fund
SQAO	School Quality Assurance Officer
SRH	Sexual and reproductive health
SRWSP	Sustainable Rural Water and Sanitation Programme (Tanzania)
SWASH	School water, sanitation and hygiene
THF	The Hans Foundation (India)
ToT	Training of trainers
TWG-HP	Technical working group – hygiene promotion
UMATA	<i>Usafi wa Mazingira</i> Tanzania (Sanitation and Hygiene Programme)
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAT	Value Added Tax
WASH	Water, sanitation and hygiene
WPC	Women's Parliamentary Caucus (Tanzania)
WSSCC	Water Supply and Sanitation Collaborative Council
YKA	Youth Ki Awaaz (India)

Terminologies - MHM and MHH

The terms menstrual hygiene management (MHM) and menstrual health and hygiene (MHH) have both been used in this report. The term MHM has been commonly used over the past decade within the WASH sector. But in an effort to also acknowledge the importance of the health aspects of menstrual management, and to promote engagement with and of the sexual and reproductive health sector on menstruation, there has been a move to include the term 'health'. The WSSCC and the new Sanitation and Hygiene Fund (SHF) have therefore made a decision to start using MHH as their preferred term.

Menstrual health and hygiene (MHH) encompass both menstrual hygiene management (MHM) and the broader systemic factors that link menstruation with health, well-being, gender equality, education, equity, empowerment, and rights. These systematic factors have been summarized by UNESCO as accurate and timely knowledge, available, safe, and affordable materials, informed and comfortable professionals, referral and access to health services, sanitation and washing facilities, positive social norms, safe and hygienic disposal and advocacy and policy¹.

However, much of the work undertaken under this review was done under the banner of MHM. Hence, both terms are used at different points in this report, to align with the particular terminology utilized by the organisations at the time when the work was undertaken. Future work undertaken by the SHF, will however use the term MHH.

Terminologies - Trainers

A range of terminologies have been used for different kinds and levels of trainers across the three main study countries. These include:

- Master MHM trainers
- Senior MHM trainers
- MHM trainers of trainers (ToTs)
- MHM trainers

However, as the terms are fluid in use and not prescribed, in terms of the level of experience or the amount of training each person has received, this report uses the term 'MHM trainers' for all kinds, levels of seniority of the trainers being discussed.

¹ <https://www.unicef.org/wash/files/UNICEF-Guidance-menstrual-health-hygiene-2019.pdf>

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1. Executive summary

Background

The Water Supply and Sanitation Collaborative Council (WSSCC) has been at the forefront of innovation in policy and practice to ensure that WASH services meet the needs of menstruating girls and women. Since 2012, WSSCC has worked with governments to address gender inequalities, discrimination and social injustice in WASH and beyond, using MHM as an entry point. In collaboration with various ministries, partners and trainers, WSSCC has facilitated inter-ministerial, multi-stakeholder policy dialogues, and has led capacity building initiatives to create a cadre of trained MHM facilitators to support and directly implement programming on MHM using a holistic rights-based 3-pronged approach. Since embarking on this work, demand has grown steadily and WSSCC has worked with governments and other partners to respond to various demands.

At the time of writing this report, WSSCC is transitioning into the Sanitation and Hygiene Fund (SHF), which starts from the 1st January 2021. The SHF strategy has been approved, which includes Menstrual Health and Hygiene (MHH) as a key component. Hence the recommendations in this report will be used to assist the SHF to decide on the activities to prioritise going forward.

This report explores the current situation of MHH in selected focus countries, reflecting on the recent progress made and the remaining challenges. The three in-depth country studies looked at progress at three levels: a) nationally; b) progress catalysed with the support of WSSCC funding (outside of the Global Sanitation Fund, GSF); and c) progress achieved through the GSF-supported programmes.

The report considers MHM progress in relation to strengths, weaknesses, opportunities and threats and presents recommendations for further promoting and mainstreaming MHH in these countries and the contribution that the SHF can make. The review was undertaken between Nov 2019 and July 2020.

Findings and discussion

The findings and discussion section of the Executive Summary has been structured around a strengths, weaknesses, opportunities and threats analysis. The strengths section has also been sub-divided into observations at three levels: a) national; b) supported by WSSCC general funding (outside of the GSF); c) undertaken with the GSF / WSSCC support, through the Kenya Sanitation and Hygiene Improvement Project (K-SHIP) and the *Usafi wa Mazingira* (Sanitation and Hygiene Programme), Tanzania (UMATA).

A - Strengths

National policies, strategies and guidelines –

National progress – A range of progress has been attained by the governments in Kenya, India and Tanzania on integrating MHM into various policies, strategies and guidelines. For example, the Government of Kenya has worked hard with sector stakeholders over the past

four years to develop a comprehensive national MHM Policy and national MHM Strategy (published in 2020)². In India, there have been policies developed on MHM in schools at national level with action plans at state levels; and in Tanzania, MHM was integrated into the School WASH Strategy and Guidelines and Toolkits (developed initially in 2010) and MHH has also been included in the National Accelerated Investment Agenda for Adolescent Health and Well-Being (final draft, 2020).

WSSCC contributions – The WSSCC has provided significant contributions to the development of the MHM Policy and MHM Strategy in Kenya, along with a wide range of other actors. The biggest contribution that the WSSCC has made to the development of the policy has been supporting the training of multiple actors at senior level, who have then led and supported the development of the policy, including senior representatives from the Government of Kenya. The WSSCC National Coordination (NC) team were also key in supporting and encouraging the government in the process and the WSSCC also contributed some of the funds for the cost of the process to develop it, in collaboration with a range of other organisations. In Tanzania, the WSSCC NC team and other senior actors, trained with support from the WSSCC and other actors, have been advocating for including MHH in the National Health Policy. In India, WSSCC has worked with the state governments of Bihar, Jharkhand and Assam to develop guidelines for MHH programming.

GSF-supported programme contributions – The K-SHIP and UMATA programme teams have engaged in national dialogue activities. In Kenya, the team members have also contributed to developing the content of the MHM Policy and MHM Strategy.

Cross-sectoral and multi-sectoral collaboration –

National progress – In Kenya MHM has regularly been included in the Government-led national Technical Working Group on Hygiene Promotion (TWG-HP), which is under the national sector-wide approach. There are plans for a national MHM Task Force, although its establishment has been delayed due to the COVID-19 pandemic. In Tanzania, there is an active and diverse MHH Coalition with more than 700 members, which is an interest-based group currently chaired by the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDEG)³. Efforts are being made to increase engagement across sectors and strengthen coordination. In India, the Menstrual Health Alliance (MHAI) is a national-level platform of approximately 35 organizations co-chaired by WaterAid and Development Solutions. In India, some progress is also being made to increase engagement of sectors, such as from the sexual and reproductive health (SRH) sector and gender and environmental actors, although there is no government-led multi-sector coordination platform relevant to MHH. UNFPA is a member of the National MHH Coalition in Tanzania and contributed to the last stages of the MHM Policy development in Kenya, but has not yet been highly engaged in Kenya or Tanzania. It is hoped that their engagement will increase over the coming years. UNFPA is a more active stakeholder on MHH in India.

WSSCC contributions – The WSSCC NC in Tanzania is one of the most experienced and active MHH actors in Tanzania and in 2019/20 was the Chair for the National MHH Coalition. The WSSCC NC team has worked hard to encourage collaboration and coordination across actors, and collaborates closely with UNICEF, one of the other key organisations leading on MHH in

² <https://www.health.go.ke/wp-content/uploads/2020/05/MHM-Policy-11-May-2020.pdf>

³ The chair changes annually on a rolling basis

Tanzania. In Kenya, the WSSCC NCs and WSSCC NC Assistant played key roles in supporting the MoH with coordination and multi-sector collaboration. They are clearly highly respected and valued by the government and other actors. A previous WSSCC NC is currently the co-convenor of the TWG-HP. In India, WSSCC⁴ has been working with partners (such as Global Interfaith WASH Alliance, Hans Foundation, Youth Ki Awaaz and the Menstrual Health Alliance India), to build momentum and alliances for ground-breaking action. WSSCC has also had a role in convening partners (together with Freshwater Action Network South Asia (FANSA) and WaterAid, to support national level consultation meetings in seven South Asian countries in advance of the SACOSAN VII⁵). They supported dialogue (such as the Pushing the Boundaries on the Menstrual Health Management Dialogue⁶), as well as contributing technical outputs (such as State MHM guidelines for Assam, Bihar and Jharkhand as well as state-level MHM training strategy).

GSF-supported programme contributions – The staff members of the UMATA and K-SHIP programmes in Tanzania and Kenya have actively engaged with collaborative activities, including related to the development of the MHM Policy in Kenya and for Menstrual Hygiene Day in both countries.

Training and teaching –

National progress – It is clear from the interviews and participants’ activities, that cross-country training and exposure has been very motivating for the people involved, some of whom have gone on to become key MHM activists in their own countries. These efforts have clearly led to a broadening of understanding of the elements required to support improved MHM. Training has also triggered the commitment of senior actors to take MHM actions forward, including influencing the development of the MHM Policy in Kenya and improving action at sub-national levels and in schools and communities.

WSSCC contributions – WSSCC have put significant effort into supporting capacity building on MHH in all three countries. They were one of the key organisations that provided leadership for training on MHH and funded a number of participants to attend trainings across countries. They also supported trainings for trainers at national level, together with other organisations, and in some cases also contributed through provision of trainers at sub-national levels. The trainings in Kenya and Tanzania mainly used the WSSCC training materials and approaches first developed in India. WSSCC Geneva Secretariat team supported a number of the key national trainings and they also recruited 5 regional trainers from the East and Southern Africa region (4 from Kenya, 1 Tanzania and 1 from Zambia).

The number of participants who have been trained as trainers, through courses with some contribution from the WSSCC (funding or provision of facilitators and training materials), in addition to contributions from others for the same trainings, is:

- **Tanzania** – international (3); national (132); sub-national (191) – with between 55-70% female participants where data was available – total 326
- **Kenya** – international (8); national (212); sub-national (193) – with 64% female participants for the sub-national trainings where the data was available – total 413

⁴ Whereas most MHH related activities in India are conducted by the ISU, the WSSCC Secretariat in Geneva has also had substantial engagement with and provides direct hands-on support to the ISU. Therefore, the term ‘WSSCC’ is meant to reflect the combined strength of the Geneva and India teams.

⁵ <https://www.wsscc.org/media/news-stories/sacosan-special-voices-people-vulnerable-situations-south-asia>

⁶ <https://www.path.org/resources/pushing-the-boundaries-on-the-menstrual-health-management-dialogue/>

- **India** – 500
- **West Africa** – 620
- **Total** – 1,859

Trainings supported by other organisations without WSSCC inputs, or undertaken by those trained with WSSCC support, but who then facilitated trainings with other resources, can be seen in [Annex II](#).

GSF-supported programme contributions – The UMATA and K-SHIP programmes have supported capacity building at sub-national level - district level in Tanzania and county level in Kenya, involving non-governmental actors, health staff, teachers and community-based volunteers. The data above includes these trainees.

Influencing and advocacy –

National progress – In all the focus countries, Menstrual Hygiene Day has been supported by a range of MHM actors. Capacity building of the County First Ladies in Kenya and the Members of Parliament in Tanzania has led to MHM being discussed at the highest levels, including in Parliament in Tanzania. In Kenya, the development of the MHM Policy and strategy and approval through the Cabinet, demonstrates commitment to MHM at the top level of government. India has in particular, undertaken a wide range of advocacy campaigns, including with the use of social media.

WSSCC contributions – Many of the key actors working on influencing and advocacy have increased their interest, knowledge and motivation through participation in the trainings facilitated and supported by the WSSCC and other partners. The trainings for the County First Ladies in Kenya and Members of Parliament in Tanzania, were led by the government and funded mainly by the WSSCC. The 'MHM lab'⁷ has also been a tool developed by the WSSCC in India, which has been utilised in some high-level advocacy events.

GSF-supported programme contributions – The UMATA and K-SHIP programme teams have engaged collaboratively with other actors for influencing and advocacy on the international MH Day and through other opportunities.

Research and learning –

National progress – A wide range of research and learning has been undertaken in India, Kenya and Tanzania, from programmatic studies to national studies and in-depth randomised controlled studies, on the impacts of use of different sanitary protection materials.

WSSCC contributions – The WSSCC was one of a number of organisations to fund the situation analysis undertaken as part of the policy development process in 2016 in Kenya. Beyond this, the WSSCC has not been involved much in large scale research in Kenya or Tanzania, although it has been supporting a study of MHH policy which is being undertaken by Columbia University, in the past year. This is focussing on the countries of India, Kenya, Senegal and the USA. Through the Joint Programme on Gender, Hygiene and Sanitation, WSSCC and UN Women funded nine studies and contributed to a better understanding of the MHM status and practices of women in vulnerable settings in Niger, Cameroon and Senegal. In India, WSSCC engaged in numerous pieces of research, including with the SHARE

⁷ The MHM Lab, is a participatory process that enables the participants to learn about menstruation through discussion, to learn about menstruation through pad making, breaking the silence through bracelet making and making a pledge and seeing a visual demonstration on disposal options. https://www.wsscc.org/sites/default/files/migrated/2018/08/MHM-Lab-Convenors-Manual-EN_web.pdf

Consortium on the specific impact of inadequate access to WASH facilities on women and girls⁸, as well as rights-based sanitation research⁹ and girls' and women's knowledge of MHH and their practices¹⁰.

GSF-supported programme contributions – The UMATA programme in Tanzania undertook a small-scale study on MHM in schools, before starting its MHM activities. In both Tanzania and Kenya learning has been supported as part of the programme processes, but not supported other stand-alone studies.

GSF- supported and other programmes –

The K-SHIP and UMATA programmes have been supported by the GSF in Kenya and Tanzania respectively. Neither integrated MHM into their initial design, but both strengthened their work on MHM as the programme progressed, with useful learning for future programming. Both focussed mainly on MHM in schools, although in Kenya, some activities have been undertaken at community level, through the triggering and follow-up processes.

Equality and non-discrimination and leaving no-one behind –

National progress – WSSCC and other actors have already made efforts to work with and reach certain groups of people who may be most disadvantaged, or are likely to be left behind. This includes people with different kinds of disabilities across the three countries, pastoralists and inmates in prisons in Kenya, and people in sexual and gender minorities (SGM) in India. A number of MHM trainers and MHM Champions themselves have disabilities, or come from marginalised groups and have become strong role models.

WSSCC contributions – Government and non-governmental actors who have been participants in the trainings supported by WSSCC and other partners in Kenya, have then gone on to undertake work on MHM in pastoralist communities and in prisons, using other resources, as part of their own work. In both Kenya and Tanzania, trainees who themselves have disabilities have also gone on to train people on MHM through their own work, without WSSCC funding. In India, WSSCC has supported people living in areas such as the Naxalite districts, covered by the Aspirational Districts' Programme, as well as in residential schools for girls from distant rural locations and people from the Scheduled Castes and Scheduled Tribes. WSSCC has worked with communities in remote and inaccessible rural areas, including in the Pindar Valley (Uttarakhand). A 2019 'Leave No One Behind Consultation' in Rishikesh, brought together women, youth, elderly, people with disabilities, shanty dwellers, homeless women, farmers, people who manually scavenge, Dalits, Adivasis, migrants and refugees, people who are transgender, sex workers and people living with HIV.

GSF-supported programme contributions – A few of the K-SHIP and UMATA sub-grantee trainees who participated in MHM trainings with support from the WSSCC and other partners, have also gone on to undertake MHM activities with groups who may be most disadvantaged, such as pastoralists in Kenya.

⁸ Sahoo, K. C., Hulland, K. R., Caruso, B. A., Swain, R., Freeman, M. C., Panigrahi, P., & Dreibelbis, R. (2015). Sanitation-related psychosocial stress: a grounded theory study of women across the life-course in Odisha, India. *Social Science & Medicine*, 139, 80-89.

⁹ Centre for Policy Research (CPR) in India Design and Implementation of Research on the Human Right to Safe Drinking Water and Sanitation: <https://www.cprindia.org/events/5456>

¹⁰ Torondel, B. et al. (2018) *Association between unhygienic menstrual management practices and prevalence of lower reproductive tract infections: a hospital-based cross-sectional study in Odisha, India.* *BMC infectious diseases* 18, no. 1: 473.

Menstrual hygiene products and materials –

National progress – Some efforts have been made across countries to increase access to a variety of sanitary products, in India this includes disposable products and in Tanzania and Kenya to locally made re-usable products. The Kenyan government committed, in 2016, to provide sanitary towels to all girls in public primary schools across Kenya and to girls in special secondary schools, although the supply is not yet consistent, or enough, to reach all girls at all times. A private sector actor, Varet Products and its associated social enterprise, Global Sanitation Environmental Products in Kenya, have undertaken a range of work in collaboration with County Governments and schools, to try and find a solution for the disposal of sanitary wastes in Kenya. In Kenya, the government has removed VAT and Excise Duty on sanitary pads (VAT), imported sanitary pads (the Excise Duty) and materials for making sanitary pads. This happened in stages in 2004, 2011 and 2016 respectively. In Tanzania, the government removed VAT from sanitary pads in 2018, but put it back on in 2019, as it was not seeing the reduction in cost of pads being sold. But this process has still been positive in starting the debate on how to make the environment more conducive for local manufacture of sanitary pads in Tanzania. In India, tax cuts have been instituted on MH products; and national standards reviewed for lower-cost/bio-degradable options; as well as to strengthen the supply chain for products made by Self Help Groups.

WSSCC contributions – In Kenya and Tanzania, the WSSCC has not been involved much in the area of menstrual hygiene products, except through the GSF-supported programmes. It's efforts in supporting the training of Parliamentarians in Tanzania, contributed to the removal of VAT from sanitary products in Tanzania.

GSF-supported programme contributions – The UMATA and K-SHIP programmes have supported the training of a few teachers and women's groups on the making of locally made pads, and in Kenya, a K-SHIP sub-grantee, the Catholic Diocese of Murang'a, in partnership with a representative of the Ministry of the Interior at sub-county level in Ithanga Division, have worked to develop a household burner for sanitary pads. But otherwise, the programmes have not been involved much in the area of menstrual hygiene products and materials.

B - Weaknesses

Policy and coordination – Only Kenya, so far has a specific national policy and strategy for MHM. MHH has not yet been integrated into an approved Health Policy in Tanzania, although advocacy efforts are on-going. Some sectors are also lagging behind in relation to their engagement in MHH, in particular actors working in sexual and reproductive health (SRH)/ reproductive and child health (RCH), gender, the environment and community development, although some progress has been made. These actors have been much less engaged than those working in WASH, environmental health and education.

In Tanzania, there has been some engagement of the SRH sector actors, with participation of the Assistant Director for RCH in a national advocacy event and MHM being integrated into the Accelerated Investment Agenda for Adolescent Health and Well-Being (final draft, 2020). There has also been some engagement of RCH actors at district and health facility levels in MHM, through adolescent clubs associated with the health facilities; and a few NGOs have also integrated activities into their RCH work, including related to post-partum bleeding. But

engagement of the RCH actors is, so far, still small-scale with significant opportunities for increased engagement and action. The Ministry of Health, Child Development, Gender, Elderly and Children, currently includes a Gender Development Division, but it is not clear that they have engaged in MHH to-date. Members of the Tanzania Gender Network Programme are active members of the national MHH Coalition. It is not clear that the ministry responsible for the environment in Tanzania has been involved in MHH to-date.

In Kenya, UNFPA started to engage during the final stages of approval of the MHM Policy development, but had not been engaged much before this. A number of County First Ladies have integrated MHM into their SRH advocacy campaigns, particularly linked to the “Beyond Zero Campaign”, and smaller NGOs have also worked to integrate SRH and MHM. But actions to date have been limited to a small number of SRH actors and there is a lot more opportunity for expanding this engagement in Kenya. The Ministry of Public Service, Youth and Gender Affairs is quite new to working in the area of MHM, but has shown interest in increasing engagement and the State Department of Gender now leads the National Sanitary Towel Programme and will also be the co-chair of the National MHM Task Force when it is established. The Ministry of the Environment attends occasional HP TWG meetings at national level. It is reported that they have been in increased dialogue and learning around the potential use of incinerators in schools, before making a decision to approve their use or otherwise, based on the costs/benefits related to the environment. In India, implementation of the state guidelines for MHH programming in Bihar, Jharkhand and Assam, still requires costed plans to be developed. Mentoring support to district level officials would help ensure that these guidelines and plans are integrated into state and district ways of working and ensure those responsible own the action plans and follow up on implementation. Effectiveness is jeopardized by a lack of follow-up and integration of the plans into government monitoring systems.

Capacity building – In Tanzania and Kenya, challenges are still faced, because even though there is commitment at Ministerial level across sectors, not all senior decision-makers in government ministries across sectors are aware of – or themselves committed to - MHM. This is influenced by the high turnover of staff, leading to a need for continual awareness-raising, advocacy and encouragement, all of which needs dedicated time and effort. There have also been limitations in the design of the training materials, i.e. neither tailored to meet the needs of different users nor systematically incorporating good practices from other organisations. In addition, there are inadequate materials for cascading the training to lower levels. The follow-up of trainers is another area where more attention is needed. In India the WSSCC training pack requires overhauling – with respect to the length, content and the session design. State level management arrangements for quality control of the training should be strengthened as well as accountability for follow-up on Action Plans post workshop. Monitoring and evaluation mechanisms should be able to clearly demonstrate and/or measure the contribution to outcome/impact level of results. For a long-lasting, sustainable effect, a long-term training strategy, with supportive supervision is important.

Disposal of sanitary pads – The disposal of sanitary pads is an area which needs more learning and work across all countries, including disposal in schools, public places and at the household level. A few efforts have already been made to improve the learning in this area, such as, in Kenya, those led by the private sector and the Ministry of the Interior at sub-county level in partnership with a religious organisation. More work is needed on supporting minimum standards for locally made materials in Kenya and Tanzania.

Engaging with communities on MHM – There are a range of case studies where engagement has been undertaken with communities on MHM, including under the GSF-supported programmes and independently by people trained in MHM through activities using their own resources, but engagement has tended to be small-scale to-date. More work is required to expand the scale of response at community level and to learn from the experience.

People who may be most disadvantaged and leaving no-one behind – More work is required to identify other groups of people who may be most disadvantaged, but who have at the moment been overlooked. Champions who themselves have disabilities and come from disadvantaged communities require resources to support their work. More appropriate guidance and training tools are yet to be developed for people with different kinds of impairments.

Gaps in WASH infrastructure in schools and public places – WASH infrastructure in schools, health facilities and other public places still have multiple gaps in the quality, number and appropriateness of the facilities for women and girls to be able to manage their menses effectively, in privacy and with dignity. This includes gaps in the availability of water, locks and even doors on toilet units. Schools in Tanzania have constructed separate girls' 'hygiene/changing/special' rooms, but these vary in quality, design and content and it is not clear how many are being used effectively.

Gaps beyond the facility functionality – There is a need to improve the systems to ensure the availability of water, soap and body/anal cleansing materials and emergency sanitary materials in toilets in schools and public places.

Monitoring – Monitoring of the outputs and outcomes of MHM interventions is still weak, and there is a need to establish key indicators to integrate into national monitoring systems, so as to be able to establish progress and to assess the effectiveness of interventions.

C - Opportunities

Cross-sectoral collaboration – Increasing engagement across sectors and integration of MHH into the policies of different sectors, are opportunities for expanding commitment and action. The established coordination mechanisms also offer an opportunity to increase engagement and coherence across sectors. The MHM Policy and Strategy in Kenya offer a clear pathway for moving forward with responsibilities already identified across sectors, backed by commitment at the highest level.

Building on the existing networks of MHM trainers and others – The wide range of people trained on MHM, some as MHM trainers of trainers, offer a significant opportunity for taking MHH forward over the coming years. But to make the most of this resource, support needs to be increased for follow-up, encouragement, sharing of experiences and monitoring of the efforts being made. There is a need to provide support to government to strengthen its coordination and facilitation of multi-sectoral work, which is critical but time-consuming.

Supporting MHM champions with disabilities and people from disadvantaged groups – The existing MHM trainers and MHM Champions who themselves have disabilities and who come from marginalised groups, offer a significant opportunity to establish increased support to groups who may be most disadvantaged. However, there is a need for increased coordination

of these actors, to identify others, who will also need to be trained and to provide dedicated resources to support them in their role as leaders, champions, trainers and role models.

Social media for outreach and engagement on MHH – The large number of youth and increasing middle classes, such as in India, offer increasing opportunities for the expansion of use of social media to reach more people on MHH. There are also opportunities to increase the use of more traditional media, such as local radio in local languages and the TV and written media, such as newspapers, for reaching people in rural areas and communities with less internet access.

Focus on MHH more broadly – There are opportunities to expand action on MHH through broader engagement across sectors, such as with actors working on SRH and more unusual areas such as in nutrition as in India. In Kenya, analysis of key actors across sectors, and their proposed responsibilities, has already been identified in the national MHH Policy and MHH Strategy.

Demographic changes – Younger populations have the potential to use their voice to challenge decision-makers and to transform social norms around MHH.

Large scale government-led WASH, education and other programmes – There is an opportunity to effectively integrate MHH from the start. So MHH actors need to be on the ball to make sure that MHH is integrated effectively into the initial design of major programmes.

D - Threats

Lack of political prioritisation and budgets for MHH – The limited awareness of senior decision-makers across sectors within ministries poses a challenge to prioritisation of resources for MHH. This is compounded by the regular transfer of senior staff, requiring continuous awareness-raising at this level.

The time and resources required for effective coordination across multiple ministries and sectors – It is very time-consuming to encourage, engage with and coordinate multiple actors across ministries and sectors, so without dedicated support and time for this process, progress is likely to be limited. This is particularly so, if the government is expected to do this without external support, as government actors often have very high workloads and are unlikely to be able to dedicate adequate time to do this alone.

Low level of hygiene promotion and menstruation/puberty education – Schools tend to only focus on the biological aspects of menstruation. Except where dedicated training has been provided for teachers on MHH, the taboos, beliefs and good practices or hygiene elements tend not to be covered in menstruation/puberty education in schools, resulting in barriers for effective MHH.

Gaps in the training for teachers, health workers and technical level across ministries – The standard training of teachers and health workers also tends to be limited to the basic biology, which limits the opportunity to change social norms and negative practices at scale.

Environmental concerns about disposable pads and limited low-cost solutions – Disposal options for single use sanitary pads remains the most under-developed aspect of MHH and

more attention to research and learning is needed, including on piloting options for improving the disposal situation.

Continuation of the COVID-19 epidemic for an extended period – The restrictions on engagement of actors within and between sectors are contributing to a loss in momentum for progressing MHH across the three countries. For example, it is contributing to the delay of the establishment of the MHM Task Force in Kenya, and reducing opportunities for continued capacity building and awareness-raising activities.

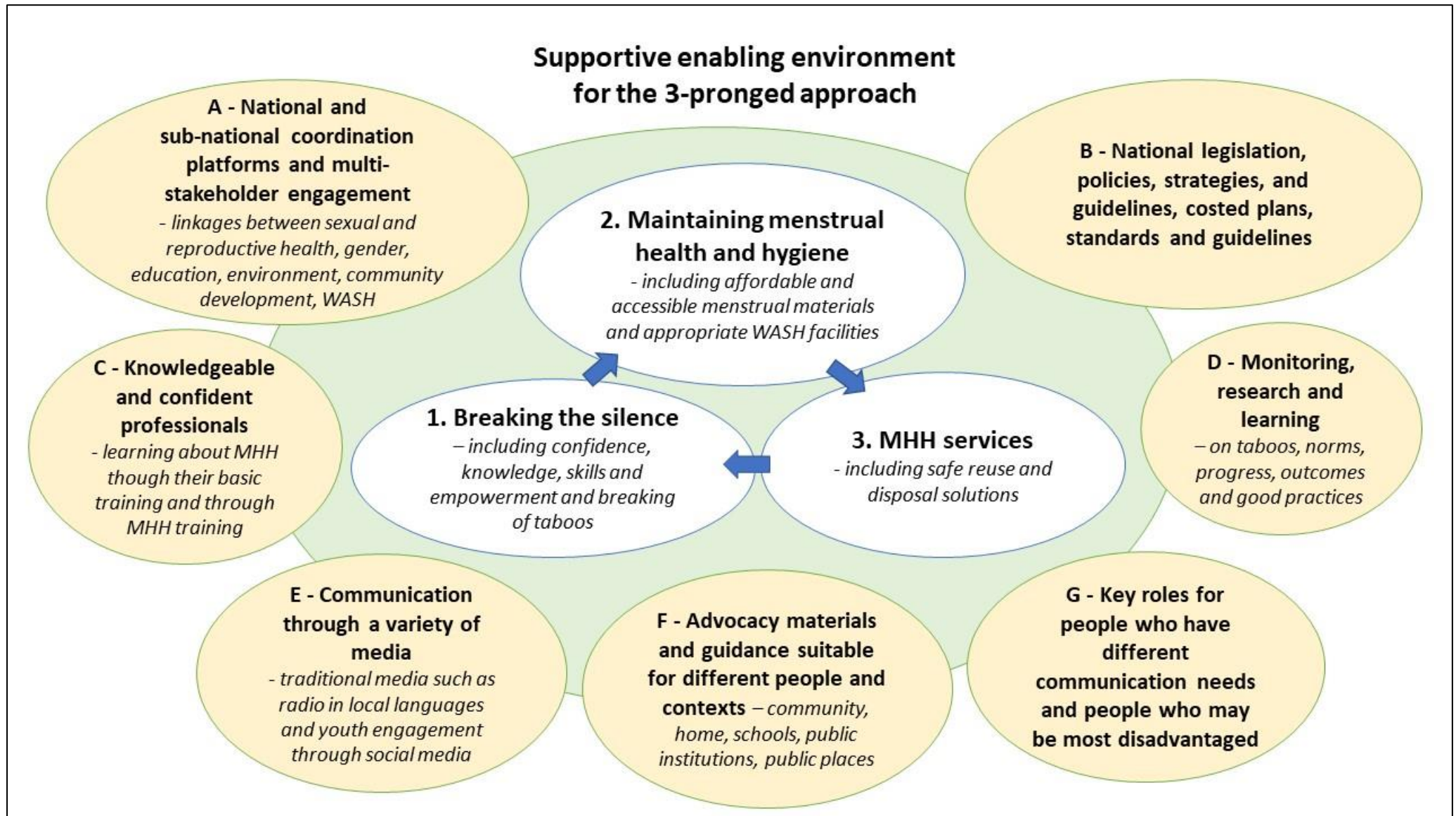
E - Other reflections related to the work of the WSSCC

Support to government and coordination across sectors – Support to governments for co-ordination, encouraging increased awareness at senior level and capacity building support, are key areas where the WSSCC has made significant contributions to-date, and which have been appreciated by governments. The SHF should continue to support this going forward, as this is likely to be one of the most effective ways that the SHF will be able to support progress at scale. Without this, governments are likely to struggle to progress increased engagement across sectors, to increase commitment to budgets and to ensure quality integration into large-scale programmes.

The 3-pronged approach – The simplicity of this approach has been very effective in increasing awareness of the components required to improve the MHM situation for women and girls, as well as in increasing commitment to MHM at senior levels and within government. With the shift to a broader focus on MHH and recognising that the enabling environment and in particular, that capacity building, monitoring and learning are important contributors to success, it is suggested that the 3-pronged approach should be continued, as it has been easy to understand, but that it be more explicitly supported by the range of components also required within the enabling environment. See [Fig 1](#).

Integrating MHM into the CLTS process – A number of recommendations have been made as to how MHM can be integrated into the CLTS process. Efforts should generally focus on the pre-triggering and follow-up phases. Examples of how this has been implemented in Kenya are included in [Annex I](#).

Fig 1 - Building on the 3-pronged approach



Recommendations

The key recommendations are split into two sets:

- The first set are made to governments and partners – these are the recommendations that we believe are most needed to address the gaps in MHH, while promoting the empowerment of women and girls. The recommendations will require resources from a range of sources. The right-hand column of the table shows recommendations for activities that could be considered for application for SHF funding. Priority recommendations have been organised into three groups 1 to 3 (with 1 being highest priority).
- An additional set of recommendations have been made for the SHF Secretariat in Geneva. These follow the table.

Recommendations to government and country partners:

	Coordination and policy	SHF priority
1	<p>Establish dedicated in-country support to current government staff, such as through a small resourced secretariat with the recruitment of full-time officer(s), with significant experience in MHH (senior MHH experts). This would be to support the government:</p> <ul style="list-style-type: none"> • In coordinating national coalitions¹¹, inter-ministry groups and other cross-sectoral engagement, with the aim to build commitment and increased action across sectors and in existing programmes. • Through providing technical advisory support in-country, to government on the development, implementation and monitoring of costed MHH policies, strategies and plans. • To identify and engage with existing and new national programmes across sectors, to effectively integrate MHH. • In a process of on-going learning and documentation on progress and challenges on MHH. 	1
2	<p>Strengthen the focus on MHH for women and girls who may be most disadvantaged - including through initiatives (such as the establishment of steering committees), led by women with different kinds of disabilities and people from different marginalised groups, with dedicated resources to take forward their priorities.</p>	1
3	<p>Increase opportunities for multi-stakeholder engagement, in particular involving stakeholders with backgrounds in sexual and reproductive</p>	2

¹¹ For example, GIZ funds a coordinator for the Menstrual Health Management (MHM) Practitioners' Alliance Nepal. The National Coordinator of WSSCC in Nepal was formerly the Convener of this Alliance.

	health and rights, gender, education and youth empowerment, and community development, as well as in solid waste management and the livelihood/employment sectors. This may be through support by the proposed secretariat, or specific capacity building activities, targeting a broader range of actors across these priority sectors.	
	Capacity building	
4	Undertake MHH capacity assessments of the learning needs of different actors, develop a costed capacity development plan and continue supporting capacity building, in alignment with this assessment and plan.	1
5	Systematise good practices on awareness-raising and teaching MHH in professionals' standard basic education and training, through: the basic training for community development professions, strengthening MHH in the school curriculum, and in the basic training for teachers and health service workers (including for nurses, doctors and community health workers).	1
6	Strengthen the existing MHH trainers' networks and provide more on-going mentoring, follow-up and monitoring and the documentation and sharing of good practices.	1
7	Expand access to training and awareness-raising. Consider the level of focus needed in each country for largest impact. <i>For example -</i> <ul style="list-style-type: none"> • <i>In India - Currently training efforts are dispersed, so it is suggested to take an area-based approach to training, so that whole local administrative areas are covered – this will help make MHH a priority.</i> • <i>In Tanzania and Kenya – More attention is needed to build more capacities at county/district levels and below, across sectors (health, education, women's representatives, disabled person's representatives, the media etc). In addition, more awareness-raising is needed for senior level decision-makers across departments at ministry level, to increase buy-in for prioritisation and action across sectors.</i> 	2
8	With government leadership and the inputs of a range of active sector partners, develop training materials for different stakeholder groups. Make sure these materials build on existing resources in country, including those related to school WASH or health services and including existing girls' MHM/adolescence books and associated resources. <i>For example - This may include practical facilitation guides, simpler materials for community level actors and others for schools, health facilities and prisons, standard operating procedures for local government authorities, and national advocacy materials.</i>	1

9	Establish a system for supplying training materials, to ensure that trainees at all levels, including those receiving cascaded training, have access to adequate numbers of appropriate tools, so that they can continue to effectively cascade the training and raise awareness on MHM.	2
Advocacy and influencing		
10	Expand reach and scale, by establishing a programme to continue to engage with and train senior decision-makers, to increase buy-in and engagement at senior levels. A system should also be established for replicating this awareness-raising over time, to respond to the turnover of senior decision-makers in government positions and roles. This system needs to be integrated into the government systems and ideally the system for replication over time, funded by its own resources for sustainability. <i>For example - This may include the Members of Parliament in Tanzania, the County First Ladies and the Council of Governors in Kenya, and more senior level actors, including decision-makers at ministry level across sectors and senior decision-makers in key institutions, such as in the prison service.</i>	1
11	Increase direct awareness-raising and engagement of the media and encourage them on their coverage of MHH related stories. <i>For example – As per the efforts already started in Tanzania</i>	
12	Expand the use of national role models and allies, harness societal engagement and establish partnerships with key organizations and influential individuals, including media celebrities and create awareness within the private sector of MHH and the contributions they can make (including in the work place).	
13	Enhance partnerships with youth and religious groups in order to change harmful social norms, behaviours, and social attitudes, and activate synergies between these partners.	
M&E, innovation, research and learning		
14	Develop an M&E plan, that integrates MHH indicators into government monitoring systems.	1
15	Establish a more structured process for learning and sharing of experiences between MHH actors, with regular engagement and updates and the documentation and sharing of the learning.	1

16	Support more training for school and healthcare facility quality assurance officers and support improvement in their quality assessment tools to also incorporate checks for required elements related to MHH.	2
	Prioritise reaching people who are most disadvantaged	
17	Undertake analysis of which groups of people are most disadvantaged and may be struggling with managing their MHH, who may not have been supported yet.	1
18	(Continue to) develop the training materials and resources for people with different communication needs. <i>For example – Particular materials for people with different kinds of impairments, including people who are blind, sight-impaired, deaf and hearing-impaired and people with mental health conditions.</i>	1
19	Build the awareness and capacity of senior decision-makers and actors who themselves have disabilities or come from marginalised groups, to encourage them to become champions in their work and within the communities they represent. <i>For example – Build the awareness and capacities of MPs or Senate representatives who have disabilities, or disabled person’s organisation representatives at county/district government levels.</i>	1
20	Open up more opportunities to systematically provide opportunities for people from marginalized groups to participate and become champions. The target groups for these efforts may vary across countries. <i>For example -</i> <ul style="list-style-type: none"> • <i>Expand targeted efforts to reach schools for children with different kinds of disabilities, country-wide across Kenya and Tanzania.</i> • <i>Prepare targeted and supportive information for people who are in sexual and gender minorities.</i> • <i>Expand efforts in prisons across Kenya and look into starting work in the prison services in Tanzania and India.</i> • <i>Build on work already started with pastoralists in Kenya to reach more nomadic communities, and other marginalised groups in India; document and share experiences internationally.</i> 	1
	Sanitary pads and solid waste management	
21	Undertake research on solid waste disposal for sanitary products and support research on practical learning on options for solid waste management at institutional, public and household levels. <i>For example – Starting in Kenya and India, support existing efforts by the private sector and other actors – both to establish the need for: disposal</i>	1

	<i>at scale, the business case and technical solutions at household and institution levels.</i>	
22	Collate or design and share options for basic designs for locally made pads, with step-by-step instructions, to help ensure they are made to a minimum quality standard.	2
23	Work with the private sector and community groups to strengthen the supply chain for sustainable, affordable and appropriate menstrual products and services, particularly focussing on options for the poorest members of the community.	3
MHH in institutions and at community levels		
24	<p>Influence increased effectiveness, use and quality of government (and partner) programmes and WASH infrastructure (existing and new) in schools, health facilities and in public places through ensuring they integrate good practice for MHH at scale.</p> <p><i>For example - This may be through:</i></p> <ul style="list-style-type: none"> <i>The development of cross-sectoral minimum standards for effective MHH in government (and partner) programmes.</i> <i>Establishing a routine review of all new programme proposals to check that MHH has been effectively integrated, in alignment with best practice – with particular attention given to large-scale programmes.</i> <i>The development of guidance for WASH in schools that integrates MHH, including for infrastructure; or ensuring that existing guidance is disseminated and used. In Tanzania this should also include working further on minimum standards and operational guidelines for the girls’ hygiene/changing/special rooms in schools.</i> 	
25	Undertake more capacity-building of community level workers, so that they can roll out MHH awareness-raising activities in their usual work and reach more vulnerable households at community-level.	3

Recommendations specifically for the SHF Secretariat:

Key priority areas for SHF resources for greatest impact at scale:

In summary, these are the key priority areas recommended for SHF funding, which would represent a unique contribution from the SHF and offer opportunities to influence the greatest action at scale, include:

1. Support to the government for coordination, encouraging broader multi-sectoral engagement, technical advice and on learning – *this is the highest priority and is likely to influence the greatest leverage across sectors, actors and programme and most progress at scale.*

2. Supporting people who are most disadvantaged, including to co-ordinate and lead their own action, and also to reach people who may be disadvantaged at scale – *this is the second highest priority, building on the existing expertise and leadership of the WSSCC and supporting its focus on LNOB going forward.*
3. Build on existing capacity building efforts, through supporting the trainers’ network, with strengthened follow-up, engagement and opportunities for learning, and through the development of more targeted capacity building materials for different user groups – *building on the WSSCC’s existing expertise and leadership for a significant roll-on effect to action at scale.*
4. To strengthen the knowledge of senior decision-makers across sectors over time - *to increase buy-in as part of standard government decision-making systems and respond to current blockages at ministry level, noted in both Tanzania and Kenya.*
5. Support learning, evidence and practice to improve the disposal of sanitary products at institutional and household levels – *a key gap globally, with learning likely to have multiple implications across countries.*

Additional recommendations to the SHF Secretariat		
1	In order to expand the understanding and engagement on MHH across sectors and programmes, establishing the SHF presents an opportunity for all staff who work on SHF funded programmes to undertake a basic level of EQND and MHH training, as a core part of the agreement. This is could break the silo mentality, where only specific people are assumed to be responsible for understanding and integrating these considerations into their work.	
2	Continue to build evidence and data, including qualitative evidence, on the effectiveness of different interventions, as well as to also establish the effectiveness of the SHF support. Provide support for the documentation and dissemination of the same.	

2. Introduction

2.1 Background

The Water Supply and Sanitation Collaborative Council (WSSCC) has been at the forefront of innovation in policy and practice to ensure that WASH services meet the needs of menstruating girls and women. Since 2012, WSSCC has worked with governments to address gender inequalities, discrimination and social injustice in WASH and beyond, using MHM as an entry point. In collaboration with various ministries, partners and trainers, WSSCC has facilitated inter-ministerial, multi-stakeholder policy dialogues, and has led capacity building initiatives to create a cadre of trained MHM facilitators to support and directly implement programming on MHM, using a holistic rights-based 3-pronged approach. Since embarking on this work, demand has grown steadily and WSSCC has worked with governments and other partners to respond to various demands.

At the time of writing this report, WSSCC is transitioning into the Sanitation and Hygiene Fund (SHF), which starts from the 1st January 2021. The SHF strategy has been approved, which includes Menstrual Health and Hygiene (MHH) as a key component. The recommendations in this report are made to assist governments and associated actors as to priority activities that are needed to move forward, including those which it is felt should be priority activities to apply for support under the SHF funding going forward.

This report explores the current situation of MHM in selected focus countries, reflecting the recent progress made and the remaining challenges. The three in-depth country studies in Tanzania, Kenya and India, looked at progress at three levels: a) nationally; b) progress catalysed with the support of (non-GSF) WSSCC funding; and c) progress achieved through the GSF-supported programmes.

This report considers MHM progress in relation to strengths, weaknesses, opportunities and threats and presents recommendations for further promoting and mainstreaming MHH in these countries and the contribution that the SHF can make. The review was undertaken between Nov 2019 to July 2020 and reports were prepared for each country, as well as the synthesis learning report.

In India, there was a full-time salaried team working on behalf of the WSSCC although the WSSCC Geneva Secretariat undertook much of the policy related MHH activities in India, along with other partners. In Tanzania and Kenya, the WSSCC National Coordinators (NCs) were volunteers with other work commitments, who have received only a honorarium / allowances for their WSSCC work, or have been specifically funded for their involvement in specific training activities as MHH Consultants - for example - when they have been trainers on specific courses. The NC Assistants in Kenya and Tanzania, also had part of their time covered by the WSSCC and in Kenya, the NC Assistant was also on a retainer contract, where he was paid as a MHH Consultant in his role as a regional trainer, for facilitating specific training activities and occasional writing tasks. The difference of resources made available between the various countries that allow staff to dedicate more or less time, to the work of the WSSCC (full-time paid staff versus volunteers with a basic honorarium, except for a few specific tasks), has impacted on how much they have been able to do to support the government and other partners on WSSCC supported activities. However, the WSSCC NC teams in both Kenya and Tanzania, have also undertaken a significant amount of voluntary work through their

commitment to the sector and to women and girls in the area in MHM, which has been very impressive.

2.2 Scope of review

Tanzania: The review in Tanzania was undertaken through a two-week visit in country and through a desk review. Interviewees included: Parliamentarians; Government ministry representatives from the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC), Ministry of Education, Science and Technology (MoEST), and the President's Office – Regional and Local Government (PO-RALG); National Bureau of Standards (NBS); Local Government Authorities (LGAs) and municipality staff (WASH Coordinators, Health Coordinators, District Reproductive Health Coordinators, School Quality Assurance Officers, District Medical Officers); teachers and pupils from primary schools, including members of Health Clubs, including two schools for children who are visually impaired; the private sector; multi-lateral donors; United Nations (UN) agencies and Non-governmental organisations (NGOs); UMATA team / Plan International; and the WSSCC National Coordinator team. A total of 60 adults (27 male / 33 female) participated in the review and 49 pupils (22 male / 27 female). 12 of the review respondents were people with visual impairments and one person has albinism. Thirteen trainees who can train other MHM trainers (MHM ToTs) were involved in the review and 29 other participants had some form of training on MHM.

India: The review was undertaken through remote interviews and a desk study¹². Interviewees included: MH Master Trainers, District staff, State focal point, UN agencies and INGOs, a Research Institute, local NGOs, a media agency and the WSSCC National Coordinator team. A total of 18 people participated in the review (8 male / 10 female).

Kenya: The review was undertaken through remote interviews and a desk study. Interviewees included: Government ministry representatives at national level, a representative from the Kenyan Prison Service, County Government representatives, a County First Lady, Kenyan community-based organisations (CBOs) / NGOs / Foundations, teachers, a religious organisation, the private sector, the WSSCC and AMREF-Kenya. A total of 20 remote interviews were undertaken (6 male / 14 female). Three of the respondents also have disabilities.

2.3 Purpose of this analysis

The main purpose of this review is to take-stock of the progress on MHH in three countries, Tanzania, Kenya and India, including the successes and challenges faced, to guide how the SHF should prioritise its efforts and resources related to MHH in its upcoming 5-year strategy. The focus of the review was at three levels: a) progress nationally; b) progress catalysed with the support of (non-GSF) WSSCC funding; and c) activities supported under the GSF-supported sanitation programmes. It aims to identify progress, gaps and priorities, as well as document country-level progress, lessons and good practices.

This review provides a comparative analysis and synthesises country level experiences from Kenya, Tanzania, India and to a lesser extent from published reports from West Africa.

The aim of this report is to provide a brief overview of the status and journey of MHM in each country context, based on the more detailed country studies, and to provide a set of general

¹² In-country reviews had been planned for India and Kenya but that these could not take place due to the COVID outbreak

recommendations for country-level engagement and recommended for SHF support on MHH.

2.4 Methodology and limitations

The analytical framework is based around a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis.

Qualitative methods were mainly used for the studies; these included a literature review and interviews with MHH practitioners and advocates in each country. In addition, in Tanzania, the field work included focus group discussions, participatory exercises, and school visits, with observations of WASH facilities and locally made-pads.

The analysis was conducted over five months. Several limitations were faced. Three country studies were planned, but only the Tanzania visit was possible before the COVID-19 outbreak began. The remaining interviews were conducted remotely for India and Kenya. Given the scope, it was not possible to conduct an exhaustive review of the context and situation in each country, but efforts were made through triangulation from different sources, to establish the situation and to identify examples of good practice.

2.5 Structure of the report

The next section provides a summary of the progress in the three countries (Tanzania, Kenya and India) and a regional overview (West Africa), with timelines and case studies. The subsequent section then assesses MHH through the analytical framework: strengths, weaknesses, opportunities and threats and the final section of the report makes recommendations for governments and partners in country for priority activities for going forward, including those it is recommended to prioritise for support under the SHF.

3. Summary of country and regional progress

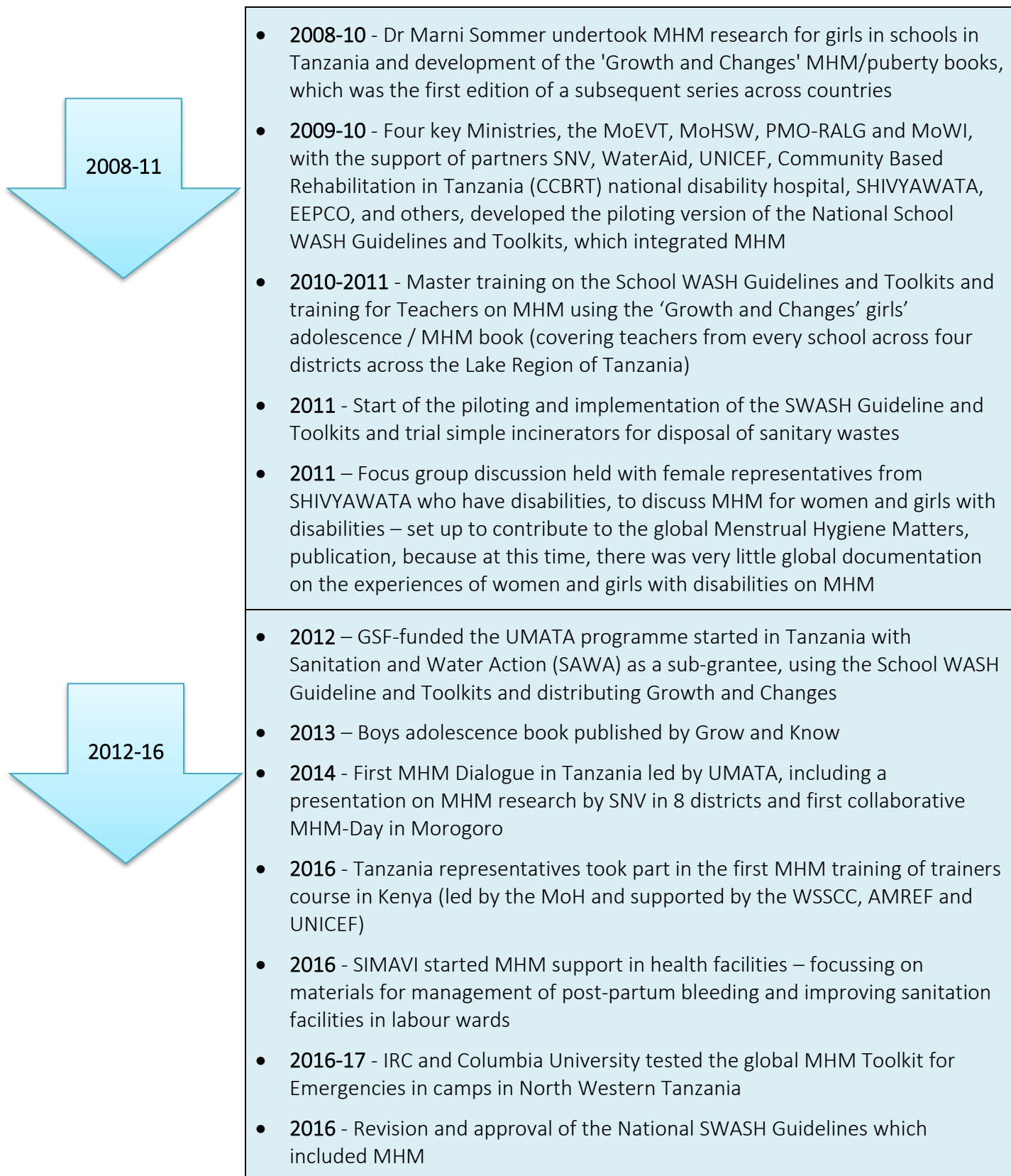
In this section the country level findings on progress are described for Tanzania, Kenya and India. A short summary is also provided for the regional partnership with UN Women in West Africa. Timelines are provided for key activities from the three main study countries, followed the overview of progress for each country, with a few human-interest stories / case studies of good practice from each of the countries.

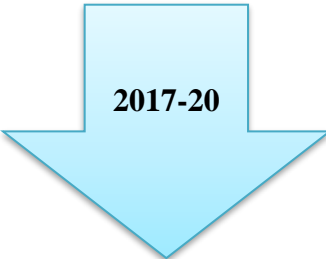
Section 3 then continues the analysis, but looks across all of the countries under a number of key areas, reflecting on the strengths and also the weaknesses, opportunities and threats in relation to progress on MHH going forward.

3.1 Progress summary – Tanzania

Figure 2 - provides an overview of the time-line of activities related to MHM/MHH in Tanzania.

Fig 2 - Stages in key progress on MHM in Tanzania





2017-20

- **2017** - First training of MHM ToTs in Tanzania based on the WSSCC global materials (with examples of modified images from Kenya) for 80 trainees, including 8 Parliamentarians (supported by WSSCC and UNICEF)
- **2017 - 2018** - WSSCC supported 2 Parliamentarians to participate in an MHM training with the Kenya County First Ladies, followed by a training for 43 Parliamentarians in Tanzania (supported by the WSSCC)
- **2017** - UMATA increased its work on MHM, including a study in 6 villages and training in Bahi District for local government authority (LGA) staff and teachers and health facility staff
- **2017 – 2020** – Some of the MHM trainers cascaded their training into schools using resources available to them
- **2018** - Parliamentarians discussed MHM in Parliament and fundraised for girls and MHM – initially for one model school toilet for every constituency in Tanzania, later changed to the construction of a model girls’ school in Dodoma Region
- **2018** - Formation of the MHH Coalition in Tanzania with WSSCC funding a communications specialist from TAWASANET to support the MHH Coalition
- **2018** – High level advocacy using the WSSCC MHM Lab, involving the Minister for Health and with pupils sharing their MHM experiences with Parliamentarians
- **2018-19** – Finance Bill of 2018 - removed VAT from sanitary pads (although it was reinstated in 2019, due to lack of perceived change in prices) – also prompted more debate on how to encourage local manufacture of sanitary pads in Tanzania, as at this time most were imported
- **2018-19** – Kasole Secrets / *Hedhi Salama* lead the development of training for people with sight impairments and other disabilities, in conjunction with the Tanzania League for the Blind, and involving youth and health professionals, and lobbied for resources for braille versions of MHM books – a number of trainings facilitated
- **2019** – WSSCC and SAWA also funded the preparation of some braille training materials on MHH (the menstrual wheel) and on hand-washing and supported a training for teachers and students at the Buigiri School for the Blind
- **2018-19** - UNICEF fund large scale research led by the MoEST on School WASH Mapping (undertaken by the National Bureau of Statistics) and PO-RALG on MHM (undertaken by National Institute for Medical Research)
- **2019-20** – A range of other trainings supported (some by WSSCC with partners, and some by other partners without WSSCC involvement) for a broader group of people, including the media, School Quality Assurance Officers, and a range of other participants, such as a Police Gender Desk Officer and the private sector

National progress on MHM in Tanzania:

There has been significant progress in MHM in the past 12 years, from very little if any action on MHM pre-2008, to increasing collaboration and action between diverse partners, who now form the Menstrual Health and Hygiene (MHH) Coalition¹³ (see the case study below). Parliamentarians have been triggered and trained to become MHM Champions¹⁴ and MHM is increasingly discussed in Parliament (see the case study below). VAT on sanitary products was removed in 2018 and whilst it was put back on a year later, it was still a significant achievement and has led to increased discussion on how to improve the enabling environment to encourage local production of low-cost pads in Tanzania. There are a range of MHM related publications being used across sectors that provide guidance on MHM – including a girls’ book called ‘Growth and Changes’ by Grow and Know (over 580,000 copies have been distributed to-date in 2020)¹⁵; a National School WASH (SWASH) Strategic Plan¹⁶ and a National School WASH Guideline and Toolkits¹⁷, which integrated MHM; and a range of training materials, including those from the WSSCC¹⁸, UNICEF¹⁹ and *Hedhi Salama*²⁰. Today, 10 years after the idea was introduced through the SWASH Guidelines and Toolkits, there is wide awareness of the need to support a girls’ hygiene/changing/special room in each school, which, although not without problems (see below), seems to have been an easy concept for people to understand and has raised the profile of the practical needs of girls when managing their periods. The recently released 2018 national SWASH Mapping report, led by the PMO-RALG, undertaken by the National Bureau of Statistics and funded by UNICEF, has indicated that 24.7% of schools across Tanzania now have one of these hygiene/changing/special rooms (from none 10 years ago)²¹. This scale-up is quite a significant achievement, even with the problems in their use, and shows what is possible, even in a reasonably short period such as 10 years, to raise awareness and make changes at scale. In addition, MHM actors are engaging with the media and religious networks and advocacy has been undertaken at the highest levels in government. A number of MHM-related research studies have been undertaken since 2018²², with two national large-scale studies on MHM and on SWASH mapping²³, both led by the Government of Tanzania and funded by UNICEF, and which are expected to be published in 2020. There are increasingly more private sector actors engaging in MHM, particularly selling sanitary products of different kinds, both disposable and re-

¹³ MHH Coalition (no date, draft) *Strategy and Theory of Change*

¹⁴ Kamowa, V and Pickup, M (2018) *BTOR Tanzania Members of Parliament Training: 7-13 February 2018*, WSSCC

¹⁵ Sommer, M (2009) *Vipindi vya Maisha, Growth and Changes*, Grow and Know Inc. <https://www.growandknow.org/tanzania-books>

¹⁶ MoEVT, United Republic of Tanzania (2012) *National Strategic Plan for School Water, Sanitation and Hygiene (SWASH), 2012-17*, <http://washinschoolsmapping.com/wengine/wp-content/uploads/2015/10/tanzania-SWASH.pdf>

¹⁷ MoEVT, MoHSW, PMO-RALG, MoWI, Government of the United Republic of Tanzania (2010) *National Guideline & Toolkits for School Water, Sanitation and Hygiene in Tanzania, First Draft for Piloting and Consultation, Oct 2010*: <https://sites.google.com/site/schoolwashintanzania/school-wash-package/english-version>;

And Ministry of Education, Science and Technology, United Republic of Tanzania (2016) *National Guideline for Water, Sanitation and Hygiene for Tanzanian Schools*, <https://www.unicef.org/tanzania/reports/national-guideline-water-sanitation-and-hygiene-tanzania-schools>

¹⁸ For example: Mbagi, D (2020) *MHM Activities in Tanzania 2016-20*; and WSSCC (2017) *A report on the Tanzania National Trainer of Trainers on Menstrual Hygiene management. Held on 21st to 27th June 2017*

¹⁹ Sommer, M. (2010) *Teacher’s Guide to Using “Vipindi vya Maisha”* http://washinschoolsmapping.com/wengine/wp-content/uploads/2015/10/TanzaniaPuberty_kubalehe_book.pdf

²⁰ For example of their training: *Hedhi Salama Training for Trainers, Feb 2018 Dar es Salaam* - <https://www.youtube.com/watch?v=6NQ1K5tJ18k>

²¹ See page 73 of: Government of Tanzania (2020) *Tanzania, 2018, School Water, Sanitation and Hygiene Assessment Report*, February 2020, President’s Office – Regional Administration and Local Government and National Bureau of Statistics and UNICEF, <https://www.nbs.go.tz/index.php/en/census-surveys/health-statistics/2018-school-water-sanitation-and-hygiene-assessment-swash/526-2018-school-water-sanitation-and-hygiene-assessment-swash>

²² For example: SNV (2014) *Baseline Survey Report on MHM, Conducted in Sengerema, Chato, Magu, Siha, Babati, Karatu, Njombe and Mufindi Districts*, https://snv.org/cms/sites/default/files/explore/download/girls_in_control_baseline_report_-_tanzania.pdf

²³ <https://www.nbs.go.tz/index.php/en/census-surveys/health-statistics/2018-school-water-sanitation-and-hygiene-assessment-swash/526-2018-school-water-sanitation-and-hygiene-assessment-swash>

usable; and pro-active efforts have been made to involve and train both teachers and children with disabilities in MHM and produce materials in braille.

There is still a long way to go in terms of being in the position that every person in Tanzania knows about MHH and every girl and women being able to manage their menstrual hygiene easily and with dignity, but there has still been significant progress. Before 2009, MHM was rarely mentioned in Tanzania, as was the situation in most countries across the globe, whereas in Tanzania, MHM was integrated into the SWASH Guidelines and Toolkits in 2010 and today there are a network of trained MHM actors with a diverse range of backgrounds and a national study that has been undertaken on MHM in 2020. All of this progress needs to be built on to respond to the gaps, but provides a very positive platform for moving forward and expanding action at scale.

Progress under WSSCC funding:

The WSSCC National Coordination Team in Tanzania has been very active in promoting and building capacity on MHM. The WSSCC National Coordinator, is a senior and well-respected WASH sector actor and was the Chair of the MHH Coalition at the time of the country visit. She spends a lot of time and effort encouraging collaboration between members to respond to the gaps and take forward MHM in Tanzania and has greatly influenced the very collaborative and supportive relationship between MHM actors. She works closely with the NC Assistant who also provides support for WSSCC supported activities. A very positive example of the spirit of this collaboration has been the support of a number of organisations and individuals for the development of braille learning materials on MHM (including the menstrual wheel) and support for teachers and pupils with disabilities. The translation was initially started with the support of *Hedhi Salama* and the Tanzanian League for the Blind, and built on by other organisations, including WSSCC, which had the menstrual wheel converted into braille, and SAWA (see the case study below).

WSSCC has supported and funded, or co-funded, a range of high-level advocacy and a wide range of MHM training, including large numbers of diverse actors, from Parliamentarians, government, local authorities, NGOs, teachers, the media, religious bodies and a range of other actors. The national level trainings in Tanzania were facilitated by a mix of the regional and national trainers and members of the WSSCC Secretariat in Geneva. A range of School Quality Assurance Officers have also been trained on MHM in the Dar es Salaam region and in Chunya District in Mbeya Region (see the case study below). In Tanzania, Rehema Darueshi, who was herself blind, trained as a national MHM trainer after having first been trained by *Hedhi Salama* on working with people with disabilities on MHM. She was a teacher, a disability activist, holding a number of senior positions in the disability sector.

During the trainings of trainers (ToTs) supported by the WSSCC and other partners, a number of useful materials and training tools were provided, which were much appreciated. These included a ToT manual, a book on the 'Menstrual Lab', the 'Menstrual Wheel' and the 'Flip chart' called 'As We Grow Up'. The trainings have clearly increased the energy and commitment to MHM – and have given momentum to MHM nationally, with an increased focus and structure around the 3-pronged approach. The wide range of actors trained, has established a network of trainers, including a number of MHM trainers of different levels and seniority. See [Section 4.1](#) – for the associated data. A number of these have also become much more active generally since having these trainings, including in the MHH Coalition, and with some undertaking other trainings and activities within their own jobs and fields of

influence. This has had multiple effects, including raising the profile of MHM at the highest levels of government.

Progress through the UMATA programme supported by the Global Sanitation Fund:

The Government of Tanzania *Usafi wa Mazingira Tanzania* (UMATA) programme started in 2012 and is managed by Plan International in Tanzania. It has been funded through the Global Sanitation Fund (GSF), a pooled-funding mechanism managed by WSSCC. Some elements of MHM were integrated into the SWASH elements of the programme from the beginning, through use of the National SWASH Guideline and Toolkits and the 'Growth and Changes' girls' adolescence/MHM book; and subsequently, attention on MHM was increased after WSSCC supported MHM ToT trainings in 2017. Efforts included the triggering and training of Local Government Authority (LGA) staff, teachers and health facility staff, and ward and village level officials and support for implementation of MHM in 2 model schools, Chikopelo Bwawani and Mundemu primary schools. They have also pro-actively contributed to high level advocacy, including facilitating opportunities for schoolgirls to share their experiences of MHM with high level decision-makers, including Parliamentarians (see the case study below).

Case studies – Tanzania:

Hereunder, find examples of human-interest stories / good practice case studies from Tanzania, showing a selection of initiatives from national level, through to the individual level.

Breaking the Silence in Parliament

In 2017, two Parliamentarians from Tanzania, Hon. Lolesia Bukwimba, M.P. and Hon. Sophia Mwakagenda, M.P., were funded by WSSCC to participate in an MHM seminar in Mombasa with the County First Ladies in Kenya. Hon. Bukwimba is the Secretary General of the Women’s Parliamentary Caucus (WPC) in Tanzania.

When they got back, they talked with the Chair and Executive Committee of the WPC on the need for MHM to be discussed in Parliament. They wrote a proposal for more MPs to be trained and ran a two-day training for female and male MPs, funded by WSSCC. Most of these trainees pledged to pass on what they had learnt and advocate for girls and women in managing their MHM needs: they were subsequently crowned as ‘MHM Champions’. After the training, MPs started talking about MHM in Parliament. Initially the Prime Minister had reservations, and felt this was a ‘private matter’. But the WPC advocated on the importance of discussing the issue in Parliament and emphasized the role of government on MHM. The Deputy Speaker is also an MHM Champion and between them they ‘broke the silence’ on MHM in Parliament.



Tanzanian Member of Parliament MHM Champions

Left to right: Hon. Edward Franz Mwalongo, M.P.; Hon. Lolesia Bukwimba M.P.; Hon. Omary Badwell M.P.; and Eng. Wilhelmina Malima, Sanitation and Water Action and WSSCC National Coordinator for Tanzania

(photo credit: S.House/WSSCC)

Menstrual Health and Hygiene Coalition magnifying progress

The MHH Coalition, an interest-based coalition, was formed in 2018. It has a diverse range of members across the WASH, Education, Health, including Reproductive Health, and Gender sectors. Its members include: government and government entities; multilateral organisations; development partners; international NGOs; local NGOs; private sector companies; community-led organizations and groups; faith-based organizations; trade unions; research institutions; the media and instrumental individuals.

The MHH Coalition leadership is a rolling position which rotates annually. In February 2020, it was Chaired by the WSSCC National Coordinator, with UNICEF as the Co-Chair, but the position of Chair has now been handed over to the MoHCDGEC. In 2020, the Coalition had more than 170 members and operates an active WhatsApp group and email group.

There is a clear collaborative enthusiasm and commitment from a range of diverse actors for finding ways forward to improve the situation of women and girls across Tanzania. There is a clear magnification of efforts through this collaboration and the joint vision and mission of its members.

Triggering the media on MHM

The MHH Coalition members have undertaken a range of lobbying with the Media Council, and the Institute for Inclusive Development in Tanzania (I4ID) has engaged with 50 media editors across Tanzania. They have established an MHH category within the **Excellence in Journalism Awards Tanzania (EJAT)** which are run by the Media Council. A range of organisations, I4ID, UNICEF, BBC Media Action and other partners, provided capacity building, with WSSCC providing a trainer.

In May 2019, a training was supported by BBC Media Action and the I4ID. The training was attended by 31 participants (16m, 15f) from local and international media organisations. They were TV and radio presenters, as well as newspaper writers. These activities have led to MHM being increasingly talked about in the media.



Arton Kayomba, District Chief School Quality Assurance Officer, Chunya District, Mbeya Region and Eng. Wilhelmina Malima, SAWA and National Coordinator, WSSCC Tanzania

(photo credit: S.House/WSSCC)

Self-funding training on MHM for Quality Assurance Officers

One MHM trainer, Arton Kayombo, the District Chief School Quality Assurance Officer (SQAQO) for Chunya District in Mbeya Region, has been very active in passing on his knowledge on MHM to his team and ensuring that MHM is integrated into their work. When he returned to his office after his own training, he arranged to train his team, 8 SQAQOs, in MHM through a 2-day training. To do this he used his own daily subsistence allowance, which had been given to him to attend the MHM ToT, to pay for drinks for the training of his staff and he photocopied in colour the MHM wheel and flip book, so they would also have copies. He has also facilitated a number of training and awareness sessions in schools using the resources available to him through his work.

The private sector actor working together with people with disabilities on MHM

Kasole Secrets develops and sells an eco-friendly pad, called the 'Glory Pad', made of 100% natural cotton, which is free from chemicals and which has a bamboo insert, contributing to odor control, which cost TShs 3,000-3,500 a pack. The company invests back 10% of the profits it generates annually to menstrual health programmes, through the *Hedhi Salama Campaign*. This provides training for MHM awareness through Tanzanian schools.

They have trained medical students, nurses and doctors, as well as social workers and youth with disabilities on MHM. They also lobbied and fund-raised to prepare braille and tactile MHM materials, which also encouraged others to fund further materials, such as WSSCC and SAWA.



Subira Rashid, Teacher at Toa Ngoma Primary School in Kigomboni, Dar es Salaam, Tanzania, showing how she typed the braille girls', boys' and teachers' books on adolescence and MHM. Her teenage sons read out the written visual books for her while she typed.

Typing 50 or 60 books by hand can take two weeks to undertake by a group of 4 to 6 people who are blind and one of whom can see the drawings and text. One book costs an average price of 65,000 TShs.

(photo credit: S.House / WSSCC)

High level advocacy on MHM by female pupils to government leadership

A female pupil from the Chikopelo Bwawani Primary School had been part of a group of pupils who undertook advocacy with the Parliamentarians. She described how they had talked about the need for changing rooms at schools and asked if sanitary pads could be distributed in schools and showed the Parliamentarians how to make local sanitary pads. The girls also asked the MPs if they could educate the community and pupils in other schools about MHM. The Parliamentarians said they could see how they could help. This advocacy activity seemed to be very impactful, both on the opportunity for the girls to speak in front of senior decision makers, and for the decision-makers to hear directly from girls the challenges they face in managing their MHM.

A well-stocked girls' 'hygiene/changing/special' room

These rooms are generally integrated into the girls' toilet block and designed for girls to be able to manage their MHM. But quality of design and content varies significantly.



Headmistress and Health Teacher in the 'girls' hygiene room' in the girls' toilet block – with water, drain, waste disposal bucket, cleaning tools, soap and a box with sanitary pads for emergency use

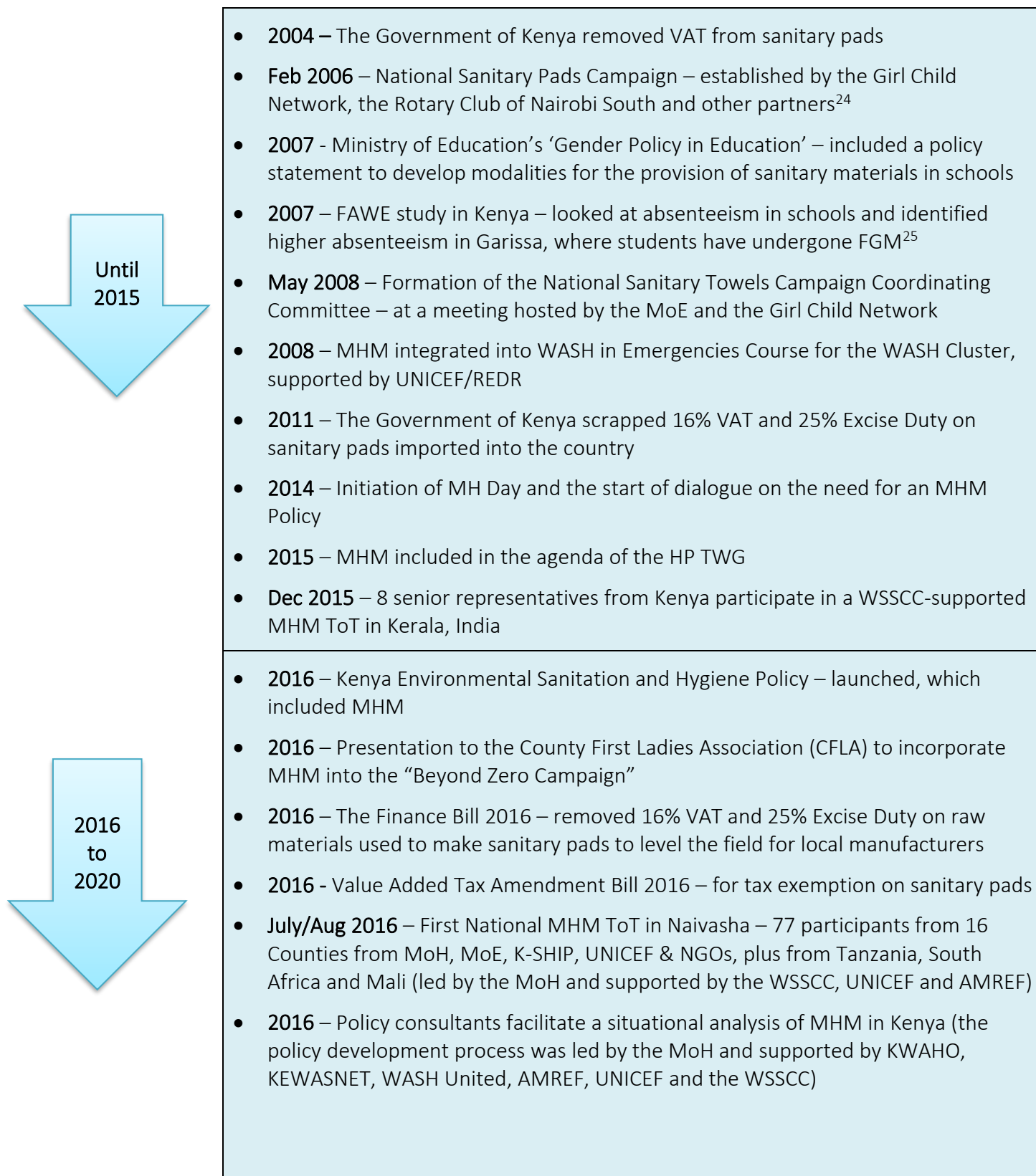
Mchito Primary School, Bahi District, Dodoma Region

(photo credit: S.House / WSSCC)

3.2 Progress summary – Kenya

Figure 3 - provides an overview of the time-line of activities related to MHM in Kenya.

Fig 3 - Stages in key progress on MHM in Kenya



²⁴ P198 – from ZanaAfrica (2011) in Menstrual Hygiene Matters

²⁵ P331 – from ZanaAfrica (2011) in Menstrual Hygiene Matters

- **Dec 2016** – Training on MHM in Wote and Emaili, Makueni County – 79 participants across sectors (Health, Gender, Youth) and Community Health Volunteers (led by the County Government and the County First Lady, with funding from county level partners, with trainers and training resources supported by the WSSCC)
- **Jan/Feb 2017** – Training on MHM in Kwale County – 47 participants from the County Government (Health, Education and Administration), NGOs, CBO, and the media (led by the Department of Health at County Government level and the County First Lady, funded by county level partners, with trainers and training resources supported by the WSSCC)
- **Feb/March 2017** – County First Ladies MHM Training, Kwale County – 12 CFLs as well as Members of Parliament, Tanzania (organised by the Ministry of Health, the County First Ladies Association and funded and supported by the WSSCC)
- **April 2017** – Two-day Kenya Policy Roundtable and Validation Workshop (led by the MoH, supported and funded by the WSSCC)
- **Oct 2017** – Second National MHM ToT, Naivasha, Nakuru County – 84 participants from National & 24 Counties – and representatives of the MoH, MoE, Ministry of Public Service, Youth and Gender Affairs (MoPSYGA), Ministry of Water and Sanitation (MoWS), Ministry of the Interior & Malawi (led by the MoH and supported and funded by the WSSCC and UNICEF)
- **2017** – Efforts on MHM were started in the Kenyan Prison Service using internal resources
- **2017** – Amendment of the Basic Education Act – committing to supply sanitary towels in schools
- **2017** – Development of the Teachers MHM Handbook (not yet launched)
- **Dec 2017** – Third National MHM ToT (led by the MoH and supported and funded by the WSSCC and WASH Alliance Kenya)
- **Aug 2018** – MHM sensitisation meeting – training for partners - CSOs, private sector organisations, line ministries and other MHM activists (led by the MoH with UNICEF funding and WSSCC supported trainers)
- **2018** – Girls adolescence/MHM book ‘Growth and Changes’ developed and published by Grow and Know
- **Nov 2019** – MHM Policy approved by Cabinet and signed by the Cabinet Secretary of Health
- **May 2020** – Launch of the MHM Policy during a Zoom briefing meeting (due to COVID-19 restrictions)

National progress on MHM in Kenya:

From the timeline it can be seen that some action was started on MHM from 2006, with initial efforts mainly being initiated by the Girl Child Network and linked to the Ministry of Education and with most effort focussing on the distribution and supply of sanitary pads. As time progressed a wider number of actors started to become involved, particularly through the global Menstrual Hygiene Day from 2014 onwards; and in 2015, MHM was included in the agenda of the national TWG on Hygiene Promotion. A larger number of actors started to become involved following the increased access to trainings from 2015 onwards, until the development and release of the MHM Policy²⁶ and MHM Strategy in 2020²⁷.

There are a wide range of actors engaged in MHM in Kenya, including the private sector, with effective coordination mechanisms at national level and efforts to engage more sectors in MHM is on-going. MHM is clearly integrated into a number of Government of Kenya policies and strategies²⁸ and there has been strong collaborative action by a wide range of actors in the development of the holistic and comprehensive MHM Policy²⁹ and MHM Strategy³⁰, both approved by the Cabinet in 2020 (see the case study below)³¹. There has also been the development of the document 'Menstrual Hygiene Management in Schools: A Handbook for Teachers'³² and an infrastructure guide for schools (both were still to be launched at the time the study was undertaken). In addition, there is also a national programme for the free distribution of sanitary pads for girls in public primary schools and girls in special secondary schools³³; and there has been some engagement with high-profile champions in the media to promote SRH and MHM. The private sector company Varet Products and its associated social enterprise, Global Sanitation and Environmental Project, have worked on establishing evidence, the business case and cross-sectoral buy-in for improving sanitary waste disposal in schools and beyond³⁴ (see the case study below). There has also been some integration of MHM into the "Beyond Zero" sexual and reproductive health (SRH) campaign (see the case study below)³⁵; and the use of youth theatre to open up debate on SRH and MHM at school level (see the case study below). A range of research and learning has been undertaken in Kenya on MHM, from small-scale studies at school or programme level, to larger randomized control trials related to the use of pads and menstrual cups³⁶.

²⁶ <https://www.health.go.ke/wp-content/uploads/2020/05/MHM-Policy-11-May-2020.pdf>

²⁷ <https://menstrualhygieneday.org/wp-content/uploads/2020/06/Kenya-MHM-Strategy-Final.pdf>

²⁸ For example: Ministry of Health, Republic of Kenya (2016) *Kenya Environmental Sanitation and Hygiene Strategic Framework (KESSEF), 2016 – 2020, Towards Universal Access to the Highest Standard of Sanitation, April 2016*; and Ministry of Public Service, Youth and Gender (2019) *National Policy on Gender and Development, Sessional Paper No 2 of 2019, Towards creating a just, fair and transformed society free from gender-based discrimination in all spheres of life practices*

²⁹ Ministry of Health, Republic of Kenya (2020) *Menstrual Hygiene Management Policy, 2019-2030* <https://www.health.go.ke/wp-content/uploads/2020/05/MHM-Policy-11-May-2020.pdf>

³⁰ Ministry of Health, Republic of Kenya (no date) *Menstrual Hygiene Management Strategy, 2019-2024*

³¹ <https://www.wsscc.org/media/news-stories/timeline-events-leading-kenyas-mhm-policy>

³² Ministry of Health (no date) *Menstrual Hygiene Management in Schools: A Handbook for Teachers*

³³ Ministry of Public Service, Youth and Gender Affairs (2018) *Background and objectives of the sanitary towels programme*: <https://gender.go.ke/sanitary-towels-program/>

³⁴ Waithera, E (2015) *Menstrual Hygiene Promising Approaches to Menstrual Waste Disposal in Schools*, 4th Annual Virtual Menstrual Hygiene Management in Schools Conference, 22 October 2015, Global Sanitation Environmental Project (GSAEP); and Waithera, E (no date) *The Sanitary Timebomb*, Global Sanitation Environmental Project (GSAEP), presentation

³⁵ Mvurya, C (2020) *Fankisha Foundation, 2019 Key Highlights*

³⁶ For example: Maseno University (2016) *Menstrual Hygiene Management Situation Analysis Report*, Republic of Kenya, https://www.researchgate.net/publication/337992059_REPUBLIC_OF_KENYA_MENSTRUAL_HYGIENE_MANAGEMENT_SITUATION_ANALYSIS_REPORT_MASENO_UNIVERSITY; Juma J, Nyothach E, Laserson KF, Oduor C, Arita L, Ouma C, Oruko K, Omoto J, Mason L, Alexander K, Fields B, Onyango C, Phillips-Howard PA. (2017). Examining the safety of the menstrual cup provided to rural primary school girls in Western Kenya, *BMJ Open*, 0:e015429, <https://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC5566618&blobtype=pdf>

Whilst, there is still a long way to go in terms of being in the position that every person in Kenya knows about MHH and every girl and woman being able to manage their menstrual hygiene easily and with dignity, there has still been significant progress. It was difficult to identify specific activities on MHM before 2004, as in most countries across the globe, whereas in Kenya, there were actions from 2004 onwards, and today there are a network of trained MHM actors with a diverse range of backgrounds; as well as a comprehensive national MHM Policy and MHM Strategy, approved and signed at Cabinet level, to support efforts across sectors going forward at scale. This is quite a big step ahead of most countries.

Progress under WSSCC funding:

Following a series of trainings initiated by WSSCC on its 3-pronged approach at the end of 2015³⁷, which were undertaken in support of the Government of Kenya and in collaboration with others, there are now a wide range of trained personnel in MHM. This includes a number of senior Government of Kenya decision-makers, CSO staff and MHM Master, ToT and other trainers (all called 'MHM trainers' below). The national level trainings in Kenya were co-facilitated by the regional and national trainers and members of the WSSCC Secretariat in Geneva. Training of the County First Ladies in MHM³⁸, including two as MHM trainers who can train others, has resulted in their support for MHM trainings at county level³⁹ and programmatic interventions on the ground (see the case study below).

Training people with different kinds of disabilities as MHM trainers, has contributed to their active involvement in MHM and becoming role models for others. For example, in Kenya, Patricia Mulongo heads the organisation, Deaf Women's Empowerment, and is also very active in the disability sector and a passionate MHM trainer, who has made links for other MHM actors with other people with disabilities in Kenya and has integrated MHM into her own work (without WSSCC funding). Training of staff from the prison service, has also resulted in funding being allocated in every prison in Kenya for sanitary pads, as well as cascading training to staff and inmates (see the case study below). These activities in the prisons have all been funded internally by the prison service (without WSSCC funding).

It is clear from the feedback from the interviewees that the series of trainings has had a significant positive impact in a range of areas. This includes expanding knowledge on good practices in supporting MHM. Prior to this, general misconceptions reported were that menstruation only requires a supply of sanitary products and that it is only relevant to women and girls. The schools only teach the biological aspects of menstruation in the curriculum. After the training, participants became more aware of the holistic 3-pronged approach, the importance in involving men and boys, the necessity of breaking the silence on MHM and on undertaking advocacy and building a network of MHM champions to influence change. Participating in the trainings has clearly built the confidence of the participants, including to speak on MHM in public. In addition, the training of senior Government of Kenya representatives across sectors, has contributed to increasing the dialogue on the need for cross-sectoral engagement in MHM and has also encouraged the Government of Kenya to become more engaged in MHM. Following this, progress has been made in a number of

³⁷ For example: Ministry of Health, WSSCC (2016) *First National Training of Trainers on Menstrual Hygiene Management – Kenya. Sweet Lake Resort, Naivasha, Kenya (28 July-3 August, 2016)*, Workshop Report

³⁸ Ministry of Health, WSSCC and County First Ladies Association (CFLA) (2017) *A Report on the County First Ladies Training Held at Leopard Beach Hotel, Kwale County 8 - 10 March 2017*

³⁹ For example: Ministry of Health, WSSCC (2016) *Makueni County Training on Menstrual Hygiene Management*

areas, including regular discussion on MHM in the TWG-HP, the development of a National MHM Policy and National MHM Strategy and the Teachers' Handbook.

One participant noted about the work of the WSSCC, that:

"Their support has been immense – this is the organisation that 'triggered' Kenya on MHM".

Another noted:

"The WSSCC has had the biggest impact in MHM in Kenya, because before 2015, the focus was more on products. The WSSCC came in with the 3-pronged approach on MHM. Before this the Government found MHM a bit obscure and didn't want to support products and so didn't get into this... but the government brought into the 3-pronged approach and this has given them the entry into the MHM space and a structure to MHM"

Progress through the K-SHIP programme supported by the Global Sanitation Fund:

When the K-SHIP programme was formulated MHM was not a specific component, but efforts have been made to integrate it into its work more comprehensively as the programme progressed. The WSSCC provided training to the K-SHIP team members, who then trained others within the K-SHIP supported programme. The K-SHIP team have contributed to the national dialogue processes, as well as supporting partners and interventions through programmes.

K-SHIP's work on MHM has contributed to increased collaboration at county level, including encouraging the government leadership and staff at county level to integrate MHM into their regular work (see the case study below). There have been very positive examples of successful engagement of working with pastoralist communities on MHM (see the case study below); some work with religious leaders to spread information on MHM (see the case study below); engaging boys as well as girls on MHM; integrating MHM into the CLTS process; and supporting innovation at sub-county level, such as the development of a household incinerator and locally made pads (see the case study below).

Case studies – Kenya:

Hereunder, find examples of human-interest stories / good practice case studies from Kenya, showing a selection of initiatives from national level, through to the individual level.

Development of the national MHM Policy⁴⁰

In 2015, eight representatives from Kenya participated in the WSSCC-supported MHM ToT training in India, including Mr Jackson Muriithi, who was the Assistant Director of Public Health and who at the time of writing this report was the Deputy Director of Public Health. In 2016, the MoH, WSSCC and UNICEF, then supported two national MHM ToT trainings for a wider range of national and sub-national stakeholders. This process started increasing awareness on MHM of senior stakeholders in Kenya, and in particular of the holistic perspective of MHM, through the 3-pronged approach; instead of focussing mainly only on the provision and supply of sanitary pads. The MoH, Ministry of Education and the Ministry of Water and Sanitation, became particularly active in the area of MHM and decided to develop an MHM Policy.

The Director of Public Health led the process and KWAHO, KEWASNET, WASH United, AMREF, UNICEF and the WSSCC, jointly funded the costs of a team from Maseno University, who facilitated the process for policy development and other associated costs. A situational analysis was undertaken in 2016 and a wide range of actors were involved in the development of the policy, including: government ministries and departments, agencies and county departments, civil society organisations (CSOs), the private sector, development partners and academic institutions. The writing of the policy took about a year, and then it took another year to finalise it, to agree on the format and logos and to launch it.

The Cabinet Secretary for Health (2018 - February 2020) and the Principal Secretary, were active in MHM and the development of the MHM Policy and supported its progress through the Cabinet, where it was signed in 2020. For any policy to be signed by a Minister, it needs to go through the Cabinet for approval. This means that all Ministers have to read each other's policies and also that they get the opportunity to ask for questions and modifications. It was noted that during this approval process by the Cabinet, that some Ministers realised that their Ministry had not been involved, but that this MHM Policy was also relevant to them and hence they asked questions and proposed changes. This process helped to establish a lot of buy-in at Ministerial level, which is a very useful lesson for other countries, considering how to attain buy-in across sectors at the most senior levels of government.

Integrating MHM into the work of the prison service across Kenya

Florence Mlewa is the Chief Public Health Officer in the Kenyan Prison Service. She participated in an MHM ToT in Nairobi and two other colleagues also undertook shorter trainings. All of these were felt to be very important learning opportunities. Since, they have trained approximately 5,000 female inmates. The women trained were excited about the learning and sometimes they also received soap distributed at the sessions.

Before the training there were no funds allocated for sanitary pads in prisons. But after the training in 2017, a budget line was established and Kenyan Shillings 280,000 (USD 200) has since been allocated every three months for sanitary pads for every prison across Kenya.

Florence noted that it would be appreciated if the prison service could be facilitated to learn how to make pads, which could be made by the women; and also to train senior decision-makers in the Kenyan Prison Service, which would facilitate increased action and commitment.

⁴⁰ Ministry of Health, Republic of Kenya (no date) *Menstrual Hygiene Management Policy, 2019-2030*

Building trust and working with pastoralist communities

As pastoralist communities treasure their animals, the Garden of Hope Foundation sometimes works on vaccination of animals as an entry point to work with pastoral communities, such as Maasai and Pakot communities. This initial step helps to build trust and enables the team to be able to continue and talk about more sensitive subjects such as MHM.

It is also known that in pastoral communities, men are often influenced by cultural beliefs and taboos. In Narok, it is said that it isn't disciplined to talk about MHM in the open, but when a woman talks to them about it, then they more easily get the concept. In Narok, at first women also often feel uneasy when talking about MHM, feeling shameful. Some put their heads under their *shuka* (traditional clothes). So, when working in pastoral communities, in Narok East sub-county, the government team involves Community Health Workers (CHWs) who form separate groups of men and women for the initial discussions. They then organise role plays and songs to promote laughter and they incorporate cultural history and promote discussion on what has already changed, what is changing and where we are heading. This opens up both men and women to be able to speak more openly on MHM.

In Wajir, they brought in a female MHM Champion, to break the silence with the communities. They then brought men and women together, so now they are able to talk about it together as a normal topic. In Narok County, Daniel uses songs and role plays to encourage humour and to break the silence on MHM. He has also written songs in Kiswahili and Maa.

Leveraging MHM as an entry point to sexual and reproductive health⁴¹

'Menstruating in dignity is part of the fundamental right of girls and women, half of the country's population. Girls' ability to manage their menstruation is influenced by broader gender inequities across Kenya and can be hindered by the presence of discriminatory social norms. There may be opportunities to leverage Menstrual Hygiene Management as an entry point to sensitive sexual, early childhood marriages, female genital mutilation (FGM) and reproductive health topics, such as reproductive rights, transactional sex, and teenage pregnancy prevention'.

Sicily K. Kariuki (Mrs). EGH, Cabinet Secretary of Health, stated as a Foreword in the national MHM Strategy

Engaging with Islamic religious leaders to reach pastoralist communities on MHM

In Wajir, 99 percent of the population are Muslims. In Islam, keeping hygienic is a religious obligation, so Shukri Isaak, the County WASH Coordinator in Wajir County Government, has engaged with religious leaders and sheiks to promote good practices in MHM and break the silence.

The religious leaders and sheiks were very positive about this subject and said: *"this is a topic that was neglected – young man – let's work together"*.

He held a session with them on MHM and encouraged that when they give sermons in the Mosque, they should give this message.

He also spoke on a radio talk show together with a religious leader, both talking about MHM from the Islamic perspective.

These activities have opened up a new channel of communication on MHM, involving leaders who are very influential with both men and women.

⁴¹ Foreword in the: Ministry of Health, Republic of Kenya (no date) *Menstrual Hygiene Management Strategy, 2019-2024*

‘Linda Dada’ CBO using youth drama groups to teach on sexual and reproductive health and MHM

Noel Lutomia is the Founder and Director of ‘Linda Dada’, a community-based initiative based in Mumias, Kakamega County.

Noel was trained in a WSSCC supported MHM 2-day training in August 2018, in Nairobi. She built her own skills in working on SRH through being invited to do sessions on MHM, when colleagues were training on SRH at community level.

Initially she undertook activities in two schools and last year she started partnering with young actors in a community organisation. Through this partnership she would go to schools and facilitate discussions on teenage pregnancy, MHM, early sex, safe abortion and contraceptive use. She also undertook out-of-school programmes and would assemble girls of ages 11-19 years of age, in churches and schools to discuss on the same issues. For example, the youth group may role play when a boy buys pads for girls and expects sex in return. The girl gets pregnant and is taken for an abortion. This promotes discussions on the need for pads, as well as safe sex and contraceptives and safe abortions.

Private sector organisation working to find a solution for sanitary wastes

Eva Muhia from a private company Varet Products and a social enterprise / NGO, the Global Sanitation Environmental Project, has been working to engage the Government of Kenya across ministries, to establish a way forward to improve the situation of the disposal of sanitary waste in schools. She has undertaken advocacy with Ministry of Education (MoE), the Ministry of Health (MoH), the Ministry of Environment and Forestry (MoEF) and the Ministry of Public Service, Youth and Gender Affairs (MoPSYGA). Initially when she tried to investigate what the policy was on this issue; it was difficult to get clarity and she was directed between different ministries and then back to the first one.

Through this engagement, the MoH accepted the need for incinerators in schools for menstrual waste disposal and for De Montfort Incinerators⁴², as possible compromise solutions. But initially the MoEF was not convinced, as it was concerned over emissions. The MoPSYGA has funds that it could potentially spend on incinerators, but first needs the approval of the MoEF. However, since there has been such a big success with the banning of plastic bags in Kenya, sanitary waste, nappies and condoms are the next big problematic waste groups on the government’s list. So, the MoEF are now more interested in the possibility of having incinerators in schools. The MoEF are monitoring the sanitary waste problems in schools and will track the impact of a number of incinerators trials. If they demonstrate positive impacts in schools, government will hopefully approve their use across Kenya.

This is an interesting example of how a private sector actor is supporting the government to strengthen its engagement in the area of sanitary waste disposal, through engaging in practical on-site observations and learning.

This is an area where significant learning is needed in many countries.

⁴² These incinerators are self-built to a specific design that leads to increased temperatures and lower emissions than is possible with simple burners or other simple incinerators.

MHM integrated into MHM Campaign in Kwale County⁴³

H. E. Christine Ndegwa-Mvurya is the Community First Lady in Kwale County. She is a National MHM Champion, one of the leading MHM ToTs in Kenya and a member of the County First Ladies Association. She started the Fanikisha Foundation in 2015, with increasing activities from 2017 to date, mainly in the areas of SRH. She also prepared a Master's thesis on MHM for girls with disabilities in 2016⁴⁴. She has facilitated the training of 90 people from different departments, such as the health services, the media, the Ministry of Education and others on MHM, through funding which was raised at county level. She involved people across sectors in the training, as she wanted to establish a team of people at County level, who will have knowledge and capacity to also train on MHM; including actors from the media. This has been useful, as if there are technical health-related questions, then the health person can respond, and if there are education questions the education person can respond, and the media person can help identify the key messages to bring to the wider area. Also, for one session with a group of men, the SRH specialists included a male gynaecologist, which gave the men an opportunity to ask questions on these issues.

Assistant County Commissioner as an MHM Champion breaking the silence

In Muranga County, a working partnership has been formed between the government and the Catholic Diocese of Muranga. Josephat Geteya Onchari is the Assistant County Commissioner for Ithanga Division for the Ministry of Interior, who Coordinates National Government in Gatanga Sub-County. Enureta Ndege is the Programme Officer for the Catholic Diocese of Muranga, a sub-grantee under the K-SHIP programme.

They have been working together to progress Community-Led Total Sanitation (CLTS) and also MHM and have been innovative in their approaches. Josephat was invited to an MHM session and also went on a CLTS exchange programme to Narok, where he learnt how to integrate MHM into the county activities. Josephat and a colleague then undertook a training to become MHM trainers. He appreciated the training and noted that *"I am an officer with a difference courtesy of the WSSCC"*, because of the MHM training provided. Josephat has introduced MHM to his colleagues and has worked to trigger the Sub-County Government as an institution. Also, he has encouraged Chiefs and Assistant Chiefs to discuss MHM and understand its advantages. Enureta has been working with the Ministry of Interior and with the Chiefs and Assistant Chiefs and the Elders Groups and she also works with the Governor, the Sub-County Public Health Officers and the County Health Volunteers.

Josephat also sometimes undertakes advocacy activities at community level together with his wife, who is an Engineer for a telecommunications company. She is a motivational speaker and encourages other young women to become engineers. She is given time from work to undertake MHM activities, as part of her company's Corporate Social Responsibility (CSR) commitments. Joseph talks about how he supports his wife in her MHM and buys her pads when he is shopping, which he feels helps men at community level, to easily understand their role in supporting their wives and daughters in MHM. This example is interesting, both from the perspective of potentially involving other husband and wife teams in community engagement activities on MHM, highlighting the importance of dialogue at household level, and also from the perspective of engaging wider actors, including those from the private sector. The private sector, in countries such as Kenya, are increasingly becoming interested in undertaking CSR activities⁴⁵, so this offers opportunities to make use of new resources for promoting MHM to wider numbers of people.

⁴³ Mvurya, C (2020) *Fanikisha Foundation, 2019 Key Highlights*

⁴⁴ Ndegwa, C. M. (2016) *Exploring MHM Practices Amongst Girls with Special Needs in Learning Institutions in Kwale County, Kenya*, MA Education, Health Promotion and International Development, University College London – Institute of Education

⁴⁵ Drummond, J and Crawford, N (2014) *Humanitarian crises, emergency preparedness and response: the role of business and the private sector*, Kenya case study, January 2014, Humanitarian Policy Group, Humanitarian Futures and Vantage Partners, Overseas Development Institute.

Innovations: sanitary pads that look like shoe liners, waterproof underwear and a household burner for sanitary wastes

Josephat and Enureta have also been innovative in their work. Where they live girls still use traditional materials such as socks, cow dung, leaves or old cloth to manage their MHM. Others use pads. The menstrual cup is also available, but it is expensive and so not everyone can afford one.

They have supported training on how to tailor local sanitary pads. They have innovated to design pads that look like shoe inner soles, so when they are hung up on the washing line in the sun, people do not realise they are sanitary pads. They have also supported the local production of menstruation panties with a waterproof liner. See the images below.



Local sanitary pad designed like a shoe liner and menstruation panties with a waterproof liner

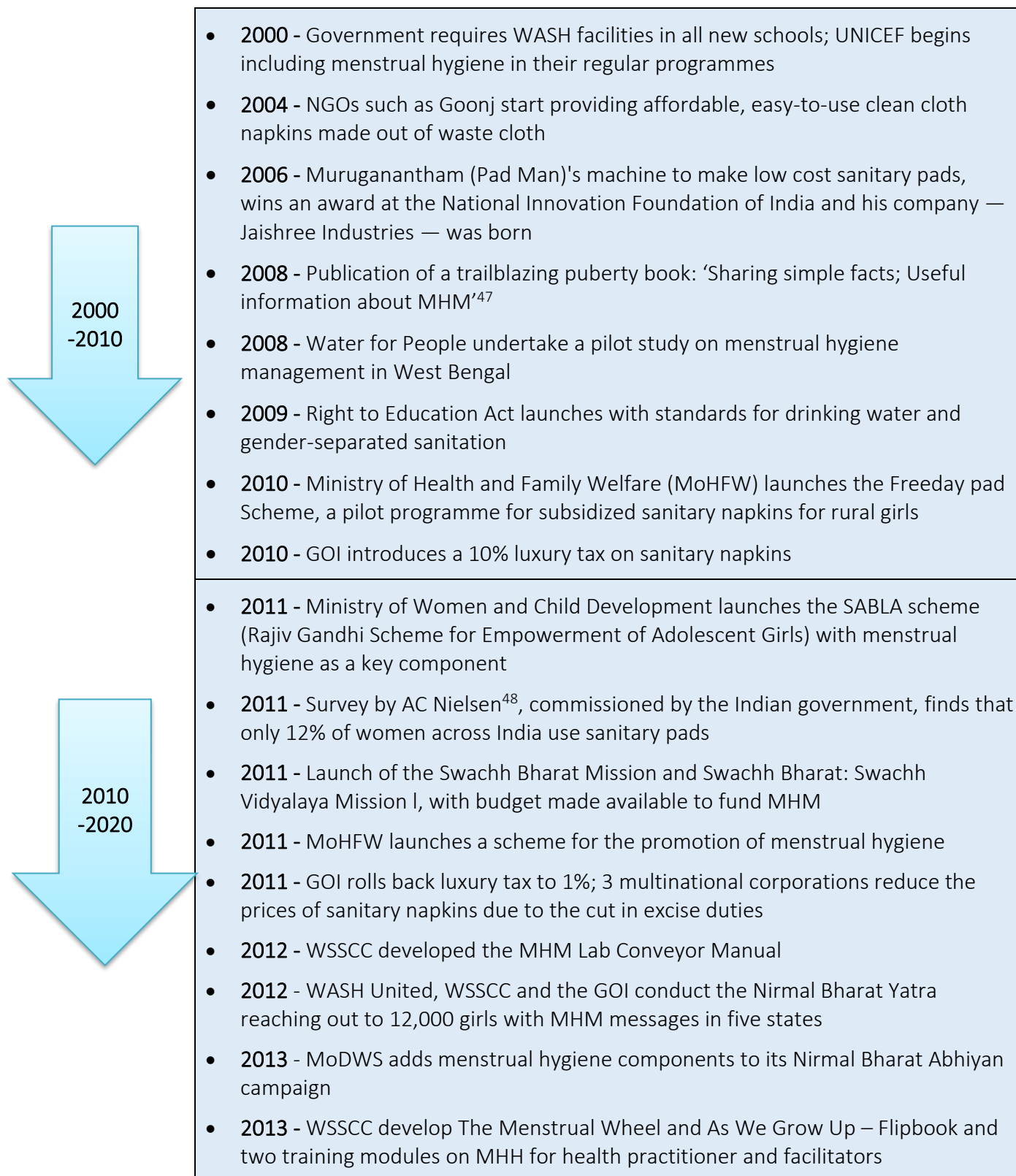
(Credit: Enureta Ndege / Catholic Diocese of Muranga)

They are also supporting innovation to make a small household stove with an emission chimney and a door, through which you can place some charcoal and the pad where it is burnt. The ash is collected in a tray. The design is still under development and in particular, how to design the chimney to minimise emissions. This innovation is owned locally and the partners are keen to finish the development of this burner themselves and then to promote its uptake in their areas and wider. This stove has the potential to be useful for households across Kenya and a wide range of other countries.

3.3 Progress summary – India

Figure 4 - provides a general time-line of activities related to MHM in India.

Fig 4 - Stages in key progress on MHH in India⁴⁶



⁴⁶ Adapted from: USAID, Dasra and Kiawah Trust Spot On! Improving Menstrual Health and Hygiene in India. Link: [Here](#)

⁴⁷ Produced by Government of India, Ministry of Rural Development, Department of Drinking Water Supply, Santha Sheela Nair, UNICEF: <https://www.susana.org/en/knowledge-hub/resources-and-publications/library/details/1151>

⁴⁸ Nielsen, A. C., and Plan India. "Sanitary Protection: Every Woman's Health Right." Community development organization Plan India (2011).

- **2013** - WSSCC, FANSA and partners in eight South Asian countries produce Leave No One Behind (LNOB) Regional Report
- **2014** - MoHFW launches Rashtriya Kishor Swasthya Karyakram (RKSK) - a comprehensive health programme for adolescents – with MHH integrated
- **2014** - Ministry DDWS includes MHH in Swachh Bharat Mission
- **2015** - MoDWS launches the National Guidelines for Menstrual Hygiene Management⁴⁹
- **2016** - WSSCC, Government of India, and partners created a platform for listening and learning on MHM during the Sanitation Action Summit
- **2016** - National Consultation on MHM in New Delhi involving government and civil society/NGOs. MHRD commits to take National MHM Guidelines forward at state level
- **2017** - NFHS 4⁵⁰ (India's DHS) includes data on use of hygienic products by women (15-25 years)
- **2017** - MHA, with WSSCC, hold a consultation event on 'Pushing the boundaries on the MHM dialogue in India'⁵¹
- **2017** - Government of Jharkhand launched the Garima (Dignity) project, supported by WSSCC
- **2017** - Jharkhand State Menstrual Hygiene Management Guidelines & Action Plan, developed with WSSCC support
- **2018** - India scraps tax on sanitary pads; Period. End of Sentence. Documentary film is launched to international acclaim.
- **2018** - Bollywood film Pad Man film released, WSSCC supported the script writing
- **2019** - MHM India Summit. India's First Menstrual Hygiene Management Summit
- **2019** - WSSCC collaborated with GIWA on the Kumbha Mela Women summit and MHM Lab, around 2 million people visited to MHM lab
- **2019** - Bihar State Menstrual Hygiene Management Guidelines & Implementation Framework, developed with WSSCC support
- **2019** - Prime Minister declared that India to be open defecation free (ODF); WSSCC provide technical support for inclusion of MHM in ODF-plus and ODF-Sustainability activities

⁴⁹ http://www.ccras.nic.in/sites/default/files/Notices/16042018_Menstrual_Hygiene_Management.pdf

⁵⁰ <http://rchiips.org/NFHS/NFHS-4Report.shtml>

⁵¹ <https://www.path.org/resources/pushing-the-boundaries-on-the-menstrual-health-management-dialogue/>

National progress on MHM

The timeline indicates national progress on MHM in India from 2000 often with government efforts focused on WASH in schools and NGOs supporting the supply of sanitary pads. Over time, a more diverse range of actors have become involved, with WSSCC engagement on MHM in India beginning around 2012.

India has a range of policies and strategies that relate to MHH including the Rural Sanitation Strategy (2019 - 2029), which lays down a framework to guide local governments, policy-makers, implementers and other relevant stakeholders in their planning for Open Defecation Free (ODF) Plus status, where everyone uses a toilet, and every village has access to solid and liquid waste management. There are a number of ways different 'sectors' (Health, Education and Rural Development) have engendered MHH as a cross-cutting issues; including the National Adolescent Health Strategy (2014) and the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) Strategy (2013). GOI has issued new guidelines for the Swachh Bharat Mission- Phase 2⁵², which include MHM. The Ministry of Housing and Urban Affairs recently launched the Gender Responsive Guidelines in urban India under the Swachh Bharat Mission. This includes guidance for community and public toilets for menstruation, as well as disposal options and implications for solid waste management. The Ministry of Drinking Water and Sanitation published the MHM National Guidelines (2015) and the Guidelines for Gender Issues in Sanitation (2017), which includes further details on how to improve MHH in schools.

MHH actors are increasingly collaborating to take forward MHH at different levels, through the formation of the MH Alliance, currently chaired by WaterAid and Development Solutions, which has a diverse range of members, including government.

The Government of India required all new schools to have WASH facilities in 2000 (under the Sarva Shiksha Abhiyan), with separate toilets for girls. There followed efforts by government and NGOs at State level to increase awareness of menstrual health and hygiene and efforts to reach girls with menstrual hygiene messages in schools and through adolescent health programmes. Government led action on MHH in a number of ways including through producing national and state level guidelines on MHH.

The training of Self-Help Groups and local entrepreneurs on low-cost pad-manufacturing has been widely adopted. Central government launched a subsidized pad distribution programme and several states took this programme forward to distribute pads to girls through schools and public health facilities. Private sector actors have been promoting MHH through disposable and reusable pads. According to the most recent data available, the National Family Health Survey (NFHS-4, 2015-2016) reported that of women age between 15-24, most (62 percent) use cloth, followed by sanitary napkins (42 percent), and locally prepared napkins (16 percent).

A range of nation-wide advocacy efforts has aimed to break the silence and foster dialogue on the subject. For instance, women's protest movements / feminist social media campaigns have included MHH, such as when 5 million [women formed a "wall" along a national highway](#) to support the legislation granting menstruating women the right to enter the Sabarimala temple, in the context of women claiming their right to public space. Online

⁵² <https://swachhbharatmission.gov.in/SBMCMS/writereaddata/portal/images/pdf/sbm-ph-II-Guidelines.pdf>

petitions have also been organised on the topics of menstrual leave, free distribution of sanitary products for the poorest menstruators and removal of tax on sanitary products. For instance, a petition in 2019 to Government of India requesting free sanitary pads or cups to women living below the poverty line attracted 229,000 signatures. Various MHH social media campaigns have been run on themes such as breaking taboos, raising awareness and promotion of biodegradable products. P&G's "Touch the Pickle" campaign in India reached 2.9 million women and the Facebook page of Red is the New Green (promoting sustainable and affordable solutions for menstruation) has over 1,000 followers. Menstruation is increasingly discussed in public and in the mainstream media, including Bollywood films, and perceptions are changing that it is not only a 'woman's issue'. Women's movements and drives towards un-stereotyping gender norms have also challenged religious taboos on MHH.

WSSCC funded support

The India Support Unit (ISU) was established in 2015 as a development partner of the then Ministry of Drinking Water and Sanitation (MDWS) of the Government of India (GOI), for the implementation of its national flagship programme, Swachh Bharat Mission-Gramin (SBM-G, or Clean India Mission – Rural Areas). The ISU is a full-time salaried team working in Delhi on behalf of WSSCC. Supported by the Geneva Secretariat including for MHH-related activities, and along with other partners, WSSCC's strength as an 'agency' is based on a number of factors, including its international brand, credibility as a technical organization, and its support (technical expertise and capacity development) to all levels of government, from the national to the local and the ability to bring knowledge of international best practices.

ISU was made a Key Resource Centre by the Ministry of Drinking Water & Sanitation, Government of India, for the capacity building of the state and district level functionaries under the Swachh Bharat Mission. Between 2018 and 2019, WSSCC has enrolled a pool of 45 trainers on MHH at the national level. WSSCC developed and supported an 'MHM Training of Trainers (ToT) Training' approach. WSSCC trainings are aimed at developing a cadre of master trainers (resource persons) at district/state level, involving key duty-bearers and service providers (male/female) in trainings and embedding training activities into existing government structures/institutions. WSSCC has facilitated a ToT programmes in different parts of the country in partnership with the GOI and state governments under the SBM. With WSSCC support, Simdega in Jharkhand became the first district in India where MHH awareness has been systematically improved, including at the village level (see the case study below). The success has since been replicated in other districts. There is a growing cadre of hundreds of district staff aware and committed to MHH. Training participants include government officials and front-line workers from Integrated Child Development Services (ICDS), Health, SBM, Education, Jharkhand State Livelihood Promotion Society, doctors, ANM's, teachers, Child Development Project Officer's (CDPO), Superintendents, International Children's Development Program, Block Coordinators, District Consultants, and Self-Help Groups. Key duty-bearers and service providers (male/female) are trained and training activities are embedded into existing government structures/institutions through action planning.

The typical WSSCC 5-day ToT begins by discussing gender roles/expectations and power as a way to start the discussion on norms. On the second day there are more participatory activities to introduce the topic of MHH using displays of MHM products, MHM Labs held as well as showing videos. The ToT also aims to improve participant facilitation skills: a field visit is organised to provide an opportunity for participants to facilitate a 45-minute session on MHH in a community or school. Action plans are developed on the last day of the training, in some

cases senior government officials are invited to join the planning. A simple 10 question quiz is organised pre- and post- assessment, analysis highlights a higher level of knowledge post-training (although no participants were able to answer 100% of questions correctly). The feedback in this review was unanimous in endorsing the need, relevance and importance of the training. Most respondents (either as trainers or participants) mentioned the usefulness of the training to their daily work and said they had acquired new skills and knowledge as well as aiding their personal development/awareness.

WSSCC's model is based on state/district functionaries carrying out further MHH training of cadres at block and then at village level in a cascading manner. There are instances where the training has been adapted to a one-day training i.e. WSSCC's trainers also trained students of Social Work at Punjab University – the students are then expected to go on to train others where they are working on their placements. WSSCC had also provided training to policewomen in Maharashtra.

Coordination - WSSCC⁵³ plays a key role in building effective partner relationships to support coordination, dialogues and events. One of the strengths of WSSCC has been its ability to work with partners (notably the Global Interfaith WASH Alliance, Hans Foundation, Youth Ki Awaaz and the Menstrual Health Alliance India) to build momentum and alliances for ground-breaking action. WSSCC has had a role in convening partners (together with Freshwater Action Network South Asia (FANSA) and WaterAid, WSSCC supported national level consultation meetings in seven South Asian countries in advance of the 7th SACOSAN⁵⁴ as well as a consultation at the 2016 Sanitation Action Summit in Mumbai), supporting dialogue (such as the Pushing the Boundaries on the Menstrual Health Management Dialogue⁵⁵), as well as contributing technical outputs (such as State MHM guidelines for Assam, Bihar and Jharkhand as well as state-level MHM training strategy). In addition to its partnership with governments at the national, state and district levels, WSSCC has focused on the development of partnerships with research institutes, community-based organizations, and NGOs. These partnerships help to build sustainability into WSSCC efforts, but also ground-truth national level advocacy/advice with experience at the local level.

Research and learning - Through supporting research and advocacy initiatives on MHH, WSSCC has played a role in evidence-based policy analysis and influencing government priorities for change. WSSCC engaged in numerous pieces of research, including with the SHARE Consortium on the specific impact of inadequate access to WASH facilities on women and girls⁵⁶ as well as rights-based sanitation research⁵⁷ and girls and women's knowledge of MHH and their practices⁵⁸.

Engagement with youth - WSSCC has supported efforts to create a citizen-led movement on menstrual health by building capacity among young people in partnership with Youth Ki Awaz

⁵³ Whereas most MHH related activities in India are conducted by the ISU, the WSSCC Secretariat in Geneva has also had substantial engagement with and provides direct hands-on support to the ISU. Therefore, the term 'WSSCC-ISU' is meant to reflect the combined strength of the Geneva and India teams.

⁵⁴ <https://www.wsscc.org/media/news-stories/sacosan-special-voices-people-vulnerable-situations-south-asia>

⁵⁵ <https://www.path.org/resources/pushing-the-boundaries-on-the-menstrual-health-management-dialogue/>

⁵⁶ Sahoo, K. C., Hulland, K. R., Caruso, B. A., Swain, R., Freeman, M. C., Panigrahi, P., & Dreibelbis, R. (2015). Sanitation-related psychosocial stress: a grounded theory study of women across the life-course in Odisha, India. *Social science & medicine*, 139, 80-89.

⁵⁷ Centre for Policy Research (CPR) in India Design and Implementation of Research on the Human Right to Safe Drinking Water and Sanitation: <https://www.cprindia.org/events/5456>

⁵⁸ Torondel, B. et al. (2018) *Association between unhygienic menstrual management practices and prevalence of lower reproductive tract infections: a hospital-based cross-sectional study in Odisha, India.*" *BMC infectious diseases* 18, no. 1: 473.

(YKA). The #PeriodPaath campaign has 4 key elements: Publishing stories; The YKA Action Challenge; My Period Story Writing Contests and Tweets to demand change (see the case study below).

Engagement with religious leaders - WSSCC and the Global Interfaith WASH Alliance (GIWA) have spread the word about MHH in faith-based events and faith leaders to galvanise religious actors in promoting change on MHH. However, this engagement on religious norms and restrictions has stopped short of supporting the political demonstrations by women of menstruation age regarding their right to enter holy sites. WSSCC, GIWA and FANSA have also engaged faith leaders in LNOB (Leave No One Behind) Consultation on SDGs (see the case study below).

Advocacy with government - WSSCC has contributed to the development of sector policies, strategies and programmes, as well as the national dialogue on MHH priorities. For instance, in 2012, the inclusion of the WSSCC Menstrual Hygiene Management Lab in the Great WASH Yatra (also known as the Nirmal Bharat Yatra⁵⁹), was a critical factor in the inclusion of MHM in the Nirmal Bharat Abhiyan Guidelines (including budgets for awareness and disposal), as well as in the subsequent Swachh Bharat Mission. WSSCC has supported the government to deliver national priorities defined by the Swachh Bharat Mission. WSSCC's efforts have similarly influenced the content of guidelines and district level MHH action plans for Bihar, Assam and Jharkhand States.

Sanitary pads and disposal - WSSCC has had some experience in supporting the local production of sanitary pads. In Simdega (Jharkhand State), WSSCC supported a women's SHG to manufacture the 'Missi Garima Pads', in order to increase adolescents' access to sanitary pads. Simdega is now aiming to become India's first menstrual waste free district, by eradicating the practice of using disposable sanitary pads. The Missi Garima brand, or other biodegradable pads are promoted instead. During the MHM Lab at the Nirmal Bharat Yatra (2012) WSSCC partnered with Goonj to demonstrate to girls how to make reusable cloth sanitary pads at home. WSSCC has promoted the PadCare Sanicure napkin disposal machine and demonstrated its operation during a number of their trainings and other events. A number of states and districts have installed this machine after participating in this training.

⁵⁹ A travelling sanitation carnival run by the non-governmental organization WASH United that journeyed through five Indian states and 2,000 km over 51 days.



The PadCare Sanicare napkin disposal machine. ©WSSCC/Rinkya Dhariya

Source : <https://www.wsscc.org/2020/02/05/tackling-indias-silent-problem-of-menstrual-waste/>

Trainings for people with visual and hearing impairments - After consultations with girls and women with disabilities at the Sanitation Action Summit (Mumbai, 2016), WSSCC led efforts in India to produce training materials for girls with sight impairments. One example is a tactile book titled “As We Grow Up”, which was developed by ISU and designed by Assitech group of IIT Delhi (see the case study below). WSSCC in partnership with Saksham Trust conducted 5 regional training of trainers, reaching special educators, teachers from inclusive and special schools, universities, disability organizations, government officials and community workers. 249 persons attended these trainings. WSSCC also facilitated a 4-day Training of Trainers workshop on MHM in 2018 at the Public Girls Senior Secondary School, Patran, in partnership with the District Administration (for Patran and Patiala) and the Government of Punjab.

Other people who may be most disadvantaged - Consistent with its mandate, WSSCC’s programming had demonstrated a clear focus on ‘leaving no one behind’ (LNOB) using a rights-based approach. WSSCC has targeted women and girls facing multiple MHH challenges, especially those in hard-to-reach places, or marginalised by caste or ethnicity, disability or disasters. Partners include GIWA and FANSA.

WSSCC has also ensured geographic targeting of training to groups of people who may be most disadvantaged, such as those living in areas such as the Naxalite districts, covered by the

Aspirational Districts' Programme, as well as in residential schools for girls from distant rural locations and girls from Scheduled Castes and Scheduled Tribes. WSSCC has worked with communities in remote and inaccessible rural areas, including in the Pindar Valley (Uttarakhand) in the Hans Foundation's Integrated Village Development Programme (see the case study below). People in urban areas can also be hard to reach and may include more people who may be most disadvantaged or vulnerable, than those living in rural areas. WSSCC has also provided technical support on MHM to people living in slums in Mumbai.

WSSCC guidance for humanitarian response – This has been provided through trainings in flood prone areas of Assam and Bihar where women face challenges in coping with menstruation when water is contaminated. Technical guidance was also provided to the MHM Guidelines for Assam and Bihar States. WSSCC has delivered trainings and support in states where people face disaster/displacement-related inequalities. In the Pindar Valley, girls are not always able to rely on supply chains for sanitary products (due to landslides or weather) to manage their periods; and they may not have access to safe and private facilities or materials. Most recently, WSSCC has provided technical guidance and advocacy in the COVID-19 response; for instance, menstruators quarantined in official care centres were provided with menstrual hygiene products, soap, and other basic essential hygiene items⁶⁰.

⁶⁰ COVID-19 information and guidance for programmes <https://www.wsscc.org/sites/default/files/migrated/2020/05/WSSCC-COVID-19-programming-guidance-v1.pdf>

Case studies - India:

Hereunder, find examples of human-interest stories / good practice case studies from India, showing the range of initiatives from national level through to the individual level.

Collaboration between Global Interfaith WASH Alliance (GIWA) and ISU

GIWA is the globe's first organization to bring together the leaders of all faiths and people from across India and around the world to inspire a planet where everyone, everywhere can have access to sustainable and healthy WASH. At the heart of the WSSCC-GIWA collaboration is an effort to advance the goals of the Swachh Bharat Mission by changing attitudes and ultimately behaviour.

GIWA in collaboration with WSSCC, and with the technical support of FANSA, hosted a Summit at Parmarth Niketan Ashram on the theme of "Leave No One Behind", including menstrual health and hygiene.

The Summit was held in December 2019 and inaugurated by the heads of 5 major faith traditions – Hinduism, Buddhism, Islam, Sikhism, Jainism & Christianity – and brings together groups who are typically left behind in access to benefits of development: 1. Youth; 2. Women; 3. Dalits; 4. Adivasis; 5. Trans-gender people and people who are LGBTIQ; 6. Migrants & Refugees; 7. Urban Poor; 8. Urban Poor- Homeless; 9. Persons with Disabilities; 10. Elderly; 11. Farmers; 12. People living with HIV; 13. Manual scavengers; and 14. Female sex workers. Day 2 of the program included high-level plenary sessions on "Moving Forward Together to Sustain ODF+" and for the faith leaders, key leaders and development partners joining together to release the Outcomes of the Summit

The # PeriodPaath पाठ campaign

The # PeriodPaath पाठ campaign by Youth Ki Awaaz in collaboration with WSSCC, highlights the need for better MHM among menstruating persons in India. The campaign has 4 key elements:

1. Publishing stories
2. The YKA Action Challenge
3. My Period Story Writing Contest
4. Tweets to demand change

The campaign is intended to help develop Menstrual Health Champions, to share personal experiences and opinions on access to menstrual health and to help decision makers address these issues and create better access to health and sanitation facilities. Activities inspired by the campaign:

- In Bangalore a young transwoman trained by YKA has been advocating on MHM for transgender people and transmen and started a petition on change.org demanding access to MHM and supplies
- In Bihar, a champion is organising local events such as open mike and spoken word poetry on taboos and stigma on MHM, which is livestreamed on Instagram
- In Pune, a campaigner has been training teachers on MHM. In the YKA bootcamp he learned that an Act exists that instructs government to allocate funds to MHM training. But that the money is not being spent. So he started a Pune based campaign to make government responsible to scale up access to MHM information and make sure that government funds are spent in the right way.

Partnership with the Hans Foundation in Pindar Valley, Uttarakhand state

Pindar Valley is located in the remote northeast of Uttarakhand state, it is characterised by tough terrain. The place is known as the Land of God. Villages typically don't have electricity, mobile network or pukka roads. Pindar Valley also lags behind on access to healthcare and education. Villagers have to hike to reach the nearby towns. Villages are scattered in the valley. The unpaved (kuchha) road is closed in monsoon rains or heavy snowfall, meaning that the valley is cut off from the rest of the region. The Valley is also prone to disasters such as landslides.

The Hans Foundation (THF) implements an Integrated Village Development Program (IVDP) to create model villages in Uttarakhand. They identified MHM as a critical area as communities have various taboos connected to religion and religious practices. Older people thought that if these taboos are broken the gods would punish them. During menstruation women (including teachers or frontline workers) stay in cow sheds (*the goth*). Women can take baths but are not allowed to use the toilet. Girls are not allowed to go to school. THF and WSSCC held a 5-day MHM training programme.

The training was in November/December 2017 and after the participants returned home, the valley was cut off for 3-4 months. When the trainers went back for a follow up visit, they heard that those trained had made a significant change in their own homes. Men trained were standing up for their wives, and not letting them sleep in the cowsheds. The wives were allowed to sleep in the house (although not in the same room as their husbands). The participants had spoken to the mothers and father-in-law's, in order to change their minds about these taboos. A self-help group in the village also has a sewing machine, which can be used by women to make their own cloth pads.

Garima Abhiyan in Simdega District

Simdega is one of the 112 aspirational districts of NITI (National Institute for Transforming India) Aayog. Aspirational districts are identified by the central government as the country's poorest districts that need maximum assistance in development. The Garima Abhiyan, (Garima means dignity) was a district-wide campaign run in 2019 by the administration of Simdega district, Jharkhand, in collaboration with WSSCC. The aim of the Campaign was to make women aware of more hygienic and safer options to manage menstruation. The campaign was supported by the district administration, ISU and Satwik Mishra, an Aspirational District Fellow of NITI Aayog, posted in Simdega.

WSSCC provided a 5-day training programme for district staff from departments of health, livelihood, children's development and sanitation. WSSCC provided knowledge resources, experts, trainers, training support and IEC materials to the campaign. The model has been replicated across the 24 districts in Jharkhand state. The District Administration, Deputy Commissioner and District Magistrate championed the model and there are also plans to declare an 'MHM village', 'MHM panchayat' and 'MHM district'. The government went on to develop a state level MHM road map to help reach Sustainable Development Goal 5 – achieving gender equality and the empowerment of women and girls. The government invested in MHM counselling in schools (and nutrition delivery centres) to help adolescent girls and peers overcome the stigma of menstruation. Teachers have been motivated to teach MHM and celebrate MH Day. The Campaign was recognized in the [Young Innovator Challenge](#) in the 3M YICA 2019.

As part of the training, men were made aware about menstruation and personal hygiene as well as breaking taboos around cooking food or taking a bath during menstruation.

Developing MHH resources for people with visual impairments

WSSCC with the Centre of Excellence in Tactile Graphics (CoETG) – Indian Institute of Technology Delhi and the Saksham Trust, designed, tested and produced materials on MHH in consultation with blind women and girls. The toolkit includes:

- *As We Grow Up: A Braille and Tactile Book on Menstrual Hygiene Management*
- Facilitator's Manual⁶¹ for the 'As We Grow Up: A Tactile Book on Menstrual Hygiene Management'
- Menstrual hygiene bracelets for people who are visually impaired
- Tactile apron on the female reproductive system using puff printing
- The MHH pledge to break the silence produced in braille on transparent stickers

The materials help women to visualize and understand their bodies, the physical changes during puberty, the biology behind menstruation and how to manage their monthly period with pride and dignity. An electronic and an audio version of the tactile book is available for persons who cannot read braille. This is the first resource for women and girls with visual impairments in India.

- The tactile books were launched by the Minister of Drinking Water and Sanitation, GoI and have been endorsed by the Swachh Bharat Mission
- 1,200 books have been distributed to users to date. The books continue to be distributed occasionally, for instance taken to a workshop and shared whenever an interested organisation requests a copy
- The audio materials have been used as course material by the Rehabilitation Council of India and Special Educators have been trained to use them

The audio book has been uploaded on Sugamya Pustakalaya, an online library for persons with visual impairments.

⁶¹ The facilitator's manual is not tactile, but explains the use of the tactile book

3.4 Progress summary – West Africa

The Joint Programme on Gender, Hygiene and Sanitation (2014-2018) was designed to support governments in West and Central Africa (Cameroon, Niger and Senegal), and was implemented by WSSCC and UN Women. The programme had a budget of \$2.65 million and was designed to deliver on four key objectives, at the level of evidence-based public policies, knowledge and practice, research and inter-agency learning:

1. Ensure that the specific needs of women and girls regarding sanitation and hygiene, are integrated into policies, laws and regulations, and are budgeted for in the target countries - Senegal, Cameroon and Niger
2. Identify good practices in the field of sanitation and hygiene for women and girls and integrate it into training materials
3. Identify knowledge gaps to improve the programme
4. Identify lessons learned to equip the two organisations to work more effectively towards a progressive reduction of inequalities

A number of studies were carried out under the Joint Programme on Gender, Hygiene and Sanitation in West and Central Africa, including:

- WSSCC/UN-Women (2017) *Menstrual hygiene management in humanitarian situations: the example of Cameroon*
- WSSCC/UN-Women (2017) *Menstrual hygiene management and female genital mutilation: case studies in Senegal*⁶²
- WSSCC/UN-Women (2018) *Menstrual hygiene management and practices: Behaviour and practices in the Louga region, Senegal*
- WSSCC/UN-Women (2018) *Menstrual hygiene management: The experience of nomadic and sedentary populations in Niger*⁶³

The outcomes of these studies provided critical information about MHM knowledge and practices in the region and were used for advocacy and changes to law and policy.

Table 1 - Summary of the Joint Programme outputs

	Cameroon	Niger	Senegal
Law adopted to include MHM		Yes	Yes
National policies revised to include MHM	Yes	Yes	Yes
People trained	5,483	6,200	8,469
Studies conducted on MHM	7	1	5

⁶² https://www.wsscc.org/sites/default/files/uploads/2018/01/20171227_Policy-GHM-Senegal-EN-WEB-1.pdf

⁶³ <https://menstrualhygieneday.org/wp-content/uploads/2017/03/Menstrual-Hygiene-Management-%e2%80%93-The-experience-of-nomadic-and-sedentary-populations-in-Niger.pdf>

The extracts from these case studies include:

MHM: The experience of nomadic and sedentary populations in Niger

Data was collected from regional and local leaders and from the general population, using a mixed research method that combined quantitative and qualitative approaches. The sample used for the quantitative data was randomly drawn from women and girls aged 12 to 49 years and men aged between 15 and 49 years. A total of 1,310 people took part in the research (868 women and 442 men).

Notable findings include:

- Women and girls from rural areas are not able to explain why women have periods.
- During their periods, women and girls observe nutritional, sexual and religious restrictions.
- Poor MHM practices are seen more among nomadic women (98%), in comparison with sedentary women (49%).
- Pads are the most common type of protection used during menstruation.
- Access to and use of WASH facilities is lower in nomadic communities – with poorly cleaned toilets which are often non-functional and unsuitable for good MHM.
- In most cases, women wash their sanitary protection at home and dry it in their bedrooms, or in another room inside the house.

MHM and female genital mutilation: case studies in Senegal

This study explores the links between MHM and female genital mutilation (FGM), for the first time.

The study was performed in the regions of Kédougou, Kolda, Matam and Sédhiou, in Senegal. The general goal was to find out if female genital mutilation had any impact on menstrual hygiene management.

The study showed that the social and religious representations developed around menstruation, led to a significant feeling of fear and embarrassment in mutilated women. Women in this group are more stigmatized or isolated during their periods; seven per cent more of them (than non-mutilated women), go into voluntary isolation, or are isolated by other members of their families during this time.

Moreover, these women experience more menstruation-related health problems: vaginal infections, abdominal pain, fever, headaches, etc. More than a quarter of them (27 per cent), say that problems related to their MHM have had a negative influence on their sexual and reproductive health.

MHM: Behaviour and practices in the Louga region, Senegal

The study was conducted in mainly urban and semi-urban areas. The sample was chosen at random with a total of 616 respondents (women and girls aged 13 to 65).

Key findings include:

- Girls have extremely limited information about why they menstruate and how to manage menstrual flows hygienically and safely.
- Most respondents reported drying menstrual cloths in secluded, private, dark locations.
- Menstrual waste materials are regularly disposed of in latrines and toilets, due to a lack of alternative waste disposal options and a lack of knowledge about the consequences.
- Menstruation is often viewed as a sign of both maturity and adulthood.
- Due to a lack of suitable spaces and facilities for proper MHM, women and girls are excluded from participating in cultural, educational, social and income-generating activities.

MHM in Humanitarian Situations: The Example of Cameroon

The study was conducted in four refugee sites in three regions of Cameroon: Lolo and Mbilé in the East Region, Borgop in the Adamawa Region and Minawao in the Far North Region. The target population for the study was refugee women and girls aged 10 to 49 years, who had had at least one period. To identify refugee men's and boys' knowledge of and attitudes towards menstrual hygiene, refugee men and boys aged 15 years and older, were also interviewed. Observations were carried out to assess the condition of the water, hygiene and sanitation infrastructure in the refugee sites. The total sample comprised of 1,079 women, 307 men and 677 households, equally divided across the sites.

The issues encountered include:

- The study found that there was a noticeable lack in both quantity and quality of facilities for water, hygiene and sanitation, in order to ensure refugee women's privacy and security. There were no separate toilets for men and women, a limited number of toilets, no space to change, insufficient water, no washing lines, no lockable doors and a lack of light.
- Most women refugees questioned, preferred to use the sanitary towels included in the hygiene kits issued quarterly by UNHCR: During their last menstrual period, *"75 per cent of women had used disposable sanitary towels, while 14 per cent had used fabric sanitary protection and 5 per cent cotton sanitary protection"*.
- With no designated place for their disposal, refugee women dispose of their sanitary towels in various places: down the toilet (72 per cent of women), as well as in waste bins, in holes dug behind the house, or in rivers. Some burn them.
- Activities most likely to be halted during periods, are domestic and household tasks, trade and education.

4. Findings and discussion on the SWOT of progress on MHH

This section summarises the key findings across the focus countries for this study, considering the strengths, weaknesses, opportunities and threats of progress on MHH nationally, as well as the contributions from WSSCC support to MHH; and reflects on what is needed in key areas going forward.

4.1 Findings and discussion – Strengths

National policies, strategies and guidelines –

National progress - All focus countries have developed policies, strategies or guidance, which includes direction on how to address and improve MHM services, often in schools. In Kenya, the government has worked hard with sector stakeholders over a four-year period, to develop a comprehensive and holistic national MHM Policy and MHM Strategy which were approved by the Cabinet in 2020. MHM has also already been integrated into the national environmental sanitation and hygiene-related policies and strategies and it is mentioned in the national gender-related policy. In Tanzania, four ministries with responsibilities for health, education, water and local government, with the support of UNICEF, SNV, Community Based Rehabilitation in Tanzania (CCBRT) national disability hospital, SHIVYAWATA, EEPKO and other partners, started the process of incorporating MHM into the National School WASH Strategy, Guidelines and Toolkits from 2010 onwards. MHM has also been included in the National Accelerated Investment Agenda for Adolescent Health and Well-Being. India has a range of policies and strategies that relate to MHH. Furthermore, the Ministry of Drinking Water and Sanitation published MHM National Guidelines (2015) and Guidelines for Gender Issues in Sanitation (2017) which include further details on how to improve MHH in schools.

WSSCC contributions – The WSSCC has provided significant contributions to the development of the MHM Policy and MHM Strategy in Kenya, along with a wide range of other actors. The biggest contribution that the WSSCC has made to the development of the policy has been through supporting the training of multiple actors at senior level, who have then led and supported the development of the policy, including senior representatives from the Government of Kenya. The WSSCC National Coordination team, were also key in supporting and encouraging the government in the process and the WSSCC also contributed some of the funds for the cost of the process of developing the policy and strategy, in collaboration with a range of other organisations. In Tanzania, the WSSCC NC team and other senior actors, trained through support from the WSSCC and other actors, have been advocating for including MHH in the National Health Policy. In West Africa, the WSSCC and UN Women Joint Programme, resulted in the integration of MHM into policies, technical notes, and sectoral documents and manuals, including introducing MHM into laws in Niger and Senegal. In India, WSSCC has supported the development of state-level MHM Guidelines (in Assam, Bihar and Jharkhand). There has also been increased momentum, programmatic progress and policies developed on MHM in schools at national and state levels (with state governments responsible for rollout and budget allocation).

GSF-supported programme contributions – The K-SHIP and UMATA programme teams have engaged in national dialogue activities. In Kenya, the team members have contributed to the content of the MHM Policy and MHM Strategy.

Cross-sector and multi-stakeholder collaboration –

National progress - In Kenya, MHM has regularly been included in the government-led national TWG-HP under the National Sector-Wide Approach, which coordinates all actors and there is a plan to set up a National Task Force on MHM to encourage coordination at sub-national levels. In Tanzania, a national Menstrual Health and Hygiene Coalition has been formed, which has a diverse range of actors committed to taking forward MHH, making it a very powerful force for change. It currently has more than 170 members and has developed its own strategy. Until recently it was not led by government, but the incoming chair will be the MoHCDGEC. In India, MHM is on the agenda of national coordination mechanisms (sectoral and cross-sectoral), such as the Menstrual Health Alliance, which is a national-level platform of approximately 35 organisations, including WSSCC.

Efforts are ongoing to strengthen coordination across sectors, including in India on nutrition, reproductive health and other health areas, and in Tanzania and Kenya in sexual and reproductive health, gender, environment and finance. UNFPA is a member of the National MHH Coalition in Tanzania and contributed in the last stages of the MHM Policy development in Kenya, but has not yet been highly engaged in Kenya or Tanzania (but has in India). It is hoped that their engagement will increase over the coming years.

WSSCC contributions – The WSSCC NC in Tanzania is one of the most experienced and active MHH actors in Tanzania and was in 2019/20 was the Chair for the National MHH Coalition. The WSSCC NC team and WSSCC NC Assistant have worked hard to encourage collaboration and coordination across actors, and they collaborate closely with UNICEF, one of the other key organisations leading on MHH in Tanzania. In Kenya, the WSSCC NC and NC Assistant, put a significant amount of effort to support the MoH to facilitate coordination across sectors and a previous WSSCC NC is currently the convenor for the national HP TWG, where MHM is discussed. In India, WSSCC and Global Interfaith WASH Alliance (GIWA) have spread the word about MHH in faith-based events and galvanise a critical mass of faith leaders. And a partnership with Youth Ki Awaaz (YKA), focuses on youth’s engagement on MHH-related issues. The Joint Programme between UN Women and WSSCC in West Africa is another example of successful multi-stakeholder collaboration between sectors (gender and WASH).

GSF-supported programme contributions – The staff members of the UMATA and K-SHIP programmes in Tanzania and Kenya, have actively engaged with collaborative activities, including related to the development of the MHM Policy in Kenya.

Training and teaching –

National progress – It is clear from the interviews and resultant activities of the participants, that cross-country training and exposure of a few key actors, was found to be motivating by people who participated, with some going on to become key MHM leaders and advocates in their own countries. WSSCC has been supporting capacity building at national level in both Tanzania and Kenya, as well as supporting the facilitators for a number of trainings at county level in Kenya and at state and district level in India. The large numbers of people who have been trained at different levels, has resulted in a large cadre of committed MHM actors in Tanzania, India and Kenya, who are taking initiative to understanding the challenges and finding solutions going forward. In Kenya and Tanzania, it is clear that training large numbers of sector actors, in particular on the 3-pronged approach, has led to significant progress and commitment in both countries, including in the formation of the MHH Coalition in Tanzania and the development of the MHM Policy and Strategy in Kenya. WSSCC developed a training

package in India, which has been rolled out across Tanzania and Kenya and is currently being translated into Kiswahili in Tanzania. In Kenya the materials were translated into Kiswahili and images changed for those more applicable to the Kenya context, but the Kiswahili version has not yet been released by the government for use at the time of this study.

WSSCC contributions – WSSCC have put significant effort into supporting capacity building on MHH in all three countries. They have been one of the key organisations who provided leadership for training on MHH and funded a number of participants to attend trainings across countries. They also supported trainings for trainers at national level, together with other organisations, and in some cases also contributed through provision of trainers at sub-national levels. To-date the trainings in Kenya and Tanzania mainly used WSSCC training materials and approaches first developed in India, but with discussions facilitated around the local contexts. WSSCC Geneva Secretariat team supported a number of the key national trainings and they also recruited 5 regional trainers from the East and Southern Africa region (4 from Kenya, 1 Tanzania and 1 from Zambia).

Table 2 - Summary of MHH trainings that the WSSCC has contributed to since 2014

Participants	Trainings in other countries			National level trainings			Sub-national trainings			Totals	Others without data
	f	m	Total	f	m	Total	F	m	Total		
Tanzania	3		3	93	39	132	44+	36+	191	326	Media training
Kenya	4	3	8	+	+	212	66+	38+	193	413	
India									500*	500	
Cameroon, Niger and Senegal										620	
Total trainers trained across the 6 countries										1,859	

* As a conservative estimate

Other trainings supported by other organisations without WSSCC inputs, or undertaken by trainers who originally participated in trainings supported in part by the WSSCC, and then who went on to facilitate trainings with other resources, can be seen in [Annex II](#).

GSF-supported programme contributions – The UMATA and K-SHIP programmes have supported capacity building at district level (Tanzania) and county level (Kenya), training sub-county level government and non-governmental actors, health staff and teachers.

Influencing and advocacy –

National progress – Menstrual Hygiene Day and other national and regional events have been used for sharing and learning. Training national and sub-national champions at senior level, with an interest and commitment to MHM, has also offered opportunities for influencing at and from the highest levels of government, such as with and through the County First Ladies in Kenya and the Members of Parliament in Tanzania. Regional events, advocacy platforms and alliances, campaigns and social media, have been raising the profile of MHM, and to secure commitments to MHM. India in particular, has undertaken a wide range of high-profile social media campaigns. In India, WSSCC has also supported disability and youth groups, as well as those tackling religious barriers to break the silence.

WSSCC contributions – Many of the key actors working on influencing and advocacy have increased their interest, knowledge and motivation, through participation in the trainings facilitated and supported by the WSSCC and other partners. The trainings for the County First Ladies in Kenya and Members of Parliament in Tanzania, were led by the government and funded mainly by the WSSCC. The 'MHM lab' is a tool developed by the WSSCC in India, which has been utilised in some high-level advocacy events.

GSF-supported programme contributions – The UMATA and K-SHIP programme teams have engaged collaboratively with other actors for influencing and advocacy on the international MH Day and in other opportunities.

Research and learning –

National progress – Tanzania, Kenya and India have all undertaken a range of MHM-focused formative research and KAP analyses to better understand the contextual and socio-cultural factors and perceptions to inform programmes and advocacy. A wider range of research has been undertaken in Kenya and India, including randomized controlled trials on different sanitary products in Kenya and investigations into the impacts of access to products on issues such as transactional sex. Earlier research in Tanzania, by Dr Marni Sommer, has informed MHM efforts globally, and a recent national study on MHM in Tanzania, has been undertaken by the National Institute for Medical Research under the MoHCDGEC and funded by UNICEF.

WSSCC contributions – The WSSCC was one of a number of organisations which funded the situation analysis undertaken as part of the policy development process in 2016 in Kenya, but other than this, the WSSCC has not been involved much in large scale research in Kenya or Tanzania. Through the Joint Programme on Gender, Hygiene and Sanitation, WSSCC and UN Women funded nine studies and contributed to a better understanding of the MHM status and practices of women in vulnerable settings in Niger, Cameroon and Senegal. In India, WSSCC has engaged in numerous pieces of research. The SHARE Research Consortium and WSSCC formed a research partnership in 2013, to investigate the specific impact of inadequate access to WASH facilities on women and girls. Findings were presented at a Gender and WASH workshop (WSSCC, SHARE, WSP), in New Delhi in 2013. WSSCC also collaborated with the Centre for Policy Research on rights-based sanitation research in 2014. WSSCC has also undertaken its own research, for instance in the MHM Lab at the Nirmal Bharat Yatra, 2012 tablet survey and focus group discussions were undertaken to understand girls and women's knowledge of MHH and their practices. WSSCC consistently produces conference papers, for instance at the WEDC Conference.

GSF-supported programme contributions – The UMATA programme in Tanzania undertook a small-scale study on MHM in 6 communities before starting its MHM activities and has supported learning as part of the programme processes in both Tanzania and Kenya, but has not supported other stand-alone studies.

GSF-supported and other programmes –

The GSF is supporting the UMATA programme in Tanzania and the K-SHIP programme in Kenya. Several programmes, led by government, NGOs and others, are addressing MHM services in schools, as part of their wider school WASH and education programming, including under these two programmes. More attention is needed for refining and testing pilots and assessing the elements of programmes that can work at scale. In Tanzania, the incorporation of MHM in the new MoEST-led World Bank funded payment-by-results project, the Sustainable Rural Water and Sanitation Programme, provides an opportunity for scaling up provision of MHM services in all primary schools in the country. But to have the greatest impact, the MHM components need to be well thought out, good quality and have collaborative support of all key actors to ensure the programmes are effectively designed. In Kenya, some activities have been undertaken at community level, through the CLTS triggering and follow-up processes.

Equality and non-discrimination and leaving no-one behind –

National progress – The SDGs focus on women and girls and efforts aimed at leaving ‘no one behind’ have raised the profile and commitment for countries and programmes to increase attention on these groups. In West Africa and India, WSSCC has been building evidence on the needs of women and girls in vulnerable situations such as living in camps, in disaster-prone areas and in remote or inaccessible regions, including those that lie beyond the normal supply chains, in order to build awareness in evidence, policy and practice. People with disabilities have also been trained as MHM trainers of trainers and have become active MHM advocates, champions and role models and who are keen to find ways to support much larger numbers of women and girls with disabilities across Tanzania, Kenya and India. In Kenya, work has also been undertaken to train a few MHM trainers and MHM Champions in the Kenyan Prison Service, who have already started making changes and rolling out training to female inmates. These activities have been funded by the prison service itself. A number of Kenyan MHM trainers and Champions have also been working out innovative approaches to reach different pastoralist communities and in India to work with people who are transgender.

WSSCC contributions – Government and non-governmental actors who have been participants in the trainings supported by WSSCC and other partners in Kenya, have then gone on to undertake work on MHM in pastoralist communities and in prisons, with other resources, as part of their own work. In both Kenya and Tanzania, trainees who themselves have disabilities, have gone on to train people on MHM through their own work without WSSCC funding. In India, WSSCC has supported people living in areas such as the Naxalite districts, covered by the Aspirational Districts’ Programme, as well as in residential schools for girls from distant rural locations and people from the Scheduled Castes and Scheduled Tribes. WSSCC has worked with communities in remote and inaccessible rural areas, including in the Pindar Valley (Uttarakhand). A 2019 ‘Leave No One Behind Consultation’ in Rishikesh, brought together women, youth, elderly, people with disabilities, shanty dwellers, homeless women, farmers, people who scavenge manually, Dalits, Adivasis, migrants and

refugees, transgender, sex workers and people living with HIV. This event builds on previous consultations at the Sanitation Action Summit (Mumbai, 2016) and the consultations in preparation for SACOSAN VII.

GSF-supported programme contributions – A few of the K-SHIP and UMATA sub-grantees trainees who participated in MHM trainings with support from the WSSCC and other partners, have gone on to undertake MHM activities, with groups who may be most disadvantaged, such as pastoralists in Kenya.

Menstrual hygiene products and materials –

National progress – In Kenya a private sector actor, Varet Products and its associated social enterprise, Global Sanitation Environmental Products in Kenya, have undertaken a range of work in collaboration with County Governments and schools, to try and find a solution for the disposal of sanitary wastes in Kenya. This work has been undertaken under its own initiative and funding, to find a solution to sanitary pad disposal in schools and elsewhere and has also been lobbying government ministries on the same. There are increasing opportunities to facilitate the supply of sanitary products to meet demand, through the international or small-scale private sector. In Kenya, the government has removed VAT and Excise Duty on sanitary pads, imported sanitary pads and materials for making sanitary pads, in stages in 2004, 2011 and 2016. In Tanzania, the government removed VAT from sanitary pads in 2018, but put it back on in 2019, as it was not seeing the respective reduction in the cost of pads. But the process has still been positive in starting the debate on how to make the environment more conducive for local manufacture in Tanzania. In India, this is also being done by supporting tax cuts on MH products; influencing national standards for lower-cost/bio-degradable options; as well as strengthening the supply chain. In India, the government is encouraging states to manufacture and increase access to disposable pads, provided the materials conform to the Bureau of Indian Standards guidelines. In Kenya in 2016, a National Sanitary Towel Programme was established, initially under the Ministry of Education and now being managed by the State Department of Gender. It has had some success, but has faced difficulty in providing its commitment to a consistent supply of sanitary towels for all girls in public primary schools across Kenya and for girls in special secondary schools. All three countries are also focussing on improving national standards for both reusable and disposable MH products.

WSSCC contributions – WSSCC has taken some steps to increase the accessibility, and affordability of sanitary pads, typically, for rural girls with lower access to disposable or reusable pads. In India, Tanzania and Kenya, the WSSCC has supported the development and manufacture of lower-cost products through Self Help Groups in India as well as through sub-grantees of the UMATA and K-SHIP programmes, particularly locally-made reusable sanitary pad options. In India, this also includes biodegradable reusable pads. In Tanzania and Kenya, this work is still very small scale. It's efforts in supporting the training of Parliamentarians, contributed to the removal of VAT from sanitary products in Tanzania, although this was re-stated the year later. The process of advocacy and debate at the level of the Parliament, around the tax issue, has however, also led to discussions on how to support increased manufacture of low-cost disposable products within Tanzania itself.

GSF-supported programme contributions – The UMATA and K-SHIP programmes have supported the training of a few teachers and women's groups on the making of locally made pads, and in Kenya, a K-SHIP sub-grantee, the Catholic Diocese of Murang'a, in partnership

with a representative of the Ministry of the Interior at sub-county level in Ithanga Division, have worked to develop a household burner for sanitary pads. But otherwise, the programmes have not been involved much in the area of menstrual hygiene products and materials. In India decentralised models for low-cost pads have some limitations, including: quality of pads, production capacity, scale, and quality of pads.

4.2 Findings and discussion – Weaknesses and gaps

Policy and coordination – Only Kenya, so far, has a specific national policy and strategy for MHM and MHH has not yet been integrated into an approved Health Policy in Tanzania, although advocacy efforts are on-going. Some sectors are also lagging behind in relation to their engagement in MHH, in particular actors working in sexual and reproductive health (SRH)/ reproductive and child health (RCH), gender and the environment, although some progress has been made. These actors have been much less engaged, than those working in WASH, environmental health or education.

In Tanzania, there has been some engagement of the SRH sector actors, with participation of the Assistant Director for RCH in a national advocacy event and MHM being integrated into the Accelerated Investment Agenda for Adolescent Health and Well-Being (final draft, 2020). There has also been some engagement of RCH actors at district and health facility levels in MHM through adolescent clubs associated with the health facilities; and a few NGOs have also integrated activities into their RCH work, including related to post-partum bleeding. But engagement of the RCH actors is so far still small-scale with significant opportunities for increased engagement and action. The Ministry of Health, Child Development, Gender, Elderly and Children, currently includes a Gender Development Division, but it is not clear that they have engaged in MHH to-date. Members of the Tanzania Gender Network Programme are active members of the national MHH Coalition. It is not clear that the ministry responsible for the Environment in Tanzania, has been involved in MHH to-date.

In Kenya, UNFPA started to engage during the final stages of approval of the MHM policy development, but had not been engaged much before this and MHM has not yet been integrated into the national SRH and adolescent SRH policies. Some of the County First Ladies have been integrating MHM into their SRH advocacy campaigns, particularly linked to the “Beyond Zero Campaign”, and some smaller NGOs have also worked to integrate SRH and MHM. But actions to date have been limited to a small number of SRH actors and there is a lot more opportunity for expanding this engagement. The Ministry of Public Service, Youth and Gender Affairs, is quite new to working in the area of MHM, but has shown interest in increasing engagement. The State Department of Gender now leads the National Sanitary Towel Programme and will also be the co-chair of the National MHM Task Force when it is established. The Ministry of the Environment attends occasional HP TWG meetings at national level. It is reported that they have been in increased dialogue and learning around the potential use of incinerators in schools, before making a decision to approve their use or otherwise, based on the costs/benefits related to the environment.

In India, further attention is needed to the implementation of costed plans and monitoring strategies to address MHH needs. Stronger post-event follow-up and M&E processes can help contribute to an understanding of the impact of events and to the improvement and development of future work.

Capacity building –

There has clearly been demand for capacity building on MHH, with demands still being made for additional capacity building at all levels. The capacity building has been provided based on the India materials, with discussions promoted within workshop exercises about the local context. However, in the three countries, the training activities are not developed for specific professions/trainee groups. Providing more targeted training for health staff or teachers could be done, based on capacity needs assessments to identify the specific learning needs for their specific job. A capacity development strategy would ensure higher return on the resources invested in the trainings. The diversity of participants trained means there is a particular need for a capacity needs assessment, given that not all roles need the same capabilities. A coherent assessment of capacity pre-training should also be an important focus for future planning.

Training participants: Whilst significant progress has been made in raising MHH up the political agenda, in Tanzania and Kenya, barriers are still being faced because senior decision-makers and technical leads in key ministries and LGAs have not grasped the importance of MHH. In India, WSSCC is mostly dependent on the government selection of the participants. The wide-ranging roles of the participants currently trained, can lead to dispersion of efforts and may slow impact on MHH. Narrowing the selection of the target stakeholders to be trained, may also help focus the training on their specific capacity needs. It is also important to consider the trade-off between the volume of people trained and seniority of attendees. Training senior decision-makers at departmental head level, would help increase awareness on MHH, and improve opportunities for integration into policies, strategies and budgets, but they may be less likely to be available to act as regular trainers, due to their main responsibilities.

Government actors, including sub-national actors, also often lack resources and training opportunities to expand their MHM knowledge, with less attention and resources to-date given to training sub-national actors in Tanzania and Kenya, than for those at national level. In all three countries, there is also a gap in the systematic capacity building of teachers and educators through their standard basic training.

Training materials: Whilst the trainings based on the WSSCC India training materials were highly valued and have clearly increased knowledge and commitment of a wide range of different actors in Tanzania and Kenya, various respondents also highlighted the fact that the materials were in English and developed for India is a weakness and gap. In Tanzania, trainers were encouraged to adapt the WSSCC materials during the initial national training, but limited action has been taken on this to-date. It is also unrealistic to train many people and expect them all to then go away and adapt the materials, rather than adapting the materials before training many people, so that all trainees would then have this as their starting point. In Kenya, the materials were translated into Kiswahili and the images changed to those more appropriate for Kenya, but at the time of the study, the government was waiting until the launch of the policy to release them. The training reports also indicate that discussions on the local contexts, was facilitated as part of the process. But in neither country, were the MHM related training materials already existing in the country, considered and also utilised as part of the trainings. For example, in Tanzania, training materials already existed for teachers, to help them use the existing girls' MHM booklet, and also the *Hedhi Salama Campaign*, had already developed training materials for girls and women with disabilities. But these were not

fully utilised, but rather the training materials developed by the WSSCC in India, were used as the main materials throughout.

Cascading approaches: Cascading trainings can compromise the quality of results, so these trainers need regular follow-up, as well as refresher trainings to keep their knowledge and skills up to date. More resources are also needed for the cascading processes and the training materials and guidance for sub-national and community levels. This will help ensure that each level, or trainee, has materials to refer to and use for facilitation. By the time the training reached people working on the ground, they may be undertaking training from memory and there is a risk of spreading misinformation. Some trainers reportedly created their own MH Wheel, apron, or Flipbook, as well as training games. This is positive in some respects; however, the quality or accuracy of these tools are not known. In all three countries, it was reported that trainers require more resources and job aids to deliver cascaded trainings, such as training guides and facilitation tools, or simple handouts or posters that could be handed over to participants to use in their own trainings. A cost-effective and scalable way to fund, print and distribute these materials to trainers is needed.

In addition, a more structured process should be established for follow-up, monitoring and supportive supervision of the people trained.

Continued opportunities to support governments at all levels with training: WSSCC has rightly focused on training to build capacity and awareness on MHH. Yet one-off training events are considered insufficient to address the long-term capacity requirements of the local government and the community. It is important to organize regular capacity development for trainers to update their knowledge, provide motivation and supportive supervision. There remains a need for additional mentoring, follow-up and refresher training. More supportive supervision would help check fidelity with the training and alignment of activities with core goals and objectives of the government/WSSCC. It would also help ensure quality control and cost-effectiveness of the training. In India, on-going mentoring, follow-up and supportive supervision to trainers and trainees, could be done by using the former WSSCC consultant's trainer pool. A number of trainers suggested the benefit of follow-up refresher workshops for the trainers to share their experiences and good practices, would help with following up progress on the action plans. Trainers could meet from time-to-time – or else hold online meetings - to discuss the problems they face, exchange examples and agree approaches to common dilemmas. This would promote exchange of experience between trainers to ensure good quality standards. Trainers could also participate in each other's trainings (as well as those of the trainers undertaking cascading), to give constructive feedback. The linkages between trainers and the state/district functionaries could be improved to ensure better planning, implementation and monitoring and evaluation. It also requires a broader based workplan for the trainers, that identifies the major activities, intended results, and roles and responsibilities. Effectiveness is further jeopardized due to the lack of government leadership for follow-up and lack of integration into their own monitoring systems. Strengthening state-level arrangements for quality control of the training, as well as accountability for follow-up post workshop, is critical.

In India, some of the reasons reported why participants said they had not put their training into practice included:

- The participants selected to be trained were not necessarily the most proactive (i.e. least likely to put their know-how into practice unless their superiors instruct them to do so).

- Where only one or two people were trained in a team or department (rather than a critical mass), they struggled to persuade their colleagues or superiors, of the importance of integrating MHH into plans and budgets.
- Lack of confidence/opportunity to work with the community, or difficulty in mobilizing people for a training.
- After the training the participants continued to have questions specific to reproductive health; WhatsApp was said to be a less useful forum for asking for advice on specific questions.

Disposal of sanitary pads –

There has also been limited attention on options for the disposal of sanitary pads across the three countries, in all contexts – schools and other public places and at household level. Pads are often still being disposed of in pit latrines, burnt in open pits, or thrown on the ground. India has standards for waste management, including MHM waste disposal, and Phase 2 of the Swachh Bharat Mission is developing these further, but not as much has been done on this area strategically in Kenya and Tanzania. But a few key actors, such as a private sector actor, Varet Products and its associated social enterprise, Global Sanitation Environmental Products in Kenya, have undertaken a range of work in collaboration with County Governments and schools, to try and find a solution for the disposal of sanitary wastes in Kenya. A K-SHIP sub-grantee, the Catholic Diocese of Murang'a, in partnership with a representative of the Ministry of the Interior at sub-county level in Ithanga Division, have also worked to develop a household burner for sanitary pads. In Tanzania, UNICEF also supported a small trial of basic and drum incinerators in schools in 2011. But otherwise, the programmes have not been involved very much in the area of menstrual hygiene products and materials. It is included in the MHM Policy and MHM Strategy in Kenya and also in the MHH Coalition Strategy in Tanzania, so it is expected that work will be undertaken in these areas over the coming years.

Engaging with communities on MHM –

There has been limited attention to engaging with communities on MHM, the focus has been on engaging with schools and on gaining buy-in from national level actors and building capacities at this level. There have been some positive efforts across the three countries to engage at community level, including under the Swachh Bharat Mission/ Swachh Bharat Abhiyan (Clean India Mission) and GSF-supported programmes, UMATA and K-SHIP and independently by people trained in MHM undertaking activities from their own resources, which provide some useful examples to learn from; but the efforts so far have been of relatively small-scale.

People who may be most disadvantaged and leaving no-one behind –

The analysis of the different groups of people who may be most disadvantaged and may be struggling to manage their MHH, has so far been limited (for example, adolescent girls in migrants' groups, trafficked girls, girls out of school) and needs more attention. There are currently no strategies for how to address the needs of people currently left behind in their MHM.

Also, MHM champions with disabilities may have been trained but not always resourced to undertake actions on MHM, by the WSSCC or other actors. They often incur additional costs

to undertake similar work to people without disabilities (e.g. a sign language interpreter, assistant, or transportation funds), which limits the scale of their action. This is a significant missed opportunity to facilitate competent and passionate people to increase the numbers of other people, they can reach with training or advocacy, than would be possible with their own resources alone.

Taking a more gender transformative starting point to MHH (allied to feminist movements and progressive men’s groups) could also help achieve wider change on gender relations in India. Menstrual health activism in India has largely excluded non-cis women⁶⁴, although WSSCC, has involved people in sexual and gender minorities in consultations.

In Kenya, additional resources (time, funding, people) are needed to reach nomadic pastoralist communities for engagement on MHM, due to the much greater distances to reach them (sometimes more than 200 km travel is needed to reach migration route areas).

Gaps in WASH infrastructure in schools and public places –

On the ground, various challenges are still faced in schools, with a proportion still lacking gender-segregated facilities. Toilets may also be of poor quality (i.e. poorly designed or constructed and do not comply with standards), or are not in a fit condition for use, so girls may prefer to return home rather than using them. Toilets and associated infrastructure may lack important features (e.g. rubbish bins, door locks), or may be dirty or without secure doors (such as in Tanzania) and hence not providing security or privacy for girls. There is also still a limited availability of hand-washing facilities with a regular supply of water and soap, in or near the toilets.

The table below shows the percentage of schools (at national level) that have access to basic, limited or no water, sanitation and hygiene services.

Table 3 - Level of water, sanitation and hygiene services in schools

	Water			Sanitation			Hygiene		
	Basic	Limited	None	Basic	Limited	None	Basic	Limited	None
Kenya	-	75%	25%	-	100%	-	-	-	-
India	69%	22%	9%	73%	3%	24%	54%	5%	41%
Tanzania	-	71%	29%	47%	28%	25%	23%	-	-

Source: <https://washdata.org/monitoring/schools/dashboard>, accessed 29th September 2020

In Tanzania, there has been a lot of progress in increasing the numbers of schools now instituting a girls’ hygiene/changing/special rooms, in the toilet block. The recently released 2018 national SWASH Mapping report, led by the PMO-RALG, with the research undertaken by the National Bureau of Statistics and funded by UNICEF, has indicated that 24.7% of schools across Tanzania now have one of these hygiene/changing/special rooms (from none

⁶⁴ ‘Cis-women’ is a term used for women who are born as women with female sex organs. Non cis-women include transgender men, women who are intersex and women who are gender fluid.

10 years ago)⁶⁵. This is a significant achievement to achieve this at scale, over such a relative short period of time. But there is still a range in the quality and content of such rooms and questions exist, as to whether they are being used effectively. The operation and maintenance of school WASH facilities is also often not prioritised. In particular, the quality of the SWASH and MHM programming needs more attention, checks and quality control, to ensure the infrastructure is of a suitable quality and that supporting items girls need to be able to effectively manage their MHM, are available in schools and other public places.

So far, less attention has been placed on support for improving WASH facilities for MHM in health facilities, although examples exist, include funding from SIMAVI in Tanzania, used to improve WASH and MHM support in maternity wards.

Gaps beyond the facility functionality –

There is a need to go further than operation and maintenance for WASH facilities, to increase attention on the systems and supply chains for hygiene, such as the availability of soap, functional hand-washing facilities, body/anal cleansing materials and emergency sanitary materials.

Monitoring –

Not much progress has been made on monitoring of MHH outputs and outcomes, either at national or programme levels. Different ways of monitoring of MHH progress are required, including how to measure girls' self-confidence and self-efficacy in their ability to manage menstruation whilst at school.

Monitoring and evaluation of training: This needs to be improved, to provide evidence of impact of the trainings. In India, the M&E mechanisms in place (a before and after survey), are insufficient to clearly demonstrate and/or measure the contribution to outcomes/impacts of the training. The WhatsApp group established, is unable to track who has been trained and how they have cascaded that training in a meaningful way. Supportive supervision would help check fidelity with the original training and alignment of activities with core goals and objectives of the government/WSSCC.

With mass events for social engagement (as seen in India), or training events without follow up, there is a significant risk that they will fail to create a step change on MHH. Lack of monitoring, means attribution of the outcomes from these events is difficult. Rather than a focus on delivering 'numbers' of attendees, attention to the depth of impact, or ability of attendees to make changes, is also important.

Integrating MHH indicators into State-level MHM strategies, as well as national or sub-national monitoring systems in India would provide an important opportunity for measuring and reporting progress, as well as incentivising action.

⁶⁵ See page 73 of: Government of Tanzania (2020) *Tanzania, 2018, School Water, Sanitation and Hygiene Assessment Report*, February 2020, President's Office – Regional Administration and Local Government and National Bureau of Statistics and UNICEF, <https://www.nbs.go.tz/index.php/en/census-surveys/health-statistics/2018-school-water-sanitation-and-hygiene-assessment-swash/526-2018-school-water-sanitation-and-hygiene-assessment-swash>

4.3 Findings and discussion – Opportunities

Policy, strategy and guidelines - With government commitments to the SDGs, and increased number of senior decision-makers who have a better awareness of the importance of MHM, increasing attention on MHM is feasible. There are opportunities in all countries for increasing achievements at policy level, building on progress so far, engaging champions across sectors and building national convergence of commitment and approaches across sectors. Policy and programmes relating to adolescents' health and well-being, also offer a broader enabling environment to enhance and expand MHM in schools and communities. There are continued opportunities to support governments at all levels with respect to policy development, system strengthening and the development of service delivery. In India, mentoring support to district level officials would help ensure that MHM Action Plans are integrated into state and district ways of working and ensure those responsible own their action plans and follow up on implementation.

Cross-sector collaboration – Kenya, Tanzania and India have set up cross-sector or cross-ministerial collaborations to coordinate and align activities, as well as to clarify roles and responsibilities. This has had a multiplier effect of increasing commitment and coherence and offers significant opportunities for continuing to build, and in particular, to encourage increased action across a wider set of sectors and actors. The engagement of a wide range of actors, such as in the MHH Coalition in Tanzania, which also includes the media, educational institutions, the private sector, trade unions and others, offers very positive opportunities for engagement of non-traditional actors in MHH.

Significant widescale progress, will require better cross-sector collaboration. For example, in India, MHH education is integrated into child protection and ending child marriages. In Kenya, some efforts have already started to integrate MHH into SRH programmes. Enhancing cross-sector and multi-stakeholder collaboration on MHH, requires identifying the actors with a role to play. This analysis has already been undertaken in Kenya and is integrated into the MHM Policy and MHM Strategy, which has been endorsed by the Cabinet. In India, ODF-Sustainability⁶⁶ represents an opportunity to take forward zero waste options for menstrual waste and build capacities of solid waste operatives (including training on safe working practices).

Support to existing coordination forums for multi-sector engagement, is very time-consuming and challenging and is an area where it would clearly be cost effective for the SHF to provide on-going support to government for coordination and building capacity and commitment of senior decision-makers across sectors. This might be through supporting a government request for funds to finance a secretariat to support MHH coordination and follow up and support to multi-sector actors and the existing network of trainers, as well as the provision of technical support.

Building on the existing commitment, the networks of MHM Master or ToT trainers and others trained in MHM – The wide range of people trained in MHM across the countries is a significant resource to build upon. Key activists, based in different kinds of organisations, often have high level of commitment and enthusiasm. Specific efforts will be needed to encourage their on-going engagement and enthusiasm through follow-up, coordination,

⁶⁶ The Government of India launched a 10-year national rural sanitation strategy to sustain India's 100 per cent Open Defecation Free (ODF). The framework, 2019 to 2029, will ensure that people sustain their usage of toilets. It will also focus on proper implementation of solid and liquid waste management (SLWM) — plastic waste, organic waste, grey water, and faecal sludge — in rural areas.

encouragement and support. There is a need to provide support to government to strengthen its coordination and facilitation of multi-sectoral work, which is critical, but time-consuming, as noted above.

Supporting MHM Champions with disabilities and people from marginalised and vulnerable groups – There are already a number of very active and committed champions who themselves have disabilities, such as MHM trainers and MHM Champions who are deaf/hearing impaired, blind/sight impaired, or face challenges with mobility. In addition, there are also MHM trainers and MHM Champions from marginalised groups, such as pastoralist communities, as well as the people from different religious backgrounds. Kenya already has three MHM trainers in MHM in the Kenyan Prison Service. If the SHF can target these champions with additional support (e.g. resources or additional training), and build on this to train others, including high profile people from groups who may be most disadvantaged, this would help reach more people with a similar background and who may themselves be most disadvantaged.

Moving forward on improved solid waste management - The leadership of Varet Products in Kenya, offers a positive opportunity to build on work undertaken to-date on solid waste management, at school and sewerage company levels, and facilitating increased discussion across ministries. A large-scale study on disposal of waste across Kenya, building on the work that they have already started, would provide evidence for advocacy, including through the development of a convincing business case. It is believed that if this is a nationwide study, this would be a first of this kind of study at scale globally, although it is understood to have been done on a smaller scale in some countries. The Diocese of Murang'a and the Ministry of the Interior at sub-county level in Kenya, have also been working on innovation to develop a household level burner for sanitary pads. Support to this team to continue to finalise their design and to produce and market it, is also a unique opportunity, which offers possible innovation for use across countries.

Social media for outreach and engagement on MHM – The use of social media, menstrual apps and mobile phones, has also gained increasing momentum to help tackle myths and stigma related to menstruation. Social media means that those in urban areas – and those in an expanding middle class - are able to seek and generate information, build virtual networks and exchange stories/ experiences in real time chat and video. Younger MHM actors are already using social media to challenge social norms around menstruation, as well as demanding accountability from duty bearers in government. These mechanisms will become increasingly important in the future. However, the priority focus group for SHF – those left behind - are less likely to be online, or have digital access for communication and public advocacy, so other more traditional media, such as puberty books in local languages, will also continue to be needed.

4.4 Findings and discussion – Threats

Lack of political prioritisation and budgets for MHM - Senior decision makers at departmental level and across a range of key ministries, must agree that MHM should be a policy priority, but when there is only one or two senior people committed to MHM, others often lack understanding and commitment, which leads to action being blocked. This in turn limits progress for integrating MHM into policies, strategies and budgets. The regular transfer of government staff between positions, means that awareness-raising and capacity building on MHH, needs to be a regular and on-going process.

The time and resources it takes for effective coordination across multiple ministries and sectors – This may limit progress, if there is no dedicated support for such coordination and to ensure coherence across sectors. Another potential challenge to progress, is ‘territory building’, especially among MHH lead/anchor ministries or departments, who may sometimes limit the information and responsibility they are prepared to give to other ministries – in fear that they will lose leadership and resources in the process.

Turnover of government staff - Where civil servants have been trained and gone on to initiate new interventions, or become an MHH Champion, the sustainability of their activities (and previous advocacy efforts) is undermined by civil servant transfers. This underscores the importance of an approach that builds capacity of organisations, rather than individuals.

Low levels of hygiene promotion and menstruation/puberty education – This is both in terms of teaching resources and school curricula, as well as appropriate education and information materials for girls of different age groups, as well as boys, men and parents. Outside the areas where external programmes have supported dedicated MHM training for teachers, taboos, beliefs and good practices, or hygiene, are generally not covered in menstruation/puberty education in schools, resulting in barriers for effective MHH.

There is also a concern about reaching those with less online and digital access for information.

Gaps in the training for teachers and health workers – The standard training for school teachers and health workers generally, does not represent a holistic approach to MHM, often only including the biology of menstruation. This limits the scale of action that can be possible in changing social norms.

Environmental concerns about disposable pads and limited low-cost solutions – Disposal options for used sanitary materials remains an underdeveloped aspect of most MHM services. Some girls dispose of pads in toilets, which can cause blockages in pour-flush toilets or sewerage systems and incinerators in schools have high maintenance costs. Others still dispose of pads on open ground.

Continuation of the COVID-19 pandemic for an extended period – The restrictions affecting the engagement of actors within and between sectors due to the COVID-19 pandemic, is contributing to a loss in momentum for progressing MHH across the three countries. Examples include the delay to the establishment of the MHM Task Force in Kenya, lockdowns have been affecting the availability of affordable menstrual products and there have been reduced opportunities for continued capacity building and awareness-raising activities.

4.5 Other reflections and discussion related to the work of WSSCC

Support to government and for coordination across sectors - Respect for the efforts of WSSCC on MHM is based on its leadership role in the development of global training materials, supporting a range of training on its 3-pronged approach, and the commitment and contribution of its staff, the National Coordinators and their assistants. The quality of these actors, sometimes in a voluntary role, has greatly raised the profile of the work of the WSSCC, and has enabled them to act at the highest level in India, Tanzania and Kenya and encourages progress and commitment at senior levels of government. This has been one of the most useful areas that the WSSCC has supported on MHM and it is recommended that the SHF approves requests for funding from government for some form of on-going support in-country, by senior, well-respected and experienced MHH actors, as this will be one of the most effective interventions that the SHF could fund. The complexities and time that it takes for coordination across sectors, will pose significant challenges to the success of taking forward improved MHH at scale. The government is likely to struggle to do this on its own without on-going support, due to the multiple responsibilities of the small numbers of senior government leaders working on MHH.

The 3-pronged approach – The 3-pronged approach has been very successful in encouraging a broader awareness of how to improve the MHM situation for women and girls. In Kenya, it is clear that the 3-pronged approach influenced the government to take up the issue of MHM, as prior to its introduction government was reticent to get too involved when the main focus was on sanitary products. One senior sector respondent, noted that the WSSCC ‘triggered’ Kenya on MHM.

With the shift to a broader focus on MHH and recognising the importance of the enabling environment, capacity building, monitoring and learning, it is suggested that the 3-pronged approach be continued. Although the simplicity of this approach is positive, a more explicit focus on the full range of components of the enabling environment would further support action. See [Fig 1](#) in [Section 1](#).

Integrating MHM into the CLTS process – The studies in Tanzania and Kenya, also offered opportunities to consider how MHM can be integrated into the CLTS process. An overview of the different options and suggestions for moving forward has been provided in [Annex I](#).

5. Recommendations

The key recommendations are split into two sets:

- The first set are made to governments and partners – these are the recommendations that we believe are most needed to address the gaps in MHH, while promoting the empowerment of women and girls. The recommendations will require resources from a range of sources. The right-hand column of the table shows recommendations for activities that could be considered for SHF funding. Priority recommendations have been organised into three groups 1 to 3 (with 1 being highest priority).
- An additional set of recommendations have been made for the SHF Secretariat in Geneva. These follow the table.

Recommendations to government and country partners:

	Coordination and policy	SHF priority
1	<p>Establish dedicated in-country support to current government staff, such as through a small resourced secretariat with the recruitment of full-time officer(s), with significant experience in MHH (senior MHH experts). This would be to support the government:</p> <ul style="list-style-type: none"> • In coordinating national coalitions⁶⁷, inter-ministry groups and other cross-sectoral engagement, with the aim to build commitment and increased action across sectors and in existing programmes. • Through providing technical advisory support in-country, to government on the development, implementation and monitoring of costed MHH policies, strategies and plans. • To identify and engage with existing and new national programmes across sectors, to effectively integrate MHH. • In a process of on-going learning and documentation on progress and challenges on MHH. 	1
2	<p>Strengthen the focus on MHH for women and girls who may be most disadvantaged - including through initiatives (such as the establishment of steering committees), led by women with different kinds of disabilities and people from different marginalised groups, with dedicated resources to take forward their priorities.</p>	1
3	<p>Increase opportunities for multi-stakeholder engagement, in particular involving stakeholders with backgrounds in sexual and reproductive health and rights, gender, education and youth empowerment, and</p>	2

⁶⁷ For example, GIZ funds a coordinator for the Menstrual Health Management (MHM) Practitioners' Alliance Nepal. The National Coordinator of WSSCC in Nepal was formerly the Convener of this Alliance.

	community development, as well as in solid waste management and the livelihood/employment sectors. This may be through support by the proposed secretariat, or specific capacity building activities, targeting a broader range of actors across these priority sectors.	
	Capacity building	
4	Undertake MHH capacity assessments of the learning needs of different actors, develop a costed capacity development plan and continue supporting capacity building, in alignment with this assessment and plan.	1
5	Systematise good practices on awareness-raising and teaching MHH in professionals' standard basic education and training, through: the basic training for community development professions, strengthening MHH in the school curriculum, and in the basic training for teachers and health service workers (including for nurses, doctors and community health workers).	1
6	Strengthen the existing MHH trainers' networks and provide more on-going mentoring, follow-up and monitoring and the documentation and sharing of good practices.	1
7	Expand access to training and awareness-raising. Consider the level of focus needed in each country for largest impact. <i>For example -</i> <ul style="list-style-type: none"> • <i>In India - Currently training efforts are dispersed, so it is suggested to take an area-based approach to training, so that whole local administrative areas are covered – this will help make MHH a priority.</i> • <i>In Tanzania and Kenya – More attention is needed to build more capacities at county/district levels and below, across sectors (health, education, women's representatives, disabled person's representatives, the media etc). In addition, more awareness-raising is needed for senior level decision-makers across departments at ministry level, to increase buy-in for prioritisation and action across sectors.</i> 	2
8	With government leadership and the inputs of a range of active sector partners, develop training materials for different stakeholder groups. Make sure these materials build on existing resources in country, including those related to school WASH or health services and including existing girls' MHM/adolescence books and associated resources. <i>For example - This may include practical facilitation guides, simpler materials for community level actors and others for schools, health facilities and prisons, standard operating procedures for local government authorities, and national advocacy materials.</i>	1

9	Establish a system for supplying training materials, to ensure that trainees at all levels, including those receiving cascaded training, have access to adequate numbers of appropriate tools, so that they can continue to effectively cascade the training and raise awareness on MHM.	2
Advocacy and influencing		
10	Expand reach and scale, by establishing a programme to continue to engage with and train senior decision-makers, to increase buy-in and engagement at senior levels. A system should also be established for replicating this awareness-raising over time, to respond to the turnover of senior decision-makers in government positions and roles. This system needs to be integrated into the government systems and ideally the system for replication over time, funded by its own resources for sustainability. <i>For example - This may include the Members of Parliament in Tanzania, the County First Ladies and the Council of Governors in Kenya, and more senior level actors, including decision-makers at ministry level across sectors and senior decision-makers in key institutions, such as in the prison service.</i>	1
11	Increase direct awareness-raising and engagement of the media and encourage them on their coverage of MHH related stories. <i>For example – As per the efforts already started in Tanzania</i>	
12	Expand the use of national role models and allies, harness societal engagement and establish partnerships with key organizations and influential individuals, including media celebrities and create awareness within the private sector of MHH and the contributions they can make (including in the work place).	
13	Enhance partnerships with youth and religious groups in order to change harmful social norms, behaviours, and social attitudes, and activate synergies between these partners.	
M&E, innovation, research and learning		
14	Develop an M&E plan, that integrates MHH indicators into government monitoring systems.	1
15	Establish a more structured process for learning and sharing of experiences between MHH actors, with regular engagement and updates and the documentation and sharing of the learning.	1

16	Support more training for school and healthcare facility quality assurance officers and support improvement in their quality assessment tools to also incorporate checks for required elements related to MHH.	2
	Prioritise reaching people who are most disadvantaged	
17	Undertake analysis of which groups of people are most disadvantaged and may be struggling with managing their MHH, who may not have been supported yet.	1
18	(Continue to) develop the training materials and resources for people with different communication needs. <i>For example – Particular materials for people with different kinds of impairments, including people who are blind, sight-impaired, deaf and hearing-impaired and people with mental health conditions.</i>	1
19	Build the awareness and capacity of senior decision-makers and actors who themselves have disabilities or come from marginalised groups, to encourage them to become champions in their work and within the communities they represent. <i>For example – Build the awareness and capacities of MPs or Senate representatives who have disabilities, or disabled person’s organisation representatives at county/district government levels.</i>	1
20	Open up more opportunities to systematically provide opportunities for people from marginalized groups to participate and become champions. The target groups for these efforts may vary across countries. <i>For example -</i> <ul style="list-style-type: none"> • <i>Expand targeted efforts to reach schools for children with different kinds of disabilities, country-wide across Kenya and Tanzania.</i> • <i>Prepare targeted and supportive information for people who are in sexual and gender minorities.</i> • <i>Expand efforts in prisons across Kenya and look into starting work in the prison services in Tanzania and India.</i> • <i>Build on work already started with pastoralists in Kenya to reach more nomadic communities, and other marginalised groups in India; document and share experiences internationally.</i> 	1
	Sanitary pads and solid waste management	
21	Undertake research on solid waste disposal for sanitary products and support research on practical learning on options for solid waste management at institutional, public and household levels. <i>For example – Starting in Kenya and India, support existing efforts by the private sector and other actors – both to establish the need for: disposal</i>	1

	<i>at scale, the business case and technical solutions at household and institution levels.</i>	
22	Collate or design and share options for basic designs for locally made pads, with step-by-step instructions, to help ensure they are made to a minimum quality standard.	2
23	Work with the private sector and community groups to strengthen the supply chain for sustainable, affordable and appropriate menstrual products and services, particularly focussing on options for the poorest members of the community.	3
MHH in institutions and at community levels		
24	<p>Influence increased effectiveness, use and quality of government (and partner) programmes and WASH infrastructure (existing and new) in schools, health facilities and in public places through ensuring they integrate good practice for MHH at scale.</p> <p><i>For example - This may be through:</i></p> <ul style="list-style-type: none"> • <i>The development of cross-sectoral minimum standards for effective MHH in government (and partner) programmes.</i> • <i>Establishing a routine review of all new programme proposals to check that MHH has been effectively integrated, in alignment with best practice – with particular attention given to large-scale programmes.</i> • <i>The development of guidance for WASH in schools that integrates MHH, including for infrastructure; or ensuring that existing guidance is disseminated and used. In Tanzania this should also include working further on minimum standards and operational guidelines for the girls' hygiene/changing/special rooms in schools.</i> 	
25	Undertake more capacity-building of community level workers, so that they can roll out MHH awareness-raising activities in their usual work and reach more vulnerable households at community-level.	3

Recommendations specifically for the SHF Secretariat:

Key priority areas for SHF resources for greatest impact at scale:

In summary, these are the key priority areas recommended for SHF funding, which would represent a unique contribution from the SHF and offer opportunities to influence the greatest action at scale, include:

1. Support to the government for coordination, encouraging broader multi-sectoral engagement, technical advice and on learning – *this is the highest priority and is likely to influence the greatest leverage across sectors, actors and programme and most progress at scale.*
2. Supporting people who are most disadvantaged, including to co-ordinate and lead their own action, and also to reach people who may be disadvantaged at scale – *this is the second highest priority, building on the existing expertise and leadership of the WSSCC and supporting its focus on LNOB going forward.*
3. Build on existing capacity building efforts, through supporting the trainers’ network, with strengthened follow-up, engagement and opportunities for learning, and through the development of more targeted capacity building materials for different user groups – *building on the WSSCC’s existing expertise and leadership for a significant roll-on effect to action at scale.*
4. To strengthen the knowledge of senior decision-makers across sectors over time - *to increase buy-in as part of standard government decision-making systems and respond to current blockages at ministry level, noted in both Tanzania and Kenya.*
5. Support learning, evidence and practice to improve the disposal of sanitary products at institutional and household levels – *a key gap globally, with learning likely to have multiple implications across countries.*

Additional recommendations to the SHF Secretariat		
1	In order to expand the understanding and engagement on MHH across sectors and programmes, establishing the SHF presents an opportunity for all staff who work on SHF funded programmes to undertake a basic level of EQND and MHH training, as a core part of the agreement. This is could break the silo mentality, where only specific people are assumed to be responsible for understanding and integrating these considerations into their work.	
2	Continue to build evidence and data, including qualitative evidence, on the effectiveness of different interventions as well as to also establish the effectiveness of the SHF support. Provide support for the documentation and dissemination of the same.	

Annex I - Options for integrating MHH into the CLTS process

Table 4 - Options for integrating MHH into the CLTS process

	Suggested activities
Pre-triggering	<ul style="list-style-type: none"> • Breaking the silence with the community leaders, such as health workers, traditional birth attendants etc. • Undertake baseline information gathering on the MHH context, taboos, practices, use of sanitary materials, etc. • Undertake advocacy with decision-makers at local government levels, to encourage budgets for MHH and influencing on WASH infrastructure in schools.
Triggering	<p>There were different opinions of how much to engage in MHM during the triggering ceremony itself or otherwise:</p> <ul style="list-style-type: none"> • Recommendations made <u>not</u> to specifically discuss MHM were made because: a) there is not enough time; b) it would take away from focus on attaining ODF status; c) because it is a sensitive subject, so it is better to first discuss with women and men separately, and then to bring them together after the silence has been broken. • Recommendations <u>to</u> integrate it into the triggering ceremony, were because: a) unless MHH is considered, then ODF cannot be reached, if some women and girls are not allowed to use toilets when menstruating, and because of disposal of soiled sanitary pads on open ground; b) households need to also consider MHM when designing household toilets; c) it is an opportunity to identify MHM champions. <p>Methods used in Kenya include:</p> <ul style="list-style-type: none"> • Littering the open defecation field with sanitary pads covered in red dye, along with children's diapers and asking questions about their disposal. • Ask men to visualise their wives and daughters having to manage their menstruation in the bush, to calculate pad numbers and to ask them to consider the design of toilets for the management of MHM. • Follow up the community triggering with an exercise for a smaller number of men and women, to discuss MHM and consider the causes the challenges women and girls face in managing their MHM. This can be undertaken at the end of the triggering session, or on the next day.
Follow-up	<ul style="list-style-type: none"> • Most MHM activities would be undertaken at this phase when ODF triggering has been completed. • Facilitate discussions in follow-up meetings, including re-cap meetings, to consider the challenges girls and women face and to propose possible solutions. • Train community leaders, women's groups, community health volunteers, youth groups and other influential actors. • Encourage small do-able actions as part of the Follow-up Mandona approach and the identification of model households. • Advocate for male involvement. • Learn more about how women and girls manage their menstruation.

Annex II - Key trainings on MHH

This Annex lists the key training supported on MHM, including the key organisations providing support.

II.1 Key MHH trainings in Tanzania

The following provides an overview and dates for key MHM trainings, including MHM Training of Trainer events, that have been undertaken in Tanzania⁶⁸.

Trainings associated with the National SWASH Guidelines and Toolkits and the girls' MHM book, Growth and Changes:

- **2010** - Some elements of MHM were incorporated in the National School WASH Guideline and Toolkits for piloting and incorporated into the Training for Master Trainers for the same SWASH Guidelines and Toolkits (UNICEF supported)
- **2010** - Training on teaching MHM was also undertaken for teachers from all 520 schools in four Districts, on how to support schoolgirls in MHM and using the 'Growth and Changes' girls' book. The Districts were Kasulu, Kibondo, Ngara and Shinyanga. 36,000 girls' books were distributed to girls in Standards V, VI and VII in the schools (UNICEF supported)

MHM ToTs:

- **2016** – 3 participants from Tanzania joined an MHM ToT in Kenya for senior MHM trainers (WSSCC supported – 3 participants)
- **2017 June** – First WSSCC MHM ToT training run in Tanzania, 7-day, held in Dodoma. This was for 80 trainees and included 8 Parliamentarians, the media, government representatives, academia, the private sector and a range of other actors (WSSCC and UNICEF supported – 73 participants – 53f/20m)

Training of Parliamentarians:

- **2017** – 2 Parliamentarians from Tanzania attended the County First Ladies MHM Training in Kenya (WSSCC supported – 2 participants)
- **2018 Feb** – 2-day training for 43 Parliamentarians and 16 Parliamentary staff in Dodoma, most of whom then became MHM Champions (WSSCC supported – 59 participants, 19m/40f)

Training of trainees with disabilities and supporting people with disabilities:

- **Feb and June 2018** – 3-day ToT organised by Ms Rehema Darueshi, Kasole Secrets and Rotaract club in Toa Ngoma Primary School in Kigamboni, Dar-es-Salaam, including 4 visually impaired teachers, 2 Special Education Teachers and 5 youth with disabilities (Kasole Secrets supported - 7 participants; Rotary Club – supported - 7 participants) - <https://www.youtube.com/watch?v=Aw8nre-1Kl>; and <https://www.youtube.com/watch?v=6NQ1K5tJ18k>

⁶⁸ A range of this information came from: Mbagi, D (2020) *MHM Activities in Tanzania 2016-20*; Stephen, R (2019) *Usafi wa Mazingira Tanzania, Umata program MHM journey*; and WSSCC (2019) *Notes from MHM Write Shop workshop – Country MHM journeys; Umata Programme – experience on MHM on CLTS; Umata MHM journey through the years*

- **2019 May** – A 2-day training in MHM for Teachers, Matrons and LGA and other participants at Buigiri School for the Blind, Primary School with a 1-day training for pupils (82 pupils - 49m/33f). Some of the trainers and teachers were also blind or sight impaired (UNICEF and WSSCC supported – 54 participants – 24m/30f).
- **2019 Nov** – *Hedhi Salama* ToT organised by Kasole Secrets in collaboration with the Tanzania League of the Blind, 10 trainees who were sight impaired and 20 people with disabilities. The training included nurses, doctors, peer educators and social workers with disabilities, with the idea that they will then integrate the knowledge into their own work (Kasole Secrets supported) - <https://www.youtube.com/watch?v=avps3AADM7M&feature=youtu.be>
- **2019 Nov** – Kasole Secrets in collaboration with Mafia District conducted MHM training to 40 teachers in Mafia Island (Kasole Secrets and Mafia District supported) - <https://youtu.be/KvoYhCZIHZk>
- **2020 Feb** - SHIVYAWATA Leaders MHM Training in Dar-es-Salaam, organized by Institution for Inclusive Development (I4ID). The training included the SHIVYAWATA leaders in Dar-es-Salaam, from both women’s and youth wings (31 participants, 29 f/2m) - (SHIVYAWATA is the network of organizations for people with disability in Tanzania)

Training of faith-based organisations:

- **2018 Nov** - FIDA-Tanzania - Conducted a MHM ToT to 20 faith-based social workers and pastors from East Africa, which took place in Arusha - Tanzania (FIDA and *Hedhi Salama* supported) – participants came from Uganda, Kenya, South Sudan, DRC, Uganda and Tanzania) - https://youtu.be/O6_XrldfpYo

Trainings for the media:

- **2019 May** – MHM Training in Dar es Salaam for 31 representatives from the media from Government and the private sector (I4ID and BBC Media Action supported – 31 participants, 16m/15f)
- **2019 Oct** – 1-day EJAT Journalist MHM Training, Dar es Salaam – for media editors for newspapers, TV and local radio presenters from different regions (I4ID, BBC Media Action, UNICEF and WSSCC supported)

Trainings for School Quality Assurance Officers:

- **2019 Nov** – 1-day training for School Quality Assurance Officers in Dar es Salaam Zone (Chief School Quality Assurance Office – Dar es Salaam Zone supported – 28 participants – 19f/9m)
- **2020 Jan** – 1-day training for School Quality Assurance Officers in Ilala and Ubungo Municipal Councils, Dar es Salaam Zone (Chief School Quality Assurance Office – Dar es Salaam Zone supported – 24 participants – 19f/5m)

Training of District and school level participants:

- **2017** – UMATA supported the training of 99 officials from Bahi District Council – teachers, supporting staff, reproductive and child health (RCH) officials from health facilities to form a pool of trainers (UMATA/GSF/WSSCC supported)

- **2019** – UMATA supported an MHM advanced training to 12 staff from UMATA partner organisations (UMATA/GSF/WSSCC supported)
- **2019 April** – MHM ToT training for Maji Safi Group, NGOs, district council staff, private sector and faith-based organisations in Rorya District, Mara Region (Maji Safi Group supported - 66 participants - 45f/21m)
- **2019 June** – MHM ToT held in Geita for Plan International staff, community development facilitators and volunteers, secondary and primary school teachers, nurses and a Police Gender Desk Officer (Plan International/UMATA/GSF/WSSCC – 26 participants – 14f/12m)

Task force meeting for MoEST/PO-RALG:

- **2019 Dec** – 10-day Task Force group meeting for MoEST, PO-RALG, on the preparation of the MoEST MHM training guidelines, with laboratory toolkit for schools and teacher's colleges (MoEST and WSSCC - 14 participants - 10f/4m)

II.2 Key MHH trainings in Kenya

In general:

- The MHM ToTs are 5-6 days
- The county operational facilitators have a training of 2-3 days – focussing on how to implement MHM interventions in different settings, such as in the community, in schools and places of worship
- The CFL training was focussed more on the policy level, where the CFLs are trained on the areas to focus on, when undertaking policy dialogue to influence policy change at county level.

Table 5 - Overview of key MHM trainings since 2015

Date	Training	Days	Location	Participants		Supporting organisations
2015 Dec	MHM ToT in India	5	Kerala, India	8	MoH representative, a County First Lady, KWAHO, WASH United, WASH Alliance Kenya, AMREF/K-SHIP and the WSSCC National Coordinator Kenya.	WSSCC and AMREF
2016 July/ Aug	First National MHM ToT training	6	Naivasha	77	2-3 participants from 16 counties in Kenya – Ministry of Health, Ministry of Education, K-SHIP, UNICEF, and NGOs. Included participants who were hearing and sight impaired and some who have motor-related disabilities. Also included participants from Tanzania, South Africa and Niger.	Ministry of Health, UNICEF, AMREF & WSSCC
2016 Dec	Training on MHM	2	Wote Makueni County	43 (29 female)	Community Health Volunteers, Social Development	Makueni County

				/ 14 male)	Officers, Counselling Psychologist and Unit Head, Youth Development Officer, Children's Officer, Health Promotion Officer, Nursing Officer, Student Nurse, Principal Gender Officer.	Government (funding) WSSCC (trainers and training resources)
		2	Emaili Makueni County	36 (22 female / 14 male)		
2017 Jan/ Feb	Training on MHM	3	Kwale	47	From the County Government (Health, Education and Administration) plus NGO and CBO partners, including Kwale School for the Deaf and Radio Kaya.	Department of Health, Kwale County Government (funding) WSSCC (trainers and training resources)
2017 Feb/ Mar	County First Ladies (CFL) MHM ToT training	3	Kwale County	26	Governor of Kwale County, Director of Public Health, County First Ladies (12) and CFL Assistants and office staff. Also included Members of Parliament, Tanzania (2).	Ministry of Health, CFLA and WSSCC
2017 Oct	Second National MHM ToT	5	Naivasha, Nakuru County	84	National and county levels – 24 counties - Ministry of Health, Ministry of Education, Ministry of Public Service, Youth and Gender Affairs, Ministry of Water, Ministry of Interior, and a delegation from Malawi.	Ministry of Health, WSSCC and UNICEF

2017 Dec	Third National MHM ToT	5	Machakos, Machakos County	51	Training representatives from 18 Counties – from government from national and county levels (Ministry of Health and Education), NGOs and two people with motor disabilities.	Ministry of Health (led the training and trainer) WSSCC and WASH Alliance Kenya as the grants manager for the WSSCC (trainers and logistics)
2018 June	Training on MHM	5	Kiambu County	24 (10 male / 15 female)	Most participants were from the Health sector and a few from the Education sector.	Not noted
2018 Aug	MHM Sensitisation Meeting	2	Nairobi Safari Club	17	Training for partners including CSOs, private sector organisations, line ministry representatives and other MHM activists.	Division of Environmental Health, Ministry of Health (Coordination and planning), UNICEF (funding), WSSCC (trainers)

II.3 Key MHH trainings in India (2018-2019)

The following provides an overview and dates for key MHH trainings, including MHH Training of Trainer events, that have been undertaken in India.

Table 6 - Overview of key MHH trainings since 2018

	District	Date	Participants	Number of participants
Training of trainers				
1	Simdega, Jharkhand	September 25-29, 2018	ANM, Multi-purpose workers (MPW), ICDS, Pratham Education (NGO)	62
2	Simdega Refresher, Jharkhand	February 4-5, 2019	Field visits to Anganwadi Centres	60
3	Deoghar, Jharkhand	October 22-26, 2018	Officials from the Department of Health, PHED, Rural Development, ICDS and NGOs	84
4	Bokaro, Jharkhand	December 2-7, 2018	Officials and frontline workers from Health, Education, Social Work Depts, NGOs, SBM (G), Panchayati Raj, JSLPS	48
5	Siwan, Bihar	December 17-21, 2018	Officials and frontline workers from Women and Child Dept, Education Dept, Health Dept, Swachh Bharat Mission and Jeevika	56
6	Muzaffarnagar, Uttar Pradesh	January 7-11, 2018	Officials and frontline workers from Women and Child Dept, Education Dept, Health Dept, Swachh Bharat Mission	80
7	Latehar, Jharkhand	March 11-15, 2018	Swachhagrahis and Jal Sahiyas	53
8	Muzaffarpur, Bihar	Feb 11-15, 2019	Government officials – from 2 departments including ICDS and education	48

Other trainings				
9	Amritsar, Punjab (one day sensitization workshop)	18 August 2018	Teachers, Anganwadi and ASHA workers	49
	Total training			500

Annex III - References

For the full set of references referred to in each county study, refer to the separate country reports.

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