

#PERIODPOVERTY



A BLOODY PROBLEM

PERIOD POVERTY,
WHY WE NEED TO END IT
AND HOW TO DO IT



MARTA FREJ



**A MESSAGE FROM DOMINIKA KULCZYK,
FOUNDER AND PRESIDENT OF KULCZYK FOUNDATION:**

Access to complete menstrual health and hygiene is a basic human right. Without it, women and girls cannot pursue full lives with dignity and confidence. It is outrageous that girls in all parts of the world miss out on better education and opportunities because they were too poor to have a period.

We have neglected this issue for too long, and I'm proud to have worked with Founders Pledge to take the first step towards understanding how we can make the biggest impact, quickly. What's clear is the need to unite the international community on global standards for reducing period poverty, and better fund those programmes that deliver the highest impact for women and girls who every month have to choose between a meal or a sanitary pad.

I invite the international community to join me and work together to end period poverty.

About Kulczyk Foundation

A private family foundation, The Kulczyk Foundation was founded in 2013 by Grażyna Kulczyk, Dr Jan Kulczyk and Dominika Kulczyk. Its primary goal is to fight the problems of discrimination and inequality that affect women in order to create a barrier-free world. The Foundation, in cooperation with partners, implements social changes based on sustainable solutions, which it calls the “Domino Effect”.

About Founders Pledge

Founders Pledge is a community of entrepreneurs committed to finding and funding solutions to global challenges. On joining the community, members commit a chosen portion of their current or future personal wealth to charity. Founders Pledge then helps them understand and elevate their social impact, offering bespoke philanthropic strategies based on the latest evidence from the sector.

Founders Pledge offers a streamlined path to impact for successful entrepreneurs, providing end-to-end giving infrastructure, charity research, and a worldwide network of experts.

Since launching in 2015, the Founders Pledge community has collectively pledged over \$3 billion for social causes, with more than \$465m of that moved to the charitable sector. Spanning 35 countries, its 1450 members include the people behind industry-leading companies such as Deepmind, Skype, Spotify, Uber, and Planet.

About this report

This is the first-ever report on effective funding recommendations to address period poverty.

The report was prepared in 2020 and presents a review of the current state of funding and solutions to ending period poverty. It showcases eight most cost-effective organisations that implement a range of interventions with built-in monitoring and evaluation activities. The report underlines the necessity to focus on high-impact programmes that are scaleable and fill the gap of lacking evidence by rigorously collecting data.

We welcome feedback on any aspect of our report.

Please contact us at endperiodpoverty@kulczykfoundation.org.pl.



TWO WHEELER
PARKING

1. EXECUTIVE SUMMARY

Menstrual Health and Hygiene (MHH) Worldwide

WHY MENSTRUAL HEALTH?

Menstrual health and hygiene has been an invisible issue for years, despite the fact that an estimated 1.9 billion people currently menstruate. Access to complete menstrual health and hygiene is a human rights issue. Without it, women, girls, and other people who menstruate cannot pursue full lives with dignity and confidence. In times of health crises – like the coronavirus pandemic – already neglected health issues are likely to become even more marginalised, as funding for under-the-radar problems gets diverted to rapid response.

The current pandemic is likely to worsen low-income women and girls' economic precarity and will likely stretch already taxed health systems to cut programmes and funding for issues perceived as less urgent. The result is that the number of women and girls who lack access to complete menstrual health and hygiene is likely to increase further.

WHAT IS MENSTRUAL HEALTH AND HYGIENE (MHH), AND WHAT ARE THE ISSUES IT ENCOMPASSES

In this report, we define complete menstrual health and hygiene as having four main components:

- Access to preferred and sufficient menstrual management materials, such as tampons or sanitary pads
- A safe and hygienic location for changing and disposing of sanitary materials as well as washing facilities
- Knowledge and understanding of menstruation as a biological process and how to manage it
- A supportive environment where menstruation is not stigmatised

As the above definition highlights, complete MHH encompasses many factors. To achieve optimal MHH, we must consider societal, environmental, interpersonal, personal, and biological factors and the interplay between them.

WHO IS ADDRESSING MHH GLOBALLY?

- The main sources of funding for MHH programming are in-country government spending, bilateral aid, UN agencies, corporate social responsibility programmes and private philanthropists. Government funding covers programmes in high-income countries (HICs), but most other donor-funded programming takes place in lower- and middle-income countries (LMICs). MHH is also addressed indirectly by Water, Sanitation and Hygiene (WASH), education, or sexual and reproductive health (SRH programming).
- Due to funding for MHH not being tracked rigorously and often being incorporated into other types of programmes, good estimates of how much is spent on specific MHH programming do not exist. We roughly estimate that this figure ranges from USD\$10 million to USD\$100 million per year (including government spending in high-income countries).

HOW DO LEVELS OF MHH VARY AROUND THE WORLD, AND WHICH REGIONS SHOULD PHILANTHROPISTS FOCUS ON?

- Of the 1.9 billion women and girls that currently menstruate, rough estimates suggest that around 500 million lack complete MHH – with this estimate drawing from numbers who lack access to adequate sanitation. The majority of these people are in low- and middle-income countries.
- When considering the number of people impacted by lack of knowledge and menstrual stigma, in addition to those who are affected by issues like lack of access to adequate hygiene facilities and menstrual products, this number could be significantly higher, though estimates for the total do not currently exist.
- There is ongoing work to develop standardised definitions for MHH measures and to build up the research base. However, there is a lack of high-quality research detailing comparable estimates of access to MHH worldwide. We have included the epidemiological information that is currently available in this report, but experts caution that these figures do not represent the complete picture of how many people and what features of complete MHH are lacking worldwide.

WHAT DO WE KNOW ABOUT THE HARMS CAUSED BY INADEQUATE MHH?

- The main harms that have been posited include:
 - Health effects: particularly urogenital infections and untreated pain
 - Psychosocial effects: stigma and feelings of shame
 - Education effects: absenteeism and forced dropping out
 - Economic effects: reduced ability to participate in the workplace
- However, the research base to substantiate and quantify these harms is not yet sufficient to firmly establish causality and severity.

THE MAIN FINDINGS FROM OUR INVESTIGATION OF THE FIELD THAT INFORMED OUR SEARCH FOR ORGANISATIONS ARE:

- There is a significant lack of existing evidence in the field, on areas including the effectiveness of different activities, the scale and burden of the problem globally, and the harms caused by a lack of MHH. Because of this we have prioritised organisations that will generate evidence in these areas through their work.
- The factors contributing to incomplete MHH are complex and vary significantly across different settings and individuals. Because of this we have focused on recommending a set of organisations that implement a range of different activities, and we have prioritised organisations that carry out activities to address multiple components of MHH and are to some extent holistic.
- The field of MHH is young, so field-building to grow and improve the field of MHH broadly is valuable. Because of this we have prioritised organisations that will be able to develop and scale sustainable programmes, such as through collaboration with governments and efforts to develop local markets.
- People who menstruate are most likely to experience multiple types of deprivations in menstrual health in low- and middle-income countries, particularly around a lack of adequate menstrual products and WASH facilities, although stigma and a lack of information also exists in high-income countries. Because of this we prioritised organisations working in low- and middle-income countries, although we didn't entirely rule out organisations working in high-income countries.



*Access to complete
menstrual health and
hygiene is a human
rights issue.*

Interventions to Improve Menstrual Health and Hygiene Worldwide

Interventions to tackle a lack of MHH include both direct interventions - such as product development and distribution, educational interventions, WASH interventions and healthcare interventions - and indirect interventions - such as movement building, raising awareness and fighting stigma, advocacy and policy, and research.

- MHH is a growing field and the evidence base is still developing. Experts agree that there is an urgent need to generate actionable data about whether, why, and how different interventions work to alleviate incomplete MHH and establish measures of impact and cost-effectiveness. There is currently not sufficient evidence available on which activities most effectively improve MHH to select organisations primarily based on the intervention they carry out.

Recommended Organisations

The scope of this section of the report was to identify organisations with a combined funding gap of USD\$10 million.

The eight organisations recommended in this report are:

- Days for Girls
- Inua Dada Foundation
- Irise International
- NFCC
- PSI
- Sesame Workshop
- Simavi
- WoMena

Days for Girls

Who are they and what do they do?

Days for Girls, founded in 2008, is an organisation headquartered in the US with offices in Uganda, Nepal, Ghana, and Guatemala that is focused exclusively on increasing access to complete MHH, chiefly through education and product distribution. Days for Girls distributes kits containing its patented reusable menstrual pad as well as supporting products such as undergarments, transport bags, and soap.

Days for Girls is active in product manufacture and distribution – both through free distribution and sales from local enterprises. They provide education to accompany distribution and work to dispel menstrual stigma among boys and men as well as in the wider community.

Why are they recommended?

- Extensive reach, including in countries with limited investment in MHH
- Product distribution meets immediate material needs for women and girls to better manage their menstruation with confidence and dignity
- Testing ways to create locally owned and sustainable supply chains and generate demand for menstrual products, which has the potential to improve the overall market and make it easier to access menstrual products
- Involving men and boys in education and anti-stigma efforts to improve enabling environment for people who menstruate

How much funding do they need, and how will they use it?

Days for Girls could productively use USD\$205,000 in the next year to support the following areas of work:

- USD\$55,000 to establish and strengthen global supply chains and build capacity for local sourcing in East and South Africa, with plans to then expand to Latin America and West Africa.
- USD\$60,000 to support a monitoring, learning and evaluation (MLE) director to guide an evaluation of the health education component of Days for Girls' work.
- USD\$90,000 (and potentially more at \$USD18,000 per liaison) to fund enterprise liaisons who will be based in countries of operation and provide training, quality control, and support to ensure the success of enterprises in-country. Initial plans to establish liaisons in South Africa, Malawi, India, Cambodia, and Zimbabwe.

Inua Dada Foundation

Who are they and what do they do?

Inua Dada Foundation is a Kenya-based organisation founded in 2014 working exclusively on menstrual hygiene issues via product distribution, advocacy work, and building awareness for girls and women in Kenya.

Currently, Inua Dada is working with other grassroots partners to deliver kits including menstrual hygiene products and other basic supplies to women and girls impacted by the Covid-19 lockdown in Kenya.

Why are they recommended?

- Local leadership, which is networked with grassroots organisations working to represent and meet the needs of women and girls in Kenya
- Addressing urgent and immediate need of women and girls for menstrual products and other material goods in response to Covid-19 crisis

How much funding do they need, and how will they use it?

Inua Dada Foundation could productively use at least \$10,000 per month in funds for immediate use to support the following areas of work:

- USD\$8,000 per month to cover distribution of care packages with menstrual hygiene supplies to 1,500 people in need of support due to Covid-19.
- USD\$2,000 per month of overhead support to continue to advocate and raise awareness of menstrual challenges during Covid-19.

Irise International

Who are they and what do they do?

Irise is a UK- and Uganda-based organisation founded in 2011 focused exclusively on MHH. Irise uses multiple approaches to increase access to complete MHH, including:

- Designing and implementing direct interventions
- Advancing the MHH knowledge base through research and dissemination
- Developing and advocating for policy changes to improve menstrual health

Currently, Irise is testing a menstruation-friendly schools programme in Uganda that combines product distribution, WASH improvements, education, and partner and community engagement to decrease absenteeism and improve menstrual health among in-school girls. The pilot for this programme has so far reached 6,000 children in 10 schools. They are also working to solve last-mile delivery challenges for menstrual products in Uganda. In addition, they are looking to develop and pilot new interventions in the UK to help end menstrual stigma.

Why are they recommended?

- High commitment to evidence to inform their programme design and public dissemination of evaluation research to improve the evidence base of MHH intervention effectiveness, including plans to carry out a randomised controlled trial
- Work with multiple groups (individuals, communities, government) to best design and position programmes to be eventually implemented at scale for greatest impact
- Thoughtful programme design that aims to address multiple factors for incomplete MHH
- Working to fill measurement gaps and intervention evidence gaps highlighted in this report.
- Unique model of drawing together information and learnings from both low-income and high-income settings to understand commonalities and reframe these learnings.

How much funding do they need, and how will they use it?

Irise estimates they could productively use GBP£1,950,000 over the next three years. They anticipate funding the following programmes:

- GBP£350,000 per year for three years to scale the menstruation-friendly schools intervention and conduct a randomised control trial (RCT) evaluating the programme in East Africa.
- GBP£300,000 to cover two to three years of work to address last mile distribution challenges for social entrepreneurs selling alternative, reusable menstrual products in Uganda.
- GBP£200,000 per year for three years to (1) design and pilot youth-led interventions to promote MHH in the UK and (2) integrate learning from these programmes into mainstream policy and service delivery.

NFCC

Who are they and what do they do?

NFCC is a Nepal-based organisation founded in 1988 that works on a spectrum of sexual and reproductive health (SRH) issues. NFCC's mission is to work with the government to ensure that good policies are enacted and implemented to advance the government's agenda on SRH.¹

NFCC began working on MHH in 2008 and has worked on the area in partnership with the government, health sector, UN agencies, bilateral funders, NGOs, and civil society organisations. NFCC works through a variety of different mechanisms including research, policy and advocacy, health service provision, training, and behavior change communication and awareness raising.² NFCC is committed to conducting research related to menstrual health both nationally and contributing their experience to international working groups designed to improve monitoring, evaluation, research, and learning for MHH more broadly.³ They have worked on a variety of studies related to menstrual health, ranging from testing uptake of new products to assessing the forms and intensity of menstrual stigma in different regions.

They have been instrumental in establishing a place for MHH on the national agenda and continue to work to ensure access to complete MHH country-wide.

Why are they recommended?

- Operating in a unique space in Nepal as the only national NGO (as of 2017) intervening to improve MHH via advocacy, policy shaping, and capacity building at the government level
- Commitment to understanding the sociocultural factors underlying menstrual stigma and conceptualising ways to effectively intervene
- Working in partnership with the government to institutionalise and scale up policies like menstrual health education and integrate MHH into other areas of work

How much funding do they need, and how will they use it?

NFCC estimates they could productively use USD\$1,937,125 in the next year to begin national roll-out of the Menstrual Health Management (MHM) package and supporting work to integrate it into local government budget and planning processes. They estimate that this programme will take three years to roll out completely and at scale would reach seven provinces, 20,354 schools, and 3,421,508 students.

Population Services International (PSI)

Who are they and what do they do?

Population Services International (PSI) is an international non-profit founded in 1970 working on global health issues throughout Africa, Asia, and Latin America. PSI is headquartered in the United States, Europe, and Kenya and has additional country and regional offices in more than forty locations.⁴ PSI is known for its work in marketing, distributing, and creating demand for health information, products, and services to promote broad uptake of needed tools and approaches. Originally focusing on contraception, PSI now works in the areas of SRH, WASH, malaria, HIV & tuberculosis, non-communicable diseases, and safe abortion, with focuses on digital health approaches and reaching adolescents and youth.⁵

Much of PSI's recent work to improve access to complete MHH is embedded in sexual and reproductive health and rights (SRHR) work designed to reach adolescents and young women. One of their ongoing commitments in this area is to "revolutionise the way young people access contraception." A variety of different approaches and levers are being tested by programmes run in different country offices, which PSI broadly groups under the categories of

1 NFCC, [Mission and Objectives](#), no date.

2 NFCC, [Menstrual Health, Hygiene and Rights](#), no date.

3 NFCC, [Advocacy](#), no date.

4 PSI, [Where We Work](#), no date.

5 PSI, [Our Practice Areas](#), no date.

1. Raising awareness of menstruation and addressing menstrual stigma;
2. Building clinical capacity to address menstrual disorders and questions in health-care settings;
3. Product-based interventions;
4. Global advocacy to continue the development of MHH as a field.

Why are they recommended?

- Focus on integrating MHH into SRH work, which experts cite as a key gap in the current MHH ecosystem and body of work.
- Thoughtful programme design that uses qualitative and quantitative research, market information, and human-centred design to iterate new strategies to address menstrual health.
- While monitoring & evaluation work for its MHH work is still being developed (due to lack of funding), PSI has an extensive track record of assessing programme impact and cost of impact, and a stated interest in building this work.
- Extensive experience in market shaping and implementing mass communication campaigns to build product and service availability and access.
- Work ongoing in multiple geographies, including many without a history of MHH work, which has the dual benefit of achieving greater coverage of services and generating evidence both in terms of MHH epidemiology and how programmes function in different contexts.

How much funding do they need, and how will they use it?

PSI estimates they have a funding gap of USD\$2,515,000 over the next five years to implement MHH programmes in a number of countries and support global advocacy. This work includes:

- **Angola:** USD\$360,000 over 1.5 years to support a digital media campaign to build awareness about MHH (USD\$200,000) and to conduct market assessment research.
- **Benin:** USD\$260,000 over three to five years to support the distribution of menstrual hygiene products, provide training and set up a call centre to answer questions about MHH.
- **Laos:** USD\$50,000 over two years to integrate a MHH package into the training curriculum for government health educators. This work would also be accompanied by additional social media and educational outreach.
- **Mozambique:** USD\$500,000 over one year to integrate MHH messages into upcoming seasons of television dramas, and to reach rural adolescents and youth with MHH messages through the programme and adapt activities to reflect Covid-19 concerns.
- **Tanzania:** USD\$500,000 over the next year for increased external communications and education work.
- **Zimbabwe:** USD\$545,000 over two years to expand existing services.

The work would also include global advocacy activities (USD\$300,000) to continue to champion MHH globally and with funders to improve attention and investment into this area.

Sesame Workshop

Who are they and what do they do?

Sesame Workshop is a US-based non-profit founded in 1969 that aims to improve children's education and development through media and education. Sesame Workshop estimates they reach 180 million children in 150 countries worldwide. Their flagship programme – Sesame Street – has been tailored for

30 different settings and the puppet characters from the show are used to help communicate difficult topics to children and educate them more broadly.

Sesame Workshop aims to improve MHH through their Girl Talk programme, which is an educational programme implemented in partnership with World Vision in schools as an addition to a WASH programme called WASH UP! Girl Talk is aimed at both girls and boys aged 10-14 and has been piloted in Zimbabwe.

Why are they recommended?

- Thoughtful programme design targeted to tackle known issues and informed by a collaborative design process involving relevant stakeholders and formative research to ensure cultural relevance.
- Targeting a younger age range, creating the opportunity to reach children with information, tackle stigma, and ensure responsive WASH facilities are in place before menarche is reached, which could avert negative menstruation-related experiences and start early to normalise menstruation.
- Track record of extensive formative research and long history of creating effective communication and learning programmes for children. Commitment to conducting evaluation of the Girl Talk programme and adapting it based on findings.
- Interest in and existing relationships/infrastructure to adapt this programme to reach a group at high risk of lacking access to complete MHH - children in humanitarian settings (e.g. Rohingya children in Cox's Bazar and displaced Syrian children).
- Approach the problem of incomplete MHH from an educational and early-childhood-development perspective, which is a sector that experts we spoke to mentioned as being a gap in this space.

How much funding do they need, and how will they use it?

Sesame Workshop have told us that expansion of the successful Girl Talk pilot requires a range of funding between \$600k to \$10M per country depending on the availability of WASH infrastructure, with \$10M providing funding for a holistic MHM programme involving school-based implementation, infrastructure support, and advocacy to elicit systematic changes. Based on the funding scenarios it has shared with us and a phased approach, we think it could absorb \$3.6m against the first year. The funding will cover costs for Sesame Workshop, as well as sub-grants to their WASH partner, World Vision. Sesame Workshop has previously received individual grants of \$100m, so believes it has capacity to accept such large multi-year grants.

Sesame Workshop estimates that over a 3-year programme, each expansion to a new geography that followed its standard expansion would reach around 30,000 girls per year.

Simavi

Who are they and what do they do?

Simavi is a Dutch NGO working in six countries in Africa (Ethiopia, Ghana, Kenya, Malawi, Tanzania, and Uganda) and four countries in Asia (Bangladesh, India, Indonesia, Nepal).⁶ Founded in 1925, Simavi's mission is to improve the well-being of women and girls by bolstering health, self-determination, and economic empowerment.⁷ Simavi's work is focused at the intersection of SRHR and WASH, as they believe these components are essential to improving and sustaining the health of women and girls worldwide.⁸

Currently, Simavi is running the Ritu programme, which aims to increase knowledge, improve facilities, and fight stigma for in-school girls in Bangladesh. It is also running a programme in Indonesia called Perfect Fit to bolster local and sustainable manufacturing of menstrual products and provide accompanying education.

⁶ Simavi, [The countries we work in](#), no date.

⁷ Simavi, [Our mission and vision](#), no date.

⁸ Simavi, [Expertise areas](#), no date.

Why are they recommended?

- Commitment to using evidence to inform its programme design and sharing research to improve understanding of programme impact in the field.
- Working at multiple levels (individuals, communities, government) to best design and position programmes to be eventually implemented at scale for greatest impact.
- Thoughtful programme design that aims to address multiple factors for incomplete MHH, leverage government buy-in, and mobilise previously committed resources for improvements to facilities.
- Clear focus on MHH work for a number of years and active globally to drive advocacy and uptake of menstrual health as an important area of intervention.

How much funding do they need, and how will they use it?

Simavi could use a total of EUR €2,925,000 of additional funding to implement its Ritu programme and Perfect fit programme.

Simavi aims to begin scaling up the Ritu programme in Bangladesh based on funder interest, at a total cost of EUR €2,775,000 over the course of four years of implementation. This includes:

- €2,000,000 to implement the direct interventions in schools and communities, conduct national-level advocacy, and evaluate the programme.
- €500,000 to conduct a communication campaign in schools.
- €275,000 for an add-on element to scale up production and market work for biodegradable menstrual products.

This programme aims to reach 89 schools, 25,000 girls, 25,000 boys, and 1,000 teachers. Simavi is also looking to scale up the Perfect Fit programme in Indonesia, for a total of €150,000 over two years, aiming to reach 10,000 women and girls per production unit.

WoMena

Who are they and what do they do?

WoMena is an NGO founded in 2012 with offices in Denmark and Uganda. It aims to drive innovative solutions to SRH challenges by applying effective research and programme development techniques to reproductive health work. An extensive portion of WoMena's portfolio deals with MHH, particularly with work surrounding acceptability and uptake of menstrual cups. WoMena has been working in partnership with other implementing organisations (such as Save the Children and International Rescue Committee) to promote uptake of menstrual cups in Uganda.

Why are they recommended?

- Commitment to using evidence to inform its programme design and sharing research to improve understanding of programme impact in the field.
- Working at multiple levels (individuals, communities, government) to best design and position programmes to eventually be implemented at scale for greatest impact.
- Working to understand whether menstrual cup uptake and promotion can be leveraged through education and market-based solutions. This is a potentially important area of impact in terms of achieving access to sustainable and long-lasting menstrual product solutions.

How much funding do they need, and how will they use it?

WoMena have a funding gap of \$552,000 over the next three years, with \$171,000 in the first year. This would be used for advocacy work, overhead costs, and to design a MHH intervention for people with disabilities.

Acknowledgements

For discussion, advice, and expertise, we are grateful to:

- Dr. Marni Sommer, Associate Professor at Columbia University
- Dr. Julie Hennegan, Research Associate at Johns Hopkins Bloomberg School of Public Health
- Dr. Anjalee Kholi, Senior Research Officer at the Institute for Reproductive Health, Georgetown University
- Natasha Piette-Basheer, Environmental Campaign Manager at Women's Environmental Network
- Gerda Larsson, Co-Founder and Director at The Case for Her
- Rolla Khadduri, Fund Director at MannionDaniels and AmplifyChange

The findings of this report are our own and do not necessarily reflect the views of those listed. Any mistakes are our own.

This report was prepared by Founders Pledge for the Kulczyk Foundation.

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2. Purpose, Scope, and Methodology

2.1 Purpose

This report was commissioned to better understand the state of menstrual health and hygiene worldwide, and to better understand some of the most promising and effective programmes driving change for women and girls.

Menstrual health and hygiene – even though billions of people currently, have, or will menstruate – has been neglected as an area for research, investment, and focus for years. The issue of menstrual health and hygiene has received increasing attention over the past decade, but still is neglected given how many people it affects.

Access to complete menstrual health and hygiene is a human rights issue. Without it, women, girls, and other people who menstruate cannot pursue full lives with dignity and confidence.⁹ However, in times of health crises – such as the coronavirus pandemic – already neglected areas of investment are at risk of becoming even more marginalised, as funding for under-the-radar issues gets diverted to rapid response.

The current pandemic is likely to worsen low-income women and girls' economic precarity and stretch already taxed governments and health systems to cut programmes and funding for issues perceived as less urgent. We believe that this will likely increase the number of women, girls, and other people who menstruate who lack access to complete menstrual health and hygiene. This is why we think that now is the time to be investing in menstrual health and hygiene worldwide.

2.2 Scope

Specifically, this report aims to answer the following questions:

1. What do we know about menstrual health and hygiene worldwide? ([Section 3](#))
 - a. Understand the landscape of menstrual health and hygiene, including the underlying components of complete MHH, the state of MHH around the world, the harms associated with a lack of MHH, and the main funders currently working in the area
2. What is currently being done to improve menstrual health and hygiene worldwide? ([Section 4](#))
 - a. Understand the different approaches currently being taken to improve MHH, including both direct interventions, such as the distribution of menstrual hygiene products, and indirect interventions, such as movement building.
3. What are the most cost-effective organisations that best improve menstrual health and hygiene? (Section 5)
 - a. Identify eight organisations with room for at least \$10m extra funding each year.

⁹ United Nations Population Fund (UNFPA), [Menstruation and human rights - Frequently asked questions](#), May 2020.

2.3 Methodology

To answer the first and second questions of the scope outlined above, we have:

- Reviewed peer-reviewed literature and reports from other funders, researchers, influencers, and implementers on menstrual health and hygiene, prioritising:
 - Literature from the last five years (with a focus on literature from the last two years);
 - Systematic reviews related to the epidemiology of menstrual health, harms caused by incomplete access to menstrual health and hygiene, and interventions aimed at improving menstrual health;
 - Guidance documents from actors like UNICEF, which aim to summarise the state of the field and assist programmers in setting up projects related to menstrual health;
 - Reports released from influential actors and norm-setting bodies in the field (e.g. UNICEF).
- Conducted interviews with researchers, funders, advocates, and implementers in the field of menstrual health and hygiene to:
 - Test, correct, and deepen the conclusions we drew from the literature review;
 - Understand where the research and evidence gaps are;
 - Learn more about organisations working in this area who are pushing the field forward.

After conducting the steps described above, we turned our attention to making funding recommendations. To do this, we:

- Longlisted 80 organisations, identified through conversations with researchers and funders, keyword searches, grant databases, and the literature.
- Shortlisted 13 of those organisations based on a number of factors including commitment to generating evidence, evidence-informed programmes, ability to absorb funding, geographic presence, and existing relationships with the funder.
- Recommended 8 organisations, based on the information provided by them on how they design and operate their programmes, commitment to increasing the evidence base for menstrual health, cost of programme, and funding needs.

The methodology we used to come to recommendations is described in more detail in Section 5.1.

Section 6 lays out the limitations of this report, and other areas that could merit future exploration.

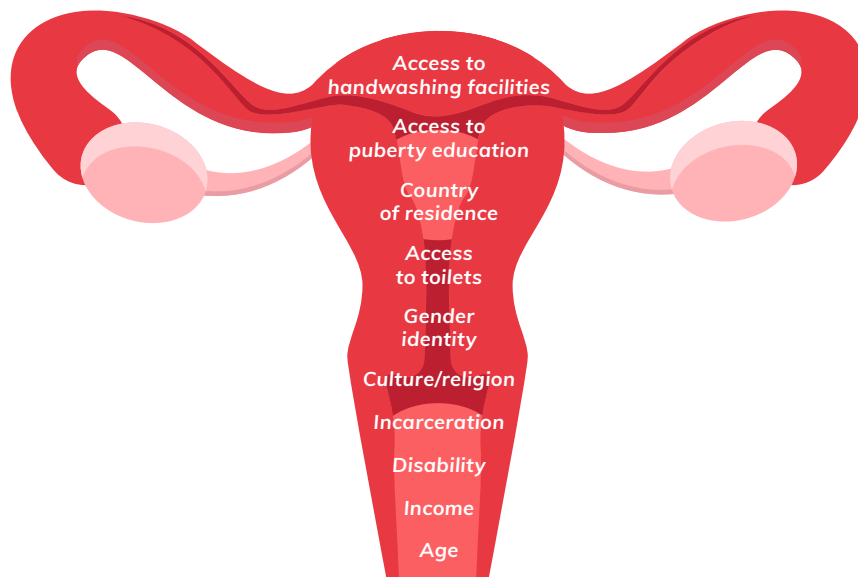


3. Menstrual Health and Hygiene Worldwide

Menstruation is a normal bodily function that is experienced by most adolescent girls and women during their reproductive years and by some transgender men and gender non-conforming people. Despite the fact that billions of people will (or currently do) experience menstruation as a routine part of their lives, menstruation is often stigmatised and invisible¹⁰. This contributes to millions of girls and women¹¹ worldwide not having what they need to achieve complete menstrual health and hygiene.

The invisibility and stigmatisation of menstruation can affect girls and women in many different ways, depending on factors such as their location, culture, and income. The hidden nature of menstruation means that many women and girls do not live in an environment where menstruating is seen as a normal part of life. This can mean they lack the knowledge, medical support, sanitation facilities, and menstrual products essential for them to achieve a good level of menstrual hygiene. Women and girls go about their daily routines while menstruating, meaning they must constantly contend with public (and often private) environments that have not been designed to accommodate menstruation. For example, schools that don't have places to dispose of menstrual products, or prisons that fail to provide enough pads.

Figure 1. Factors impacting access to MHH



In response to these conditions, there has been a swell of advocacy, research, and policy changes around menstrual hygiene over the last few decades – particularly in the past decade – with interested parties working to ensure that menstruation receives proper attention in terms of its impact on girl's and women's lives worldwide.

In the 1990s, advocates and researchers began looking into menstruation and in 2001, the first paper to “articulate MHM [menstrual health management] as a priority in research and policy in

10 “...too often, menstruation is shrouded in mystery, leading to exclusion, neglect and discrimination.” UNFPA, [Menstruation is not a girls' or women's issue – it's a human rights issue](#), May 2019.

11 For the purposes of this report, we will adopt the terminology conventions used by UNICEF – one of the major international bodies involved in moving the menstrual health and hygiene agenda forward – and use ‘girls and women’ as a general catch-all term when we are describing the population of people of menstruate. In part, this is because most of the research around menstruation has focused on cisgender women. However, we want to be clear that some transgender boys and men and gender non-conforming people menstruate and also need to receive adequate attention and services. We will address the needs of transgender boys and men and gender non-conforming individuals specifically later in this report.

development agendas” was released.¹² In 2004, another paper laid out a call to action for menstrual hygiene asserting that “the absence of MHM in the policy debate and hence in investments and action, is striking. This points to a glaring need to highlight this issue in the policy debate together with practical work on what adolescent girls and women require to manage their menstrual needs in terms of materials, education and facilities for management and disposal.”¹³ The advocacy and work by researchers and programmers worldwide led to “the Joint Monitoring Programme of UNICEF and the WHO [that] collaboratively decided to push for MHM to be incorporated into the next generation of development goals [in 2012]. This decision marks a high-level commitment to MHM.”¹⁴

While menstrual hygiene does not have its own goal in the Sustainable Development Goals (SDGs) – a set of global goals to shape development priorities – components of some of the goals (such as SDG 6, which states the aim of ensuring access to water and sanitation for all) align with the necessary components for complete MHH. Others, such as SDG 5, which states the aim of achieving gender equality, cannot be achieved without attention paid to menstrual health, as menstrual stigma is likely to contribute to gendered discrimination.¹⁵

The progress described above in advocating for menstrual health and hygiene as a recognised field has been celebrated by advocates, programmers, and researchers working in this area. However, there is still significant work to be done. We need to build understanding of where menstrual hygiene interventions are needed, which interventions are effective, and the benefits of achieving complete MHH.

12 Bobel C. Making Menstruation Matter in the Global South: Mapping a Critical History. In: *The Managed Body*. Palgrave Macmillan, Cham, 2018.

13 Bobel C. Making Menstruation Matter in the Global South: Mapping a Critical History. In: *The Managed Body*. Palgrave Macmillan, Cham, 2018.

14 Bobel C. Making Menstruation Matter in the Global South: Mapping a Critical History. In: *The Managed Body*. Palgrave Macmillan, Cham, 2018.

15 WASH United and Simavi, [Menstruation matters to everyone, everywhere](#). 2017.

3.1 What is Menstrual Health and Hygiene (MHH)?

This section outlines the key components of complete menstrual health and hygiene, and its main underlying causes.

3.1.1 DEFINING MHH

The main components of complete menstrual health and hygiene are:¹⁶

- Access to preferred and sufficient menstrual management materials, such as tampons or sanitary pads;
- A safe and hygienic location for changing and disposing of sanitary materials as well as washing facilities;
- Knowledge and understanding of menstruation as a biological process and how to manage it;
- A supportive environment where menstruation is not stigmatised.

An individual's likelihood of experiencing complete MHH is influenced by a number of societal, environmental, interpersonal, personal, and biological factors.

As the field of menstrual health and hygiene is relatively new, definitions have evolved quickly over time. In 2014, UNICEF and the WHO agreed to the definition of 'menstrual hygiene management' (MHM), as:

*"Women and adolescent girls using a clean menstrual management material to absorb or collect blood that can be changed in privacy as often as necessary for the duration of the menstruation period, using soap and water for washing the body as required, and having access to facilities to dispose of used menstrual management materials."*¹⁷

The definition of MHM was a step forward as it introduced specific materials and facilities that are necessary to achieve satisfactory MHM for women and girls. However, it did not include key factors that help to reduce stigma and create a supportive environment for menstruating women and girls, such as education. As such, recent guidance put forth by UNICEF and reflecting the work of UNESCO, defines the more comprehensive term – 'menstrual health and hygiene' – as encompassing:

*"[The factors included in 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 summarised 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 policy."*¹⁸

In this report, we will use the above terms as defined. However, as these definitions have only been codified recently, literature that we cite in this report may not adhere to these standard terms. When that is the case, we will endeavour to clarify any discrepancies.

16 This definition is adapted from the key terms defined in UNICEF's 2019 report. UNICEF. [Guidance on Menstrual Health and Hygiene](#). Published March 2019. Accessed April 1, 2020, pg. 8.

17 Sahin, Murat. "Guest editorial: tackling the stigma and gender marginalization related to menstruation via WASH in schools programmes." *Waterlines* 34.1 (2015): 3-6.

18 (UNICEF, 2019, pg. 8)

3.1.2 POLITICAL, ENVIRONMENTAL, SOCIAL, AND INDIVIDUAL FACTORS INFLUENCING ACCESS TO COMPLETE MHH

Access to complete MHH is impacted by issues spanning many different political, environmental, social, and individual factors. This complex web of factors means that it is important for policymakers, programmers, and researchers to detangle the different strands contributing to the lack of access to complete MHH. This will help them address the underlying issues contributing to incomplete MHH in different communities.

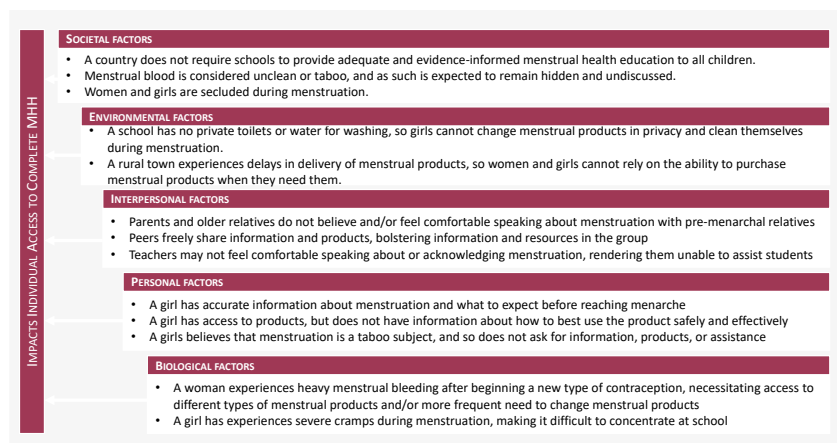
Experts from UNICEF, UNGEI, and researchers from Emory University created a socio-ecological framework¹⁹ for MHH mapping these factors according to how they influence whether an individual has access to complete MHH.²⁰ The different levels identified include:

- “Societal factors (policy, tradition, cultural beliefs);
- Environmental factors (water, sanitation, and resource availability);
- Interpersonal factors (relationships with family, teachers, peers);
- Personal factors (knowledge, skills, beliefs);
- Biological factors (age, intensity of menstrual cycle).”²¹

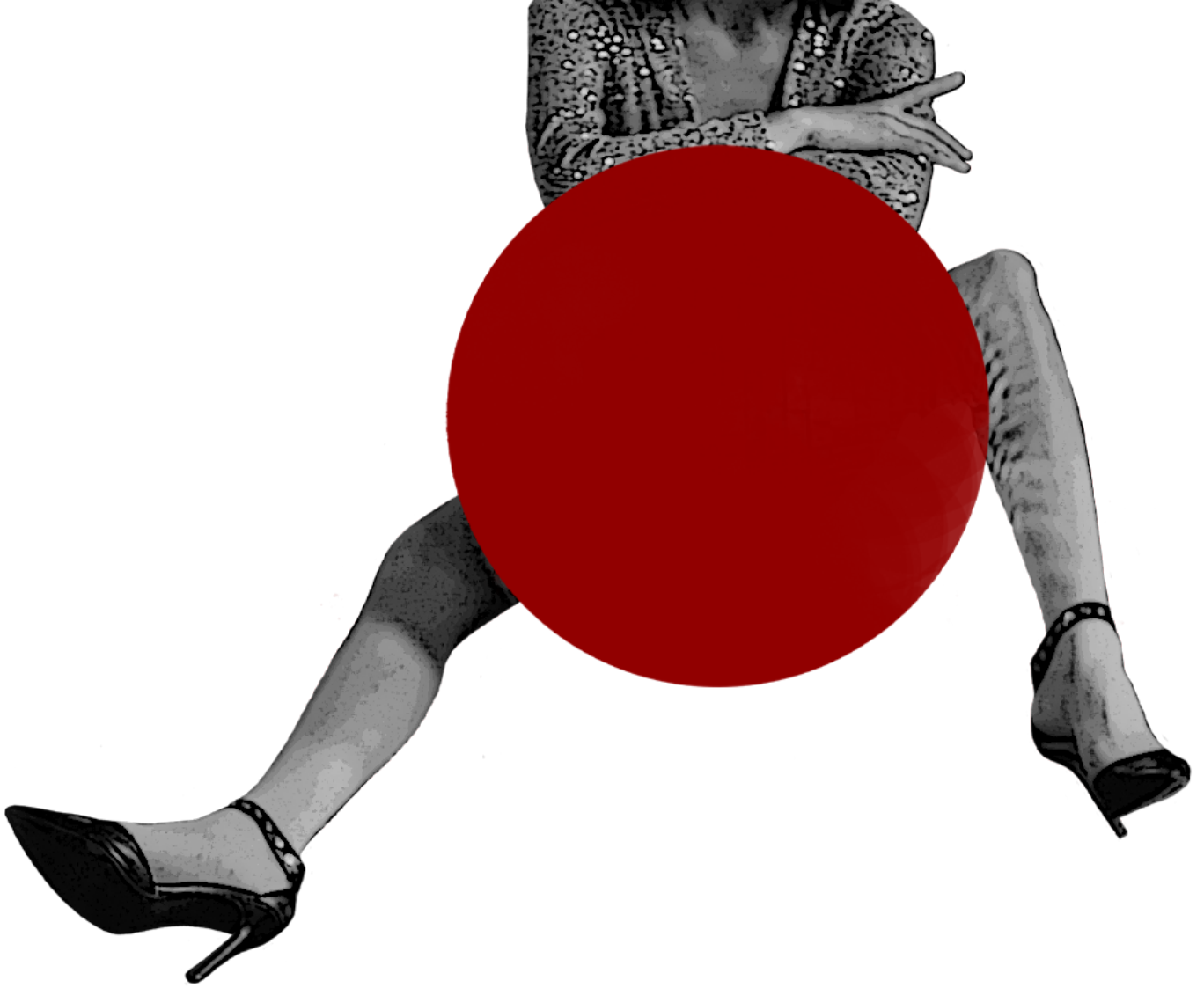
Societal factors are policy decisions and cultural beliefs and practices that have broad impacts on entire countries or communities. Environmental factors refer to features of the built and lived environment that individuals and communities interact with in their daily lives. Interpersonal factors encompass the ways in which relationships with others (both authority figures and peers) influence knowledge, beliefs, attitudes, and self-efficacy. Personal factors refer to the actual knowledge, beliefs, attitudes, and perception of self-efficacy that individuals hold. And finally, biological factors encompass the bodily characteristics of menstruation.

An individual’s access to complete MHH is shaped and mediated by factors across these political, environmental, social, and biological levels. Considering how these factors differ country-to-country, community-to-community, and person-to-person helps illustrate the complexity that must be navigated when considering how to measure lack of access to complete MHH and design programmes to address these factors.

Figure 2. Examples of different factors that impact individual access to complete MHH²²



- 19 A socio-ecological model is a type of framework used to understand the different facilitators and barriers originating from political, environmental, social and individual characteristics and how they may exert an influence on whether individuals can achieve particular health outcomes.
- 20 UNICEF. [Guidance on Menstrual Health and Hygiene](#). Published March 2019. Accessed April 1, 2020, pg. 8. and Emory University, UNGEI and UNICEF (2014). WASH in Schools for Girls E-Course. Available online at <http://washinschoolsmapping.com/the-wins4girls-e-course>
- 21 UNICEF. [Guidance on Menstrual Health and Hygiene](#). Published March 2019. Accessed April 1, 2020, pg. 8. and Emory University, UNGEI and UNICEF (2014). WASH in Schools for Girls E-Course. Available online at <http://washinschoolsmapping.com/the-wins4girls-e-course>
- 22 UNICEF. [Guidance on Menstrual Health and Hygiene](#). Published March 2019. Accessed April 1, 2020, pg. 8. and Emory University, UNGEI and UNICEF (2014). WASH in Schools for Girls E-Course. Available online at <http://washinschoolsmapping.com/the-wins4girls-e-course>



There is no consensus in the field on either how much money is currently allocated to MHH programming or how much money it would take to ensure complete MHH for every person who is currently menstruating.

3.2 Funding for Menstrual Health and Hygiene

From our review of the field, we believe funding for projects and research specifically geared to address menstrual hygiene as a standalone area is limited. Funding is derived and driven by in-country government spending, bilateral donors, UN agencies, corporate social responsibility spending, and private philanthropy. In addition, while menstruation-focused businesses do not receive donor funding, they do receive private sector investment. Our estimate is that programming designed to specifically address MHH has been receiving somewhere in the range between \$10 million - \$100 million in funding per year, with this figure likely to be trending upwards in recent years. Given the lack of transparency and data around funding for MHH, it is not possible to specify exact spending, and our estimate does not necessarily include spending on interventions that improve menstrual health through indirect impacts (such as spending on WASH which indirectly improves facilities for the disposal of sanitary materials).

One reason why it is hard to define an exact direct funding figure is because MHH overlaps with work in areas such as WASH, education, and sexual and reproductive health. Given that adequate toilets and handwashing facilities are critical to MHH, WASH programming focusing on these areas benefits MHH. According to the WASH funders database, \$2.9 billion in bilateral aid and \$335 million in philanthropic donations were recorded for WASH projects in 2017. The World Bank estimates the amount of investment required to meet SDG 6 (achieving water and sanitation for all) is USD\$114 billion per year.²³ In addition, given that knowledge of menstruation is a key component of complete MHH, education efforts funded through sexual and reproductive health projects - be they in-school education or family planning counselling - may also help address incomplete MHH. In 2018, \$1.3 billion of donations in total were recorded as going towards family planning programming (IHME) from all funding sources tracked (bilateral, private philanthropy, etc.).

However, we believe that funding for MHH-specific programmes is significantly more limited. In terms of in-country government spending, the amount committed depends on country income level, population size, and the package of services dedicated to menstrual hygiene. For instance, New Zealand recently announced they would be committing USD\$1.7 million²⁴ to pilot a programme to provide free menstrual products in schools. In addition, Scotland passed a bill aimed at providing free products to anyone who cannot afford them, which they estimate will cost USD\$31 million per year to implement.²⁵ With all in-country government spending, there may be differences between what is committed compared to what is spent in practice.

Bilateral aid may go to country governments, UN agencies, or implementing partners and flows from HICs to LMICs. We reviewed the [WASH funders database](#) to help us establish a lower-bound of bilateral spending for MHH since 2006. This database noted \$9.5 million in bilateral aid for MHH projects with Sweden committing \$4.1 million in total, the UK committing \$2.4 million in total, Canada committing \$1.4 million in total, and the USA committing \$1.1 million in total. Finland, Norway, and Spain have also made bilateral grants for MHH-specific work. This work is geared towards sub-Saharan Africa and South Asia. Bilateral funding was recorded for MHH-related WASH interventions, menstrual hygiene material distribution, and education. We heard from experts that development agencies in Canada, the UK, the Netherlands, and Sweden have funded non-WASH-related projects for MHH that would not be captured in this database, so the total amount of bilateral funding is likely to be higher than what we're able to track here.

The [WASH funders database](#) shows \$5.5 million in grants from private funders (the majority from the Bill & Melinda Gates Foundation) for projects specifically addressing MHH since 2006. In February 2020, the Bill & Melinda Gates Foundation Grand Challenges programme opened a grant for "[Innovations in Materials Science for a Transformative Menstrual Health and Hygiene Product](#)". The Grand Challenges

23 Hutton, G and Varughese, M, [The Costs of Meeting the 2030 Sustainable Development Goal Targets on Drinking Water, Sanitation, and Hygiene](#), World Bank, January 2016.

24 Regan H, New Zealand to provide free sanitary products in schools to fight period poverty, CNN, 4 June 2020.

25 Wamsley L, [Scotland Poised To Become 1st Country To Make Period Products Free](#), NPR, 27 February 2020.

grants are for \$100,000 (and up to 50 awardees) to make meaningful contributions to developing better menstrual health management materials. All of this work is geared towards LICs and emergencies. From a review of grants from the Bill & Melinda Gates Foundation database, most funding seems to be going to support development and distribution of menstrual hygiene materials. Philanthropic Funds that support MHH work as a core part of fulfilling their mission include *The Case For Her*, which focuses exclusively on supporting work to improve MHH and female sexual pleasure and *AmplifyChange*, which supports sexual and reproductive health and rights (SRHR) work via civil society organisations across global, national, and local levels.

While there is MHH work occurring worldwide, there is a particular focus on funding in East Africa (Kenya, Tanzania, Uganda, Ethiopia) and South Asia (Nepal, India, Bangladesh) found on review of externally communicated grants, including those listed in the [WASH funders database](#).

The information above does not include funding coming through UN agencies (with UNICEF leading on much of the work, UNHCR active in the emergencies, UNFPA providing coordinating functions, and WHO providing technical guidance), individual philanthropy, and corporate social responsibility programmes. Private corporations also make in-kind donations to programmes. In addition, many of the organisations that we have come across that work on improving MHH incorporate a social enterprise component via manufacturing and selling menstrual management materials that help sustain operations.

The experts we spoke to all confirmed our assumption that there is no consensus in the field on either how much money is currently allocated to MHH programming or how much money it would take to ensure complete MHH for every person who is currently menstruating. The reasons experts gave us for this include:

- Due to MHH being a relatively new field, there is not enough research to reach a consensus on how many women and girls lack complete MHH, what the resulting negative outcomes are, and what solutions will best solve the problem. This means that we cannot quantify what it would take to solve this problem.
- Funding for MHH is often a side consideration in a larger project – such as a WASH project or funding for refugee camps – which means that the actual spending on MHH is included in a larger line item and so cannot be tracked separately from other expenses.
- There is no existing estimate that includes corporate social responsibility work, including in-kind donations, and private sector investments in menstruation-focused companies.

3.3 MHH Levels Worldwide

Researchers and programmers cite the lack of standardised definitions and good epidemiological data on prevalence and severity of incomplete menstrual health and hygiene as an ongoing challenge in growing the field.^{26,27,28} The lack of standardised definitions about what complete menstrual health and hygiene encompasses means that it is difficult to assess how widespread the problem is. The MHH indicators and proxy indicators that do exist tend to only measure a limited component of complete menstrual health – such as access to handwashing facilities or access to preferred sanitary products.

Most sources tend to coalesce around an estimate of at least 500 million women and girls lacking access to complete MHH worldwide.²⁹ This figure is based on data concerning access to sanitation facilities. Experts we spoke to cautioned that while it is unlikely this figure is an underestimate, access to sanitation is a rough proxy measure to gauge access to complete MHH. In addition, experts also noted that sanitation is one of the components of MHH that is particularly lacking in LMICs. If we consider aspects of complete MHH like freedom from menstrual stigma, adequate treatment of pain, and knowledge of menstruation, the figure of women and girls worldwide could be significantly higher than 500 million and prevalent in countries of all income levels worldwide. A recent study testing a new scale for assessing complete MHH found that when assessing aspects of MHH beyond use of menstrual products, prevalence was much higher than previously assumed.³⁰

We believe that the lack of quantitative knowledge concerning access to complete MHH shows this important component of health has been historically neglected, which contributes to lack of investment and attention.

Currently, researchers rely on a few quantitative sources of methodologically rigorous, national epidemiological data directly assessing MHH in a limited portfolio of countries. They also rely on multiple proxy measures and small surveys to estimate levels of incomplete MHH worldwide.

The main measures we will discuss are shown below for each component of complete MHH.

Component of MHH: Access to physical products and facilities to manage MHH

Measures:

- **Access to adequate products and facilities**
 Performance Monitoring for Action (PMA) carry out [surveys](#) questioning specific MHH factors such as access to adequate sanitary materials, access to safe and private toilets, and access to handwashing facilities, which were combined into one composite measure.
 - **PMA carries out well-needed MHH-specific surveys providing comparable and country-specific data.**
 - **The surveys have only been rolled out in a few countries so far and they concentrate only on the physical aspects of MHH.**

26 UNICEF. [Guidance on Menstrual Health and Hygiene](#). Published March 2019. Accessed April 1, 2020, pg. 8.

27 Hennegan, Julie M. "Menstrual hygiene management and human rights: the case for an evidence-based approach." *Women's Reproductive Health* 4.3 (2017): 212-231.

28 Chandra-Mouli V, Ferguson BJ, Plesons M, et al. The Political, Research, Programmatic, and Social Responses to Adolescent Sexual and Reproductive Health and Rights in the 25 Years Since the International Conference on Population and Development. *J Adolesc Health*. 2019;65(6S):S16-S40. doi:10.1016/j.jadohealth.2019.09.011

29 UNICEF and World Health Organization (WHO), [25 Years Progress on Sanitation and Drinking Water: 2015 Update and MDG Assessment](#), 2015, pg. 45.

30 Hennegan, Julie, et al. "Measuring the prevalence and impact of poor menstrual hygiene management: a quantitative survey of schoolgirls in rural Uganda." *BMJ open* 6.12 (2016).

- **Access to Sanitation and Hygiene Facilities**

Due to the lack of data in MHM, UNICEF presume that a figure for the number of women that defecate in the open can be used as a lower bound for the number of women lacking adequate facilities for MHM.

- Using the well-recorded, concrete measure as a proxy provides a methodologically rigorous, comparable, nationally representative figure.
- A rudimentary figure that does not account for the many other factors of MHH.

Component of MHH: Adequate knowledge of menstruation as a biological process and how to manage it

Measures:

- **Knowledge of fertility** - The proportion of women who incorrectly believe when their fertile period is during their menstrual cycle has been measured. This can be used to assess how many women have received adequate education about their menstrual cycles in order to understand how their bodies work.
 - Data is from methodologically rigorous, comparable, nationally representative surveys implemented across multiple countries.
 - This proxy measure is related to biological knowledge that doesn't necessarily assess more detailed understanding of management.
- **Knowledge of menstruation** - A literature review of 81 studies published in peer-reviewed journals between 2000 and 2015 describes the experiences of adolescent girls from 25 different countries. It documents the lack of knowledge that girls have as they approach the first occurrence of menstruation (menarche).
 - The review directly assesses the knowledge component and investigates the different aspects of it.
 - Data is assessed via separate, non-standardised surveys of variable quality in individual countries and/or regions and therefore is not methodologically rigorous.

Component of MHH: An supportive environment that does not stigmatise menstruation

Measure:

- **Impact of menstrual stigma on daily life** - A 2017 review focused on adolescent girls' experiences of menstruation in LMICs documents how it impacts their everyday life. It found they tended to avoid physical or social activities or missed school or work due to menstruation.
 - The review directly assesses the impact of menstrual stigma and the enabling environment.
 - Data is assessed via separate, non-standardised surveys of variable quality in individual countries and/or regions; therefore it is not methodologically rigorous.

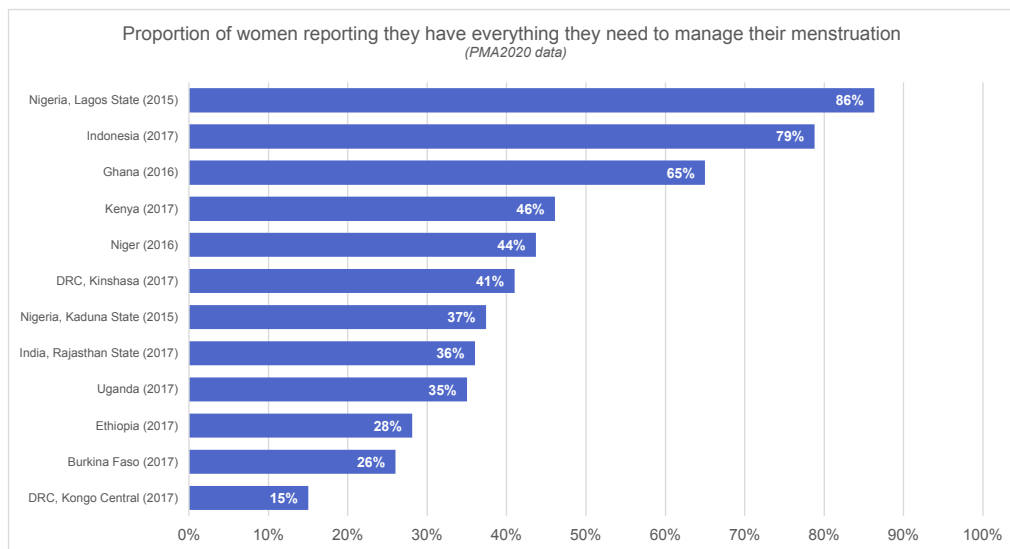
There are no globally comprehensive, standardised, and rigorous sources of data looking at access to preferred menstrual hygiene materials, complete menstrual knowledge, and the prevalence, level, and impact of menstrual stigma. As a relatively new field, one of the main challenges for MHH research and programming is lack of knowledge, in terms of both the epidemiology of MHH and the impact of interventions designed to promote MHH.

In the following sections, we will describe in more detail the measures outlined above.

3.3.1 PMA SURVEYS

The current best data that exists for measuring access to MHH in LMICs comes from the Performance Monitoring for Action (PMA2020) surveys that were implemented in 11 LMICs and/or subnational regions between 2015 and 2017. Using standardised measures, these surveys looked at access to some of the elements necessary for MHM among girls and women of reproductive age (15-49) – such as access to adequate sanitary materials, access to safe and private toilet facilities, and access to handwashing facilities. These findings were then constructed into a composite measure of the “proportion of those surveyed who reported they had everything they needed to manage their menstruation”. The findings – summarised in Figure 3 below – ranged from 86% of women in the urban Lagos State of Nigeria reporting they had everything they needed to just 15% of women in the Kongo Central region of the Democratic Republic of the Congo (DRC) reporting that they did.

Figure 3. Proportion of women with adequate MHM³¹



The wide range reflected in the PMA2020 surveys means that making generalisations across countries from the limited data can be difficult. However, the PMA2020 figures are very useful for understanding the different dynamics of access to material factors needed for complete MHM. We believe MHH programmes operating in countries or regions with PMA2020 data should be designed to be responsive to this information.

As with all the measures discussed here, experts highlighted that this measure only captures one component of complete MHH. Given that questions are only being recently tested and incorporated into standard surveys, it is likely that current questions will need to be expanded on as a more complete understanding of the components of MHH and how to measure them develops.

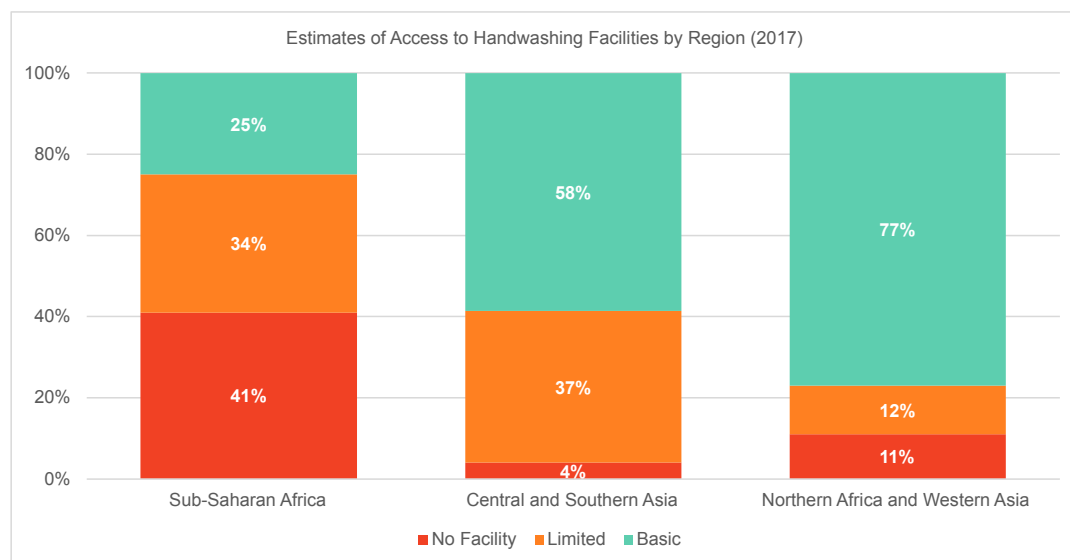
31 Performance Monitoring and Accountability 2020 (PMA2020), [Menstrual Hygiene Management briefs](#), 2015-2017.

3.3.2 ACCESS TO SANITATION AND HYGIENE FACILITIES

In 2015, UNICEF estimated that around 500 million women and girls do not have adequate facilities to manage their menstruation.³² The majority of these people are in low- and middle-income countries. This estimate is based on what we know about access to adequate sanitation facilities and does not encompass national data specific to menstruation.³³ An estimation of the total number of people lacking complete MHH will be higher as it would include the additional conditions of having adequate knowledge and not experiencing stigma due to menstruation. However, we have no standardised measures to quantify these factors and we do not have the evidence to quantify their severity. Therefore, we believe that the 500 million figure represents a reasonable lower-bound estimate and encompasses those lacking the most urgently needed materials for complete MHH.

As access to soap and water for washing is an essential part of achieving complete MHH, and data on access to handwashing facilities is well-studied from WASH surveys in LMICs, handwashing information can be used as a useful proxy measure for lack of complete MHH. According to data displayed in Figure 4, this component of MHH is most severely lacking in sub-Saharan Africa. Handwashing data can also provide national proxy estimates and we would expect MHH programmes operating both across and within countries to use this type of data to help design responsive programming.

Figure 4. Access to handwashing facilities³⁴



32 "Globally, there is very little comparable information available on menstrual hygiene management. However, the lack of basic sanitation and drinking water facilities, as documented earlier in this report, suggests that many women lack a suitable place for managing menstruation. Assuming at least half of the 946 million people globally who lack any kind of facility and defecate in the open are female, a conservative estimate would suggest that at least 500 million women and girls lack adequate facilities for MHM." (UNICEF and World Health Organization (WHO), [25 Years Progress on Sanitation and Drinking Water: 2015 Update and MDG Assessment](#), 2015, pg. 45)

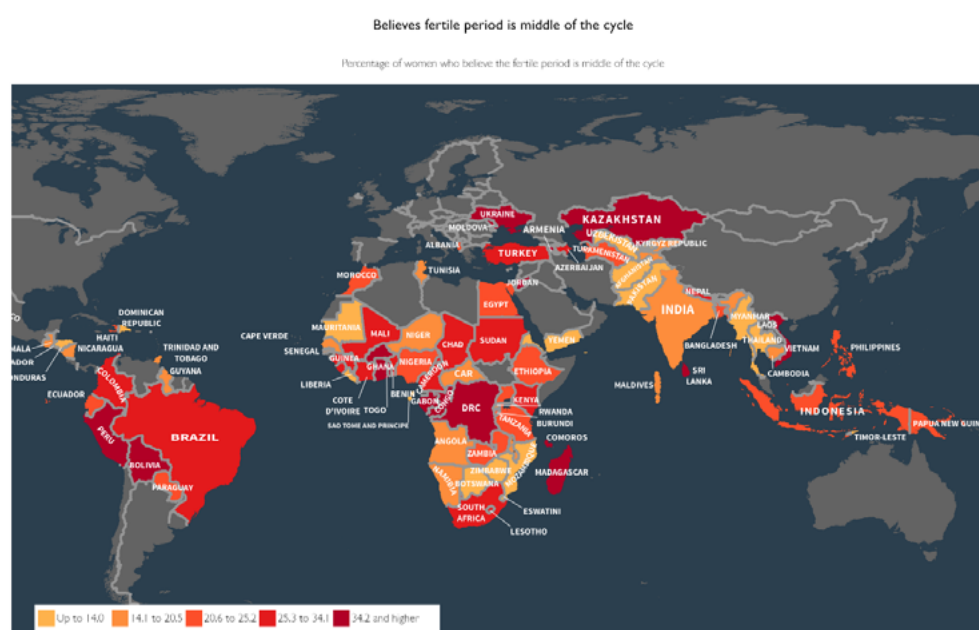
33 While this figure is commonly cited as the estimate for the number of people lacking adequate MHM worldwide, one expert cautioned that using lack of access to toilets as a proxy measure is likely a very imprecise way. While they did not consider this figure to be an overestimate due to the imprecision, it more referred to the problems in terms of measurement.

34 UNICEF, [Hygiene](#), June 2019.

3.3.3 KNOWLEDGE OF FERTILITY

Another potential proxy indicator that can be used to assess lack of access to MHH in LMICs is knowledge of fertility. Knowledge of the menstrual cycle and how it corresponds to fertility may be used as a proxy for having received accurate menstrual health education, which relates to the knowledge component of complete MHH. This measure does not get at material deprivation, but rather highlights the lack of knowledge component that presents a barrier to complete MHH. The Demographic and Health Surveys (DHS) regularly ask women to report when during their menstrual cycle they are fertile as a way of assessing appropriate use of family planning methods. This proxy can be used to assess how many girls and women have had the benefit of receiving adequate education about their menstrual cycles in order to understand how their bodies work. Data from the latest rounds of DHS surveys show that in most countries, less than half of women of reproductive age are able to accurately state when they are most fertile during their menstrual cycle, and, in many countries in sub-Saharan Africa and South Asia, less than a quarter are able to do so (see Figure 5 below).

Figure 5. Awareness of fertile period (DHS³⁵)



ICF 2019. The DHS Program 5700 compiler. Funded by USAID. <https://www.dhsprogram.com>. April 7, 2020

3.3.4 KNOWLEDGE OF MENSTRUATION

While standardised data surrounding knowledge of menstruation is not available for many countries, this section and the next, present data from a [systematic review](#) of available literature from LMICs about MHH and adolescents.³⁶ While this data is not necessarily comparable or generalised across countries, they do provide a useful overview of how different components of complete MHH may be lacking in different areas. They also highlight that one-size-fits-all MHH programming is not an appropriate technique given that different issues might be more or less severe in different locations.

For instance, this review of the impact of menstruation on girls in LMICs from 2017 documented the lack of knowledge that girls experience as they approach menarche.³⁷ The studies documented that before they reached menarche, anywhere between 5.6% and 100% of girls knew what menstruation was and that they would likely experience it (see Figure 6 below). This wide range of estimates demonstrates

35 DHS, STATcompiler [indicator selected was “believes fertile period is middle of the cycle”], accessed April 2020.

36 Chandra-Mouli, Venkatraman, and Sheila Vipul Patel. “Mapping the knowledge and understanding of menarche, menstrual hygiene and menstrual health among adolescent girls in low-and middle-income countries.” *Reproductive health* 14.1 (2017): 30.

37 Menarche refers to the first occurrence of menstruation

both that there is an urgent need for information for many girls in LMICs and that, for programmes to be appropriately targeted, researchers and programmers also need more information about where the need for MHH programming is.

Figure 6. Awareness of menstruation prior to menarche³⁸

Table 2 Awareness of menstruation prior to menarche

First author, Year	Country	Setting	School status	N	Aware
North Africa					
Eswi 2012 [45]	Egypt	Urban	School-going	200	74.0%
South Asia					
Bosch 2008 [28]	Bangladesh	Rural	Unclear	156	35.0%
Khanna 2005 [11]	India	Mix	Out of school	358	5.6%
Dambhare 2012 [32]	India	Mix	School-going	561	75.6%
Juyal 2013 [65]	India	Mix	School-going	453	64.5%
Khanna 2005 [11]	India	Mix	School-going	372	9.8%
Thakre 2011 [12]	India	Mix	School-going	387	37.0%
Khanna 2005 [11]	India	Rural	Mix	NR ^a	2.8%
Dasgupta 2008 [8]	India	Rural	School-going	160	67.5%
Shanbhag 2012 [10]	India	Rural	School-going	329	57.9%
Sudeshna 2012 [15]	India	Rural	School-going	190	47.4%
Dhingra 2009 [29]	India	Rural	Unclear	200	64.0%
Tiwari 2006 [11]	India	Unclear	School-going	763	62.7%
Khanna 2005 [11]	India	Urban	Mix	NR ^a	12.1%
Omidvar 2010 [46]	India	Urban	School-going	336	64.5%
Yasmin 2013 [13]	India	Urban	School-going	147	42.2%
Bobhate 2011 [7]	India	Urban	Unclear	241	20.3%
Udgiri 2010 [23]	India	Urban	Unclear	342	18.4%
Ali 2010 [6]	Pakistan	Urban	Government school	425	47.8%
Ali 2010 [6]	Pakistan	Urban	Out-of-school	425	38.8%
Ali 2010 [6]	Pakistan	Urban	Private school	425	34.1%
West Asia					
Reis 2011 [27]	Turkey	Urban	Mix	310	67.4%
Ersoy 2004 [2]	Turkey	Urban	School-going	1017	100.0%

NR Not reported

^aOf 730 girls, the number in rural versus urban settings was not specified

3.3.5 IMPACT OF MENSTRUAL STIGMA ON DAILY LIFE

While national data on access to handwashing give probably the most generalisable and methodologically sound estimate of lack of complete MHH, focusing on only material deprivation misses some of the psychological and social harms linked to stigma around menstruation. The 2017 review of the evidence from LMICs about adolescent girls' experience of menstruation documented that a significant number felt that menstruation significantly impacted their everyday life. Anywhere from 18% to 86% reported they avoided physical or social activities and between 2% and 61% said they missed school or work due to menstruation (see Figure 7 below).

38 Chandra-Mouli, Venkatraman, and Sheila Vipul Patel. "Mapping the knowledge and understanding of menarche, menstrual hygiene and menstrual health among adolescent girls in low-and middle-income countries." *Reproductive health* 14.1 (2017): 30.

Figure 7. Impact of menstruation on participation in daily life³⁹
Table 6 Social impacts of menstruation

First author, Year	Country	Setting	School status	N	Avoid physical or social activities ^a (%)	Abstain from religious activities (%)	Miss school or work (%)
East Africa							
Zegeye 2009 [21] ^b	Ethiopia	Mix	School-going	407	NR	NR	48.2%
Boosey 2014 [16]	Uganda	Rural	School-going	140	NR	NR	61.7% (of 133)
North Africa							
Abd El-Hameed 2011 [44]	Egypt	Mix	School-going	160	54	NR	NR
West Africa							
Adinma 2009 [26]	Nigeria	Urban	School-going	550	NR	NR	4.5%
Ajah 2015 [42]	Nigeria	Urban	School-going	482	NR	NR	12.2%
Aniebue 2009 [40]	Nigeria	Urban	School-going	495	37.6%	NR	20%
Oche 2012 [14]	Nigeria	Urban	School-going	122	4.9%	43.4%	NR
South America							
Pitangui 2013 [58] ^b	Brazil	Urban	School-going	127	NR	NR	30.7%
South Asia							
Dambhare 2012 [32] ^b	India	Mix	School-going	561	NR	NR	13.9%
Juyal 2013 [65]	India	Mix	School-going	453	8.6%	87.4%	NR
Thakre 2011 [12]	India	Mix	School-going	387	NR	44.7%	52%
Rana 2015 [63]	India	Rural	Mix	400	28.0%	53.2%	26.4% ^c
Bodat 2013 [67]	India	Rural	School-going	622	NR	NR	43.2%
Dasgupta 2008 [8]	India	Rural	School-going	136	36.3%	60.0%	13.8%
Kanotra 2013 [92] ^b	India	Rural	School-going	59	76.6%	NR	NR
Mudey 2010 [34]	India	Rural	School-going	300	NR	87.0%	NR
Shanbhag 2012 [10]	India	Rural	School-going	329	NR	94.2%	NR
Sudeshna 2012 [15]	India	Rural	School-going	190	NR	75.8%	37.9%
Chaudhuri 2012 [60] ^b	India	Unclear	School-going	128	53.5%	NR	25.8%
Sharma 2008 [64]	India	Urban	Mix	156	25.6%	NR	17.2% (of 116) ^c
Goel 2011 [9]	India	Urban	School-going	478	42.7%	76.2%	14.0%
Sharma 2003 [25]	Nepal	Urban	School-going	67	20.0%	NR	NR
Yasmin 2013 [13]	India	Urban	School-going	147	18.4%	90.5%	NR
Bobhate 2011 [7]	India	Urban	Unclear	241	24.1%	90.0%	NR
Ali 2010 [6]	Pakistan	Urban	Government school	425	67.3%	NR	NR
Ali 2010 [6]	Pakistan	Urban	Out-of-school	425	58.1%	NR	NR
Ali 2010 [6]	Pakistan	Urban	Private school	425	58.1%	NR	NR
Southeast Asia							
Lee 2006 [37]	Malaysia	Mix	School-going	2247	NR	NR	7.0%
Wong 2011 [47] ^b	Malaysia	Rural	School-going	984	58.6%	NR	18.1%
Wong 2010 [78] ^b	Malaysia	Urban	School-going	801	50.2%	NR	NR
Wong 2011 [48]	Malaysia	Urban	School-going	1076	61.5%	NR	NR
West Asia							
Poureslami 2002 [79]	Iran	Urban	School-going	250	33.0%	NR	15.2%
Santina 2012 [59]	Lebanon	Urban	School-going	389	NR	NR	41.4%

^aAvoid or reduce physical activities (including playing and sports) or social activities (including functions and friendships with males)

^bAmong girls with dysmenorrhea

^cAmong school-going girls

Moreover, these figures do not capture lack of access to MHH in HICs, which may take a different form. For instance, [women in prison](#) in HICs have been shown to lack access to MHM,⁴⁰ [face menstrual stigma](#),⁴¹ and, in some cases, [lack access to running water](#) that facilitates handwashing.⁴²

39 Chandra-Mouli, Venkatraman, and Sheila Vipul Patel. "Mapping the knowledge and understanding of menarche, menstrual hygiene and menstrual health among adolescent girls in low- and middle-income countries." *Reproductive health* 14.1 (2017): 30.

40 Michaels S, [Getting Your Period in Prison Is Hell. These Numbers Prove It](#), Mother Jones, 3 May 2019.

41 WHO, [Tackling the taboo of menstrual hygiene in the European Region](#), 8 November 2018.

42 Stead Sellers F, [It's almost 2020, and 2 million Americans still don't have running water, according to new report](#), Washington Post, 11 December 2019.

3.3.6 A CLOSER LOOK AT DATA UNCERTAINTIES

Experts we spoke to highlighted the lack of high-quality data on complete MHH access as one of the key challenges that advocates, researchers, and practitioners in the field face. The lack of research and data around menstruation highlights that the issue has been neglected for decades. Policymakers and funders are swayed by data when setting priorities and committing funding. Therefore, advocates for MHH programming must try to bring visibility to an invisible issue, without the aid of high-quality quantitative data. However, syntheses of the qualitative evidence around menstrual health suggest that there is a “need for practitioners and policymakers to attend to menstruation to improve the physical and psychological health, educational attainment, and social participation of women and girls.”⁴³

Experts noted that the inclusion of MHH measures was a good first step in developing a solid knowledge base around menstruation. However, the indicators and proxy measures currently available do not provide the comprehensive data needed to conduct more in-depth analyses of lack of MHH worldwide and determine where investment is most urgent. Based on our review of recent publications by major researchers and implementers in MHH and conversations with experts in this field, we are confident that there is a consensus opinion that there is a lack of quantitative evidence around MHH.^{44,45}

In addition, the issue of measurement definitions also poses a challenge for comprehensively assessing the state of MHH worldwide. Researchers, programmers, and advocates are working to develop standardised measures to assess the many facets of MHH. These standardised definitions will improve the field’s ability to conduct comparable research to allow for reliable, quantitative estimates of the prevalence, severity, and consequences of incomplete MHH worldwide. Setting standard definitions will also help define what is encompassed by MHH – be it lack of access to water for washing or experience of menstruation-related stigma.

For low- and middle-income countries, there is a lack of epidemiological data pointing to the age of menarche and menopause (which is needed to accurately quantify the number of people menstruating at any one time in a given context).^{46,47} Moreover, the standard health censuses – such as the Demographic and Health Surveys (funded by USAID) and the Multiple Indicator Cluster Surveys (funded by UNICEF) – that are regularly used to capture baseline data and quantify need for programmes such as malaria, HIV, and family planning, either do not or have only recently begun incorporating ways to capture MHH measures.⁴⁸ Experts believe that the inclusion of MHH-specific questions is a positive step forward for the field. Still, they note that more time is needed to determine what additional questions and framing are required to produce the routine, comprehensive indicators essential for good programming.⁴⁹ Bringing together the limited epidemiological data that do exist in terms of LMICs (usually implemented at a subnational level in a particular country) is also challenging as there has been a lack of standardisation of measures and agreed-upon definitions to measure what, exactly, is meant by MHH or MHM. A 2019 audit of work conducted around MHH found that “measures [to capture MHH] were inconsistent in conceptualisation and operationalisation across studies. Findings suggest that interdisciplinary efforts are needed to better define core constructs such as menstrual and hygiene practices, menstrual knowledge, attitudes, norms and restrictions.”⁵⁰

In HICs, while standard national health surveys capture items such as age at menarche and menopause – making it easier to work out how many people currently menstruate – the invisibility of menstruation worldwide means that large-scale surveys about access to MHH (and indeed, MHM) are not common.⁵¹

43 Hennegan, Julie, et al. “Women’s and girls’ experiences of menstruation in low-and middle-income countries: A systematic review and qualitative metasynthesis.” *PLoS medicine* 16.5 (2019): e1002803.

44 Chandra-Mouli, Venkatraman, et al. “The political, research, programmatic, and social responses to adolescent sexual and reproductive health and rights in the 25 years since the International Conference on Population and Development.” *Journal of Adolescent Health* 65.6 (2019): S16-S40.

45 UNICEF, [Guidance on Menstrual Health and Hygiene](#), March 2019.

46 Chandra-Mouli, Venkatraman, et al. “The political, research, programmatic, and social responses to adolescent sexual and reproductive health and rights in the 25 years since the International Conference on Population and Development.” *Journal of Adolescent Health* 65.6 (2019): S16-S40.

47 UNICEF, [Guidance on Menstrual Health and Hygiene](#), March 2019.

48 UNICEF, [Guidance on Menstrual Health and Hygiene, March 2019, pg. 25](#).

49 The MICS and DHS have incorporated MHH indicators, but experts concur that these measures will likely need to be revisited as understanding of what MHH encompasses involves and more information on how to measure these components is collected.

50 Hennegan, Julie, et al. “Measurement in the study of menstrual health and hygiene: A systematic review and audit.” *Plos one* 15.6 (2020): e0232935.

51 Kuhlmann, Anne Sebert, et al. “Unmet menstrual hygiene needs among low-income women.” *Obstetrics & Gynecology* 133.2 (2019): 238-244.

Moreover, the assumption that all women and girls in HICs achieve complete MHH due to the ubiquity of adequate sanitation facilities and the relatively greater availability of menstrual hygiene products means that this issue has not been studied due to a (most likely mistaken) belief that it is only a problem in LMICs. There is not significant enough data to draw accurate conclusions about access to complete MHH in HICs. While we think it is reasonable to assume that a greater number of people in LMICs lack more components of complete MHH, we think that lack of access to complete MHH under our definition – especially in terms of education, positive experience, and treatment for pain – is also common in HICs.

*The lack of research
and data around
menstruation highlights
that the issue has been
neglected for decades.*



3.4 The State of MHH Across Different Countries

Based on the data available, we believe that a higher proportion of women and girls in LMICs lack access to the sanitation facilities and products necessary for complete MHH than in HICs. Given this, we believe that investments in MHH programming in LMICs should be prioritised.

As described in the previous section, there is a significant lack of quantitative data describing the prevalence and severity of lack of complete MHH worldwide. Because lack of MHH is considered more likely in LICs (due to inadequate sanitation and increased difficulty of accessing commodities of any type due to poverty), much of the focus on measuring lack of MHH has been concentrated in these settings, where the need is presumed to be the greatest. This means that these countries may have more recent and complete data than in HICs, although it is still extremely limited compared to other health issues.⁵²

3.4.1 LOW- AND LOWER-MIDDLE-INCOME COUNTRIES

In general, we believe a lack of complete MHH to be more prevalent in low- and lower-middle-income countries than in HICs, due to a number of factors that tend to be present in low- and lower-middle-income countries, including:

- Broad lack of access to adequate sanitation and hygiene facilities (which contributes to lack of access to menstruation-friendly toilet and washing facilities);
- Lack of access to schooling and therefore access to sexual health education, contributing to lack of knowledge of menstruation;
- High prevalence of poverty, which can make it difficult to afford menstrual hygiene materials;
- Large rural populations and supply chain issues, which means that preferred menstrual hygiene products may not be available where women and girls live;
- Increased difficulty of reaching vulnerable populations, such as women and girls with disabilities.

In addition to these factors, women and girls in these countries are also subject to menstrual stigma, which we believe to be globally prevalent.

While we believe that incomplete MHH is more prevalent in lower-income countries, there is considerable energy by a number of LMICs governments to address menstrual health issues – from affordability of products to tackling stigma. For instance, Kenya was the [first nation](#) to abolish the so-called ‘tampon tax’,⁵³ which refers to sales tax or VAT being applied to menstrual products and to commit to distribute [free menstrual products](#) to girls in schools.⁵⁴ And Tanzania has established a national MHH working group, composed of high-level stakeholders from government, implementing partners, and civil society to shape MHH policy. In 2018, the Tanzanian government eliminated VAT on sanitary products.⁵⁵ While many governments in lower-income countries are actively working to increase MHH, one issue that must be contended with is the frequently limited budgets they have to work with, which could potentially curtail progress and access (including choice) to safe, quality menstrual products.

Another challenge that lower-income countries must contend with is providing for women and girls who are refugees or internally displaced. Women and girls who are refugees, displaced, or migrants are at high risk of lacking complete MHH due to living in temporary conditions, having limited ability to purchase or access products, and disruptions to schooling. As the majority of displaced people are

⁵² While we believe that data on MHH in high-income countries is very limited, one note of caution to this conclusion is that we may be missing items not published or translated into English.

⁵³ No author, “[Kenya’s schoolgirls to get free sanitary pads from government](#),” BBC News, 22 June 2017.

⁵⁴ Salam M, [Goodbye, Tampon Tax \(at Least for Some\)](#), New York Times, 9 November 2018.

⁵⁵ UNICEF, [Guidance on Menstrual Health and Hygiene](#), March 2019.

currently staying in lower-income countries worldwide, this population faces many challenges.⁵⁶

3.4.2 UPPER-MIDDLE- AND HIGH-INCOME COUNTRIES

We currently believe that access to complete MHH is relatively high in HICs, with the most prominent issues likely being stigma (which we believe to be prevalent worldwide), lack of menstrual education, and lack of access to treatment for pain. We also think that low-income women and girls and people who are incarcerated may struggle to access preferred menstrual hygiene products. We have also found limited data on access to MHH in HICs, with most information coming from small-scale or marketing surveys.

Although access to sanitation facilities, products, and healthcare is likely to be much higher in HICs, evidence from surveys in the US and the UK suggests that low-income women and girls may still struggle to afford sufficient menstrual materials.^{57,58} Research commissioned by the Kulczyk Foundation found that every fifth Polish woman sometimes cannot afford to buy appropriate sanitary products.⁵⁹ This is likely to be true in other HICs with high rates of poverty or income inequality. In the UK, 10% of girls in a non-representative survey reported they were unable to afford menstrual management products and 1 in 5 said that they were using non-preferred products due to cost concerns.⁶⁰

Moreover, adequate knowledge of menstruation may be limited due to a lack of quality sexual and reproductive health education or stigma that prevents sharing of information in HICs. Prevalence of lack of adequate information likely varies between different countries and different populations. For instance, Denmark has mandated sexuality education for all pupils, which suggests at least some exposure to menstrual knowledge among girls and women.⁶¹ According to a non-representative marketing survey conducted by Clue, 93% of Danish women report having received sufficient information about their period before they started menstruating.⁶² However, in Poland, while sexuality education was mandated in 1993, an [advocacy group's review](#) of the curriculum found that while puberty is highlighted, material may be incomplete.⁶³ Moreover, due to [separate complaints about comprehensive sexuality education](#) in Poland, there has been a concerted push to reduce or remove it from schools.⁶⁴ Research commissioned by the Kulczyk Foundation found that 35% of adolescent girls in Poland that were surveyed reported not having discussed menstruation until after menarche^{65,66} A non-representative survey conducted by Plan UK among girls 13-21 found that a quarter of girls surveyed reported not knowing what to do when they started their periods and that half of girls felt embarrassed by menstruation.⁶⁷

According to Joint Monitoring Programme data, the vast majority of HICs report having near-universal coverage of adequate sanitation and handwashing facilities in homes and in schools.⁶⁸ However, lack of a positive enabling environment may still contribute to making these hygiene facilities unfriendly for menstruation. Qualitative research commissioned by the Kulczyk Foundation found that students reported that school toilets often lacked privacy and adequate disposal facilities, meaning they struggled to change and dispose of menstrual materials without feeling anxiety or shame.⁶⁹

56 Huang C and Graham J, [Where Do Internally Displaced People Live and What Does that Mean for Their Economic Integration?](#), Center for Global Development, 10 May 2019.

57 Kuhlmann, Anne Sebert, et al. "Unmet menstrual hygiene needs among low-income women." *Obstetrics & Gynecology* 133.2 (2019): 238-244.

58 Plan International UK, [Plan International UK's Research on Period Poverty and Stigma](#), 20 December 2017.

59 Difference Market Research, *Menstruation: Report on Quantitative and Qualitative Research Conducted on Behalf of the Kulczyk Foundation*, February 2020.

60 Tingle C and Vora S, [Break the Barriers: Girls' Experiences of Menstruation in the UK](#), Plan International UK, January 2018, pg. 46.

61 Directorate-General for Internal Policies, [Policies for Sexuality Education in the European Union](#), 2013.

62 Austin-Evelyn K, [Blood, Sweat, and Tears: How Menstruation Holds Women and Girls Back](#), 3 March 2016.

63 Grupa Ponton, [Sex Education in Poland](#), no date.

64 Amnesty International, [Poland: Law criminalizing sexuality education "recklessly retrogressive"](#), 16 October 2019.

65 Menarche refers to the first instance of menstruation

66 Difference Market Research, *Menstruation: Report on Quantitative and Qualitative Research Conducted on Behalf of the Kulczyk Foundation*, February 2020.

67 Tingle C and Vora S, [Break the Barriers: Girls' Experiences of Menstruation in the UK](#), Plan International UK, January 2018, pg. 11.

68 WHO and UNICEF, [JMP Global Database](#), accessed May 2020.

69 Difference Market Research, *Menstruation: Report on Quantitative and Qualitative Research Conducted on Behalf of the Kulczyk Foundation*, February 2020.

We believe that stigma also negatively impacts the experience of menstruation for girls and women in high-income countries. For instance, Sweden has been the [highest](#) ranked country in the EU on the Gender Equality Index, which includes measures across a broad range of domains.⁷⁰ However, there is still stigma around the issue of menstruation, specifically in the workplace. This was highlighted by a recent online survey which asked 800 participants about their experiences at work. Although 96% of respondents said they currently or previously experienced issues related to menstruation, and 58% admitted menstruation affected their work, only 25% said they were able to rest when necessary during a regular working day.⁷¹ Research commissioned by the Kulczyk Foundation found that 27% of Polish women surveyed said they felt they could not do many things they would normally do when they were menstruating.⁷²

Another area of policy we have assessed is the rate of tax on menstrual hygiene products - the so-called 'tampon tax' - which have been called a form of "gender discrimination" as menstrual management products are essential goods.⁷³ Denmark still levies a 25% VAT on menstrual products, the same rate as for luxury goods.⁷⁴ In the UK, campaigns to bring attention to incomplete MHH have achieved some success. For instance, in [February 2020](#), Scotland passed legislation aiming to make disposable menstrual products free to everyone who needs them.⁷⁵ While these policy changes are positive in that they are raising awareness of incomplete MHH, one expert we spoke to cautioned that it would be important for these changes to be tied to evaluation, so that a portfolio of effective policy changes can be developed.

70 European Institute for Gender Equality, [Gender Equality Index 2019: Sweden](#), 7 October 2019.

71 Equal Times, [It's time to bring menstrual awareness to workplaces](#)

72 Difference Market Research, Menstruation: Report on Quantitative and Qualitative Research Conducted on Behalf of the Kulczyk Foundation, February 2020.

73 Crawford, Bridget J., and Carla Spivack. "Tampon Taxes, Discrimination, and Human Rights." *Wis. L. Rev.* (2017): 491.

74 Schmidt N and McKenzie S, [Tampons will no longer be taxed as luxury items, after landmark German vote](#), CNN, 8 November 2019.

75 Yeginsu C, [Scotland Set to Be First Country to Provide Free Pads and Tampons](#), New York Times, 27 February 2020.



There is a significant lack of quantitative data describing the prevalence and severity of lack of complete MHH worldwide.

3.5 What are the harms caused by lack of access to MHH?

One complicating issue regarding growing the MHH evidence base is the fact that there is a lack of high-quality quantitative evidence conclusively linking lack of MHH (and specific aspects of MHH) to concrete and generalisable harms experienced by women and girls. This means we cannot make good estimates about the type, severity, and prevalence of the harms experienced by girls and women worldwide, nor can we determine which specific aspects of MHH are the best to focus on in order to alleviate these harms.

In general, it is well understood in the field that there is a shortfall of high-quality evidence linking lack of MHH to harms experienced by women and girls. Experts we spoke to emphasised that research around harms was critical to building support for MHH.

Some evidence suggests that the following harms may be caused by a lack of access to adequate MHH:

- **Health harms** - urogenital and reproductive tract infections, untreated pain or irregular bleeding, and discomfort or irritation.
- **Psychosocial harms** - stigma and feelings of shame and fear, inability to participate in familial and cultural life, and pressure to enter unsafe environments to obtain menstrual products.
- **Educational harms** - absenteeism and dropping out of school.
- **Economic harms** - a lack of ability to participate in the workplace.

The rest of this section describes these harms and any existing evidence in more depth.

3.5.1 HEALTH HARMS FROM LACK OF MHH

Urogenital and reproductive tract infections related to lack of adequate MHH

There is some evidence that lack of access to MHM may be linked to urogenital and reproductive tract infections in girls and women, however, this evidence is “weak and contradictory” according to a meta-analysis of studies on the issue.⁷⁶ Of the eleven studies included in the initial review, seven found an association between reproductive tract infections and “worse MHM” (the measure of “worse” was inconsistent across studies which makes comparison difficult) with odds ratios (the strength of association) of increased risk of infection and inadequate MHM ranging from 1.34 to 25.07. Three of the studies found no association and one resulted in a statistically significant increase of infections among the intervention group with “better MHM.”⁷⁷ When the authors of this meta-analysis calculated a pooled odds ratio of the higher quality studies in this analysis (n=5), they found no association between risk of infection and “worse MHM” (pooled OR = 1.07). The authors concluded that “the methodological shortcomings mean that we cannot draw strong conclusions regarding [the link between MHM and reproductive tract infections]. More research, and specifically more methodologically consistent research, is required in the area of RTI and MHM.”⁷⁸

The hypothesised pathway for infection would be inadequately cleaned, changed, or dried menstrual hygiene materials, which could change the bacterial flora of the urogenital region and lead to infections such as urinary tract infections and bacterial vaginosis. This is an urgent area for further research as things like bacterial vaginosis have been hypothesised to reduce the immune defences of the genital region and make women and girls more susceptible to sexually transmitted infections like

76 Sumpter, Colin, and Belen Torondel. “A systematic review of the health and social effects of menstrual hygiene management.” *PLoS one* 8.4 (2013): e62004.

77 Sumpter, Colin, and Belen Torondel. “A systematic review of the health and social effects of menstrual hygiene management.” *PLoS one* 8.4 (2013): e62004.

78 Sumpter, Colin, and Belen Torondel. “A systematic review of the health and social effects of menstrual hygiene management.” *PLoS one* 8.4 (2013): e62004.

HIV.⁷⁹ However, this research requires significantly more investment and careful study, due to the high probability of confounders.

Untreated pain or irregular bleeding due to lack of menstrual knowledge

Lack of access to adequate MHH, including knowledge of what symptoms could be considered abnormal or ability to access medical care, can lead to women and girls dealing with dysmenorrhea – menstrual cramping and pain – without treatment or access to care. A review of dysmenorrhea prevalence studies in most HICs found that between 2% and 29% of respondents reported experiencing severe pain.⁸⁰ For women and girls living in settings where they do not know this is not normal, what types of treatment are effective in managing cramps, or do not have the ability to access or afford treatment, this could lead to untreated and unmanaged pain. A review of MHH practices of adolescents in LMICs found that “consultation of health professionals for menstrual-related problems was minimal, generally reported by less than a fifth of girls.”⁸¹

Lack of knowledge about what might be considered ‘normal’ bleeding and/or shame about seeking medical care could also prevent women and girls from getting treatment for potential symptoms of progressive diseases, such as endometriosis or reproductive cancers that may result in pain or irregular bleeding.⁸²

Discomfort or irritation related to lack of MHH

For women and girls who cannot afford or do not have access to adequate menstrual hygiene materials or washing facilities, this may lead to dampness or improper fit, leading to skin irritation or rashes and discomfort with movement.

In addition, as menstrual products are not subject to regulation in many countries, they might contain additives or manufacturing defects contributing to certain problems. These could include carcinogens in products or additives like fragrances. While menstruation is a huge business, large-scale manufacturers of menstrual products mostly produce disposable pads and tampons (which are generally confined to HICs). This means both choice and economies of scale for products such as menstrual cups and underwear with built-in menstrual pads are limited in their reach and affordability.

3.5.2 PSYCHOSOCIAL HARMS FROM LACK OF MHH

Experience of stigma and feelings of fear or shame

Women, girls, transgender men, and gender non-conforming individuals may all feel stigma about menstruation which can negatively impact life satisfaction and ability to complete daily activities. People may experience extensive feelings of anxiety during their periods, related to attempting to hide or manage menstruation. This experience of stigma may be connected to societal norms and interpersonal and personal beliefs and attitudes that frame menstruation as a shameful or negative event. Studies have attempted to demonstrate this link by implementing interventions related to increasing knowledge and feelings of empowerment around menstruation to decrease negative attitudes towards menstruation. For instance, one study conducted in Iran among 19-25-year-old women found that a peer- and health-provider-led education curriculum reduced self-reported attitude scales of “menstruation as debilitating” by 1.26 points and “menstruation as bothersome” by 0.40 points.⁸³

Lack of ability to participate in familial and cultural life during menstruation

As indicated in Figure 7, some studies have reported that menstruation has a significant impact on girls’ ability (or perceived ability) to conduct their normal activities.

79 Centers for Disease Control and Prevention (CDC), [Bacterial Vaginosis](#), 10 February 2020.

80 Ju, Hong, Mark Jones, and Gita Mishra. “The prevalence and risk factors of dysmenorrhea.” *Epidemiologic reviews* 36.1 (2014): 104-113.

81 Chandra-Mouli, Venkatraman, and Sheila Vipul Patel. “Mapping the knowledge and understanding of menarche, menstrual hygiene and menstrual health among adolescent girls in low- and middle-income countries.” *Reproductive health* 14.1 (2017): 30.

82 Punzi MC and Hekster O, [Technical brief for the Integration of Menstrual Health in SRHR](#), 2019.

83 Abedian, Zahra, Maryam Kaborian, and Seyed Reza Mazlom. “The effects of peer education on health behaviors in girls with dysmenorrhea.” *Journal of American science* 7 (2011).

In some areas, menstruation is seen as unclean and women and girls may be barred from participating in normal family life or be barred from important cultural activities. For instance, in some parts of India and Nepal, women report being confined to [sheds or outbuildings for the duration of their periods](#).⁸⁴ However, this happens in all countries across the world and should not be seen as being confined to LMICs. For instance, in the United States, the [Latter Day Saints church](#) was barring menstruating girls and women from participating in certain church services, only changing policy after it was publicised in 2012.⁸⁵

Pressure to comply in unsafe situations to obtain menstrual products

Some literature has documented cases of girls who cannot afford menstruation products engaging in transactional sex in order to obtain adequate menstrual management materials.^{86,87}

3.5.3 EDUCATIONAL HARMS FROM LACK OF MHH

Absenteeism

The hypothesised pathway between lack of MHH and absenteeism is that girls who lack what they need for adequate MHH may miss school when menstruating. This could be related to one or many of the following factors:

- Fear of being discovered as menstruating at school lacking menstrual products to collect blood for the entire period of menstruation and staying home in order to prevent leaking at school
- Schools may lack sufficient toilets and/or hygiene spaces to manage changing and disposing of menstrual products in privacy, so girls stay home in order to avoid embarrassment
- Girls may experience painful cramps or heavy bleeding and feel unable to concentrate or manage those symptoms while at school.

Several studies document conflicting results about whether lack of MHH leads to girls not attending school. Thorton and Oster found that lack of access to menstrual products in Nepal was associated with a slight increase in missing school and that providing menstrual products did not address this absenteeism.⁸⁸ However, a more recent study conducted in Kenya, which used a more robust measure of attendance, found that menstruation was significantly linked to missing school and that providing menstrual pads reduced this absenteeism by 5.4%.⁸⁹

Given that education is positively linked to economic empowerment and security, more conclusive research that covers a broader range of areas is needed as this component of menstrual hygiene must be urgently addressed.

Dropping out of school

It has been suggested that the factors described above are linked to permanent drop-out from school. This needs to be studied as it represents an even more urgent reduction in girls and women's ability to achieve economic empowerment via education.

84 Vaughn E, [Menstrual Huts Are Illegal In Nepal. So Why Are Women Still Dying In Them?](#), NPR, 17 December 2019.

85 Stack PF, [Menstruating Mormons barred from temple proxy baptisms?](#), Salt Lake Tribune, 5 March 2012.

86 Oppenheim M, [Kenyan girls forced into sex in exchange for sanitary products](#), The Independent, 15 September 2018.

87 Phillips-Howard, Penelope A., et al. "Menstrual needs and associations with sexual and reproductive risks in rural Kenyan females: a cross-sectional behavioral survey linked with HIV prevalence." *Journal of women's health* 24.10 (2015): 801-811.

88 Oster, Emily, and Rebecca Thornton. "Menstruation, sanitary products, and school attendance: Evidence from a randomized evaluation." *American Economic Journal: Applied Economics* 3.1 (2011): 91-100.

89 Benschaul-Tolonen, Anja, et al. "Pupil Absenteeism, Measurement, and Menstruation: Evidence from Kenya." (2019).

3.5.4 ECONOMIC HARMS FROM LACK OF MHH

Lack of ability to participate in the workplace

Women who work may experience the same problems as girls attending school, fearing that they cannot manage their periods given the products they have on hand and the toilet facilities or breaks available to them in their workplaces. This can impact women's ability to earn enough money to support themselves and their families, as well as affect their opportunity to advance in hierarchical workplaces.

One qualitative study in Pakistan conducted among female factory workers found that women reported missing up to three days of work each month due to menstruation.⁹⁰ Another recent study used PMA2020 data from Burkina Faso to test if there is a difference in self-reported absenteeism from work due to menstruation between women who use disposable pads and those who use old cloth. After matching pairs of women using propensity scores, the authors found that use of disposal pads reduced the "probability to miss days working due to their menstrual period by about 21 percentage points." After dividing women by religion, this figure remained significant for Muslim women but not women identifying as Christian.⁹¹

90 Hennegan, Julie M. "Menstrual hygiene management and human rights: the case for an evidence-based approach." *Women's Reproductive Health* 4.3 (2017): 212-231.

91 Krenz, Astrid, and Holger Strulik. "Menstruation hygiene management and work attendance in a developing country." *CEGE Discussion Papers, Number* (2019).

3.6 Why don't we know more about the impacts of lack of access to MHH?

As the previous sections have demonstrated, there is a significant lack of quantitative evidence about the prevalence of incomplete MHH, high-quality national data about what components of MHH are incomplete, the populations most impacted by lack of MHH, and the associated harms.

The main concrete harms that have been hypothesised are based on formative and qualitative research, many conducted in specific locations, which are not necessarily generalisable. Experts in the area point to a mutually reinforcing situation in which the lack of evidence contributes to under-funding and under-recognition of the problem, which in turn means that new research is not generated. As several experts put it in a position paper on what is needed to advance MHH for adolescents in LMICs:

“Ultimately, while great advances have been made in the MHH research evidence base to date, there remain a number of important gaps in our collective knowledge. Filling these gaps will require new research studies that use an expanded range of methodologies, that enable the global community to better understand the magnitude of the problem surrounding MHH for adolescent girls (in and out of school), the impact of MHH interventions, and the costs incurred to implement them effectively. Without broadening the existing evidence-based knowledge, opportunities to improve an essential component of adolescent lives will remain limited.”⁹²

Leading researchers in the field emphasise that getting good-quality trials of these potential harms is essential to building the field. As the latest guidance on implementing MHH programmes from UNICEF phrases it:

“Many studies have described how menstruation and a lack of an ability for girls to control MHH impact girls’ dignity, wellbeing, and engagement, particularly in a school setting. But while MHH interventions have been designed and implemented in many countries, studies have yet to confirm the effectiveness of these interventions on education and health outcomes for girls. In 2016, a review of the evidence on the effect of MHH on health, development and empowerment outcomes found the evidence base to be ‘scant, not statistically significant, and largely inconclusive’, citing a combination of small sample sizes and an over-reliance on self-reported or anecdotal data.”⁹³

Other researchers go so far as to say that the lack of evidence-based programming and ongoing research around MHH is a violation of the rights of women and girls:

“It is imperative that we take an evidence-based approach in order to do no harm and to act as swiftly, effectively, and efficiently as possible to address the threat that poor MHH presents to human rights. Many significant gaps were noted in the available research...To attract attention commensurate with the size of the threat that poor MHH poses to women’s dignity and human rights, it is essential that researchers in this field build a strong and considered evidence base. We must conduct and report studies comparable with the level of rigor in more established areas of global public health. The research community has a responsibility to substantiate claims of human rights violations and to push for interventions with evaluations that stand up to scrutiny. Funding bodies, advocates, policy makers, researchers, and agents in the field have an ethical imperative to invest in MHH and to ensure that resources are not wasted on ineffective or harmful interventions.”⁹⁴

While the MHH field has grown, there is still a lack of evidence to guide impactful and targeted programming. In assessing how to donate most impactfully to improve MHH worldwide – and especially for those who need it most – we are swayed by the conclusions of some of the leading researchers in the field. They advocate for more robust research into both the epidemiology and the interventions that could improve MHH. This research would create a solid evidence base that can lead to scalable, effective, and cost-effective programming. This includes focusing on programming that is designed to address multiple factors at different levels within the socioecological framework of MHH ([see section 3.1.2](#)).

92 Phillips-Howard, Penelope A., et al. “Menstrual hygiene management among adolescent schoolgirls in low-and middle-income countries: research priorities.” *Global health action* 9.1 (2016): 33032.

93 UNICEF. [Guidance on Menstrual Health and Hygiene](#). Published March 2019. Accessed April 1, 2020, pg. 75.

94 Hennegan, Julie M. “Menstrual hygiene management and human rights: the case for an evidence-based approach.” *Women’s Reproductive Health* 4.3 (2017): 212–231.



4. Interventions to Improve Menstrual Health and Hygiene Worldwide

In this section, we will outline the broad types of interventions to improve MHH that have been developed and implemented.

MHH programming may operate at many different levels of the socioecological framework and many of the programmes listed below are implemented together to address multiple reasons for incomplete MHH. For instance, work to improve access to washing facilities for women and girls who are menstruating may involve carrying out all of the following activities together:

- Working with government ministries to integrate recommendations into country-wide programming
- Working with implementing partners to build and maintain washing facilities
- Working with educators to integrate knowledge about these facilities into the curriculum at the government level and then into teacher training.

These programmes may also be integrated into existing programmes, rather than implemented as standalone interventions. For instance, “a well-designed MHH intervention could be added to existing successful programmes in WASH in schools, skills development, sexual and reproductive health and rights, adolescent nutrition, or adolescent participation.”⁹⁵ While experts we spoke to emphasised that MHH should be a priority and seen as a health issue in its own right; the opportunity to scale MHH programmes by incorporating them into larger projects that are being implemented and/or supported by governments is a valuable opportunity to reach more girls and women.

As has been detailed above, MHH is a growing field and the evidence base is still developing. Therefore, it would be premature to choose any one intervention as the best means for improving access to complete MHH worldwide. Rather, we think that a strategy to fund productive MHH programming can take the following general approach:

Identify programmes that:

95 UNICEF. [Guidance on Menstrual Health and Hygiene](#). Published March 2019. Accessed April 1, 2020, pg. 39.

- Use existing research (qualitative and quantitative) to develop programmes that target MHH gaps found using routine surveillance data or formative research (e.g. Use existing research to develop a WASH intervention for girls in a country where access to toilets and washing facilities are known to be very low, based on routine data from MICS.)
- Test these programmes through rigorous research and validated measures to better understand the harms of lack of access complete MHH, the cost of these programmes, and to tweak programme design to improve effectiveness.
- Aim to integrate MHH into broader programmes of work and sensitise governments, communities, and funders to the need for improved MHH.

As the below sections demonstrate, there are many thoughtful programmes currently being designed and implemented. Meanwhile, advocates are working to bring governments and other influencers on board the MHH agenda, and researchers are currently working to improve measurement for MHH. It seems likely that with appropriate investment, design, and testing of these strategies, the field is progressing towards identifying high-impact interventions that can be translated across different settings.

4.1 Direct Interventions

MHH interventions are often offered as a package to address multiple challenges that women and girls face in terms of being able to achieve complete MHH. In addition, interventions may be implemented at points along the socioecological framework that do not directly impact women and girls who lack complete MHH. In this section, we will lay out the types of interventions that have been designed and implemented to directly serve women and girls who lack at least one component of complete MHH.

4.1.1 PRODUCT DEVELOPMENT AND DISTRIBUTION

The development and distribution of menstrual hygiene materials is a bedrock of MHH programming. As everyone who menstruates needs materials to manage menstrual blood, this intervention is relevant across all geographies and groups. Product development and distribution is useful for anyone who is not well served by current products (due to discomfort or poor performance), anyone who cannot access preferred products (due to lack of physical availability), and anyone who cannot afford preferred products (due to lack of funds). Those who experience multiple challenges (experiencing more than one challenge with performance, availability, and affordability) are in particular need of product development and distribution interventions. These populations include people who are incarcerated, people living in poverty in rural areas, and people in humanitarian settings.

Product distribution includes any intervention that distributes familiar products or introduces new products. This is an effective means of meeting people's immediate need for menstrual hygiene materials. There may be additional positive outcomes of meeting the product needs of women and girls, such as increasing attendance to school or work and reducing shame or fear of leakage or odours, as documented in a synthesis of the qualitative literature on the topic.⁹⁶ One study found that the ability of product-focused interventions to reduce absenteeism among in-school girls is one of the most widely studied interventions for MHH. There have been conflicting results from RCTs about whether product-focused interventions improve school attendance,⁹⁷ but recent studies have continued to find associations between menstrual product distribution and a reduction in absenteeism.⁹⁸ There are at least two additional RCTs that are currently awaiting results testing this issue. One recent study found a correlation between distribution of reusable menstrual products and a reduced prevalence of STIs.⁹⁹ A recent review of qualitative components of intervention studies found that interventions that involve product distribution led to "changed perceptions of the level of comfort a menstrual material should provide and what one should be able to do while wearing it"¹⁰⁰ among women and adolescents. Another qualitative study found "those receiving reusable pads experienced improvements in comfort and reliability. This translated into reduced fears around garment soiling and related school absenteeism"¹⁰¹.

Product-focused interventions are supported by all types of funders currently involved in MHH programming. As discussed above, governments are supporting product distribution in schools and bilateral funding organisations like Global Affairs Canada and independent funders like the Bill & Melinda Gates Foundation are supporting innovative new product development.

- 96 Shannon, Alexandra K., G. J. Melendez-Torres, and Julie Hennegan. "How do women and girls experience menstrual health interventions in low-and middle-income countries? insights from a systematic review and qualitative metasynthesis." *Culture, Health & Sexuality* (2020): 1-20.
- 97 Hennegan, Julie, and Paul Montgomery. "Do menstrual hygiene management interventions improve education and psychosocial outcomes for women and girls in low and middle income countries? A systematic review." *PLoS one* 11.2 (2016): e0146985.
- 98 Benschaul-Tolonen, Anja, et al. "Pupil absenteeism, measurement, and menstruation: Evidence from western Kenya." *CDEP-CGEG WP 74* (2019).
- 99 "Provision of menstrual cups and sanitary pads for ~1 school-year was associated with a lower STI risk, and cups with a lower bacterial vaginosis risk, but there was no association with school dropout. A large-scale trial on menstrual cups is warranted." From Phillips-Howard, Penelope A., et al. "Menstrual cups and sanitary pads to reduce school attrition, and sexually transmitted and reproductive tract infections: a cluster randomised controlled feasibility study in rural western Kenya." *BMJ open* 6.11 (2016).
- 100 "In response to both product and information-focused interventions, women and adolescents in high and medium trustworthiness studies consistently expressed a change in expectations for their menstruation, and this theme was also evident in two low trustworthiness studies. This included changed perceptions of the level of comfort a menstrual material should provide and what one should be able to do while wearing it. It also included new expectations about what menstrual information should be discussed with others." from Shannon, Alexandra K., G. J. Melendez-Torres, and Julie Hennegan. "How do women and girls experience menstrual health interventions in low- and middle-income countries? insights from a systematic review and qualitative metasynthesis." *Culture, Health & Sexuality* (2020): 1-20.
- 101 Hennegan, Julie, et al. "A qualitative understanding of the effects of reusable sanitary pads and puberty education: implications for future research and practice." *Reproductive health* 14.1 (2017): 78.

Meanwhile, The Case For Her is investing in market-based interventions, and corporate social responsibility¹⁰² contributes both funding and products to support these interventions.

Both the experts we interviewed and the policy guidance we reviewed in the course of this report emphasised that product distribution interventions must be well-designed and should be combined with other MHH interventions to ensure uptake, impact, and sustainability. For instance, to ensure uptake of disposable pads, women and girls may need to be provided with suitable undergarments¹⁰³ and information about how and when to change and dispose of the pad. To ensure impact, a product-based intervention must also identify what other changes are necessary to provide complete MHH. For instance, if in-school girls are provided with disposable pads as a way of attempting to reduce absenteeism, they also need to be educated about how to use them and given a safe and appropriate place to change them while at school. Otherwise, they may not use the pads and thereby no impact of the intervention will be seen.¹⁰⁴ Sustainability also must be considered.

As women and girls need menstrual products on a (roughly) monthly basis, programmes must ensure that products are routinely affordable and available.¹⁰⁵ Reusable menstrual products (such as cups or reusable pads) last longer without replacement, but tend to have higher upfront costs and require education about their usage. Disposable technologies (such as tampons or disposable pads) must be made available every month in order to ensure women and girls are able to maintain any gains in access to complete menstrual hygiene.

Product interventions must also be rooted in formative research to ensure that the products provided either meet the existing needs and wants of women and girls in the community or there is adequate education and sensitisation to allow them to feel confident in how to use the products correctly and comfortably. As several experts described, this can be a challenge in some settings – particularly emergency or humanitarian settings – where many people are brought together who may have different norms around preferred products.

Formative research not only guides the development of appropriate interventions to distribute menstrual materials, but also works to develop and popularise new or improved menstrual products that might better meet the needs of women and girls in different settings. This is an area of interest for private philanthropic donors such as the Bill and Melinda Gates Foundation¹⁰⁶ and The Case for Her.¹⁰⁷

Menstrual product development¹⁰⁸ and improvement is also a focus of a slate of organisations working in the MHH space. For instance, social enterprises such as Afripads and Days for Girls have focused on continuously iterating their products to make sure they are meeting the needs of their customers.

102 Some experts noted that corporate social responsibility funds or in-kind donations require navigating the tension between the need for funding or products to adequately serve women and girls lacking complete MHH and also the parallel goal of corporations to build market share. This must be navigated for in-kind product donation in particular if the products cannot be sustainably provided or meet the needs and wants of the women and girls they are supposed to serve.

103 Not accounting for the fact that many women and girls who lack access to complete MHH do not have undergarments with which to secure products like disposable pads was mentioned by more than one expert as an issue that had occurred during implementation of product interventions and was used as an example of why formative research is a necessary component of designing appropriate and effective interventions.

104 “In contrast, women in slums exposed to a programme to support door-to-door sales of sanitary pads which was not paired with education reported more hesitance to adopt new technologies. Participants reported a preference for a more familiar reusable product than the disposable pads promoted, with one participant stating: ‘I don’t know how to use pads, once I tried and it leaked ...’” Shannon, Alexandra K., G. J. Melendez-Torres, and Julie Hennegan. “How do women and girls experience menstrual health interventions in low-and middle-income countries? insights from a systematic review and qualitative metasynthesis.” *Culture, Health & Sexuality* (2020): 1-20.

105 “The UN-OCHA HRP documents published between 2016 and 2018 were retrieved from the UNOCHA Humanitarian Response database. A search strategy for MHM-related products including dignity kits as well as other kits that may or may not contain MHM-related products (i.e., water, sanitation & hygiene (WASH) kits; non-food items (NFI) kits) was employed. Notably, in 2016, 31% of HRP from African countries and 40% of HRP from Asian countries explicitly mentioned dignity kits. In 2017, we found that only 33% of HRP from African and 100% of HRP from Asian countries mentioned dignity kits whereas in 2018, it was 50% of HRP from African and 67% of HRP from Asian countries. There was also a temporal and spatial variation in the number of countries that mentioned MHM-related terms including dignity kits. Overall, only a few countries have adopted dignity kits to address women’s unique needs in a humanitarian context, others intend to address this topic through WASH and/or NFI kits, and some do not address MHM at all. The lack of universal policy surrounding the implementation of MHM in a crisis has implications not only for women’s health and dignity, but also for a country’s progress towards the related SDG targets.” Anjum, Zoha, et al. “A synthesis report analyzing menstrual hygiene management within a humanitarian crisis.” *OIDA International Journal of Sustainable Development* 12.05 (2019): 61-72.

106 BMGF recently supported a [Grand Challenges application](#) for developing innovative menstrual products.

107 The Case for Her [supports a portfolio](#) of social enterprises and other innovators in developing and marketing new products.

108 One aspect of product development that was mentioned by experts we interviewed and in the literature is the need for global standards for menstrual products to govern quality and safety of products.

This can include such tweaks as the Days for Girls pad that looks like a washcloth when hung out to dry. This means that girls are able to properly wash and fully dry their pads based on best practices, without the worry that they will be stigmatised if their pad is seen. Other work in this field includes the growing popularity of menstrual cups and menstrual undergarments.¹⁰⁹ The promise of reusable menstrual products (and of environmentally friendly disposable products) is linked to the global conversation about environmental sustainability and waste.

One area of interest for those who are working on and funding product development and distribution is market-based solutions. These solutions and “total market approaches”¹¹⁰ aim to use marketing solutions to ensure that all income levels of a population are able to access the products that they need. This aims to bring together the public, social marketers, and private companies to adequately target all wealth sectors of the population to create sustainable solutions. This has long been used for sexual health products like condoms in an attempt to ensure that reliance on donor subsidies is not the only source of products. The aim of these programmes is to ensure that there are robust and reliable markets for menstrual products worldwide, that do not require reliance on donor subsidies.¹¹¹

4.1.2 EDUCATIONAL INTERVENTIONS

Educational interventions aim to increase knowledge of menstrual health and also shift attitudes and beliefs, particularly among women and girls – but also among men and boys. The goal is to ensure that people who menstruate have the knowledge they need to manage menstruation appropriately and safely, and to recognise when pain or discomfort linked to menstruation may require medical attention. Interventions also aim to break down stigma, shame, and myths surrounding menstruation.^{112,113} Again, as with all MHH interventions, the evidence supporting these interventions is limited and due to the lack of commonly agreed-upon standards, resists being aggregated. However, some evidence does point to menstrual education improving the knowledge, attitudes, and practices of girls.^{114,115,116} Given that lack of knowledge about menstruation is commonly reported globally, the need for educational interventions is present worldwide, and the intensity of the need likely does not correlate neatly with country income level.^{117,118,119}

109 Jones L, [Why are menstrual cups becoming more popular?](#) BBC News, 4 October 2018.

110 MEASURE Evaluation, [Total Market Approach](#), no date.

111 PSI, [Increasing Access to Menstrual Hygiene Management Products in Ethiopia](#), 13 September 2018.

112 “Education interventions reframed menstruation as a natural process and prompted girls to raise menstruation as a topic with parents (Hennegan et al. 2017; Blake et al. 2018), possibly breaking existing communication barriers. These interventions resulted in new expectations around what girls felt was appropriate to share with others. For example, many quotations from Blake et al. (2018) captured girls’ new perspectives that menstruation was normal and should not be kept secret. It [the book] encourages us to tell our family when we see menstruation for the first time. Moreover, it also gives us confidence about our physical growth (Blake et al. 2018, 13). When contrasting education conditions against control and product-only interventions, Hennegan et al. (2017) noted that girls who had received education were freer discussing menstruation and using terms for female anatomy in interviews.” Shannon, Alexandra K., G. J. Melendez-Torres, and Julie Hennegan. “How do women and girls experience menstrual health interventions in low-and middle-income countries? insights from a systematic review and qualitative metasynthesis.” *Culture, Health & Sexuality* (2020): 1-20.

113 Hennegan, Julie, and Paul Montgomery. “Do menstrual hygiene management interventions improve education and psychosocial outcomes for women and girls in low and middle income countries? A systematic review.” *PloS one* 11.2 (2016): e0146985.

114 “The studies were mostly successful in bringing about a change in the menstrual knowledge, attitudes and practices of young girls.” Rastogi, Shreya, Aparna Khanna, and Pulkit Mathur. “Educational interventions to improve menstrual health: approaches and challenges.” *International Journal of Adolescent Medicine and Health* 1.ahead-of-print (2019). pg. 4.

115 “These findings are consistent with other recent studies showing that puberty education programs have a positive effect on girls’ knowledge and attitudes about puberty and menstruation (Afsari et al., 2017; Hennegan, Dolan, Steinfeld, & Montgomery, 2017; Rani, Sheoran, Kumar, & Singh, 2016). Overall, there is promising evidence that educational programs targeting menstrual hygiene improve knowledge and hygienic practices, but may fall short on changing related psychosocial and educational outcomes (Hennegan & Montgomery, 2016; Kuhlmann, Henry, & Wall, 2017). Despite the number and diversity of programs that exist globally, evaluations of puberty programs are rare, especially rigorous evaluations using randomized controlled trials.” Crockett, Lisa J., et al. “Puberty education in a global context: knowledge gaps, opportunities, and implications for policy.” *Journal of Research on Adolescence* 29.1 (2019): 177-195.

116 “Whilst heterogeneous with regard to intervention, context and delivery, software interventions were generally found to improve knowledge of menstruation.[45,46] Menstrual knowledge is hypothesised to improve girls’ MHM and reduce negative psychosocial consequences.[17,28–30] Some supporting evidence for these outcomes was found, with management practices reported to have been improved by education in three studies.[46–48] However, unclear measures and self-report biases mean results should be interpreted with caution. In terms of psychosocial outcomes, more positive attitudes towards menstruation were found for girls who had received education in two studies.” Hennegan, Julie, and Paul Montgomery. “Do menstrual hygiene management interventions improve education and psychosocial outcomes for women and girls in low and middle income countries? A systematic review.” *PloS one* 11.2 (2016): e0146985.

117 Chandra-Mouli, Venkatraman, and Sheila Vipul Patel. “Mapping the knowledge and understanding of menarche, menstrual hygiene and menstrual health among adolescent girls in low-and middle-income countries.” *Reproductive health* 14.1 (2017): 30.

118 Difference Market Research, *Menstruation: Report on Quantitative and Qualitative Research Conducted on Behalf of the Kulczyk Foundation*, February 2020.

119 Coast, Ernestina, Samantha R. Lattof, and Joe Strong. “Puberty and menstruation knowledge among young adolescents in low-and middle-income countries: a scoping review.” *International journal of public health* 64.2 (2019): 293-304.

Education interventions can take many forms. People can be provided with standalone resources like workbooks or comic books that educate girls and boys about puberty. They can be digital, like apps or other online sources. They can be lessons of various duration administered in schools or in other settings.¹²⁰ They can take the form of community initiatives in which religious and cultural leaders bring together community members of all ages to provide information about menstruation.

One aspect of educational interventions is that they are most effective when tailored to cultural norms, delivered in local languages, and constructed in a variety of ways to benefit those with low literacy.¹²¹ For classroom-based or in-person learning, educational interventions require trained facilitators. Depending on the format of these interventions, this could mean specifically trained facilitators coming in to present on these topics or classroom teachers and other educators being trained on MHH so that they are able to provide this education routinely.

Frequently, educational interventions are aimed at adolescents, but experts and guidance flag the need for educational interventions to also be targeted at pre-menarchal children to build comfort with the idea of menstruation and prepare girls for what to do when they do begin to menstruate. Experts also flag that there is a need for education among adults, which both builds knowledge in adults about how to handle their own menstruation (if applicable) but also provides a general knowledge base that can then be shared with peers and younger people.¹²² Qualitative evidence indicates that social support from peers, parents, and communities may positively influence uptake of other types of interventions (like products).¹²³

Education interventions are commonly paired with other types of direct interventions, such as product distribution and WASH interventions. For some women and girls, education can help make up the gap in access to complete MHH, but for others, education must be accompanied with products or safe washing and changing facilities.

One population, which experts drew particular attention to, is the disability community. This group should be considered when thinking about how to design menstrual education programmes and how to use knowledge to build self-efficacy.

As education is almost always a component in some form of MHH interventions, these interventions are funded by all types of actors that support MHH work. However, for education interventions to take place at scale, it is usually necessary to work with governments as one of the most efficient ways of delivering

120 Some qualitative evidence suggests that the form education influences success of the intervention “When introducing new products, the way the information was shared with recipients was important for their trust and acceptance of the technology. Technologies were often introduced in the format of FGDs where girls could digest new information together (Hyttel et al. 2017; Averbach et al. 2009), or with accompanying nurses who could answer questions. (Mason et al. 2015).” From Shannon, Alexandra K., G. J. Melendez-Torres, and Julie Hennegan. “How do women and girls experience menstrual health interventions in low-and middle-income countries? insights from a systematic review and qualitative metasynthesis.” *Culture, Health & Sexuality* (2020): 1-20.

121 UNICEF. Guidance on Menstrual Health and Hygiene. Published March 2019. Accessed April 1, 2020.

122 “Development of teaching and learning materials, working with health and education sectors, is often a key area of work for UNICEF. Where materials do not already exist, UNICEF can work with partners to develop supplementary resources for MHH. Past examples have included puberty or MHH books or comics for girls and boys, that can be used as part of the curriculum, as a self-guided resource, or through extracurricular programmes. The materials developed often include biological facts and address prevalent harmful beliefs and behaviours such as bullying and stigma. In some contexts, self-guided resources are delivered through apps or online platforms. Some country offices have used human-centred design as a process to co-design learning materials with girls and boys. The UNICEF Supply Division maintains long-term arrangements, or LTAs, with institutions that can facilitate human-centred design. Another priority is developing capacity and institutional support within the health and education systems to deliver MHH information to girls and boys. In many places, teachers or health workers may lack accurate information about menstruation and MHH themselves, or may perceive resistance to engaging with children around topics related to puberty. Furthermore, because teachers and health workers are influenced by the culture in which they live, and therefore may perpetuate non-factual beliefs about menstruation. UNICEF can support supplemental teacher and health worker trainings to be integrated into national professional training programmes. This may also include the integration of MHH information and care (such as how to manage complications like infections or menstrual pain) into Adolescent Friendly Health Services. Lastly, ensuring a link to caregivers and community leaders as in pillar 1 above (section 3.4) is critical. In formative studies around the world, parents and other caregivers are cited as among the highest influencers and sources of information and support for girls regarding their period. In many contexts, community leaders – be they administrative, traditional, or religious – have influence over the social restrictions for menstruating girls. Similar to teachers or health workers, parents and community leaders may lack basic information about menstruation, or the confidence to initiate conversations with girls at menarche, or may promote harmful beliefs or practices. Within UNICEF, C4D, child protection, and gender colleagues can bring valuable expertise to this programme area. In some contexts, social media and digital platforms may be available and appropriate and can also be a very effective option for sharing information and increasing knowledge and skills.” From UNICEF. Guidance on Menstrual Health and Hygiene. Published March 2019. Accessed April 1, 2020.

123 “Social support sources included peers, parents and female teachers. Across studies, support sources either enhanced the impact of the interventions or presented a barrier to positive experiences (WoMena 2017; Mason et al. 2015; Hyttel et al. 2017; Hennegan et al. 2017; Stopford 2011; Rajagopal and Mathur 2017). For example, mothers’ reactions to the menstrual cup featured in their successful uptake.” From Shannon, Alexandra K., G. J. Melendez-Torres, and Julie Hennegan. “How do women and girls experience menstrual health interventions in low-and middle-income countries? insights from a systematic review and qualitative metasynthesis.” *Culture, Health & Sexuality* (2020): 1-20.

menstrual education is via government schooling systems. As experts pointed out to us, this is why the field has been eager to bring representatives from Ministries of Education on board when planning for MHH interventions occurs.

4.1.3 WASH INTERVENTIONS

WASH interventions aim to address changing, washing, and disposal challenges that women and girls face when it comes to managing menstruation. As broader WASH education elements (including safe handwashing, drinking water, and defecation practices) are common, menstrual hygiene can be integrated into these lessons. WASH interventions aim to ensure that women and girls do not experience negative effects from not changing sanitary products frequently enough, and are able to wash their hands and bodies, safely dispose of materials, and participate in public life without worrying about where or when they will be able to change menstrual materials.¹²⁴

WASH interventions are relevant worldwide, but are most urgently needed in countries that still lack complete access to running water and toilet facilities.¹²⁵ This lack is highly correlated to a country's income level. This is also an urgent need for women and girls in humanitarian settings. In addition, transgender men and gender-nonconforming people worldwide may be particularly underserved in this area due to their lack of safety in accessing gender-affirming toilet facilities that also include provisions for managing menstruation. The disability community may also need special consideration in designing appropriate washing, changing, and disposal facilities. WASH interventions are relevant for all age groups and in many different environments (home, community, school, and work).

From a structural perspective, WASH interventions should aim to address the challenges that women and girls face in both their public and their private lives in terms of accessing a safe place to change, wash, and dispose of their used menstrual hygiene products. This can look like making sure there are private, safe, well-lit toilets with water, soap, and other necessary cleaning materials in homes, communities, schools, and workplaces. It also means considering what types of products are commonly used in communities and understanding how women and girls might dispose of these (e.g. incineration, flushing, burying).^{126,127}

As toileting and sewage systems are often planned centrally, many WASH interventions focus on reaching planners and ensuring that menstrual health considerations are taken into account when planning, designing, and building systems. This could look like doing formative research around what types of products are used and integrating it into planning systems, mapping toilets in a community to figure out if areas women and girls congregate are underserved by toilets, and building awareness for the need for all public toilets to include a gender-sensitive component.¹²⁸ Safety is also a key consideration in terms of WASH interventions. Toilets and other washing, changing, and disposal options should be both safe and private.

124 "In sum, our study found that many girls in rural Bangladesh do not report feeling confident to manage their menstruation, especially at school. Findings suggest that there is unlikely to be a single 'silver bullet' to improving menstrual experiences, but that multiple factors contribute. Nuanced assessment of menstrual experience in quantitative studies and trials is needed to better understand this experience and develop and evaluate interventions." From: Hennegan, Julie, and Lidwien Sol. "Confidence to manage menstruation at home and at school: findings from a cross-sectional survey of schoolgirls in rural Bangladesh." *Culture, health & sexuality* 22.2 (2020): 146-165.

125 WHO and UNICEF, [JMP Global Database](#), accessed May 2020.

126 Sommer, Marni, Marianne Kjellén, and Chibesa Pensulo. "Girls' and women's unmet needs for menstrual hygiene management (MHM): The interactions between MHM and sanitation systems in low-income countries." *Journal of Water, Sanitation and Hygiene for Development* 3.3 (2013): 283-297.

127 "In service delivery, the disposal of menstrual hygiene materials is often overlooked, to the detriment of both girls and the facilities. Where there are not alternative disposal options, girls and women often dispose of used menstrual materials in toilets. This may stop toilets from functioning, for example, or clog vacuum hoses during desludging of septic tanks. Building private, well-managed disposal options that consider local beliefs around disposal into facility planning and construction helps prevent operational problems in the future." From UNICEF. *Guidance on Menstrual Health and Hygiene*. Published March 2019. Accessed April 1, 2020, pg. 55.

128 "On any given day, around 300 million people globally are menstruating.²⁰ They need a private and accessible toilet to change their menstrual products; water and soap to wash their hands, bodies and any reusable products; and somewhere to dispose of menstrual products in a safe, culturally appropriate and dignified way. Being unable to manage menstruation hygienically affects women's and girls' health, mobility and dignity. Using the same sanitary product for too long can increase the risk of infection, while not washing hands after changing menstrual products can help spread infections such as Hepatitis B and thrush.²³ Not having access to safe, clean and appropriate toilets during menstruation can cause discomfort and psychological stress, and adds to the discrimination women and girls already face because of menstruation-related taboos. Perimenopause (the time leading up to and around menopause) and pregnancy can increase a woman's need to use the toilet because the bladder is weakened or compressed. And hormonal changes during perimenopause can lead to heavier bleeding, requiring more frequent changing and washing." From: WaterAid, *Water & Sanitation for the Urban Poor*, UNICEF, [Female-friendly public and community toilets: a guide for planners and decision makers](#), October 2018, pg. 7.

While integrating MHH into WASH planning is exceptionally important, it is also key that WASH planners take into account broader cultural norms. For instance, designating a toilet as “menstruation-friendly” may mean that girls and women will refuse to use it, because others can see them going into it and will know they are menstruating, which may lead to them experiencing stigma. In addition, WASH availability should be considered in light of preferred products. For instance, one review found that “restricted waste disposal options for single-use sanitary pads made this less attractive than the reusable cloths provided in two studies in India. Girls in rural Uganda and in Ugandan refugee camps reported challenges in sourcing containers for boiling menstrual cups, finding time and space to boil the cup, the need to transport water to latrines to clean the cup between uses.”¹²⁹ Therefore, culturally sensitive and locally informed integration of MHH into WASH projects is essential.

Given the complexity and scale of WASH interventions, they will frequently be funded by governments or major health donors (e.g. UN agencies). While WASH interventions may be expensive, they are also likely to have broadly applicable and wider-ranging benefits that go beyond ensuring access to menstrual health and hygiene. The WASH sector has been a key driver in bringing more attention to the issue of menstrual health, and may serve as an important link to bringing more sectors on board, such as the education sector. For instance, a review of educational policy in 21 countries found that Ministries of Education policy frequently did not provide for menstruation-friendly WASH facilities and improvements in schools.¹³⁰

4.1.4 HEALTHCARE INTERVENTIONS

Women and girls worldwide are often very underserved by health systems for menstrual needs. Many of the experts we spoke to mentioned this area of intervention as an important one for growth, especially when it comes to integrating menstrual health into sexual and reproductive healthcare. Healthcare interventions are relevant across all age groups worldwide. While people in LMICs are most likely to lack access to qualified providers and most likely have the most intense need for healthcare interventions, the invisibility of menstruation (and in some countries – like the United States – relative unaffordability of healthcare) means that healthcare interventions are relevant worldwide.

This component of MHH interventions are growing and could include:

- Building awareness among women and girls about what levels of pain, discomfort, and abnormal bleeding do not need to be endured and building confidence to bring them up with a healthcare provider.¹³¹
- Increasing the number of women and girls who can access and take advantage of appropriate pain management.^{132, 133}

129 Shannon, Alexandra K., G. J. Melendez-Torres, and Julie Hennegan. “How do women and girls experience menstrual health interventions in low-and middle-income countries? insights from a systematic review and qualitative metasynthesis.” *Culture, Health & Sexuality* (2020): 1-20.

130 “Recent decades have seen a push for gender parity in education in low resource countries. Attention is shifting to how school environments hinder the achievement of gender equality. One effort, primarily led by the water, sanitation and hygiene sector, includes a focus on the needs of menstruating girls. This policy review aims to understand how the education sector is addressing menstruation management. We conducted an analysis of select education policy documents in 21 countries, including a frequency count and narrative analysis of relevant keywords. Findings suggest that existing national education policies inadequately provide for sufficient water and sanitation facilities or other menstruation-related improvements needed in schools. More recently developed WASH in schools policies present examples of potential approaches for education stakeholders to better address girls’ menstrual needs in school through policy and program responses.” Sommer, Marni, et al. “Attention to menstrual hygiene management in schools: An analysis of education policy documents in low-and middle-income countries.” *International Journal of Educational Development* 57 (2017): 73-82.

131 “Girls also stated that they would be too embarrassed to seek help if they experienced genital itching or discharge.” From Shannon, Alexandra K., G. J. Melendez-Torres, and Julie Hennegan. “How do women and girls experience menstrual health interventions in low-and middle-income countries? insights from a systematic review and qualitative metasynthesis.” *Culture, Health & Sexuality* (2020): 1-20.

132 “Self-care was used by over half of all young women (55%, 95%CI 34.1–74.3) with both pharmaceutical (48%, 95%CI 40.0–57.0) and non-pharmaceutical (51.8%, 95%CI 31.3–71.7) options used. Paracetamol was the most common analgesic used (28.7%, 95%CI 19.6–39.9) but did not always provide sufficient pain relief in almost half of those using it. Contraceptive use was significantly higher ($P<0.001$) in HIC (22%) compared to LMIC (1%). Only 11% (95%CI 8.4–15.2) of young women reported seeing a medical doctor for their period pain.” From: Armour, Mike, et al. Self-care strategies and sources of knowledge on menstruation in 12,526 young women with dysmenorrhea: A systematic review and meta-analysis.” *PloS one* 14.7 (2019): e0220103.

133 “There were high levels of uptake of the individual and behavioural intervention components (puberty education, drama skit, menstrual hygiene management (MHM) kit and pain management). The proportion of girls reporting anxiety about next period decreased from 58.6% to 34.4%, and reported use of effective pain management increased from 76.4% to 91.4%. Most girls (81.4%) reported improved school toilet facilities, which improved their comfort managing menstruation. The diary data and qualitative data indicated a potential intervention impact on improving menstrual-related school absenteeism.” From: Kansime, Catherine, et al. “Menstrual health intervention and school attendance in Uganda (MENISCUS-2): a pilot intervention study.” *BMJ open* 10.2 (2020).

- Developing guidance for clinical care for menstrual issues and training providers to build their clinical knowledge and ability to treat menstrual pain and bleeding abnormalities.
- Integrating menstrual health into adolescent-friendly health services, to reduce fear and stigma among adolescents about accessing health services, and building their knowledge.¹³⁴
- Integrating menstrual health into sexual and reproductive healthcare. This could look like using contraceptive consultations or maternal health visits (highly common points of contact for women and girls and the healthcare system worldwide) as vehicles for also discussing any menstrual health problems and educating women and girls about menstrual hygiene and different types of products.
- Integrating menstrual health into healthcare interventions that aim to reach transgender men and gender-nonconforming people.

Healthcare interventions may be well-suited to sit alongside product distribution and education initiatives. Funders could include a broad range of actors from governments and large private foundations down to small granting organisations piloting work in local facilities.

134 Punzi MC and Hekster O, [Technical brief for the Integration of Menstrual Health in SRHR](#), 2019.

*There is still a lack of
commitment in many
countries to address
menstrual hygiene in
a systematic way.*



4.2. Indirect Interventions

The interventions described above aim to directly provide access to at least one component of MHH that the programme audience lacks. However, there are several categories of indirect interventions that aim to improve the programmes themselves and enhance the enabling environment they operate in, leading to more effective programmes at great scale.

4.2.1 MOVEMENT BUILDING

MHH is a relatively recent field that is experiencing rapid growth and surging interest. While experts we spoke to are pleased to see interest in the field growing, they cautioned that work is still being done on “shoestring” budgets and MHH still hasn’t found a firm foothold in the global health agenda. Moreover, despite strides being taken in terms of policy work (e.g. provision of free products, eradication of tax on menstrual products) at the government level, there is still a lack of commitment in many countries to address menstrual hygiene in a systematic way.

As such, leaders in the field are working to create effective partnerships and institutions to help formalise the field and leverage cooperation to best make use of the resources available. This includes interventions such as establishing knowledge management hubs – such as Menstrual Health Hub – to collate available data and create links between researchers, programmers, and advocates. Other work includes coalitions to bring together researchers and programmers.

Experts we spoke to emphasised that cooperation and coordination efforts to strengthen the movement would be essential for ensuring that funds are well-allocated, research gaps are plugged, and collective action can be leveraged accordingly.

4.2.2 RAISING AWARENESS, FIGHTING STIGMA, AND CHANGING SOCIAL NORMS

Qualitative and formative work has found that how menstruation is conceptualised culturally – via invisibility, myths, menstrual taboos, stigma, and negative social norms – most likely plays an important role in the success of direct interventions. However, “these risk factors have received limited attention in interventions.”¹³⁵

The aim of awareness-raising efforts are to build knowledge about lack of complete MHH and break down stigma and negative attitudes around menstruation. These actions seek to normalise menstruation and reduce shame around the topic, thereby creating better enabling environments for people who menstruate. They also aim to ensure menstruation is regularly incorporated into planning and programming so that women and girls’ needs are met.

Awareness raising can take the form of formalised actions such as Menstrual Hygiene Day, which was established by WASH United in 2014 and is now a global movement of 630 partner organisations working to leverage UN bodies, governments, social media, and in-person organising to educate people about menstruation and start the conversation around why it shouldn’t be shamed. It can take the form of activists campaigning through advertisement, social media, art, performance, and other means to draw attention and question menstrual stigma. It can also involve community-based interventions to create a more positive local environment and break down stigma.

Interventions to break down menstrual stigma can be funded from the very highest level (e.g. governments, UN agencies) down to very small grassroots campaigns targeting a single community.

4.2.3 ADVOCACY AND POLICY

Shifting government policy is one of the best tools for operating programmes at scale. As such, experts we spoke to highlighted that getting governments to take up MHH and integrate it into other areas of programming is an essential component of broadening the scope and reach of programmes designed to alleviate incomplete MHH.

¹³⁵ Hennegan, Julie, et al. “Women’s and girls’ experiences of menstruation in low-and middle-income countries: A systematic review and qualitative metasynthesis.” *PLoS medicine* 16.5 (2019): e1002803.

Policies that advocates are urging governments to take up include providing menstrual products for free (either to in-school girls or more broadly), creating a specific budget line item to fund menstrual hygiene programming, mandating that menstruation be considered in any WASH strategy, integrating menstrual hygiene education into official school curricula, and dropping “tampon taxes” where menstrual hygiene products are taxed at high rates.

These advocacy and policy-shifting exercises have had success, with governments dropping menstrual product taxes and agreeing to provide free products. However, several experts we spoke to mentioned that evaluating the impact of these policies on whether they increased access to complete MHH is an essential component of identifying what levers work to increase overall access to MHH.

4.2.4 RESEARCH

As has been discussed previously in this report, there is consensus in the field that strengthening the practice and quality of research for MHH is necessary to best identify effective and cost-effective programmes to improve MHH. It is also needed to determine the negative outcomes averted as a result of these programmes (which is key for moving funding), and to work out how to appropriately scale programmes to different contexts.

Some of the ongoing work occurring in research involves developing consistent definitions and measures to define inputs, outputs, and outcomes of menstrual health interventions. This will allow routine monitoring of programmes and improve the ability to pool data from multiple studies for analysis.^{136,137}

Other work that has been highlighted as extremely important is attempting to quantify the harms of lack of access to complete MHH as well as what causes it. This will allow programmers and policymakers to prioritise what interventions are most important to addressing the most severe harms and to adapt programmes to best suit them.

136 Hennegan, Julie, et al. “Measuring menstrual hygiene experience: development and validation of the Menstrual Practice Needs Scale (MPNS-36) in Soroti, Uganda.” *BMJ open* 10.2 (2020).

137 Sommer, Marni, et al. “Improving the impact of menstrual health innovations in low-and middle-income countries: a theory of change and measurement framework.” *Journal of Global Health Reports* 4.e2020007. (2020).



5. Recommended Organisations

This section outlines the methodology used to select organisations, and the organisations themselves.

5.1 Methodology for Organisation Selection

The scope of this section of the report was to identify eight organisations, with a minimum combined funding gap of USD\$10 million.

5.1.1 GENERATING A LONG LIST OF ORGANISATIONS

First, we generated a list of 80 organisations working to improve MHH worldwide. We populated this list via personal knowledge and previous relationships with organisations working on MHH, search engine keyword searches, reviewing participant lists for MHH-related conferences and guidance documents, conversations with experts, and searches of grant databases.

5.1.2 NARROWING TO A SHORTLIST OF ORGANISATIONS

After generating a long list of organisations, we took the following steps to narrow down to a shortlist of organisations.

First, after coming to the conclusion that it would be premature to designate any one intervention (given the lack of evidence and cost-effectiveness information) as a gold standard for addressing incomplete MHH, we established the following principles to help guide our selection process of opportunities for investment.

- Given the lack of evidence in the area, we prioritised organisations that are committed to evidence and will generate learnings. This could take the form of conducting and incorporating formative research into programme design, conducting RCTs to test programmes, or conducting human-centred design to improve programmes. We think that a promising way to improve access to complete MHH worldwide is to fund the design of evidence-informed programmes, test those programmes, and disseminate that information to ensure that the entire field is pushing forwards to a set of high-impact interventions.
- The factors contributing to incomplete MHH are complex and look different across different settings and from individual to individual. We do not think there is a “silver bullet”¹³⁸ intervention waiting to be found that will work in all cases. Rather, we think that a set of adaptable and scalable practices to address different reasons for incomplete MHH in different settings will be necessary to make meaningful headway in improving MHH worldwide. Therefore, we aimed to shortlist organisations that were implementing different types of programmes, distributing different types of products, and exploring different sectors and activities through which to improve MHH. In addition to looking across organisations to ensure a diverse mix of interventions, we also prioritised organisations implementing interventions that aimed to address multiple components of incomplete MHH (e.g. product distribution and education).

138 Hennegan, Julie, and Lidwien Sol. “Confidence to manage menstruation at home and at school: findings from a cross-sectional survey of schoolgirls in rural Bangladesh.” *Culture, health & sexuality* 22.2 (2020): 146-165.

- Moreover, to grow and improve the field of MHH broadly, we looked to shortlist organisations exploring ways to create sustainable, equitable, and scalable programmes and change, such as through market shaping or collaboration with government.
- Given that the scope of the project aimed to identify at least USD\$10 million in funding gap, we prioritised more established organisations for the shortlist as they are more likely to be able to absorb and use large grants for immediate programming.
- While several of the pre-determined geographies of interest are HICs, we think that people who menstruate in LMICs are most likely to experience multiple types of deprivations in menstrual health (e.g. lack of knowledge, lack of facilities, lack of products, stigma). We think that on average, fewer people who menstruate in HICs experience deprivations like lack of adequate facilities and product shortages. Therefore, we prioritised organisations working in LMICs over those working in HICs. However, we believe, when considering lack of access to information and having to contend with stigma, that millions of women and girls in HICs also experience lack of complete MHH. Therefore, we did not exclude entirely organisations working in HICs.

Based on these principles, we created a rubric which we used to score organisations based on publicly available information. This rubric can be found in appendix 1. We then selected thirteen organisations to reach out to based on those who scored highest on the rubric and funder preference.

5.1.3 RECOMMENDING ORGANISATIONS

To narrow the shortlisted organisations to our final recommendations, we reached out to organisations to obtain further information about:

- evidence of impact and reach
- plans to scale
- funding needs
- any organisation-specific questions

Of the thirteen we reached out to, we recommend eight organisations. The final organisations were selected based on those who responded and provided sufficient information about their interventions, cost per outcome, and funding needs to determine their eligibility and likelihood of producing impact and information related to MHH.

5.1.4 OUR APPROACH TO COST-EFFECTIVENESS AND HOW IT HAS BEEN APPLIED IN THIS REPORT

Our approach to cost-effectiveness

Founders Pledge's research methodology places a high weight on the cost-effectiveness of an organisation. The cost-effectiveness of an organisation is how large a benefit the organisation will provide for a given cost. For example, an organisation distributing life-saving medical treatments may be able to save a life for each \$10,000 donated to it. This then allows us to compare between organisations to see which will provide a larger impact for a given grant.

When analysing cost-effectiveness, it is important to distinguish between outputs and outcomes. Outputs measure things that are produced by a charity, such as the number of vaccines distributed, number of schools opened, or the number of cows gifted. Outcomes, on the other hand, measure things we ultimately care about, such as saving a life, averting a Disability-Adjusted Life Year (DALY), or providing a given learning improvement.

Looking at outputs is important because it tells us what charities are concretely doing. But ultimately what we care about is outcomes: whether (for example) charities are making people healthier, more educated, and less hungry. And the step from one to the other can't be taken for granted - there are many ways in which the distribution of a vaccine may not ultimately lead to the health benefits we ultimately care about.

Ideally, when evaluating an organisation carrying out a direct intervention, we would build a model to estimate the total size of the benefits from the programme and the total costs to run it. Examples of these models can be found in reports on our [website](#).

How cost-effectiveness has been applied in this report

To build a robust cost-effectiveness model for organisations carrying out direct interventions, it is important to estimate how large an effect the programme has on a given outcome. This requires a randomised controlled trial or other high-quality impact evaluation, so that we have the necessary information about the effect of a programme.

In the case of MHH, as we have already detailed in this report, this evidence rarely exists because the field is young and has not yet received widespread attention in the development community. Until those data are available, most MHH programmes can only be assessed by cost per input or output.

In addition to this, because the evidence base for the effectiveness of different interventions to address MHH is currently weak, we believe a better approach than funding organisations which have the highest cost-effectiveness estimates based on weak or non-existent data is to fund a wide range of interventions being tested, in order to learn more about the most impactful approaches. In other words, it is currently too early to prioritise interventions solely on cost-effectiveness estimates, before enough different approaches have been developed and tested.

Because of this, for most of the organisations below we have calculated high-level costs to provide a given *input* or *output* (for example, the cost to provide menstrual health products to one individual).

From our discussions with experts and organisations, we believe that more comprehensive cost-effectiveness estimates will be possible in the near future as several RCTs are set to publish data to this effect soon.



5.2 Recommended Organisations

Days for Girls

Who are they?

Days for Girls (DfG), founded in 2008, is a global organisation headquartered in the US with offices in Uganda, Nepal, Ghana, and Guatemala that focuses exclusively on increasing access to complete MHH, chiefly through education and product distribution. Days for Girls distributes kits containing its patented reusable menstrual pad as well as supporting products such as undergarments, transport bags, and soap. Along with products, they include health education with each distribution.

What do they do?

Product manufacturing and distribution: Days for Girls manufacture and distribute menstrual product kits ('DfG Menstrual Kits') to girls and women who do not have the products they need to adequately manage menstruation. In order to carry out this work, Days for Girls supports local leaders to start Enterprises who manufacture menstrual kits for distribution throughout the world. The core component of this kit is the Days for Girls patented menstrual pad. The standard Days for Girls kit (which is called the Supreme Kit) contains components of the menstrual pad, soap, a washcloth, transport bag, underwear and an information guide on use and care for their kit. Days for Girls volunteers form Chapters and Teams that make DfG Kits to distribute to hard to reach areas such as refugee camps and low resourced countries. Enterprises offer multiple versions of the kit, including the standard version, a streamlined version containing only the pad, a heavy flow kit, and a menstrual cup kit.¹³⁹¹⁴⁰ Through the combination of social Enterprises and volunteer efforts, Days for Girls has distributed DfG Kits and education in 144 countries reaching more than 1.7 million women and girls, with an estimated 55% distributed in Africa, 22% in Asia, and 16% in Latin America (as of mid-2018).¹⁴¹

As noted above a core component of the Days for Girls model is mobilising thousands of volunteers around the world to contribute to the organisation's mission. Volunteers fundraise, sew products that go into the Day for Girls kits, advocate to improve access and reduce barriers to menstrual health, and draw attention to menstrual health in their communities. Days for Girls makes detailed patterns and guidelines available to ensure that products are standardised and made with the appropriate materials to ensure quality.

While Days for Girls distributes a large portion of their products for free to those in need, five years ago they established an enterprise distribution model as a way of helping to create sustainable, local markets for menstrual products and education. This is described in more depth below.

DfG reports that 85% of its income comes from donations, with the remaining 15% coming from earned revenue (kit sales, training, membership dues & resource shop). This doesn't include DfG Kit sales from Enterprises, which keep their own budgets.

Education: Days for Girls also offers several different education programmes to build knowledge and combat menstrual stigma. Enterprise programme leaders that distribute kits are trained to provide education to recipients along with volunteers. This education includes information about menstruation and instruction on how to use the Days for Girls products safely and appropriately. Discussions to combat shame and stigma around menstruation are included along with hand washing, basic reproductive education, and self-defense. The standard course is always offered as part of kit distribution. In addition to this standard course, Day for Girls has developed a course called "Men Who Know" specifically designed to reach men and boys and engage them in shifting norms around menstruation in their communities.

Enterprise program: In order to ensure sustainable supplies of quality menstrual products and invest

139 Days for Girls, [The Days for Girls Kit](#), no date,

140 Days for Girls, [The Days for Girls Kit](#), no date,

141 Days for Girls, [2017 Annual Report](#), 2018.

in local communities, Days for Girls established an enterprise programme. The Enterprise programme identifies local entrepreneurs to start new DfG Enterprises and provides them with seed support and training on how to manufacture and sell Days for Girls products. This model aims to create healthy markets for menstrual products to ensure continuous availability and form locally owned solutions to increase access to menstrual products. In addition to producing and distributing products, Enterprise leaders provide menstrual health education.

To complement its primary activities of product distribution and education, Days for Girls also aims to influence policy development and support advocacy to improve menstrual health globally. They aim to do this by mobilising their volunteers and partners worldwide to create a grassroots movement supporting the improvement of menstrual health. Days for Girls advocacy strategy includes:¹⁴²

1. Supporting governments to develop and implement policy
2. Participating in coalitions across sectors to improve coordination around menstrual health
3. Initiating and participating in campaigns for increased awareness
4. Encouraging their volunteer base to improve menstrual health and increase awareness in their communities

Is there existing evidence for their programme?

Product manufacturing and distribution: As highlighted above, there is evidence that a significant portion of women and girls do not have access to reliable and affordable menstrual supplies and adequate health education. PMA2020 monitoring data (outlined in Section 3) indicates that of women who use pads, 26.4% of respondents reported that they had needs for materials that were not being met. This figure was higher for rural women who exclusively use pads (38.5%) and women in the lowest wealth quintile (45.9%).¹⁴³ Days for Girls aims to bridge that gap through free distribution and affordable sales - accompanied by education - of menstrual health products.

Days for Girls has based the design of their primary product on user data and evidence. For example, Days for Girls focuses on washable, reusable pads because they are highly acceptable to users in many different contexts. The pad itself is designed to last for multiple years, which is an important consideration because qualitative evidence suggests that families often opt to not spend limited funds on menstrual products.¹⁴⁴ A long-lasting product means that girls and women will not have to justify purchasing products within their families as frequently.

Days for Girls has enhanced the design of their product 29 times based on extensive user feedback to ensure that it overcomes as many barriers to use as possible.¹⁴⁵ For instance, the design currently includes a unique feature that allows the absorbent material in the pad to be removed and expanded for washing and drying in a way that makes it look like a washcloth or handkerchief, thereby reducing unwillingness or inability of girls and women to adequately wash and dry their materials due to stigma or shape. In addition, they have switched out their single use plastic bags to place used pads into a reusable transport bag as a way to reduce plastic waste and help the environment.

Enterprise design: The design of the Enterprise programme reflects information we also heard from experts: that market-based solutions are needed for long-term and sustainable access to products for women and girls worldwide. In LMICs (and especially in rural areas or in humanitarian settings), there may be highly limited or no availability of menstrual products where many women and girls live.¹⁴⁶ Therefore, supporting local manufacturing and distribution capacity for menstrual products can ensure a sustainable supply.

As with the design of their pad, Days for Girls has evaluated the performance of their Enterprise programme in order to adapt it to achieve a greater impact. One key finding from Days for Girls' ongoing

¹⁴² Shared in email communication

¹⁴³ Smith et al National Monitoring for Menstrual Health and Hygiene: Is the Type of Menstrual Material Used Indicative of Needs Across 10 Countries? 2020

¹⁴⁴ Hennegan, Julie, et al. "Women's and girls' experiences of menstruation in low-and middle-income countries: A systematic review and qualitative metasynthesis." PLoS medicine 16.5 (2019): e1002803.

¹⁴⁵ Days for Girls, [The Days for Girls Kit](#), no date,

¹⁴⁶ Hennegan, Julie, et al. "Women's and girls' experiences of menstruation in low-and middle-income countries: A systematic review and qualitative metasynthesis." PLoS medicine 16.5 (2019): e1002803.

evaluation was the need to ensure that donated kits were not competing with micro-enterprise sales, as this would undercut the value of Days for Girls' products. In response to this feedback, Days for Girls is revising their enterprise strategies to direct donated kits only to areas without an established enterprise or to refugee and humanitarian settings.¹⁴⁷

Why are they recommended?

- Extensive reach, including in many LMICs where there has been limited investment in MHH
- Product distribution meets immediate material needs for women and girls to better manage their menstruation with confidence and dignity
- Testing solutions to create locally owned and sustainable supply chains and generate demand for menstrual products, which has the potential to improve the overall market and make it easier to access menstrual products
- Involving men and boys in education and anti-stigma efforts to create an enabling environment for people who menstruate

From our review, Days for Girls seems to have one of the broadest reaches in terms of the geographic breadth they cover through kit distribution. As we heard from experts, MHH investment has been concentrated in a few countries and regions and there is a need to ensure that the requirements of women and girls in other countries are met. We think that Days for Girls is well-positioned to meet product needs in areas such as West Africa and Latin America, where investment in menstrual health is less prevalent than in East Africa and South Asia. Moreover, Days for Girls kits have also been distributed in humanitarian and emergency settings, which we also believe is a high-need area.

Secondly, we think that the need for reusable products will continue to be an important component of the menstrual product market, especially for women and girls in rural areas and those living in poverty who may be unable or unwilling to use limited resources to purchase disposable menstrual hygiene products. By focusing on reusable pads (and adding menstrual cups into their Enterprise models), Days for Girls is ensuring that menstrual hygiene product markets have an adequate balance of reusable products to meet the needs and wants of women and girls who prefer this type of product.

Thirdly, social enterprise solutions are often more likely to be sustainable. In order to strengthen markets, the ability to ensure a continuous supply of locally sourced and manufactured products is important for preventing interruptions in supply and access to menstrual hygiene products for women and girls. Moreover, these solutions have the added benefit of aiming to keep community dollars in communities and build income among – often women – entrepreneurs.

Finally, Days for Girls is working to tackle lack of knowledge, stigma, and lack of involvement from men and boys to ensure complete MHH for women and girls in the areas in which they work. A key component of complete MHH is breaking down menstrual stigma so that girls and women are not shamed or excluded during menstruation. As such, engaging men and boys is a critical component of changing broader societal norms and creating a more enabling environment. Moreover, because volunteers come from the communities they work with, the education they provide is more likely to build awareness about menstruation and the harms of menstrual stigma.

How much does it cost to provide a given benefit?

Robust cost-effectiveness estimates across different types of MHH programmes will not be possible until there is more data quantifying the harms caused by lack of MHH and how different interventions alleviate those harms. Until that data is available, most MHH programmes will only be able to be assessed by cost per input. From our discussions with experts and organisations, we believe that better cost-effectiveness estimates will be possible in the near future as several RCTs are set to publish data to this effect soon.

¹⁴⁷ Days for Girls, [Enterprise Evaluation](#), January 2018.

Days for Girls estimates that it costs between USD\$6.50-\$10.00 to create and sell a kit and provide the associated health education. If you assume that each kit provides enough menstrual products to last an individual one year, this translates to a cost of between USD\$6.50 – 10.00 to meet one year of material need for one person and to boost their knowledge of menstruation.

How much funding do they need, and how will they use it?

Days for Girls could productively use at least USD\$205,000 in additional funding in the next year to support the following areas of work:

- USD\$55,000 to establish and strengthen global supply chains and build capacity for local sourcing in East and South Africa, with plans to then expand to Latin America and West Africa.
- USD\$60,000 to support an MLE director to guide an evaluation of the health education component of Days for Girls work.
- At least USD\$90,000 to fund additional enterprise liaisons based in countries of operation to provide training, quality control, and support to enterprises in-country. Additional liaisons would most likely be established in South Africa, Malawi, India, Cambodia, and Zimbabwe. DfG also indicated there may be other countries where they could fund liaisons, and each would cost between \$USD12,000 - \$USD18,000 per year.

Days for Girls also indicated that they could take on additional funds to support DfG Kit manufacture and distribution in areas receiving free menstrual kits.

Inua Dada Foundation

Who are they?

Inua Dada Foundation is a Kenya-based organisation founded in 2014 working exclusively on menstrual hygiene issues via product distribution, advocacy work, and building awareness for girls and women in Kenya.

What do they do?

Production distribution and education sessions: One of Inua Dada's core programmes is to meet the needs of girls who lack adequate information and menstrual products. This is accomplished through the distribution of menstrual hygiene kits containing an information packet and a year of menstrual pads in primary schools. Accompanying the distribution of products, Inua Dada hosts an education session for girls to cover topics such as information about menstruation, appropriate product use, and self-esteem building exercises.¹⁴⁸ Inua Dada has worked closely with the government to deliver these sessions, which focus on girls who live in marginalised settings. Inua Dada has reached 10,120 girls through its programmes and distributed 90,000 menstrual hygiene kits.

Covid-19 response: In response to the lockdown in Kenya due to Covid-19, Inua Dada saw a need to provide expanded kits to women and girls who would be unable to access menstrual hygiene products due to lack of income or product availability. As such, Inua Dada Foundation has been working with multiple grassroots partners to compile and distribute customised kits based on the needs of identified recipients. Products can include things like menstrual pads, undergarments, diapers, soap, masks, and basic foodstuff. As of mid-June 2020, 2,567 kits had been distributed.

The foundation has also shared that due to a reported increase in teenage pregnancies in Kenya during the COVID-19 pandemic, the Foundation has organised various sessions with girls who have had teenage pregnancies to understand their challenges and provide support. Inua Dada plans to scale up these sessions in the future.

Advocacy programme: Via its advocacy programme, Inua Dada works to leverage media coverage to increase awareness of the challenges of incomplete MHH faced by in-school girls, lobby for policy changes to improve conditions for menstruation for in-school girls, and advocate for the rights of girls more broadly.

Inua Dada Foundation is also a member of the MHM Technical Working Group that advises the Government on how to run MHH activities in the country.

Finally, the founder of the Foundation has worked to promote MHM in the mainstream media and to bring together various policy makers, influential individuals and grassroots organisations to discuss MHM issues, and has published a book, 'My First Time', which documents the stories of women and men and their first experience or interaction with menstruation, in order to increase awareness on this issue.

Is there existing evidence for their programme?

Product distribution and education: as outlined above, access to appropriate and sufficient products to manage menstruation is a component of complete MHH that many women and girls lack in LMICs.¹⁴⁹ Inua Dada aims to bridge that gap for in-school girls through pad provision.

In addition, the available evidence indicates that girls frequently reach menarche without being educated about menstruation or how to use the products available to them correctly.¹⁵⁰ Inua Dada aims to help fill in that gap by ensuring that product distribution is accompanied by education and information.

¹⁴⁸ Inua Dada Foundation, [Menstrual Health Management Program](#), no date.

¹⁴⁹ For instance, PMA2020 monitoring data indicates that for women who use pads, 26.4% of respondents reported that they had needs for materials that were not being met. This figure was higher for rural women who exclusively use pads (38.5%) and women in the lowest wealth quintile (45.9%)., Smith et al National Monitoring for Menstrual Health and Hygiene: Is the Type of Menstrual Material Used Indicative of Needs Across 10 Countries? 2020

¹⁵⁰ Chandra-Mouli, Venkatraman, and Sheila Vipul Patel. "Mapping the knowledge and understanding of menarche, menstrual hygiene and menstrual health among adolescent girls in low-and middle-income countries." *Reproductive health* 14.1 (2017): 30.

Moreover, Inua Dada is also working via media and advocacy work to help create a more positive enabling environment where menstruation is not invisible. The literature indicates that stigma and negative social norms are likely to create additional barriers to achieving complete MHH, even if other needs, such as products, are met.¹⁵¹

Product Distribution: Anecdotal evidence has demonstrated that women and girls worldwide have struggled to access menstrual products during Covid-related lockdowns. As such, it stands to reason that women and girls – especially those already experiencing economic hardship and likely to lack access to menstrual products – are in need of assistance to obtain the products necessary to manage menstruation. Anecdotal responses to Inua Dada’s Covid-19 programming indicate that the sanitary products are better enabling women and girls to manage menstruation with dignity.

Why are they recommended?

- Local leadership, that is networked with grassroots organisations working to represent and meet the needs of women and girls in Kenya
- Addressing urgent and immediate need of women and girls for menstrual products and other material goods in response to the Covid-19 crisis

One of the common themes from our expert interviews was the need to fund local-led and grassroots-connected organisations working in LMICs. The idea behind this is to fund organisations that have extensive connections with organisations that can reach the most vulnerable women and girls. It will also support work that is rooted in local context and understands how to work within that context, and build sustainable movements that are rooted both in local and national context, rather than being top-down. Given this, we think that Inua Dada’s experience with Kenya’s media and advocacy environment, as well as its relationships with partners on the ground, means they are well-placed to expand within the country.

In addition, Inua Dada’s Covid-19 response is addressing a particularly urgent and immediate need. As this work demonstrates, Inua Dada is well-positioned to implement emergency programmes and to leverage the relationships and learning built during operation of these programmes to continue to grow and shape their programming.

How much does it cost to provide a given benefit?

As highlighted above, robust cost-effectiveness estimates will not be available until more data is available quantifying the harms caused by lack of MHH and how effectively different interventions alleviate those harm. Here we give a high-level cost per output figure.

Inua Dada estimates that it costs approximately USD\$8 to package and distribute a care package including the components described above, such as menstrual hygiene management supplies, food, and other necessities. We interpret this as the cost required to meet immediate material needs (including menstrual materials) per person during lockdown.

How much funding do they need, and how will they use it?

Inua Dada Foundation could productively absorb at least USD\$10,000 each month for immediate use to support the following areas of work:

- USD\$8,000 per month to cover distribution of care packages with menstrual hygiene supplies to 1,500 people in need of support due to Covid-19.
- USD\$2,000 per month of overhead support to continue to advocate and raise awareness of menstrual challenges during Covid-19.

It is unclear how long the Covid-19 response work is likely to last.

¹⁵¹ Hennegan, Julie, et al. “Women’s and girls’ experiences of menstruation in low-and middle-income countries: A systematic review and qualitative metasynthesis.” *PLoS medicine* 16.5 (2019): e1002803.

Irise International

Who are they?

Founded in 2011, Irise is a UK- and Uganda-based organisation focused exclusively on addressing barriers to complete MHH. They work in both the UK and East Africa, using multiple approaches to increase access to complete MHH including designing and implementing direct interventions, advancing the MHH knowledge base through research and dissemination, and developing and advocating for policy changes to improve menstrual health. Irise conceptualises their programmes and builds them up along a continuum, from piloting and development to testing and transition, to scale-up.

What do they do?

Irise has operated a number of different programmes through different methods to tackle incomplete MHH in the UK and Uganda. Below, we highlight some of the larger programmes recently carried out and evaluated by Irise.

Irise considers its work in the UK and Uganda to be at different stages. In the UK, Irise considers their work to be in a 'piloting and development' phase, focusing on understanding the issue and initial development and testing of interventions. In Uganda, Irise are in a 'testing and transition' phase, in which they are testing a specific intervention and plan to scale up their work.

UGANDA-BASED WORK

Menstruation-friendly schools: This programme has been piloted in 10 schools in Uganda and provides a package of interventions to each school. An ongoing impact evaluation will assess whether a package of interventions designed to tackle incomplete MHH improves girls' menstrual health and psychosocial well-being, decreases absenteeism, and decreases social stigma around menstruation. The package of interventions includes:

- Distribution of products
- Low-cost WASH facility adaptation to make them gender sensitive
- Teacher training
- Puberty education for both girls and boys
- Parent and community engagement to drive behavior change
 - This model was based on an adaptation of a framework designed to encourage the necessary community and individual mindset shifts and norm change to end female genital mutilation

This programme was piloted in 10 schools and reached 6,000 girls and boys. Evaluations of this project have been used to refine the programme and approach with the end goal of developing a replicable and scalable strategy that can be implemented broadly. This project was also used to test and validate a new scale – the Menstrual Practice Needs Scale – which aims to become the standard instrument used to assess the multiple domains of MHH.^{152 153}

Irise is also currently delivering this program to 13 schools in the Soroti district of Uganda.

Establishing sustainable, local access to affordable menstrual products (completed): This programme was developed and implemented in several communities in Uganda that had incomplete access to an adequate selection of menstrual products and held beliefs that prevented uptake of products.¹⁵⁴ The aim of this project was to simultaneously address lack of access to products and widely held beliefs and community norms that prevented product uptake. The reasoning guiding the design of the intervention was:

¹⁵² Irise International, [Annual Report and Financial Statements For the Year ending 31st December 2018](#), no date.

¹⁵³ Irise International, [Mid-way evaluation report for: FDYV-NBXV-ZK: Developing a replicable package for creating menstruation friendly schools in Uganda](#), 28 November 2019.

¹⁵⁴ Irise International, [Genesis Charitable Trust Impact Report](#), no date.

1. An NGO-supported market and awareness campaign was necessary to shift community norms preventing uptake of menstrual products and to address lack of availability of an acceptable suite of products. A subsidised market would be required initially to establish demand.
2. Training entrepreneurs can help drive demand, make contact with women and girls to provide access to products, and help educate and challenge stigma that depresses demand and access to menstrual products.
3. NGO-supported markets can help support and facilitate the relationship between suppliers and entrepreneurs and support the development of accurate forecasting and supply chains to ensure the right level of products are present in the community.

In implementing this project, 200 local individuals were recruited and trained to become entrepreneurs that sell affordable menstrual products in the community. The idea was to establish both demand and the market for these products to self-sustain.¹⁵⁵ This project led to an estimated 25,100 women and girls being able to better access menstrual hygiene products.¹⁵⁶

UK-BASED WORK

Irise is currently in the pilot phase of their work to test ways to break down menstrual stigma in the UK, build knowledge, and ensure that women and girls have positive experiences of menstruation. Some of these pilots include:

- 13 Moons: A project that tested a drama-based and creative curriculum and facilitation approach to break down menstrual stigma and build self-esteem in participants.¹⁵⁷
- Agents of Change: Through the Agents of Change programme and other engagement channels, Irise builds the capacity and provides support to young people to lead awareness raising, fundraising, advocacy, and peer support projects in their communities.
- Young People in Control: A project in which peer educators delivered information and support to their peers to build knowledge and break down stigma.

Irise prioritises rigorous monitoring and evaluation and works to incorporate research and learning into all aspects of their work. This takes different forms, such as working with Johns Hopkins University to pilot the Menstrual Practice Needs Scale¹⁵⁸ in Uganda, and serving as the conveners for the Data and Evidence working group of the UK's Period Poverty Taskforce.

Irise also aims to empower individuals, communities, and other organisations to advocate for access to complete MHH in both the UK and East Africa. For individuals and communities, Irise operates programmes to empower individuals and communities to campaign for change. For organisations, they have a menstrual health education toolkit available for reference and offer their services to assist organisations in integrating menstrual health into their work and measuring the impact of that work.

Is there existing evidence for their programme?

A pillar of Irise's model is that evidence generation is essential to building the MHH field and improving access to complete MHH. To that aim, their model of programme development calls for them to iteratively build, test, and adjust pilot programmes to optimise them for impact before considering them ready to be scaled up. Irise's programmes are based on previous research and knowledge of menstrual health programming and aim to build on that work.

In addition, one notable feature of Irise's work is their focus on including components designed to address menstrual stigma and bolster community and social support. This reflects learnings from the MHH field – as well as other health domains such as HIV where stigma is prevalent – that to shift behaviour and uptake of hardware interventions, it is necessary to shift knowledge, attitudes, and beliefs.

¹⁵⁵ Irise International, [Genesis Charitable Trust Impact Report](#), no date.

¹⁵⁶ Irise International, [Genesis Charitable Trust Impact Report](#), no date.

¹⁵⁷ Irise International, [13 Moons – A creative approach to end period shame: Final Report](#), no date.

¹⁵⁸ Hennegan, Julie, et al. "Measuring menstrual hygiene experience: development and validation of the Menstrual Practice Needs Scale (MPNS-36) in Soroti, Uganda." *BMJ open* 10.2 (2020).

Menstruation-friendly schools: Evidence is available for this programme as an impact evaluation is being carried out. The final results are not yet available, but the midline assessment found a statistically significant 49% reduction in self-reported absenteeism among girls. In addition, it also found improvements in knowledge and attitudes among the girls themselves, evidence of a change in community attitude towards menstruation, and increased support from men and boys. Based on these positive impacts, Irise plans to test this intervention using a randomised controlled trial (RCT) in order to better understand its impact.

The midline assessment also highlighted gaps in the programme, including that the programme did not positively affect all of the measures of MHH being tested. Irise has developed recommendations to improve the programme based on the findings. For instance, upon finding that teacher knowledge had improved but not met targets, Irise developed a recommendation to intensify training for teachers and offer more support.¹⁵⁹

Publicly publishing an impact evaluation that includes areas for improvement is strong evidence of Irise's commitment to testing and learning, and should be commended.

Establishing sustainable, local access to affordable menstrual products (completed): This work was based on formative research demonstrating that there were barriers – including affordability, accessibility, and lack of knowledge – to women and girls in Uganda acquiring preferred menstrual products.¹⁶⁰ While social entrepreneurship and market-shaping work for menstrual products is receiving increased attention, Irise emphasised the community norm shift component of this work, which reflects ongoing consensus in the field that addressing incomplete MHH requires working across multiple domains.

Based on an evaluation, this programme saw positive changes across several different outcomes. Community “readiness to change” was assessed via a scale at baseline and during follow-up found that readiness to change increased across multiple different sub-domains, including community knowledge of menstrual health, efforts to improve menstrual health and the attitude of leaders towards menstrual health.¹⁶¹ In addition, confidence among parents and teachers to talk about menstruation increased and boys’ knowledge and attitudes shifted as well. Entrepreneurs also saw positive outcomes from the project, with an average 52% increase in monthly earnings among the entrepreneurs.¹⁶²

UK-based work: The UK-based work was based on synthesis of Irise's experience in Uganda and growing consensus that incomplete MHH is not unique to LMICs. It is clear that lack of knowledge, community stigma, and inadequate or non-existent government policy exists in HICs. One piece of evidence for this is a non-representative survey conducted by Plan UK among girls aged 13-21, which found that a quarter of girls surveyed reported not knowing what to do when they started their periods and that half of girls felt embarrassed by menstruation.¹⁶³ In our conversations with experts from the first part of this process, it was also noted that there has been very little evaluation work done on programmes in high-income countries and on the impact of policy changes, to assess whether programmes are designed effectively and are achieving impact. Irise aims to pilot and test different methods in order to identify what leads to impact.

Irise's work in the UK is in an earlier stage than its work in Uganda, so less programme-specific evidence is currently available.

Why are they recommended?

- High commitment to evidence to inform their programme design and public dissemination of evaluation research to improve the evidence base of MHH intervention effectiveness
- Work with multiple groups (individuals, communities, government) to best design and position programmes to be eventually implemented at scale for greatest impact
- Thoughtful programme design that aims to address multiple factors for incomplete MHH

159 Irise International, [Mid-way evaluation report for: FDYV-NBXV-ZK: Developing a replicable package for creating menstruation friendly schools in Uganda](#), 28 November 2019.

160 Irise International, [Genesis Charitable Trust Impact Report](#), no date.

161 Irise International, [Genesis Charitable Trust Impact Report](#), no date.

162 Irise International, [Genesis Charitable Trust Impact Report](#), no date.

163 Plan International UK, [Break the Barriers: Girls' Experiences of Menstruation in the UK](#), 2017, pg. 11.

- Working to fill measurement gaps and intervention evidence gaps highlighted in this report
- Unique model of drawing together information and learning from both low-income and high-income settings to understand commonalities and reframe learnings.

As more work is needed to determine the most impactful practices and strategies for improving menstrual health, we think that organisations could be particularly promising if they design and test new solutions. Given this, we think that Irise's commitment to piloting and tweaking strategies with the aim of developing a replicable programme that can then be translated and scaled to different settings is an important strategy for improving MHH. Irise have published impact assessments publicly on their website, which demonstrates their commitment to testing and an impressive level of transparency. Irise is also planning to conduct an RCT of their menstruation-friendly schools work, which will produce more rigorous impact and cost-effectiveness data.

Moreover, we think that Irise's strategy – especially in their East Africa work – to identify multiple levers that must be engaged to drive sustainable change aligns with the consensus in the field that achieving complete MHH requires acting across different domains. Given the consensus in the field that widely scaling menstrual health programming is most likely to be successful by working through existing government initiatives and policies, we think that Irise's model of testing and adapting solutions that can then be replicated and owned by different actors is well-suited to maximise impact.

Irise is already working to engage governments at the local and national level in Uganda and the UK. By engaging governments as a partner in creating these programmes and driving discussion of menstrual health integration into the national agenda, Irise is well-placed to publicise and disseminate successful packages of interventions.

Thirdly, as we have highlighted in this report, we think the fact that there are many underlying and varied aspects to incomplete MHH should encourage organisations to run programmes that address multiple factors. Irise's programming fits with this. For example, the menstruation-friendly schools programme doesn't just provide a single intervention (such as menstrual products), but provides a package of interventions aimed at creating a menstruation-friendly school as a whole.

Fourthly, we think that Irise's commitment to research and learning means they are well-positioned to help shape programmes and drive impact beyond their own work. For instance, they have been active in helping to pilot the Menstrual Practice Needs Scale – which aims to become a standardised measure for assessing MHH across multiple domains – and will allow for validated and comparable assessments of baseline and impact measures. This work directly fills a measurement gap highlighted previously in this report.

Finally, we think Irise's framing of bringing in learnings from both Uganda and the UK to inform their full body of work is a unique focus that could bring further attention to the psychosocial harms stemming from incomplete MHH. It can also tell us how community-based programming can be translated across different settings.

How much does it cost to provide a given benefit?

Unlike many of the other recommended organisations, Irise has estimated the cost-effectiveness of their programme in relation to the benefits of averting absenteeism among in-school girls. They estimate that, based on current data, they will avert one drop-out for every 90 girls reached through the menstruation-friendly schools programme and averting this drop-out will cost GBP£702.16 (~USD\$866.57). This figure is the cost for an outcome, so is not directly comparable to costs for outputs (such as girls provided with products) presented for the other organisations.

Estimates have suggested that an extra year in school for girls can increase eventual earnings by 10-20%.¹⁶⁴ If we take the median estimated annual income for an individual in Uganda and assume 30 years of work, potential returns on this investment for girls in different wealth quintiles could look like:

¹⁶⁴ Global Partnership for Education, [Education data highlights](#), 23 June 2020.

	Median average individual income over 30 years of work (PPP-adjusted) ¹⁶⁵	10% increase in earnings over 30 years of work	20% increase in earnings over 30 years of work
QUINTILE 1	\$9,146.10	\$10,060.71 (+\$914.61)	\$10,975.32 (+\$1,829.22)
QUINTILE 2	\$16,701.60	\$18,371.76 (+\$1,670.16)	\$20,041.92 (+\$3,340.32)
QUINTILE 3	\$25,370.70	\$27,907.77 (+\$2,537.07)	\$30,444.84 (+\$5,074.14)

How much funding do they need, and how will they use it?

Irise estimates they could productively use GBP£1,950,000 in additional funding over the next three years, based on their current funding priorities. They anticipate funding the following programmes:

- GBP£350,000 per year for three years to scale the menstruation-friendly schools intervention and conduct an RCT evaluating the programme in East Africa.
- GBP£300,000 to cover two to three years of work to address last mile distribution challenges for social entrepreneurs selling alternative, reusable menstrual products in Uganda.
- GBP£200,000 per year for three years to (1) design and pilot youth-led interventions to promote MHH in the UK and (2) integrate learning from these programmes into mainstream policy and service delivery.

This work would be most likely to start in early- to mid-2021.

¹⁶⁵ Metrics for Management, [Asset to Income Estimator: Uganda](#), no date.

NFCC

Who are they?

NFCC is a Nepal-based organisation that works on a spectrum of sexual and reproductive health issues. Established in 1988, NFCC works in-country to drive the agenda on a number of SRH issues, including menstrual health. NFCC's mission is to work with the government to ensure that good policies are enacted and implemented to advance the government's agenda on SRH.¹⁶⁶ NFCC began working on MHH in 2008 and has worked on the area in partnership with the government, health sector, UN agencies, bilateral funders, NGOs, and civil society organisations. They have been instrumental in establishing a place for MHH on the national agenda and continue to work to ensure access to complete MHH country-wide. They also view menstrual health as a key component of health that should be integrated into other areas of work, which they do in their own programming and in-country by working collaboratively with government agencies such as the departments that oversee WASH and education planning.¹⁶⁷

NFCC works through a variety of different mechanisms including research, policy and advocacy, health service provision, training, and behaviour change communication and awareness raising.¹⁶⁸ NFCC has a commitment to conducting research related to menstrual health both nationally and via contributing their experience to international working groups designed to improve monitoring, evaluation, research, and learning for MHH more broadly.¹⁶⁹ They have worked on a variety of studies related to menstrual health, ranging from testing uptake of new products to assessing the forms and intensity of menstrual stigma in different regions.

NFCC also has experience providing healthcare services and training healthcare providers and other key workers to improve quality of care. Part of NFCC's stated vision is "to provide health-related services and training to the Government of Nepal, NGOs' and INGOs' personnel."¹⁷⁰

What do they do?

NFCC has operated a number of programmes through different methods to tackle incomplete MHH in Nepal. Below, we highlight some of these projects.

Chhaupadi and menstrual taboo work: NFCC has worked on multiple projects related to chhaupadi – a banned practice that confines women to outhouses or sheds during menstruation and excludes women and girls from participation in family and/or community life – including a USAID-funded assessment to understand the prevalence, impact, and strategies to eliminate this practice.¹⁷¹ This work also included fostering cooperation among key stakeholders such as the government and development partners on identifying and implementing strategies to reduce chhaupadi.¹⁷² Currently, NFCC is implementing an AmplifyChange-funded project to create awareness that chhaupadi is illegal and promote behavior change where this practice is still occurring via a radio campaign.¹⁷³ NFCC also worked in partnership with Liverpool John Moores University, SOAS University of London, and Tribhuvan University, Kathmandu to use innovative and participatory research methods to better understand the root causes of menstrual taboo in Nepal and develop strategies to tackle them.¹⁷⁴ This work finished earlier this year.

Menstrual health education: NFCC worked in collaboration with the Government of Nepal and other partners to develop a menstrual health training curriculum to ensure that teachers and health workers were equipped with correct knowledge and ability to help students and patients with menstruation-related challenges and questions. The Menstrual Hygiene Management (MHM) package incorporates lessons on menstruation – including premenstrual symptoms, understanding the course of the menstrual

¹⁶⁶ NFCC, [Mission and Objectives](#), no date.

¹⁶⁷ NFCC, [Menstrual Health, Hygiene and Rights](#), no date.

¹⁶⁸ NFCC, [Menstrual Health, Hygiene and Rights](#), no date.

¹⁶⁹ NFCC, [Advocacy](#), no date.

¹⁷⁰ NFCC, [Mission and Objectives](#), no date.

¹⁷¹ NFCC, Assessment Study on Chhaupadi in Nepal: Towards a Harm Reduction Strategy, March 2015.

¹⁷² NFCC, [Research and Publications](#), no date.

¹⁷³ NFCC, [Research and Publications](#), no date.

¹⁷⁴ NFCC, [Research and Publications](#), no date.

cycle, information about menstrual products, and menstrual hygiene information – over eight sessions.¹⁷⁵ The package, with cooperation from the Department of Education and Department of Women and Children, has been rolled out in some districts in-country through schools and in communities. Currently, NFCC is looking to roll out more broadly by working with local governments.¹⁷⁶

Advocacy work: NFCC has been instrumental in advocating via different means to improve the enabling environment for menstruation in-country. This work includes coordinating Menstrual Hygiene Day since 2014, helping to establish and participating in the MHM Practitioner Alliance, and lobbying for the right to self-determination as a guiding principle for the design and implementation of MHH programmes implemented in Nepal, to ensure that all people have a right to free choice in terms of products.

Is there existing evidence for their programme?

Chhaupadi and menstrual taboo work: Despite the criminalisation of chhaupadi, there is still evidence that the practice continues. A 2014 survey indicated that up to 71% of women and girls in the Mid-Western Mountains region were still experiencing chhaupadi.¹⁷⁷ Moreover, NFCC has undertaken and continues to work on a research portfolio to better understand the roots of this practice and develop innovative methods to tackle the issue. An NFCC assessment proposed a harm-reduction strategy, acknowledging that social norms take time to change and adapt.¹⁷⁸

Menstrual health education: The evidence that exists indicates there is a significant lack of adequate menstrual knowledge among women and girls in Nepal. The 2011 DHS indicated that a quarter of girls did not know about menstruation prior to menarche and other surveys have found that less than half of girls demonstrated adequate knowledge of menstruation.¹⁷⁹ As such, NFCC's work to increase the pool of appropriate individuals (teachers and health workers) in communities that can serve as conduits of information about menstrual health targets a major gap in achieving complete MHH for all individuals in Nepal. Some evidence exists that supportive teachers and health workers may be preferred sources of information for girls in some settings.^{180 181}

Why are they recommended?

- Operating in a unique space in Nepal as the only national NGO (as of 2017) intervening to improve MHH via advocacy, policy-shaping, and capacity building at the government level
- Working in partnership with the government to institutionalise and scale up policies like menstrual health education and integrate MHH into other areas of work
- Commitment to understanding the social and cultural factors underlying menstrual stigma and conceptualising ways to effectively intervene

175 NFCC, Integrating Menstrual Hygiene Management into School Health Program: Final report, no date.

176 NFCC, [Research and Publications](#), no date.

177 Karki, K. B., Poudel, P. C., Rothchild, J., Pope, N., Bobin, N. C., Gurung, Y., Basnet, M., Poudel, M., Sherpa, L. Y. [SCOPING REVIEW AND PRELIMINARY MAPPING: Menstrual Health and Hygiene Management in Nepal](#) (pp. 1-96).

178 NFCC, Assessment Study on Chhaupadi in Nepal: Towards a Harm Reduction Strategy, March 2015.

179 Karki, K. B., Poudel, P. C., Rothchild, J., Pope, N., Bobin, N. C., Gurung, Y., Basnet, M., Poudel, M., Sherpa, L. Y. [SCOPING REVIEW AND PRELIMINARY MAPPING: Menstrual Health and Hygiene Management in Nepal](#) (pp. 1-96).

180 Coast, Ernestina, Samantha R. Lattof, and Joe Strong. "Puberty and menstruation knowledge among young adolescents in low- and middle-income countries: a scoping review." *International journal of public health* 64.2 (2019): 293-304.

181 "Teachers and parents felt unprepared to answer questions about menstruation and focused on the maintenance of restrictions. Teachers and students were embarrassed discussing menstruation in school and classes were not question driven or skills-based. Gender disaggregated teaching of menstruation and engagement of health facility staff may have positive effects." From Morrison, J. L., et al. "Girls' menstrual management in five districts of Nepal: Implications for policy and practice." *Studies in Social Justice* 12.2 (2018): 252-272.

NFCC operates in a unique space in Nepal according to a 2017 landscaping assessment of MHH work in the country, being the only national NGO to be involved in supporting the development of policy and guidelines, building capacity, and creating awareness for MHH programming.¹⁸² Based on the review of the literature and conversations with experts, we think that at-scale improvements in access to complete MHH will come from working closely with governments to integrate MHH into existing programmes and prioritise it as an area for action. We think that NFCC has shown success in doing this, with a history of getting menstruation on the agenda and authorisation to begin rolling out training and incorporating menstruation into different aspects of government programming.

Also based on the literature review and conversations with experts, we think that menstrual stigma is a very important component of MHH that must be addressed before complete MHH can be realised worldwide, and NFCC's work directly addresses this.¹⁸³ Not only do we think that NFCC's work to reduce chhaupadi and other practices stemming from menstrual stigma has the potential to benefit girls and women in Nepal, but we also think that lessons learned from this work and the research they are conducting to understand the roots of the stigma, and ways to change it, could be adapted into different contexts. It may also establish research practices to tackle stigma elsewhere. For instance, in a co-authored paper, it is suggested that MHH programming "consider the use of local languages and context-specific content that incorporates indigenous beliefs, as well as cultivate partnerships with indigenous health organisations" to promote improved access to MHH.¹⁸⁴ These learnings – while generated in the Nepal-context – are broadly relevant to other MHH programmers looking to design and adapt programmes that will be appropriate and effective in different contexts.

How much does it cost to provide a given benefit?

As highlighted above, robust cost-effectiveness estimates will not be available until more data is available quantifying the harms caused by lack of MHH and how effectively different interventions alleviate those harm. Here we give a high-level cost per output figure.

NFCC estimates that it will cost approximately USD\$1,937,125 per year to roll out the menstrual health education training programme to reach 3,421,508 students over three years. Assuming that a third of the target audience would be reached by year, that is approximately USD\$0.58 per student reached by the menstrual health education package. This low cost reflects a more light-touch programme compared to the other recommended organisations.

How much funding do they need, and how will they use it?

NFCC estimates they could productively use USD\$1,937,125 in additional funding in the next year to begin national roll-out of the MHM package and supporting work to integrate it into local government budget and planning processes. They estimate that this programme will take three years to roll out completely and at scale would reach seven provinces, 20,354 schools, and 3,421,508 students.

182 Karki, K. B., Poudel, P. C., Rothchild, J., Pope, N., Bobin, N. C., Gurung, Y., Basnet, M., Poudel, M., Sherpa, L. Y. [SCOPING REVIEW AND PRELIMINARY MAPPING: Menstrual Health and Hygiene Management in Nepal](#) (pp. 1-96).

183 Hennegan, Julie, et al. "Women's and girls' experiences of menstruation in low-and middle-income countries: A systematic review and qualitative metasynthesis." *PLoS medicine* 16.5 (2019): e1002803.

184 Baumann, Sara E., Pema Lhaki, and Jessica G. Burke. "Assessing the role of caste/ethnicity in predicting menstrual knowledge, attitudes, and practices in Nepal." *Global public health* 14.9 (2019): 1288-1301.



Population Services International (PSI)

Who are they?

Founded in 1970, Populations Services International (PSI) is an international nonprofit working on global health issues throughout Africa, Asia, and Latin America. Headquartered in the United States, Europe, and Kenya and with additional country and regional offices in more than forty locations, PSI is well-connected in the global health space.¹⁸⁵ In terms of approaches, PSI is known for its work in marketing, distributing, and creating demand for health information, products, and services to promote broad uptake of needed tools and approaches, such as insecticide-treated nets, contraception, and condoms. Originally focusing on contraception, PSI now works in the areas of SRH, WASH, malaria, HIV and tuberculosis, non-communicable diseases, and safe abortion, with focuses on digital health approaches and reaching adolescents and youth.¹⁸⁶

Demand generation and market shaping are a key part of how PSI approaches achieving health impact, which they conceptualise as consumer and market research to understand what will resonate with consumers and the market barriers that need to be addressed. They identify opportunities to make solutions easier to access for consumers, use communication, media, and digital campaigns and tools to generate demand, and leverage technology to deliver and monitor services.¹⁸⁷

Measurement is also one of PSI's stated values, and they aim to assess the impact and cost of their programmes.¹⁸⁸ PSI has developed its own Impact Calculator to allow for transparent viewing of estimates of impact from its different programmes in the countries it works in, assessing DALYs averted, deaths averted, and couple-years of protection (CYPs), depending on the intervention.¹⁸⁹

What do they do?

A large part of PSI's recent work to improve access to complete MHH is embedded in SRHR work designed to reach adolescents and young women. Reaching adolescents and young women with appropriate SRHR information and services is a major area of focus for PSI, with one of their ongoing commitments being to "revolutionise the way young people access contraception". A variety of different approaches and levers are being tested by programmes run in different country offices, which PSI broadly groups under the categories of:

1. Raising awareness of menstruation and addressing menstrual stigma
2. Building clinical capacity to address menstrual disorders and questions in health care settings
3. Product-based interventions
4. Global advocacy to continue the development of MHH as a field.

Raising awareness of menstruation and addressing menstrual stigma: The PSI Angola office is using Facebook and other digital platforms to break barriers around talking about menstruation and attempting to normalise it. Information shared includes standard menstrual health and hygiene information and information about how menstruation relates to contraceptive use and changes in bleeding patterns. The page uses moderators to provide accurate information in response to questions and correct myths and incorrect information. Individuals who contact moderators with questions receive answers or are connected with healthcare providers if warranted. The PSI Angola team has worked to ensure that this resource has remained available and fully staffed during Covid-19 lockdowns in order to ensure that women and girls do not lose a valuable source of information. As of May, the page was averaging 1,400 interactions per day, and since January 2020, 1,726 people have contacted the call centre to ask questions. This type of model (using social media to make information about MHH more available) is also ongoing in programmes in Benin and Laos. Other types of multi-purpose digital tools have also been introduced to help build knowledge about menstruation. For instance, in India, PSI participated in promoting a menstruation tracking app – Dot – that helps women better track their menstrual cycle and understand how it impacts their fertility, allowing them to make decisions about pregnancy.¹⁹⁰

¹⁸⁵ PSI, [Where We Work](#), no date.

¹⁸⁶ PSI, Our Practice Areas, no date.

¹⁸⁷ PSI, How We Will Shape Markets, no date.

¹⁸⁸ PSI, About Us, no date.

¹⁸⁹ PSI, [Impact Calculator](#), no date.

¹⁹⁰ Punzi MC and Hekster O, [Technical brief for the Integration of Menstrual Health in SRHR, 2019](#).

More interactive programmes have also been tested, such as in Mozambique, where a campaign called Aquele Papo was developed to reach young people aged 10-24 with information about puberty, reproductive and sexual health. The campaign hinges around a film following teens navigating these questions and includes interactive sessions at pop-up events near schools, where information is provided on puberty, menstruation, contraception, and reproductive health. These events are staffed by a healthcare worker who can answer questions about contraception and provide contraceptive services. In the five weeks after the launch of the programme, 6,000 young people attended these events.¹⁹¹

PSI Tanzania developed an event-based programme called Kuwa Mjanja ('Be Smart') to provide interactive sessions to promote understanding of SRHR, including menstrual health and hygiene. These events are staffed by a nurse in order to provide counseling or care related to menstrual health or contraception. The PSI Tanzania team also leveraged digital health interventions and communication strategies by creating a video about menstrual health and the menstrual cycle, games to help recognise and dispel myths about menstruation, and a digital tool to connect users with answers to questions they might have.

PSI Zimbabwe is also conducting both in-person and mass communication campaigns to raise awareness about menstrual health.¹⁹² Peer educators bring together groups of adolescent girls to speak about menstrual health, contraception, and pre-exposure prophylaxis treatment to prevent HIV infection. The digital and media campaigns are aimed at raising awareness of menstrual health, combating stigma, and building knowledge.

Building clinical capacity to address menstrual disorders and questions in healthcare settings: This category of intervention aims to ensure that there are knowledgeable and accessible providers and appropriate avenues for girls and women to seek and receive treatment for menstrual disorders or ask questions. For instance, in Benin, the team worked with providers at youth-friendly health centres to build capacity to manage 400 cases of dysmenorrhea. In Tanzania, all health providers at Kuwa Mjanja events are oriented on youth-friendly services.

PSI also worked with FHI360 to create a resource – NORMAL – that is designed to be used by health workers when providing contraceptive counselling to a client. This tool helps explain to women how different types of contraception might impact menstruation and sensitise them to these changes.¹⁹³

Product-related interventions: Several PSI platforms have engaged in work to provide products and consider market-shaping interventions for menstrual products. For instance, market research was conducted in India and Ethiopia to understand the product landscape¹⁹⁴ and PSI Zimbabwe has distributed menstrual cups to adolescent girls. Meanwhile, PSI Niger and the Benin affiliate both have explored work to set up a local manufacturer of menstrual hygiene products such as menstrual undergarments and reusable pads.

Global advocacy: PSI, in close collaboration with PSI Europe, is also running a Global Menstrual Health Advocacy Project to bring greater attention to menstrual health as an issue of concern and raise its profile on the international agenda, particularly around the need to integrate MHH into SRHR care. This work entails building the technical MHH knowledge base and shaping MHH policies and programs. Outputs include blogs and digital campaigns to raise the profile of menstrual health work; webinars and stakeholder consultations to share learnings and best practices and increase issue salience; promoting MHH at major global health convenings; engaging with funders, researchers, and programmers to drive consensus and progress; and sharing knowledge across PSI platforms and external platforms to build capacity. For instance, based on work focused on integrating MHH into SRHR programmes, PSI and PSI Europe developed and released a technical brief detailing levers for interaction that in-country programmes could use and build on to better integrate MHH into SRHR work.¹⁹⁵

191 Muiambo F, [Taking "The Talk" to the Big Screen](#), 30 October 2019.

192 PSI et al., [Making the Case for Menstrual Health: Lessons from the Field](#), 26 May 2020.

193 Punzi MC and Hekster O, [Technical brief for the Integration of Menstrual Health in SRHR](#), 2019.

194 PSI, [Access to Pads: Five Takeaways from Menstrual Hygiene Management \(MHM\) Research with Adolescent Girls and Young Women in India and Ethiopia](#), 26 October 2018.

195 Punzi MC and Hekster O, [Technical brief for the Integration of Menstrual Health in SRHR](#), 2019.

Is there existing evidence for their programme?

The factors contributing to incomplete MHH that PSI seeks to address with its interventions include issues like lack of knowledge, lack of access to menstrual products, not seeking care for menstrual disorders, non-use of contraception due to menstrual bleeding changes associated with their use, and social stigma. That these issues are relatively common across the LMICs where PSI works is backed up by the literature, indicating that PSI's programmes are aiming to fill real gaps in programming. For instance, in terms of the need to increase knowledge of menstruation, the available evidence indicates that girls frequently reach menarche without receiving education about menstruation or how to use the products available to them correctly.¹⁹⁶ In addition, PSI reports that evidence exists that shows the relationship between menstrual bleeding changes associated with contraceptive use and contraceptive discontinuation and non-use of contraception.¹⁹⁷ This is particularly relevant to PSI as one of the major players in family planning. Stigma is also common worldwide, which can make girls and women unwilling or fearful to ask questions about menstruation.¹⁹⁸

Stigma and shame around menstruation may also contribute to a reluctance to seek care for those impacted by menstrual disorders as well as lack of knowledge on how or when to address the issue among healthcare workers.^{199 200}

Menstrual hygiene product access is also a common issue in LMICs.²⁰¹ Research conducted by PSI in India and Ethiopia found that many adolescent girls and young women could not afford to purchase their preferred type of menstrual product.^{202,203}

As described above, PSI also roots many of its interventions in a sexual and reproductive health programme. This is an approach that has been advocated for by many researchers and programmers in the field as a key area that could benefit from MHH integration, but has not yet sufficiently prioritised this type of intervention.²⁰⁴

PSI has both reviewed the evidence on menstrual health and hygiene generally (and published an evidence review to guide menstrual health programming in 2016²⁰⁵) and conducted in-house research – including a literature review, quantitative and qualitative work, stakeholder interviews, and participatory workshops – to better understand menstrual product access, preferences, and market features in India and Ethiopia.²⁰⁶ Programme design is also informed by human-centred design principles – for instance, in the case of the Tanzania programme²⁰⁷ – and other forms of market research. In addition, learnings from challenges in programmes also helped with the development of menstrual health components. For instance, in Zimbabwe, the team identified that uptake of contraceptive and HIV services were low among their target audience of adolescent girls and young women because they did not want to be perceived as engaging in conversations concerning sexual activity. However, integrating and leading with the menstrual health component made the programme more palatable and increased uptake.²⁰⁸

196 Chandra-Mouli, Venkatraman, and Sheila Vipul Patel. "Mapping the knowledge and understanding of menarche, menstrual hygiene and menstrual health among adolescent girls in low-and middle-income countries." *Reproductive health* 14.1 (2017): 30.

197 Rademacher K et al. Menstrual Bleeding Changes Are NORMAL: Proposed Counseling Tool to Address Common Reasons for Non-Use and Discontinuation of Contraception, 2018.

198 Hennegan, Julie, et al. "Women's and girls' experiences of menstruation in low-and middle-income countries: A systematic review and qualitative metasynthesis." *PLoS medicine* 16.5 (2019): e1002803.

199 Armour, Mike, et al. Self-care strategies and sources of knowledge on menstruation in 12,526 young women with dysmenorrhea: A systematic review and meta-analysis." *PloS one* 14.7 (2019): e0220103.

200 Hennegan, Julie, et al. "Women's and girls' experiences of menstruation in low-and middle-income countries: A systematic review and qualitative metasynthesis." *PLoS medicine* 16.5 (2019): e1002803.

201 PMA2020 monitoring data indicates that for women who use pads, 26.4% of respondents reported that they had needs for materials that were not being met. This figure was higher for rural women who exclusively use pads (38.5%) and women in the lowest wealth quintile (45.9%). Smith, Annie D., et al. "National Monitoring for Menstrual Health and Hygiene: Is the Type of Menstrual Material Used Indicative of Needs Across 10 Countries?." *International journal of environmental research and public health* 17.8 (2020): 2633.

202 PSI, [Expanding Access to Menstrual Hygiene Products in India](#), 2018.

203 PSI, [Increasing Access to Menstrual Hygiene Management Products in Ethiopia](#), 13 September 2018.

204 Hennegan, Julie, Amy O. Tsui, and Marni Sommer. "Missed Opportunities: Menstruation Matters for Family Planning." *International perspectives on sexual and reproductive health* 45 (2019): 55-59.

205 PSI, [Evidence Series: Menstrual Hygiene Management](#), 2016.

206 PSI, [Expanding Access to Menstrual Hygiene Products for Adolescent Girls and Young Women in Ethiopia](#), Washington, D.C.: PSI; 2018.

207 [Adolescents 360](#), HCD for Adolescent Services, no date.

208 PSI et al., Making the Case for Menstrual Health: Lessons from the Field, 26 May 2020.

PSI has also produced a technical brief summing up how programmes in different country offices have intervened to improve MHH to help facilitate knowledge sharing.²⁰⁹

Visitor metrics for digital engagement have also been high, which tracks with a review of the literature that digital sources are cited by girls and young women as key sources of information about menstrual health.²¹⁰ For instance, the Facebook page of the PSI affiliates in Central Africa found that engagement rate goes from a normal rate of 3% to 20% when menstruation is mentioned.²¹¹ In addition, “between November 2018 and January 2019 Entre Nous, the Facebook page of the project Ignite under PSI Cote d’Ivoire, received 1134 messages. Of this 1134, 458 were about the menstrual cycle (a little over 40%).”²¹²

Why are they recommended?

- Centering integration of MHH into SRHR work, which experts cite as a key gap in the current MHH ecosystem and body of work.
- Thoughtful programme design that uses qualitative and quantitative research, market information, and human-centred design to iterate new strategies to address menstrual health.
- While monitoring & evaluation work for its MHH work is still being developed (due to lack of funding), PSI has an extensive track record of assessing programme impact and cost of impact, and a stated interest in building this work.
- Extensive experience in market shaping and implementing mass communication campaigns to build product and service availability and access.
- Work ongoing in multiple geographies, including many without a history of MHH work, which has the dual benefit of achieving greater coverage of services and generating evidence both in terms of MHH epidemiology and how programmes function in different contexts.

One key reason we are interested in the work being conducted by PSI is that they are focusing heavily on integrating MHH into SRHR work and services. This is an area that experts have cited is critically important to improving access to complete MHH worldwide²¹³, and likely has additional benefits for sexual and reproductive health (e.g. increased knowledge about menstrual cycle patterns and shifts due to contraception may decrease the likelihood that a woman discontinues a method of contraception that works for her if she knows the shift is an expected side effect). Given that the existing evidence doesn’t yet exist to support a gold-standard package of menstrual health interventions, organisations aiming to work in this area must be both thoughtful and creative in designing and testing solutions that are likely to improve access to complete MHH. We think that PSI’s focus on testing different ways to integrate MHH and SRHR is an important area of work to be tested and evaluated to continue to build the evidence base for what works and what is most effective in improving menstrual health.

While monitoring data for menstrual health-specific outcomes are limited for PSI’s ongoing programmes due to funding constraints, PSI has an ongoing commitment to designing, testing, iterating, and communicating their findings to achieve impact and have indicated an interest in being able to do this for ongoing and future MHH programmes. Moreover, they have been disseminating qualitative findings from ongoing programmes and have contributed to the research base through studies on menstrual product markets in Ethiopia and India.²¹⁴

209 Punzi MC and Hekster O, [Technical brief for the Integration of Menstrual Health in SRHR](#), 2019.

210 Chandra-Mouli, Venkatraman, and Sheila Vipul Patel. “Mapping the knowledge and understanding of menarche, menstrual hygiene and menstrual health among adolescent girls in low-and middle-income countries.” *Reproductive health* 14.1 (2017): 30.

211 Punzi MC and Hekster O, [Technical brief for the Integration of Menstrual Health in SRHR](#), 2019.

212 Punzi MC and Hekster O, [Technical brief for the Integration of Menstrual Health in SRHR](#), 2019.

213 Hennegan, Julie, Amy O. Tsui, and Marni Sommer. “Missed Opportunities: Menstruation Matters for Family Planning.” *International perspectives on sexual and reproductive health* 45 (2019): 55-59.

214 [Expanding Access to Menstrual Hygiene Products in India](#), PSI [Expanding Access to Menstrual Hygiene Products for Adolescent Girls and Young Women in Ethiopia](#), PSI

In addition, experts indicated that menstrual health product gaps will not be made up through donor funding alone and market-based solutions need to be engaged to ensure quality menstrual products are affordable and accessible down to the last mile. PSI is known for their expertise in social marketing, demand generation, addressing issues in the market that fail women and girls, and leveraging market-based solutions to improve access to health products, and we think their expertise in this area is a promising foundation on which to test market-shaping solutions for menstrual product access.

Finally, experts and our research indicated that menstrual health funding and programming has been concentrated in several areas (such as East Africa and South Asia), which means that many countries with high need do not have much ongoing work to address MHH challenges. Given PSI's global reach and ongoing projects in several of the geographic areas experts flagged they would want to see more work (e.g. West Africa), we think this is an important factor to consider to ensure that MHH solutions are developed and tested to have equitable reach worldwide.

How much does it cost to provide a given benefit?

As highlighted above, robust cost-effectiveness estimates will not be available until more data is available quantifying the harms caused by lack of MHH and how effectively different interventions alleviate those harms. Here we give a high-level cost per output figure.

As many of PSI's programmes involving MHH have been implemented via other programmes and have not been monitored specifically for menstrual health outcomes, it is difficult to assess the cost per programme. For programmes that estimated costs, the range varied based on the intensity and components of the engagement. For instance:

- PSI Laos conducted four Facebook Lives on menstrual health that had a combined view count of 24,811, produced an educational video that has a view count of 20,990, and posted five MHH-focused Facebook posts with a total of 993 engagements (comments, likes, or shares). They estimate this work cost approximately USD \$1,670. Taking only the Facebook Lives into account, this would equate to approximately USD\$0.06 per person reached with additional MHH knowledge.²¹⁵
- In Zimbabwe, during MHH, SRH, and HIV education sessions, a total of 8,512 menstrual cups were distributed. If we assume an average menstrual cup lasts three years and that 73% of participants²¹⁶ continued use of the menstrual cup, this intervention (which had costs of USD\$215,000), cost \$11.50 per year of menstrual product need met. This excludes additional positive outcomes from these programmes like increased knowledge of menstruation, contraception uptake, and pre-exposure prophylaxis for HIV uptake.

How much funding do they need, and how will they use it?

PSI estimates they have a funding gap of USD\$2,515,000 over the next five years to implement a suite of MHH programmes and support global advocacy. This work includes:

- **Angola:** USD\$360,000 over 1.5 years to support a digital media campaign to build awareness about MHH (USD\$200,000) and to conduct market assessment research to understand the need and potential for including menstrual pads into PSI Angola's suite of products.
- **Benin:** USD\$260,000 over three to five years to support the distribution of menstrual hygiene undergarments and menstrual cups, train providers to better manage dysmenorrhea, set up a call centre to support adolescent clients with questions about MHH, and conduct broader demand-generation activities.
- **Laos:** USD\$50,000 over two years to integrate a MHH package into the training

²¹⁵ The full statistics for these activities are:

- 4 FB Lives: combined reach of 124,603, combined engagement of 8,625, and combined view count of 24,811.

- MHH educational video: reach 100,387, engagement of 25,999, and 20,990 views

- 5 MHH-focused FB posts: reach of 16,860 and an engagement of 933

²¹⁶ Van Eijk, Anna Maria, et al. "Menstrual cup use, leakage, acceptability, safety, and availability: a systematic review and meta-analysis." *The Lancet Public Health* 4.8 (2019): e376-e393.

curriculum for government health educators (that are dispatched into communities to provide health education), train health educators on this package, and integrate MHH into the supportive supervision plan. This work would also be accompanied by additional social media and educational outreach.

- **Mozambique:** USD\$500,000 over one year for ongoing MHH activities, including to integrate more MHH messages into upcoming seasons of the Aquele Papo television dramas, to reach rural adolescents and youth with MHH messaging and adapt activities to reflect COVID-19 concerns.
- **Tanzania:** USD\$500,000 over the next year to create a focused MHH component through communication activities and education of ongoing work around adolescent and youth SRHR.
- **Zimbabwe:** USD\$545,000 over two years to intensify and broaden the reach of MHH programming to three additional districts in urban (high-density) and peri-urban areas by leveraging an existing school-based mobilization and education programme for boys on male circumcision. This would also aim to distribute an additional 23,400 menstrual cups and 23,400 disposable pads. In addition, the ongoing media campaign would be expanded to videos, radio, and more materials to elevate the conversation about MHH more broadly.

The work would also include global advocacy and technical assistance work (USD\$300,000) to continue to champion MHH worldwide and with funders to improve attention and investment into this area.



Sesame Workshop

Who are they?

Sesame Workshop, is a US-based non-profit organisation that aims to improve children's education and development and achieve social impact through media products, communication strategies, and curricula designed to improve children's knowledge, health, and resilience. Sesame Workshop estimates they reach 180 million children in 150 countries worldwide. Their flagship programme – Sesame Street – has been tailored for 30 different contexts and the 'Muppet' characters from the show are used to help communicate difficult topics to children and educate them more broadly. In addition, localized or thematic Muppets have been developed based on formative research to create culturally specific and impactful ways of reaching children coping with difficult circumstances, like trauma and displacement. In all, Sesame Workshop has programmes aimed at children with autism, children coping with traumatic experiences (e.g. substance use among family members), children who are refugees, and children of military families. It also has programmes that promote gender equity, health and hygiene, and financial empowerment.²¹⁷ In addition, localized or thematic Muppets have been developed based on formative research to create culturally specific and impactful ways of reaching children coping with difficult circumstances, like trauma and displacement.

In order to best tailor programmes to the settings and issues they aim to address, Sesame Workshop conducts extensive formative and participatory research to create specific, culturally appropriate interventions that are tied to impact objectives. They explore how best to disseminate programmes – be it through television, radio, in-person, or mobile learning centres – to best reach their target audience. Sesame Workshop works with local partners to both inform programme development and to disseminate these programmes. In addition, Sesame Workshop aims to evaluate their programmes to determine impact and to inform future iterations and improvements to curricula and outreach.

What do they do?

Sesame Workshop aims to improve MHH through an addition to their WASH UP! programme. The WASH UP! initiative, a partnership between Sesame Workshop and World Vision, is active in 15 countries and is designed to improve WASH knowledge and practices among children in primary school. Recognising that as girls approach menarche, they need additional knowledge, skills, and facilities to manage their menstruation, the Girl Talk programme was developed. This initiative is aimed at both girls and boys aged 10-14 and has been piloted in Zimbabwe to test for promise. Zimbabwe was chosen due to exploratory research indicating that menstruation is highly stigmatised in the country and girls are likely to lack information about menstrual hygiene prior to reaching menarche.

The Girl Talk programme aims to leverage aspects of WASH UP! and combine them with menstruation and puberty education to better meet menstrual needs of girls.

As part of the pilot, Sesame Workshop's partner, World Vision provided schools with design support and construction materials to build improved WASH facilities. Schools participating in the WASH UP! pilot committed to building facilities within six months.

The educational portion of the programme – Girl Talk – consists of ten in-person sessions led by teachers trained to facilitate these sessions after school (though this approach can vary depending on the context and availability of after-school programs). Of note, Sesame Workshop is exploring if the teacher training component of the programme could be offered remotely due to Covid-19.²¹⁸ The Girl Talk curriculum was developed in partnership with the Zimbabwean government, Sesame Workshop, World Vision, and other stakeholders in order to assure the materials created were suitable for local context.

Girl Talk after-school programming is open to both girls and boys, although girls were purposefully targeted as part of the pilot and programme-monitoring data reflects that more girls enrolled than boys. The programme stipulates that there are both male and female teachers leading the club.

²¹⁷ Sesame Workshop, [What We Do](#), no date.

²¹⁸ Sesame Workshop noted in personal communication that it would be important that child-facing activities require a trained facilitator (rather than a parent or caregiver) to ensure content and messages are delivered with accuracy and fidelity

These teachers receive additional training to lead the Girl Talk programme, but have also been designated by the government as health extension point people and have been trained to provide health information more generally. The Girl Talk educational sessions include information on puberty, menstruation, and menstrual hygiene practices, and aim to combat myths about menstruation.

Sesame Workshop supports these activities through research-driven content, such as teacher training manuals, child-facing materials like storybooks and activity sheets, and videos. These materials feature Muppets specific Sesame Workshop's WASH programming, and are created and drawn to reflect local culture, context, and landscape.

Is there existing evidence for their programme?

The Girl Talk programme is guided by a theory of change, informed by underlying WASH research from UNICEF and WHO, among others.²¹⁹ It was designed for and piloted in Zimbabwe based on exploratory research and pre-existing studies indicating a need for menstrual hygiene education in schools, work to combat menstrual stigma, and adequate facilities to manage menstruation in Zimbabwe. For instance, one survey found that 52% of young people surveyed in Zimbabwe said there was MHH education provided in schools.²²⁰ In addition, qualitative work found multiple reports of menstrual stigma in Zimbabwe, such as isolating menstruating girls and women.²²¹ JMP data indicates that 37% of schools in Zimbabwe don't have washing facilities to help girls manage their menstruation.²²²

Participatory design methods were used to solicit input and feedback from government stakeholders, local partners, and other key informants to help design a programme that would meet the needs on the ground and be culturally appropriate. This is in line with Sesame Workshop's approach of developing content in any context for any platform.

An evaluation of the Girl Talk pilot found that students participating in the programme gained knowledge of puberty and menstruation, compared to students in the control group. On average, students exposed to the programme saw knowledge scores increase from an average of 58% on the pre-test to 81% on the post-test, compared to the control group which scored on average 61% and 60% on the pre- and post-tests, respectively. This difference was found to be statistically significant.²²³

There was also a positive result found for some – but not all – measures of menstrual stigma and myths. The proportion of the intervention group students who reported believing that “boys and girls should not play or do activities together when a girl is menstruating” declined from 90.4% of respondents at the pre-test to 44.7% of students during the post-test. Among the controls, 87.5% reported believing this at pre-test and 85.8% reported believing this at post-test.

Qualitative findings from interviews with teachers were positive. First, “teachers noted how practical the Girl Talk programme was compared to their standard teaching materials about menstruation and human development.”²²⁴ Teachers also noted that they believed the way the curriculum was designed made students feel more free to ask questions and discuss puberty and menstruation with them. Teachers conducting the intervention were asked at pre-test and post-test whether they had been approached by a student to discuss puberty or menstruation in the last 30 days. Results indicated that while 50% of teachers said they had been approached by a student at pre-test, at post-test 70% said they had been approached by a boy in the last 30 days to discuss puberty and 80% said they had been approached by a girl to discuss menstruation.

As the evaluation was conducted prior to the expiry of the six-month window for schools to build improved WASH facilities, none of the schools selected for the evaluation had completed facilities and so it was not possible to measure whether improved knowledge was put into practice.²²⁵ The evaluators also noted that because so few girls in the population evaluated had reached menarche, it was not

219 See Sesame Workshop Girl Talk Theory of Change

220 Tamiru S, et al. “Towards a sustainable solution for school menstrual hygiene management: cases of Ethiopia, Uganda, South-Sudan, Tanzania, and Zimbabwe.” *Waterlines* (2015): 92-102.

221 Ndlovu, Everson, and Ednah Bhala. “Menstrual hygiene—A salient hazard in rural schools: A case of Masvingo district of Zimbabwe.” *Jambá: Journal of Disaster Risk Studies* 8.2 (2016).

222 WHO and UNICEF, WASH in Schools: [Zimbabwe](#), no date.

223 Light D, et al. Final Report on the Impact of the Girl Talk Program in Zimbabwe, EDC, November 2019.

224 Light D, et al. Final Report on the Impact of the Girl Talk Program in Zimbabwe, EDC, November 2019.

225 Light D, et al. Final Report on the Impact of the Girl Talk Program in Zimbabwe, EDC, November 2019.

feasible to assess whether Girl Talk improved menstrual hygiene practice. Sesame would like to carry out a longer study in the future to understand the impact on behaviour change.

Sesame Workshop has said that they seek to strengthen the programme based on results of the evaluation and other feedback, such as engaging men and boys more and continuing to expand the ability of the curriculum to address social norms.

Why are they recommended?

- Thoughtful programme design, targeted to tackle known issues and informed by a collaborative design process involving relevant stakeholders and formative research to ensure cultural relevance.
- Targeting a younger age range, creating the opportunity to reach children with information, tackle stigma, and ensure responsive WASH facilities are in place before menarche is reached, which could avert negative menstruation-related experiences and start early to normalise menstruation.
- Track record of extensive formative research and long history of creating effective communication and learning programmes for children. Commitment to conducting evaluation of the Girl Talk programme and adapting it based on findings.
- Interest and existing relationships/infrastructure in adapting this programme to reach a group at high risk of lacking access to complete MHH - children in humanitarian settings (e.g. Rohingya children in Cox's Bazar and displaced Syrian children).
- Approaching the problem of incomplete MHH from an educational and early-childhood-development perspective, which is a sector that experts we spoke to mentioned repeatedly needs to be engaged to holistically improve MHH.

Given that the evidence doesn't yet exist to support a gold-standard package of menstrual health interventions, organisations aiming to work in this area must be both thoughtful and creative in designing and testing solutions that are likely to improve access to complete MHH. We think the Girl Talk programme meets the bar of being thoughtfully designed and leveraging available information to create a package of interventions designed to fill multiple gaps in MHH for pre-menarchal girls (and boys) in Zimbabwe. Moreover, we think embedding this work into an ongoing and scaling WASH education programme is an effective way to harness investments and interest across sectors to improve MHH.

We think that reaching younger children is an important component to be tested when it comes to designing and testing menstrual health programmes. Research has shown that girls who knew nothing about menstruation prior to menarche may feel fear or shame and not know how to safely manage their menstruation.²²⁶ We think that there is an opportunity to test if programmes reaching pre-menarchal girls can help normalise menstruation and establish good menstrual hygiene practices. In addition, involving boys in these programmes may also aid in normalising menstruation and combating menstrual stigma.

We also appreciate Sesame Workshop's commitment to evaluating programmes – including the Girl Talk pilot – and incorporating the learnings into ongoing programme adaptation. Sesame Workshop has also communicated an intent to publish their findings, which we believe is important for building the evidence base for what works in menstrual health.

Another reason we are interested in this work is Sesame Workshop's focus on adapting it to be delivered to children in humanitarian settings. Not only does the data indicate that women and girls in refugee settings are at high risk of lacking the necessary components for complete MHH, data also suggests that living in a humanitarian setting disrupts children's education²²⁷, potentially eliminating a valuable source of knowledge about menstruation. Therefore, we think these children are in high need of receiving interventions to educate them about and improve menstrual health.

²²⁶ Chandra-Mouli, Venkatraman, and Sheila Vipul Patel. "Mapping the knowledge and understanding of menarche, menstrual hygiene and menstrual health among adolescent girls in low-and middle-income countries." *Reproductive health* 14.1 (2017): 30.

²²⁷ Hammadi S, A 'lost generation' of Rohingya children will have nowhere to go, Amnesty International, 24 January 2020.

How much does it cost to provide a given benefit?

As highlighted above, robust cost-effectiveness estimates will not be available until more data is available quantifying the harms caused by lack of MHH and how effectively different interventions alleviate those harm. Based on the information provided about the pilot in Zimbabwe, we calculate a high-level cost per output figure.

For the pilot programme, the total funding received was \$952,000, and this programme has so far reached more than 25,000 girls and nearly 14,300 boys. This means that the pilot has cost around \$24 for each child reached. This calculation does not account for additional benefits, including the contribution to the MHH evidence base, benefits to the community and social support for girls managing their periods in a healthy way, and the reach of messages passed by beneficiaries to their families, siblings and peers.

For future expansion within Zimbabwe, this cost would likely be lower because content has already been produced and tested locally.

How much funding do they need, and how will they use it?

Expansion of the successful Girl Talk pilot requires a range of funding between \$600k to \$10M per country, depending on the availability of WASH infrastructure and level of programming. The funding will cover costs for Sesame Workshop, as well as sub-grants to their WASH partner, World Vision.

Sesame Workshop gives three scenarios for a country expansion, in each case covering three-year terms.

- **Scenario 1 - \$600-800k per country:** Expansion of Girl Talk where WASH UP! Has already been implemented. This allows us to build on World Vision's programming and investment in school infrastructure. There are 10-15 countries, particularly in sub-Saharan Africa, where this scenario would be immediately possible because WASH UP! has already been implemented. The scale-up in Zimbabwe would also be an example of this scenario. Sesame Workshop estimates that over a 3 year program, each expansion to a new geography would reach around 30,000 girls per school year (approximately 3 school terms).
- **Scenario 2 - \$1-2m per country:** Expansion of Girl Talk to countries where school infrastructure upgrades have not yet been implemented, or the existing curriculum would need significant alteration (including in refugee settings, such as Cox's Bazaar, the Syrian Response Region, and others).
- **Scenario 3 - \$5-10m per country:** A much more in-depth, holistic approach to expand the program to a new country including an initial assessment of development of a fully contextualised curriculum, engagement with government ministries to raise awareness and bring about systemic change, mass media campaigns, and community work.

Sesame Workshop, in partnership with World Vision, imagines the explanation and scale up of Girl Talk as a mix of the scenarios presented, including some light touch (Scenario 1) and some more intensive approaches (Scenarios 2 and 3) depending on the country context. Sesame Workshop can initially absorb at least \$3M in the first year, with increasing levels of funding in year 2-5, expanding to new countries each year of the program.

Simavi

Who are they?

Simavi is a Dutch NGO working in six countries in Africa (Ethiopia, Ghana, Kenya, Malawi, Tanzania, and Uganda) and four countries in Asia (Bangladesh, India, Indonesia, Nepal).²²⁸ Founded in 1925, Simavi's mission is to improve the well-being of women and girls by bolstering health, self-determination, and economic empowerment.²²⁹ Simavi's work focuses on the intersection of SRHR and WASH, as they believe these components are essential to improving and sustaining the health of women and girls worldwide.²³⁰ Given its relevance to both SRHR and WASH, Simavi has positioned menstrual health as one of its five key areas of expertise.

In order to design and implement programmes, Simavi works closely with local partners. This ensures that programmes are locally rooted and take existing norms and structures within communities into account.²³¹

Simavi uses existing evidence and formative research to design their programmes. They are committed to generating evidence of their impact and shaping their programmes to be sustainable in the long term.²³² Monitoring and evaluation of programme impact is guided by Simavi's overall theory of change.²³³ As this theory of change demonstrates, Simavi's path to impact not only encompasses giving women and girls the knowledge and self-efficacy they need to make good health choices, it also aims to improve the enabling environment, social norms, and supporting structures (via work with communities, governments, and through making products available).

What do they do?

Simavi has two main programmes that address MHH; the Ritu programme in Bangladesh and the Perfect Fit programme in Indonesia. These two programmes are described in more depth below.

Ritu: The Ritu programme is a MHH intervention in Bangladesh, with direct interventions in the Netrakona region, that ran until March 2020. It is primarily targeted at in-school girls aged 10-13, and the overall objective is to "Improve menstrual health and related well-being of girls between 10 and 13 years in Bangladesh".²³⁴ Secondary populations targeted by this intervention include teachers, parents, and broader Bangladeshi society. The outcomes targeted by this programme to achieve its objective are:²³⁵

- Increased knowledge and improved attitudes and practices on menstrual health of girls, boys, men, and women
- Increased commitment towards menstrual health by the government and civil society in Bangladesh
- Access to better MHM facilities in schools and affordable biodegradable sanitary napkins for girls and women

This programme has three components:

- Direct interventions for in-school girls:
- Training teachers and parents on a broad WASH and SRHR curriculum that includes a thorough menstrual health component, and working with teachers to integrate this information into their lessons
- Facilitating the construction or adaptation of existing facilities to create gender-sensitive toilets in schools and in communities, including budget mobilization

²²⁸ Simavi, [The countries we work in](#), no date.

²²⁹ Simavi, [Our mission and vision](#), no date.

²³⁰ Simavi, [Expertise areas](#), no date.

²³¹ Simavi, [In-country partners](#), no date.

²³² Simavi, [Our guiding and working principles](#), no date.

²³³ Simavi, [Theory of Change](#), no date.

²³⁴ Communication with organisation.

²³⁵ Simavi, [Ritu](#), no date.

- National communication and advocacy campaign
 - Providing “edutainment” materials to “influence the national discourse on menstrual health”, including Ritu’s Facebook page and website
 - Lobbying for the integration of menstrual health into the national curriculum and implementing gender-sensitive WASH facilities in schools
 - Training local NGOs on menstrual health
- Development of a biodegradable sanitary pad
 - Currently working with a locally based menstrual pad manufacturer to integrate the production of a biodegradable sanitary napkin that is sold for USD\$0.05. (This napkin is not included in the direct intervention in Netrakona).

Direct intervention activities in Netrakona have worked with 149 schools and reached 34,010 girls, 29,102 boys, 9,230 parents, and 1,000 teachers.²³⁶

The Perfect Fit: The Perfect Fit programme is currently being implemented in Indonesia and is led by Kopernik, with Simavi as a key partner in the design and implementation of the intervention. This programme is a combination intervention aimed at designing, manufacturing, and distributing reusable menstrual pads via a social enterprise model and disseminating menstrual knowledge (via social marketing) in rural areas of Indonesia.

The first phase of this project recently wrapped up, achieving the following outputs and outcomes according to the Phase 1 endline assessment:

- Distribution of 23,941 Perfect Fit menstrual pads to 5,964 women and adolescent girls
- 81% of users saying they were “very satisfied” with the final iteration of the Perfect Fit product
- 10% increase in menstrual knowledge
- Determining that menstrual product costs borne by women can be cut in half over three years by switching from disposable menstrual pads to Perfect Fit reusable pads

Is there existing evidence for their programme?

Ritu: The Ritu programme was designed in conjunction with Impact Centre Erasmus at Erasmus University. The features of the programme were developed in response to the gaps and strategies identified through a literature review and formative research conducted in Netrakona District where the programme was implemented.²³⁷

A randomised controlled trial has been carried out assessing the effects of the Ritu programme on school attendance and wellbeing. The study protocol can be found [here](#). The results have not yet been published for this study, but Simavi reports that preliminary results show positive effects. Simavi has reported preliminary results to us:

“The Ritu programme significantly reduced school absence rates, and reduced the likelihood of dropping out of school before grade 8. The program also improved subjective wellbeing during menses, but this did not translate into an improvement of general wellbeing or mental health. The Ritu programme did successfully increase empowerment levels of the girls, with improvements in gender attitudes, aspirations and mobility during menses. When comparing the impact on girls that received school interventions with the girls that received both school and community interventions, most results show no significant difference in treatment effects between the two arms, even though the school and community interventions were more costly than the school interventions. However, the school and community interventions do seem to have created a more supportive MH environment at home. With girls reporting to feel less insecure and worry less during their menstruation than girls that only received school interventions.”

²³⁶ Simavi, [Impact Report 2019](#), 1 June 2020.

²³⁷ Simavi, [Impact Report 2019](#), 1 June 2020.

The WASH and knowledge focus of this intervention is responsive to identified gaps in MHH for in-school girls. A cross-sectional survey of in-school girls in Bangladesh found that 82% of respondents perceived that the toilets in their schools were an appropriate place to change materials or otherwise manage their menstruation, but only 28% of schools had an unlocked toilet that girls could access freely.²³⁸ Moreover, 64% of girls reported that they had received no information about menstruation prior to menarche and less than 1% of girls reported receiving this information from a teacher.²³⁹ Based on these figures, the Ritu programme's goal to reach girls with both menstruation-friendly WASH facilities and education seems to meet a real gap in complete MHH.

In addition, policy and context research was conducted to identify appropriate levers for change. For instance, a financial analysis was carried out to understand where there were discrepancies between funding committed to WASH projects for local schools and actual expenditures on that project. Using that information, communities undertook a "resource mobilisation" process to unlock committed funding that could be used to adapt WASH facilities in local schools to make them gender-sensitive.

Moreover, the training curriculum developed for the Ritu programme was designed to be responsive to current national priorities and structured to help teachers understand where health education fits into their lessons in accordance with government policy.

The Perfect Fit: The Perfect Fit programme is a variant of the social enterprise model for designing responsive products and distributing them sustainably. Product- and knowledge-based interventions are designed to respond to the need for preferred menstrual products and information. As highlighted above, there is evidence that there is a lack of access to menstrual products in LMIC's.²⁴⁰

Why are they recommended?

- Commitment to evidence to understand programme impact and inform programme design
- Working at multiple levels (individuals, communities, government) to best design and position programmes to be eventually implemented at scale for greatest impact
- Thoughtful programme design that aims to address multiple factors for incomplete MHH, leverage government buy-in, and mobilise previously committed resources for improvements to facilities
- Clear focus on MHH work for a number of years and active globally to drive advocacy and uptake of menstrual health as an important area of intervention

As we've highlighted already, given that the evidence doesn't yet exist to support a gold-standard package of menstrual health interventions, organisations aiming to work in this area must be both thoughtful and creative in designing and testing solutions that are likely to improve access to complete MHH. We think the Ritu programme meets the bar of being thoughtfully designed and leveraging the information that is available to create a package of interventions designed to fill multiple gaps in MHH for girls in Bangladesh. Moreover, we think that the programme was designed not just to be evidence-informed but also to consider practical implications and give it the best chance of uptake. For instance, the programme took care to ensure that the gender-sensitive WASH facilities portion of the work took place before the training and education portions in order to ensure that girls had the conditions they needed to act on new knowledge and beliefs.

As detailed above, we think that the Ritu programme used the evidence that does exist well, and we were also impressed by the way the programme is designed to leverage existing resources to improve menstrual health and hygiene while also involving the government. As mentioned in the research summary, experts think that one of the best ways to scale menstrual health programming is to identify how to integrate it into existing government priorities and programmes so it can be implemented and

238 Alam, Mahbub-UI, et al. "Menstrual hygiene management among Bangladeshi adolescent schoolgirls and risk factors affecting school absence: results from a cross-sectional survey." *BMJ open* 7.7 (2017): e015508.

239 Alam, Mahbub-UI, et al. "Menstrual hygiene management among Bangladeshi adolescent schoolgirls and risk factors affecting school absence: results from a cross-sectional survey." *BMJ open* 7.7 (2017): e015508.

240 For instance, PMA2020 monitoring data indicates that for women who use pads, 26.4% of respondents reported that they had needs for materials that were not being met. This figure was higher for rural women who exclusively use pads (38.5%) and women in the lowest wealth quintile (45.9%). Smith, Annie D., et al. "National Monitoring for Menstrual Health and Hygiene: Is the Type of Menstrual Material Used Indicative of Needs Across 10 Countries?" *International journal of environmental research and public health* 17.8 (2020): 2633.

monitored at scale. By identifying already committed resources for WASH enhancements and improving adherence to existing national standards and curricula for health education, the Ritu programme is smartly filling gaps between policy and implementation.

Moreover, this programme is being tested by an RCT, which will help bolster the information available for programmers and determine whether this area for investment continues to be promising. While the results of the Ritu trial have not yet been published, regardless of what they show they will help steer the development and implementation of other MHH programmes and add to the knowledge base about harms of inadequate access to complete MHH.

The Perfect Fit programme is similar to several other programmes in terms of using market-based social enterprise strategies to meet unmet needs for menstrual products. This programme is looking to test different ways of reaching potential customers via social media and other mechanisms to broaden their reach and manner of communicating information.

Beyond these specific programmes, we also think that Simavi is committed to sharing knowledge and building the field as a whole, which will be critical to shape and scale effective, evidence-based practices and secure a reliable funding base and advocacy clout. Simavi has developed a menstrual health training manual that is available to other NGOs for use, routinely trains other NGOs on implementing and integrating menstrual health programming into other work, and advocates internationally for more attention on menstrual health work (Annual Report).

How much does it cost to provide a given benefit?

As highlighted above, robust cost-effectiveness estimates will not be available until more data is available quantifying the harms caused by lack of MHH and how effectively different interventions alleviate those harm. Here we give a high-level cost per output figure.

Cost-effectiveness estimates for the Ritu programme are expected in the near future, as data from the RCT is currently being analysed.

For the Ritu programme, Simavi estimates that it costs €53.00 per girl reached for the standard Ritu package (school-based interventions) and €83.00 per girl reached with both school- and community-based interventions. Based on the standard package of interventions, we can estimate that it costs approximately €53.00 to ensure that an in-school girl has access to improved WASH facilities and information about menstruation, for as long as she remains in that school.

The Perfect Fit programme estimates that it costs €2.00 to reach each recipient with improved products and information about menstruation.

These different costs illustrate why better information about harms, impacts, and costs of menstrual health programmes will be a critical area for research. For instance, WASH-focused interventions are likely to be more expensive upfront, but are also more likely to provide sustained, broad impact (and have other wider benefits, like handwashing).

How much funding do they need, and how will they use it?

Simavi could use a total of EUR €2,925,000 of additional funding to implement its Ritu programme and Perfect fit programme.

Simavi aims to begin scaling up the Ritu programme in Bangladesh based on funder interest, at a total cost of €2,775,000 over the course of four years of implementation. This includes:

- €2,000,000 to implement the direct interventions in schools and communities, conduct national-level advocacy, and evaluate the programme
- €500,000 to conduct a communication campaigns in schools
- €275,000 for an add-on element to scale up production and market work for biodegradable menstrual products

This programme aims to reach 89 schools, 25,000 girls, 25,000 boys, and 1,000 teachers. Simavi is also looking to scale up the Perfect Fit programme in Indonesia, for a total of €150,000 over two years, aiming to reach 10,000 women and girls per production unit.

WoMena

Who are they?

WoMena, founded in 2012, is an NGO with offices in Denmark and Uganda. It focuses on applying effective research and programme development techniques to reproductive health work to drive innovative solutions to Sexual and Productive Health challenges. An extensive portion of WoMena's portfolio deals with MHH and the promotion of safe, accessible, and hygienic MHM products. WoMena has been working in partnership with other implementing organisations (such as Save the Children International, International Rescue Committee and CARE International in Uganda) to promote uptake and continued usage of menstrual cups in Uganda.

WoMena focuses on both short- and long-term outcomes to promote access to complete MHH. For instance, their short-term outcomes of interest include improving access to comfortable, affordable and environmentally responsible products, boosting knowledge, and enhancing social support factors around MHH. In the long term, they aim to work towards gender equality, dignity, and social and economic mobility via improving MHH more broadly.

What do they do?

One of WoMena's main focuses to date has been introducing menstrual cups in Uganda and providing assistance in product uptake. In addition, they work on broader MHH projects in Uganda.²⁴¹ WoMena's theory of change governing their menstrual cup work envisions their role as:²⁴²

- Undertaking policy and advocacy work
- Raising public awareness
- Providing implementation support to drive improvements for menstrual health in low-resource contexts

WoMena also carries out research to ensure that their work is underpinned by rigorous evidence.

In the long-term, WoMena sees its impact as supporting the creation of replicable policies and programmes that can be adapted and implemented in different contexts to support improved access to complete MHH. WoMena undertakes the policy aspect of their work by attempting to close the gap between research and policy, develop briefs, and conduct policy and stakeholder reviews to better understand the current landscape and where there is the greatest opportunity to intervene.²⁴³

These projects include:

Menstrual Cup Market Accessibility Project: This project tested different market strategies for selling menstrual cups in collaboration with several partners, including Marie Stopes. It reached more than 1,200 girls and women with menstrual cups and generated learnings about market strategies.²⁴⁴

- Menstrual Health and School Attendance among Adolescent girls in Uganda (**MENISCUS**): This study was conducted to test the effect of a multicomponent MHM intervention on school attendance, including (1) puberty education, (2) drama performances, (3) menstrual management kit (including reusable pads) and training, (4) pain management (including provision of analgesics), and (5) improvements to school water, sanitation and hygiene (WASH) facilities.
- APEAL: WoMena is the technical lead on menstrual health management within APEAL consortium, lead by CARE International, to provide gender-sensitive programming and protection from gender-based violence to refugees arriving in Uganda.

Is there existing evidence for their programme?

Menstrual cup and product distribution work: As we have highlighted, there is a lack of access to

²⁴¹ WoMena, [Multidisciplinary Research](#), no date.

²⁴² WoMena, [Theory of Change: Menstrual Cups and Health](#), no date.

²⁴³ WoMena, [Our Approach](#), no date.

²⁴⁴ WoMena, [Menstrual Cup Market Accessibility Project Evaluation Report](#), May 2020.

menstrual health products in LMIC's.²⁴⁵ WoMena aims to bridge this gap by determining ways to meet the needs of women and girls in their local environments. For many, this means that the menstrual cup might be the best option they currently have in terms of discretion, protection, and ability to wash and store the product effectively. WoMena has supported initial work showing that the acceptability and uptake for menstrual cups were higher when women and girls were supported on how to use them and care for them correctly.^{246, 247} One of the barriers to menstrual cup use is that it has a high upfront cost. WoMena is actively working to test market solutions to lower this cost and contribute to the evidence base for the next round of market shaping. WoMena have reported to us that results thus far indicate that women are willing to pay around USD\$7 for a menstrual cup, and that the costs of cups can be lower when the reduced frequency of costs is taken into account.

WoMena is also using all their programmes to add to the evidence base to help guide the next generation of MHH programming. They have been active in the research, in partnership with the London School of Hygiene and Tropical Medicine, leading up to an RCT in Uganda²⁴⁸ and are consistently testing their interventions. They aim to disseminate their research through publications, meetings, and coalition work (both non-governmental and through government working groups) to attempt to bridge the gap between research and policy.

Why are they recommended?

- Commitment to evidence to understand programme impact and inform programme design.
- Working at multiple levels (individuals, communities, government and social enterprises) to best design and position programmes to be eventually implemented at scale for greatest impact.
- Working to understand whether menstrual cup uptake and promotion can be leveraged through education and market-based solutions - a potentially important area of impact in terms of achieving access to sustainable and long-lasting menstrual product solutions.

We think WoMena's plans are likely to be an effective means of ensuring the sustainability and scalability of menstrual health interventions. Moreover, we think that WoMena's current focus on menstrual cups is an important component of a global MHH strategy. Interest in menstrual cups is rising and despite the fact they require a higher initial investment and learning curve than other products such as menstrual pads, they offer several important features. These include long-term reusability, less water required for washing, discrete drying, and no need for disposal, which could make them a good product for women and girls – especially for those in low-resource settings. In addition, the component of their strategy to engage national procurement planning in obtaining menstrual cups offers the opportunity to negotiate volume-based price reductions.

In addition, based on our review of the literature and conversations with experts, we think that bringing together research and policy for programme and policy design is an essential component of building the case for menstrual hygiene and effectively allocating the limited resources that currently exist. WoMena is actively contributing to the research base and is involved in the set-up of a proposed RCT to test the impact of menstrual cups on MHH-linked factors. By producing research and linking that research to programme design and policy decisions, the MHH field can hope to establish a suite of effective programmes, policies, and products supported by a robust evidence base and cost-effectiveness analyses to make the case to governments, development partners, and other funders that MHH is a field worth investing in.

245 PMA2020 monitoring data indicates that for women who use pads, 26.4% of respondents reported that they had needs for materials that were not being met. This figure was higher for rural women who exclusively use pads (38.5%) and women in the lowest wealth quintile (45.9%). Smith, Annie D., et al. "National Monitoring for Menstrual Health and Hygiene: Is the Type of Menstrual Material Used Indicative of Needs Across 10 Countries?" *International journal of environmental research and public health* 17.8 (2020): 2633.

246 WoMena and Uganda Red Cross Society, [Pilot Study Report](#), December 2012.

247 WoMena, [Menstrual Cup Interventions Follow-up Study Report](#), 2019.

248 Kansiime, Catherine, et al. "Menstrual health intervention and school attendance in Uganda (MENISCUS-2): a pilot intervention study." *BMJ open* 10.2 (2020).

How much does it cost to provide a given benefit?

As highlighted above, robust cost-effectiveness estimates will not be available until more data is available quantifying the harms caused by lack of MHH and how effectively different interventions alleviate those harms. Here we give an approximate cost per output (rather than outcome).

WoMena estimates that the average cost, per participant, in a pilot programme is around USD\$50. This includes menstrual cup distribution. If we assume a menstrual cup lasts for three years, works out to \$16.67 per year of meeting the menstrual product needs, per person. WoMena notes that the relatively high cost per participant includes the following activities and opportunities to generate and disseminate learning:

- Evidence generation
- Education
- Community support interventions
- Engaging healthcare providers
- Creating sustainable supply mechanisms for MHM products

How much funding do they need, and how will they use it?

WoMena could use additional funding of around \$551,000 over the next three years, with \$171,000 in the first year.

WoMena's direct implementation activities (such as their menstrual cup work) are supported by implementation support subgrants from international NGOs, such as CARE International in Uganda and Save the Children International. However, these grants do not cover their advocacy work, a project to revise their MHM training toolkits, or overhead costs, and for these activities they could use additional funding.

Given this, funding would be spent in the following way:

- \$32,335 for policy activities: to hire an external consultant to carry out a review of policies in Uganda and make recommendations for how to adapt policies to account for MHM, and publicise it within the government.
- \$37,000 for networking: to run stakeholder meetings, presentations, and workshops, and print and disseminate any relevant results.
- \$3,248 to produce a toolkit to guide practices within MHM for people with disabilities.
- \$37,000 for the ESA MHM Research Network: to run stakeholder meetings, presentations, and workshops, and print and disseminate any relevant results, specific to the ESA MHM Research network.
- \$124,355 to carry out a MHM intervention for people with disabilities in Kampala
- \$58,000 for travel costs
- \$166,834 for staff, including a M&E officer, a training coordinator, and an accountant.
- \$92,287 for overhead and administrative costs.



6. Limitations and Future Recommendations

As previously described, the scope of this report was to survey the field of menstrual health and develop recommendations for organisations doing excellent work in this area. We aimed to find organisations with a combined funding gap of USD\$10 million that could be utilised and prioritise organisations working in certain preferred geographies. This scope helped us narrow down the list of organisations we reviewed in more depth, but we would be remiss to not describe what is not included in this report due to the scope.

From this work, we believe that the menstrual health and hygiene field will continue to grow and innovate rapidly. In the last decade, there has been a surge of new resources, research, and organisations. We hope that the interest in menstrual hygiene will not wane, but rather continue to grow thanks to the work of the advocates, programmers, researchers, and funders. Due to that, we believe that recommended organisations for investment will likely grow and shift.

There are several limitations in this report that we would like to specifically flag. Part of our mandate in this work was to identify organisations working in several priority geographic regions that could absorb a potentially large amount of investment initially. While we think the organisations identified above are doing exciting and innovative work and are committed to expanding the evidence base, we also believe there will be a growing need for funding in a few additional directions.

6.1 Funding for local-led and grassroots organisations

Given that menstrual hygiene is highly taboo and shaped by cultural factors worldwide, we think that local groups are often best placed to deeply understand what needs to be done and what interventions would be acceptable in their communities. In addition, there is a lot of room for innovative programming and new models to be developed and tested. Therefore, we think that funding local and grassroots organisations is an essential component of building the evidence base and programming menu in this field. This report focused on identifying larger organisations with the capacity to immediately absorb funding and we are impressed with their models and work, but also think that there is need to support smaller and locally led organisations to stimulate long-lasting sustainable societal change.

One model we were particularly impressed by is AmplifyChange, which provides grants for menstrual health work, in addition to other sexual and reproductive health work. They work with small, grassroots organisations both to fund programme implementation and to support these organisations to build their accountability and financial capacity for organisational growth. We think that models like this are an excellent way of ensuring that newly established organisations are able to fund and test their work as funding in this area grows. AmplifyChange has indicated they have a funding gap for MHH projects, due to receiving more applications for support than they have the funding to make grants to.

6.2 Funding in geographic areas without ongoing MHH work

We looked to certain priority geographies when longlisting organisations to evaluate. This was reinforced by our prioritisation of more established organisations. As such, our recommendations cluster in geographies where individuals and organisations have done exceptional work championing MHH as a field.

However, there are millions of people who menstruate living in countries without access to champions and on-the-ground innovators. Therefore, we think that there is room to fund and support this type of work in areas that aren't receiving as much investment.

6.3 Address populations not currently served

One factor highlighted by many experts was the need to expand menstrual health and hygiene programming beyond in-school girls. These programmes are important and should continue to be administered, but many other populations are under-served. The issue of absenteeism and potential links to lack of adequate menstrual health and hygiene are one of the areas that have received a great deal of attention in terms of investment and evidence generation. Ensuring girls are not deterred from receiving schooling due to menstruation is extremely important and has many potential benefits. However, we also think that other populations are under-served, such as women in the workplace, people who are incarcerated, people with disabilities. These groups could be better served by supporting innovation and evidence-generation to identify barriers and solutions to ensuring complete MHH.

6.4 Follow the growing evidence base when evaluating future opportunities

As MHH implementers continue to innovate and the evidence base continues to grow, it is likely that standout and cost-effective interventions will continue to be validated and identified. As in any field where the evidence base is changing rapidly and new actors are coming into play, we think that these recommendations will need to be reviewed more rapidly than they would in a more established field. Based on our survey, we think that results from multiple RCTs can be expected in the next few years, accompanied by cost-effectiveness data. As this information is added to the evidence base, it will be important to consider more closely. For this iteration of recommendations, cost figures are based on outputs, rather than impact, and are not comparable due to the differing nature of the programmes they apply to.



Appendix 1. Organisation evaluation rubric

The rubric that was used to score selected organisations is laid out below. This rubric was used as a tool to assist in the selection of organisations for the shortlist to reach out to, and in some cases we shortlisted organisations with lower scores than organisations that weren't reached out to.

Organisations were scored on the following items:

1. **Evidence-based:** what evidence exists supporting the MHM interventions implemented by this organisation?
2. **Theory of Change:** does this organisation have a robust theory of change supporting its activities?
3. **Monitoring & Evaluation:** does this organisation have an M&E system in place (in line with their theory of change) and what outcomes are they tracking?
4. **RCT evidence:** has this organisation conducted studies (esp. RCTs) of their MHH programmes, or does it plan to conduct an RCT in the future?
5. **Cost:** has this organisation collected cost data or performed a cost-effectiveness analysis about their interventions, or does it plan to conduct a CEA in the future?
6. **Holistic:** do the interventions this organisation implements address at least two aspects of incomplete MHH, or has it partnered with another organisation to ensure a more complete approach to MHH?
7. **Sustainable:** has this organisation made plans for the long-term sustainability of its interventions?
8. **Scalable:** do we believe these interventions are scalable beyond the current geography and reach?
9. **Equitable:** are the interventions implemented by the organisation designed to reach especially marginalised and vulnerable populations?
10. **Organisation Strength:** Is this a strong and healthy organisation equipped to meet the needs of those who it serves? Measured by factors such as:
 - a. Transparency with data, funding plans, needs
 - b. Stability of leadership and staff
 - c. Leadership and staff are representative of the population being served

