Menstrual Health in East and Southern Africa:
Update of the 2018 Rapid Review and Stocktaking
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<th>Abbreviation</th>
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<tr>
<td>ACMHM</td>
<td>African Coalition for Menstrual Health Management</td>
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<td>CIMC</td>
<td>Contraceptive-induced menstrual change</td>
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<td>DHS</td>
<td>Demographic and Health Surveys</td>
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<td>ESARO</td>
<td>UNFPA East and Southern Africa Regional Office</td>
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<td>LMHICs</td>
<td>Low, middle and high income countries</td>
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<td>IASC</td>
<td>Inter-Agency Standing Committee</td>
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<td>ICPD</td>
<td>International Conference on Population and Development, 1994</td>
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<td>IFRC</td>
<td>International Federation of Red Cross and Red Crescent Societies</td>
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<td>IRC</td>
<td>International Rescue Committee</td>
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<td>IUD</td>
<td>Intrauterine contraceptive device (sometimes referred to as IUCD)</td>
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<td>JMP</td>
<td>Joint Monitoring Programme for Drinking Water, Sanitation and Hygiene of WHO/UNICEF</td>
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<td>KII</td>
<td>Key informant interview</td>
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<td>LARCs</td>
<td>Long-acting reversible contraceptives</td>
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<td>LSHTM</td>
<td>London School of Hygiene &amp; Tropical Medicine</td>
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<td>MC</td>
<td>Menstrual cup</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MH</td>
<td>Menstrual health</td>
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<td>MHH</td>
<td>Menstrual health and hygiene</td>
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<td>MHHM</td>
<td>Menstrual health (and) management, menstrual hygiene management</td>
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<td>MICS</td>
<td>Multiple Indicator Cluster Surveys</td>
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<td>NGO</td>
<td>Non-Governmental organization</td>
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<td>PMA</td>
<td>Performance monitoring and accountability</td>
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<td>RTIs</td>
<td>Reproductive tract infections</td>
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<td>SDGs (MTR)</td>
<td>Sustainable Development Goals (mid-term review)</td>
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<td>SRHR</td>
<td>Sexual and reproductive health and rights</td>
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<td>STIs</td>
<td>Sexually transmitted infections</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UN OHCHR</td>
<td>UN Office of the High Commissioner for Human Rights</td>
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<td>Universal Periodic Review</td>
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<td>WASH</td>
<td>Water, sanitation and hygiene</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WRA</td>
<td>Women of reproductive age (aged 15 to 49)</td>
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<td>WSSSCC</td>
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Acknowledgements

This document was developed by the UNFPA East and Southern Africa Regional Office under the leadership of the African Coalition on Menstrual Health Management (ACMHM) and the support of the Swiss Agency for Development and Cooperation through the UNFPA’s youth flagship programme – Safeguard Young People (SYP).

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Renata Tallarico, Jyoti Tewari, Puleng Letsie and Meron Negussie from UNFPA East and Southern Africa Regional Office were responsible for providing technical guidance in the development of the document, and reviewers included Janie Hampton, Julie Hennegan, Penelope A. Phillips-Howard, and Marni Sommer.
Key concepts and terminology

**MH:**
Many terms are used to address menstrual needs: menstrual hygiene management (MHM), menstrual health (and) management (MHM), menstrual health and hygiene (MHH). We will primarily use the term ‘menstrual health’, but will refer to other terms, if used in the cited literature.

**Inadequate MH:**
We use this term to refer to a situation that does not live up to the varying definitions of MHM, MHH or MH.

**Menstruators:**
Not all women and girls menstruate, and not all people who menstruate are women or girls. We will use the terms ‘women’, ‘women and girls’, ‘people who menstruate’ and ‘menstruators’ depending on circumstance and sometimes interchangeably, building on the terms used by the cited literature.

**Menstrual cycles:**
Future research may give more precise estimates, but at present, the literature often refers to there being on average 28 days in a cycle, and 5 days of menstruation in each (for example, the choice of 28/5 for Menstrual Hygiene Day), and consistently assumes there are 12 cycles per year. We note that 365 days divided by 28 equals 13 cycles, and therefore use that.

**Women of Reproductive Age (WRA):**
WRA is a standard demographic term, referring to females aged 15 to 49 years, loosely reflecting the ages between menarche and menopause. In 2021, that demographic group constituted 1.92 billion, or 24.6 per cent of the total world population ([UN DESA, 2019](#)). We will refer to ‘approximately 25 per cent’. We note that this is different from the estimate often used: ‘approximately 26 per cent’, which seems to be based on 2012 data.

**Women menstruating on any given day:**
We will use the figure of 300 to 400 million. We base our estimate on the following: there are 1.92 billion women aged 15 to 49 years. Using an average of 28 days per cycle (13 cycles per year) and bleeding lasting five days per period, that would yield 300 to 400 million on any given day. For further precision, this number should be adjusted for (1) decreasing age at menarche, (2) decreasing years of pregnancy and post-partum amenorrhoea, and (3) numbers using menstruation-suppressing hormonal contraceptives. However, we do not see how this could translate into the widely used figure of 800 million (which we have not seen explained), or why many sources mention 12 cycles per year.

**MH impact, programmatic components:**
Various definitions refer to a list of impacts of inadequate MH, as well as programmatic components that need to be addressed to achieve adequate MH. This rapid assessment will make that distinction throughout.

**Products, supplies and/or material:** In the absence of consistent terminology, we will use the term ‘MH materials’ to refer to items for absorbing or collecting blood (cloth, pads, cups, tampons), and ‘supplies’ to refer to ‘supporting items’ (soap, painkillers, buckets, underwear).
Executive summary

Background and methodology

In May 2018, the UNFPA East and Southern Africa Regional Office (ESARO) convened the inaugural East and Southern Africa Menstrual Health Management (MHM) Symposium. This was the first time UNFPA in such a visible manner had addressed the issue of menstruation as an integral part of sexual and reproductive health and rights, which in turn builds on the WHO definition of ‘health’ (WHO, 1948), and considered the role that UNFPA might play.

The symposium led to the Johannesburg Call to Action: Improving Menstrual Health Management in Africa, with a number of recommendations and commitments. These included the establishment of the African Coalition for Menstrual Health Management (ACMHM), created as an effort to continue the convergence and exchange of perspectives seen at the Symposium and to tap into the excitement of the MHM movement across the continent. UNFPA ESARO has hosted the ACMHM from September 2018 to date. The Call to Action recommended a follow-up symposium, to be held within two years (i.e., 2020 extended to 2021 due to COVID-19 pandemic).

As part of the extensive preparations for the 2021 Symposium, a review paper was commissioned. It considered some of the key issues, highlights, successes and challenges within menstrual health management, with a specific focus on East and Southern Africa. This rapid review was commissioned to take stock and document progress made in ESA since the 2018 Symposium, including at country level, and with the additional purpose of assessing and documenting the impact of the strengthened advocacy through the ACMHM.
Findings from the review

Sources generally agree that attention to menstrual health has grown rapidly over the past decade, not least in the last three years.

The human development goals, including menstrual health, have broadened over time. The focus on school attendance has extended to wider linkages to goals of health, social well-being, and economic and gender equality. The overall goal of ‘dignity’ has been present since 2001, and is increasingly ‘operationalized’, although somewhat implicitly, for example, as independence (‘freely’), and absence of fear, stigma and shame.

The list of explicit programmatic components considered necessary to achieve the menstrual health goals have expanded apace, from a focus on menstrual materials (UNFPA, 2001), to WASH including disposal (WHO/UNICEF JMP, 2012) and education (JMP, 2014), to access to services, including health as well as advocacy and awareness-building to generate positive social norms (UNICEF, 2019, consolidated by Hennegan et al., 2021).

In 2018, a lack of agreed indicators to measure challenges and track the impact of the response was seen as a major problem. The 2018 review suggested developing indicators to track ‘unmet need’ for menstrual health, which had been a productive approach for the family planning field, as it takes an explicit human rights approach. Since 2018, much work has gone into this, and models have been developed. Studies also repeatedly note that there are many international data-collection initiatives such as Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and Performance Monitoring and Accountability surveys (PMA) which are collecting data on issues directly or indirectly related to menstruation. The review has not yet found a consolidated, simple and agreed list of priority indicators, covering all sectors (along the lines of the WHO/UNICEF JMP recommendations for the WASH field). Some key informants noted that data collection at the project level may be influenced by individual donor requirements.

Since 2018, there has been no updated, agreed, comprehensive list of priority research, although there is at least one in process, initiated by the Global Menstrual Collective. This review is based on repeated mention of gaps, as well as narrower studies of prioritizations that do exist (for example, on adolescents):

- Identification of validated indicators, including clarity on issues such as stigma, or standard definitions of what constitutes ‘hygienic behaviour’ (presumably with the intention of identifying, what, if any, influence this has on infection rates/irritation, as opposed to ‘arbitrary standards’);
- Increasing calls for evaluations of effectiveness, as well as cost and cost-effectiveness of programme components, both hardware and software, as well as opportunity cost and cost of inaction (cost in terms of both budgetary and social and health terms);
- Better evidence on creating ‘positive social norms’ at all levels, including theory-driven and community-based approaches to addressing stigma and norms surrounding menstruation; and issues related to male engagement, which is seen as an important factor in other areas of SRHR.

A substantial list of human rights instruments was already in place in 2018, and this review did not find any additions, apart from reaffirmations.

‘Soft law’ (with intergovernmental commitment) includes the 2016–2030 SDGs, and contains only indirect mention of MH. One hope has been to add direct mention in the SDG midterm review. However, the ICPD+25 conference in 2019, for the first time, had a side event dedicated to menstrual health, where a wide range of commitments were made by a variety of actors – governments, NGOs, academics and the private sector.

Since 2018, a number of organizational guidelines and standards for programmes have been developed, not least for the humanitarian sector (for example, UNFPA/UNICEF/UNHCR for commodities, UNICEF for programming and monitoring, IFRC and Sphere Standards in 2018). Some are broad, while
others cover only certain components or parts of organizations (for example, the mandate for action still needs to be clearly assigned in the humanitarian Inter Agency Standing Committee).

The number of actors seems to have grown rapidly, including a number of networks. This Review does not aspire to do a full mapping or full analysis\(^1\).

The 2018 Call to Action made little reference to cost, or to financing, apart from calling for greater attention to public/private partnerships. Indeed, there was little available literature at the time. There are now calls for better evaluation of cost-effectiveness (that is, what components have been included, whether they work, and how much they cost). The calls are for studies for all programmatic components, both ‘hardware’ (for example, menstrual materials) and ‘software’ (for example, initiatives to improve social norms). For some programmatic components, there is clarity and apparent agreement on standards (for example, WASH is tracked by the JMP of WHO/UNICEF), including, at least in principle, what one might call ‘mWASH’ (menstruation-related WASH). There are several comparisons of different menstrual materials, but they do not always refer to price/cost, with UNICEF’s being an exception.

The effects of COVID-19 are still being documented, but several preliminary studies indicate negative effects: the additional inconvenience of dealing with menstruation at work or school (for example, health workers wearing hazmat suits); increased prices of menstrual materials (possibly exacerbated by panic-buying of toilet paper and menstrual materials such as pads) while income has decreased; and increased gender-based violence, which may be exacerbated as privacy is reduced, and the cost of menstrual materials increases. Some studies indicate a growing interest in reusable materials. One study identifies reduced access to menstrual material and information as one of the most negative effects of COVID-19 on sexual and reproductive health and rights (SRHR).

The 2018 Symposium theme was that inadequate MH has a wide spectrum of negative impact, for several SDGs. For health (SDG3), one main objective was to draw attention to menstruation as an integral part of SRHR, with its physical, mental and social components. This included, for example, the effect of menstrual side effects on discontinuation of long acting reversible contraception (LARCs), or other physical ill health (for example, dysmenorrhoea). Since 2018, this has become more visible. For example, there is growing recognition that pain is a major factor in girls’ school attendance and participation. MH as a life cycle issue (including menopause and beyond) is receiving some, although still limited, attention (there are few studies on adult women in general). With respect to mental and social health, the issues of fear, shame and anxiety are increasingly documented in a variety of studies, both for adolescent and adult women.

For Education (SDG4), although numerous small-scale studies document a strong negative effect, it remains a challenge to quantify the level of school absenteeism caused by poor menstrual health. Since 2018, increasing numbers of studies have taken a wider view, including partial absence (missing a few hours), as well as diminished participation in class activities. For gender (SDGs 5, 10) there are frequent references to fear, stigma, shame and dependence, although apparently little agreement on how these terms should be referenced in the SDGs.

With respect to work (SDG8) there is long-standing awareness that menstruation may affect work, but, with a few exceptions, there are still relatively few studies referring to adult women, and even fewer to work.

Environment (SDGs 11, 12, 13, 14) increasingly appears in the literature, for example giving ample evidence of the effect on sewage systems. Tool kits for dealing with waste management have been further developed, for instance, in humanitarian situations. However, this relates mostly to waste management and plastic, and less on the impact of the full production cycle, or on harmful substances such as dioxins in different materials, and their effect on either the environment or the individual.

The link to poverty (SDG1, somewhat surprisingly, has mostly been explicit in High Income Countries – for example, the term ‘period poverty’ from the UK).

\(^1\) A partial list is given in Annex I.
The operational response has grown rapidly. The ESA region is seen as particularly active, both for grassroots advocacy and pilot projects, but also proactive national government policies and programmes (for example, removal of import duties and taxation of menstrual health products, and inclusion of puberty education in school curricula).

There is also a growing body of evidence that the response is having an effect, for example, on school attendance/dropout, or on issues such as feelings of dignity or shame. Observers, including donors, note that there is a rich body of information on policies and programme plans, but less on results of implementation, and this can be a barrier, both to programme effectiveness and policy commitment.

The recommendations drawn from the findings of the study focus on three main areas: 1. Research and measurement; 2. Conducive legal and policy environment and its translation into strategies and programmes; and, 3. Sustainable financing.
Methodology

The intention of this rapid review is to update that of 2018. The 2018 review was intended as a basis for policy discussion at the Symposium, and therefore attempted to capture a wide range of experiences and a dynamically changing landscape. In addition to the topics explored in 2018, the present review also attempts to analyse the experiences of the ACMHM since its beginnings in 2018, as well as giving more detail on country experience since 2018. The focus is on East and Southern Africa, but, where applicable, a broader geographic focus is provided. To serve a policy objective, within the limits of the available resources, the review emphasizes breadth and perspective rather than academic depth, as any one of the topics would require much more time to give a full picture.

The methodology is therefore a rapid review. For all but the academic literature, there is little in the way of an inventory. WoMena has a literature surveillance system, which includes both grey and academic literature (for example news articles may give useful leads for further investigation into programmes or changes in legislation). The results are posted as monthly global updates, and this was a major source. The global picture was complemented by a search of human rights instruments (website of High Commissioner on Human Rights), information about conferences and strategies through UNFPA as well as through the knowledge of the authors, organizational guidelines on websites and in academic literature, and peer-reviewed literature enlarged with searches on PubMed. For the assessment of ACMHM, the methodology includes published reports by the ACMHM, responses to a survey of ACMHM members and non-members, as well as 18 key informant interviews (KII’s), which also provided their views on key developments in the field. There is no inventory of relevant grey literature, and this review does not purport to capture every piece of useful information. The cut-off date was 28 February 2021 (with one exception) but, given that major publications have been added in the last few months, an attempt has been made to reflect this, or at least mention such initiatives, where the authors have been informed of them. Nevertheless, the field is evolving so quickly that any broad assessment risks being out of date the moment it is published.

There are limitations to this methodology, given the wide scope and limited resources. The rapid review does not approximate an academic ‘systematic review’ or an attempt to assign quality to sources. Apart from PubMed (and UN OHCHR), the accessed data banks make no claim of completeness. In particular, mapping grey literature on developments at national level was challenging.

As mentioned, the intention of the rapid review is to generate comments, additions and corrections, which are invited and welcome.
1. Developments on global frameworks, indicators, actors and sustainable financing

1.1 The evolving concept of menstrual health

The 2018 Review noted that attention to menstruation had increased rapidly over the preceding two decades (Hennegan et al., 2021).

At the level of overall menstrual health goals, ‘dignity’ was prominent throughout, but was gradually detailed and supplemented. The list of programmatic components had expanded, from a focus on material, to WASH and education. The widely used terminology referred to ‘menstrual hygiene management’ (MHM).

The purpose of the UNFPA ESARO Symposium in May 2018 was to make explicit the broad impact of inadequate MHM on a wide range of the SDGs, and in particular the linkages to sexual and reproductive health and rights (SRHR). Whereas both academics and NGOs had previously suggested this, it had not yet been ‘mainstreamed’. The Symposium therefore widened the terminology from ‘hygiene’ to ‘menstrual health management’, referring back to the WHO definition of ‘health’ in the Constitution: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948).

Since 2018, authors have reflected on the dynamics of this transition, noting that a deliberate focus on “innocuous’ WASH may have facilitated early interest
and prevented resistance" (Roaf & de Albuquerque, 2020; Miller & Winkler, 2020), and that one early training manual explicitly advised trainers to de-link the “teaching of sex education from training in menstrual hygiene practices, to avoid causing ethical or religious offense” (McCarthy & Lahiri-Dutt, 2020).

Academic articles further supported the importance of integrating MH with reproductive health (for example, Hennegan et al., 2019b; Thomson et al., 2019).

In 2019, UNICEF developed a guidance note with a definition of ‘Menstrual Health and Hygiene’ (MHH) as “encompass(ing) both MHM and the broader systemic factors that link menstruation with health, wellbeing, gender equality education, equity, empowerment and rights. These systemic 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”. This was restated in a monitoring guideline from 2020 (Gibson & Yamakoshi, 2019; UNICEF, 2020).

After the closing date for data collection for this Review, an article initiated by the Menstrual Health Collective, published 29 April 2021, proposes to use the term ‘menstrual health’ (Hennegan et al., 2021). The article intends to consolidate the concept, goals and programmatic components. This seems a logical progression from the 2018 review, and the term ‘menstrual health’ will therefore be used. Given time constraints, it has not been possible to reflect all the ideas expressed in the article in this review, but, as was the intention, the programmatic components align with previous developments.

There seems to be accumulating agreement:

- That the population of interest has gone beyond the original focus on girls in school (and people in humanitarian settings) to include girls out-of-school, adults, and special populations such as the disabled or refugees;
- The focus still seems to be mainly on individuals, although increasingly on broader society;
- The identified impact has gone beyond school attendance, to educational quality, health and well-being, gender equity and empowerment;
- More recently, there has been attention beyond waste disposal to the wider environmental impact of production, use and disposal of menstrual products, although as yet little on harmful substances;
- **Programmatic components** are going beyond materials, WASH (including disposal) and education for individual menstruators, to referral to health and other professional services, as well as to positive social norms, advocacy and policy;
- That there appears to be limited focus on the programmatic component of **financing**, beyond the cost of products.

Guidelines for providing programmatic components often emphasize that they should be ‘culturally appropriate’, operationalized in programmes as consultations with women and girls about products.

- The explicit mention of positive social norms, advocacy and policy could therefore be a significant step to further define the broad concept of ‘culturally acceptable’, beyond those who menstruate, to their cultural environment, all the way to the international level.
- The practical components of creating ‘positive social norms’ are not widely documented, but there are some practical examples from related fields (Plesons et al., 2020).
1.2 Indicators for monitoring and research

The 2018 review and Symposium noted the importance of identifying and agreeing on a limited number of meaningful indicators, with realistic and reproducible methods for gathering the data, to generate and monitor global action. Indeed, identifying such indicators in the SDGs (2016–2030) had been the purpose of the 2012 JMP meeting, and it was seen as particularly important to include more explicit indicators in the upcoming midterm review of the SDGs. The review noted that it was not unique for this to be a lengthy process: the indicator ‘unmet need for family planning’ took about 50 years to develop from the time it was identified until it was included in the MDGs in the midterm review in 2008. Yet it is now one of the most widely used for the family planning field.

Since the Symposium, additional efforts have gone into identifying MHM indicators and targets, reflected in an extensive body of literature. As yet, there is little agreement, possibly related to: 1) the evolving understanding of the concept, 2) a lack of global priority to the topic, as well as, 3) a lack of clarity on who decides – an international body, researchers or national bodies?

- Studies use a heterogeneity of indicators. A systematic review of 54 studies finds no two studies measuring the same menstrual or hygiene practice (Hennegan et al., 2020a).
- Many efforts have gone into defining ‘unmet need for MHM’. Metrics based only on the single indicator of materials have proved to be ineffective (Smith et al., 2020), and a wider range of components has been developed (see footnote) (Hennegan et al., 2020).
- An expert group, convened at Columbia University in 2019, defined priority areas for monitoring: sexual and reproductive health, psychosocial health, education, WASH and gender. The meeting did not list precise indicators, but suggested guidelines for the types of questions. It made a recommendation to the DHS to include “girls’ awareness around menstruation prior to menarche” (Sommer et al., 2019) although this particular indicator has not been accepted by DHS (Sommer, 26.04.2021 personal communication).

- Priority indicators by the Global Action for Measurement of Adolescent Health (GAMA) advisory group do not include menstruation (WHO, 2020b).
- Sommer has suggested indicators related to theory of change (Sommer et al., 2020).
- A guidance note from UNICEF suggests key indicators for WASH in schools (Gibson & Yamakoshi, 2019), and another on monitoring (UNICEF, with ACMHM, UNFPA and others) notes there is no agreement on indicators, but suggests a few central ones (UNICEF, 2020a).

Meanwhile, established international monitoring systems are collecting data, both direct MHM indicators and proxies, although they are not always standardized:

- Since 2017, Multiple Indicator Cluster Surveys (MICS) conducted by UNICEF in over 100 countries have included questions on MHM, for example, privacy, products, participation in social activities.
- The International Household Survey Network (IHSN) conducted in around 100 countries includes data on personal care products (such as soap and sanitary pads) in almost all surveys, although indicators are heterogeneous.
- Performance, Monitoring and Accountability (PMA) surveys in 11 countries include an evolving...
range of MHM questions (for example, safety, cleanliness and privacy of MHM facilities).

- Demographic and Health Surveys (DHS) collect data on open defecation (Loughnan et al., 2020).
- DHS also include four questions asking what women used to collect or absorb menstrual blood during their last menstrual period, whether they were able to wash and change in privacy while at home, and two knowledge-based questions on the menstrual cycle and pregnancy risk (Smith et al., 2020).

1.3 Global norms, strategies and operational guidelines

The 2018 review identified a wide range of human rights instruments relevant to MHM, starting with inclusion in the right to water and sanitation in 2013. It noted that the Millennium Development Goals contained no reference to menstruation, but the SDGs do contain indirect (proxy) reference, for example, under Goal 4 on education (‘building and upgrading facilities that are gender sensitive’) and Goal 6 on WASH (‘Access to sanitation and hygiene for all with special attention to the needs of women and girls’). The review also noted that a strategy such as the UN Global Strategy for Women’s, Girls’ and Adolescent Health 2016–2030 does not mention menstruation (UN, 2015). The few operational guidelines at the time were mostly in the field of WASH, and to some extent the humanitarian sector.

1.3.1 Human rights instruments and conferences

Human rights instruments in principle are committal for states. This review found no major additions to global human rights instruments since 2018, but many reaffirmations:

- The Conclusions of the 63rd session of the Commission on the Status of Women, which identify the importance of inadequate menstrual hygiene management as an impediment to girls’ education, and calls for better facilities in school (UN, 2019);
- The Human Rights Council 2019, which had supportive side events (WSSCC, 2019);
- The 2019 Nairobi review of the International Conference on Population and Development at 25, which, for the first time, addressed MHM, included commitments from governments, UN organizations, NGOs, etc. (ICPD25).

Perhaps the most prominent process for monitoring implementation of human rights commitments is the Universal Periodic Review, which covers every member state at four-to-five-year intervals. This review did not have the scope to make a full review, but a preliminary search yielded no UPRs referencing MH since 2018.

Commenters on this review have noted that articles were in press that update this analysis, but given that they were not published by 29 April, they unfortunately could not be included.

1.3.2 Global strategies

The logo for the 2018 Symposium strategically situated menstruation in the middle of the 17 goals. The ACMHM notes that MHM is critical for the attainment of SDG 3 (Good Health and Wellbeing), SDG 4 (Quality Education), SDG 5 (Gender Equality), SDG 6 (Clean Water and Sanitation), SDG 8 (Decent Work and Economic Growth), SDG 10 (Reduced Inequalities), SDG 12 (Responsible Consumption), as well as SDG 17 (Partnerships for the Goals) (ACMHM). UNICEF notes a connection with SDGs 3,4,5,6 and 8 (UNICEF, 2020a). NGOs such as WASH United emphasize the connection with SDGs 3, 4, 5, 6, 8, 12 (WASH United). WoMena has presented evidence for linkages for each of those goals. In addition, it has identified the

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3 African Coalition for Menstrual Health Management: https://acmhm.org/goals/
linkage to SDG 1 (poverty), quoting political leaders such as the Minister of Higher Education of Uganda, who has stated that the SDGs will not be reached without overcoming problems with MHM (WoMena FAQ4 and video5).

1.3.3 Operational guidelines, committal or general:

Since 2018, several organizations have developed operational guidelines, which may be assumed to be indicative of commitment by the respective organizations.

- For example, in 2019 UNICEF published a guidance note (Gibson & Yamakoshi, 2019).

The humanitarian sector has been particularly productive.

- In humanitarian settings, as governmental capacity for coordination may be stretched, global guidelines for international action take on particular importance. Inter-Agency Standing Committee (IASC) guidelines commit at least IASC members (UN agencies and a number of civil society organizations). Menstruation was included in such guidelines before 2018, for example, mental health (IASC, 2007) and reproductive health (IAWG, 2010) and have been reaffirmed for gender (IASC, 2018) and reproductive health (IAWG, 2018; IAWG, 2020). Guidelines make repeated suggestions to provide ‘culturally appropriate’ products, to make WASH facilities more sensitive to MHM, as well as to provide curricula with information about menstruation (particularly menstrual cycles, to help with family planning).

- However, there is limited agreement on who should do it, and for how long (especially beyond the initial three months) (Tellier et al., 2020a).

- The International Federation of Red Cross and Red Crescent Societies published a guide for MHM in 2018 (IFRC, 2018).

- Guidelines without organizational commitment, but widely used as minimum standards, include the 2018 Sphere Handbook 2018 (Sphere Association, 2018).

- Technical guidance (non-committal) has been produced, for example, by IRC/Columbia University and humanitarian organizations (Schmitt et al., 2020) and IDA (Nelis, 2018). Operational guidelines related to the individual operational components: education, WASH and products, are listed under section 3.

1.4 Actors

The 2018 review listed a wide number of actors, both at the global and national level.

Since then, the list of actors has expanded; governments have reported increasing activity. UN organizations that have strengthened their focus include UNFPA, UNICEF and UNHCR (Bevan, 2019; MoES et al. 2019; Roeckel et al., 2019). Some NGOs focus on provision of products, but a large number also provide training/education, and a smaller number include advocacy for policy change (see section 3). Some observers find that the topic has gone from pariah to poster child, with organizations seeing MHM as a fundraising opportunity. Yet there is still limited agreement on goals, indicators, tools, coordination and evidence, which makes it more difficult to arrive at coordinated action and accountability (Miller & Winkler, 2020). We will discuss the various attempts at coordination in section 4.
1.5 Financing

The 2018 review did not address issues of financing, not least because at the time there was very limited information. Yet, financing is obviously a key component, especially as the field moves towards scaling up.

As remarked at the Global Research Meeting hosted by WHO on menstrual health in 2018 (Tellier, 2018), there still seems to be little in the way of tracking either needs or funding. The following is therefore not complete.

MHM financing is here seen through the lens of WHO’s health systems financing goals for Universal (Menstrual) Health Coverage:

1. Reducing financial barriers through reduced costs/impact on out-of-pocket payments;
2. Allocating/using funds in way that promotes efficiency and equity;
3. Raising funds for MH.

In this section we will focus on goal 3, discussing goal 1 in section 3, and goal 2 in section 5.

The issue of financing still receives limited attention (Plesons et. al, 2021). To set a goal, it helps to have estimates of funding needs for all the programmatic components mentioned above. A number of sources have reviewed the cost of products, including cost-effectiveness in terms of outcomes (for example, van Eijk et al, 2019; Babagoli et al., 2020) but have not yet mapped the cost of overall programmatic components.

With respect to funding, at the international level, the Founder’s Pledge estimates current annual expenditure at US$10 to 100 million but it does not make an estimate of how much is needed (Kulczyk Foundation & Founders Pledge, 2020).

One of the latest donors is the Sanitation and Hygiene Fund, launched in November 2020, which replaces the Water and Sanitation Services Consultative Council (SHF, 2020). It seeks to raise US$2 billion over the coming five years to “provide 21st Century solutions to the decades-old crisis on sanitation, hygiene and menstrual health”.

Many donors have added menstruation to the list of issues they fund, including private foundations (the Case for Her being one of the earliest), multilateral organizations (World Bank, 2019), bilateral government donors (for example, France, Switzerland), and several consultancy firms (for example, FSG, PSI, KOIS). Advocacy for investment is increasing (Ljungberg & Coates, 2020; PSI et al., 2021; Kulczyk Foundation & Founders Pledge, 2020) adding to the pressure for the standardization of indicators and generating evidence.

Innovative financing mechanisms are emerging, such as development impact bonds for MHM to design incentives for greater impact in MHM programming (KOIS, 2020).

Some UNICEF regional offices track sector financing for WASH, including specific operational components such as menstrual products (Ofori-Kuma, 2018).

Going to scale in a sustainable manner will presumably depend on commercial sales and national government funding, as well as the cost of cottage industries and home-made funding. This review could not locate estimates for national-level funding, but as noted in section 3, there seems to be an upsurge in the provision of free products in schools, or forgoing income from value added tax. Financial sector analyses provide estimates of commercial sales.

It is not clear who is receiving most of the funding (public, private, non-for-profit) nor is there clear data being captured on allocative or technical efficiency and equity (for example, distribution between programme components, which programmes are most efficient, and which groups are receiving most support).

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1.6 COVID-19

Regarding COVID-19, ‘periods don’t stop for pandemics’ seems to have become a slogan for many actors, including the World Bank, UN organizations and NGOs. Challenges have been identified: 1. The additional inconvenience of dealing with menstruation for women and girls at work or school (for example, health workers wearing hazmat suits); 2. There is some evidence that prices of menstrual materials have increased, while income has decreased; 3. It is well documented that, in many countries, gender-based violence has increased. This may exacerbate MHM-related violence, as privacy is reduced, and the cost of products increases; 4. Panic-buying of toilet paper in many countries has also extended to menstrual products such as pads (UNFPA & UNICEF, 2020; ACMHM et al., 2020; Gardner et al., 2020; WoMena, 2020; Regmi et al., 2020, UN Women and UNFPA, 2021); 5. There are indications that reusable materials are becoming more popular as access becomes more difficult (Menstrual Cup Coalition, 2020).

Operational guidelines for mitigating the impact of these factors have been published (for example, UNICEF, 2020b; WSSCC, 2020). Observers expect the COVID-19 pandemic to have a negative effect on efforts to improve MH, as less urgent health issues are deprioritized, mobility and access to products, education and services is reduced; project implementation and monitoring is interrupted; and the economy suffers in general (Kulczyk Foundation & Founders Pledge, 2020). There is currently a limited evidence base, but a cross-national study by Rutgers (including Kenya and Uganda) concludes that: “Across all national settings, one of the biggest impacts of school closures and/or lockdown has been that girls could not access sanitary products or information about menstrual hygiene” (Rutgers, 2021). There appears to be a need to identify the lessons learned, including both negative and positive effects (for example, changed habits with respect to hygiene).
2.

Impact of inadequate MH, with particular focus on ESA

The overall impact of inadequate MH on ‘dignity’ is often mentioned, although not always in explicit, operational terms. Some advocacy groups place ‘dignity’ at the centre of their approach (Regmi et al., 2020), and criticize sectoral approaches. Dignity may indeed be an umbrella impact, but here, a positive impact on education, health, work and agency, and the promotion of positive norms and policy, are assumed to be contributors to dignity.

2.1 Impact on education

The 2018 review noted that the negative effect of inadequate MHM on school attendance has been a major reason for interest in the field. Much of the attention was focused on Africa (“one in ten girls in Africa miss school because of menstruation”). However, the evidence remained of insufficient quality to support that estimate, or to be conclusive about universal, exact levels.

Recent studies have highlighted that problems also exist in HICs.

- A study from the UK estimates that “One in ten girls aged 14 to 21 years in the UK can’t regularly afford menstrual products, forcing some to stay home from school” (Tingle & Vora, 2018). The study uses the term ‘period poverty’, thus linking it to poverty.
At the global level, a desk review by Sommer et al. concludes that the evidence base for MHM in schools has strengthened considerably (Sommer et al., 2021), including for Africa:

- A cross-sectional survey among 730 adolescent girls aged 12 to 19 years in Ghana found that 27.5 per cent of respondents reported menstruation-related school absenteeism, ranging from one to seven days during the menstrual period (Kumbeni et al., 2021).

- A 2020 review identified 18 studies in LMICs (including Kenya, South Africa, Uganda, Malawi, Ethiopia, Zimbabwe, South Sudan and Tanzania) which quantify absenteeism, with three indicating no effect and the rest indicating an absenteeism of between 10 and 40 per cent (WoMenA, 2020).

- A cross-sectional study of 352 school children in secondary schools in Uganda found that boys and girls had similar rates of absence (two days during the last month). Reasons differed: for boys, the prime reason was inability to pay school fees while for girls it was pain. Generally, girls missed school on 28 per cent of period days, and 7 per cent of non-period days. All policy makers cited menstruation and poverty as barriers (Miiro et al., 2018).

Given the numerous studies suggesting a strong connection, the lack of conclusive evidence may relate to methodological issues, for example, heterogeneity of indicators/protocols (Benshaul-Tolonen et al., 2020; Babagoli et al., 2020).

The 2018 review noted a growing recognition that complete absence may not be the most sensitive indicator. Partial absence (skipping class) or lack of participation are also significant.

- Haver supports this, and suggests measuring part-day attendance, or low participation in school activities (Haver et al., 2018).

- The above-mentioned study by Miiro et al. notes that girls’ education was influenced not only by absence from school, but also absence from class (Miir et al., 2018) and the outcome study indicates that there were high levels of uptake of components (puberty education, drama skits, menstrual hygiene management (MHM) kits and pain management), fewer girls reporting anxiety (from 58.6 per cent to 34.4 per cent) increased use of effective pain management (from 76.4 per cent to 91.4 per cent), with a potential intervention impact on improving menstrual-related school absenteeism (Kansiime et al., 2020).

### 2.2 Impact on health

The 2018 Symposium was intended to reframe the understanding of MHM as having a broad impact (beyond education), and in particular to highlight linkages with sexual and reproductive health (SRH).

#### 2.2.1 Urogenital infections and hygiene

The 2018 review noted that, while MH has long been associated with hygiene, there was little agreement on what constitutes ‘adequate’ versus ‘inadequate’ hygiene behaviour. Nor was there robust evidence regarding the effect of MHM on infection, and particularly, whether any particular menstrual product or behaviour carries a higher infection risk than others. A few studies from India in particular discussed hygiene with regard to menstrual pads, and one study from Kenya compared menstrual cups and disposable pads.

There has been limited additional evidence since 2018, and only a few examples from the ESA region:

- A cross-sectional study among 791 high school girls in Ethiopia found that more than half cleaned their external genitalia with water and soap, but 60.3 per cent had ‘poor’ menstrual hygiene practices, associated with poor knowledge, lower age and longer duration of menses. The article does not include estimates of infections (Belayneh & Mekuriaw, 2019).

- A cross-sectional study from Ethiopia conducted among 602 women aged 15 to 49 years indicated that changing MHM products and washing the genital area only once per day during menstruation were associated with 8.99
and 5.76 times higher rates of developing RTIs, respectively, and not washing hands with soap before touching the genital area was significantly linked with RTIs compared with those who washed the genital area two or more times per day during menstruation (Ademas et al., 2020).

2.2.2 SRHR: contraceptive use and discontinuation

The 2018 review indicated a connection between menstruation and contraception, particularly contraceptive discontinuation. The evidence has been strengthened:

- Several studies further confirm the association between menstrual changes caused by contraception, and subsequent contraceptive discontinuation, in particular affecting young people. A new term, contraceptive-induced menstrual bleeding changes (CIMBCs), has been coined, and counselling tools developed (Rademacher et al., 2018; Polis et al., 2018; Amaya et al., 2020).
- A qualitative component of the ASPIRE clinical trial in Malawi, Zimbabwe, Uganda, and South Africa analysed the experiences of participants using the vaginal contraceptive ring. Women expressed powerful feelings of shame and disgust related to menstrual blood, making it a barrier to handling the ring (Duby et al., 2020).
- Girls and young women express fear of illness or infertility if their periods are not within what they understand to be ‘normal’. There is a need to understand both the wide range of ‘normal’, but also what constitute danger signals (WoMena, 2018).

2.2.3 SRHR: transactional sex and risk factors for HIV

The 2018 review noted that MHM-related transactional sex is a common occurrence, as young, poor girls especially have no other access to cash, including to purchase MH products. This is being followed up:

- A protocol for a three-year study has been published, to assess the impact of providing menstrual cups versus cash transfers, or both, on outcomes such as STIs and school dropout (Zulaika et al., 2019). This is the only study captured by this review which assesses the effect of cash transfers.

2.2.4 SRHR: Menstrual disorders, menopause, menstrual anaemia, dysmenorrhoea

The 2018 review noted that issues related to the menopause had received little attention to date. However, there are early signs that this is changing:

- A business article notes that the post-menopausal population constitutes more than one billion people, and increasing numbers of apps address this segment (Hall, 2021).

The 2018 review did not examine menstrual bleeding as a contributor to anaemia, but the topic is receiving increased attention:

- The 2020 WHO report on anaemia noted that anaemia levels have increased in many countries (WHO, 2020a), but efforts to date have focused on nutrition, whereas debilitating heavy bleeding has received less attention. Menstruators may be more motivated to comply with treatments for heavy bleeding than with dietary interventions (Critchley et al., 2021).

The 2018 review noted that schoolgirls often mention pain (rather than lack of products) as the main problem making them miss school. Evidence from the ESA is accumulating:

- A cross-sectional study among 791 high school students in Ethiopia found 77.7 per cent had experienced dysmenorrhoea within the last three menstrual cycles, but it did not estimate absence (Belayneh & Mekuriaw, 2019).
Another study in Ethiopia found that more than half of students had a family history of dysmenorrhea. Self-medication was practiced among 78.2 per cent of students, including taking ibuprofen, resting in bed, and drinking hot water and tea (Yesuf et al., 2018).

A study by Miiro et al. in Uganda indicates that menstrual pain is the main reason for absence from school (Miiro et al., 2018), and also holds true for refugees (Ivanova et al., 2019).

2.2.5 SRHR: early marriage

The 2018 review noted that there was a widespread perception that onset of menses was associated with early marriage, but little evidence was available. Unfortunately, this review found no new literature on the topic.

2.2.6 Mental and social well-being

The 2018 review noted that feelings of shame, fear and disgust associated with MHM were widely documented. Recent studies confirm this:

- A systematic review and qualitative meta-synthesis assessing women’s and girls’ menstrual experience, such as menstrual stigma, in LMICs – including seven from Kenya, six from Uganda and five from Ethiopia – found that it affected both physical and mental health (Hennegan et al., 2019a).

2.3 Impact on work

The 2018 review noted that there was recent, but growing, global literature on the impact of MHM on work. Further evidence is accumulating, indicating such a linkage.

- Studies from the US, India and Bangladesh, in particular, indicate that menstruation is associated with absence from work, and that women resort to drastic measures to be able to work (for example, seeking hysterectomies) (Czura et al., 2019).

In Uganda, a study of 35 women aged 18 to 49 found that the women felt ‘being responsible’ meant keeping menstruation secret and the body clean, at all times, and this resulted in some women missing work and income (Hennegan et al., 2020b).

2.4 Impact on the environment, harmful substances

The 2018 review noted that many stakeholders identify disposal of MH materials as a major, often overlooked issue. The conceptual framing of MH repeatedly refers to access to disposal for individuals, but rarely to the societal and environmental impact of mass disposal.

There seems to be growing attention to the societal impact, including the harmful substances contained in various MHM products.

- Sommer and Phillips-Howard have developed a theory of change, and a measurement framework that includes impact on the environment (Sommer et al., 2020).

- A literature review, covering 75 articles and reports, notes the impact on menstruators, sanitation workers, sanitation systems and the environment. Disposable sanitary pads made from super absorbent polymers (SAP) to collect blood also absorb other fluids, which then swell up and block sewer lines (one estimate from Kenya is that around 40 per cent of the material cleared from...
2.5 Special groups, particularly in humanitarian settings

The theme of the SDGs is ‘leaving no one behind’. The thought that different groups have varied situations has been mentioned frequently for MHM, with calls for ‘granular’ (disaggregated for different groups) approaches. For example, out-of-school children, orphans, people with disabilities, those in prison, sex workers, as well as women past the age of menopause may have special considerations. One group often identified as having particular health challenges is people living in humanitarian settings, including refugees.

- A review of the situation in humanitarian settings indicates that affected populations may face the same problems with MHM as elsewhere, but they are often exacerbated by a lack of ‘usual products’, having to ask unfamiliar male service providers, needing to walk long distances for food distribution, stress, poverty, crowding leading to lack of privacy, and gender-based violence (Tellier et al., 2020a).

- Attention to other groups, such as disabled people, has been limited, but is accumulating.

- A systematic review of 22 peer-reviewed studies, including from Uganda, Kenya and South Africa, indicated a number of challenges: menstruators have difficulties using and changing products, especially if they have no privacy; and they have difficulties understanding their situation, including premenstrual syndrome (PMS). Carers, both institutional and family, also face barriers; mothers may keep their daughters at home or seek ways to suppress menstruation (for example, hysterectomies). They may feel they cannot seek help as it is private (Wilbur et al., 2019). Fathers and daughters feel embarrassed when fathers have to change soiled menstrual products such as tampons (von Reding & Gottlieb, 2019).
2.6 Research gaps

The 2018 review noted that research on MH was a young field. There was a need for more conclusive studies, but at this early point also for formative, qualitative research which could help identify clearer research questions.

Since then, several suggestions have been made for research priorities.

- There are repeated calls for more robust definitions, indicators and methods, including recall versus observational studies, as well as encouragement not to have too many core indicators, to prevent overloading (Miller & Winkler, 2020).

- In particular, core constructs such as menstrual and hygiene practices, menstrual knowledge, attitudes, norms and restrictions need better definitions (Hennegan et al., 2020a).

- The issue of the impact on school attendance should not be overlooked, but better methods and aspects (total versus partial absence and participation) should be pursued (Benshaul-Tolonen et al., 2020).

- There has been recognition that cost and cost-effectiveness studies are needed, including ones that look at the different programmatic components (Benshaul-Tolonen et al., 2020; see also Plesons et al., 2021).

- ‘The denominator’ – that is, the number of user-years for different products (van Eijk et al., 2019) as well as ‘adverse events’ (usually collected through surveillance systems) still need to be established.

- ‘Granular’ data for different groups should be mapped, for example, for out-of-school girls (Miller & Winkler, 2020).

- A consultation on adolescent health has defined the following research priorities, which seem applicable to the broader field:
  
  - Validated indicators, including on stigma;
  - Effectiveness and cost-effectiveness of programme components;
  - Safety, availability, prevalence, cost, reasons for use and non-use of different materials;
  - Water and sanitation – both availability and needs, including methods, factors in safety and effectiveness and education;
  - Evidence of the social and economic costs of inadequate MH, and cost and cost-effectiveness of different interventions and intervention delivery approaches (Plesons et al., 2021).

- There is an ongoing update of research priorities through the Global Menstrual Collective, which has invited cross-sectoral contributions to define top priorities (Phillips-Howard PA, personal communication 21.04.2021).

- WHO reports on research priorities in the Africa region, including in humanitarian settings, seem to make no reference to menstruation (WHO Africa Region, 2021a; 2021b).
Country-level programmes and policies, especially in the ESA region

The 2018 review noted a great deal of activity in the ESA region, and since then, a review has confirmed this, albeit with great variation among countries (Ofori-Kuma, 2018).

3.1. Education and awareness of menstrual health management

3.1.1. In-school education

The 2018 review noted that, even where there was school education about SRH, it often focused on specific issues (sometimes donor driven), such as AIDS or pregnancy prevention. However, parents would welcome menarche education. Students lacked basic knowledge about menstruation, but also about the fertile period or abnormal menstruation patterns. UNESCO had published guidelines for MHM (UNESCO, 2014).

Since then:
- UNESCO has published evidence-based guidelines for sexuality education (including MHM), cosponsored by UNAIDS, UNFPA, UNICEF, UN Women and WHO (UNESCO et al., 2018).
- A systematic review concludes that the evidence base is building strength (including through the MHM in Ten process), but guidelines for MHM
in schools have yet to be created (Sommer et al., 2021), and the lack of evidence presents a barrier for policy priority and funding (Burgers et al., 2019; Sommer et al., 2021).

Reviews indicate that MHM education is still often not reflected in school policy (Kulczyk Foundation & Founders Pledge, 2020; MAGGA & UNFPA, 2020), and even where it is, it is not always prioritized (Kulczyk Foundation & Founders Pledge, 2020).

There is increasing understanding that menarche education can be an age-appropriate, neutral entry point for broader reproductive health education and agency (Amaya et al., 2020; Diamond-Smith et al., 2020; WoMena, 2020).

Studies from the ESA region confirm that students have low knowledge about SRH, even where there is education. For example, DHS studies in Kenya indicated that only 26 per cent of respondents knew the correct fertile window (Diamond-Smith et al., 2020).

Many country-level initiatives are ongoing:

- The Ministry of Health in Kenya is highlighting the importance of MHM education to address the issue of myths and taboos in learning institutions, workplaces, public places and at household level (MoH Kenya, 2019b), and the Ministry of Education and Sports has developed a national training manual and booklet for that purpose (MoES et al., 2019).

- South Africa’s Sanitary Dignity Framework is addressing the issue of insufficient MHM education, urging involvement of traditional leaders, particularly in rural areas, and recommending awareness campaigns for the public, including women and girls outside the formal school system (DWYPD, 2019a).

- In Uganda, school health clubs have been initiated. One report has found that 96 per cent (out of 137 schools) were teaching girls about MHM and 84 per cent were preparing girls for their first menstruation, before menarche. However, challenges remain due to insufficient budgets and facilities (Ali, 2018).

- In Tanzania, the involvement and commitment of religious leaders has challenged menstrual shame (Mhepela et al., 2020).

- There are repeated calls for the inclusion of men, boys and the community, as well as traditional/religious leaders, to create awareness and combat stigma and taboos (DWYPD, 2019a; MoH Kenya, 2019b; Ali, 2018).

- The importance of the quality of education is also emphasized, such as participatory approaches (Tellier et al., 2020b).

There is rich literature on country experiences, and to a lesser extent, on the results.

- A number of authors have concluded that there is emerging evidence of the effectiveness of education interventions to improve knowledge of MHM (Hennegan, 2020).

- Zambia has core SDG questions in national education surveys, for example, regarding WASH, but also as to whether MHM education is offered in schools, thus facilitating accountability (Ofori-Kuma, 2018).

- A study protocol for a longitudinal study over five terms of 3,489 schoolgirls in Kenya will assess the impact of providing disposable pads, and/or reproductive health education, and on issues such as school retention, reduced unwanted sex, and delayed first sex and pregnancy (Muthengi & Austrian, 2018). At the time of going to production, unfortunately this review could not access the outcome paper.

- A cross-sectional study of 168 primary schools in Ethiopia distributed
booklets to both males and females, and menstrual hygiene kits to girls. After the intervention, the girls had 24 per cent fewer school absences than boys, whereas before the intervention, gender was not a predictor of absence (Belay et al., 2020).

A longitudinal study involving 369 female and male students in Uganda tested a multifactor MHM intervention (puberty and MHM education, drama skits, MHM kit (with reusable pads), pain management, and WASH facility improvements). The results included a decrease in the proportion of girls reporting anxiety about their next period (from 58.6 per cent to 34.4 per cent), use of effective pain management (increasing from 76.4 per cent to 91.4 per cent), 81.4 per cent of girls reported improved school toilet facilities, improving their comfort. The intervention helped girls to talk about MHM with their parents, including their fathers (Kansiime et al., 2020; Nalugya et al., 2020; Miiro et al., 2018).

A process evaluation in Uganda, including 369 female and male students, assessed the feasibility of an intervention employing five factors: puberty education, drama skits, MHM kit (including reusable pads), pain management, and improved WASH. It reported was increased management of pain (analgesics but also other pain relief). Components delivered by the school (WASH, puberty education) were implemented less than those from the outside teams (Kansiime et al., 2020; Nalugya et al., 2020). While 86.9 per cent of girls used disposable pads, only 1.1 per cent reported adequate MH, and the study suggests introducing new methods such as menstrual cups (Miiro et al., 2018).

3.1.2 Education for out-of-school children

The 2018 review noted that out-of-school education has received little focus:

- Out-of-school girls, particularly at secondary or higher levels, constitute large numbers in the region (UIS, 2018). They may face particular problems; one study reports that 80 per cent of girls out of school feel MHM-related shame, compared with 40 per cent in school (Amaya et al., 2020).

- Several organizations and agencies undertake MHM education through projects and programmes, such as AFRipads and WoMena in Uganda (AFRipads, 2020; WoMena, n.d.*) and the Twaweza Programme in Kenya and Tanzania (Femme International, 2020).

- In Burundi, a nun is educating girls about menstruation and other taboo-related topics (Ndayikengurukiye, 2019), and in Rwanda, the radio is used as a way to reach the public with information about MHM through a drama broadcast (WaterAid, n.d.).

- In Zimbabwe, an advocate and researcher, Mandikudza Tembo, has founded a virtual space for information and support, The Bleed Read (Just a Cup, 2020).

- Numerous online apps, many free, are becoming available, with downloads in the hundreds of millions (UNFPA EECA, 2018; WoMena, 2021). The consultancy firm FSG notes that this could help in early education (Amaya et al., 2020).

3.1.3 Awareness and advocacy campaigns

- Campaigns are increasingly being used to help put MHM on the public agenda (IRC Uganda & WSSSCC, 2019; Fox, 2020).

- In Zimbabwe, the Happy Flow Campaign in 2018 (Moyo, 2018) has shed light on the issue of unaffordable sanitary wear, putting tax exemption onto the agenda.

- In South Africa, the #TamponTaxMustFall campaign was initiated to end taxation on sanitary products (Fox, 2020).
In Namibia, the "My Period Is Awesome" blog and campaign was launched, to create a positive perception of menstruation (NBC, 2018), and is used across the region (MPIA, 2020).

Apart from grey literature, there is little mapping from ESA of what a successful campaign entails, but experience from other regions may help provide a framework (Plesons et al., 2020).

3.2. Menstrual health materials and supplies

The 2018 report emphasized that MH materials are a necessary, although not sufficient, factor for adequate MHM, and that ‘traditional’ products (rags, corn cobs, isolation in a hut), although used for millennia, may not automatically mean ‘adequate’ in terms of safety, comfort, effectiveness and privacy. ‘Modern’ products, such as disposable pads or tampons, and, more recently, reusable products such as washable pads, menstrual cups or menstrual panties, have had a positive impact. The Symposium emphasized that menstruators should have an informed choice of a range of products, including a widely agreed (and evidence based) comparison of products or brands.

It recommended assessing estimates of prevalence of use to help assess safety. The report noted that any comparison (and standards) should include homemade improved products (including the same factors as for commercial products: availability, accessibility/affordability, acceptability and quality).

Since then, much has happened (Fox, 2020; Tull, 2019; Kulczyk Foundation & Founders Pledge, 2020). A highly useful seminar series throughout 2020 examined three different types of menstrual materials: disposable pads, reusable pads and menstrual cups (RHSuppliesCoalition 2020).

3.2.1. Availability, accessibility (and affordability)

Availability of commercial MHM products is limited in African countries.

The review found no conclusive overview of the availability of different products in these countries.

On the commercial market, disposable pads seem to be widely available, and reusable pads increasingly so, including through local manufacturing social enterprises such as AfriPads, starting in Uganda. Financial sector analyses project global sale of menstrual hygiene products at over 6 per cent yearly (Global Newswire, 2020). Tampons and menstrual panties seem to be available in only a few countries. MCs are widely available in HICs (one estimate is that hundreds of millions are sold every year) but not yet in many African countries (van Eijk et al., 2019). A few African countries such as Nigeria and South Africa are producing and selling MCs.

Governments are providing free products in a number of countries, both disposable and reusable pads, as well as MCs (see below).

Given that MCs are not widely available, a number of NGOs and social enterprises are piloting their introduction (for example, in Kenya, Botswana and Angola through Ruby Cup; in Malawi through the organization MAGGA (MAGGA & UNFPA, 2020); in Tanzania, through a local entrepreneur (Flora Njelekela) (Shah, 2020); in Ethiopia through Sara Eklund/Noble Cup (Uthman, 2019); and in Uganda through WoMena, in collaboration with CARE, Red Cross and other partners.)

In Ethiopia, local campaigners have addressed the issue of the lack of local producers of products, which has sparked initiatives to combat this issue (Berhane, 2019).

Several concerns have also been noted. For example, in Uganda, studies suggest that if there is no informed choice of products, or adequate access to dispose of pads, it might hinder usage (Barrington et al., 2019).

The limited availability in terms of product type and brand may lead to less competition and higher costs (Rossouw & Ross, 2020).
Alternative ways have been found to improve access and availability:

- The **Rwandan** application Kasha provides a platform for purchasing menstrual products online to be shipped to a private place, thus avoiding potential stigma (Hitching-Hales, 2019).

Affordability has received much attention.

- As mentioned in section 2, the issue affects both low, middle and high income countries. Citing ‘period poverty’, in 2019, Scotland introduced, a law to provide free products to those in need, which was enacted in January 2021 (The Scottish Parliament, n.d.; The Guardian, 2020). New Zealand will provide free products in schools in June 2021 (BBC News, 2021).

However, there seems to be limited availability of cost comparisons. The 2018 review made some estimates, which are quite consistent with recent estimates of recurrent yearly costs by UNICEF:

- Cloth, 1 m2: US$2s
- Reusable pads: US$1.5-3
- Disposable pads: US$30-90
- Menstrual cups: US$1-8
- Tampons: US$60-90
- (No estimate for menstrual panties).

The above are recurrent, yearly costs, except for menstrual cups, where costs are averaged over a lifespan of 5 to 10 years (Roeckel et al., 2019).

These estimates do not include home made or cottage industry products. The 2018 review attempted to give some estimates: an Indian homemade pad was found to cost around US$1,000 for the machine (Venema, 2014) and about half the cost of commercial pads (US$13-26 per year) for materials. Production of reusable pads may also incur costs (possibly sewing machines) and materials (for example cotton cloth) bought at the local market.

Several strategies have been identified to overcome the cost barriers: reducing costs by eliminating taxes, increasing competition, providing free products or subsidies, supporting home production, or identifying innovative products which are lower cost.

**Eliminating Taxation**

- Removing taxes from MHM products (import duty or sales tax) is increasingly common in African countries, in particular in **East Africa**. The East African Legislative Assembly (EAC body) has recommended member countries to remove tax on MHM products and stimulate local production (Welham, 2020).
- **Kenya** has some of the most far-reaching MH tax exemption policies worldwide (Rossouw & Ross, 2020).
- **South Africa** removed VAT on sanitary pads in 2019, through the National Sanitary Dignity Framework and Programme (South Africa Government News Agency, 2019). However, tampons are not exempted as it is argued that these are used only by wealthier women (Rossouw & Ross, 2020).
- **Ethiopia** has removed customs duties (date unknown) (Welham, 2020).
- **Tanzania** removed tax in 2018 but re-imposed it in 2019 (Welham, 2020; Period Tax, n.d.9) as prices did not decline (Lila, 2021).
- **Lesotho** removed tax from ‘sanitary wear’ in 2019 (Gender Links, 2019).
- **Zimbabwe**’s parliament is discussing tax exemption (Louw, 2019).
- **Uganda** removed VAT, for example, for cups, in 2017 (Rossouw & Ross, 2020; ParliamentWatch, 2017).

However, an analysis indicates that this may not be a sufficient measure.

- The impact on pricing may be modest. A tax cut does not automatically translate into lower prices, unless there is competition. Advocacy, quality control and monitoring of price changes may be necessary. Prices in LMICs are at times

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higher than in LMICs, as competition is low (Fox, 2020; Rossouw & Ross, 2020).

Therefore, it is suggested that the removal of tax may need to be supplemented with the provision of free products for the poorest sectors (Rossouw & Ross, 2020).

Providing free or subsidized MH products is widespread.

- In South Africa, the distribution of pads for girls in non-fee-paying schools was initiated in 2018 (DWYPD, 2019a; Pilane, 2019).
- In Lesotho, a law was introduced that made it mandatory for the government to provide ‘sanitary wear’ to schoolgirls to avoid absenteeism from school (Ramolibe, 2019).
- In Kenya, the government announced that they would provide all public schoolgirls with sanitary pads (4.2 million girls) in 2018 (Gelardi, 2018).
- Kenya and Zambia stand out as the two countries in the region with national budgets that allocate for the provision of sanitary pads in schools (Ofori-Kuma, 2018).
- Campaigns have been initiated to provide free pads for girls in schools, for example, in Ethiopia (Berhane, 2019), Uganda (Daily Monitor, 2019), Namibia (Ngutjinazo, 2018) and Burundi (Rehme, 2019).

3.2.2 Acceptability

As a wider range of modern MHM products is becoming available, there is increasing attention to their acceptability, often expressed as whether they are ‘culturally appropriate’ or ‘culturally acceptable’. This is perhaps not surprising, as modern products are new in many settings. However, this term is rarely defined, for example in terms of ‘acceptable’ to whom, when, how, and why? Many studies assess uptake, continued use and satisfaction of users, but much less frequently the views of the community, service providers or national/international policy makers and programme staff. Most studies focus on menstrual cups (possibly because they are perceived to be challenging in this respect) but also some other reusable products (Lenia, 2019).

- A cohort study of 509 female students aged 18 to 24 years in South Africa reported that around 50 per cent of students found inserting the MC to be easy at first insertion; 80 per cent of the rest required two or three insertions to achieve comfort. More than 90 per cent of students who had used the MC reported that they would continue to use it (Beksinska et al., 2020).
- A cluster-randomized pilot study in Kenya with schoolgirls aged 14 to 16 years found that 83.9 per cent of 143 girls screened within three
months said they had used the MC; this increased to 96 per cent after nine months. Problems with insertion, emptying, or dropping decreased over time. Most girls reported good habits regarding hygiene. Colour change of the MC, as an indicator of use, was adopted to supplement student self-reporting (van Eijk et al., 2018).

- A prospective interventional study involved 54 sexually active women in Zimbabwe, who were given training and received MCs. After three months 94 per cent of the participants found the MC easy to maintain, and 56 per cent reported preferring a sterilizing solution over boiling. The study concluded that MCs are an acceptable product for low-income women, and they will continue for one year to study the longer-term experiences (Madziyire et al., 2018a & 2018b).

- In Uganda, a number of pilot projects undertaken by WoMena Uganda in partnership with CARE, Red Cross, totalling more than 10,000 users to date, work with both reusable pads (especially AfriPads) and MCs (Tellier et al., 2012; CARE International & WoMena Uganda, 2018). The findings confirm those of the other studies mentioned above, although there may be some initial scepticism, as MCs are new, and take several cycles to get used to. Initial uptake varies between 48 and 83 per cent, but after that, continued use is consistently over 85 per cent (often higher than for other products), and satisfaction rates are generally between 95 per cent and 99 per cent, often highest where users have access to both reusable pads and MCs. The projects also address acceptability by family members, communities (especially males), local officials (for example, in health care and schools) as well as at national and international policy level (WoMena Website, n.d., WoMena Resources, n.d.)

- 'Acceptability' has different meanings for different stakeholders. For example, users refer to ease of use, family members may appreciate that the quantity of water needed to clean MCs is limited.

- In Zimbabwe, a youth empowerment programme includes a small-scale study of acceptability of different products, intended to guide future programming (Chiedza, 2020).

### 3.2.3 Quality

Globally, there is an expanding number of products and brands. There are periodic public scares about the safety of individual products (whether pads, tampons or MCs), which are not necessarily evidence-based. There is also increasing criticism of products which provide insufficient information about their safety, prompting calls for standards (SIS 2020; WoMena, 2020a).

Regulation by governments or manufacturers can contribute to ensuring safety and quality, although their effectiveness depends on the capacity to enforce the standards. Home-made products, products imported over the Internet by individuals, and counterfeit products etc., are not necessarily covered (RHSC, 2020).

- Globally, there is no agreed industrial regulation for widely available products such as disposable pads. The Reproductive Health Supplies Coalition, partnering with ACMHM and others, have carried out a series of webinars on disposable pads, reusable pads and menstrual cups in 2020. It noted the absence of standards, including for common products such as disposable pads, or for the claim that any particular product is ‘biodegradable’ (RHSC, 2020).

- Classification and standards vary among countries, although the US Federal Drug Administration is often referenced.

- UNFPA, UNICEF and UNHCR have developed generic standards for products available in their catalogues (WoMena, 2020a), which means the
products can be purchased at favourable prices, and with generic quality standards (the latest addition is for MCs, to be posted in 2021).  

- UNICEF has published a guide for MH products for use by field staff (Roeckel et al., 2019).
- The African Union has increased its focus on the regulation of drugs and medical devices. Menstrual products will probably not be included as they seem to be classified as consumer products (African Union, 2019), but other regulatory bodies could develop model standards.
- At country level, several countries are developing standards, for example Ethiopia has standards for disposable and reusable pads (ESA, 2018a; 2018b), and Uganda does for reusable pads (UNBS, 2017).

Given the challenges of regulatory surveillance, consumer awareness is important. For example, the campaign “My Always Experience” addressed the issue of poor quality pads (Fox, 2020).

- FSG finds that stakeholders are beginning to emphasize the importance of including environmental concerns in any standards (Gade & Hytti, 2017; Amaya et al., 2020).
- The 2018 review noted that there were several comparisons of products (for example, PATH, 2013)14. Others have been added (Roeckel et al., 2019; Plesons et al., 2021) but they are not consistent (for example, only Roeckel includes cost estimates), possibly complicated by the multitude of brands. This would still appear to be an outstanding issue.

3.3. Water and sanitation facilities

The 2018 report noted that sanitation, and to some extent water, are the only issues related to MHM which are explicitly included in the SDGs. The WASH sector, in particular the WHO/UNICEF JMP, produced early guidelines for including MHM in WASH facilities, particularly in schools, and continues to monitor progress.

However, progress for sanitation (and to some extent water) is limited.

- According to the Global Sanitation and Hygiene Fund, “half the world’s population does not have access to safely managed sanitation. 620 million children attend schools that do not have toilets. One in three schools do not have even basic sanitation and hygiene services, and one in five health-care facilities have no sanitation services whatsoever” (UNSDG, 2020).

- For the ESA region, a scoping review of sanitation in schools found that only between 47 and 88 per cent of schools in Rwanda, Uganda, Malawi, Zambia, Burundi, Mozambique, Tanzania and Namibia had ‘basic services’. In other countries, no schools did (Ofori-Kuma, 2018).

- Many guidelines have been produced, including by UNICEF/WHO (UNICEF & WHO, 2018; Burgers et al. 2019), as well as the WASH and Learn programme, suggesting six steps (Aqua for All & Simavi, 2018).

- The importance of designing WASH facilities in accordance with user preferences in Bangladesh is emphasized by Schmitt et al. (Schmitt et al., 2021).

- Nevertheless, WaterAid concludes that MHM is the least well-included hygiene component in policies in the region (WaterAid, 2018).

- A report from Uganda notes that, although schools in Uganda had received a circular from the government, few had acted upon it. Many had made efforts, but had insufficient budgets (Ali, 2018).

- An intervention study from Uganda found that the software components, such as education, were well implemented, but the hardware

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Several academic studies have emphasized the need to consider menstruators’ lived experiences, for example, in terms of privacy to design interventions (Goddard & Sommer, 2020), including at household level (Hennegan et al., 2018), so that poor health and environmental outcomes can be reduced (Elledge et al., 2018).

3.4. Policies on menstrual health management

Section 1 refers to a number of policies and strategies on MHM at global level. At the ESA regional level, there is much progress. Indeed, it is now seen as one of the regions in the world with the most policies directly focusing on MHM (Jurga, 2019). (Developments with regard to taxation policy are given in section 3.2.)

- UNICEF reports that 13 countries either have fully developed MHM guidelines, or have strategies under review for adoption. Six countries have no policies (Comoros, Eritrea, Malawi, Mozambique, Namibia and Somalia) and the remaining two countries have no data (Ofori-Kuma, 2018).

- A few countries have policies in the making or include MHM in other sector policies, such as Lesotho, Tanzania, and Botswana (MH Hub)\(^{15}\). Eswatini and Zimbabwe include MHM in hygiene lead ministry policy (WaterAid, 2018), and in Namibia MHM is included in the national Safe School Framework (MEAC & UNICEF, 2018).

- Many policies were initiated before the 2018 review, but recent examples include South Africa, which launched the Sanitary Dignity Framework in 2019 (Dlamini, 2019; DWYPD, 2019b). Kenya updated both an MHM policy and a strategy (2019–2024) (MoH Kenya, 2019a; 2019b). In Uganda, an MHM Steering Committee was established, and in 2018, a national MHM symposium was hosted (UYAHF, 2018).

There are many recurrent themes:

- a) The overall goal of dignity, with the need to combat stigma and taboos (MoESTS Uganda, 2015; FMoH Ethiopia, 2016; DWYPD, 2019b; MoH Kenya, 2019b); b) period poverty and the importance of improving availability/accessibility (MoESTS Uganda, 2015; FMoH Ethiopia, 2016; DWYPD, 2019b; MoH Kenya, 2019b); c) the importance of coordinated cross-sectoral action; as well as d) monitoring and evaluation (MoESTS Uganda, 2015; FMoH Ethiopia, 2016; WaterAid, 2018; DWYPD, 2019b; MoH Kenya, 2019b); e) school infrastructure as well as public toilets and facilities for out-of-school girls and in the work environment (FMoH Ethiopia, 2016; DWYPD, 2019b; MoH Kenya, 2019b); and f) waste management (Villalonga & Abella, 2019). Several also suggest g) creating national and/or regional MHM task forces/committees.

Despite this strong commitment, several barriers are mentioned:


- This in turn hinders budgetary commitment, which remains insufficient (Ofori-Kuma, 2018).
3.5. Interventions for special groups, including humanitarian settings

The 2018 report and Symposium strongly highlighted the need to address particular vulnerable groups, including the disabled, LGBTQI+ and women in prisons. Humanitarian agencies are increasingly addressing MHM, by distributing products:

- A mixed-method study of 260 refugee adolescent girls aged 13 to 19 years old in Uganda found that 78 per cent had access to disposable pads (distributed by the UNHCR), but only five to six packets of pads over six months, which sometimes had to be shared with other female family members. The girls had limited knowledge on SRH issues: 11.7 per cent were not aware of how HIV is prevented, 15.7 per cent did not know of any sexually transmitted infections, and 13.8 per cent were not familiar with any methods of preventing pregnancy. A total of 30 per cent of the female adolescents had visited a SRH service centre, mostly to test for HIV and to seek medical aid for menstrual problems (Ivanova et al., 2019).

- A literature review of 51 articles grouped the literature into six categories of supportive menstrual materials, sanitation infrastructure, knowledge and education, health and social context, gaps between policy and practice, and current guidelines. It found a lack of evidence on the application of interventions and there was a failure to renew supplies on a monthly basis. Although there was agreement to assess needs, the distributed products were mainly disposable, with no studies about new products. Indicators for monitoring were not clear (Vanleeuwen & Torondel, 2018).

- A systematic review of SRH interventions for adolescents in humanitarian settings in LMICs concluded that this group generally receives little focus. It found only one report which referred to menstruation, with most referring to prevention of pregnancy, HIV/AIDS, prevention of sexual and gender-based violence and maternal and newborn health (Jennings et al., 2019).

- A cross-sectional study among females aged 15 to 49 in Bidibidi refugee settlement in Uganda found that, despite widely available information about MHM, about 40 per cent had a lack of knowledge of menstruation. The participants preferred to use disposable pads, although aid agencies recommended reusable pads (Lenia, 2019).

- The International Federation of Red Cross and Red Crescent Societies carried out operational research between 2012 and 2016 in Burundi, Uganda, Somaliland and Madagascar. After consultation, three types of ‘MHM kits’ were designed and tested. Conclusions included that distribution is not enough; information and demonstration is necessary. Men and boys, and male and female staff must be involved, and a link must be made with sexual and reproductive health service providers (Giles-Hansen et al., 2019).

- A review notes that products are often distributed for only the first three months, and that there is no clear agreement on the role of different actors (Tellier et al., 2020a).
What has the ACMHM’s contribution been?

The purpose of this section is to review the contribution of the ACMHM, from the Call to Action in May 2018 (UNFPA, 2018) to February 2021, as perceived by stakeholders. This is based on: (a) published reports and newsletters; (b) qualitative feedback on the ACMHM in a survey of members and non-members undertaken by UNFPA in 2020; and (c) 18 key informant interviews (KIIs) with government, civil society, donor agencies and the private sector, asking about contributions to date and suggestions for the future.

4.0.1 Coalition aims and resources

The three aims of the ACMHM are:

1. Strengthen coordination among key stakeholders;
2. Build on and support the evidence base to better transition research to action;
3. Support multi-sectoral policy making and the scale-up of evidence-based and sustainable programmes that address the menstrual health management needs of girls, women and all people who menstruate in Africa, throughout their menstrual life cycle.

Their aims have been adjusted over time (see Annex IV), complemented by joint commitments at the ICPD25 Nairobi Summit in 2019 by the ACMHM in collaboration with the MHH Collective and MH Day Secretariat: (1) Advocate for more and improved investment for MHH (by 2025, 30 countries will be committing resources to MHH); (2) increase reach for #ActionforMHEducation; and (3) include menstrual health in relevant SRHR, public health and multisectoral policies, strategies and frameworks.
The Coalition Secretariat had very limited funding from its inception, and at present there is no dedicated budget. Two UNFPA ESARO staff have added 10 per cent to their time dedicated to ACMHM work, on top of their existing job descriptions. This review did not identify any other source of capacity.

4.0.2 Stakeholder overall views of the coalition and its aims

Most respondents are highly positive, noting that much has been achieved, and phrasing their comments in terms of helping the ACMHM to advance further. Respondents note that the issue of MHM is receiving increasing attention, and the ACMHM has helped create a platform for MHM in Africa. ACMHM should continue to help form the evolving narrative around MHM. There is great potential for the ACMHM to grow into a strong leader on the continent, as a valuable source of technical support, best practices, MHM knowledge and network building. Not all aims are equally important or successful, and given human resource and funding constraints, priorities for the ACMHM should be clearly defined, responding to changing needs over time. One of the biggest strengths of the ACMHM is that it includes governmental and intergovernmental organizations, civil society and academia. Future plans should build on that.

4.1 Strengthen coordination among key stakeholders

4.1.1 Coalition governance structure

Since September 2018, the Coalition has been hosted by UNFPA, which acts as a secretariat. An inaugural leadership meeting for ACMHM was held in Johannesburg on 3–4 December 2018, to determine short-term and long-term strategic plans and goals, and priorities, as well as the governance structure.

The leadership team is composed of 25 individuals, including UNFPA, supported by the leads and co-leads of seven ACMHM task forces, which are considered the pillars of the Coalition:

1. MHM and education (Leads: MyAge Zimbabwe & MIET South Africa & MRC/UVRI and LSHTM Uganda Research Unit).
2. MHM in humanitarian settings (Leads: Precious Pearls Trust & WoMena Uganda).
3. MHM and marginalized groups (Leads: Refugee Social Services & SRHR African Trust).
4. MHM products and standards development (Leads: AFRIpads (U) Ltd & I4ID/ Mkakati Action).
5. Research and M&E (Leads: MaTCH & GAGE & Femme International).
6. MHM and sexual and reproductive health and rights (Leads: Amplify Change & Hope Centre & Biomedical Research and Training Institute).
7. Water, sanitation, hygiene and disposal (Leads: WSSCC & WaterAid).

This structure has not changed over time, apart from the Research and M&E task force which, since February 2020, has transitioned to a cross-cutting role.

The leadership team and task force members meet quarterly on a virtual basis, and yearly face-to-face. The intention is that the function of host/secretariat will either be passed from UNFPA ESARO to another institution, or expanded to include more than one institution. This is intended for discussion at the next Symposium (pushed from 2020 to 2021 due to COVID-19).

Feedback from respondents indicated that not all were aware of the task forces, that some were much more active than others, and that clear definition of roles would be helpful. One felt that representation was skewed for certain countries or regions. Several suggested a more bottom-up approach to governance, with wider inclusion of actors.
4.1.2 Membership

One original goal of the Coalition was to expand to West, Central, and North Africa. The ACMHM started out with 262 members. Since then, 328 have been added, reaching a total of 590 members in 2020, with wide geographic membership:

**North Africa:** Egypt, South Sudan; **West and Central Africa:** Cameroon, DRC, Ghana, Nigeria, Senegal, Sierra Leone; **East and Southern Africa:** Burundi, South Africa, Malawi, Comoros, Ethiopia, Eritrea, Kenya, Uganda, Lesotho, Zimbabwe, Namibia, Zambia, Tanzania, Mauritius; **Outside Africa:** Canada, Afghanistan, Australia, Germany, India, Sweden, United States, United Kingdom, Switzerland, and the Netherlands.

Interest in new membership seems to be continuing: 70.4 per cent of non-member respondents to the ACMHM questionnaire were willing to become members. Some were unsure of their own membership status, and a few suggested payment of membership fees.

Key informants noted that geographic reach is expanding, although not as quickly as initially hoped. Both key informants and survey respondents identified barriers related to language (in particular for francophone, lusophone and Arabic-speaking countries) as well as accessibility (for example, the cost of attending face-to-face meetings). They noted a particular interest in including North Africa, which is seen as less connected with the global MHM community. Respondents acknowledged that active outreach requires resources; communications need translation, and meetings require translators and breakout sessions.

Key informants suggested that efforts should be made to include government officials. Almost all suggested additional efforts to include grassroots and key populations (for example youth, people with disabilities), and that online platforms and digital meetings might reduce barriers.

4.1.3 Communications, networking and engagement with members and beyond

ACMHM has defined communications as a priority area, both externally (for example, human interest stories) and internally (for example, newsletters with updates from ACMHM task forces). Activities have been hampered due to the departure of the communications officer.

Internally, ACMHM membership engagement is mainly done through listserv and newsletters (distributed three times) as well as through a 2019 annual report. Respondents appreciate this, but suggest a more structured and frequent engagement, focusing on ACMHM priorities, as there are overwhelming numbers of information streams.

There is an expressed wish by some members to become more engaged. Some would like to represent the Coalition at meetings/webinars. For example, two members of the ACMHM leadership team represented the Coalition in Zimbabwe at a national MHM and SRHR symposium held on 2 December 2020.

Respondents to the survey who were not members of task forces were keen to become more involved, for example supporting the Secretariat with: (1) communication activities and initiatives; (2) organization of webinars, leadership and task force meetings, and regional events; and (3) financial support to the ACMHM Secretariat, including funding for office space, human resources, meetings, and other activities.

Externally, in 2019, the Coalition and UNFPA ESARO partnered with colLABorate: ideas and images to develop “WOMENstruate”, a film capturing the menstrual experiences of seven women and girls across Africa. A website was fully launched in November 2020.

Key informants noted that ACMHM has established a recognised brand, illustrated through the 2019 receipt of the Global Women's Political Forum #PowerTogether award. Small partners have gained visibility from having the backing of a well-known network. There is a need to strengthen membership engagement, for example, identifying incentives, and ACMHM should focus on its own work, but contribute to existing streams (for example, MH Hub on activities, WoMena...
and ESA research network on research). If possible, presence on social media (such as Twitter) should be strengthened.

Respondents found that the ACMHM networking enabled a better sense of the MH players in the region. One key informant noted that the ACMHM helped governments better identify, support and supervise ongoing initiatives. Several observed that much of the networking was driven by individuals, and there was a need for more resources to actively map and connect local communities of practice, particularly grassroots organizations. Suggestions included a mapping of active organizations, including contact details, possibly increasing collaboration with other mapping initiatives such as the MH Hub Global MH Registry.

4.1.4 Partnerships with other actors and coalitions for advocacy

There is a rather overwhelming list of MHM actors and coalitions, including a large number in Africa, with many having been established since 2018 (see Annex IV). ACMHM has linked with many of these:

**Global MHH Collective**: the ACMHM is a member of the Core Group, representing African experience. At the Nairobi Summit on ICPD25 in November 2019 this partnership, with the MH Day Secretariat, collaborated to give visibility to the concept of MHM as part of SRHR, and deliver joint commitments. Respondents noted that this was an excellent event for networking.

**Days for Girls**: the Coalition co-hosted a MHM and COVID-19 Lessons Learnt Web Dialogue, resulting in a position paper released as part of the International Day of the Girl Child.

**Columbia University**: The Coalition has supported the ‘Period Posse’ webinar series, which brings together technical experts in MHH.

**Reproductive Health Supplies Coalition, PATH and Menstrual Health Alliance India**: as mentioned in section 3, ACMHM has collaborated on a series of webinars to advance MH product standards through discussion with a range of stakeholders, including manufacturers.

Finally, the ACMHM has provided technical support to smaller, regional coalitions, for example, the launch of the South Africa Coalition for Menstrual Health and Hygiene (SACMHM), March 2020.

Respondents expressed appreciation of efforts to date, and suggested strengthening, but also prioritizing linkages, particularly with stakeholders such as governments and key populations.

Advocacy is a key aim of the ACMHM. Whereas precise assessment of attribution/contribution can be difficult, ACMHM has contributed to several ‘wins’: the inclusion of MHM indicators in the Demographic and Health Survey indicators (a follow-up to the 2019 consultation at Columbia University); development of regional (East African community) and national (South African) standards for washable/reusable sanitary pads; VAT tax exemptions on menstrual health products in Lesotho, Ethiopia and Zimbabwe; and finalization and approval of Kenya’s draft comprehensive MHM policy.

Key informants affirmed ACMHM contributions, such as tax removal and development of MH product standards. They recommended support for regional bodies to further harmonize standards, including those recently developed by UNFPA/UNICEF/UNHCR for menstrual cups. They noted that members need incentives to work on these issues on top of other priorities, and that ACMHM has no official representational role in many processes. The key informants recommended that the various advocacy processes be documented, identifying lessons learned.

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4.1.5 Resource mobilization

The 2018 Call to Action suggested that the ACMHM should engage in resource mobilization, although with little detail. This was also a commitment at the ICPD25. There is little feedback on this. The ACMHM has planned and undertaken resource mobilization plans for ACMHM activities, as well as collaborating with partners on various calls (for example, Global Affairs Canada (GAC) – Health and Rights for Women, Adolescent Girls and Children). Key informants are acutely aware that the ACMHM has funding limitations, and any recommendation for future activities is contingent on mobilizing funding.

4.2 Build on and support the evidence base

In its first leadership meeting report, the ACMHM recognized that research on MHM in Africa continued to lag behind, particularly on data gathering and M&E, and this should be supported. As mentioned in section 1, the lack of agreement on indicators for M&E or their introduction in the SDGs is seen as a major issue for stimulating action and accountability. Suggestions for research, such as Plesons (2021), refer to the definition of indicators, and feedback on the cost-effectiveness of operational responses, as major impediments.

The ACMHM has contributed to a number of activities related to indicators, for example, the Global MHM Measures Advisory Group that led to the release of the Monitoring Menstrual Health and Hygiene: Measuring Progress for Girls related to Menstruation Green Paper in March 2019 by Columbia University and WSSCC, and to the Guidance on Monitoring Menstrual Health and Hygiene by UNICEF. Key informants reiterated the need for leadership in the development and adoption of standardized measurement tools and indicators, and this would be an important role for ACMHM. Many key informants suggested that the lack of evidence was a major constraint, in terms of policy and funding.

UNFPA ESARO contributed to The Palgrave Handbook of Critical Menstruation Studies, bringing particular attention to the need for coordination and leadership in the field.

Key informants noted that there was a gap in the gathering of practical documentation (unpublished literature) of good practices and lessons learned, and there is a need to incentivize members to submit reports (not in terms of funding, which at this point is unrealistic), and facilitate exchange. There is potential for ACMHM to lead a centralized documentation management system for members’ unpublished literature. However, at present the Secretariat may not have the budget/structure to implement this, so either additional funding is needed, or another member might need to step up.
4.3 Support multi-sectoral policy making and scale-up

The 2018 Symposium aimed at highlighting the importance of MHM within SRHR, and the Call to Action states: Strengthening integration and coordination of menstrual health management matters into existing development and humanitarian programmes in areas such as health, including sexual and reproductive health and rights, education, water and sanitation, trade and industry, environment, gender equality, and empowerment programmes.

Much has been done in this respect. In 2019, the AMHM, along with partners, contributed to the ICPD+25 conference in Nairobi, organizing special sessions on MHM, including neglected areas such as vaginal bleeding, which resulted in specific commitments by governments, civil society, academia and donors. This seems to have been the first time the issue of MHM was brought up in connection with an official review of the ICPD, thereby building commitment (indirectly also for the SDGs, where the ICPD is referenced). According to the quarterly ACMHM MHM updates, it has also responded to requests for technical guidance at national level; reviewing advocacy material for MHM and SRHR in South Africa, providing support on MHM to the UNFPA Ethiopia country office for its inclusion into its SRHR and human rights work, and presenting at the Zimbabwe National Symposium on MHM and SRHR.

The ACMH has contracted the production of Technical Guidance on the Integration of Menstrual Health Management into SRHR Policies and Programmes for early 2021, also consulting with PSI, which has published a related brief (PSI 2021).

Key informants cited these efforts, starting with the Symposium, as one of the achievements of the ACMHM, noting that it had fostered collaboration, ensuring that MHM was no longer seen as a siloed issue. Respondents singled out issues which were seen as particularly helpful: the awareness created in humanitarian work; the emphasis on the life-cycle approach; awareness of dysfunction such as abnormal bleeding; the attempts to include key, marginalized populations; linking MHM with gender-based violence, the impact of MHM on SRHR such as family planning (including menstrual equity); and strengthening male involvement. Respondents recommended continued emphasis on these issues in communications and education.
5. Recommendations

The review of the literature and the interviews indicate a general view that the field has continued to evolve remarkably quickly, and many suggestions have been made to build on this.

UNFPA suggested that the review might add its own conclusions and recommendations. The following recommendations focus on what might be useful as the field transitions from ‘leading edge’ to gradual scaling up, and list some existing tools (such as those available from UN processes) to facilitate this. The recommendations are based on broad programmatic principles such as taking a cross-sectoral, life cycle and human rights approach.

**RESEARCH and MEASUREMENT:**

Experience with the MDG/SDGs over the last two decades confirms the importance of agreed, simple, realistic indicators for generating scaled up attention, monitoring and action at national and global level. It also affirms that arriving at those indicators can be time-consuming, and that many data are not available, including in HICs. Much progress has been made, especially on some programmatic components such as WASH.

The ongoing efforts to use existing data collection initiatives, such as demographic health surveys, multiple indicator cluster surveys and performance monitoring and accountability, could be key, and should be followed closely in the ACMHM.

In addition, given the increasing awareness of the importance of physical ‘disease and infirmity’ related to MH, tools such as the disability adjusted life years (DALY) metric, and the International Classification of Disease, 11th Edition (ICD-11) might be considered, as these systems are agreed

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18 DALYs - disability adjusted life years, which quantifies both premature death and years lived with disability
19 ICD-11: the 11th version of the International Classification of Disease, produced by the WHO, which will come into force in 2022, and which is used by all member states.
among member states of the WHO, are widely used, and contain several classifications related to MH. It could be explored whether a disease being classified in the ICD-19 facilitates access to care and insurance. As mentioned in the 2018 review, at least one study already uses the DALY tool. This might particularly help focus on the life cycle approach, beyond the age of adolescence, to include post-menopause.

At programme level, there is a growing body of literature on indicators, which might be considered. For research, the review very much supports the calls to shift attention to better evaluation of implementation (see below).

**CONDUCTIVE LEGAL and POLICY ENVIRONMENT and its translation into STRATEGIES and PROGRAMMES:**

At the global level, there are many instruments for scaling up programming and policy, and the review suggests they might be utilized more consistently.

There are already many human rights instruments relevant to MH, but they could be better used in Universal Periodic Reviews (UPR). In 2021, UPRs for Somalia and Mozambique are scheduled for review in May, and Sudan, Tanzania and Eswatini in November.

For the SDGs, reference has been made to relevant targets and indicators related to WASH: SDG 4 (education) and SDG 6 (WASH). Given that MH is increasingly accepted as part of SRHR, this opens up the possibility of reference to SDG 5 (gender), including reference to the Programme of Action of the International Conference on Population and Development (ICPD) and its review conferences, access to services and legal reform (Target 5.6). The 2019 ICPD+25 review in Nairobi for the first time included a wide range of commitments related to MH. All of these could be used to energize national action.

As mentioned, at country level, the ESA region has been described as one of the most active in terms of country-level programmes and initiatives. There are numerous recommendations to map and evaluate the cost-effectiveness (in monetary and social/health terms) of different programme components, which would seem to be key for scaling up. Although it is implied, this review would suggest explicit focus being placed on the wider effects such as gender relations (as some actors call it: transformation of male roles, including male engagement as part of ‘positive social norms’, which have received limited attention). In addition, given the high level of activity in the region, this review suggests analysing the drivers and challenges involved in developing these initiatives, for use within the region and beyond.

Presumably, the programmatic components identified as prerequisites for comprehensive MH programming would form the basis for an intersectoral approach, including the health sector, for referrals on menstrual ill-health, and the education sector, for integration of quality puberty education. It is therefore important that global sectoral strategies, such as WHO for health, or UNFPA specifically for SRHR, are explicitly inclusive. For example, UNFPA, with the support of UNICEF and UNHCR, has initiated the inclusion of menstrual products in the reproductive health commodities, as of June 2021, as well as collaboration with UNHCR on MH in humanitarian settings. It is important that global commitments are encouraged in all relevant sectors.

**SUSTAINABLE FINANCING:**

This is key for scaling up. As mentioned, there are many calls for costing and cost-effectiveness, for all programmatic components, to also cover opportunity cost and the cost of inaction. This review suggests that, for example for menstrual materials, this should go beyond market prices to include the environmental cost of production and disposal.

In addition, the review recommends studies to assess financing strategies, and the provision of information on the effect of various strategies intended to lower costs. For example, in terms of materials, at this point there is limited evidence that the reduction of value added tax translates into lower prices of products, so it would be important to assess the benefit, for example, of promoting market competition with regard to sales, or lowering prices through long-term framework agreements with UN organizations.

There is also a global gap with regard to the technical oversight of MH financing, as is the case for other areas of health. The review recommends surveying...
existing mechanisms, and the possibilities of inclusion of MH-related financing.

The ACMHM

The review was asked to describe the contribution of the ACMHM over the last two to three years, as well as recommendations.

Structure and governance:

The ACMHM is composed of seven (now six) task forces led by members, together with the Secretariat, hosted by UNFPA, consisting of one or two UNFPA staff with ACMHM functions added to their existing job descriptions, but with no additional funding. The intention is that the structure should be reviewed at the follow-up Symposium, including the possibility of shifting or sharing Secretariat tasks with other member organizations.

The aims have been revised and simplified over time and are now:

Aim 1: Strengthen coordination among key stakeholders.
Aim 2: Build on and support the evidence base to better transition research to action.
Aim 3: Support multi-sectoral policy and scale-up of evidence-based, sustainable programmes.

Respondent feedback:

The majority of respondents are highly positive about the ACMHM, and see it as meeting a need, having established a platform for collecting and sharing information specific to the Africa Region, discussing best practice, and feeding African perspectives into global processes. A large number of respondents suggest that grassroot organizations should be included in the leadership (although ‘grassroot’ may need definition). However, some also note that hosting by a UN organization lends credibility.

Aims: Several noted that the aims need to be further simplified, and adjusted to existing capacity. Some topics have received particular attention from the Secretariat (for example, indicators, commodities, support to national policy development, integration of MHM into SRHR). There was no suggestion to change this, but additional topics might need more focus (for example, working with key populations, or including menstrual disorders).

Membership recruitment and registration:

Membership has grown from 262 to 590 since 2018. Respondents suggested aiming to include a greater geographic spread (including Northern Africa). Some noted that they were unclear about their own membership, and indicated that updating the website, which would be key to this effort, had been subject some delays. The diversity of membership, including governments, intergovernmental organizations such as the UN, NGOs and academia is seen as a major strength, which should be used.

Membership engagement: A main avenue for membership engagement is through the six to seven task forces, led by members. Several members have expressed interest in further engaging in specific tasks. Not all respondents were aware of their own membership in the task forces, or of the results. Members most frequently referred to the task force dealing with commodities.

Partnerships: Respondents noted that the ACMHM is working in an environment with many coalitions and actors, with some having similar goals to the ACMHM, suggesting a need to prioritize a few key partnerships.

Some of the barriers mentioned include a lack of incentives for members to register their activities, language (for the four to five official languages in the Africa region), travel costs, budgetary and staff limits, as well as uncertainties about goals and roles.

Informants expressed enthusiasm about the future potential, and there were many suggestions for strengthening it. Overall, it seems clear that this structure (and its activities) is under-resourced, limiting its ability to deliver on its mandate and the potential seen by its members.
6. Conclusion

Two main functions of the ACMHM have emerged from this review. One is the facilitation of a community of practitioners, providing a forum for sharing and discussing experience. The other is to facilitate scaling up, in particular linkages to global goals, and governmental commitment.

The overall recommendation is:

- In the short term (for example, over a few months), the goal should be to prioritize tasks and identify concrete, time-bound targets, explicitly prioritizing partnerships and division of tasks, either with members (for example, in task forces) or outsiders.

- Longer term, it is essential that additional resources should be sought to expand on the ACMHM’s mandate and potentially consolidate or agree on the division of tasks with some of the many networks and coalitions. Topics could be aligned with task forces, optimizing the use of virtual consultations.

- For hosting, UNFPA has comparative strength in its intergovernmental convening role, linking with global processes, but if possible it should be complemented by one or two co-hosts with strengths in communications, and virtual platforms for dialogue or research.


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ANNEX I: A partial list of actors and coalitions

Actors include WaterAid Southern Africa, Regional WASH Media Network, Days for Girls, Global Citizen, Procter & Gamble, She Decides, Global South Coalition on Dignified Menstruation (GSCDM), Menstrual Health Hub, UNICEF, MH Day Secretariat/WASH United, WSSCC, and CoLaborate. Coalitions include the Global MHH Collective where the ACMHM is part of the Core Group of the Collective, representing the diverse African MHM experiences and landscape. This partnership was visible at the Nairobi Summit on ICPD25 (November 2019) where the two coalitions and the MH Day Secretariat collaborated to further anchor the concept of MHM into SRHR and deliver joint commitments. Collaboration with the Reproductive Health Supplies Coalition, PATH and Menstrual Health Alliance India produced the Menstrual Health Standards Webinar series, and to commemorate MH Day 2020, the Coalition co-hosted the MHM & COVID-19 Lessons Learnt Web Dialogue with Days for Girls that resulted in a position paper released in October as part of the International Day of the Girl Child. The Coalition has also been active in its support for the Period Posse webinar series – run by the Columbia University Mailman School of Public health – which brings together technical experts in MHH. Finally, through partnership, the ACMHM also provides technical support to smaller, more regional coalitions. For example, the ACMHM was instrumental in the launch of the South Africa Coalition for Menstrual Health and Hygiene Launch (SACMHM), 9–10 March 2020. The Coalition offered technical support in its establishment and remains actively involved with the SACMHM. Overall, through its partnerships, the ACMHM has been able to support ongoing efforts and contribute to various guidance documents, assuming a key supportive role as outlined in subsequent sections.

The ACMHM entered a growing pool of coalitions in MHM and SRHR both on the continent and globally:

**African Coalitions:**
- Youth End Period Stigma – An East and Central Africa Consortium on Menstrual Health Management
- South Africa Coalition for Menstrual Health and Hygiene (Est. March 2020)
- Menstrual Cup Coalition (Est. Jan 2018)
- Menstrual Hygiene Hub Cameroon
- WASH Alliance Kenya (Est. 2011)
- Sex Rights Africa Network
- Shabab Le Shabab (South Sudan) – Youth-Led Health Alliance addressing HIV, Sexual Reproductive Health and Rights and Gender Equality
- The Water and Environment Sanitation Network (Est. 2005)
Global and Regional Coalitions

- World Menstrual Network (Est. 2016)
- Global Menstrual Collective (Est. March 2019)
- Global South Coalition for Dignified Menstruation
- Washington DC MH day Coalition (Est. 2013)
- Pacific Menstrual Health Network (Est. 2020)
- Alliance for Period Supplies (Est. May 2018)
- Menstrual Hygiene Alliance (Est. 2017)
- Period Empowerment Network (Est. 2018)
- Menstrual Health Alliance India
- Society for Menstrual Cycle Research (Est. 1977)
- Women’s Environmental Network (Est. 1988)
- Global MHM Measures Advisory Group
- Menstrual Health Management Alliance in Nepal (Est. 2017)
ANNEX II: Aims of the Coalition, as formulated in the Call to Action (2018)

(1) Strengthen coordination among key stakeholders;

(2) Enhance collaborative partnerships, joint resource mobilization and advocacy for menstrual health policies towards effective and sustainable menstrual health management in Africa;

(3) Build on and support the evidence base to better transition research to action;

(4) Support multi-sectoral policy making and scale-up of sustainable, evidence-based programmes that address the menstrual health management needs of girls, women and other people who menstruate throughout their menstrual lifecycle in Africa; and

(5) Ensure that Menstrual Health Management is recognized as an essential requirement for African countries to harness the Demographic Dividend, and to advance the African Union’s Agenda 2063, as well as a key element in implementing the Global Strategy for Women’s, Children’s and Adolescent’s Health 2016-2030 (UNFPA 2018).
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