

TECHNICAL BRIEF ON

THE INTEGRATION OF MENSTRUAL HEALTH INTO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS POLICIES AND PROGRAMMES



CONTENTS

Acknowledgements	iv
Joint Foreword	iv
Executive Summary	vi
Abbreviations	viii
Key Terms	ix
Introduction	2
Relevance for the Achievement of Universal Access to Sexual and Reproductive Health	3
Purpose and Scope of this Technical Brief	3
Intended Audience for the Brief	4
Methodology	4
PART 1: RATIONALE FOR THE INTEGRATION OF MH AND SRHR	5
Human Rights Imperative	5
Intersections Between MH and SRHR	7
Sociocultural Linkages Between MH and SRHR	8
Menstrual Stigma, Gender Inequality and SRHR	8
Menstrual Knowledge and SRHR	8
Menstruation and Gender-Based Violence	9
Age at Menarche and SRHR Outcomes	9
Menstruation and School/Workplace Participation	9
Period Poverty and SRHR	9
Menstruation, Psychosocial Well-being and SRH	10
Biological Linkages Between MH and SRHR	10
Menstrual Irregularities and SRH	10
Contraception, Family Planning and MH	10
HIV and MH	11
Urogenital Infections and MH	12
Maternal Health and MH	12
The Importance of MH and SRHR of People in Vulnerable Situations	12
People with Disabilities	12
Transgender and Gender Non-Binary People	12
Humanitarian Settings	13
PART 2: TECHNICAL GUIDANCE FOR THE INTEGRATION OF MH AND SRHR	14
Guiding Principles for Integration	15
Creating an Enabling Policy and Legislative Environment	16
Guidance for Action	17
Comprehensive Sexuality Education and Puberty Education	19
Guidance for Action	20
Adolescent and Youth SRH Services and Programmes	21
Guidance for Action	21
Family Planning and Contraceptive Services	23
Guidance for Action	23
Reproductive and Maternal Health Care	24
Guidance for Action	24
HIV Prevention, Treatment, and Care	24
Guidance for Action	24
Gender-based Violence Programming	25
Guidance for Action	25
Community Engagement	26
Guidance for Action	26
Leaving No One Behind: MH and SRHR of People in Vulnerable Situations	27
Guidance for Action	27
Transgender and Non-binary Persons	30
Guidance for Action	30
Humanitarian Settings	31
Guidance for Action	31

Data and Measurement	33
Guidance for Action	33
Priority Research Questions	34
CONCLUSION	35
Annex 1: Detailed Methodology and Limitations	36
Annex 2: Key Technical Guidance Resources	38
Annex 3: Checklist for MH and SRHR Integration in Policies and Programmes	49
REFERENCES	57

TABLES

Table 1: Types of bleeding episodes experienced from menarche to menopause	8
Table 2: Cross-sectoral stakeholders for integrated approaches to MH and SRHR	16
Table 3: Key terms used for database search	37

BOXES

Box 1: Universally agreed human rights that can be undermined by poor MH	6
Box 2: MH and Sustainable Development Goals	8
Box 3: What works for MH?	15
Box 4: Examples of menstrual hygiene and health policies in ESA [1]	18
Box 5: Subsidising menstrual products in Kenyan schools	19
Box 6: Relationship between CSE and puberty education	19
Box 7: Puberty booklets to improve menstrual knowledge	21
Box 8: Adolescent- and youth-responsive health services	21
Box 9: Integrating MH in HPV vaccination services in Togo	22
Box 10: Integrating MH and SRH for adolescent girls in Zimbabwe	22
Box 11: The NORMAL job aid for counselling clients on CIMBCs	23
Box 12: MH in the UNFPA-UNICEF Global Programme to Accelerate Action to End Child Marriage	26
Box 13: Examples of engaging men and boys in MH	27
Box 14: Considerations for informed consent for people with disabilities	29
Box 15: Examples of CSE Programmes for people with disabilities	30
Box 16: Training health-care providers to offer integrated health services for transgender individuals in South Africa	31
Box 17: Building a menstrual health strategy based on a humanitarian needs assessment in Tanzania	33
Box 18: Examples of dignity kits in East and Southern African countries	33
Box 19: Priority research questions	34

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JOINT FOREWORD

Technical Guidance on the integration of MH in SRHR policies and programmes

Menstruation is a natural and essential part of the reproductive cycle; roughly half the human population has or will experience it. Menstrual Health (MH) is an integral part of sexual and reproductive health and rights. Access to good Menstrual Health is also a human right and essential to public health. MH is critical for the health, well-being, mobility, education, economic empowerment, and dignity of women, girls and people who menstruate. Yet shame, stigma and misinformation surrounding the menstrual life cycle undermine the well-being of women, girls, and those who menstruate, making them vulnerable to gender discrimination, child marriage, exclusion, violence, poverty and untreated health problems.

Enabling women, girls and those who menstruate to manage their menstruation hygienically, with normalcy and without shame enables them to maintain their dignity, agency and autonomy and enjoy certain human rights. It gives them choice and control of their bodies and lives.

2020 was a year of pain, pause and adaptation for billions of people around the world. The COVID-19 pandemic disrupted health delivery systems at a magnitude that ushered in a new world. It also had impacts on girls' and women's ability to manage their menstruation and their health. An estimated 1.8 billion girls, women, and gender non-binary persons menstruate. Regardless of lockdowns, social mobility restrictions, stock-outs and supply chain disruptions, they continue to require menstrual materials, safe access to toilets, soap, water, and privacy.

One in ten girls in Africa are still missing school when they have their periods and too many women struggle with period poverty. Many still lack access to the necessary information, resources, services, and products to positively experience menstruation and other forms of uterine bleeding in a dignified, empowering, safe, and healthy manner. This is especially true of persons who experience intersecting layers of discrimination and who live in humanitarian settings, informal settlements or are on the move.

Fortunately, many countries are moving towards more holistic responses to MH, such as introducing national MH Management policies including removal of import duties and taxation of products to make them more affordable; inclusion of education on puberty in school curricula while providing free products to school girls; grassroots advocacy addressing period poverty; and taking proven pilot MHM projects to scale. Civil society, the private sector, and individuals are championing innovative strategies to meet the MH needs of all people who menstruate.

UNFPA envisions a world where women and girls have the power of choice over their bodies, their lives and their world. UNFPA believes that the integration of MH and SRHR can realize universal access to information, resources, services, and products and offers many benefits for sustainability, cost-effectiveness and ensuring the highest attainable standard of health and well-being for all girls, women and people who menstruate. It enables every person to make empowered choices about their health and well-being across the life cycle. Yet, while the rationale for integrating MH as an integral part of SRHR is relatively clear, the 'how to' of integration at the policy, planning, financing, service delivery, and community levels is less widely known and practised.

The present guidance has been written for policymakers, programme managers and practitioners. It provides a framework for integrated menstrual health within broader SRHR policies and programmes in East and Southern Africa and beyond.

The guidance developed by UNFPA East and Southern Africa Region in collaboration with UNFPA Technical Division in New York, experts in MH, non-governmental organizations and academia, maps out an extensive review of global and regional evidence on the integration of MH and SRHR with findings and recommendations.

We hope that the information and recommendations in this brief will contribute to an increasingly robust and actionable understanding of effective integration of MH and SRHR at all levels, which will translate into effective, sustainable, and equitable actions to make a positive difference in the lives of all girls, women and people who menstruate.



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EXECUTIVE SUMMARY

Menstruation and other forms of uterine bleeding are priorities across the full life cycle. However, around the world, several factors prevent girls, women and people who menstruate from accessing the information, resources, services, and products they need to experience menstruation and other forms of uterine bleeding in a dignified, empowering, safe, and healthy manner. These include gender inequality, discriminatory social norms, poverty, and structural and systemic barriers.

Menstrual health is also an important determinant and outcome of sexual and reproductive health and rights (SRHR). Yet, until recently, menstrual health (MH) was largely overlooked by the international SRHR community. This represents a missed opportunity for the adoption of holistic, integrated and rights-based policies, programming, and care.

This two-part technical brief provides guidance on how to strengthen and operationalize the integration of MH in SRHR policies and programmes at global, regional, and national levels. Part 1 provides an overview of the evidence-based rationale for integrating MH and SRHR. Part 2 offers technical guidance for the integration of MH in SRHR in policies and programmes. The technical brief focuses primarily on policies and programmes in low- and middle-income countries (LMICs), particularly in East and Southern Africa. It also uses a life cycle approach to consider the MH and SRHR needs of girls, women and all people who menstruate, from pre-menarche to post-menopause.

RATIONALE FOR THE INTEGRATION OF MH AND SRHR

There is a clear human rights imperative to integrate MH and SRHR: when the human rights, including sexual and reproductive rights, of girls, women and all people who menstruate are met, they are more likely to experience menstruation and SRH in a safe, healthy and dignified manner. Also, people's experience with menstruation either facilitates or impedes a broad range of human rights. MH is also increasingly recognized as critical for the attainment of several other SDGs.

Menstrual health and SRH intersect in various ways, all of which influence the experience and expression of sexuality, bodily autonomy and health-related decision-making. The linkages include intersections between:

- Menstrual stigma, gender inequality and SRHR
- Menstrual knowledge and SRHR
- Menstruation and gender-based violence
- Age at menarche and SRHR outcomes
- Menstruation and school or workplace participation
- Period poverty and SRHR
- Menstruation, psychosocial well-being and SRH
- Menstrual irregularities and SRH
- Contraception, family planning and MH
- HIV and MH
- Urogenital infections and MH
- Maternal health and MH

For people in vulnerable situations or with special needs – including people with disabilities, transgender or gender non-binary persons, and people in humanitarian contexts – these linkages intersect with various inequalities, resulting in heightened barriers to information, services and support.

TECHNICAL GUIDANCE FOR THE INTEGRATION OF MH AND SRHR

An integrated approach to menstrual health and SRHR recognizes that menstrual experiences affect both the physical and social determinants of SRH. It calls upon those working on MH, notably in the education and water, sanitation and hygiene (WASH) sectors, to better understand the linkages between MH and SRH and to recognize that integration with SRHR has the potential to amplify impact across all sectors. An integrated approach moves beyond implementing discrete and isolated interventions towards a systems approach that enables all relevant sectors to adapt their systems to allow sustainable, coherent policies and programmes to be delivered at scale.

The following list of general recommendations should guide integration efforts. Each general recommendation can be achieved through specific actions aimed at different levels and phases of the policy and programme cycle:

- Galvanize commitment and political leadership for an integrated approach to MH and SRHR, while fostering cross-sectoral collaboration and sustaining social accountability mechanisms;
- Ensure that all adolescents and young people have access to MH education through puberty education and/or CSE programmes, both in- and out of school. Ensure that all people who menstruate have access to MH information and education throughout the full life course;
- Integrate MH as an essential component in adolescent and youth SRHR programmes and in integrated adolescent- and youth-responsive health services;
- Ensure all reproductive health and contraceptive counselling includes comprehensive information on the menstrual cycle and contraception-induced menstrual bleeding changes;
- Integrate MH as an integral part of reproductive and maternal health care;
- Ensure that MH is included as an essential component of HIV prevention, treatment, and care;
- Ensure MH is a crucial component of GBV initiatives, including interventions to eliminate CEFM and FGM;
- Engage communities to create a supportive environment for MH and SRHR with the aim of shifting gender and social norms that underpin adverse MH and SRHR outcomes;
- Invest in high-quality research, monitoring, evaluation and learning, including standardized measures, and utilize data to inform MH and SRH policies and programmes; and
- Leave no one behind:
 - Ensure that SRH and MH information, education, services, and programmes meet the specific needs of diverse people with disabilities;
 - Ensure access to tailored information and affordable trans-competent care that integrates MH and SRH with other key health services while ensuring safety and confidentiality and tackling stigma and discrimination; and
 - Ensure that appropriate and timely SRH and MH information, education, services, and products are prioritized in all phases and sectors of humanitarian responses.

The time is now to improve the integration of MH in SRHR policies and programmes.

An integrated approach to menstrual health and SRHR can empower girls, women and people who menstruate with the knowledge, skills, support and services to thrive through the life cycle. Menstrual health should, therefore, be an essential component of SRHR efforts nationally, regionally, and globally.

ABBREVIATIONS

ACMH	African Coalition for Menstrual Health Management
ART	Active Anti-Retroviral Treatment
AUB	Abnormal Uterine Bleeding
AYSRH	Adolescent and Youth Sexual and Reproductive Health
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEFM	Child, Early and Forced Marriage
CHW	Community Health Worker
CIMBCs	Contraceptive-Induced Menstrual Bleeding Changes
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
DHS	Demographic and Health Survey
ESA	East and Southern Africa
ESARO	East and Southern Africa Regional Office
GBV	Gender-Based Violence
GSM	Genitourinary Syndrome of Menopause
HAART	Highly Active Anti-Retroviral Treatment
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
ICESCR	International Covenant on Economic, Social and Cultural Rights
MH	Menstrual Health
MHH	Menstrual Health and Hygiene
MHM	Menstrual Health and Management
MISP	Minimum Initial Service Package
MNCH	Maternal Newborn Child Health
MP	Monthly Period
PCOS	Polycystic Ovary Syndrome
RTI	Reproductive Tract Infection
SRGBV	School-Related Gender-Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UHC	Universal Health Coverage
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Sexual and Reproductive Health Agency
UNICEF	United Nations Children's Fund
VYA	Very Young Adolescents
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WLWH	Women Living With HIV

KEY TERMS

Abnormal uterine bleeding	Includes bleeding or spotting after sex, blood loss heavier than 80 millilitres per menstrual period and menstrual cycles longer than 38 days or shorter than 24 days among menstruators who are not using contraception [1].
Adolescence	UN sources refer to the age bracket of 10-19 years [2].
Dysmenorrhea	Pain (e.g. cramps) or discomfort related to menstruation, either primary (associated directly with menstruation) or secondary (related to an underlying gynaecological disorder) [2].
Gender non-binary person	Persons who have a gender identity that is neither 'male' nor 'female'. Their gender identity blends elements of being a man or a woman.
Menarche	The onset of menstruation signalling when the female body is biologically able to conceive [2].
Menopause	The cessation of menstruation signalling the end of the fertile age [2].
Menstrual health	A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in relation to the menstrual cycle, in which women, girls and all people who menstruate experience a positive and respectful environment, free from stigma and psychological distress, with the resources and support they need to confidently care for their bodies and make informed decisions about self-care throughout the life course; and the freedom to decide whether and how to participate in all spheres of life, including civil, cultural, economic, social, and political, free from menstrual-related exclusion, restriction, discrimination, coercion, and/or violence. Achieving menstrual health implies that women, girls, and all other people who experience a menstrual cycle are able to access accurate, timely, age-appropriate information about the menstrual cycle, menstruation, and changes experienced throughout the life course, as well as related self-care and hygiene practices. It also includes care for their bodies during menstruation such that their preferences, hygiene, comfort, privacy, and safety are supported (including accessing, using and disposing of effective and affordable menstrual materials and supportive WASH facilities), and access to timely diagnosis, treatment and care for menstrual cycle-related discomforts and disorders, including access to appropriate health services and resources, pain relief, and strategies for self-care [194].
Menstrual products	Products used to catch or absorb menstrual flow, such as pads, cloths, tampons or cups [4].
Menstrual supplies	Supportive items needed for MHH, such as body and laundry soap, underwear and pain relief items [4].
Menstruation or menses	The natural bodily process of releasing blood and associated matter from the uterus through the vagina as part of the menstrual cycle [2, 4].
Polycystic ovary syndrome	An endocrine disorder among women of reproductive age characterized by chronic anovulation and polycystic ovary morphology and/or hyperandrogenism [5].
Puberty	<p>A key process of human development into adulthood, involving the most rapid physical growth outside of the prenatal and neonatal stage.</p> <p>Hormonal changes lead girls to experience their first menstruation (menarche), while boys will have their first ejaculation (semenarche). The physical growth of puberty is accompanied by new and complex emotions, including sexual desire and gender identity. These changes are also associated with peer pressure to behave in a certain way [6].</p>
Sexual and reproductive health and rights	A state of physical, emotional, mental, and social well-being concerning all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. A positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and access services that support that right. Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights [7].
Transgender	An umbrella term used to describe people whose gender identity is different from the one assigned to them at birth [8].



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INTRODUCTION

Over half of the world's population experiences menstruation at some point during their lifetime. This natural biological process is a key indicator of health and well-being [9, 10] and a cornerstone for the fulfilment of human rights [11]. However, around the world, gender inequality, discriminatory social norms, poverty, and structural and systemic barriers prevent girls, women and people who menstruate from accessing the information, resources, services, and products they need to experience menstruation and other forms of uterine bleeding in a dignified, empowering, safe, and healthy manner. As a result, menstruation is often experienced negatively and is associated with shame, distress, poor health outcomes and restrictions in social participation [2, 3, 12]. This is especially true for those living in low- and middle-income countries and humanitarian settings.

Menstruation and other forms of uterine bleeding are a priority across the full life cycle of girls, women and all people who menstruate. As life expectancy increases in many countries, and birth rates and age at menarche decrease [2], there is growing recognition that menstrual health (MH) is a critical public health and human rights issue. Evidence is emerging globally of the importance of MH for the broader health, well-being, mobility, dignity, and educational and economic empowerment of women, girls and all people who menstruate. This is supported by a growing body of literature demonstrating MH's importance as a determinant of sexual and reproductive health and rights (SRHR). The linkages between SRHR and MH are twofold: the biological associations between MH and fertility, contraceptive use, reproductive tract infections, maternal health, and HIV are increasingly evident, while sociocultural barriers, including stigma, lack of knowledge, restrictive social norms and practices, gender norms, and structural barriers, also create bi-directional linkages between MH and SRHR. These biological and sociocultural barriers result in girls, women and people who menstruate being ill-prepared to make and have agency over decisions related to sex, relationships, family planning, and health, thereby perpetuating the cycle of poor SRHR and broader development outcomes [1, 13].

Despite these linkages, until recently, MH was largely overlooked by the international SRHR community. For example, global SRHR strategies omit or include only very limited references to MH [2]. As a result, MH interventions are often delivered in parallel to, or in isolation from, broader SRHR initiatives. Also, SRHR interventions often do not take into consideration the effects of menstruation on people's experience and expression of sexuality, sexual and reproductive decision-making, health-

seeking behaviour, participation in society and agency [14]. This represents a missed opportunity for holistic, integrated and rights-based policies, programming, and care.

The time is now to improve the integration of MH in SRHR policies and programmes.

In many countries, holistic MH strategies are emerging that address the needs of women, girls and people who menstruate across the full life cycle [2]. A growing global movement for MH is also making big strides towards dismantling the stigma, discrimination and taboos surrounding menstruation. Addressing the linkages between MH and SRHR in an integrated manner can propel this momentum even further while advancing the common goal of both sectors, namely to improve the health and well-being of girls, women and all people who menstruate throughout the full life cycle.

Relevance for the Achievement of Universal Access to Sexual and Reproductive Health

MH is essential to achieving a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. Supporting girls, women and all people who menstruate to manage menstruation safely and with dignity is necessary for the attainment of the Sustainable Development Goals, the full implementation of the ICPD Programme of Action, the United Nation's Youth 2030 Agenda, and the implementation of Africa's Agenda 2063: The Africa we want. Further, promoting integrated programming and policies to address both MH and SRHR will contribute to the implementation of UNFPA's new global strategy for adolescents and youth, My body, My Life, My World! Rights and Choices for all Adolescents and Youth [15].

UNFPA currently has four broad approaches to promoting and improving MH [16]:

- 1 Ensuring that women, girls and people who menstruate have direct access to menstrual supplies and safe sanitation facilities. For example, UNFPA was instrumental in introducing 'dignity kits' in humanitarian settings, which contain disposable and reusable menstrual pads, along with other MH items.
- 2 Working to improve education and information about menstruation directly with adolescents and their communities. This includes comprehensive sexuality education (CSE), including MH as part of in-school and out-of-school curricula, and raising awareness about the linkages between menstruation and harmful practices such as child, early and forced marriage (CEFM) and female genital mutilation (FGM).
- 3 Supporting national adolescent-responsive health systems to strengthen and scale-up adolescent- and youth-friendly health services that meet the MH needs of girls, young women and all young people who menstruate.
- 4 Collecting data and evidence about MH and demonstrating its connection to local, regional, and global development.

These approaches can be strengthened and broadened with linkages to other areas such as family planning and maternal health by developing a strategic vision for the holistic integration of MH and SRHR.

Purpose and Scope of this Technical Brief

This technical brief is intended to provide guidance for UNFPA and other partners on how to strengthen and operationalize the integration of MH in SRHR policies and programmes at global, regional, and national levels. It is divided into two main parts: Part 1 provides an overview of the evidence-based rationale for integrating MH and SRHR, while Part 2 offers technical guidance for the integration of MH in SRHR in policies and programmes.

This technical brief focuses primarily on policies and programmes in low- and middle-income countries (LMICs), particularly in East and Southern Africa.¹ Informed by the principles of the Programme of Action of the International Conference on Population and Development (ICPD) and the Fourth World Conference on Women, the brief uses a life cycle approach to consider the MH and SRHR needs of girls, women and all people who menstruate, from pre-menarche to post-menopause.

¹ This technical brief was commissioned by UNFPA's East and Southern Africa Regional Office, which is why there is a particular focus on the 23 countries in the East and Southern African (ESA) region: Angola, Botswana, Burundi, Comoros, Democratic Republic of the Congo, Eritrea, Eswatini, Ethiopia, Kenya, Madagascar, Malawi, Mozambique, Namibia, Lesotho, Kenya, Rwanda, South Africa, Seychelles, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe.

Intended Audience for the Brief

This technical brief is intended for use by UNFPA technical staff in country offices, regional offices, and headquarters, as well as other technical partners working on adolescent health, education, gender-based violence (GBV), maternal, newborn and child health (MNCH), SRHR, including family planning, universal health coverage (UHC), harmful practices, water, sanitation, and hygiene (WASH), and other sectors. The brief is intended to guide the design, implementation, quality improvement, monitoring, and assessment of integrated MH and SRHR programmes at national, regional, and international levels.

The guide can also be used by advocates to call for policies and programmes that advance an integrated approach to menstrual justice and sexual and reproductive health rights, as well as by policymakers to guide the development of integrated policies for MH and SRHR. This guide may also be relevant for funding institutions to guide strategic investments in MH and SRHR.

Methodology

This technical brief is based on a desk review of academic and grey literature conducted in September 2020. A total of 187 peer-reviewed articles were included, as well as 76 grey publications, with a range of formats including technical reports and guidance documents, meeting reports, toolkits, job aids, research reports, project reports and discussion papers.

A key limitation was the limited empirical evidence available about the integration of MH and SRHR. Therefore, this brief draws largely from descriptive data and posits several hypotheses that have yet to be confirmed by rigorous evaluative data.





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PART 1: RATIONALE FOR THE INTEGRATION OF MH AND SRHR

Human Rights Imperative

Sexual and reproductive rights are a constellation of civil, political, economic, social and cultural rights recognized in existing national laws, international human rights instruments and other consensus documents related to the sexual and reproductive health and life of individuals and couples [17, 18]. They assert that all individuals have the right to decide over their bodies, to attain the highest possible standard of SRH, and to be free from violence and discrimination. Menstruation is fundamental to the fulfillment of these rights (Text Box 1) [4, 19]. When the human rights of girls, women and all people who menstruate are met, they are more likely to experience menstruation and SRH in a safe, healthy, and dignified manner. Additionally, people's experience with menstruation either facilitates or impedes a broad range of human rights[11, 19].

Human rights treaties such as the Convention on the Rights of the Child (CRC), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of Persons with Disabilities (CRPD) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) all articulate an array of human rights that are particularly relevant to MH and SRH. Regional human rights instruments, including the African Charter on Human and Peoples' Rights, the Maputo Protocol on Human and People's Rights on the Rights of Women in Africa, and the African Charter on the Rights and Welfare of the Child, also enshrine rights associated with MH and SRH. Further, in 2018, the Human Rights Council explicitly acknowledged menstruation and menstrual hygiene as integral to the right to water and sanitation [20].

Box 1: Universally agreed human rights that can be undermined by poor MH

The right to health

Women, girls and all people who menstruate may experience negative health consequences when they lack the supplies and facilities to manage their MH. Menstruation stigma, limited understanding of what constitutes a 'normal period', and lack of knowledge of when and where to access services, can also prevent women and girls from seeking treatment for menstruation-related disorders or pain, adversely affecting their enjoyment of the highest attainable standard of health and well-being.

The right to education

Lack of safe and private toilets, menstrual products, and medication to treat menstruation-related pain and discomfort can negatively affect girls' engagement at school. Menstrual-related stigma and discrimination also create barriers to ensuring a safe and equitable educational environment for girls and all young people who menstruate.

The right to work

Poor access to safe places and insufficient means to manage MH limit job opportunities for women, girls and all people who menstruate as they may refrain from taking certain jobs or be forced to forgo working hours and wages. Menstruation-related needs, such as bathroom breaks, may be penalized, leading to unequal working conditions and loss of income. Women and girls may also face workplace discrimination related to menstruation taboos.

The right to non-discrimination and gender equality

Stigma and norms related to menstruation can reinforce discriminatory practices and can even be harmful. Menstruation-related barriers to school, work, health services and public activities also perpetuate gender inequalities.

The right to water and sanitation

Water and sanitation facilities, such as bathing facilities that are private, safe, and culturally acceptable, along with a sufficient and affordable water supply, are basic prerequisites for MH.

Adapted from <https://www.unfpa.org/menstruationfaq#menstruation%20and%20human%20rights>

MH was excluded from previous international norm-setting agendas, including the ICPD Programme of Action (1994), the Beijing Declaration and Platform for Action (1995) and the Millennium Development Goals. Although the Sustainable Development Goals (SDG) do not include direct reference to menstruation, the reference to "the needs of women and girls and those in vulnerable situations" in SDG target 6.2 on access to adequate and equitable sanitation and hygiene is commonly understood to include MH [21, 22]. In addition, MH is increasingly recognized as critical for the attainment of several other SDGs (Text Box 2).



Box 2: MH and Sustainable Development Goals

SDG 3 Ensure healthy lives and promote well-being at all ages

Target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

SDG 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

Target 4.a: Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive, and effective learning environments for all.

SDG 5 Gender Equality Achieve gender equality and empower all women and girls

Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

SDG 6 Ensure availability and sustainable management of water and sanitation for all

Target 6.2: By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying particular attention to the needs of women and girls and those in vulnerable situations.

SDG 8 Promote sustained, inclusive, and sustainable economic growth, full and productive employment, and decent work for all

Target 8.8: ...promote safe and secure working environments for all workers, including migrant workers, in particular women migrants....

SDG 12 Ensure sustainable consumption and production patterns

Target 12.9: "Support developing countries to strengthen their... capacity to move towards more sustainable patterns of consumption and production."

Intersections Between MH and SRHR

MH and SRHR intersect in various ways, all of which influence the experience and expression of sexuality, bodily autonomy, and health-related decision-making. This section summarizes the main sociocultural and biological linkages between MH and SRHR. Menstruation and other forms of uterine bleeding occur and change throughout various life stages (Table 1). A full life cycle approach is critical to understanding these linkages and their impact on the SRHR of women, girls and all people who menstruate.



Table 1: Types of bleeding episodes experienced from menarche to menopause

Type/Cause of Bleeding	Age Range	Definition/Symptoms
Cervical cancer	Any age, median age is 49	Cancer in the cells of the cervix linked to the human papillomavirus; bleeding is often not related to menses
Endometriosis	Most cases diagnosed between 25 and 35 years of age	A condition resulting from the appearance of endometrial tissue outside the uterus; heavy monthly period (MP), irregular MP, painful MP or spotting, abdominal cramping, constipation, or nausea
Menarche	Usually between 8 and 16 years	First menstrual cycle. Can be accompanied by cramps, irritability/heightened emotions, tender breasts
Abnormal uterine bleeding ²	From age of menarche to menopause (ages ~8-60)	Abnormally heavy menstrual bleeding; MP lasts longer than 7 days or is too frequent (less than 21 days between periods), spotting or bleeding between MPs or during pregnancy
Menstrual bleeding	From age of menarche to menopause (ages ~8-60)	Process of discharging blood and other materials from uterine lining monthly, can be accompanied by cramps, irritability/heightened emotions, tender breasts
Miscarriage or induced abortion	From age of menarche to menopause (ages ~8-60)	Expulsion of a fetus from the womb before childbirth; irregular uterine bleeding, pain (abdomen, lower back, pelvis), vaginal discharge, uterine contractions, nausea
Perimenopause/ menopause	Usually mid-40s to early 60s; average age 51-52	The time before and during the end of menstruation in the life cycle; absence of MP, spotting, heavy or irregular MP, hot flashes/night sweats, vaginal dryness
Postpartum haemorrhage	Menarche to menopause (ages ~8-60)	Excessive bleeding after childbirth; vaginal bleeding, fast heart rate or low blood pressure
Sexually transmitted infections	Any age if sexually active	Diseases passed on through sexual contact (e.g., chlamydia, gonorrhoea); pelvic inflammatory disease, menorrhagia, bleeding after intercourse, spotting between periods
Uterine fibroids	Can occur by age 20, usually between 35 and 54	Non-cancerous growths in the uterus that can develop during childbearing years; heavy MP, prolonged MP, pelvic pressure/pain, frequent/difficult urination
Uterine polyps	Rare before 20, can occur after menopause	Usually non-cancerous growths attached to inner wall of uterus; irregular or excessive bleeding and bleeding after menopause can occur

Adapted from Sommer, M., et al., *Beyond menstrual hygiene: addressing vaginal bleeding throughout the life course in low and middle-income countries* [23]

Sociocultural Linkages Between MH and SRHR

Menstrual stigma, gender inequality and SRHR

Although menstruation is a natural process, experiences of menstruation in many places around the world are underpinned by gender inequality, stigma, and discriminatory social norms. In some settings, menstrual stigma manifests as restrictions on bathing, handling food, swimming, participating in religious gatherings, eating certain foods, or sleeping in the same household as non-menstruating family members [24-29]. Discrimination in schools and workplaces, where girls, women and people who menstruate are unable to manage their menstruation safely, with dignity and privacy, is also a manifestation of menstrual stigma. All forms of menstrual-related discrimination are violations of human rights. As such, dismantling menstrual stigma and transforming harmful social and cultural norms is pivotal for the achievement of SRHR and gender equality.

Menstrual knowledge and SRHR

Studies consistently demonstrate a lack of menstrual knowledge and widespread misconceptions about menstruation among girls, women and all people who menstruate in LMICs. Girls often enter menarche with no or very little information about menstruation or other puberty-related changes [3, 30-35]. As a result, menarche is commonly experienced with shock, shame, fear and embarrassment [3, 30] 29]. Even those with some knowledge generally lack an understanding of menstruation's link with fertility [3, 30]. The very limited evidence on boys' and men's menstrual knowledge suggests that they also have

² Previously, the term 'menorrhagia' was widely used, but has subsequently been replaced by "Abnormal uterine bleeding" under the recommendation of leading Obstetric and Gynecological bodies.

considerable knowledge gaps, which contributes to menstrual stigma and discrimination [12, 36-38].

In many settings, mothers are the primary source of information for girls about menstruation [3, 25, 30, 39]. However, many adult women have insufficient knowledge or deeply held misconceptions about menstruation and SRH [30, 40, 41]. Adult women's lack of menstrual knowledge contributes to their own disempowered menstruation experiences and also perpetuates the cycle of misinformation and misconceptions. These, in turn, may contribute to a lack of bodily autonomy, limited ability to negotiate safer sex and limited capacity to seek health care for MH and SRHR concerns across different life stages [1].

Comprehensive sexuality education (CSE) and puberty education can be effective channels to share accurate, age-appropriate education on MH and SRHR and address stigma among peers. While many LMICs have made progress towards integrating CSE in national curricula, programmes are poorly implemented and puberty and MH are commonly overlooked [42, 43]. Teachers also lack sufficient training and support, leaving them feeling uncomfortable or resistant to teach about SRHR or MH [44]. Another challenge is that, in many settings, misunderstandings about the nature, purpose and effects of CSE have generated perceived or anticipated community resistance [45-48]. This resistance can limit access to puberty and MH related information. School-based programmes that are complemented by digital and community-based CSE and puberty education will further ensure that no one is left behind [49-52].

Menstruation and gender-based violence

Several forms of gender-based violence (GBV) are directed against people specifically because of their menstruation status. Bullying or teasing in school settings or workplaces due to menstruation is a common occurrence [2, 12, 27, 28, 32, 53, 54]. Other examples include menstrual-related restrictions on mobility, eating certain foods, social participation, and seclusion. When restrictions are imposed upon girls, women and people who menstruate, they can be considered acts of violence as they deprive people of the right to free movement.

Structural barriers, notably inadequate WASH infrastructure and limited access to affordable and effective menstrual products, contribute to the risk of girls, women and people who menstruate experiencing GBV. Women in many settings report going to the toilet to manage their menses to avoid stigma and shame [53, 55, 56]. This can place girls and women at higher risk of sexual assault, harassment, and rape, especially when latrines are located far away, are dimly lit and/or do not have a door or lock [6, 12, 27, 55, 56]. The risk of violence is particularly high in humanitarian contexts, where female-friendly, adequate and safe WASH infrastructure can be very limited [56].

Menstruation is also associated with CEFM. In many societies, menarche is understood as a sign that a girl is ready for marriage [1]. A recent review of 24 studies from LMICs found that early age at menarche was associated with an early age of marriage [10]. There are also important linkages between MH and FGM. Studies show that FGM is associated with menstrual disorders, including heavy menstrual bleeding, dysmenorrhea or difficulties passing menstrual blood [2, 57, 58].

Age at menarche and SRHR outcomes

In addition to CEFM, early menarche³ is associated with early pregnancy and some sexually transmitted infections (STIs) in LMICs [10]. These linkages present a clear opportunity to integrate MH and SRHR programmes and services to better support the needs of adolescent girls, especially very young adolescents (10 - 14 years). However, many SRHR programmes and services primarily target adolescents 15 and older, and most national health information systems only collect SRH data from 15 years and above.

Menstruation and school/workplace participation

Numerous studies from LMICs demonstrate an association between educational attainment and positive SRH outcomes [59]. However, evidence suggests that menstrual stigma and gender discriminatory environments in school settings may contribute to girls' limited participation and engagement [3, 12, 35, 60-62]. For example, bullying and teasing from male teachers and male peers due to menstruation is reported in many studies [2, 12, 28, 32].

The limited data that exists on the impact of MH on workplace engagement and safety suggests that menstruation contributes to women missing work in some settings [2, 63]. This remains an overlooked issue that warrants further research.

Period poverty and SRHR

Poverty is both a cause and a consequence of poor SRH outcomes [64]. 'Period poverty' refers to the lack of access to menstrual products due to financial constraints. It also refers to the increased economic vulnerability that girls, women, and all people who menstruate face due to the financial burden posed by menstrual products, including menstrual absorbents,

3 Early menarche is generally defined as menarche before age 12 years

pain medication and underwear [16]. Period poverty is particularly prevalent in LMICs, with detrimental consequences on SRH [3, 32]. When unable to buy affordable menstrual products, girls, women and people who menstruate may resort to using unreliable absorbents, which can be a barrier for civic and social participation, as well as a cause of stress and anxiety [65, 66]. Also, studies in Ghana, Kenya, South Sudan, and Tanzania suggest that some girls may engage in transactional sex to pay for menstrual products, increasing their risk of HIV and other STIs, unintended pregnancy, and GBV [54, 67-71].

Many groups who are at highest risk of adverse SRHR outcomes are also those most susceptible to period poverty. For example, sex workers, transgender men, incarcerated people, refugees, migrants, and homeless people generally experience intersecting forms of marginalization and discrimination, which limit their access to financial resources and menstrual products, as well as places them at higher risk for adverse SRH outcomes. Another example is women who experience obstetric fistula. Constant urinary leakage, combined with cyclical menstrual bleeding, increases their demand for absorbents. Yet, they are also often in lower socio-economic strata due to stigma, poor health, and lack of mobility, which prevents them from accessing income-generating activities.

Menstruation, psycho-social well-being and SRH

One of the most consistent findings across studies and settings is that menstruation is associated with feelings of shame, fear, and distress [3, 12, 30]. This can have detrimental effects on broader psychosocial well-being and mental health, including anxiety, low self-esteem, and depression throughout the life cycle [3, 72]. Such mental health problems are associated with poor SRH outcomes [73]. Data from high-income countries have shown that shame related to menstruation can influence subsequent sexual decision-making and risk-taking [41]. Thus, it is plausible that improved menstrual experiences could contribute to increasing personal agency and decreasing sexual risk-taking, thereby supporting efforts to advance SRH.

In addition, data from high-income countries show that prevalence rates of mental health illnesses, including severe depression, are particularly high for women and people who menstruate during perimenopause [74, 75]. However, there remains a large evidence gap in the recognition and provision of appropriate treatments for middle-aged women and people who menstruate experiencing depression related to the hormonal changes of menopause [75].

Biological Linkages Between MH and SRHR

Menstrual irregularities and SRH

Menstrual irregularities, including dysmenorrhea and abnormal uterine bleeding (AUB), are directly linked to aspects of SRH and can greatly affect the quality of life for people who menstruate [61, 76]. Fibroids, endometriosis and polycystic ovary syndrome (PCOS) are among the common causes of AUB [77] and can impact fertility [78]. Furthermore, AUB is associated with anaemia – a leading contributor to maternal morbidity in LMICs. AUB is also associated with cervical cancer – the most common form of cancer reported among women in sub-Saharan Africa [23].

Postmenopausal bleeding is increasingly important as life expectancy increases in LMICs. One cause of perimenopausal bleeding is genitourinary syndrome of menopause (GSM), which refers to a collection of symptoms that affects roughly half of postmenopausal women [79] and has considerable negative effects on quality of life, sexual functioning and emotional well-being [80]. Other causes of postmenopausal bleeding include benign cervical or uterine polyps, endometrial hyperplasia (a thickening of the uterine lining) and, less commonly, endometrial cancer [81]. Very little data on postmenopausal bleed in LMICs exist; however, it is likely that this form of bleeding is shrouded in the same taboos and stigma as menstrual bleeding, thereby limiting older women's access to important health services.

Contraception, family planning and MH

There are several intersections between MH and contraception. One link is that hormonal contraceptives are among the first-line treatments to alleviate symptoms of AUB and dysmenorrhea [5, 77, 82-87].

A second intersection relates to contraceptive-induced menstrual bleeding changes (CIMBCs), referring to changes in bleeding patterns resulting from the use of hormonal contraception. For some people, CIMBCs can be considered a non-contraceptive benefit of specific hormonal methods [88]. However, CIMBCs are often linked to side effects reported as reasons for contraceptive non-use and discontinuation [88-95]. Despite the important role that CIMBCs play in contraceptive decision-making, contraceptive counselling in LMICs often does not adequately prepare girls, women and people who menstruate to understand, anticipate, or manage CIMBCs [88, 89].

A third link relates to contraceptive use during perimenopause. Although fertility levels decline with age, at age 45, approximately half of all women are still fecund [41]. Access to contraception is therefore important, especially since irregular bleeding patterns during perimenopause present a risk of unintended pregnancy. In addition to pregnancy prevention, hormonal contraception can also alleviate symptoms of dysmenorrhea and endometrial hyperplasia, which commonly arise during perimenopause [96, 97]. However, not all contraceptive methods are suitable during perimenopause [96]. Therefore, tailored contraceptive counselling that includes considerations for the transition between hormonal contraception and possible hormone therapy must be prioritized for perimenopausal women and people who menstruate.

HIV and MH

There are several linkages between MH and HIV prevention. Studies have shown that susceptibility to HIV infection and viral load among women living with HIV (WLWH) can vary at different phases of the menstrual cycle [98-100]. While the risk of HIV transmission through menstrual blood is low, this is an important consideration for HIV prevention strategies in LMICs, where HIV treatment gaps persist. Another link is that sociocultural beliefs and practices associated with menstruation have been shown to interfere with HIV prevention technologies, specifically the dapivirine vaginal ring⁴ [101]. In addition, studies show that postmenopausal women may be at increased risk of acquiring HIV due to the natural decline of the immune function in the lower genital tract, especially in generalized epidemic settings [102].

With regards to the MH of people living with HIV, there is evidence from high-income countries that WLWH have a significantly higher risk of amenorrhea than seronegative women [103-105]. In addition, the effects of frequent or heavy menstrual bleeding can increase the risk of anaemia among girls and women living with HIV more so than their HIV-negative counterparts [23].

As life expectancy for people living with HIV is increasing, the experiences of perimenopausal and menopausal WLWH is more and more relevant. Studies from high-income countries and from Peru demonstrate that the severity of menopausal symptoms experienced by WLWH is associated with non-adherence to High Acting Anti-Retroviral Treatment (HAART) [106, 107]. WLWH have unique menopausal considerations, including possible interactions between HAART and menopause hormone therapy [108]. Also, peri-menopausal WLWH are significantly more likely to experience depressive symptoms and anxiety than seronegative peri-menopausal women [109]. However, the lack of adequately trained health-care providers means that many WLWH are unable to access appropriate care and support for MH and SRHR during perimenopause.

4 The dapivirine vaginal ring is a monthly intravaginal, flexible, silicone ring that progressively delivers the antiretroviral drug dapivirine into vaginal tissue to help protect against HIV. The ring is designed to provide women with a discreet and long-acting option for HIV prevention..



Urogenital infections and MH

Results from several studies suggest an association may exist between 'poor'⁵ MH and higher levels of urogenital infections, including reproductive tract infections (RTIs) [67, 110-113]. However, methodologies vary greatly and the overall quality of many studies is low, thereby limiting conclusions about the specific infections, the strength of effect, and the route of transmission. Nevertheless, it is clear that tackling menstrual taboos and stigma, along with providing method choice and supplies to properly care for and/or dispose of menstrual products, are critical for girls, women and people who menstruate to adopt 'adequate' MH practices.

Maternal health and MH

The link between heavy menstrual bleeding and anaemia is particularly important for maternal health efforts in LMICs. It is estimated that 35 per cent of women of reproductive age in sub-Saharan Africa are anaemic [2], partly due to heavy menstrual bleeding. Anaemic women are at increased risk of peripartum haemorrhage and maternal mortality [63]. Many of the underlying causes of heavy menstrual bleeding and other forms of AUB can have negative effects on fertility and maternal health [78].

In addition, the uterine bleeding episodes associated with pregnancy, abortion (spontaneous and induced) and childbirth are important aspects of a life cycle approach to MH. Ensuring that women and clinicians understand these bleeding episodes is important to identify deviations from normal and recognize when women may be at risk for delayed post-partum haemorrhage. Early detection of potential complications is especially important in resource-constrained health systems, where access to emergency post-partum care may be limited.

The Importance of MH and SRHR of people in vulnerable situations

For people in vulnerable situations, the linkages described above intersect with various inequalities, resulting in heightened barriers to access information, services, and support. This section focuses on three specific groups for special consideration in integrated MH and SRHR programmes: people with disabilities⁶, transgender and non-binary people, and people living in humanitarian contexts.

People with disabilities

More than 1 billion people worldwide are estimated to have a disability [4]. Disability discrimination is common in countries around the world and is compounded by intersecting inequalities related to gender, age, socio-economic status, ethnicity, sexuality, race and nationality [114, 115]. This has detrimental effects on SRHR and MH, which vary for different disabilities (e.g., mobility limitations, vision impairments, intellectual or developmental impairments, etc.). Generally, experiences of menstruation among people with disabilities are negative and disempowering, especially since their bodies are often subject to control by carers and medical personnel [4, 114, 116, 117].

Evidence relating to this cohort's experiences with SRHR and MH is limited. Nevertheless, the literature highlights common barriers that prevent people with disabilities from accessing information and services, including: stigma and discrimination; lack of training and support for service providers and caregivers; exclusion of persons with disabilities from programmes; inaccessible WASH facilities; and a lack of appropriate menstrual materials [4, 114, 116, 117]. Exclusion from information and services increases the vulnerability of persons with disabilities to sexual abuse, sexually transmitted infection, unintended pregnancy, and adverse pregnancy-related outcomes [114]. In addition, persons with disabilities are sometimes subject to coercive interventions and medical procedures, including forced sterilization, forced abortion, forced menstrual suppression and forced contraception [116].

Transgender and gender non-binary people

The global population of transgender people is estimated to be in the tens of millions, and likely higher since stigma prevents accurate data collection [4]. Transgender and gender non-binary people are often marginalized and experience exclusion, discrimination, violence, and self-stigmatization based on their gender identity. These forms of gender-based discrimination, compounded by intersecting socio-economic vulnerabilities, mean that transgender and gender non-binary people experience formidable barriers when accessing health, education and other social services [4]. Consequently, they are at higher risk of adverse SRH outcomes, including GBV [118, 119].

5 The definition of 'poor' menstrual health varies between studies. Examples of elements include: inadequate washing or drying of reusable absorbents, insufficient changing of absorbents, and lack of clean water and soap.

6 The Convention on the Rights of Persons with Disabilities states that "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." (Convention on the Rights of Persons with Disabilities. 2006.)

Menstruation is of particular concern for people assigned the female sex at birth and who have a masculine identity, either as transmen or gender non-binary. Research from high-income countries indicates that many people on the transmasculine spectrum experience deeply negative sentiments and discomfort about menstruation, as well as stress and anxiety related to menstruation [73, 120]. Menstruation can also be a source of gender dysphoria⁷, as it is a reminder of the discord they may feel about a biological process that is deeply intertwined with social expectations, norms, and stereotypes of femininity and which does not resonate with transmasculine identities .

The lack of access to menstrual products and adequate WASH facilities in LMICs creates heightened difficulties for transmasculine individuals. In addition to the common concern of lack of privacy in public toilets, transgender men may fear being 'outed' by leaks, or by being seen or heard changing or disposing of menstrual products [123]. These situations may lead to exclusion, harassment, violence, and abuse [4]. Also, transgender people who menstruate may avoid discussing menstruation with health-care providers out of fear of stigma and discrimination [120].

Some transmasculine people choose to use hormonal contraception to suppress the menstrual cycle [121]. Some may also use testosterone or 'puberty blockers' to alter their physical appearance to become more congruent with their gender identity [123]. Although testosterone treatments suppress menstruation, breakthrough bleeding is still possible [124]. Access to menstrual products is therefore important. Also, testosterone does not reliably inhibit ovulation, thus, pregnancy can occur, especially if there are lapses in adherence to testosterone therapy. It is also important to note that some transmasculine individuals who wish to suppress their menses may still desire to have children. Therefore, transmasculine individuals require tailored contraceptive counselling that includes non-biased discussions on fertility goals [121].

Humanitarian settings

Currently, an unprecedented number of people live in states of crisis or emergency [125]. Deficiencies in infrastructure, service delivery, and security contribute to an increased risk of STIs, including HIV, unintended pregnancy, and sexual and gender-based violence [126, 127]. This results in disproportionately high adverse health outcomes. For example, globally, 60 per cent of preventable maternal deaths take place in humanitarian settings [126]. In addition, girls, women, and people who menstruate living in humanitarian settings face increased barriers to managing their menstrual health and hygiene. These can include disruptions to habitual MH practices; limited availability of menstrual products and supplies; limited access to adequate and safe facilities to change, wash and dry menstrual products; limited access to water; loss of income to purchase menstrual products; limited access to health services; insufficiently trained (and predominantly male) first response teams; and exposure to stress and trauma, which may lead to unpredictable bleeding patterns [2, 4, 128-130]. The needs of vulnerable groups, including people with disabilities, transgender and gender non-binary individuals, and very young adolescents, are exacerbated in humanitarian contexts, as their already limited access to information, education, support, care, and justice is even further reduced [131].

The humanitarian sector has taken SRHR and MH into account for some time. This is reflected in the inclusion of SRHR and MH in key guidance tools and frameworks, such as The Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM) [132], the accompanying Minimum Initial Service Package, SPHERE Standards in Humanitarian Response [133]. However, several challenges continue to limit the reach, scope, and quality of SRHR and MH service delivery in humanitarian settings. For example, community resistance to certain SRH services and for particular groups, such as adolescents and youth, as well as social stigma and taboos about sexuality and menstruation is a key challenge [2, 134]. Challenges for MH also include sectoral leadership gaps; the lack of consensus on how best to allocate responsibilities among involved clusters (WASH, protection, health, education, camp management); and insufficient guidance on monitoring and evaluation, including standardized indicators [2, 129].

⁷ Gender dysphoria involves a conflict between a person's physical or assigned gender and the gender with which he/she/they identify. People with gender dysphoria may be very uncomfortable with the gender they were assigned, sometimes described as being uncomfortable with their body (particularly developments during puberty) or being uncomfortable with the expected roles of their assigned gender. (<https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria>)



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PART 2: TECHNICAL GUIDANCE FOR THE INTEGRATION OF MH AND SRHR

This section recommends practical ways to create a holistic approach to integrating MH into SRHR programmes and policies. Few examples exist of rigorously evaluated interventions that intentionally integrate MH and SRHR. As such, this section draws on the nascent evidence-base on integrated approaches as well as evidence from the respective areas of MH and SRHR that show promise for integration. The recommendations build upon the main enablers of MH (Text Box 3) and high-impact practices for SRHR.

An integrated approach to MH and SRHR calls upon organizations, funders, decision-makers, and implementers working on SRHR to recognize that menstrual experiences affect both the physical and social determinants of SRH, including how people make decisions about their bodies, sexuality, fertility and health-seeking. Equally, an integrated approach calls upon those working on MH, notably in the WASH and education sectors, to gain a better understanding of the linkages between MH and SRHR, and to recognize the added value of integration with SRHR to amplify impact across all sectors. An integrated approach moves beyond implementing discrete and isolated interventions towards a systems approach that enables all relevant sectors to adapt their systems to allow sustainable, coherent policies and programmes to be delivered at scale.

While the recommended actions in this section are organized by SRHR thematic area, an integrated approach to MH and SRHR should weave activities across the various areas for maximum impact.

Box 3: What works for MH?

There is a growing evidence-base on what works to improve MH in LMICs. UNFPA ESARO's *Menstrual Health Management in ESA: Review Paper* [2] refers to four main enablers, drawing from the global evidence-base. An 'enabler' is a factor that is essential to ensure adequate MH.

- 1 Education and awareness on MH** Access to accurate, timely and appropriate information on the menstrual cycle, how to manage menstruation without discomfort or fear, and how to tackle discriminatory cultural and social perceptions and practices related to menstruation [2, 14, 16].
- 2 Menstrual methods/products and supplies** Access to safe, effective, acceptable and preferred methods/products to absorb and collect blood, including disposable sanitary napkins, reusable sanitary napkins, disposable tampons, menstrual cups, and clean, absorbent fabrics such as rags or underwear [14, 16]. Supplies can include soap, basins, and pain medication. While MH is much more than only products, they remain crucial [2, 44].
- 3 Sanitation facilities** Access to private and appropriate facilities that allow girls, women and people who menstruate to change menstrual materials in safety and privacy, to clean reusable products, and to dispose of disposable products, as well as facilities to bathe and wash with soap and water [14, 16].
- 4 Policies on MH** National and sub-national policies and guidelines to improve MH.

MH interventions have historically been categorized into two main groups: 'hardware' interventions designed to address material needs such as menstrual products and improved WASH facilities; and 'software' interventions designed to improve menstrual knowledge, attitudes and practices [135]. Traditionally, MH interventions prioritized 'hardware' outcomes, primarily for in-school settings and humanitarian contexts [3, 44, 136]. There is now growing recognition of the importance of integrated interventions for a wider range of settings and across the full life cycle. An integrated approach to MH and SRHR requires going beyond these enablers to create more holistic and synergistic programmes and policies. For example, while access to health care for girls, women and people who experience menstrual disorders is critical for an integrated approach, it is absent from the four main pillars.

Guiding Principles for Integration

The following principles should underpin efforts to integrate MH and SRHR:

- Human rights-centred:** Recognising all people's right to the highest attainable standard of menstrual health and SRH, regardless of age, marital status, socio-economic status, ethnicity, gender identity, etc. Recognising that menstrual injustice in any form is a violation of human rights and impedes the fulfillment of a range of other human rights.
- Gender-transformative:** Policies and programmes reinforce gender equality and intentionally offer opportunities for individuals and communities to actively challenge gender norms, promote positions of social and political influence for women in communities, and address power inequities between persons of different genders. Gender equity is woven into all aspects of policy and programming, and gender-transformative strategies are prioritized.
- Meaningful participation:** Ensure the meaningful participation of girls, women and people who menstruate in decision-making and all phases of the design, implementation, and evaluation of MH and SRHR policies and programmes. Recognising that what is suitable for people across contexts, cultures and life stages varies. It is critical to create systems and structures for diverse voices to inform decision-making.
- Evidence-based and context-specific:** All policies, programmes and interventions are guided by the latest evidence-base (both qualitative and quantitative) and by context-specific needs assessments. Results from studies and operational learning are contextualized to the needs of each setting. Investments are made to expand the global evidence base through robust monitoring, evaluation, and research.
- Equitable, accessible and people-centred:** Aim for universal coverage of MH and SRHR, ensuring that no one is left behind. Strategies and policies respond to the needs of diverse groups of people. Special consideration for groups that are commonly excluded and/or most affected by menstrual-related stigma and discrimination.
- Positive framing:** Policies and programmes recognize sexuality and menstruation as natural and positive aspects of life, rather than focusing solely on problems (morbidity, mortality, harmful practices). Framing sexuality, SRH and menstruation as problems and diseases perpetuates misconceptions, stigma, and discrimination. A more positive approach includes framing SRH and menstruation within the framework of aspirations and life goals.

- **At scale:** All policies and programmes are strategically designed to be scaled-up. National and sub-national governments are actively involved in all stages to increase the capacity of public institutions to manage and implement proven solutions at scale.
- **Sustainable:** All policies and programmes are designed to be sustained over time and to be feasible under the routine operating conditions of the country or settings in which they are implemented. A systems approach is applied to policy and programme development rather than a project-based approach.
- **Accountable:** Leaders and decision-makers are held accountable for the commitments made for improving MH and SRHR at international, regional, and national levels.

Creating an Enabling Policy and Legislative Environment

General recommendation:

Galvanize commitment and political leadership for an integrated approach to MH and SRHR, while fostering cross-sectoral collaboration and sustaining social accountability mechanisms.

Integrating MH and SRHR will be most effective when positioned within a supportive policy and legislative environment. This involves galvanizing commitment and political leadership, fostering cross-sectoral collaboration, and sustaining social accountability mechanisms [137]. Many countries have developed national or subnational laws and policies related to reproductive, gender and HIV. Most LMICs also have national or sub-national family planning and adolescent sexual and reproductive health strategies and action plans [138]. A small number of countries, including in East and Southern Africa, have recently developed MH policies (Text Box 4) [2, 44, 139]. An integrated approach requires coherencies between these various policy instruments. Cross-sectoral collaboration that leverages diverse expertise of an array of stakeholders in a 'whole-of-community' manner (see Table 2) is one of the keystones of an integrated approach.

Table 2: Cross-sectoral stakeholders for integrated approaches to MH and SRHR

Stakeholder Types	Examples
Government bodies	Ministry of Education, Ministry of Health, Ministry of works/Drinking Water and Sanitation, Ministry of Labour, Ministry of Gender, Ministry of Youth, Ministry of Finance, Ministry of Social Development, etc.
UN agencies	UNFPA, UNICEF, UNESCO, UNHCR, UN Women, WHO, WSSCC/UNOPS
Non-government organizations (NGOs) and social movements	International and national NGOs, Civil Society Organizations (CSOs), associations and youth-led organizations, as well as multi-stakeholder networks, platforms, and partnerships.
Research institutions and researchers	Universities, research societies and councils, advisory bodies, and regulatory bodies.
Private sector producers	International and national (private sector and small, medium, and large-scale social enterprises) producers of disposable and reusable products such as pads, cups, tampons, underwear.
Community leaders	Religious leaders, cultural leaders, youth leaders, champions, men and boys, etc. This is very context specific and could include educators and parent-teacher associations.
People who menstruate	Girls, women, and people who menstruate, regardless of age or circumstance, including vulnerable and marginalized groups.

Adapted from section 1.4 from "Menstrual Health Management in East and Southern Africa: A Review Paper", UNFPA, 2017

Guidance for Action

For galvanizing commitment

- Conduct a landscape analysis to assess the extent to which MH and SRHR are incorporated into national and sub-national policies, strategies, and guidelines across sectors – notably education, WASH, gender, SRH, adolescent health and HIV.
- Review or develop strategies, guidelines and protocols that support the integration of MH and SRHR at all levels, including national social safety nets.
- Develop or update policies to support the provision of essential reproductive and MH commodities, including menstrual products and a full range of contraceptive methods.
- Review or develop new laws and legal frameworks to remove import taxes for essential SRH and MH commodities and raw materials. Promote the local production of these commodities. Introduce incentives and flexibility for start-ups in this field, where appropriate.
- Introduce policies to subsidize the costs of menstrual products (Text Box 5), especially for those at highest risk of period poverty. Ensure viable and sustainable fiscal measures to implement these subsidies, as well as safeguard to prevent the distortion of local markets [140].
- Develop or update policies to ensure that all schools, public health facilities and other public settings are equipped with clean water and safe bathrooms to allow for private, dignified MH.
- Advocate for government budgets to include specific lines allocated for integrated MH and SRHR interventions.
- Monitor national and sub-national budget disbursement to assess the extent to which established budget lines are financed, and hold governments to account through advocacy.
- Include menstruation-related, age- and sex-disaggregated indicators in national health, social development, and education information systems.
- Incorporate MH and SRHR into universal health coverage plans and schemes [138]. For example, ensuring that MH and SRHR services are included as eligible services in insurance programmes or schemes for direct funding to facilities. Voucher programmes for SRHR and MH services can also be included in universal health coverage plans.

For cross-sectoral collaboration

- Clearly identify a government body to lead national and sub-national MH efforts [4, 24]. Build the capacity of this entity to coordinate across sectors and establish close collaboration with the lead government body for SRHR.
- Develop guidelines on inter-sectoral and inter-ministerial collaboration to ensure reciprocal integration between all involved sectors.
- Create a new technical work group (or expand the mandate of an existing technical working group) to provide oversight for MH and SRHR in an integrated manner [4, 33, 34]. Ensure that membership includes civil society, non-governmental organizations, research institutions, private partners and other technical experts in SRHR and across the various domains of MH (including education, WASH, gender, social development, local governments, disaster management, etc.) [4, 141]. The decision to expand the mandate of an existing group or create a new one will depend on the context.
- Identify shared goals and targets across sectors with relevance to MH and SRHR [14].
- Develop cross-sectoral platforms, costed plans and budgets to coherently address MH and SRH in an integrated manner [14].
- Establish a shared understanding of menstrual health across all sectors, which includes the hygiene-related aspects traditionally used in the WASH sector, as well as the broader systemic factors and determinants of health, including education, human rights, gender equality, and cultural practices and beliefs [24, 56].

For accountability mechanisms

- Ensure the meaningful participation of girls, women and all people who menstruate throughout the life course in all programmes and policy-development related to MH and SRHR [28].
- Invest in new or strengthened social accountability mechanisms that build local capacity for collective action around MH and SRHR, inclusive of vulnerable and marginalized groups. Social accountability mechanisms can include social audits, community score cards, youth-led accountability tracking mechanisms, participatory budgeting, public expenditure tracking, legal redress mechanisms, and health committees [142].
- Organize cross-sectoral advocacy initiatives around shared goals for MH and SRHR.
- Produce scorecards or other social accountability tools to assess commitments to MH and SRHR integration and their implementation. Alternatively, ensure that MH is included in existing or future SRHR accountability tools and scorecards. Ensure that scorecards and tools are positioned in a larger, collaborative social accountability process [142].

Box 4: Examples of menstrual hygiene and health policies in ESA [1]

Botswana	Inclusion of MH as part of puberty education in the National Health and School Health policies and strategies for in- and out-of-school .
Ethiopia	<ul style="list-style-type: none">• Development of National Menstrual Hygiene Management Policy and Implementation Guidelines in 2016• MH included in the National Adolescent and Youth Health Strategy with a cost plan (2016 - 2020)• Government commitment to create supportive conducive work policies for menstruating women, increasing access to adequate WASH infrastructure, and addressing cultural, social norms and taboos on menstruation.
Kenya	<ul style="list-style-type: none">• Establishment of the National Sanitary Towels Campaign Coordinating Committee in 2008• Removal of import duties and VAT on menstrual products in 2011• Inclusion of MH elements in the Ministry of Health's Environmental Sanitation and Hygiene Policy (2016 - 2030)• Adoption of the National Menstrual Hygiene Management Policy (2019 - 2030)
South Africa	<ul style="list-style-type: none">• Development of the national Sanitary Dignity Framework and Sanitary Dignity Programme (SDP)• Allocation of national budget for the SDP• Removal of VAT on menstrual products in 2019
Tanzania	<ul style="list-style-type: none">• Integration of MH in national WASH plans and strategies with a focus on schools.
Uganda	<ul style="list-style-type: none">• Establishment of National Menstrual Hygiene Steering Committee under the Ministry of Education in 2014• Development of a Menstrual Hygiene Management Charter by the Ministry of Education in 2015 [143]• National Strategy for Girls' Education (2015 - 2019) included commitments to improve MH through a comprehensive approach including a menstrual booklet, improving school sanitary facilities, awareness-raising, teacher training and reusable pad production
Zambia	<ul style="list-style-type: none">• Development of National Menstrual Health Management Guidelines and toolkit in 2016• Introduction of "Mother's Day" law, allowing women one day off a month during menstruation in 2017• Creation of a new budget line for menstrual products in 2017
Zimbabwe	<ul style="list-style-type: none">• Inclusion of MH in the Education Act, including appointing SRHR focal persons in schools.

These commitments and actions by governments in East and Southern Africa are promising. Going forward, a more intentional focus on integrating these policy measures with SRHR policies and guidelines, as well as expanding the scope beyond school settings, will amplify their impact.



Box 5: Subsidizing menstrual products in Kenyan schools

In Kenya, political support garnered through cross-sectoral advocacy resulted in parliament allocating additional funds for the Ministry of Education, Science and Technology in 2011 to launch the National Sanitary Towels Programme. This programme provides free disposable pads to school girls with the goal of reducing school absenteeism and was implemented in conjunction with expanding puberty education in schools [58]. While there have been concerns about the sustainability and high cost of this programme [2, 58], it is nevertheless achieving greater scale than many NGO or donor-funded programmes [58].

Key lessons learned from Kenya's experience include [66, 144]:

- 1 Have thorough and coherent policies and strategies in place;
- 2 Conduct a landscape analysis to identify areas most in need and prioritize these for distribution;
- 3 Establish functional coordination mechanisms to ensure those in hard-to-reach places are included;
- 4 Involve teachers from the outset;
- 5 Allocate a budget line for free sanitary provision in the national budget;
- 6 Coordinate, cooperate and collaborate with other similar national initiatives;
- 7 Avoid duplications in the supply chain to ensure efficient and equitable distribution of pads; and
- 8 Ensure appropriate WASH and disposal facilities in schools.

Similar policies have been introduced in South Africa and India. Further research will be required to assess the extent to which this programme has reduced school absenteeism.

Comprehensive Sexuality Education and Puberty Education

General recommendation:

Ensure all adolescents and young people have access to MH education through puberty education and/or CSE programmes, both in- and out-of-school. Ensure that all people who menstruate have access to age- and life-stage-appropriate MH information and education throughout the full course of their lives.

Comprehensive sexuality education (CSE) and puberty education (Text Box 6) are key strategies to improving knowledge on MH and SRHR and helping adolescents to build skills and foster attitudes that can contribute to positive health outcomes throughout the life cycle [6, 47, 145]. This, in turn, can contribute to positive behavioural, health and development outcomes [3, 47, 119]. Multi-component interventions, combining CSE or puberty education with adolescent responsive services and community engagement are the most effective at achieving wider SRH outcomes [44, 47].

While the bulk of existing evidence focuses on school-based programmes, there is growing awareness of the importance of focusing on out-of-school adolescents through multiple delivery modalities, especially since they are generally those most left behind [34, 35, 58].

Box 6: Relationship between CSE and puberty education

While CSE and puberty education are closely related, there are also important distinctions between them. CSE refers to a "curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality" [47]. Puberty education refers to teaching and learning about the physical and psychosocial aspects of pubertal development [6, 72]. Both aim to equip learners with knowledge, skills, attitudes, and values that will empower them to realize their health, well-being, and dignity. However, while puberty education has a specific focus on the pubertal transition, CSE covers a wider range of concepts related to sexuality. UNESCO's vision is that puberty education is a part of CSE, which itself should be a part of a larger health curriculum, and this curriculum is integral to a whole-school approach to health [6]. However, some experts posit that puberty education or MH-specific education may be less sensitive than CSE and might be more easily accepted in conservative settings [43]. It may also serve as a useful entry point to cultivate support for wider CSE programmes. Further research is required on this topic.

Guidance for Action

- Review and revise policies from ministries of Education, Youth, Gender, Social Welfare and any related departments to ensure the integration of SRHR and MH in puberty education and/or comprehensive sexuality education programmes for all education levels [48, 139].
- Review and revise official school-based curricula and out-of-school CSE and puberty education programmes to align with UNESCO and UNFPA's international technical guidance on content areas and characteristics of proven effectiveness, ensuring culturally relevant content.
- Ensure that curriculum approaches are gender-transformative, promote gender equality, prevent GBV and create a safe environment for all learners [119, 147]. Approaches should engage male, female, and non-binary learners and vulnerable groups, ensuring they all have access to information on SRHR and MH.
- Ensure that curricula promote a positive approach to menstruation and sexuality. This includes:
 - Describing positive aspects of change and growth associated with puberty, rather than focusing on puberty as a problem [145];
 - Avoiding the use of the term 'pre-menstrual syndrome', being careful to describe menstrual-related experiences as changes and not symptoms. It is important not to embed menstruation within the context of illness [145];
 - Allowing learners to explore ways to celebrate menstruation as a milestone for girls [148];
 - Deliberately challenging ideas of the stigma associated with menstruation and menstrual blood [6];
 - Describing sexuality as an inherent part of being human. Include sex-positive messages that focus on the benefits of certain behaviours (gain-framing) rather than only sharing negative messages about risk (loss-framing) [149-151];
 - More accurately depict variations in menstrual cycles beyond the stereotypical 28-day cycle [152].
- Address the needs and experiences of diverse young people in curricula. For example:
 - Acknowledge variations in sexual orientation and gender identity, provide positive representations of LGBTQ youth and promote acceptance of diverse orientations and experiences [72];
 - Include examples and images of people from diverse backgrounds, with varying body shapes and with different levels of physical and cognitive abilities;
 - Design appropriate channels, modalities, and learning materials to ensure access to diverse groups of learners.
- Provide educators with sensitization, values-clarification, quality pre- and in-service training and continuous professional development opportunities on CSE and puberty education [47, 151]. The training strategy should:
 - Provide practice-leading participatory learning methods;
 - Provide a good balance between learning content and skills;
 - Be based on the curriculum that is to be implemented;
 - Provide opportunities to rehearse key lessons in the curriculum;
 - Have clear goals and objectives;
 - Provide constructive feedback to each teacher on their effectiveness in delivering the content;
 - Help educators distinguish between their personal values and the health needs of learners;
 - Increase the confidence and capability of the educators;
 - Encourage educators to teach the curriculum in full, not selectively [47];
 - Build capacities to frame messages positively while reconciling personal values with those that underpin effective CSE.
- Create didactic tools and/or self-directed learning tools to support the delivery of CSE and puberty education. Puberty booklets are an example of demonstrated effectiveness at improving knowledge and attitudes related to menstruation in several countries (Text Box 6).
- Start CSE and puberty education programmes early, ideally before the onset of puberty [72, 119, 153]. This will help learners to better prepare for the changes ahead. Information about MH should start to be offered prior to the age of menarche, which is declining in many low- and middle-income countries [3, 10]. Education on sexual activity, the prevention of STIs and pregnancy, consent and bodily integrity, and the promotion of healthy relationships should take place before young people have sex for the first time [119].
- Conduct formative research to assess how to position puberty education most strategically vis-à-vis CSE (Text Box 6). Where puberty education and CSE run in parallel to one another, ensure coherency between the two programmes.
- Implement CSE and puberty education as part of multi-component strategies that also include adolescent-responsive health services and community engagement [44, 50].
- Build community support for CSE and puberty education, including among parents/family members, community leaders, health providers, religious and cultural leaders, and young people themselves.
- Introduce sustainable models of CSE and puberty education in non-formal and community-based settings to reach out-of-school adolescents of both sexes and all genders, especially since they generally experience more barriers to accessing reliable information and are at higher risk of negative health and development outcomes [33, 35, 58]. This is especially important in countries where school attendance is low or where adequate CSE is not included as part of the national curriculum [119]. It is also important in other contexts to complement in-school programmes.
- Consider complementary educational models, including edutainment and digital learning platforms, to reinforce or fill gaps in curriculum-based education [72, 154].
- Position CSE and puberty education within a life cycle approach, providing accurate and age-appropriate information about menstruation and sexuality throughout different life stages [144]. Design specific interventions for life-long learning of adults to increase their own knowledge and understanding of menarche, puberty, and post-adolescence menstrual health-related changes, as well as equip them with skills for effective parent-child communication.

Box 7: Puberty booklets to improve menstrual knowledge

Ministries of education and NGOs in several countries have produced puberty booklets, sometimes referred to as 'readers', to support the delivery of puberty education. These booklets aim to provide information to girls (and boys) on puberty-related changes, including menstruation. They can be used as part of the curriculum, as a self-guided resource, or through extracurricular programmes. Evaluations of puberty booklets developed in Ethiopia and Indonesia showed that they were associated with statistically significant improvements in menstrual knowledge, attitudes around menstruation and emotional responses to menstruation [153, 155]. Experiences from Ethiopia, Tanzania and Uganda suggest that puberty booklets are likely to be most impactful when combined with multi-faceted investments in creating more gender-equitable physical and social school environments in addition to ensuring adequate WASH facilities and access to menstrual products. Providing links with extra-curricular girls' clubs, and ensuring sufficient training and support for teachers on puberty education [6, 155], also increased the impact of puberty booklets.

Box 8: Adolescent- and youth-responsive health services

Adolescent-responsive health services are equitable, accessible, acceptable, appropriate and effective [156]. Quality of care, a multi-sectoral approach, accountability, and meaningful and effective youth participation are fundamental principles of adolescent-responsive health services [119].

Adolescent and Youth SRH Services and Programmes

General recommendation:

Integrate MH as an essential component of adolescent and youth SRHR programmes and integrated adolescent- and youth-responsive health services.

MH and SRHR are critical to a healthy transition through adolescence and youth. Certain aspects of SRHR are unique to adolescents, including menarche – sometimes accompanied by the onset of dysmenorrhea and other menstrual disorders, social and gender norm formation, CEFM, the recommended age of HPV vaccination, and sexual initiation (for many). For other aspects of SRHR – including unmet needs for contraception, rapid repeat pregnancies and unsafe abortions – adolescents are at a higher risk for adverse outcomes, and these risks interplay with MH concerns. Meeting the needs of the world's largest-ever population of adolescents and youth requires adolescent- and youth-responsive health systems that offer integrated MH and SRHR services (Text Box 8). Dismantling the stigma associated with adolescent sexuality – an underlying cause of poor SRH and MH outcomes – is a critical component of adolescent and youth SRHR programmes.

Guidance for Action

- Develop or update policies to ensure access to quality, integrated and equitable adolescent- and youth-responsive health care, including SRHR and MH counselling and services [15].
- Apply a systems approach to establish adolescent- and youth-responsive health systems by adapting policies, procedures, and programmes across the entire health system to respond to the diverse SRH and menstrual needs and preferences of adolescents [157].
- Employ a variety of channels to reach different groups of adolescents with integrated SRH and MH services and products (Text Box 9). This includes going beyond health facilities and schools, expanding community-based service delivery (including mobile and household-level outreach and distribution of self-care methods), as well as reducing or eliminating any financial or physical barriers [112, 157].
- Design specific strategies to reach very young adolescents with integrated MH and SRHR information, counselling and services, in light of the declining age at menarche in LMICs [10].
- Train and support health care providers and community health workers to offer adolescent-responsive contraceptive counselling that includes comprehensive information on CIMBCs, framing contraceptive choices around life goals and explaining changes in menstrual bleeding within the context of future fertility desires [1, 158, 159]. Ensure that such counselling is routinely offered as part of antenatal, post-partum, and safe and/or post-abortion care for adolescents [122].
- Train and support health care providers in adolescent-responsive active management of contraceptive side effects with particular focus on CIMBCs [119].
- Train and support health care providers to understand the therapeutic use of hormonal contraceptives for conditions that often arise during adolescence, such as acne, dysmenorrhea, endometriosis symptoms, or polycystic ovarian syndrome [119].
- Train and support health care providers to offer high-quality adolescent- and youth-responsive antenatal, intrapartum, postnatal, abortion and post-abortion care, including skills for counselling on post-partum and post-abortion bleeding [119, 160].

- Train and support health care providers to identify signs of mental health problems in adolescents and establish functional referral systems to link facility- and community-based SRH services with mental health and psychological support services [119].
- Include measures to address period poverty in programmes and services for young, vulnerable populations.
- Train health care providers and community health workers to counsel adolescent girls and young women living with HIV on the increased potential for amenorrhea, contraceptive options, and the importance of dual protection with condoms.
- Ensure adolescents and youth benefit from universal health coverage and national insurance schemes. For example, include adolescents and youth in risk pools and subsidize adolescent SRHR and MH services using vouchers or other demand-side financing schemes [119, 161, 162]. and
- Link integrated adolescent- and youth-responsive SRH services with community-based and interpersonal social and behaviour change interventions that include a focus on MH [155,157,159,161] (Text Box 10). Orient teachers and other community-based frontline workers to refer adolescents and youth to SRH and MH services.

Box 9: Integrating MH in HPV vaccination services in Togo

HPV immunization programmes, which target young adolescents, provide an opportunity to offer an integrated package of SRHR care for adolescents [163, 164]. The World Health Organization includes MH education and counselling as one of the main interventions that can be delivered in combination with the HPV vaccine [165]. In Togo, the Ministry of Health collaborated with the Ministry of Education to provide education on puberty, MH, and handwashing practices for adolescent girls and boys alongside the roll-out of the HPV vaccine [119, 166].

Box 10: Integrating MH and SRH for adolescent girls in Zimbabwe

PSI Zimbabwe is implementing an integrated MH and adolescent SRH programme. PSI developed a multi-component strategy based on formative research with adolescent girls and communities, comprising two main interventions:

- A mass and digital media campaign to prevent unintended pregnancies and HIV transmission that helps adolescent girls understand menarche and take ownership of their changing bodies. The campaign included working with influencers to break the silence and shame around menstruation and ignite conversations in the community;
- Integrated MH and adolescent SRH awareness-raising activities with adolescent girls run by peer mobilizers. This included creating a MH manual and menstrual products guide; and the distribution of menstrual cups.

These social and behaviour change interventions were shown to have increased the uptake of modern contraception and PrEP among adolescent girls between the ages of 5 and 19.



Family Planning and Contraceptive Services

General recommendation:

Ensure all reproductive health and contraceptive counselling includes comprehensive information on the menstrual cycle and contraception-induced menstrual bleeding changes

An integrated approach to menstrual and health and SRH requires that programmes and services address the effects of hormonal contraception on bleeding patterns and how this shapes the menstrual experience and contraceptive choices of girls, women and all people who menstruate [88]. This is particularly relevant for the current momentum around increasing access to long-acting reversible contraceptives (LARCs), including for adolescents and young women, as several LARCs affect menstrual bleeding patterns. Promoting a better understanding of how contraception may affect bleeding and providing a non-judgmental environment in which to consider the merits of various contraceptive options could contribute to increased contraceptive uptake, improved satisfaction, higher continuation rates, and more positive and empowering experiences with menstruation [1, 89].

Guidance for Action

- Improve FP programme designers', programme managers', health care providers' and frontline workers' understanding of underlying cultural and structural menstrual-related restrictions and stigma affecting contraceptive choice [41].
- Build health care providers' and community health workers' (CHW) competencies to include information on CIMBCs as part of all contraceptive counselling, including:
 - Improving pre- and in-service training curricula to comprehensively address CIMBCs for all available contraceptive methods;
 - Providing supportive supervision to health care providers and CHW on CIMBCs;
 - Producing or adapt job aids to support providers and CHW to offer evidence-based, non-judgmental contraceptive counselling (Text Box 11); and
 - Ensure all contraceptive counselling includes questions on clients' preferences regarding bleeding patterns and adapt counselling to different life stages.
- Build health care providers' competencies to diagnose, counsel and treat AUB and dysmenorrhea, including through hormonal contraceptives. This includes:
 - Updating pre- and in-service training curricula with the most current evidence-based protocols for treating AUB and dysmenorrhea;
 - Training and offering supportive supervision to providers to offer non-judgmental counselling. Of particular importance is being mindful that counselling on menstrual suppression to alleviate symptoms of menstrual disorders with contraception does not reinforce stigma by framing menstruation as 'unhealthy' and requiring medical intervention [167]; and
 - Producing evidence-based job aids.
- Build providers' competencies to assess appropriate contraceptive options during perimenopause, including awareness of which contraceptive methods increase risks of stroke and other comorbidities common during perimenopause, as well as awareness of how to transition between hormonal contraception and hormone therapy.
- Explore how girls, women and people who menstruate respond to CIMBCs as a key issue for contraceptive research and product development [88].
- Include evidence-based information on CIMBCs in family planning-related communications' campaigns and other social and behaviour change interventions.
- As a complement to interpersonal communication and in-person counselling, consider promoting digital apps that track the menstrual cycle as tools for empowering girls, women and all people who menstruate with information and skills relevant for MH, fertility, contraception and SRH more broadly [1].

Box 11: The NORMAL job aid for counselling clients on CIMBCs

A multidisciplinary team from FHI360 and PSI developed the NORMAL job aid - a simple tool that guides providers on how to counsel family planning clients on bleeding changes associated with hormonal contraception and the copper intrauterine device (IUD). The tool has been well received by providers and FP programme managers in several countries. Additional research is required to evaluate the feasibility and effectiveness of incorporating the NORMAL tool into family planning counselling sessions as well as women's comprehension of these messages, and the ultimate impact on changing providers' and women's attitudes and behaviours [89]. The tool is available in several languages at: <https://www.fhi360.org/resource/normal-counseling-tool-menstrual-bleeding-changes-job-aid>.

Reproductive and Maternal Healthcare

General recommendation:

Integrate MH as an integral part of reproductive and maternal health care.

Reproductive and maternal health services are an entry point for addressing MH irregularities and disorders. Yet, there is little evidence of programmes aimed specifically at caring for dysmenorrhea and AUB [2]. An integrated approach to MH, reproductive health and maternal health care would enable health systems to better serve the many girls, women and people who suffer from dysmenorrhea and AUB. In addition, an integrated approach has the potential to improve prevention and treatment efforts for RTIs, given the possible linkages between MH and urogenital infections. Also, an integrated approach to MH, antenatal and abortion care would ensure that girls and women are empowered to manage regular post-partum bleeding and identify early signs of possible complications. Finally, an integrated approach would help to meet the specific needs of girls and women with obstetric fistula.

Guidance for Action

- Increase investment in programmes to address dysmenorrhea and AUB [2]. This includes improving access to quality health care, as well as educational and awareness programmes to help girls, women and all people who menstruate to understand what 'normal' bleeding patterns are, as well as when and how to seek care for abnormal bleeding.
- Train and support reproductive and maternal health care workers to screen for, counsel on and offer treatment for menstrual disorders, including dysmenorrhea and the underlying conditions leading to AUB[2, 23]. This can include the development of simple job aids.
- Train and support maternal health-care providers to include discussions on regular post-partum bleeding (lochia) and signs of haemorrhage to empower girls and women to manage post-partum bleeding with confidence.
- Train and support maternal healthcare providers to counsel girls and women on variations in the menstrual cycle after pregnancy and during breastfeeding, as well as post-partum contraceptive options, as part of antenatal and post-partum counselling. Understanding that fertility can return before the resumption of menstrual bleeding, can help avoid unintended, closely spaced pregnancies [1].
- Although, levels of RTIs attributable to MH appear to be low, it is nevertheless important to ensure that programmes include emphasis on how to properly wash and dry menstrual products, and also ensure access to supplies necessary for washing and drying [2].
- Include provisions for accessible and affordable menstrual products in programmes and services for girls and women with obstetric fistula. Those with fistula may need to use absorbents on a daily basis for incontinence, as well as for menstruation, and may struggle with costs to procure and clean them [168].

HIV Prevention, Treatment, and Care

General recommendation:

Ensure that MH is included as an essential component of HIV prevention, treatment, and care.

The limited data that exists on the linkages between MH and HIV suggests that the menstrual cycle may affect HIV transmission, menstrual stigma may be detrimental for HIV prevention strategies, and WLWH have specific MH needs. An integrated approach to MH and SRHR includes MH considerations in HIV prevention, treatment, and care. The linkages between MH and HIV remain underexplored and warrant further investigation.

Guidance for Action

- Train and support health-care providers and community health workers, where appropriate to:
 - Share accurate information on the menstrual cycle — including the increased likelihood of amenorrhea — when offering HIV counselling and SRH or contraceptive counselling to WLHIV [98, 103-105];
 - Offer specialized contraceptive counselling for WLWH that includes comprehensive information on CIMBCs and possible drug-drug interaction between certain hormonal contraceptives and ART regimes [1, 169]; and
- Assess the underlying causes of heavy menstrual bleeding and make referrals to HIV services if necessary, especially in generalized epidemics and when serving key populations [1].
- Invest in research to better understand the interaction of the menstrual cycle with HIV transmission and integrate findings in HIV prevention strategies, especially in generalized epidemics and among key populations [98].

- Integrate efforts to dispel myths and address menstrual stigma when rolling out the dapivirine vaginal ring for HIV prevention [101].
- Design awareness campaigns and social and behaviour change strategies tailored to reduce HIV transmission in postmenopausal women, especially in generalized epidemics [102].
- Create or sustain support groups or adherence clubs for peri-menopausal women living with HIV to share options for managing menopausal symptoms, in addition to HIV specific support [98, 106, 107].
- Train and support HIV health-care providers to help WLHW manage menopause, including considerations for interactions between HAART and hormone therapy.

Gender-based Violence Programming

General recommendation:

Ensure MH is a crucial component of GBV initiatives, including interventions to eliminate CEFM and FGM.

The current evidence-base shows a clear link between menstruation and various forms of GBV. Some forms of GBV target girls and women because of menstruation (e.g., social restrictions related to menstruation, school-related gender-based violence directed at menstruating students,⁸ and violence experienced around unsafe latrines). Other forms of GBV are either exacerbated by cultural beliefs about menarche and menstruation (e.g., CEFM) or have negative consequences on MH (e.g., FGM). An integrated approach to MH and SRHR incorporates menstrual justice into GBV initiatives, while also addressing the underlying and systemic causes of gender inequality that drive poor MH outcomes and GBV.

Guidance for Action

- Develop and enact laws that prohibit menstrual restrictions, as part of efforts to strengthen legal and judicial frameworks for addressing GBV. Accompany such laws with interventions to shift cultural and gendered norms and practices that contribute to menstrual restrictions [44].
- Foster collaboration between WASH, SRHR and gender equality sectors to improve the safety of latrines for girls, women and people who menstruate, while also ensuring access to sexual and GBV services.
- Engage communities in behaviour change communication and community-level education across a range of sectors to shift the discriminatory gender norms that lead to menstruation-related social restrictions. Particular focus should be on engaging with parents, teachers religious and cultural leaders and other community influencers [28] (see community engagement section).
- Include interventions to improve MH in strategies for eliminating school-related GBV. This can include integrating MH into the six guiding strategies for national action on SRGBV promoted by UNESCO and UN women [147]. For example:
 - Include MH in multisectoral national policies and action plans to prevent and respond to SRGBV;
 - Include safe and adequate facilities and toilets for changing and washing menstrual products as part of a whole-school approach to ensuring a safe and supportive school environment for all learners;
 - Ensure that bullying and teasing related to menstruation are included in codes of conduct to prevent and sanction against SRGBV;
 - Train teachers and other educational staff on how to respond to menstrual-related GBV in school settings;
- Provide easily-accessible, child-sensitive and confidential reporting mechanisms for menstrual-related GBV in school settings; and
- Offer menstrual education, including values clarification related to menstrual stigma for all students (see CSE and puberty education section).
- Increase investments to eliminate CEFM in areas where age of menarche is low and in settings where menarche is culturally believed to signal readiness for marriage [10]. This should include community-based efforts to eliminate or establish alternate adolescent rites of passage [170, 171], as well as address social and cultural norms that perpetuate the belief that menarche is a sign of girls' readiness for marriage [144] (Text Box 12). Similarly, in settings with a low age of menarche, MH programmes should have a clear focus on CEFM, so they can be used as entry points to discuss CEFM [55].
- Include interventions to improve parent-child communication in primary prevention efforts to reduce CEFM. Studies in several countries show that the quality of parent-child relationships and communication in early adolescence protects against CEFM [172].
- Create linkages between MH initiatives and specialist organizations campaigning and working with girls, women and communities on FGM [168].
- Support and train health-care workers to meet the specific MH needs of girls and women who have experienced FGM. This includes treating symptoms of dysmenorrhea and AUB, which may be particularly severe among this population group [2, 57, 58].

⁸ School-related gender-based violence is defined as “acts or threats of sexual, physical or psychological violence occurring in and around schools, perpetrated as a result of gender norms and stereotypes, and enforced by unequal power dynamics.” 145. UNESCO and UN Women, Global Guidance: School-Related Gender-Based Violence. 2016, UNESCO and UN Women: Paris.

Box 12: MH in the UNFPA-UNICEF Global Programme to Accelerate Action to End Child Marriage

UNFPA and UNICEF positioned MH as one of the main pillars to end CEFM in their Global Programme to Accelerate Action to End Child Marriage. The 12 Global Programme countries account for over 300 million of the 650 million girls and women globally who are married in childhood [170].

The Programme reached over 6 million adolescent girls with health or protection services in its first phase. It supported adolescent girls to participate in life-skills and CSE in safe spaces and mentorship programmes at community level or through school-based activities and enabled the provision of MH products and school materials to help keep girls in school. As a result, adolescent girls reported increased self-confidence and better knowledge of SRH (with a strong focus on MH), and a desire to complete their education as part of their future aspirations. In Ethiopia, this contributed to increasing girls' transition rate from primary to lower secondary school in the programme focus areas, from 60 per cent in 2016 to 76 per cent by the end of 2019. All Programme countries engaged individuals, families, local leaders, and gatekeepers in community dialogues to shift gender norms related to child marriage and gender equality, including a focus on MH. On an advocacy and policy level, the Global Programme helped the African Coalition for Menstrual Health Management to support countries to issue policies, remove VAT on menstrual products and launch national menstrual hygiene programmes [173]. An external evaluation of the Programme's first phase suggests that it may be a promising approach to reduce CEFM [174].

Community Engagement

General recommendation:

Engage communities to create a supportive environment for MH and SRHR and to shift the gender and social norms that underpin adverse MH and SRHR outcomes.

Community engagement is an essential component of effective SRH and MH programmes [161, 175, 176]. Communities play a fundamental role in shaping and reinforcing social and gender norms. In addition, community members are key influencers and gatekeepers who influence SRHR and MH. Social, behavioural, and community engagement interventions are crucial for an integrated approach to MH and SRHR, helping to shift the attitudes, beliefs and social norms that drive the stigma and discrimination underpinning poor MH and SRH outcomes [24, 28]. Evidence on what works to engage communities in MH is only recently emerging, partly because early MH programming (referred to as 'menstrual hygiene management' at the time) was primarily led by the WASH sector and had a stronger focus on 'hardware' solutions [136, 177]. The recommendations in this section draw on both bodies of evidence, specifically areas of synergy between the two sectors.

Guidance for Action

- Involve diverse community members in the design of integrated MH and SRHR programmes through participatory approaches to define problems and identify solutions [32]. The voices of girls, women and all people who menstruate should be prioritized. Redefining local norms and practices is most effective when driven by people within the community themselves [32].
- Conduct a mapping or other types of formative research on cultural beliefs and practices related to menstruation, sexuality and SRH to inform policies and programmes [4].
- Identify cross-sectoral opportunities to create spaces for intergenerational and gender-transformative community dialogue on MH and SRHR [24, 144].
- Use a variety of community-based channels to share accurate information on MH and SRHR directly with girls, boys, women, men and people who menstruate including women's groups, home visits by community health workers, mother and child health days, youth groups, small peer groups for adolescents and youth, HIV support groups, digital health apps, informational leaflets in menstrual product packaging, etc. [23, 51, 161].
- Ensure that MH information addresses more than biological facts about the menstrual cycle. These include how to use, dispose of and care for various menstrual products; understanding normal versus abnormal bleeding, how to recognize signs of menstrual disorders, and how to seek care; values clarification to dispel myths, misconceptions and discriminatory beliefs and attitudes; how gender and social norms affect menstrual experiences.
- Design strategies to educate parents and other adults on MH and SRHR, while also equipping them with skills for effective parent-child communication [24, 167]. Such strategies should also include values clarification to reduce stigma related to menstruation, girls' and women's sexuality and SRH issues more broadly [178]. Special attention should be given to mothers and female adult relatives, as they are the main source of information on menstruation and SRH in many contexts [25, 30, 39, 179]. Strategies can include engaging women's groups, parent-teacher associations, and conducting home visits.
- Include teachers and teachers' unions in community mobilization to promote MH and SRHR, in addition to

professional training and support for teachers (see CSE and puberty education section) [178].

- Engage cultural and religious leaders in MH and SRHR community engagement strategies, providing them with accurate information on both topics [29, 65]. Identify champions among cultural and religious leaders and create spaces for reflection and dialogue on how cultural practices and traditions can be used to support the right to MH and SRHR.
- Design context-specific strategies to ensure that boys and men have access to accurate, rights-based and gender-transformative menstrual and SRH education [2, 33]. (Text

Box 13). This can include in- and out-of-school CSE or puberty education, informal adult education interventions, and community awareness and mobilization activities, among others. A particular focus on reducing teasing and harassment must be included in school-based education for male and female students, as well as male teachers [28].

- Design and implement mass media strategies to raise awareness about MH and SRHR, such as radio, television, newspapers, magazines, books, and the Internet to supplement other information sources [30].
- Develop partnerships with menstrual product manufacturers to insert leaflets with accessible MH and SRHR information [1].

Box 13: Examples of engaging men and boys in MH

In India, WaterAid and Vatsalya established and sensitized groups of men and boys as part of a programme that started in December 2011. Male teachers and masons were also trained to provide MH services in schools. As a result of the initiative, men and boys began to talk more freely about menstruation and were better able to support the MH needs of women and girls within the household, community, and school [180].

In Malawi, Plan International included boys in menstrual hygiene training in response to reported teasing of girls on menstruation issues. The outcomes of the initiative suggest that it helped to increase boys' support for menstrual issues [2].

In Uganda, WoMena involved men and boys as key stakeholders in MH training and other community engagement to encourage men to adopt an advocacy and protection role. Key findings from this experience included that men often feel left out, are keen to know more about menstruation and are interested in opportunities to become advocates [73].

In Ethiopia, Kenya, and Tanzania (among others), Grow and Know produced puberty books for boys that included information on menstruation and gender-respectful behaviour. The books, which are grounded in the social, cultural, and economic context of each country, were developed through participatory research that included boys and girls and government policymakers [181].

Leaving No One Behind: MH and SRHR of People in Vulnerable Situations

General recommendation:

Ensure that SRH and MH information, education, services, and programmes are designed to meet the specific needs of diverse people with disabilities.

It is important that people in vulnerable situations be fully included in integrated MH and SRHR policies and programmes. Thus, programmes and policies should be informed by a context-specific mapping to identify population groups that require specific attention. As in Part 1, this section focuses on technical guidance for three specific vulnerable groups: people living with disabilities, transgender and non-binary people, and people living in humanitarian contexts.

There is little rigorous evidence on effective interventions to meet the MH and SRHR needs of people with disabilities [117]. Nevertheless, findings from operational learning and descriptive studies offer useful guidance to take into consideration for integrated MH and SRHR policies and programmes.

Guidance for Action

- Collaborate with persons with disabilities to review existing laws and regulations and identify current laws and regulations that obstruct access to information and services. Advocate for the revision of laws and regulations to ensure they are responsive to, and inclusive of, people with disabilities [114].
- Ensure the meaningful participation of persons with disabilities at all stages of policy and programme development, implementation and assessment [4, 114] 114]. This includes creating space for varying communication and engagement styles.

- Advocate for and ensure that national accountability mechanisms allow for reporting, monitoring, and redress of violations experienced by people with disabilities, including sexual and reproductive rights violations [114]. Self-advocacy by people with disabilities should be central to these efforts, recognizing that persons with disabilities are most effective in advocating for their own rights and needs. Disabled Persons Organizations are a key mechanism for supporting and organizing self-advocates.
- Ensure that educational, health, WASH and other public facilities are accessible to people with diverse disabilities. This includes involving people with disabilities in the design and audit of such facilities [4].
- Ensure that mainstream services are inclusive of people with disabilities, alongside the creation of services tailored specifically to diverse groups of persons with disabilities [114].
 - This includes adapting service delivery environments and modalities to ensure accessibility for people with different disabilities;
 - Mobile and community-based outreach service delivery models may be especially important to reach certain groups of people with disabilities; and
 - Specific services for people with disabilities should take into account the needs of those living in isolation in institutional settings, camps, nursing or group homes, family residences, rural or remote settings, or those who are homeless.
- Train and support service providers and caregivers to respect people with disabilities' legal capacity, informed consent and privacy (see Text Box 14).
 - For example, people with disabilities must be allowed and supported to make their own decisions about contraceptive use and method choice. This includes accessible information and counselling on CIMBCs. No individual with a disability should undergo sterilization or be given contraception without their voluntary and fully informed consent [114]; and
- Guidelines for rights-based supported decision-making mechanisms and confidentiality safeguards should be rolled out to service providers and caregivers [114].
- Train (pre- and in-service) and support health-care providers and support staff on the rights and needs of people with different disabilities and how to provide accessible and respectful care [114]. Create accompanying job aids to support health-care providers to offer quality care.
- Adapt MH and SRHR health-care procedures and equipment to accommodate the specific needs of people with disabilities. Where possible, design services utilizing universal design principles to allow for a broader range of usage and not just for persons with disabilities.
- Establish effective referral systems and inter-agency coordination to ensure a coherent continuum of accessible and respectful MH and SRHR care for persons with disabilities to meet their multifaceted needs [114].
- Create CSE, puberty education and MH education programmes that respond to the needs of persons with disabilities (Text Box 15). This includes [114]:
 - Covering the full range of topics recommended by UNESCO's International Guidance on Sexuality Education [47] and adapting content to reflect the diverse experiences of people with disabilities;
 - Ensuring that mainstream CSE, puberty education and MH education programmes help learners to dispel myths and misconceptions about the MH and SRHR needs of people with disabilities;



- Using accessible techniques and activities to teach persons with disabilities about key MH and SRHR topics; and
- Creating safe spaces where people with disabilities can learn about and discuss their MH and SRHR in a safe, supportive, and educational way. Small support groups can be particularly useful to help people with disabilities to feel more comfortable discussing sensitive topics.
- Ensure that information and education materials on MH and SRHR are accessible and suited to diverse communication needs, including braille, large print, audio, digital formats compatible with screen readers, sign language with an interpreter, captioning, simplified formats, pictorial guides, and local language interpretation [4, 114].
- Design interventions to engage caregivers and family members in sensitization and capacity building to better meet the MH and SRHR needs of persons with disabilities [114].
- Create menstrual products with accompanying appropriate information that responds to the needs of different groups of people with disabilities. For example, the Keela Cup, is an accessible menstrual cup designed by a woman with a disability specifically for women with disabilities [114].
- Ensure that people with disabilities are included in SRHR and MH interventions in humanitarian settings and ensure that dignity kits take the needs of people with disabilities into consideration [114, 128].
- Invest in evidence-generation and learning about the intersecting MH and SRHR needs of people with disabilities. This includes adapting national information systems to collect data disaggregated by sex, age, and disability. People with disabilities should be involved in monitoring, evaluation and feedback processes [4, 114].

Box 14: Considerations for informed consent for people with disabilities [114]

Informed consent refers to the voluntary agreement of an individual who has the legal capacity to give consent. It requires that individuals have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent. It is important that service providers and caregivers never assume a person lacks the capacity to provide free and informed consent simply because they have a disability [114]. Determining who is legally able to give consent for health services depends on the legal and policy framework in each setting. The age of consent for various SRH services may differ, depending on the type of service. Hence, it is important for service providers to be aware of local laws, guidelines, and protocols for consent to services.

To establish informed consent for people with disabilities, The Women's Refugee Commission and International Rescue Committee's 'Guidance for GBV Service Providers: Informed Consent Process with Adult Survivors with Disabilities' suggests the following three components [182]:

- Provide all possible information, including benefits, risks, and alternatives, to a person with a disability in their preferred format and in a way they can understand; offer and utilize supported decision-making tools if desired;
- Determine if the person can understand the information and their decisions (also known as 'capacity to consent'); and
- Ensure that the disabled person's decisions are voluntary and not coerced by others (e.g., family members, caregivers, or service providers).

In some situations, and only after taking all necessary steps to acquire informed consent, service providers and support staff may encounter people who are unable to provide informed consent even with the necessary supports. In such situations, the service provider must consult the ethical and legal standards in their country for acquiring informed consent and determining a person's capacity. Service providers must also ensure that the person with the disability remains involved in the decision-making process as much as possible and that the person's best interests and preferences are prioritized.

Box 15: Examples of CSE programmes for people with disabilities

In Kenya, *Huru International* supported the integration of inclusive MH into five 'special schools' and 12 'inclusive schools'. Strategies included conducting the baseline survey in sign language, creating an adapted curriculum and intervention techniques for girls with disabilities, implementing activity-based education for boys with disabilities, and organizing educational seminars in sign language, among others. The project reached over 1,000 girls with disabilities aged 10 - 14 years [183].

In Tanzania, *Femme International (FI)* and *Youth with Disabilities Community Program* developed a project to bring FI's 'Feminine Health Empowerment Program' to girls with disabilities in the community. Girls with disabilities in the project area, particularly those with intellectual disabilities, face difficulties in understanding the menstruation process, especially given the local tradition of learning about menstruation from a female elder. The programme aims to teach girls and boys with and without disabilities about how their bodies work, the menstrual cycle, and how to make safe and healthy SRHR choices [114].

Transgender and Non-Binary Persons

General recommendation:

Ensure access to tailored information and trans-competent care that integrates MH and SRH with other key health services, while ensuring safety and confidentiality and tackling stigma and discrimination.

Including a clear focus on transgender and non-binary persons' perspectives on and experiences with menstruation, sexuality, and SRH is essential to ensure that no one is left behind in integrated MH and SRHR programmes. The evidence-base on transgender and non-binary person's MH and SRHR needs in LMICs is virtually non-existent. The following guidance draws from good practice principles of inclusive policies and programming, relevant data from high-income countries, descriptive data from some LMICs and technical guidance for key populations from the HIV sector.

Guidance for Action

- Advocate for legal recognition of transgender and gender non-binary people, particularly to ensure they are afforded rights to health, and freedom from violence and all forms of discrimination [118].
- Advocate for the implementation of anti-discrimination and protective laws, derived from human rights standards, to eliminate stigma, discrimination and violence against people from key populations, including transgender and gender non-binary individuals [118].
- Ensure the meaningful participation of organizations comprised of, and serving, transgender or gender non-binary people who menstruate in relevant decision-making processes and as partners in programme design and delivery [4, 118].
- Design and implement a package of interventions to enhance community empowerment among transgender and gender non-binary people. This includes engaging and mobilizing transgender people to increase awareness of their rights, build the skills to claim their rights, develop leadership skills, develop solutions to their collective problems, and to advocate for protection of their human rights [118, 184, 185].
- Train and support transgender and gender non-binary people as peer educators and counsellors to reach their peers with accurate, non-judgmental information on MH and SRHR, as well as facilitate linkages with appropriate services. Peer involvement is especially important to build trust and to determine appropriate communication styles and channels that resonate with diverse transgender and non-binary individuals [184].
- Where possible, consult with transgender and gender non-binary people to develop safe and desirable options for menstrual products and WASH facilities, avoiding generalisation by recognizing the diversity of transgender and non-binary experiences [4].
- Design programmes and services with the principle of 'do no harm' and avoid reinforcing stigmatization or exposure to vulnerability through the provision of services for transgender and gender non-binary people. Confidentiality and privacy are particularly important. Safety audits for health-care settings and public toilets are useful tools to ensure that these settings meet the needs of diverse transgender and gender non-binary individuals, while placing them at least risk of harassment, violence and abuse [4].
- Ensure access to justice for transgender and non-binary individuals. This can include establishing partnerships with law enforcement agencies to prevent the arbitrary arrest and detention of transgender and non-binary individuals and to establish functional referral mechanisms to report violations of their human rights, including GBV [184, 185].
- Include MH services in an integrated package of care for key populations for HIV. In many countries and regions, including SADC, transgender individuals are included among key populations for HIV [73]. This presents an opportunity to integrate MH information and services into a comprehensive package of HIV services recommended by the WHO for key populations [186]. These services include PrEP, harm reduction interventions for substance use, behavioural interventions HIV testing and counselling, HIV treatment and care, prevention and management of co-infections and comorbidities, including tuberculosis and hepatitis B and C, as well as STI screening.
- Train and support health-care providers to be sensitive and knowledgeable about the specific MH and SRHR needs of transgender and non-binary people (see Text Box 16). In addition to clinical skills for integrated service delivery, training should include [4, 118, 121, 185]:
 - How to offer respectful, confidential care;
 - How to avoid using gendered terms when taking a sexual history;
 - How to ask what language clients use to describe their anatomy and menstruation, and use this preferred language;
 - How to avoid assumptions about clients' sexual orientation, sexual behaviours and reproductive intentions based on gender identity;
 - How to avoid assumptions about and respectfully inquire about which anatomical parts they and their partners use for sexual activity in order to determine the most appropriate approaches for examinations and screening;
 - How to use positive or neutral framing to discuss MH and SRHR, rather than focusing solely on risks or fear-based messaging, to avoid reinforcing stigma; and
 - How to offer contraceptive counselling that considers the specific fertility and gender-affirming desires of individual clients. This includes counselling on contraceptive options to avoid unintended pregnancy, whether on testosterone therapy or not, as well as the use of contraception for menstrual suppression.

Box 16: Training health-care providers to offer integrated health services for transgender individuals in South Africa

The Anova Health Institute is a South African NGO focusing on HIV-related advocacy and programming. In 2017, they developed Health4Trans: Transgender Healthcare Training Manuals with the aim of extending access to competent sexual health services for the transgender and gender non-conforming populations. The package includes a facilitator's manual and a participant's manual to build the capacity of health-care workers to offer quality health services to transgender people. The manuals include specific content on how to take a sexual history and offer MH counselling, including how to choose appropriate terminology to refer to menstruation and menstruation-related anatomy, understanding effects of testosterone therapy on menstruation and how to address bleeding while on testosterone therapy, and how to inquire about dysmenorrhea. The manuals also offer useful guidance on considerations for contraceptive services and cervical cancer screening for transgender people who menstruate [187, 188].

Humanitarian Settings

General recommendation:

Ensure that appropriate and timely SRHR and MH information, education, services, and products are prioritised in all phases and sectors of humanitarian responses.

Taking an integrated approach to MH and SRH programming in humanitarian settings has the potential to reduce preventable deaths, disease and disability. An integrated approach involves adapting the guidance described in the sections above to the specific needs and contexts of diverse humanitarian settings. This includes applying the "4 Cs of effective Menstrual Hygiene Management" described in Columbia University and IRC's *Toolkit for Integrating Menstrual Hygiene Management (MH) into Humanitarian Response* [128] and the fundamental principles of SRH programming in humanitarian settings described in the IAWG's *Inter-Agency Field Manual on Reproductive health in Humanitarian Settings* [132] for the design, implementation and assessment of interventions. A particular emphasis should be placed on safety, privacy and dignity in interventions across a range of sectors/clusters, including health, education, WASH, protection, non-food items and shelter [128]. This emphasis will not only improve the effectiveness of SRHR and MH programming, but will also benefit cross-sectoral objectives.

Guidance for Action

- Strengthen cross-sectoral collaboration for the delivery of integrated SRHR and MH programmes and services. This includes clearly designating a lead sector for MH and ensuring close collaboration with the sectoral lead for SRHR. It also includes clarifying roles and responsibilities for all relevant sectors, including shelter, protection, health, nutrition, education, and WASH to play a vital role in planning and delivering SRH services [132, 189].
- Build partnerships with organizations comprised of or serving: people with disabilities; adolescents and people with diverse sexual orientations and gender identities; and other marginalized groups to ensure the needs of vulnerable groups are adequately integrated into SRHR and MH programming and services in humanitarian settings [126, 129].
- Include MH and SRHR in emergency preparedness strategies. For example, collect data, including through consultative processes, on preferences for the design of WASH facilities for managing menses; preferences for menstrual products and supplies; cultural practices and beliefs about menstruation and sexuality; and preferences for contraceptive methods [4, 132].
- Include questions on MH and SRHR in the initial needs assessment conducted at the onset of a crisis and in subsequent needs assessments in later stages of a humanitarian response (Text Box 17). Understanding local beliefs, practices and need, as well as how they may evolve in different stages of an emergency, is essential for effectively integrating MH and SRHR in humanitarian responses [128, 129].
- Include questions on menstruation and SRH in existing health or protection screenings upon arrival at border points and reception centres [128].
- Train all first responder staff and other service providers on MH and SRHR, with the aim of gaining the knowledge and skills to comfortably discuss MH and SRHR in a non-stigmatizing way, and how to make referrals to appropriate services [128]. In many contexts, girls, women and people who menstruate prefer to speak with women about menstruation and this should be taken into account when planning services across sectors/clusters [128, 129].
- Provide in-depth training and support for health-care providers on how to adapt the clinical and counselling needs described in previous sections to humanitarian contexts [126, 129]. This should include training on the use of key tools and guidance resources for offering SRHR and MH programmes and services in humanitarian settings, such as the MISP for SRH [132], the Inter-Agency Manual on Reproductive Health in Humanitarian Settings [132], and the Toolkit for Integrating Menstrual Hygiene Management (MH) into Humanitarian Response [128]. Online modules on the MISP for SRH [190] and adolescent SRH in humanitarian settings [191] are available when in-person training is not possible or appropriate.

- Engage, train and support lower cadre health workers from refugee or internally displaced populations to provide integrated SRHR and MH services, both at health facilities and through community-based services [192].
- In addition to integrated services at health facilities, specific outreach strategies should be implemented to reach groups who are less likely to seek SRH or menstrual health services at facilities due to stigma and discrimination. These groups can include adolescents, transgender and non-binary individuals, people with disabilities and other people with special needs. Outreach service delivery points should be strategically selected to improve access to these groups. For example, schools, protection centres, and youth centres can be useful outreach points for adolescents, while food distribution centres would be relevant points for women [128, 189].
- Ensure adequate stocks of appropriate menstrual products and supplies (including underwear, soap and washbasins) are available for diverse groups on a continuous monthly basis [130]. When procuring menstrual products, considerations should be given to which products are most familiar to local populations, as well as which products can be most easily used, disposed of, or cleaned and dried, in the specific humanitarian context [128, 129]. Menstrual products should be included in dignity kits (Text Box 18), as well as available at health facilities and non-food item distribution points. Cash or vouchers for purchasing individual menstrual products and materials can also be considered [130].
- Design interventions to increase access to information and education on SRHR and MH. This should include a variety of channels to reach diverse population groups, including [128, 129, 189, 192]:
 - Curriculum-based CSE or puberty education in formal education settings;
 - Community-based CSE or puberty education, including peer-led approaches;
 - Interpersonal interventions or small group sessions with specific population groups (e.g., girls, women, people with disabilities, transgender and non-binary, boys, men) to discuss MH and SRHR issues. If such groups already exist to discuss protection-related issues, such as GBV, or other sectoral issues, MH and SRHR information can be incorporated, as appropriate.
 - Social and behaviour change interventions to address harmful cultural or social norms related to menstruation and sexuality;
 - Distribution of information, education and communication (IEC) materials on MH and SRHR [189];
 - Mass media campaigns on MH and SRHR; and
 - Community-based or facility-based health promotion activities.
- Create mechanisms for community involvement in every phase of designing, offering and assessing MH and SRHR services [129, 132].
- Ensure that the MH and SRHR needs of very young adolescents (VYA) (10 – 14 years) are adequately incorporated in assessments, interventions, and monitoring. Approaches to improve SRH during early adolescence in humanitarian settings need to move beyond facility-based care and reach VYAs in places where they feel safe and where they usually congregate. Engaging parents and other trusted adults is also key [131].
- Include MH and SRHR considerations in shelter and WASH infrastructure planning [128, 129]:



- Incorporate considerations about the types of settings that girls, women, and people who menstruate need for changing and disposing of, or cleaning and washing, their menstrual products;
- Ensure latrines have doors that lock, a reliable source of water, and soap;
- Where appropriate for gender, age or cultural reasons, install family and/or gender-segregated partitions to provide privacy;
- Provide internal and area lighting to improve safety and provide flashlights or torches to female household members; and
- Ensure that the disposal mechanisms are discussed and agreed upon with the communities and those who menstruate.

Box 17: Building a menstrual health strategy based on a humanitarian needs assessment in Tanzania

A rapid assessment conducted in refugee camps in Tanzania identified a range of menstruation challenges experienced by girls and women while travelling from the Democratic Republic of Congo and Burundi to Tanzania. This included a lack of menstrual products, poor access to water, and challenges finding safe and private spaces for changing or disposing of materials. A few women expressed extreme embarrassment at blood-stained clothing upon arrival at the border. In response, the health sector led a small pilot project in which health staff were trained on how to interact with menstruating girls and women during routine health screenings sensitively. Girls and women were then provided with a basic menstrual hygiene kit comprising reusables pads, a bucket, underwear, soap, and a clothesline. In addition, WASH actors also worked towards improving existing toilets and washing spaces at the border points, including adding new doors and latches [128].

Box 18: Examples of dignity kits in East and Southern African countries [2]

- In Burundi, IFRC piloted a study on improving MH in emergencies in the Bwagiriza refugee camp and provided “MH kits” with disposable and reusable pads. Women and adolescent girls who received the kits reported health, economic and lifestyle benefits.
- In the Democratic Republic of Congo (DRC), the response included constructing washing facilities, as well as providing “intimate hygiene kits” to vulnerable, displaced women
- In South Sudan, the humanitarian response led by Oxfam included the provision of ‘feminine hygiene kits’ to newly arrived refugees in Gendrass, Jamam and Jamam transit camps. The kits included new clothes, and women were supported to reuse old clothes to make MH products.
- In Uganda, UNFPA provided dignity kits, including menstrual pads, to South Sudanese and Congolese refugees.

Data and Measurement

General recommendation:

Invest in high-quality research, monitoring, evaluation and learning, including standardized measures, and utilise data to inform MH and SRH policies and programmes.

A common conclusion in MH literature is the lack of rigorous empirical data to better understand the determinants of health, the impact of specific intervention packages and the cost-effectiveness of various interventions.

There remain a number of priority research questions that should be explored through rigorous and comparable methods to develop a more robust evidence-base (Text Box 19). Several high-quality studies to address some of these gaps are currently underway. The literature also highlights the following recommendations to improve data and measurement strategies:

Guidance for Action

- Develop standardized definitions of outcomes and indicators for MH through cross-sectoral collaboration to guide research, monitoring and evaluation efforts at the global, regional, and national levels [139, 144]. Involve girls, women and people who menstruate from LMICs in the consultative processes to establish these definitions [2, 193].
- Include indicators and targets related to MH in accountability frameworks for women’s empowerment, SRHR and adolescent health [14, 193].
- Design and conduct joint research initiatives with gender, WASH and SRHR experts to gain a better understanding of the social, cultural and gender norms that affect SRHR and MH, and how these norms intersect with structural and systemic inequalities [14, 24].
- Design integrated MH and SRHR interventions and strategies based on clear and measurable theories of change. Invest in quality research and operational learning to test the assumptions of these theories of change, as well as identify mediators and moderators of effect [135, 193].

Priority Research Questions

The literature review conducted as part of the preparation of this technical brief identified several gaps in the evidence base related to MH and SRHR integration. The following research questions warrant further investigation, especially within LMICs.

Box 19: Priority research questions

- How do integrated MH and SRHR interventions compare to non-integrated interventions in terms of sustainability, effectiveness and cost-effectiveness?
- What is the impact of specific 'hardware' and 'software' MH interventions on health, education, empowerment and broader development outcomes?
- What types of interventions are most effective for reaching marginalized groups in LMICs, especially out-of-school adolescents, transgender and non-binary individuals, and people with disabilities, as well as their key influencers, with MH and SRHR information, education and services?
- What types of interventions are most effective for reducing menstrual-related harassment and bullying in- and out-of-school settings in LMICs?
- What types of interventions are most effective for supporting women through the full life cycle with age- and life-stage appropriate MH and SRHR information, education, support and services?
- What is the impact of menstrual stigma and discrimination on workplace participation in LMICs? What interventions are most effective to support girls and women of all ages to manage their menses in the workplace?
- How do girls, women and people who menstruate experience uterine bleeding unrelated to menstruation and what are their specific needs in LMICs?
- What are the most strategic ways to position puberty education vis-à-vis CSE, especially in conservative settings with high resistance to CSE?
- How will girls' self-efficacy in managing menstruation correlate to later decision-making about their bodies (e.g., age at first sex, sex negotiation, condom negotiation and contraception use)?
- What are the most effective interventions to offer integrated MH and SRHR information, education and services at different stages of humanitarian crises?
- What are the specific causal pathways and impacts of negative menstrual experiences on mental health in LMICs?
- What are the specific SRHR needs of perimenopausal and postmenopausal women in LMICs? What barriers do they face to access information, support and health services? What approaches are most effective at reaching women and people who menstruate at this life stage?



CONCLUSION

There is a growing awareness of the many advantages of taking an integrated approach to MH and SRHR. Not only does integration offer opportunities for cost-effectiveness and sustainability by preventing duplication of efforts when it comes to realizing sexual and reproductive health rights for all, it can also achieve the common goal of ensuring the highest attainable standard of health and well-being for all girls, women and people who menstruate.

Going forward, the aim is to build on the rich evidence base on effective SRHR practices, as well as the emerging evidence on what works for MH in diverse settings and with diverse populations to weave together the interconnected components for maximum effectiveness and reach.

The most successful integration programmes are grounded in a context-specific understanding of the bi-directional sociocultural, biological, and human rights linkages between MH and SRHR. This requires effective multisectoral collaboration and coordination with sectors including health, education, WASH, gender, and protection and a firm commitment to leaving no one behind, especially those most at risk.

Further investments are required to develop a robust body of actionable evidence on causal pathways connecting MH with SRHR as well as wider development outcomes including education and gender equality.

Where MH has been included as an essential (as opposed to incidental) component of SRHR efforts, it has been shown to empower girls, women and people who menstruate with the knowledge, skills, support, and services to thrive through the life cycle. MH should therefore be included as an essential component of SRHR efforts nationally, regionally, and globally.



ANNEX 1:

DETAILED METHODOLOGY AND LIMITATIONS

An online desk review was conducted in September 2020 to identify relevant peer-reviewed and grey literature using a two-fold search strategy:

- (1) A search for peer-reviewed literature using online databases (PubMed and Google Scholar) and key terms related to menstruation, menstrual health management and sexual and reproductive health and rights (see table below for key terms); and
- (2) A purposive search of literature produced by members of the African Coalition for Menstrual Health Management (ACMH) and other organizations working in MH.

The following inclusion criteria guided the literature search:

- Type of literature: Published academic literature (including peer-review journal articles, book chapters, etc.), as well as grey literature (including reports, briefs, guidelines, working papers, etc.).
- Focus of literature: Documentation of the process, results and/or impact and evaluation of programmes and policies that have either successfully integrated MH with SRHR or demonstrate promising potential for the integration of MH and SRHR. Documents that examine less successful interventions and the reasons for their limited effectiveness were also considered. Programmes and policies that address all life stages were considered. Description literature examining the bi-directional linkages between determinants and outcomes of MH and SRHR were also included.
- Publication date range: within the past 5 years (since 2015).
- Language: English and French.⁹
- Geographies: Low- and middle-income countries (LMICs), including countries from Africa (specifically East and Southern Africa), Asia, Latin America and the Middle East.
 - Literature from high-income countries was considered when relevant to the SDGs' principle of universality and when examples could be adapted in LMIC contexts; and
 - Specific attention was given to countries in the ESARO region.¹⁰

A total of 160 peer-reviewed articles were included after screening for relevance based on title and abstract, followed by full-text screening. An additional 27 peer-reviewed articles were included through a snowball approach of identifying relevant articles from citation lists. A total of 76 grey publications were included, with a range of formats including technical reports and guidance documents, meeting reports, toolkits, job aids, research reports, project reports and discussion papers.

The following limitations are noted:

There is little empirical evidence about the integration of MH and SRHR and limited empirical evidence on effective MH interventions independent of SRHR. There is also considerable variation in the evidence-base related to MH – both in terms of design, use of methodologies, and academic strength. Therefore, this brief draws largely from descriptive data and posits several hypotheses that have yet to be confirmed by rigorous evaluative data. Literature in languages other than English and French were not included, which means that data from Latin America and other regions where French or English are not dominant languages may be underrepresented.

⁹ These two languages are proposed since they are the International Consultant's working languages

¹⁰ Angola, Botswana, Burundi, Comoros, Democratic Republic of Congo, Eritrea, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, South Africa, South Sudan, Tanzania, Uganda, Zambia, Zimbabwe

Table 3: Key terms used for database search

MH-related search terms	SRHR-related search terms
<ul style="list-style-type: none"> • Menstrual health (menstrual health management) • Menstrual hygiene (Menstrual hygiene management) • Menstrual disorder • Menstruate (menstruation, menstruate, menstruating) • Menses • Menopause • Perimenopause • Menarche • Dysmenorrhea • Amenorrhea • Vaginal bleeding • Uterine bleeding • Water sanitation and hygiene • Menstrual cycle awareness, menstrual cycle tracking 	<ul style="list-style-type: none"> • Sexual health (sexual and reproductive health services, Sexual and reproductive health information) • Reproductive health (reproductive health services, reproductive health education) • Sexuality education • Sex education • Life skills education • Sexuality • Family planning • Contraception (contraceptive) • Maternal health • Antenatal care • Post-partum care • Fistula (obstetric fistula) • Abortion • Post-abortion care • HIV (HIV prevention education) • AIDS • Sexually transmitted infections (STI) and sexually transmitted diseases (STDs) • Reproductive tract infections • Urogenital tract infections • Cervical cancer • HPV • Pelvic inflammatory disease • Sexual violence • Gender-based violence • Female genital cutting/ mutilation • Child marriage • Early marriage • Forced marriage • Pleasure



ANNEX 2:

KEY TECHNICAL GUIDANCE RESOURCES

TITLE, AUTHOR, DATE	DESCRIPTION
MENSTRUAL HEALTH AND SRHR INTEGRATION	
<p>A shared agenda: Exploring links between water, sanitation, hygiene, and sexual and reproductive health and rights in sustainable development</p> <p>2019 Hugget, C., Zielinski, D., Nee, M. WaterAid, IWHC, MSI, Simavi</p>	<p>Explores the links between WASH and SRHR in comprehensive and integrated policy and programming in low- and middle-income countries. The paper seeks to:</p> <ol style="list-style-type: none"> 1. Examine the critical role of WASH in a broad, inclusive, and human rights-based definition of comprehensive and integrated SRHR. 2. Demonstrate how combined efforts in SRHR and WASH will improve outcomes in health, equality and attainment of human rights. 3. Identify the opportunities and entry points for WASH and SRHR actors to collaboratively drive greater action across sectors at the national, regional, and global levels. <p>This paper also looks at ways that joint action can improve health outcomes and contribute to gender equality, explore where an SRHR lens can prioritize WASH investments where it is needed most, and examine where SRHR initiatives can be integrated into WASH-led efforts.</p>
<p>Technical brief for the Integration of Menstrual Health in SRHR</p> <p>2019 Hekster, O. and Punzi, M. PSI</p>	<p>A 10-page technical brief for integrating menstrual health in existing SRHR programmes based on the work of PSI's network members. The brief includes a summary of evidence on linkages between menstrual health and SRHR, lessons learned from PSI's local network members, and tips on integrating menstrual health into existing SRHR programmes.</p>
<p>First East and Southern Africa Regional Symposium: Improving Menstrual Health Management for Adolescent Girls and Women</p> <p>2018 UNFPA ESARO</p>	<p>Report from the first East and Southern African Symposium on Menstrual Health Management, held from 28 to 29 May 2018 in Johannesburg, South Africa, co-hosted by UNFPA East and Southern Africa Regional Office and the Department of Women in the Presidency of the Republic of South Africa. The report synthesizes the symposium's presentations and discussions and includes the Call to Action developed during the symposium.</p>
<p>The Intersections between Menstrual Health and Reproductive Health: An Annotated Bibliography</p> <p>2018 McMahon, S. and Wilson, L. FHI360</p>	<p>An annotated bibliography that presents sources of evidence on potential synergies to advocate for the inclusion of menstrual health within an expanded definition of reproductive health. It was prepared with an intended audience of professionals in the reproductive health field. It includes a background section with resources that provide an overview of menstrual health, detailing the literature on menstrual hygiene management and related challenges as well as interventions focused on ameliorating these issues. The remainder of the articles and reports provide information on the potential linkages and intersections of menstrual and reproductive health to highlight existing evidence and opportunities for integrated services.</p>
<p>Menstrual Health Management in East and Southern Africa: a Review Paper</p> <p>2017 Tellier, S. and Hyttel, M. UNFPA ESARO</p>	<p>A literature review was commissioned by the UNFPA East and Southern Africa Regional Office (ESARO). It is intended to form the basis for a situational analysis of the current state of menstrual health management in East and Southern Africa (ESA) to guide UNFPA ESARO in the development of a strategic and holistic approach to MHM, including its approach to humanitarian situations, within its corporate strategic goals and principles. The review explores the impact of inadequate menstrual health management, enablers and barriers for menstrual health management, MHM in humanitarian contexts, and concludes with a set of recommendations.</p>

TITLE, AUTHOR, DATE	DESCRIPTION
<p>Guidance for Monitoring Menstrual Health and Hygiene</p> <p>2020 UNICEF</p>	<p>The purpose of this guide is to support the development and/or improvement of MHH monitoring, by highlighting basic principles (including ethical considerations) and example questions to monitor the various elements of MHH. The questions and the wider guidance are not intended to be comprehensive or prescriptive; rather, they represent practical suggestions for monitoring MHH, based on sector experiences and the best available information at the time of publication. This guidance can be used to inform the development of indicators and the design of data collection tools, including routine administrative reporting formats and occasional surveys to monitor MHH at institutions (e.g., schools, health care facilities, workplaces) or households.</p>
<p>A Blood Problem: Period poverty, why we need to end it and how to do it</p> <p>2020 Kulczyk Foundation</p>	<p>The first-ever report on effective funding recommendations to address period poverty. The report presents a review of the current state of funding and solutions in 2020 to ending period poverty. It showcases the eight most cost-effective organizations to implement a range of interventions with built-in monitoring and evaluation activities. The report underlines the necessity to focus on high-impact programmes that are scalable and fill the evidence-gap by rigorously collecting data.</p>
<p>Guidance on Menstrual Health and Hygiene</p> <p>2019 UNICEF</p>	<p>A guidance document to help design, implement, monitor, and evaluate menstrual health and hygiene programmes. It was developed primarily for UNICEF WASH, education, health, and gender specialists or focal points in country offices who are working with their partners to develop programmes related to menstrual health and hygiene (MHH). It focuses on the process of designing and supporting programmes from the vantage point of UNICEF, rather than detailed technical notes and descriptions of menstrual health and hygiene programmes. Content includes an overview of the global opportunity to work on MHH; programme design; a core package of MHH interventions; MHH for girls and women in vulnerable situations; and learning, monitoring, reporting and evaluation.</p>
<p>Understanding Menstrual Hygiene Management and Human Rights</p> <p>2017 Human Rights Watch</p>	<p>This document sets out how the biological fact of menstruation, the necessity of managing menstruation, and society's response to both is linked with women's and girls' human rights and gender equality. It explains the bi-directional relationship between menstruation and human rights. It is primarily intended for practitioners, both at country level and internationally, who work directly or indirectly on menstrual hygiene management (MHM). It aims to support them and to explain the human rights framework relevant to MHM.</p>
<p>An Opportunity to Address Menstrual Health and Gender Equity: A Global Menstrual Health Landscape Analysis</p> <p>2016 Geertz, A., et al. FSG</p>	<p>This overview report includes a description of the evidence base on menstrual health challenges and outcomes, the response to these challenges, and opportunities for future programmes and innovation. The report addresses the response from multiple sectors including sexual and reproductive health; water, sanitation, and hygiene; and education. Within the sexual and reproductive health sector, there is an increasing focus on using puberty as an entry point for reproductive health education. Comprehensive programmes that address puberty education and menstrual hygiene are mentioned as "bright spots" in the field. In the conclusion, the authors describe four cross-cutting opportunities to ameliorate menstrual health challenges. These opportunities include: using menstruation as an entry point for other services, encouraging collaboration across menstrual health actors, tackling social norms surrounding puberty, and catalyzing market development.</p>

TITLE, AUTHOR, DATE	DESCRIPTION
<p>Save the Children Operational Guidelines on MHM</p> <p>2016 <i>Save the Children</i></p>	<p>This document aims to provide in-depth programme guidance, using the Focusing Resources on Effective School Health (FRESH) framework and Save the Children’s Common Approach to Programming, so that school health practitioners can incorporate Menstrual Health Management into their programmes. The Guidelines consist of three written chapters with corresponding appendices that provide explicit and comprehensive guidance on conducting an MHM Situation Analysis, designing a MHM programme and monitoring and evaluating an MHM programme. The MHM Guidelines also contain planning and implementation documents and tools that are not easily accessible online, or were developed through the piloting of these guidelines, including template budgets, Knowledge, Attitude and Practice (KAP) survey questions, as well as qualitative research tools.</p>
<p>Supporting the Rights of Girls and Women through Menstrual Hygiene Management (MHM) in the East Asia and Pacific Region: Good Practice Guidance Note</p> <p>2016 <i>House, S., et al.</i> <i>UNICEF</i></p>	<p>This Good Practice Guidance Note provides an overview of good practices that contribute to ensuring an MHM-supportive environment; whether at school, at work, in the household and the community, or during a humanitarian emergency. The Guidance note was developed primarily for the East Asia and Pacific context. It includes sections on: an introduction to MHM in East Asia and the Pacific; why MHM is important; overview of good practice for MHM-supportive environment; MHM-supportive enabling environment; research, learning, monitoring and evaluation; teaching and learning materials and methods for MHM; sanitary protection material options; MH-supportive schools, workplaces, and other institutions; MHM-supportive school: integrating MHM into the curriculum; integrating MHM into community work, youth work and health services; MHM for girls and women in special circumstances or from minority groups; MHM-supportive environment in emergencies; useful resources.</p>
<p>Menstrual hygiene matters: A resource for improving menstrual hygiene around the world</p> <p><i>and</i></p> <p>Menstrual Hygiene Matters: Training Guide for Practitioners</p> <p>2012 <i>House, S., Mahon, T., Cavill, S.</i> <i>SHARE and WaterAid</i></p>	<p>The main purpose of this resource is to provide a comprehensive resource on menstrual hygiene that supports the development of context-specific information for improving practises for women and girls in lower- and middle-income countries. This resource brings together examples of good menstrual hygiene practice from around the world, related to policies, strategies, programmes, and interventions, so that knowledge can be shared and adapted to different contexts. It provides guidance on building the competence and confidence of WASH and other sector staff to start engaging in menstrual hygiene and break the silence surrounding the issue. It encourages increased engagement in advocacy on menstrual hygiene and encouraging relevant sectors to collaborate for effective advocacy and implementation. The resource includes modules and toolkits on: the basics of menstrual hygiene; getting started on menstrual hygiene; sanitary protection materials and disposal; working with communities on menstrual hygiene; working with schools on menstrual hygiene; working in emergencies on menstrual hygiene; supporting girls and women in vulnerable, marginalized, or special circumstances; menstruation hygiene in the workplace; and research, monitoring and advocacy.</p>

TITLE, AUTHOR, DATE	DESCRIPTION
SEXUAL AND REPRODUCTIVE HEALTH TECHNICAL GUIDANCE	
<p>Accelerate progress — sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission</p> <p>2018 Starrs, A.M. et al.</p>	<p>Sexual and reproductive health and rights (SRHR) are essential for sustainable development because of their links to gender equality and women’s well-being, their impact on maternal, newborn, child, and adolescent health, and their roles in shaping future economic development and environmental sustainability. Yet progress towards fulfilling SRHR for all has been stymied because of weak political commitment, inadequate resources, persistent discrimination against women and girls, and an unwillingness to address issues related to sexuality openly and comprehensively. As a result, almost all the 4.3 billion people of reproductive age worldwide will have inadequate sexual and reproductive health services over the course of their lives.</p> <p>To address this unfinished agenda, this 2018 Guttmacher-Lancet Commission proposes a new, comprehensive definition of sexual and reproductive health and rights, an associated essential package of health services, and outlines actions needed beyond the health sector to change social norms, laws, and policies to uphold human rights. Not only are the necessary investments modest and affordable for most low-income and middle-income countries, the benefits of investing in sexual and reproductive health services pay dividends over many years, making it easier to achieve other development goals.</p>
COMPREHENSIVE SEXUALITY EDUCATION AND PUBERTY EDUCATION TECHNICAL GUIDANCE	
<p>International technical guidance on sexuality education: an evidence-informed approach</p> <p>2018 UNESCO</p>	<p>The Guidance was developed to assist education, health and other relevant authorities in the development and implementation of school-based and out-of-school comprehensive sexuality education programmes and materials. The Guidance is also useful for anyone involved in the design, delivery, and evaluation of sexuality education programmes both in and out of school, including stakeholders working on quality education, sexual and reproductive health (SRH), adolescent health and/or gender equality, among other issues. The Guidance emphasizes the need for programmes that are informed by evidence, adapted to the local context, and logically designed to measure and address factors such as beliefs, values, attitudes, and skills which, in turn, may affect health and well-being in relation to sexuality.</p> <p>The Guidance comprises seven sections. The first four sections provide the definition and rationale for CSE, together with the updated evidence base. The fifth section presents the key concepts and topics, together with learning objectives sequenced by age group. The final two sections provide guidance on building support for CSE and recommendations for delivering effective programmes. This comprehensive package, taken as a whole, constitutes the recommended set of topics, as well as guidance on delivery, for effective CSE. These global benchmarks can and should be adapted to local contexts to ensure relevance, provide ideas for how to monitor the content being taught, and assess progress towards the teaching and learning objectives.</p>
<p>Puberty Education & Menstrual Hygiene Management</p> <p>2014 UNESCO</p>	<p>This guidance document describes good policies and practices around puberty education and menstrual hygiene management (MHM). It encourages a holistic approach to health promotion, starting with education, creation of healthy environments, and linkages to health services. For this volume, puberty education refers to the teaching and learning about physical and psychosocial maturation within the cultural context of the learning community. The guidance document puts forth a vision of puberty education that is skills-based, inclusive and comprehensive. It is part of a comprehensive sexuality education curriculum, which forms part of a larger health curriculum, which in turn is an integral part of a comprehensive school health approach. The guidance document touches on a range of issues to help the education sector address puberty education and menstrual hygiene management systematically and effectively. Examples of good practices are provided concerning curricula content and delivery, community and parental involvement, policy development, advocacy, and teacher training. Sustainability, which includes quality, coverage, and partnerships, is similarly covered.</p>

TITLE, AUTHOR, DATE	DESCRIPTION
<p>Adolescent Sexual and Reproductive Health (ASRH) Toolkit for Humanitarian Settings: 2020 Edition</p> <p>2020 Inter-Agency Working Group on Reproductive Health in Crises</p>	<p>The Toolkit's vision is for all adolescents to exercise making informed and autonomous decisions about their sexual and reproductive health (SRH), have their SRH rights guaranteed, and be able to reach their full potential – no matter what circumstances they are living in. This Toolkit provides strategies and tools to help close the SRH service provision gap for adolescents by building upon the advocacy endeavours and lessons learned from the past decade to advance SRH prioritization for adolescents in humanitarian contexts. The Toolkit does not promote a one-size-fits-all approach; instead, it calls on humanitarians to prioritize life-saving SRH services throughout the entire programme cycle and humanitarian continuum – not only during the crisis phase, but also before its onset, during the recovery, and beyond, toward long-term development.</p>
<p>WHO recommendations on adolescent sexual and reproductive health and rights</p> <p>2018 WHO</p>	<p>This document provides an overview of sexual and reproductive health and rights issues that may be important for the human rights, health, and well-being of adolescents (aged 10–19 years) and the relevant World Health Organization (WHO) guidelines on how to address them in an easily accessible, user-friendly format. The document serves as a gateway to the rich body of WHO guidelines, and as a handy resource to inform advocacy, policy and programme/project design and research. It aims to support the implementation of the Global Strategy for Women's, Children's, and Adolescents' Health 2016–2030, and is aligned with the WHO Global Accelerated Action for the Health of Adolescents (AA-HA!) as well as the WHO Operational Framework on Sexual Health and Its Linkages to Reproductive Health. This document is intended to be used by policy-makers and decision-makers in ministries of health responsible for ASRHR policies and programmes, international and national non-governmental organizations carrying out ASRHR projects, and international organizations that provide technical or financial support for ASRHR work. The document is intended to be accessible to people with or without expertise in ASRHR. It is not intended as a technical reference for frontline professionals such as health-care providers, teachers, or community development professionals.</p> <p>The document compiles WHO recommendations on the following: CSE provision, contraception counselling and provision, antenatal, intrapartum, and postnatal care, safe abortion care, STIs prevention and care, HIV prevention and care, violence against women and girls' prevention, support and care, and harmful traditional practices.</p>
<p>Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to Support Country Implementation</p> <p>2017 WHO</p>	<p>The AA-HA! guidance aims to assist governments in deciding what they plan to do – and how they plan to do it – as they respond to the health needs of adolescents in their countries. It is intended as a reference document for national-level policy-makers and programme managers to assist them in planning, implementing, monitoring and evaluation of adolescent health programmes. After a brief introduction that summarizes the main arguments for investing in adolescent health, the document details the key steps from understanding the country's epidemiological profile, to undertaking a landscape analysis to clarify what is already being done and by whom, to conducting a consultative process for setting priorities, to planning, implementing, monitoring, and evaluating national adolescent health programmes, and ends with key research priorities. It provides case studies to illustrate that what is being recommended can be done, and in some cases has already been done.</p>
<p>Technical guidance for prioritizing adolescent health</p> <p>2017 UNFPA</p>	<p>This technical guidance, developed by the UNFPA- and WHO-led Adolescent Working Group of Every Woman Every Child, aims to support countries to both advocate for increased investments in adolescent health and to guide strategic choices and decision-making for such investments to be reflected in national development policies, strategies, or plans. It describes a systematic process for identifying the needs, priorities, and actions for adolescents to survive, thrive and transform their societies as envisioned through the Global Strategy of Every Woman Every Child. Data sources, resources, and tools for conducting a situation assessment and prioritization exercise are also included.</p>

TITLE, AUTHOR, DATE	DESCRIPTION
<p>Our future: A Lancet commission on adolescent health and well-being</p> <p>2016 Patton, G. et al.</p>	<p>The largest generation of adolescents and young people in human history (1.8 billion) demands more attention and action. Adolescents and young adults face unprecedented social, economic, and cultural change. The Lancet is dedicated to creating discussion around this critical topic by publishing the best research to lead to better lives for all. Adolescence is generally thought to be the healthiest time of life, and young people have therefore attracted little interest and too few resources. The 2016 Lancet Commission concluded that investing in adolescents will yield a triple benefit—today, into adulthood, and the next generation of children. The latest Health Policy paper shows that investments in adolescent health and well-being are some of the best that can be made, resulting in a 10-fold economic benefit, and are vital for the progress towards achieving the UN's Sustainable Development Goals. Investments in adolescent health and well-being will not only transform the lives of girls and boys around the world, but will also generate high economic returns, especially in low-income countries. The costs of inaction are too great to ignore.</p>
<p>FAMILY PLANNING AND CONTRACEPTIVE SERVICES TECHNICAL GUIDANCE</p>	
<p>NORMAL Counselling Tool for Menstrual Bleeding Changes (job aid)</p> <p>2019 FHI360 and PSI</p>	<p>This job aid contains guidance for health-care providers to counsel family planning clients on bleeding changes associated with the use of hormonal contraception and the copper intrauterine device (IUD). Fears and misconceptions about menstrual bleeding frequently contribute to discontinuation and non-use of contraception. In addition, although amenorrhea or reduced bleeding can have important non-contraceptive health and lifestyle advantages for women, these potential benefits are often not emphasized in counselling sessions.</p> <p>A review of counselling and training materials commonly used in international family planning programmes found that current materials inadequately address women's concerns about bleeding changes. As a result of the review, FHI 360 co-developed this tool in collaboration with PSI and with funding from the U.S. Agency for International Development.</p>
<p>Family Planning: A Global Handbook for Providers 2018 Edition</p> <p>2018 WHO and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Knowledge for Health Project</p>	<p>This Handbook offers technical information to help health-care providers deliver family planning methods appropriately and effectively. It incorporates and reflects the Medical Eligibility Criteria and the Selected Practice Recommendations as well as other WHO guidance. This third edition brings the Global Handbook up to date with current WHO guidance on all topics covered. A thorough reference guide, the handbook provides specific and practical guidance on 21 family planning methods. It also covers health issues that may arise in the context of family planning services. The intended primary audience for this handbook is health-care providers who offer family planning in resource-limited settings around the world. Health-care managers, supervisors, and policy-makers may also find this book helpful.</p>
<p>Ensuring human rights within contraceptive service delivery: Implementation guide</p> <p>2015 UNFPA and WHO</p>	<p>This implementation guide for ensuring human rights within contraceptive service delivery is a companion document to the WHO guidelines on Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations. This implementation guide sets out core minimum actions that can be taken at different levels of the health system and provides examples of implementation of the recommendations in the WHO guidelines. This guide is addressed to midlevel policymakers and programme managers/implementers involved with family planning service provision in all settings.</p>

TITLE, AUTHOR, DATE	DESCRIPTION
<p>Quality of care in contraceptive information and services, based on human rights standards: A checklist for health-care providers</p> <p>2015 WHO</p>	<p>International and regional human rights treaties, national constitutions and laws provide guarantees specifically relating to access to contraceptive information, commodities, and services. In addition, over the past few decades, international, regional, and national legislative and human rights bodies have increasingly applied human rights to contraceptive information and services.</p> <p>This document presents a user-friendly checklist specifically aimed at primary health-care providers involved in the direct provision of contraceptive information and services. It is complementary to WHO guidelines on Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations, and the Implementation Guide published jointly with UNFPA in 2015. This checklist also builds on the WHO vision document on Standards for Improving Quality of Care for Maternal and Newborn Care and its ongoing work under the Quality, Equity and Dignity initiative. The checklist should be read along with other guidance from WHO and from partners.</p>
<h2 style="text-align: center; background-color: #0070C0; color: white; padding: 5px;">HIV PREVENTION, TREATMENT AND CARE TECHNICAL GUIDANCE</h2>	
<p>Menstrual health and HIV</p> <p>2019 Webb, R. aidsmap</p>	<p>This web page, part of aidsmap, contains a summary of a set of questions and evidence-based answers on the relationship between menstrual health and HIV. Key points include:</p> <ul style="list-style-type: none"> • Women living with long-term HIV may be more likely to have missed periods, but this is not a symptom of recent HIV infection. • Menstrual blood touching intact skin poses no HIV transmission risk. • Some hormonal contraceptives can be used to suppress periods, but women living with HIV need to take their HIV treatment into account when choosing a contraceptive.
<p>Consolidated guideline on sexual and reproductive health and rights of women living with HIV</p> <p>2017 WHO</p>	<p>This guideline is meant to help countries to more effectively and efficiently plan, develop and monitor programmes and services that promote gender equality and human rights and hence are more acceptable and appropriate for women living with HIV, taking into account the national and local epidemiological context. It discusses implementation issues that health interventions and service delivery must address to achieve gender equality and support human rights.</p> <p>This guideline aims to provide:</p> <ul style="list-style-type: none"> • Evidence-based recommendations for the SRHR of women living with HIV in all of their diversity, with a particular focus on settings where the health system has limited capacity and resources; and • Good practice statements on key operational and service delivery issues that need to be addressed to (i) increase access to, uptake of, and the quality of outcomes of sexual reproductive health (SRH) services, (ii) improve human rights and (iii) promote gender equality for women living with HIV.

TITLE, AUTHOR, DATE	DESCRIPTION
GENDER-BASED VIOLENCE TECHNICAL GUIDANCE	
<p>Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Water, Sanitation and Hygiene</p> <p>2015 Global Protection Cluster, IASC</p>	<p>This Thematic Area Guide (TAG) is excerpted from the comprehensive Inter-Agency Standing Committee Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience, and aiding recovery (IASC, 2015). The purpose of this TAG is to assist water, sanitation, and hygiene (WASH) actors and communities affected by armed conflict, natural disasters and other humanitarian emergencies to coordinate, plan, implement, monitor, and evaluate essential actions for the prevention and mitigation of gender-based violence (GBV) across the WASH sector.</p> <p>Part One introduces this TAG, presents an overview of GBV and provides an explanation for why GBV is a protection concern for all WASH actors. Part Two provides a background to and summarizes the structure of the WASH guidance in Part Three. It also introduces the guiding principles and approaches that are the foundation for all planning and implementation of GBV-related programming. Part Three provides specific guidance for the WASH sector to implement programming that addresses the risk of GBV.</p>
<p>Violence, Gender & WASH: A Practitioner's Toolkit - Making water, sanitation and hygiene safer through improved programming and services</p> <p>2014 House, S., Ferron, S., Sommer, M., Cavill, S. Share</p>	<p>This toolkit has been developed in response to an acknowledgement that although the lack of access to appropriate water, sanitation, and hygiene services (WASH) is not the root cause of violence, it can lead to increased vulnerabilities to violence of varying forms. Incidences have been reported from a wide range of contexts, often anecdotally but with regular occurrence, with several targeted studies confirming the same.</p> <p>By recognizing both the risks of violence associated with WASH and the potential benefits of WASH, this toolkit aims to shine a light on this problem and encourage practitioners to recognize their capacity to make WASH safer and more effective. Effectively considering gender in the process of establishing sustainable WASH services can also contribute to the process of longer-term change in attitudes and relationships between men and women. This in turn can contribute to a transformative process that can help reduce vulnerabilities to violence. However, for WASH actors, particularly for those working in the longer-term developmental contexts, there has been a lack of clarity on the practical steps that can be taken so that they can contribute to reducing vulnerabilities through improved policy and programming. This toolkit aims to fill this gap.</p>
MENSTRUAL HEALTH AND SRHR FOR PEOPLE WITH DISABILITIES TECHNICAL GUIDANCE	
<p>Health Care for Adults with Intellectual and Developmental Disabilities: Toolkit for Primary Care Providers: Women's Gynecological and Reproductive Health</p> <p>2018 The Developmental Disabilities Primary Care Program</p>	<p>This is a subsection of the publication <i>Primary care of adults with intellectual and developmental disabilities: 2018 Canadian consensus</i>. Adults with Intellectual and developmental disabilities (IDD) are a heterogeneous group of patients and have health conditions and factors affecting their health that can vary in kind, manifestation, severity, or complexity from those of others in the community. They require approaches to care and interventions that are adapted to their needs. These guidelines provide advice regarding standards of care. References to clinical tools and other practical resources are incorporated. The approaches to care that are outlined here can be applied to other groups of patients that have impairments in cognitive, communicative, or other adaptive functioning. This section specifically outlines recommendations for women's gynaecological and reproductive health.</p>

TITLE, AUTHOR, DATE	DESCRIPTION
<p>Women and Young Persons with Disabilities: Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights</p> <p>2018 UNFPA and WEI</p>	<p>The purpose of these Guidelines is to provide practical guidance to ensure that GBV and SRHR services give full effect to the rights of women and young persons with disabilities. These Guidelines are grounded in international human rights standards and are the result of extensive consultation with international experts in the areas of disability rights, women's and girl's rights, SRHR services, and GBV services.</p> <p>The recommendations in these Guidelines are aimed at all types of service delivery settings, including low-, middle-, and high-resource settings and humanitarian emergency settings.</p>
<p>Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings: A Toolkit for GBV Practitioners</p> <p>2015 Women's Refugee Commission (WRC) and International Rescue Committee (IRC)</p>	<p>This Toolkit was developed by the Women's Refugee Commission (WRC) and International Rescue Committee (IRC), as one of the outputs of a two-year project entitled <i>Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings</i>. The project was conducted in humanitarian settings in four countries - Ethiopia, Burundi, Jordan, and the Northern Caucasus in the Russian Federation - with the goal of identifying barriers and piloting approaches to disability inclusion in GBV programming in humanitarian settings. Section 1 includes tools for disability inclusion in GBV programme planning; Section 2 includes tools for disability inclusion in GBV programme implementation; and Section 3 includes tools for monitoring and evaluating disability inclusion in GBV programmes</p>

MENSTRUAL HEALTH AND SRHR FOR TRANSGENDER AND NON-BINARY PEOPLE TECHNICAL GUIDANCE

<p>Regional Strategy for HIV and Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations</p> <p>2018 SADC</p>	<p>This Strategy is expected to serve as a guide to Member States in designing and implementing appropriate Sexual and Reproductive Health (SRH) and HIV prevention, treatment and care programmes for key populations focusing on the major issues that need to be addressed at policy, legal, institutional and facility levels.</p> <p>Given the vulnerability of key populations, this strategy seeks to operationalise current global, continental, and regional commitments and address these gaps by providing Member States with a framework to develop specific programming aimed at key populations. The strategy is to be used in conjunction with existing SADC initiatives, including SADC's new strategic framework on the integration of HIV, tuberculosis, sexual and reproductive health, and malaria, as well as existing international and continental initiatives, such as the SDGs and the Catalytic Framework. The strategic framework is not a strategic plan but a guiding framework for SADC Member States. It aims to provide details on how key populations are and remain more vulnerable to HIV than the general population. It further identifies the key barriers they face in accessing HIV and SRH services and identifies steps Member States can take to address these obstacles and thereby lower the vulnerability of key populations to HIV and increase their access HIV and SRH services.</p>
<p>Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations - 2016 update</p> <p>2016 WHO</p>	<p>In this consolidated guidance document, the World Health Organization (WHO) brings together all existing guidance relevant to five key populations - men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people - and updates selected guidance and recommendations. These guidelines aim to: provide a comprehensive package of evidence-based HIV-related recommendations for all key populations; increase awareness of the needs of and issues important to key populations; improve access, coverage, and uptake of effective and acceptable services; and catalyse greater national and global commitment to adequate funding and services. This consolidated guidance addresses the issues and elements for effective HIV service delivery that are common to all key populations as well as those specific to one or more groups.</p>

TITLE, AUTHOR, DATE	DESCRIPTION
<p>Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions</p> <p>2016 UNDP</p>	<p>This tool contains practical advice on implementing HIV and sexually transmitted infection (STI) programmes with transgender people. It is based on recommendations in the “Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations,” published in 2014 by the World Health Organization.</p> <p>Topics covered include community empowerment and human rights, addressing violence, stigma and discrimination and delivering trans-competent services, especially for HIV and STI prevention, diagnosis, treatment, and care. The tool also covers community-led outreach, safe spaces and the use of information and communications technology in programming, and it offers strategies for managing programmes and building the capacity of trans-led organizations. It contains examples of good practices from around the world that can be used to support efforts to plan programmes and services with trans people.</p> <p>The tool is designed for use by public-health officials, managers of HIV and STI programmes, NGOs – including community and civil-society organizations – and health workers. It may also be of interest to international funding agencies, health policy-makers and advocates.</p>

MENSTRUAL HEALTH AND SRHR FOR HUMANITARIAN SETTINGS TECHNICAL GUIDANCE

<p>Adolescent Programming Toolkit: Guidance and Tools for Adolescent Programming and Girls' Empowerment in Crisis Settings</p> <p>2020 Plan International</p>	<p>The Adolescent Programming Toolkit has been designed to support frontline teams to work with and for adolescents in emergencies and protracted crises. The guidance and tools have been developed by Plan International staff working in emergencies and protracted crises based on programme evidence, numerous accounts from adolescents and good practices shared by frontline staff globally. It contains four chapters:</p> <ol style="list-style-type: none"> 1. Why we should invest in adolescents in crisis settings; 2. Theory of Change to support adolescents to learn, lead, decide and thrive in crisis settings; 3. Programmatic Framework, which presents our results framework and key interventions; 4. Step-by-step Guide for programming with and for adolescents in crisis settings, with key considerations for reaching and supporting adolescent girls.
<p>Adolescent Sexual and Reproductive Health in Refugee Situations: a practical guide to launching interventions in public health programmes</p> <p>2019 UNCHR and Save the Children</p>	<p>The goal of this document is to guide UNHCR and partner staff to develop programmes ensuring adolescents' rights to access sexual and reproductive health (SRH) information and services. This practical guide provides information and guidance in the form of Ten Steps on how to effectively launch adolescent sexual and reproductive health (ASRH) interventions in refugee situations. It outlines what steps UNHCR and partner staff, in cooperation with refugee communities and adolescents, can follow to ensure a successful ASRH programme. This guide also presents specific strategies and tools that UNHCR and partners can use to disseminate accurate sexual and reproductive health information to adolescents and improve, provide, as well as track adolescent-friendly health services (AFHS) at service delivery points. Every refugee situation and its population are unique, and it is expected that the strategies within are general enough for adaptation to suit context-specific needs.</p>

TITLE, AUTHOR, DATE	DESCRIPTION
<p>Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings</p> <p>2018 <i>Inter-Agency Working Group on Reproductive Health in Crises</i></p>	<p>The Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM) is the result of a collaborative and consultative process engaging hundreds of representatives from United Nations agencies and non-governmental organizations that make up the Inter-Agency Working Group on Reproductive Health in Crises (IAWG). Based on guidelines issued by normative bodies, particularly those of the World Health Organization, the 2018 IAFM incorporates specific evidence from, or examples about, the application and adaptation of global SRH or human rights standards in humanitarian settings. The 2018 IAFM reflects the wide application of the manual's principles and technical content beyond refugee situations, extending its use into diverse crises, including conflict zones and natural disasters.</p>
<p>A toolkit for Integrating Menstrual Hygiene Management (MHM) into Humanitarian response Sommer, M., Schmitt, M., Clatworthy, D.</p> <p>2017 <i>Columbia University, Mailman School of Public Health and International Rescue Committee</i></p>	<p>This document serves as a more extensive guidance resource and follows the same chapter structure as the mini-guide, providing deeper discussion on each topic, including key assessment questions, case studies from around the world, design considerations, resources for gathering monitoring and feedback, and links to additional resources.</p>



ANNEX 3:

CHECKLIST FOR MH AND SRHR INTEGRATION IN POLICIES AND PROGRAMMES

Creating an enabling policy and legislative environment

General recommendation: Galvanize commitment and political leadership for an integrated approach to MH and SRHR, while fostering cross-sectoral collaboration and sustaining social accountability mechanisms.

For galvanizing commitment:

- Conduct a landscape analysis to assess the extent to which MH and SRHR are incorporated into national and sub-national policies, strategies, and guidelines across sectors – notably education, WASH, gender, SRH, adolescent health and HIV.
- Review or develop strategies, guidelines and protocols that support the integration of MH and SRH at all levels, including within national social safety nets.
- Develop or update policies to support the provision of essential reproductive and MH commodities, including menstrual products and a full range of contraceptive methods.
- Review or develop new laws and legal frameworks to remove import taxes for essential SRH and MH commodities and raw materials.
 - Promote the local production of these commodities. Introduce incentives and flexible for start-ups in this field of work, where appropriate.
- Introduce policies to subsidize the costs of menstrual products, especially for those at highest risk of period poverty. Ensure viable and sustainable fiscal measures to implement these subsidies, as well as safeguard to prevent the distortion of local markets.
- Develop or update policies to ensure that all schools, public health facilities and other public settings are equipped with clean water and safe bathrooms to allow for private, dignified menstruation.
- Advocate for government budgets to include specific lines allocated for integrated MH and SRHR interventions.
- Monitor national and sub-national budget disbursement to assess the extent to which established budget lines are financed and hold governments to account through advocacy.
- Include menstruation-related, age- and sex-disaggregated indicators in national health, social development, and education information systems.
- Incorporate MH and SRHR into universal health coverage plans and schemes

For cross-sectoral collaboration

- Clearly identify a government body to lead national and sub-national MH efforts.
 - Build the capacity of this entity to coordinate across sectors and establish close collaboration with the lead government body for SRHR.
- Develop guidelines on inter-sectoral and inter-ministerial collaboration to ensure reciprocal integration between all involved sectors.
- Create a new technical work group or expand the mandate of an existing technical working group to provide oversight for MH and SRHR in an integrated manner.
 - Ensure that membership includes civil society, non-governmental organizations, research institutions, private partners, and other technical experts in SRHR and across the various domains of MH (including education, WASH, gender, social development, local governments, disaster management, etc.).
- Identify shared goals and targets across sectors with relevance to MH and SRH.
- Develop cross-sectoral platforms, costed plans and budgets to coherently address MH and SRH in an integrated manner.
- Establish a shared understanding of 'menstrual health, (MH)' across all sectors.

For accountability mechanisms

- Ensure the meaningful participation of girls, women and all people who menstruate throughout the life course in all programmes and policy-development related to MH and SRHR.
- Invest in new or strengthened social accountability mechanisms that build local capacity for collective action around MH and SRHR, inclusive of vulnerable and marginalized groups.
- Organize cross-sectoral advocacy initiatives around shared goals for MH and SRHR.
- Produce scorecards or other social accountability tools to assess commitments to MH and SRH integration and their implementation.
- Alternatively, ensure that MH is included in existing or future SRHR accountability tools and scorecards.

Comprehensive sexuality education and puberty education

General recommendation: Ensure all adolescents and young people have access to MH education through puberty education and/or CSE programmes, both in schools and out-of-school. Ensure that all people who menstruate have access to age- and life-stage-appropriate MH information and education throughout the full life course.

Guidance for Action

- Review and revise Ministry of Education, Ministry of Youth, Ministry of Gender, Ministry of Social Welfare, and other related policies to ensure the integration of SRH and MH in puberty education and/or comprehensive sexuality education programmes for all levels of education.
- Review and revise official school-based curricula and out-of-school CSE and puberty education programmes to align with UNESCO and UNFPA's international technical guidance on content areas and characteristics of proven effectiveness, while ensuring content is culturally relevant.
- Ensure that curriculum approaches are gender-transformative, aimed at promoting gender equality, preventing GBV and creating a safe environment for all learners.
- Ensure that curricula promote a positive approach to menstruation and sexuality (see *Guidance for Action in the Comprehensive Sexuality Education section for more details*).
- Address the needs and experiences of diverse young people in curricula (see *Guidance for Action in the Comprehensive Sexuality Education section for more details*).
- Provide educators with sensitization, values clarification, quality pre- and in-service training and continuous professional development opportunities on CSE and puberty education (see *Guidance for Action in the Comprehensive Sexuality Education section for more details*).
- Create didactic tools and/or self-directed learning tools to support the delivery of CSE and puberty education.
- Start CSE and puberty education programmes early, ideally before the onset of puberty.
- Conduct formative research to assess how to position puberty education most strategically vis-à-vis CSE (see *Text Box 6 in the Comprehensive Sexuality Education section for more details*).
- Implement CSE and puberty education as part of multi-component strategies that also include adolescent-responsive health services and community engagement.
- Build community support for CSE and puberty education, including among parents/family members, community leaders, health providers, religious and cultural leaders, and young people themselves.
- Introduce sustainable models of CSE and puberty education in non-formal and community-based settings to reach out-of-school adolescents of both sexes and all genders.
- Consider complementary educational models, including edutainment and digital learning platforms, to reinforce or fill gaps in curriculum-based education.
- Position CSE and puberty education within a life cycle approach to providing accurate and age-appropriate information about menstruation and sexuality throughout different life stages.
- Design specific interventions for life-long learning of adults to increase their own knowledge and understanding of menarche, puberty, and post-adolescence MH related changes, as well as equip them with skills for effective parent-child communication.

Adolescent and youth SRH services and programmes

General Recommendation: Integrate MH as an essential component in adolescent and youth SRHR programmes and in integrated adolescent- and youth-responsive health services.

Guidance for Action

- Develop or update policies to ensure access to quality, integrated and equitable adolescent- and youth-responsive health care, including SRH and MH counselling and services.
- Apply a systems approach to establish adolescent- and youth-responsive health systems, by adapting policies, procedures, and programmes across the entire health system to respond to the diverse SRH and MH needs and preferences of adolescents.
- Employ a variety of channels to reach different groups of adolescents with integrated SRH and MH services and products, including health facilities, schools, community-based service delivery, mobile and household-level outreach, and distribution of self-care methods.
- Design specific strategies to reach very young adolescents (10 – 14 years) with integrated MH and SRH information, counselling and services, in light of the declining age at menarche in LMICs.
- Train and support health-care providers and community health workers to offer adolescent-responsive contraceptive counselling that includes comprehensive information on CIMBCs, framing contraceptive choices around life goals and explaining changes in menstrual bleeding within the context of future fertility desires.
 - Ensure that such counselling is routinely offered as part of antenatal, post-partum, and safe and/or post-abortion care for adolescents.
- Train and support health-care providers on:
 - Adolescent-responsive active management of contraceptive side effects with particular focus on CIMBCs;
 - The therapeutic use of hormonal contraceptives for conditions that often arise during adolescence (e.g. acne,

dysmenorrhea, endometriosis symptoms, or polycystic ovarian syndrome);

- How to offer high-quality adolescent- and youth-responsive antenatal, intrapartum, postnatal, abortion and post-abortion care, including skills for counselling on post-partum and post-abortion bleeding; and
- How to identify signs of mental health problems in adolescents and establish functional referral systems to link facility- and community-based SRH services with mental health and psychological support services [119].
- Include measures to address period poverty in programmes and services for young vulnerable populations.
- Train health-care providers and community health workers to counsel adolescent girls and young women

living with HIV on the increased potential for amenorrhea, contraceptive options, and the importance of dual protection with condoms.

- Ensure adolescents and youth benefit from universal health coverage and national insurance schemes (*See Guidance for Action in the AYSRH services section for more details*).
- Link integrated adolescent- and youth-responsive SRH services with community-based and interpersonal social and behaviour change interventions that include a focus on MH.
 - Orient teachers and other community-based frontline workers on how to refer adolescents and youth to SRH and MH services.

Family planning and contraceptive services

General recommendation: Ensure all reproductive health and contraceptive counselling includes comprehensive information on the menstrual cycle and contraception-induced menstrual bleeding changes.

Guidance for Action

- Improve FP programme designers', programme managers', health-care providers' and frontline workers' understanding of underlying cultural and structural menstrual-related restrictions and stigma that affect contraceptive choice.
- Build competencies for health-care providers and community health workers (CHW) to include information on CIMBCs as part of all contraceptive counselling (*See Guidance for Action in the Family planning and contraceptive services section for more details*).
- Build health-care providers' competencies to:
 - Diagnose, counsel, and treat AUB and dysmenorrhea, including through hormonal contraceptives (*See Guidance for Action in the Family planning and contraceptive services section for more details*);
 - Assess appropriate contraceptive options during perimenopause (*See Guidance for Action in the Family planning and contraceptive services section for more details*).
- Explore how girls, women and people who menstruate respond to CIMBCs as a key issue for contraceptive research and product development.
- Include evidence-based information on CIMBCs in family planning-related communications' campaigns and other social and behaviour change interventions.
- Consider complementing interpersonal communication and in-person counselling with the promotion of digital apps that track the menstrual cycle as tools for empowering girls, women and all people who menstruate with information and skills relevant for MH, fertility, contraception and SRH more broadly.

Reproductive and maternal health care

General Recommendation: Integrate MH as an integral part of reproductive and maternal health care.

Guidance for Action

- Increase investment in programmes to address dysmenorrhea and AUB (*See Guidance for Action in the Reproductive and maternal health care section for more details*).
- Train and support reproductive and maternal health-care workers to screen for, counsel on and offer treatment for menstrual disorders, including dysmenorrhea and the underlying conditions leading to AUB.
- Train and support maternal health-care providers to include discussions on regular post-partum bleeding (lochia) and signs of haemorrhage to empower girls and women to manage post-partum bleeding with confidence.
- Train and support maternal health-care providers to counsel girls and women on variations in the menstrual cycle after pregnancy and during breastfeeding, as well as post-partum contraceptive options as part of antenatal and post-partum counselling.
- Ensure that programmes include an emphasis on how to properly wash and dry menstrual products, and also ensure access to supplies necessary for washing and drying.
- Include provisions for accessible and affordable menstrual products in programmes and services for girls and women with obstetric fistula.

HIV prevention, treatment, and care

General recommendation: Ensure that MH is included as an essential component of HIV prevention, treatment, and care.

Guidance for Action

- Train and support health-care providers and community health workers, where appropriate to:
 - Share accurate information on the menstrual cycle, including the increased likelihood of amenorrhea, when offering HIV counselling and SRH or contraceptive counselling to WLHI;
 - Offer specialised contraceptive counselling for WLWH that includes comprehensive information on CIMBCs and possible drug-drug interaction between certain hormonal contraceptives and ART regimens; and
 - Assess the underlying causes of heavy menstrual bleeding and make referrals to HIV services if necessary, especially in generalised epidemics and when serving key populations.
- Invest in research to better understand the interaction of the menstrual cycle with HIV transmission and integrate findings in HIV prevention strategies, especially in generalised epidemics and among key populations.
- Integrate efforts to dispel myths and address menstrual stigma when rolling out the dapivirine vaginal ring for HIV prevention.
- Design awareness campaigns and social and behaviour change strategies tailored for post-menopausal women to reduce HIV transmission among this population segment, especially in generalised epidemics.
- Create or sustain support groups or adherence clubs for perimenopausal women living with HIV to share options for managing menopausal symptoms, in addition to HIV specific support.
- Train and support HIV health-care providers to help WLHW manage menopause, including considerations for interactions between HAART and hormone therapy.

Gender-based violence programming

General Recommendation: Ensure MH is a crucial component of GBV initiatives, including interventions to eliminate CEFM and FGM.

Guidance for Action

- Develop and enact laws that prohibit menstrual restrictions as part of efforts to strengthen legal and judicial frameworks for addressing GBV.
- Foster collaboration between WASH, SRHR and gender equality sectors to improve the safety of latrines for girls, women and people who menstruate, while also ensuring access to sexual and GBV services.
- Engage communities in behaviour change communication and community-level education across a range of sectors to shift the discriminatory gender norms that lead to menstruation-related social restrictions.
- Include interventions to improve MH in strategies for eliminating school-related GBV (*See Guidance for Action in the Gender-based violence programming section for more details*).
- Increase investments to eliminate CEFM in areas where the age of menarche is low and in settings where menarche is culturally believed to signal readiness for marriage (*See Guidance for Action in the Gender-based violence programming section for more details*).
- Include interventions to improve parent-child communication in primary prevention efforts to reduce CEFM.
- Create linkages between MH initiatives and specialist organizations campaigning and working with girls, women, and communities on FGM.
- Support and train health-care workers to meet the specific MH needs of girls and women who have experienced FGM.

Community engagement

General recommendation: Engage communities to create a supportive environment for MH and SRHR and to shift the gender and social norms that underpin adverse MH and SRHR outcomes.

Guidance for Action

- Involve diverse community members, especially girls, women and people who menstruate, in the design of integrated MH and SRHR programmes through participatory approaches.
- Conduct a mapping or other types of formative research on cultural beliefs and practices related to menstruation, sexuality and SRH to inform policies and programmes.
- Identify cross-sectoral opportunities to create spaces for intergenerational and gender-transformative community dialogue on MH and SRHR.
- Use a variety of community-based channels to share accurate information on MH and SRHR directly with girls, boys, women, men, and people who menstruate including (*See Guidance for Action in the Community engagement section for more details*).

- Ensure that MH information addresses more than biological facts about the menstrual cycle (*See Guidance for Action in the Community engagement section for more details*).
- Design strategies to educate parents and others on MH and SRH, while also equipping them with skills for effective parent-child communication (*See Guidance for Action in the Community engagement section for more details*).
- Include teachers and teachers' unions in community mobilization to promote MH and SRHR, in addition to professional training and support for teachers.
- Engage cultural and religious leaders in MH and SRHR community engagement strategies, providing them with accurate information on both topics.
 - Identify champions among cultural and religious leaders and create spaces for reflection and dialogue on how cultural practices and traditions can be used to support

the right to MH and SRH.

- Design context-specific strategies to ensure that boys and men have access to accurate, rights-based and gender-transformative menstrual and SRH education (*See Guidance for Action in the Community engagement section for more details*).
- Design and implement mass media strategies to raise awareness about MH and SRHR, such as radio, television, newspapers, magazines, books, and the Internet to supplement other sources of information.
- Develop partnerships with menstrual product manufacturers to insert leaflets with accessible MH and SRHR information.



LEAVING NO ONE BEHIND: MH AND SRHR OF PEOPLE IN VULNERABLE SITUATIONS

People with disabilities

General recommendation: Ensure that SRH and MH information, education, services, and programmes meet the specific needs of diverse people with disabilities.

Guidance for Action

- Review existing laws and regulations in collaboration with persons with disabilities to identify current laws and regulations that obstruct access to information and services.
 - Advocate for the revision of laws and regulations to ensure they are responsive to and inclusive of people with disabilities.
- Ensure the meaningful participation of persons with disabilities at all stages of policy and programme development, implementation, and assessment.
- Advocate for and ensure that national accountability mechanisms allow for reporting, monitoring, and redress of violations experienced by people with disabilities, including sexual and reproductive rights violations (*See Guidance for Action in People with disabilities section for more details*).
- Ensure that educational, health, WASH and other public facilities are accessible to people with diverse disabilities.
- Ensure that mainstream services are inclusive of people with disabilities, alongside the creation of services tailored specifically to diverse groups of persons with disabilities (*See Guidance for Action in People with disabilities section for more details*).
- Train and support service providers and caregivers to respect people with disabilities' legal capacity, informed consent, and privacy (*See Guidance for Action in People with disabilities section for more details*).
- Train (pre- and in-service) and support health-care providers and support staff on the rights and needs of people with different types of disabilities, and how to provide accessible and respectful care.
 - Create accompanying job aids to support health-care providers to offer quality care.
- Adapt MH and SRHR health-care procedures and equipment to accommodate the specific needs of people with disabilities.
- Establish effective referral systems and inter-agency coordination to ensure a coherent continuum of accessible and respectful MH and SRHR care for persons with disabilities to meet their multifaceted needs [114].
- Create CSE, puberty education and MH education programmes that respond to the needs of persons with disabilities (*See Guidance for Action in People with disabilities section for more details*).
- Ensure that information and education materials on MH and SRHR are accessible and suited to diverse communication needs, including: braille, large print, audio, digital formats compatible with screen readers, sign language with an interpreter, captioning, simplified formats, pictorial guides, local language interpretation.
- Design interventions to engage caregivers and family members in sensitization and capacity building to better meet the MH and SRHR needs of persons with disabilities.
- Create menstrual products with accompanying appropriate information that responds to the needs of different groups of people with disabilities.
- Ensure that people with disabilities are included in SRHR and MH interventions in humanitarian settings and ensure that dignity kits take the needs of people with disabilities into consideration.
- Invest in evidence-generation and learning about the intersecting MH and SRHR needs of people with disabilities (*See Guidance for Action in People with disabilities section for more details*).

Transgender and non-binary persons

General recommendation: Ensure access to tailored information and trans-competent care that integrates MH and SRH with other key health services, while ensuring safety and confidentiality and tackling stigma and discrimination.

Guidance for Action

- Advocate for legal recognition of transgender and gender non-binary people, particularly to ensure they are afforded with their rights to health, to freedom from violence and freedom from all forms of discrimination.
- Advocate for the implementation of anti-discrimination and protective laws, derived from human rights standards, to eliminate stigma, discrimination, and violence against people from key populations, including transgender and gender non-binary individuals.
- Ensure the meaningful participation of organizations comprised of and serving transgender or gender non-binary people who menstruate in relevant decision-making processes and as partners in programme design and delivery.
- Design and implement a package of interventions to enhance community empowerment among transgender and gender non-binary people (*See Guidance for Action in Transgender and gender non-binary section for more details*).

- Train and support transgender and gender non-binary people as peer educators and counsellors to reach their peers with accurate, non-judgmental information on MH and SRHR.
- Where possible, consult with transgender and gender non-binary people to develop safe and desirable options for menstrual products and WASH facilities, avoiding generalisation by recognising the diversity of transgender and non-binary experiences.
- Design programmes and services with the principle of 'do no harm' and avoid reinforcing stigmatization or exposure to vulnerability through the provision of services (See *Guidance for Action in Transgender and gender non-binary section for more details*).
- Ensure access to justice for transgender and gender non-binary individuals (See *Guidance for Action in Transgender and gender non-binary section for more details*).
- Include MH in an integrated package of care for key populations for HIV (See *Guidance for Action in Transgender and gender non-binary section for more details*).
- Train and support health-care providers to be sensitive and knowledgeable about the specific MH and SRH needs of transgender and gender non-binary people (See *Guidance for Action in Transgender and gender non-binary section for more details*).

Humanitarian settings

General Recommendation: Ensure that appropriate and timely SRH and MH information, education, services, and products are prioritized in all phases and sectors of humanitarian responses.

Guidance for Action

- Strengthen cross-sectoral collaboration for the delivery of integrated SRHR and MH programmes and services (See *Guidance for Action in the Humanitarian settings section for more details*).
- Build partnerships with organizations comprised of or serving people with disabilities; adolescents and people with diverse sexual orientations and gender identities; and other marginalized groups to ensure the needs of vulnerable groups are adequately integrated into SRHR and MH programming and services in humanitarian settings.
- Include MH and SRHR in emergency preparedness strategies (See *Guidance for Action in Humanitarian settings section for more details*).
- Include questions on MH and SRHR in the initial needs assessment conducted at the onset of a crisis and in subsequent needs assessments in later stages of a humanitarian response (See *Guidance for Action in Humanitarian settings section for more details*).
- Include questions on menstruation and SRH in existing health or protection screenings upon arrival at border points, reception centres.
- Train all first responder staff and other service providers on MH and SRHR (See *Guidance for Action in Humanitarian settings section for more details*).
- Provide in-depth training and support for health-care providers on how to adapt clinical and counselling protocols for humanitarian contexts (See *Guidance for Action in Humanitarian settings section for more details*).
- Engage, train, and support lower cadre health workers from refugee or internally displaced populations to provide integrated SRH and MH services, both at health facilities and through community-based services.
- Implement specific outreach strategies to reach groups who are less likely to seek SRHR or MH services at facilities due to stigma and discrimination. These groups can include adolescents, transgender and non-binary individuals, people with disabilities and other people with special needs (See *Guidance for Action in Humanitarian settings section for more details*).
- Ensure an adequate stock of appropriate menstrual products and supplies (including underwear, soap, and washbasins) are available for diverse groups on a continuous monthly basis (See *Guidance for Action in Humanitarian settings section for more details*).
- Design interventions to increase access to information and education on SRH and MH. This should include a variety of channels to reach diverse population groups, (See *Guidance for Action in Humanitarian Settings section for more details*).
- Create mechanisms for community involvement in every phase of designing, offering, and assessing MH and SRH services.
- Ensure that the MH and SRH needs of very young adolescents (10 – 14 years) are adequately incorporated in assessments, interventions, and monitoring.
- Include MH and SRHR considerations in shelter and WASH infrastructure planning (See *Guidance for Action in Humanitarian settings section for more details*).

Data and Measurement

General Recommendation: Invest in high-quality research, monitoring, evaluation and learning, including standardized measures, and utilize data to inform MH and SRH policies and programmes.

Guidance for Action

- Develop standardized definitions of outcomes and indicators for MH through cross-sectoral collaboration, to guide research, monitoring and evaluation efforts at the global, regional, and national levels.
 - Involve girls, women and people who menstruate from LMICs in the consultative processes to establish these definitions.
- Include indicators and targets related to MH in accountability frameworks for women's empowerment, SRHR and adolescent health.
- Design and conduct joint research initiatives with gender, WASH and SRHR experts to gain a better understanding of the social, cultural and gender norms that affect SRHR and MH, and how these norms intersect with structural and systemic inequalities.
- Design integrated MH and SRHR interventions and strategies based on clear and measurable theories of change.
 - Invest in quality research and operational learning to test the assumptions of these theories of change, as well as identify mediators and moderators of effect.



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