Menstrual Hygiene Management

Operational Guidelines

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Acronyms

AD – Adolescent development

ASRH – Adolescent Sexual and Reproductive Health

CASP – Common Approach to Sponsorship-funded Programs

DM&E – Design, Monitoring & Evaluation

ERC – Ethics Review Committee

FGD – Focus Group Discussion

FRESH – Focusing Resources on Effective School Health

IDI – In-Depth Interview

IEC – Information, Education and Communication

IR – Intermediate Result

IRB – Institutional Review Board

KAP – Knowledge, Attitudes and Practices

KII – Key Informant Interview

M&E – Monitoring & Evaluation

MDG – Millennium Development Goals

MEAL – Monitoring, Evaluation, Accountability and Learning

MHM – Menstrual Hygiene Management

MoE – Ministry of Education

MoH – Ministry of HealthNGO – Non-Government Organization

PTA – Parent Teacher Association

SCI – Save the Children International

SHN – School Health & Nutrition

SIP – School Improvement Plans

SMC – School Management Committee

TA – Technical Assistance/Advisor

UNICEF – United Nations International Children's Emergency Fund

WASH – Water, Sanitation and Hygiene

WinS – WASH in Schools

WHO – World Health Organization

Introduction to the Menstrual Hygiene Management (MHM) Operational Guidelines

There is an increase in attention on girls' education by the global development community. As a result, we have seen improved retention and grade promotion for girls in many countries. With this progress, we find ourselves confronting both new challenges and opportunities for girls to achieve an equitable education. Menstrual hygiene management (MHM) is one among several challenges and opportunities – and it is the focus of these guidelines.

Adolescence and puberty is a time of intense physical and emotional change for young people between the ages of 10 and 17. Puberty marks a transition between childhood and adulthood that impacts adolescents' physical, emotional and social wellbeing. Evidence shows that during puberty, adolescents embrace and solidify the gender norms of their society. So the way girls and boys see themselves within their family, community and society can be drastically altered for the rest of their lives.

In some contexts, puberty leads to increased social restrictions for girls and increased social freedom for boys. Many adolescents, especially girls, will experience a severe drop in self-confidence during puberty. All of these factors, and more, contribute to the increased rates of risky social and health-related behaviors that many adolescents practice.

Interventions that target younger adolescents, before these risky behaviors and norms are fully engrained, are more effective at mitigating the behaviors and negative health and education outcomes that ensue. At this critical and extended juncture in their development, we have the opportunity to empower adolescent boys and girls, support girls' transition into secondary school and increase girls' opportunities to learn and thrive into adulthood.

For girls, menarche and menstruation is the physical, highly visible, and at times erratic, marker of this transition. As a result, over the past decade, MHM has gained more attention from researchers and development practitioners. Formative research across the world has shown that girls in low-resource settings face many challenges managing menstruation in school. These challenges have numerous causes but can include inadequate water and sanitation facilities at school, limited access to effective, hygienic materials for menstrual management and inaccurate information about menstruation and the biology of puberty. Research-supported recommendations have been proposed on how to address these challenges; however, the international development community is lacking proven program interventions. Key MHM stakeholders have come to consensus that a clearly defined package of evidence-based interventions is required.

At this stage of MHM evidence building and with more girls in school than ever, we know girls often lack the tangible and social-emotional support that they need during this critical transition. While we are still evaluating MHM interventions, we know that comprehensive education and health approaches are always needed. To fully address MHM in schools, practitioners should consider programming that ensures that girls and boys have access to services, a safe and enabling learning environment, skills-based learning and community and policy support. This document aims to provide in-depth program 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 MHM into their programs.

While MHM is not different from other school health interventions in its requirement of careful planning and collaboration, this topic is sensitive and sometimes stigmatized due to the link between menstruation and sexual and reproductive health. It is our responsibility to design, implement and monitor our program to

respect those sensitivities, as well as reduce the social stigma of menstruation and puberty. To do this, the process often starts by evaluating our own beliefs and biases. In fact, throughout the program cycle steps, staff may encounter a stigma towards MHM. There may also be teachers, parents, students and high-ranking officials with negative beliefs on MHM, or simply inaccurate information. Throughout the program cycle, program staff should take care not to further propagate or reinforce the misinformation along the way.

While this document has been written in the context of school health and nutrition, MHM can be integrated with programs that focus on Water, Sanitation, and Hygiene (WASH) in Schools (WinS), comprehensive sexuality education, gender-based violence, gender empowerment and normalization and other adolescent development programming. MHM interventions should not be implemented in isolation of other programs or of other partners. Research and interventions that aim to change policies and norms should be undertaken in alliance with government, bilateral and Non-Government Organizations (NGO) partners. Making the effort to bring these partners and stakeholders in from the beginning will increase the success and sustainability of MHM interventions.

Development, Structure and Use

The MHM Operational Guidelines (MHM Guidelines) were reviewed and piloted internally by Save the Children and reviewed by external MHM stakeholders. First, Save the Children School Health and Nutrition (SHN) staff wrote each chapter. The chapters were reviewed by senior SHN advisors and MHM researchers for initial feedback. Feedback was incorporated into a second draft, which was piloted by Save the Children Country Offices in Bangladesh, Bolivia, China, El Salvador and the Philippines, with MHM learning activities tested in Kenya.

In the first five countries mentioned, the program teams implemented each chapter of the MHM Guidelines and provided bi-monthly feedback to the SHN U.S. team. Comments were provided regarding the utility of each chapter and the logistical and budget considerations that accompanied the process. Program teams discussed how the guidelines helped them plan and implement, as well as the challenges along the way. Their feedback was integrated into a third draft of the MHM Guidelines, which were then reviewed by 15 people representing seven organizations, as well as four separate teams within Save the Children.

The MHM Guidelines consist of three written chapters with corresponding appendices that provide explicit and comprehensive guidance on conducting an MHM Situation Analysis, designing an MHM program and monitoring and evaluating an MHM program. The chapters are meant to be read and implemented in that order, with each chapter building on the chapter before it; it is strongly advised to read all three chapters prior to beginning any MHM program planning. However, we understand that practitioners may be in varying stages of MHM programming, and if they are not starting a program from scratch, this document can still provide helpful programming tools. We encourage practitioners to take and apply the parts they find most useful to their context and their program.

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. This includes items like template budgets, consultant terms of reference and MHM Knowledge, Attitude and Practice (KAP) survey questions, as well as qualitative research tools. The MHM Guidelines build on previous fundamental MHM efforts, referencing and linking to resources produced by UNICEF, WaterAid, the Joint Monitoring Programme, UNESCO, Emory University and others. Save the Children will provide soft copies of this document to anyone who is interested in using it.

Getting Started: Planning and Financing the development of your MHM Program

Develop a timeline, budget and brief implementation plan for the Situation Analysis, Program Design and M&E planning. Details may shift and evolve over time, but this first part of the program cycle (Situation Analysis to baseline assessment) typically takes 4-6 months. Tools for planning your budget, timeline and consultant requirements are in the Planning & Implementation Resources folder on the flash drive.

Remember to build in time to obtain relevant local and ethical approvals. Local approval from the Ministry of Education, municipal officials and headmasters will be required regardless of whether this is an experimental study or program monitoring; some countries and institutions may require parental consent for minors to participate in activities. Other local and international ethical standards may apply.

Factors to consider for your budget and timeline include:

1. Desk review of relevant reports and research.
2. Design of situation analysis and evaluation
    a. Non-experimental vs. Quasi-experimental vs. Experimental study design
    b. Sampling strategies and participant recruitment.
    c. Tool development
    d. Informed consent and assent
3. Facilitator and enumerator trainings
    a. Staffing
    b. Hiring external consultants or evaluators
4. Data management, monitoring and analysis
5. Feedback to participants and key stakeholders after each program step.

Menstrual Hygiene Management (MHM)
Situation Analysis

Before implementing an MHM program it is important to develop an understanding of the problem, the needs, and influencing factors that could potentially affect your program.

Goal of this step:

Identify the status, problems and needs in the impact (program) area to inform Program Design. Overarching themes to investigate include:

- Existence and availability of school and community WASH infrastructure
- Existence and availability of health services, such as health posts or community health workers, and determine if they facilitate positive knowledge and practices for MHM
- Knowledge, attitudes and beliefs surrounding menstrual hygiene for pre-adolescent girls and boys, adolescent girls and boys, parents, teachers and the community
- Availability and access to hygienic menstrual management materials in school and the community
- Current policies and advocacy efforts surrounding menstrual hygiene

This chapter includes the following sections:

1. Purpose of including MHM as a Part of a SHN Situation Analysis
2. How to Conduct a Situation Analysis in Seven Steps
3. Appendices A - F

What you will need:

- This Menstrual Hygiene Management (MHM) Situation Analysis Module
- The 2010 School Health & Nutrition (SHN) Common Approach to Sponsorship Programming (CASP) module[1] *(Document #1 in the Planning & Implementation Resources folder on the flash drive)*
- The WASH in Schools Empowers Girls' Education: Tools for Assessing Menstrual Hygiene Management in Schools[2] *(located in the Planning & Implementation Resource folder on flash drive)*

The outputs of this step will be:

- A set of adapted MHM tools to collect Situation Analysis data
- A Situation Analysis report that will be used to inform an MHM Program Design
- Sharing results of Situation Analysis with community stakeholders

1. The Purpose of Including MHM as a Part of a SHN Situation Analysis

In nearly every country, an increasing number of girls are attending primary school and then continuing on to secondary school.[3] The global community's successes in primary education has led to a greater focus on addressing barriers to girls' attendance, quality of educational experience and completion of secondary school. Adolescent girls face numerous barriers to continuing their education related to the onset of menses, as many girls receive little to no information concerning puberty, the biology of menstruation or hygienic methods to manage menstruation. As a result, many are uncomfortable, insecure and ashamed to manage their menstruation *(see Appendix C for Menstrual Hygiene, the Basics)*.[4]

At school, girls may face an unsupportive social and physical environment, where there is also insufficient water, sanitation and hygiene (WASH) facilities to properly manage menses or proper student/teacher codes of conduct to protect girls from bullying and teasing. They may also lack access to proper menstrual management materials.[5-10]

When girls experience menstruation without adequate facilities, information or materials to manage their menses at school, they may become distracted and unable to concentrate.[8-17] As a result, girls may stop participating in class, isolate themselves or become socially excluded by peers. Some may even skip school altogether.

To address MHM challenges that inhibit girls' educational experience, we need to create an enabling learning and community environment where girls feel confident to participate in school during their menstrual cycle and are able to keep their dignity intact.

Many of the existing SHN strategies impact MHM and are already a fundamental component of SHN programming. Each Focusing Resources on Effective School Health (FRESH) pillar has key strategies that directly relate to MHM programming *(SHN CASP, p. 50)*. For example, Intermediate Result (IR) Two calls for the improved quality of the school environment. Typical activities for IR Two include provision of appropriate hand-washing facilities, separate child-friendly and sanitary latrines for girls and boys and solid waste and environment management. However, during assessments and program planning, how girls interface with the WASH environment when they menstruate is not fully examined and applied when designing programs. WASH infrastructure is not the only example of MHM and SHN program overlap, but is one component that may help to ensure that girls' and boys' school experiences are more equitable.

A Situation Analysis will help us understand the context, cultural attitudes and traditional practices of puberty, menstruation and MHM in the impact area so that interventions are meaningful and positively impact girls.

2. How to Conduct a Situation Analysis

As stated in the SHN-CASP module, the goal of a Situation Analysis is to "identify problems and needs in the impact area to inform Program Design." Please review pages 17-20 from the SHN-CASP module for information on how to conduct a Situation Analysis. Below we provide information for each step that is specific for the MHM portion of a Situation Analysis. *(More details about each step listed below are included in the appendices and the Planning & Implementation Resources folder on the MHM Operations Guidelines flash drive. Operational limitations may require an abbreviated process to integrate MHM into SHN programs. For critical steps for MHM-SHN integration, see Appendix B: Critical Steps for an Abbreviated MHM-SHN Integration Program Cycle.)*

Step 1: Plan the Logistics of Your Situation Analysis.

Refer to the steps on page 7, Getting Started: Planning and Financing the development of your MHM Program. Ensure that all relevant ethical approvals and protocol are in the pipeline prior to data collection activities.

Step 2: Review the Questions in Appendix D: Key Questions for MHM Situation Analysis.

An MHM Situation Analysis is typically integrated within a larger SHN or Adolescent Development (AD) program, so Key Questions should be pulled from WASH in Schools Empowers Girls Education Tool Kit and from SHN or AD sections of the SHN-CASP module. Secondary and primary data should be collected for the Situation Analysis.

Step 3: Conduct Desk Review.

Though formative research has been conducted in many countries, it may be difficult finding nationally or regionally representative MHM data. You may need to examine studies in your region, or among similar populations (religious, ethnic, etc.). Coordinate with local Non-Government Organizations (NGOs) and agencies to understand what information or studies are underway. Information on WASH, sexual and reproductive health, gender and child protection can also help us make inferences about the potential needs, challenges and sensitivities surrounding MHM *(see Appendix D for more information on secondary data collection and refer to resources listed on page 18 of the SHN-CASP module).*

Step 4: Preparation for Primary Data Collection.

Discussions with various groups and individuals at the local and community level should occur in order to understand the diverse perspectives of MHM. Use qualitative tool guides to conduct focus group discussions (FGD), in-depth interviews (IDIs) and key informant interviews (KIIs). To do this, adapt existing tool guides prior to conducting Situation Analysis activities. Examples of generic tools for girls, boys, parents and school staff are available through the WASH in Schools Empowers Girls Education Tool Kit. Assistance from an SHN or AD Technical Assistance/Advisor (TA), or an expert in this field, is strongly recommended during this stage. Consider contacting other NGOs to identify surveys or tools that have been used in your country and are contextually relevant.

Menstrual hygiene may be a taboo topic in a community. People may hesitate to speak openly about practices and beliefs that are private or that they do not understand well themselves. These challenges can hinder data collection. For this reason, during tool adaptation and MHM training, it is beneficial to include a gender and/or child protection advisor in discussions to provide additional context and to assist in identifying potential challenges discussing MHM with girls and communities. Qualitative data collection and participatory methods are the preferred method when little information is known on a subject. Qualitative methods permit facilitators to ask "which" behaviors exist and "why" people practice them, which are important questions when designing a contextually relevant school health MHM intervention. (For more information on qualitative and quantitative research, see Appendix E.)

Staff may also give a brief two-to-three day training for data collectors and facilitators prior to holding school and community discussions. Training should prepare them to (1) discuss sensitive topics with children and communities; (2) understand and apply research ethics and protocols; (3) present basic information about menstrual hygiene; (4) have all data collectors review tools and consent forms; (5) practice conducting interviews and focus groups (pilot); and (6) collect feedback from research assistants on effectiveness of the tools to engage participants and then adapt the MHM tools based on the feedback.

The main data sources include:

- **FGDs and IDIs:** The main data collection method will be adolescent girl FGDs and IDIs. It is important to discuss the topic with other community members, including mothers, men and boys. What men and boys believe about menstruation is an integral piece of designing an MHM program.
- **KIIs:** Key Informants provide additional access to information and/or populations and are important for building local relationships. KIIs are usually conducted with school staff, community leaders, health extension workers and local government health and education officials.
- **WASH facility observation survey:** If WASH facility observations have already been conducted for a previous project, review findings from the assessment. Then compare the observation survey questions with those in the WASH in Schools Empowers Girls Education Tool Kit and add on MHM-related questions, if necessary. The WASH environment is a critical factor impacting MHM programming. WASH observations should be done for school WASH facilities to assess the functionality, accessibility and condition of facilities to better understand if facilities enable girls to manage menstruation. There may be WASH tools specific to the country – so it is important to check in with the government and/or the UNICEF WASH desk.

Tools should be piloted in one school to ensure that they adequately collect the information required and data collectors can apply their training. Below are key tool adaption and implementation principals:

- **Consider using only female facilitators for all activities with girls, and women and male facilitators for activities with men and boys.**
- **Select facilitators who are experienced interacting with children and are comfortable speaking about sensitive topics.**
- **Include a statement at the beginning of the activity guide that ensures participant privacy and anonymity, as well as explains that all participation is voluntary. See Appendix A.** Explain to participants that they should keep the conversation private and that each participant and facilitator agrees not to reveal the identity of others or what they said with their friends, teachers or parents. Participants should understand that all activities are voluntary. They have the right to withdraw at any time, or simply not answer questions.
- **Use local language and local terminology in the tools.** It is important to ask participants which language they are most comfortable discussing the topic. Facilitators then should be able to speak the local language and move between languages during FGDs. If there are well-known terms for "menstruation" or other body parts, use those words throughout the activity.
- **Ensure that questions and their answers will touch on all four FRESH pillars:** Access, Safe Environment, Skills-based Education and Community Support.

- **Design FGDs and IDI guides to ease into sensitive questions.** Questions should start with general, but relevant, topics that girls and boys can easily discuss, such as favorite classes, school bathrooms, etc. Then questions should progress into the MHM questions. Questions should go from broad, to narrow, to broad again. And the end of the discussion or interview should end on a lighter note. For example:

Introductions:	**"What is your favorite class at school?"**
General:	**"What are the bathrooms like at your school?"**
General MHM:	**"What words do people use to talk about menstruation?"**
Key/Sensitive MHM:	**"How does Rosita feel when she realizes she has stained her uniform?"**
Recommendations:	**"How can parents, teachers and other students help improve schools for girls who are menstruating?"**

To see example FGD and IDI guides for primary data collection, refer to WASH in Schools Empowers Girls Education Tool Kit.

- **If conducting IDIs with minors,** talk to your program manager and TA regarding the best way to protect the privacy of the interviewee during discussions, while abiding by the Child Safeguarding policy. An example solution for one-on-one interviews is to have the adult and child in a location that is visible to others, but where students and adults cannot overhear the conversation.
- **Focus group discussions and interviews should last between 45 and 90 minutes.** Adjust guides so that you are not asking excess questions. In general, FGDs should have between 15 and 20 questions, and IDIs should have between 20 and 25 questions. If FGDs and IDIs are ending in under 45 minutes, likely you are not getting enough in-depth information from participants and you should ensure that the facilitator is adequately engaging and probing on questions. Activities that take longer than 90 minutes may lead to participant fatigue.
- **Make it fun! Think of creative ways to engage girls and boys** – make the FGD a game, include opportunities to brainstorm, write, draw, role play or small group work, etc.
- **Track how well the tools worked.** Decide what questions need to be changed, or adapted, when using the tools for the rest of the Situation Analysis activities. The Example Question Critique Guide (#9 in the Planning & Implementation folder) is an example of what could be used to correct issues with the interview or streamline the tool.

Planning for ethical considerations

- **General ethical considerations**
  - Ensure that the participant or his/her parents provide assent, or consent, to discuss the topic (See Appendix A. for example oral assent script).
  - Conduct the discussion in a private, discrete and safe setting so other people cannot hear.
  - Prior to the discussion, confirm anonymity and that their responses will not be shared with others or impact their grades in any way.

- **Guidance on ethical research conduct**
  - Engage appropriate enumerators/facilitators; female are preferable when discussing MHM.
  - Understand background information on menstruation, its implications for health and education, the social context and best practices for improving MHM.
  - Brainstorm among facilitators and teams to understand potential cultural norms, taboos and the implications for MHM.
  - When forming FGD groups, make participants as similar as possible; always separate male and female participants, keep them in the same age range and from the same communities. Do not mix urban and rural or secondary and primary age participants.
  - Determine whether basic MHM information will be provided after the activity and prepare facilitators to address common MHM questions.

Box 1: Providing information to participants:

At the end of the activity, girls, boys, parents and teachers may be eager for more information on the subject. Program staff can decide to present a short MHM education session to the participants that include the basics of MHM and puberty. They may also develop brief leaflets or pamphlets with basic information and details of where the participants can learn more. Keep in mind that this information may bias Knowledge, Attitudes & Practice (KAP) Surveys and if feasible, should be conducted after the program Baseline.

- **Guidance on discussion about sensitive topics**
  - Ensure that the participant understands that her/his opinion is valued.
  - Use ice breakers and participatory methods (drawing, brainstorming, games and drama) to engage girls and make the activity fun.
  - Do not correct participant's knowledge during the FGD – if you provide MHM education in that session, wait until the end of the discussion.
  - Maintain neutrality – do not react to their comments with negative or positive emotions that may influence their responses.
  - Ensure that the participant knows where to find more information on MHM.

Step 5: Gather Primary Data.

Gather the information you will need to answer the questions you identified in Step 1 from the suggested sources.

Collect Primary Data: If possible, record all discussions, then listen and take notes directly from the recording. If recording is not an option, at least one note taker should accompany each facilitator for each discussion. Note takers can modify the Example Interview Note sheet provided in the Planning & Implementation Resources folder and use it to write down information collected during the interview and debrief session. Immediately after each activity, the facilitator and note taker must debrief and take notes on the major findings of each activity.

A small number of schools and corresponding communities (three to five) per distinct region within an impact area should be selected for primary data collection. Qualitative methods create a large amount of data (one FGD transcript can be 100 pages or 90 minutes of recording), therefore we recommend smaller sampling strategies in this phase of the program cycle (See Appendix F for suggested qualitative sampling).

Box 2 How to select girls for IDI and FGD activities – How do I know if they're menstruating?

1. Ask a trusted female teacher to select 6-8 girls who they think have begun menstruating. If possible, explain this process to the teachers in advance of formal data collection activities.
2. Allow girls to opt out of activities during the consent process. Once the topic is shared with the group, girls will realize whether this a conversation they want to have. Do not insist that girls who have not had their first period should leave, because this may embarrass them; it is likely that girls who are not yet menstruating will self-select out.
3. If a teacher selects a girl for an IDI who has not reached menarche, give her the option to talk to you about what she knows and what she has seen her family or friends experience – but it will likely be a short interview. You may decide to do a second IDI with another girl to ensure you have captured adequate MHM information.

Ask the same questions to multiple stakeholders to triangulate your data (see example below). Change the wording of questions so they are applicable for each type of participant but help you understand various perspectives of the MHM situation. For example, to understand how comprehensively menstrual hygiene is taught, you will want to ask teachers, mothers, fathers, grandparents and students similar questions about knowledge:

Teacher:	"What information is given to girls and boys in school about menstruation?"
Family:	"What do family members teach their children about menstruation at home?"
Child:	"What more would you like to know about menstruation? From whom?"
MoE:	"What menstruation or puberty education is required to be taught in the curriculum?"

Step 6: Analyze the Data and Synthesize Findings in a Report.

The information gathered must be processed and summarized into a report. Reach out to your TA provider to decide what methods are best suited to the context for analyzing the collected information. A suggested outline of a Situation Analysis report can be found on page 49 of the SHN-CASP module. To process the information:

- **Analyze the information**
  - Review all notes and worksheets from interviews and debrief sessions.
  - Listen to recordings and take notes on the key questions established in the tools.
  - Summarize participants' responses and important information gained from recordings, notes and worksheets.
  - When listening to subsequent recordings, notice whether information is repeated in multiple interviews (this is likely a norm) or whether it's new (likely a different perspective or facet of the issue).
  - When reviewing, try to identify key themes of interest and use these themes to review information. These key themes should be included when developing the tools, and tools should be reviewed to make sure they include these key themes.

- **Identify key findings**
  - Examine and seek out contextual information, such as traditional practices and beliefs, which may influence any progra strategy within the four pillars.
  - Highlight examples of positive deviants. Positive deviants are individuals or groups (girls, boys, parents, teachers, schools, etc.) who have overcome MHM challenges. Document the support or systems in place that enable these individuals/groups to practice healthy behaviors or promote MHM. Determine whether your program can mimic those solutions through program strategies.

Box 3: Triangulating data:

Compare information learned from one source to another source as a form of validation and to better understand all facets of a complex situation. Information learned during a FGD with mothers is compared with the information that is collected from a FGD with girls and a FGD from boys. For example, girls may report that they do not to eat certain foods during menstruation, and boys may say they can tell a girl is menstruating because she becomes physically weak. From this finding, a program may address beliefs about menstruation to improve nutrition.

Box 4: Lesson from the Philippines:

Formative research and a Situation Analysis were conducted in the Philippines. Presenting the findings from the Situation Analysis to the communities through town hall meetings was helpful to garner community support. Additionally, it is important to engage male and female SCI staff to present the results; demonstrating MHM can be discussed by both sexes reduces stigma, creates space for men and boys to support MHM and broadens acceptable program solutions in the entire community.

Step 7: Share Findings and Use for Program Design

Sharing MHM findings from the Situation Analysis with stakeholders and partners, and allowing community members to respond and propose program strategies, is an essential contribution to successful Program Design and implementation. After the Situation Analysis is conducted, and prior to the Program Design workshop, the program team should hold validation workshops with community and government stakeholders. This may require two or three small meetings. Share major findings with stakeholders and ask them to prioritize the issues they have heard. Then ask stakeholders for their ideas on how to address the problems. This essential piece of the process elevates children and the community voice, creating buy-in for the program strategies and ownership over the change they want to see in their schools. *(For more information, see page 20 of the SHN-CASP module.)*

Appendix A
Example Oral Assent Script for Focus Group Discussions with Girls

Introduction/Purpose:

Hello, my name is _____, and this is my colleague _____. We work with Save the Children on a project about menstrual hygiene management for girls at schools. You are being asked to participate in a group discussion with several other girls. We would like to talk about experiences girls have when they become teenagers; for instance, how girls deal with their menses at school, what hygiene practices they are aware of and what they know about menstruation. We will talk and do some activities together so that we can hear about girls' experiences, hear your ideas and learn from you. We will use the information that you all share with us today to improve school programs.

Procedures:

Our discussion will last between 45 minutes and two hours. All opinions are important to us. If you agree with others in this room, please share. If you don't agree, please share. There are no right or wrong answers. We are not here to grade your answers. Nobody should feel bad about sharing opinions. I know this is a private topic. If you're not comfortable talking, you do not have to and you can leave at any time.

Language:

We speak _____ languages, so please feel free to use these languages while you communicate with us.

Participation:

Your participation is completely voluntary. Your teachers cannot force you to participate. If you do not like a question you do not have to answer it. You are free to stop at any time. We would like to tape record what you say so that we do not miss anything. We are going to take notes too. I'm going to put the recorder here. If at any time, you feel uncomfortable, tell me and I will press this button and the recorder will be off. Once you have finished saying what you need to say without the microphone on, I will press this button again and resume recording. However, we would like to invite everybody to share what they know and their ideas. Your input is very important because what you say can help us to understand the issues girls face and find good solutions.

Confidentiality:

We will not tell your teachers or parents, or other pupils in the school what you say. We will only share the ideas you have with the people in the project. None of your names will be recorded to assure your privacy. Members of the research team will be the only people that listen to the recording of our conversation. We also ask that each of you keep this conversation private. Please do not share it with others outside the group. We ask you this because if people talk about the discussion afterward, other people outside of this conversation may know what you said and may talk about or tease you. We do not want this to happen. To prevent this, we should keep this private. Are there any questions?

Contact Information

If you have any questions or concerns about this research or the rights of the children, you may contact _____. If you have any questions about your rights as a participant in this research, please contact _____.

Assent: If you would not like to participate, you do not have to say anything. You may excuse yourself from the discussion. If you would like to participate, please stay seated. I will now turn the recorder on. We will go around the room and I will ask you individually if you are willing to participate. If you are willing to participate, once it is your turn, please say 'Yes, I will participate.'

1 This document was adapted from the Philippines Emory – UNICEF research: Haver, J., Caruso, B.A., Ellis, A., Sahin, M., Villasenor, J.M., Andes, K.L. & Freeman, M.C. (November 2013). *WASH in Schools Empowers Girls' Education in Masbate Province and Metro Manila, Philippines: An assessment of menstrual hygiene management in schools.* United Nations Children's Fund. New York.

Appendix B
Critical Steps for an Abbreviated MHM-SHN Integration Program Cycle

The following guidance is a summary of basic steps that program managers can take to integrate MHM into their existing SHN programs. This abbreviated guidance is most useful when significant MHM research has already taken place in your country, or you have minimal resources to conduct an in-depth Situation Analysis but still want to address MHM in your programs.

Below are seven abbreviated steps that we recommend you take to ensure that MHM is adequately addressed within your SHN program. These steps still correspond to the typical Save the Children program cycle. For more information on each step, please go to the corresponding MHM Operational Guidelines Situation Analysis, Program Design and Monitoring and Evaluation chapters.

Situation Analysis

1. Conduct a desk review of MHM peer-reviewed literature, program or NGO reports and policy review to understand MHM in the region. At a minimum, inform the program by investigating:
    a. The cultural norms, practices and beliefs associated with MHM;
    b. The education and health policies regarding MHM or puberty and whether they are implemented;
    c. Other NGOs, agencies or programs working on MHM;
    d. Existing MHM IEC materials and whether they are applicable to the program.
2. Review the FGD and KII guides in the WASH in Schools Empowers Girls Education Tool Kit to understand the type of questions that should be asked to girls, boys, parents and teachers.
    a. Develop/adapt your own guides for school discussions based on the information learned from the desk review.
3. Conduct informal discussions, interviews and observations on MHM at two to three schools:
    a. Discuss MHM with the head teacher and upper primary-level teachers.
    b. Conduct a brief discussion with a group of girl students and a group of boy students (separately). During the discussion, explain why you are talking to them about MHM, ask them to identify challenges with MHM in schools and ensure that you gather their ideas for how MHM can be improved.
    c. Visit the latrines/toilets with girls and boys to identify concerns that students have with using the facilities.
4. Debrief after each school visit and compile the major challenges that arose from girls, boys and teachers, as well as the solutions proposed.

Program Design

5. Discuss challenges and solutions with janitors, teachers, School Management Committee (SMC) and Parent Teacher Association (PTA) to further prioritize activities and place MHM activities on the school improvement plan and budget.

6. Develop and plan for small but achievable MHM activities that the school can manage, such as:

    a. Making inexpensive updates to WASH facilities so that they provide a more enabling environment for girls – e.g., putting locks on the doors, moving trashcans into the latrine blocks, etc.

    b. Creating and enforcing school policies that enable MHM, such as anti-bullying, permission to use latrines when needed and a "no-boy zone" near the girls' latrines.

    c. Conduct teacher trainings so that they are prepared, knowledgeable and comfortable teaching MHM and puberty education, and where appropriate, comprehensive sexuality education.

    d. Integrate MHM and puberty health lessons into school health club lessons.

Monitoring and Evaluation

7. Create MHM program indicators to monitor progress of the MHM activities integrated into the school and continue adjusting MHM within the larger SHN program.

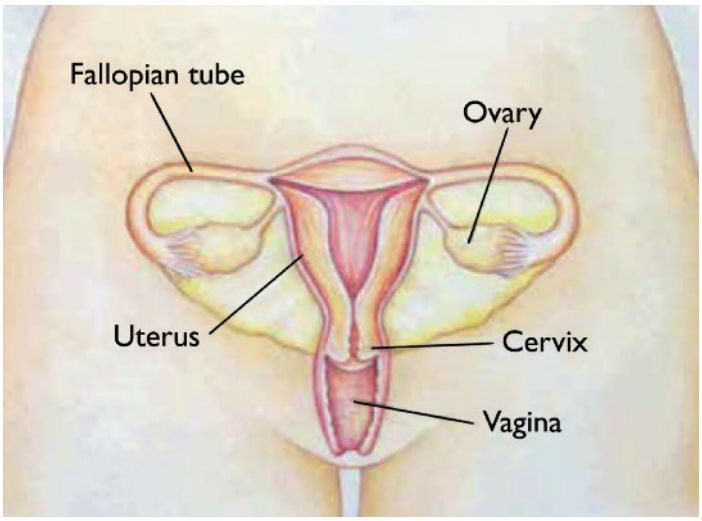
    a. This should also involve including relevant MHM questions in your Knowledge, Attitudes and Practices (KAP) survey and WASH facility observation.

Appendix C
Menstrual Hygiene, the Basics. An Excerpt from WaterAid's *Menstrual Hygiene Matters*[18]

What is menstruation?

Girls start to menstruate (the time of menarche) during puberty or adolescence, typically between the ages of ten and 19. At this time, they experience physical changes (e.g., growing breasts, wider hips and body hair) and emotional changes due to hormones. Menstruation continues until they reach menopause, usually between their late forties and mid-fifties. Menstruation is also sometimes known as "menses" or described as a "menstrual period."

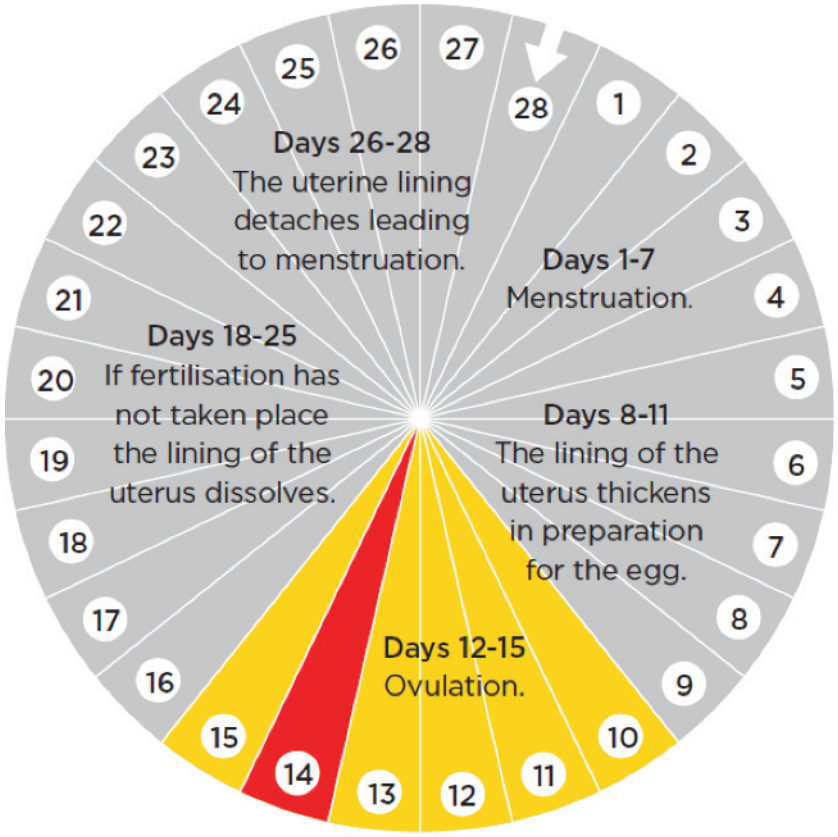
The female reproductive system[19]



Source: Kanyemba (2011)[19]

The menstrual cycle

The menstrual cycle is usually around 28 days but can vary from 21 to 35 days. Each cycle involves the release of an egg (ovulation), which moves into the uterus through the fallopian tubes. Tissue and blood start to line the walls of the uterus for fertilization. If the egg is not fertilized, the lining of the uterus is shed through the vagina along with blood. The bleeding generally lasts between two and seven days, with some lighter flow and some heavier flow days. The cycle is often irregular for the first year or two after menstruation begins.



Source: UNICEF[20]

Premenstrual Syndrome (PMS)

Most women and girls suffer from period pains, such as abdominal cramps, nausea, fatigue, feeling faint, headaches, back ache and general discomfort. They can also experience emotional and psychological changes (e.g., heightened feelings of sadness, irritability or anger) due to changing hormones. This varies from woman to woman and can change significantly over a woman's life. Women and girls may also experience these symptoms during menstruation.

A Natural Process

Menstruation is a natural process linked to the reproductive cycle of women and girls. It is not a sickness, but if not hygienically managed, it can result in health problems, such as yeast infections or urinary tract infections.

Appendix D
Key Questions for MHM Situation Analysis

Note: Guiding Questions from the SHN-CASP module should be tailored to the MHM context in order to help inform the Situation Analysis. The matrix below contains MHM-specific questions to supplement the SHN-CASP questions and ensure a more comprehensive MHM Situation Analysis.

Desk Review

There is a dearth of national-level information on menstrual hygiene. Formative studies have been performed in many countries but often focus on a specific region or population. It is important to reach out to other in-country stakeholders, especially UNICEF and other international NGOs working on WASH and girls empowerment, along with other programs in the country office that may address adolescents, puberty and youth.

Formative studies will often examine the challenges girls face managing menses, as well as the traditional beliefs and practices. Even if there is no research performed in your country or region, it is useful to read reports or papers that focus on populations of a similar region, religion or ethnicity. This desk review may help refine your Situation Analysis tools by providing insight into some of the issues girls and women may face in their community.

- Summaries of MHM research can be found for the countries below from the Proceedings of the 2012 MHM Virtual Conference[21]: Bolivia, Rwanda, Philippines, Sierra Leone, India, Tanzania, Nigeria, Nepal, Malawi, Ethiopia, Somalia, Afghanistan and Pakistan.
- Summary information regarding MHM methods used in various contexts can be found in Proceedings from the 2013 and 2014 MHM Virtual Conference.[22-23]
- Companies that produce feminine hygiene products have market data that may be useful to understanding MHM in your country. Information on menstruation can be found on their websites. Be cautious when reviewing these materials, as the information may be biased and focused on selling products. (See Appendix C and N for basic facts about menstruation.)

Situation Analyses that have been conducted for other programs should be used to find relevant secondary data. The general status of education, health and WASH can shed light on the issues associated with menstrual hygiene and/or education, as well as the needs of girls and the potential MHM strategies required in schools. The following statistics and questions may not be directly tied to menstrual hygiene but are applicable to an MHM Situation Analysis:

Education

- Comparison of attendance, enrollment, attrition and performance rates by sex.
- Average educational attainment and known barriers to continued education.
- Puberty and comprehensive sexuality education requirements in the national and district level curriculum and specific mention of menstruation and menstrual hygiene.
- Country-level evidence of the associations between health and education.
- Gender parity in education (primary and secondary).

Health

- Anemia prevalence, disaggregated by adolescent girls and boys.
- Principal causes of mortality and morbidity among girls and young women.
- Existing national health policies, programs and services on menstrual health and hygiene, puberty and sexual and reproductive health that target youth (aged 10+).
- Age at first birth.
- Contraception use.
- Birth spacing.
- Child marriage prevalence, age at marriage.
- Pregnancy rate, especially among women younger than 18 years.
- Sexually transmitted infection rates, including HIV/AIDs.
- Average age at menarche.
- Traditional sexual and reproductive health or gender-specific practices, such as female genital cutting (FGC), gender-based sexual violence, early marriage, etc.

Water and Sanitation

- The status of WASH in the country (http://www.wssinfo.org, DHS).
- Access to improved sanitation in households.
- Access to water in households for girls to use for menstrual hygiene management and bathing.
- The status of WASH in schools (http://www.washinschoolsmapping.com/projects.html)
- Ministries that are responsible for maintaining WASH in schools.

Please refer to page 21 in the SHN module, page 21 in the BE module and page 16 in the AD module of the CASP manual for specific sources and methods for secondary data.

Appendix E
Qualitative & Quantitative Research; Why, How, Proportions, Frequency, Amounts[24]

	Qualitative Research WHY and HOW	Quantitative Research PROPORTIONS, FREQUENCY, AMOUNTS
Purpose	• Understand reasons, motivations and perspectives. • Understand the meaning of behaviors, events or objects. • Understand cultural norms or the common experience. • Investigate sensitive or not-well studied topics. • Generate hypotheses for later quantitative research.	• To measure the prevalence or incidence of a health issue or phenomenon. • To generalize results from a sample to the population of interest. • To measure the incidence of various views and opinions in a chosen sample.
Population	• Sample population is small and deliberate – identify who is in the best position to answer your questions.	• Sample sizes are large; participants are selected randomly and should represent the study population.
Data Collection	Semi-structured or non-structured techniques, such as: • Focus groups • In-depth interviews • Key informant interviews • Observation Questions are open-ended and can be adjusted throughout the data collection process to gain more information – both in wording and order.	Structured surveys and questionnaire techniques with set questions and pre-determined responses. • Questions are standardized, and a quantitative value or category can be recorded. • All enumerators must ask the same questions using the same language. • Observation.
Considerations	• Pay close attention to the way questions are presented (in accordance to social norms, age, sex).	• Findings are generalizable to larger populations. • Qualitative research may follow quantitative studies to understand the explanation behind a finding.

Source: Hennik et al (2011)[24]

Appendix F
Situation Analysis Community and School Activities

This table explains the types of activities to conduct in a school or community. This table should NOT limit who participates in a Situation Analysis; include relevant stakeholders as needed. Budget, logistics and timing will influence the total number of activities undertaken during a Situation Analysis.

Suggested activities per impact area region		
Activity Type	**No. of activities per region**	**No. of participants per activity**
FGDs		
Girls*	3-5	6-8
Boys	2-3	6-8
Mothers	1-3	6-8
Fathers	1-3	6-8
IDIs		
Girls	2-5	2-5
KIIs		
Doctor/nurse	1-2	1-2
Local community leaders	1-2	1-2
District government officials	1-2	1-2
Headmaster*	3-5	3-5
Teacher*	3-5	3-5
Other		
School WASH Observation*	3-5	3-5

* Indicates that at least one activity should be conducted per school visited; i.e., one teacher from each school should be interviewed, one girl FGD should occur and WASH observations should be conducted at every school visited during the Situation Analysis.

Every school will not necessarily have the same activities. Here's an example schedule of activities conducted per school/community:

Activity	School 1	School 2	School 3	Total
FGDs				**6**
Girls*	X	X	X	3
Boys	X			1
Mothers		X		1
Fathers			X	1
IDIs				**1**
Girls		X		1
KIIs				**9**
Doctor/nurse/community health worker	X			1
Local community leaders			X	1
District government officials			X	1
Headmaster*	X	X	X	3
Teacher*	X	X	X	3
Other				**3**
School WASH Observation*	X	X	X	3
Total = 19 activities				

* Indicates that at least one activity should be conducted per school visited; i.e., one teacher from each school should be interviewed, one girl FGD should occur and WASH observations should be conducted at every school visited during the Situation Analysis.

Menstrual Hygiene Management (MHM)
Program Design

Now that you've gathered information about the MHM needs and context of your impact area, you are ready to begin using that information to design your program. The two central elements to develop your Program Design are creating your results framework and selecting the strategies that best address the gaps you found in your Situation Analysis.

Goals of this step:

- Build MHM into your SHN results framework.
- Involve government and local stakeholders in the planning and execution of programs, as they will be responsible for ensuring that the program is sustainable long after you leave the impact area.
- Choose strategies that will best address the needs you identified in your Situation Analysis and enable the program to achieve the desired results.
- Incorporate MHM into SHN programming.

This chapter includes the following sections:

1. Program Design Process Overview
2. Selecting Program Strategies
3. Integrating MHM into SHN Programming – Goals, Strategies and Special Considerations for Intermediate Results One through Four
4. Appendices G-K

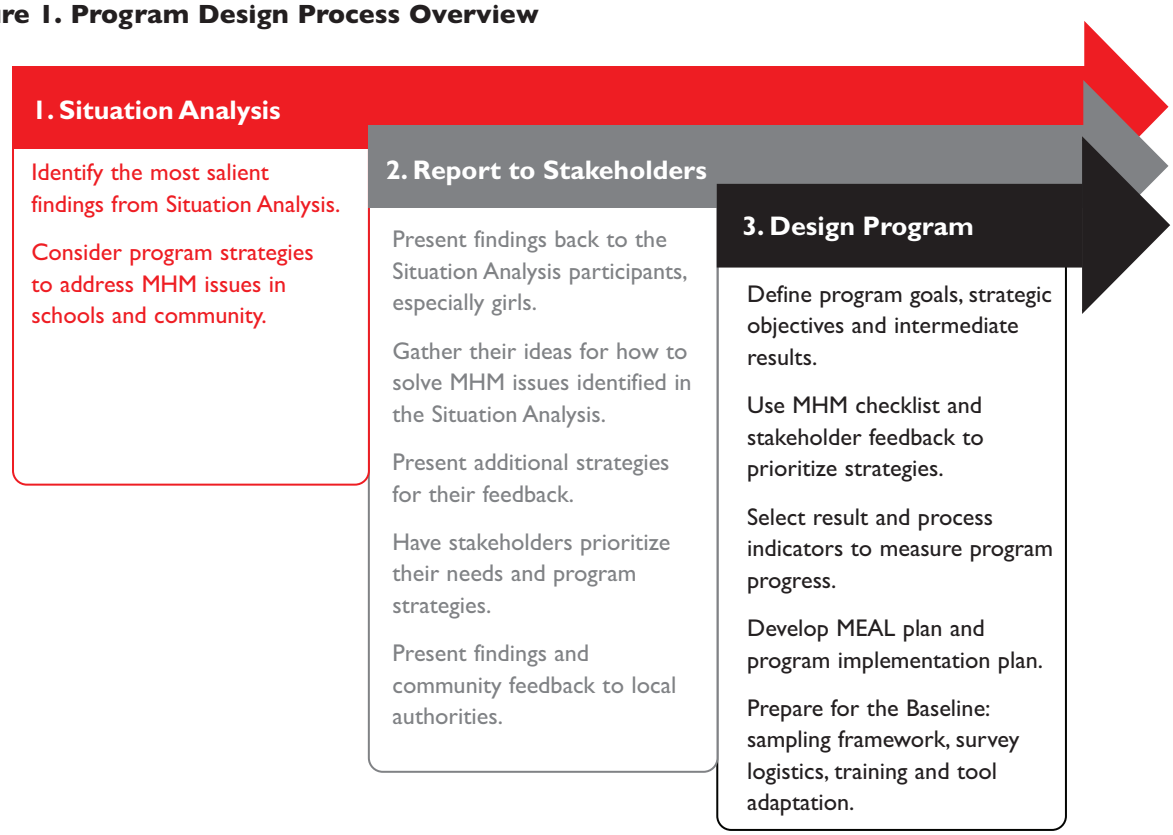
What you will need:

- This MHM Program Design module
- The 2010 School Health & Nutrition Common Approach to Sponsorship Programs (CASP) module *(document #1, Planning & Implementation Resources folder; and located on Savenet and Onenet)*
- The Situation Analysis report
- Completed Intervention Assessment, Appendix I
- Example Results Framework

The outputs of this step will be:

- A Program Design Workshop
- A results framework that includes MHM in the SHN program
- A summary and/or detailed implementation plan and timeline

Figure 1. Program Design Process Overview



Selecting Program Strategies

After a Situation Analysis report is written, but before the program is designed, the most salient findings should be presented back to the schools and community members who participated in FGDs, IDIs and KIIs. During the presentation, gather feedback from participants about the findings and also solicit their ideas for how to solve the issues facing the school and community. You may also want to present some solutions considered by your team to gauge whether girls, boys, teachers and parents agree with the strategy.

If there are more issues than can be addressed immediately, or with the funding available, ask stakeholders to prioritize their needs and the changes they want to see in their schools and among their youth. Determine if there are activities that the school staff, students, parents or others can manage with minimal support from Save the Children.

In collaboration with community members, present these findings, priorities and strategies to local officials. This demonstrates community ownership and a strong voice. You may find that education and health officials are eager to contribute to the program and discuss the sustainability of school changes over time. Partnership with the local government is necessary for long-term program change.

With the Situation Analysis and stakeholder feedback in hand, design the MHM program and develop a results framework. An example of a MHM results framework can be found in Appendix G. If you are including MHM strategies within an existing program, integrate MHM strategies within the program's larger results framework – do not create a new one. *(See page 34 in the SHN-CASP module for more information on developing a comprehensive SHN program.)*

Appendix H provides a checklist of potential, but not exhaustive, MHM activities. Use the MHM Checklist for Intervention Assessment (Appendix I) to prioritize program strategies by assessing the level to which a strategy is needed, feasibility and availability of program assets to support the intervention. The MHM Checklist for Intervention Assessment can also guide conversations with community members prior to program design.

Integrating MHM into SHN Programming – Goals, Strategies and Special Considerations

The strategies listed in the sections below are suggestions and should not be implemented without careful consideration of your context, the feasibility of implementation and the level of need.

Intermediate Result One: Availability of Services

The first intermediate result aims to increase the availability of school-based health, hygiene and nutrition services, with special consideration for how these services can address MHM-related challenges. Incorporating services that address the needs of menstruating girls supports their participation in class and keeps them in school. The services selected for the MHM program should directly relate to the needs determined in the Situation Analysis. It is important that MHM services are integrated within existing SHN services when possible.

Strategies for IR 1 may include:

- Stocking pain medications in the first aid kit and making them available to girls who are experiencing menstrual pain.
- Making menstrual materials accessible in school stores, clinics, first aid kits or through the girl identified location.
- Lending extra school uniform skirts if a girl student experiences an accident at school.
- Providing a room for students to use if they are feeling unwell.
- Administering iron with folate supplementation to girls over the age of 10 in populations with a greater than 20% anemia prevalence. *(See Appendix J.)*
- Creating referral services to health posts/clinics where girls can seek additional health information or services related to menstruation, such as headaches, abdominal cramping, heavy bleeding, low back pain or reproductive tract infections. Health professionals may also provide health education workshops or sessions in school *(see IR3 and ASRH indicators related to youth-friendly adolescent services, document #7, Planning & Implementation Resources folder, flash drive).*

Box 5: Menstrual Materials

Menstrual materials include disposable and reusable options. Choice or preference for materials is based on affordability, availability and cultural acceptability.

Disposable options include:

- Sanitary napkins
- Handmade pads
- Soft cups (http://softcup.com/)
- Tampons.

Reusable Options include:

- Cloths
- Handmade pads
- Menstrual cups.

Issues related to IR 1 may include:

- Sustainability of maintaining the supply of pain medications and sanitary pads. There is a need to link IR 1 (Improved access to services) with IR 4 (Policy and Community support) to ensure that access and financial resources are maintained.
- Girls require simple and discrete mechanisms to access MHM services; school faculty must consider easy ways for girls to seek support. In some settings, female faculty may manage the distribution and access to materials, while in others, an older girl prefect may assist. But the access mechanism needs monitoring to ensure that girls are utilizing the services.
- Providing pain relievers is dependent on the policies and acceptability of teachers providing medication. Consider whether there are safe and natural remedies commonly used in those communities that are acceptable, such as a hot compress, hot tea or yoga stretching.

Intermediate Result Two: Quality of the School Environment

A quality school environment provides a safe and healthy place for students to learn. WASH is an essential component of SHN programming, and many of the strategies outlined for MHM in IR 2 should already exist within the greater SHN program. Integrating MHM requires identifying and addressing the additional WASH needs of adolescent girls who have reached menarche. An ideal school environment permits girls to anonymously manage menstruation. Girls who feel confident managing menstruation in school will concentrate better, participate more and miss less school, providing a more equitable learning experience.

Private and safe WASH facilities should ensure water access and menstrual material disposal. These elements are essential to promote personal hygiene, keep facilities clean and ensure that toilets are not broken.

Strategies for IR 2 may include:

- Latrines/toilets that:
  - Are gender-separated;
  - Have private toilet/latrine stalls for individual use (if culturally appropriate and requested by girls);
  - And have doors that close and lock from the inside.
- Latrines that are constructed with the national or UNICEF/WHO recommended pupil-to-toilet ratio.[22]
- Water access for cleaning bathrooms and flushing toilets.
- Water access for personal hygiene within the toilet/latrine stall.
- Water access for hand washing after toilet use, within a few meters of the toilet/latrine block.
- Discrete waste disposal – waste bins in each toilet stall or within the toilet/latrine block.
- Waste management plans to account for menstrual waste.
- For more information on international WASH standards, visit the UNICEF WASH in Schools website.

Box 6: Disposal of Menstrual Waste

To help plan or evaluate current menstrual waste disposal methods, ask the following questions:

- Can girls discretely dispose of menstrual materials?
- How often are containers for waste emptied? Where does the waste go? Who is responsible for emptying containers?
- Who manages the disposal process? Is it sustainable?
- Are there social or cultural considerations identified in the Situation Analysis that would prevent women and girls from using this method?
- Are there legal constraints that would prevent schools from taking up this method?

Methods of Disposal of Menstrual Waste:

- Burying
- Incineration or burning
- Disposal into a commercial or public waste management collection and disposal system
- Disposal into a disposal pit or pit latrine
- Composting (for biodegradable menstrual materials only)

IMPORTANT:

1) *Disposing of menstrual waste in pit latrines causes the pit to fill quickly.*
2) *Menstrual cloth slows the decomposition process in eco-san toilets and commercial sanitary pads are NOT biodegradable. If you are using this sanitation technology, make sure girls are not putting menstrual materials in the latrine.*
3) *Sanitary pads and cloths should not be flushed down toilets. This increases the risk of clogging the pipes.*

Issues related to IR 2 may include:

- Reliance on a maintenance system (e.g., school hygiene committees) for maintaining WASH facilities and hygiene promotion.
- MHM WASH infrastructure improvements can be cost-prohibitive (e.g., incinerators, covered trashcans, toilet paper or hand-washing basins in the bathroom). Alternate strategies may be necessary to sensitize girls to using less-ideal but adequate infrastructure improvements. Use Water, Sanitation and Hygiene for Schools in Low-cost Settings as an initial WASH resource *(document #15, Planning & Implementation Resources Folder, flash drive).*[25]
- The surrounding environment, WASH infrastructure and MHM strategies directly affect each other. For example, pit latrines or composting latrines often exist in water-scarce areas, but sanitary pads do not decompose and menstrual cloth slows down decomposition, making toilet composting unsafe. Additionally, water scarcity may make access to water in individual stalls difficult.
- The social and emotional environment of the school needs to complement the clean and safe physical environment so that girls will properly utilize WASH infrastructure. For example, if waste bins are placed outside the latrine stall, but girls are teased by their peers when they throw away sanitary pads, girls will not use the waste bins and may dispose of them in the latrine. Or in schools that feature female urinals, girls may avoid using them when menstruating for fear that they may not have privacy. A holistic approach involves creating an environment in which girls are socially and emotionally safe through anti-bulling policies (safe school policies in IR 4) and supportive, knowledgeable teachers and peers (skills-based education and training in IR 3), while simultaneously addressing the physical school WASH infrastructure.
- Understanding traditional MHM practices that can affect WASH infrastructure use is essential to designing a WASH-MHM strategy.[18] The local culture and policy environment may dictate which WASH and environmental strategies are appropriate. The Situation Analysis should investigate local customs and beliefs regarding menses. Traditional beliefs or practices may contradict safe WASH behaviors, such as hand washing and menstrual waste disposal, as well as nutrition.
- Equitable school WASH policies (IR 4) must complement WASH infrastructure. Framing MHM WASH needs as a female-focused issue can lead to unfair gender-biased policies. Girls and female teachers should not be responsible for fetching all water, cleaning all latrines or dealing with waste in all facilities if these facilities are used by both girls and boys.
- Sufficient budget allocation from schools and government for WASH in Schools.

Intermediate Result Three: Knowledge, Attitudes and Practice

Improvements in knowledge, attitudes and interest towards using health services and health-protective behaviors can be developed through skills-based health education. Menstrual hygiene and puberty education should be linked to grade specific curriculums; all students should start receiving age appropriate puberty lessons at age nine. It is important to provide skills-based health education before girls have their first menstrual period (menarche) so that they are prepared with the knowledge and skills to practice safe and hygienic behaviors as soon as they start menstruating.

Strategies for IR 3 may include:

- Conduct teacher training on comprehensive puberty education and how to deliver sensitive information to adolescents *(reference the SHN Health Education Manual sections on puberty).*
    - Refer to UNESCO's Puberty Education & Menstrual Hygiene Management Policy and Practice Booklet for additional guidelines *(document # 16, Planning & Implementation Resources folder, flash drive)*.[26]
    - Collaborate with Sexual Reproductive Health colleagues to review content and ensure that Comprehensive Sexuality Education (CSE) is properly included for program-related activities.
- Connect community health workers to schools to deliver comprehensive puberty education and potentially, comprehensive sexuality education.
- Develop and/or adapt MHM lessons:
    - Address harmful traditional practices and provide biologically accurate information to counteract those practices.[18]
    - Discuss WASH facility use during menses (e.g., how to dispose of menstrual waste, where to access water for flushing and personal cleansing and sensitization of shower use available on school grounds).
    - Demonstrate all locally available menstrual materials and how to use them.
    - Show how to hygienically make and wash homemade menstrual cloths or pads.
    - Provide tools (calendars, cycle beads, etc.) to track one's menstrual period so girls are better prepared, even if periods are irregular during puberty.
    - Educate boys and girls so that they understand how menstruation is linked to fertility.[18]
- Create peer education and girls' clubs to sensitize and promote self-esteem, camaraderie and mentorship.
- Integrate gender norm education, such as the Save the Children Choices, Promises or Voices curriculum or resources from the Very Young Adolescents program. Contact your TA for resources.

Issues related to IR 3 may include:

- Menstruation is a taboo topic in many cultures. Parents must be included in conversations on the importance of MHM education and, when possible, given tools to facilitate conversations with their children about menstruation and puberty.
- Overburdened community health workers may not have the time, inclination or training to teach on menstruation or puberty.
- MHM education alone will not facilitate hygienic practices. If girls cannot manage menses in school bathrooms, do not have access to menstrual materials or are teased in school when they are menstruating, girls may turn to negative strategies to cope with the challenges.
- Traditional customs and beliefs about menses can contradict the biologically accurate education and

hygienic MHM practices taught in school. Understanding the roots of customs and beliefs is extremely important to ensure that we do not offend communities. Addressing contradictions must be done carefully through community engagement and education (IR 4) with all stakeholders. Addressing harmful traditional customs and beliefs can improve healthy and hygienic practices and reduce the stigma of menstruation.

- Determine how MHM education should be presented so that it is gender-sensitive and will be well-received by students, teachers and parents. Boys and girls must receive the same information and understand puberty developments of both sexes.
  - If the topic falls to a male biology teacher, will the information be as well received by girls?
  - Is it appropriate for girls and boys to receive the lessons together?
  - Will the gender dynamics and education needs change by age and grade? Can girls and boys start receiving information on puberty together, then move to separate classes for more in-depth information?
  - Consider how to get information to older students who are in lower grade levels.
- MHM overlaps with SHN and AD program teams; ensure that collaboration with the adolescent sexual and reproductive health (ARSH) team in your country office reduces redundancy in programming and brings in adequate expertise for your program.

Box 7: Men in menstruation

For some communities, a situation analysis and program design may be the first time men and women have the chance to talk openly about menstruation and learn factual information about MHM. It's important to engage men and boys at these early program development stages. Here are some ideas for how to engage men and boys:

- Ask boys and men to think about how they could support their wives, daughters, or sisters with the challenges they face during menses.
- Play a fun game that helps people talk openly about MHM.
- Ensure male enumerators lead MHM activities with men and boys.
- Strengthen your male staff members to be MHM champions. Save the Children staff are recognized, respected and trusted in the community. If a male staff member is seen talking confidently about MHM, the community may be more receptive and open.
- Connect WASH Operations & Maintenance to MHM, as an entry point to discuss MHM with boys and men.
- Build up school boys to become MHM champions by having them speak out against puberty-related bullying.
- Teach boys to empathize with girls. In Kenya, boys participated in MHM demonstrations, learning how to place sanitary pads in underwear and how to dispose of sanitary pads in trash bins.
- Listen to boys' ideas too. In the Philippines, boys suggested they help sew reusable sanitary pads that could be sold at the school and community stores.

Intermediate Result Four: Policy and Community Support

Save the Children advocates for the development of national SHN policies to facilitate sustainability and scalability. MHM and puberty education should be integrated within SHN policies and advocacy initiatives. MHM and puberty education requirements may already exist as a part of education and/or WASH/health policies. Ensure that policies are explicit, policy implementation guidance is provided and both policies and implementation is understood by local teaching staff. MHM advocacy efforts should align within the overarching SHN advocacy efforts (SHN-CASP module, p. 33) and integrate with all four SHN pillars. For example:

- **IR 1** – Local health posts or community health workers are mandated to provide regular MHM education and services to girls.
- **IR 2** – MHM is incorporated into national WASH in school standards.
- **IR 3** – Pre-service teacher training on MHM is included in national teacher curricula.
- **IR 4** – Contingency pads are included as a budget item covered by local Ministry of Education (MoE).

Many of the strategies outlined in IR 4 are strategies that are already taking place within regular SHN programming, including WASH in Schools. The following strategies demonstrate where MHM can be integrated in ongoing IR 4 activities.

Strategies for IR 4 may include:

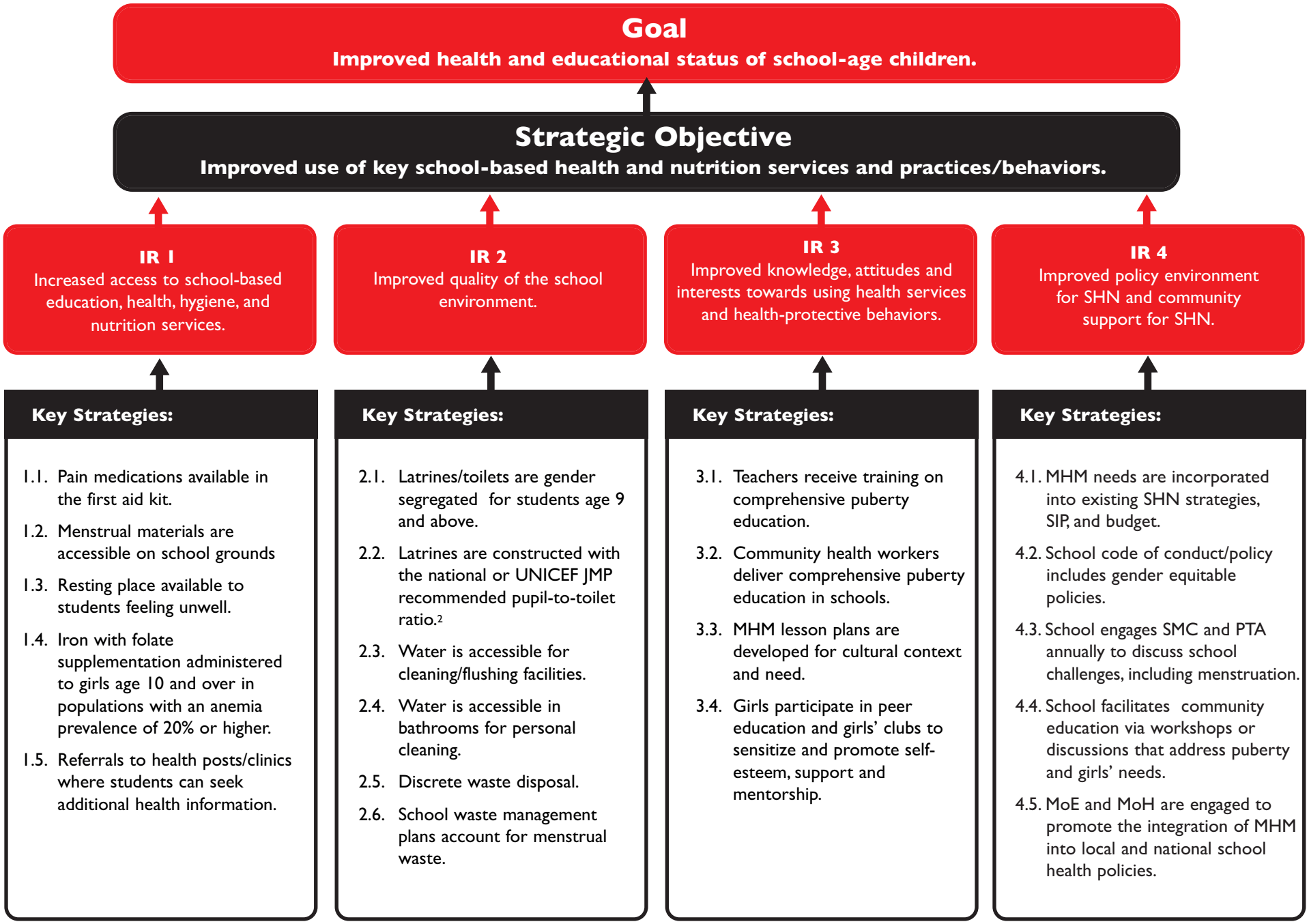
- Building on existing SHN School Improvement Plans (SIP):
  - Mechanisms for girls to access menstrual materials at school.
  - Budget line items for contingency sanitary pads and soap.
  - WASH facility operations and maintenance, including menstrual waste disposal.
- Creating a code of conduct/policy that supports girls through menstruation. Examples include:
  - Anti-bullying campaigns that create awareness and sensitize students to the physical changes in both boys and girls during puberty. Campaigns should acknowledge the challenges associated with menstruation and encourage a supportive school environment.
  - Always granting girls and boys permission to leave class to use the toilets.
  - Not requiring students to stand in class to answer a question.
  - Establishing a female teacher or prefect that acts as a mentor to very young adolescents.
  - Enforcing school policies that protect girls' privacy—e.g., boys peeking into girls' bathrooms.
- Engaging the SMC and PTA annually (minimum) to discuss challenges impacting students in school, including menstruation. Engage community health workers to facilitate discussions or workshops that ensure that biologically correct information is shared in schools with students, teachers and parents.

- Participating in coordination meetings between Ministry of Education (MoE) and Ministry of Health (MoH) officials to promote the development, integration and implementation of MHM into national school health policies.
- Documenting and presenting the impact of MHM programs on girls' education, including retention, attendance and school performance.
- Establishing relationships with local partners that complement MHM programming (education, child protection, sexual and reproductive health, etc.) and collaborating on advocacy efforts.

Issues related to IR 4 may include:

- Advocacy efforts take years to produce results. Policymakers may be in agreement with some aspects of MHM policy and not others; strong evidence and community mobilization may be required to make larger changes over time. The first step is establishing a relationship with government entities.
- Menstrual hygiene and puberty education are closely tied to sexual and reproductive health and as a result, may face additional barriers to policy change when compared with traditional SHN policies. Speaking with education officials and partners can help determine the best way to frame this issue.
- Empowering community members to be the voice that advocates on behalf of their daughters on MHM is challenging, but strengthens advocacy efforts.

Appendix G: Example Results Framework



2 UNICEF/WHO guideline standard for student-to-toilet compartment ratio is 25 girls per toilet compartment and 50 boys per toilet compartment when a urinal is available, plus one toilet for male staff and one for female staff.

For more information on a Results Framework, please refer to SHN-CASP module, p. 29-30.

Appendix H
Example Program Activity Checklist for SHN Program Managers

Program Level Activity Checklist for MHM Basic Interventions

Program Implementation	✔
Involve district government on MHM plans within SHN.	
Work with schools to include MHM elements into SIP.	
Work with schools to include MHM elements in school budget.	
Engage PTA, SMC, Local/District Government Units to share information about inclusion of MHM in Schools.	
Follow Toilet/Latrine Construction O&M guidelines for MHM supportive infrastructure, according to national level guidelines or in accordance with the UNICEF/WHO WASH in Schools guidance.	
Development of contextual and age appropriate IEC materials for MHM .	
Adaptation of MHM lesson plans for contextual application.	
Training to teachers on MHM (minimum 2 teachers per school); training to include: • How to teach MHM • How to make reusable sanitary pads (when appropriate)	
Training to teachers, SMC and PTA on WASH O&M.	
Work with Education and Child Protection team to address MHM anti-bullying strategies.	
Check with AD/ASRH to determine if they have resources or knowledge on MHM that is easily adaptable for MHM in SHN.	
Check in with other sectors: • What are they doing to address MHM? • Can SHN learn from their experiences? • Is there room for collaboration?	
Work with schools on sustainability of first aid kit and inclusion of pain medications.	
Work with schools to ensure that boys and girls ideas are included in the development of contextual MHM interventions.	
Identify if iron/folate targeted micro-nutrient supplementation is needed for girls older than nine years.	
Work with schools on sustainable access to sanitary pads.	
Work with schools and community on environmentally friendly waste management system.	

Local and National Advocacy	✔
Advocate at the school level for ownership over MHM SHN interventions.	
Advocate at national level for inclusion of MHM into national policies/strategy.	
Advocate at national level for inclusion of MHM lessons into curriculum.	
Advocate at national level for inclusion of MHM into teacher training/training institutes.	
Advocate at national and district level for sustainable MHM/WASH infrastructure in schools.	
Advocate at national level for development of toilets that consider MHM needs.	

Appendix I: MHM Checklist for Intervention Assessment

Problem identified during Situation Analysis	**Priority:** rank the severity of the problem 1=high 2=medium 3=low	**Goal to achieve:** if this problem were reversed, what would be the outcome?	**Intervention/s required to achieve goal**	**Does the solution link directly to the root causes of the problem identified in the situation analysis?**	**IR**	**Feasibility** How easy or difficult is it to implement? 1 = Easy 2 = Medium 3 = Difficult	**Explanation of feasibility score**	**Assets** Which partners, resources, policies, etc. exist related to the activity?
EXAMPLE: Girls do not use school latrines when menstruating.	1	Girls always use school latrines.	Latrines are gender segregated.	Yes	2	3	High construction costs.	• Some funding available in budget. • Trusted construction vendors exists. • School Health policy mandates gender segregated facilities.
			Latrine stalls have waste bins.	Yes	2	1	Low cost options available.	• Waste bins easy to procure.
			School has a waste management system.	Yes	4	2		• Active SMCs. • Schools have janitors.
			Latrine designs adapted for privacy.	Yes	2	3	High construction costs and need more understanding of privacy.	• Consider partnership with WASH NGO to discuss "privacy".
			Water is available for personal use and flushing.	Yes	1 & 2	2	Water exists on school grounds; need system for refilling water drums.	• Functioning borehole. • Jerry cans easy to procure.
			Girls know how to dispose of menstrual waste.	Yes	3	2	Easy topic to teach, requires adaptation of IEC materials and dissemination.	• MHM curricula already exists for adaptation.

Problem identified during Situation Analysis	**Priority:** rank the severity of the problem 1=high 2=medium 3=low	**Goal to achieve:** if this problem were reversed, what would be the outcome?	**Intervention/s required to achieve goal**	**Does the solution link directly to the root causes of the problem identified in the situation analysis?**	**IR**	**Feasibility** How easy or difficult is it to implement? 1 = Easy 2 = Medium 3 = Difficult	**Explanation of feasibility score**	**Assets** Which partners, resources, policies, etc. exist related to the activity?
EXAMPLE: Girls report being teased about menstruation at school and feel shame and embarrassment.	2	Boys and Girls learn that menstruation is normal and respect themselves and other during menstruation.	Boys and girls puberty booklets are developed and distributed to students at school.	Yes	3	3	Time, budget and support from local MoE are needed to develop the puberty books. Schools require instructions/training on how to distribute/share information.	• New government policy that mandates that puberty should be taught to grade 5 students.
			Parents are provided an overview of student experiences with menstruation and puberty; parents are provided biologically accurate information about menstruation and puberty through a Parent Education Session.	No	3	2	Getting parents to attend the meetings can be difficult. Getting both father and mothers involved may be even more difficult.	• Community health workers can help share information to parents.
			At the school level rules/policy are put in place about bullying/teasing and students/teachers are made aware of the updated regulations.	Yes	4	1	The schools are very open to updating policies, what is more challenging is helping the schools to appropriately enforce the rules.	

Appendix J
Suggested Scheme for Intermittent Iron and Folic Acid Supplementation in Menstruating Women

Supplement composition	Iron: 60 mg of elemental iron[a] Folic acid: 2800 µg (2.8 mg).
Frequency	One supplement per week.
Duration and time interval between periods of supplementation	Three months of supplementation followed by three months of no supplementation after which the provision of supplements should restart. If feasible, intermittent (i.e. once, twice or three times a week on non-consecutive days) supplements could be given throughout the school or calendar year.
Target group	All menstruating adolescent girls and adult women.
Settings	Populations where the prevalence of anemia among non-pregnant women of reproductive age is 20% or higher.

Source: WHO (2011)[27]

For more information on supplementation interventions, please refer to page 9 of the WHO Guideline: Intermittent iron and folic acid supplementation in menstruating women.

Appendix K
Potential Health Risks of Poor Menstrual Hygiene

Hygiene

Practice	Health Risk
Unclean sanitary pads/materials	Bacteria may cause local infections or travel up the vagina and enter the uterine cavity.
Changing pads infrequently	Wet pads may cause skin irritation, which can then become infected if the skin is broken.
Insertion of unclean material into vagina	Bacteria potentially have easier access to the cervix and the uterine cavity.
Using highly absorbent tampons during a time of light blood loss	Toxic Shock Syndrome
Use of tampons when not menstruating (e.g., to absorb vaginal secretions)	Can lead to vaginal irritation and delay the seeking of medical advice of unusual vaginal discharge.
Wiping from back to front following urination or defecation	Makes the introduction of bacteria from the bowl into the vagina more likely.
Unprotected sex	Increased potential for transmission of Hepatitis B. Increased potential for transmission of HIV. Risk of infecting others, especially for Hepatitis B
Unsafe disposal of used menstrual materials or blood	Risk of infecting others, especially with Hepatitis B
Frequent douching (forcing liquid into the vagina)	Can facilitate the introduction of bacteria into the uterine cavity.
Lack of hand-washing after changing a sanitary pad	Can facilitate the spread of Hepatitis B or Thrush.

Source: House et al (2012)[18]

Menstrual Hygiene Management (MHM)
Monitoring & Evaluation

The following document provides basic guidance for designing and conducting an M&E plan and data collection activities, with the purpose of program learning.

Goals of this step:

To design your M&E plan and to collect data on the status of menstrual hygiene management in schools in the impact area. Establishing how program indicators will be monitored and how the program will be evaluated, before program implementation ensures that we are meeting our program targets to improve MHM in schools. The M&E section follows the situation Analysis and program design steps, but must be conducted prior to program implementation.

This chapter includes the following sections:

1. Overview of Steps required to develop your M&E plan
2. MHM Program Evaluation, Assessment and Sampling
3. Linking the MHM Program Design to M&E Indicators and KAP Questions
4. Getting from Indicators to KAP questions
5. Appendices L – O

What you will need:

- This module
- The DM&E module (p. 37, 47-52) from the 2010 CASP module *(document #17 and #18, Planning & Implementation Resources folder, flash drive).*
- The completed results indicator planning tool.
- Save the Children's MHM Knowledge, Attitude and Practice (KAP) menu of questions *(document #19, Planning & Implementation Resources folder, flash drive).*
- WASH in Schools Empowers Girls' Education Tools for Assessing Menstrual Hygiene Management *(document #2, Planning & Implementation Resources folder, flash drive).*

The outputs of this step will be:

- A MHM M&E plan that can stand alone or be integrated within a comprehensive SHN or AD program. An M&E plan should include the following key elements:
  - Evaluation Design
  - M&E and assessment protocol
  - MHM Tools that measure key program indicators

- A MHM Assessment should include the following components:
    - MHM KAP survey *(document #19, Planning & Implementation Resources folder, flash drive).*
    - WASH infrastructure survey and observation (WASH in Schools Empowers Girls' Education Tools for Assessing Menstrual Hygiene Management, *p. 28-48).*
    - Teacher/health officer MHM survey *(same tool as above).*
    - **Optional:** Capillary blood samples to test for iron deficiency. Consider whether secondary data suggests a high prevalence of iron deficiency, as well as feasibility and acceptability of collecting blood samples *(collecting bio samples requires additional ethical clearance).* For more information about collecting baseline data, see page 39 of the SHN-CASP module *(document #1, Planning & Implementation Resources folder, flash drive).*

M&E indicators should link directly to the program results framework, and all tools should feed into the proposed program indicators *(see DM&E CASP Module, p. 47-52, for process and outcome indicator tools).*

The general guidance for this section is for non-experimental evaluation designs. Results from this type of design allow you to make inferences about the success of the program by comparing the status of your intervention schools over time. Determining whether key target groups are benefiting and planning for program and policy improvement. Results from this type of evaluation do not allow you to make causal statements or generalizations about larger populations. For example, you cannot say conclusively that the MHM-SHN program resulted in an outcome, such as improved MHM in the region or increased attendance rates of girls. To support that type of statement, programs require quasi-experimental or experimental evaluation designs. For more rigorous quasi-experimental or experimental design methods that permit for impact evaluations, contact your TA for additional input *(see Table 1 for M&E Design).*

I. Overview of Steps required to develop your M&E plan:

1. Confirm global and project-specific indicators with partners. Indicators should draw from situation analysis findings and Program Design strategies, and be measured through the M&E plan assessments.
2. Select your evaluation design (see Table 1). Consult your TA to discuss the design and its implications for a comparison or control group, as well as sampling strategies.
3. Determine who will conduct the baseline, mid-line or end-line assessment. Will this involve internal Save the Children staff and MEAL teams? Or will there be an external consultant, university or agency involved?
    a. If conducted by an external agency, develop the Terms of Reference. To reduce bias in your results, especially for program mid-line and end-line surveys, evaluators should be independent from the intervention.
    b. If assessments are conducted by an external agency, it must be involved with all the steps listed below. However, Save the Children staff must remain involved in the M&E plan; hiring an external consultant requires significant oversight from Save the Children to ensure the assessment is meeting ethical protocol, quality standards and is responsive to MHM program M&E requirements.
4. Develop evaluation design protocol.
5. Develop assessment tools, consent forms, data entry templates and analysis plan.
    a. Assessment tools will be used at baseline and at each follow-up point based on the evaluation design. If there is a comparison/control group, they will also be assessed with the same tools.
    b. Select the assessment instrument type (paper, tablet, etc.). If staff has experience using *Tangerine*[3] or other of electronic data collection platforms, this is preferable, as electronic data collection has been found to save time, eliminate data entry errors and provide cleaner data for analysis.
6. Submit M&E protocol, tools and consent forms for local and ethical approval.
    a. Determine the approval requirements and mechanisms from national and local government bodies.
    b. All projects funded or tied to Save the Children US, must submit their M&E protocol, tools and consent to the Ethical Review Committee, unless going through a university Institutional Review Board (IRB).
    c. If working with a university partner, submit protocol, tools and consent through their IRB. IRB waiver or approval must be forwarded to the SCUS Ethical Review Committee (ERC).
7. Organize logistics. Steps may vary if using an external evaluator:
    a. Hire and train enumerators on protocol, tools, consent and data entry.
    b. Arrange transportation.
    c. Orient relevant community members and school staff regarding the assessment procedures and activities that will occur. Obtain consent from Head Teachers for all activities.

3 Tangerine is a customizable data collection software designed specifically for assessments. The program runs on any android-compatible device and compiles results into csv file for easy use in excel, STATA or SPSS.

d. Schedule dates for school visits with Head Teachers and orient teachers regarding protocol for the day of the survey. Ensure that there will be a private space to conduct the MHM KAP survey with the student, which also adheres to the Save the Children Child Safeguarding policy.

8. Field test/pilot tools based on M&E protocol and logistics (see Appendix L for more information on piloting tools). The pilot should be a dry run of every part of your protocol, including data entry. Two days of pilot testing is recommended.

    a. Adjust protocol, tools or consent processes based on pilot, if needed, and resubmit updated versions to IRB or ERC, as required.

9. Carry out data collection activities.

10. Enter, clean and then analyze data

11. Present preliminary findings to school and community stakeholders for feedback.

12. Report writing.

13. Repeat steps 3 through 12 for follow-up data collection points (mid-line and end-line evaluation)

    - Disseminate recommendations. Remember that this includes reporting full results back to school and community stakeholders who participated in the MHM assessment. This may also include a larger dissemination strategy to health and education government officials as part of advocacy efforts.

Table 1: Program M&E Designs, the use of comparison groups and randomization[4]

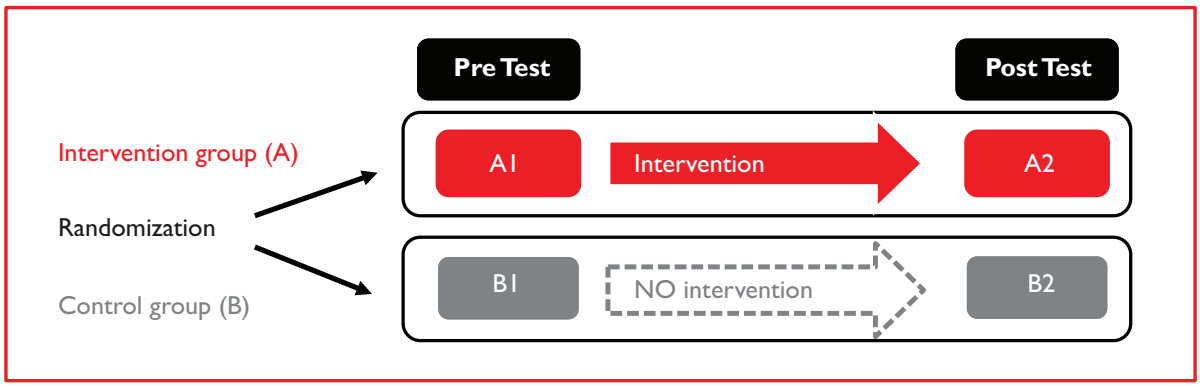
Type of evaluation or design	Comparison or Control	Suggested evaluation design
Process evaluation *Process evaluations focus on the types and quantities of services delivered, the beneficiaries of those services, the resources used to deliver the services, the practical problems encountered, and how problems were resolved.*	**None**	Baseline and end-of-project analysis with close monitoring of project inputs and activities. In some process evaluations, outcome indicators are also measured.
Non-experimental design *Consists of an intervention group only and lacks a comparison group*	**None**	In this design, the participants act as their own control group and the comparison of pre and post survey data examines their change over time. However, change in program indicators cannot be attributed to the program. Common designs • Pre-test/post-test designs • Time-series designs • Post-test only
Quasi-experimental design *Designs use an intervention and comparison group[5], but assignment to the groups is nonrandom.*	**Comparison group**	Quasi-experimental designs approximate experimental designs, but are used when randomization[6] at community, school or individual level is not practical or feasible Common designs • Pre-Test/Post-Test with Non-Random Assignment to Intervention or Control Groups • Post-Test Only with Non-Random Assignment
Experimental design *This is the most rigorous evaluation design, often referred to as the "gold standard."* *In randomized experiments, study participants (or groups) are randomly assigned to a group that receives the program intervention or a control group that does not receive the intervention.* *With a control group, the program can more confidently attribute the demonstrated changes to the program activities and inputs.*	**Control group**	Pre-Test/Post-Test with Random Assignment to Intervention or Comparison Groups (see Figure 2) **RCTs vs CRTs** **Randomized Control Trial** – Individuals are randomized into control or intervention groups (e.g., individuals receive the intervention: medicine, book, pad, lessons, etc.). **Cluster Randomized Control Trial** – the intervention is conducted at the school or community level and the school or communities are randomized into control or intervention groups (e.g., some schools receive WASH improvements or MHM education and others do not).

4 Table and figure adapted from the Save the Children Evaluation Handbook[28] and the Measurement, Learning & Evaluation Project for the Urban Health Reproductive Health Initiative[29]

5 A comparison group differs from a control group because the comparison group is NOT randomly assigned. Comparison groups can be identified through matching individuals or groups that are similar on all relevant characteristics, or program exposure, or through phasing the program intervention to different areas.

6 *Randomization denotes* "random assignment." This is not the same concept as random selection, which is an example of how survey participants are selected to take a survey. Randomized means that if there is a pool of schools or participants, they are randomly assigned to the intervention group or the control group.

Figure 2: Pre-Test/Post-Test with Random Assignment to Intervention or Comparison Groups



II. MHM Program Evaluation, Assessment and Sampling

The following steps are general guidance for establishing the sampling framework. Ultimately, decisions must be made based on the study design selected for the program M&E. Many programs conduct non-experimental designs to monitor changes over time. **Please review design options in Table 1 and discuss sampling implications with your TA.**

If this assessment is being conducted within a greater SHN or AD project, the MHM questions should be integrated and administered within the larger KAP, keeping in mind that boys and girls aged nine and older are the target age group for an MHM KAP survey.

1. Determine which schools will take part in the MHM program.

- If conducting a process evaluation or non-experimental design (no comparison/control) all schools will take part in the MHM program
- For quasi-experimental designs, the program team must decide which schools will receive the intervention and which schools will act as a comparison group.
- If using an experimental design, schools must be randomly assigned to the intervention or control group.

2. Select the schools that will participate in the MHM assessment. The number of schools selected is based on several factors, including:

- The total number of schools participating as intervention or comparison/control group.
- The total number of girls and boys enrolled in the grade to be surveyed
- The number of girls and boys to be recruited or sampled.
- If program staff want to monitor, disaggregate or compare data by school or community characteristics (urban vs. rural, ethnicity, religion, or environmental factors like water scarcity). The more groups created for comparison, the more schools and participants will be required for the sample.

If there are few schools participating in the MHM program, either as intervention and/or comparison schools, it is possible that ALL schools will be included in pre and post assessments. However, if there are many schools, a random sample of schools can be selected to participate in the pre and post assessments. The decision to take a smaller sample of school is based on donor expectations, evaluation design, budget and logistical considerations.

3. Randomly select girls and boys to participate in the MHM KAP questionnaire. In total, the program should aim to assess a total of 200-400 girls and at least 200 boys.

- Aim to sample close to 400 girls. The closer the sample is to n=400, more precise the program findings will be.
- For more representative data, sample fewer children from more schools. For example, 10 children per school, among 20 schools is a preferable sampling strategy compared with 20 children per school from 10 schools.
- Should you sample boys for the MHM KAP? **YES, ALWAYS.** There are questions in the MHM KAP that are relevant for both girls and boys regarding their puberty knowledge, beliefs and attitudes, and bullying.
- Use the school roster to randomly select girls and boys, or randomly select them on the school grounds at the beginning of the school day. Random selection strategies can be found in Appendix M. Similarly to the Situation Analysis, a Baseline Report should be written to share the baseline findings. *(See p. 40-41 of the SHN-CASP module for directions on how to write a Baseline Report.)*
- **Detailed information on MHM practices can only be gathered from girls who have begun menstruating.** If MHM practices are key to understanding program outcomes, and there are likely girls in your sample that have not reached menarche, the assessment team may need to randomly select girls from the school roster throughout the day until the number of menstruating girls is sufficiently sampled.

III. Linking the MHM Program Design to M&E Indicators and KAP Questions

MHM programs are typically integrated within existing school health or adolescent programming in order to contribute to the larger program goals. Indicators may vary across programs, regions and countries.

Below is a Table of ***potential, not exclusive***, strategic objective and intermediate result indicators. This is not an exhaustive list, however, indicators with an asterisk (*) were recommended by the WHO/UNICEF Joint Monitoring Program (JMP) by the WASH and food hygiene working group for the 2025 Sustainable Development Goals[30].

Table 2: Key MHM Program Indicators by Strategic Objective and Intermediate Result

	Example Indicators
Strategic Objective: Improved use of key school-based health and nutrition services and practices	**Increased participation in school during menstruation** • % of girls that report increased concentration in the classroom during menses. • % of girls that report increased participation in the classroom during menses. • Equal promotion rates of girls and boys into upper primary and secondary grades • Reduced menstruation-related absenteeism
	Increase in positive menstrual hygiene practices • % of girls who report properly disposing of absorbent materials (sanitary napkins or menstrual cloth) • % of girls who report hygienically washing and drying reusable menstrual cloth.
IR1: Increased access to school-based services	• % of schools that provide contingency sanitary napkins • % of girls 9 and older who receive iron with folate supplementation
IR2: Improved quality of the school environment	• % of schools with private disposal or incineration facilities for disposable napkins* • % of schools serving any girls older than 10 years of age with sufficient gender appropriate latrines; i.e., latrines reserved for females that provide privacy, water, soap and disposal facility for absorbents. *
IR2: Improved quality of MHM services	• % of health centers (of all types) teaching good MHM in their reproductive health clinics* • % of health workers who can answer a basic set of questions regarding MHM*
IR3: Improved knowledge, attitudes and interests towards using health services and health protective behavior	• % of girls and boys aged nine to 16 that can answer a basic set of questions about MHM (refer to Box 4: Basic Facts about Menstruation) * • % of girls and boys aged nine to 16 that know how to hygienically manage menses* • % of girls and boys aged nine to 16 that know how to dispose of menstrual material waste • % of girls and boys aged nine to 16 that can identify that menstruation is a normal biological function of the female body
IR4: Improved community support and social norms for MHM	• % of schools with MHM in their curriculum* • % of girls who received information regarding MHM in school before the onset of menstruation* • % of parents who have spoken to their children about menstruation* • % of men who understand menstruation* • % women and girls reporting any restrictions on their freedom during menstruation*
IR4: Increase in MHM Policies	• Existence of locally relevant policy that promotes good menstrual hygiene management e.g. regulations that stipulate menstrual disposal facilities in school toilets* • % of relevant national institutions able to clearly demonstrate implementation of policy* • Existence of monitoring of policies implementation by independent body (e.g. health / education inspectorate)* • % of governments who have in place fiscal policies that encourage MHM (e.g. removal of VAT on menstrual hygiene products)*

Results and process indicators should be developed based on your results framework for the MHM program. For more information on indicators, refer to pages 19-24 of the 2010 DM&E CASP Module *(document #17, Planning & Implementation Resources Folder, flash drive).*

Box 7: Basic Facts about Menstruation

The following list is a set of minimum basic facts that all MHM education should address with teachers, girls, boys and parents.

a. Menstruation is when your body sheds the lining of the uterus (womb).

b. Cramping is caused by contractions of the uterus and is normal.

c. On average, menstruation starts between the ages of 10 and 15.

d. On average, menstruation ends between the ages of 45 and 55.

e. The average menstrual cycle is between 28 and 35 days.

f. Menstruation is a normal bodily function for women.

g. Menstruation signals that a girl can become pregnant.

h. Bathing during menstruation is safe.

i. Girls and women should not douche (wash the inside of their vagina).

j. During menstruation, girls and women need to wash the skin outside and around their vagina (vulva) at least once a day.

k. Homemade menstrual cloth needs to be washed with water and soap and then dried in the sun.[7]

l. Menstrual materials (sanitary pads or homemade cloth) should be changed three to six times a day.

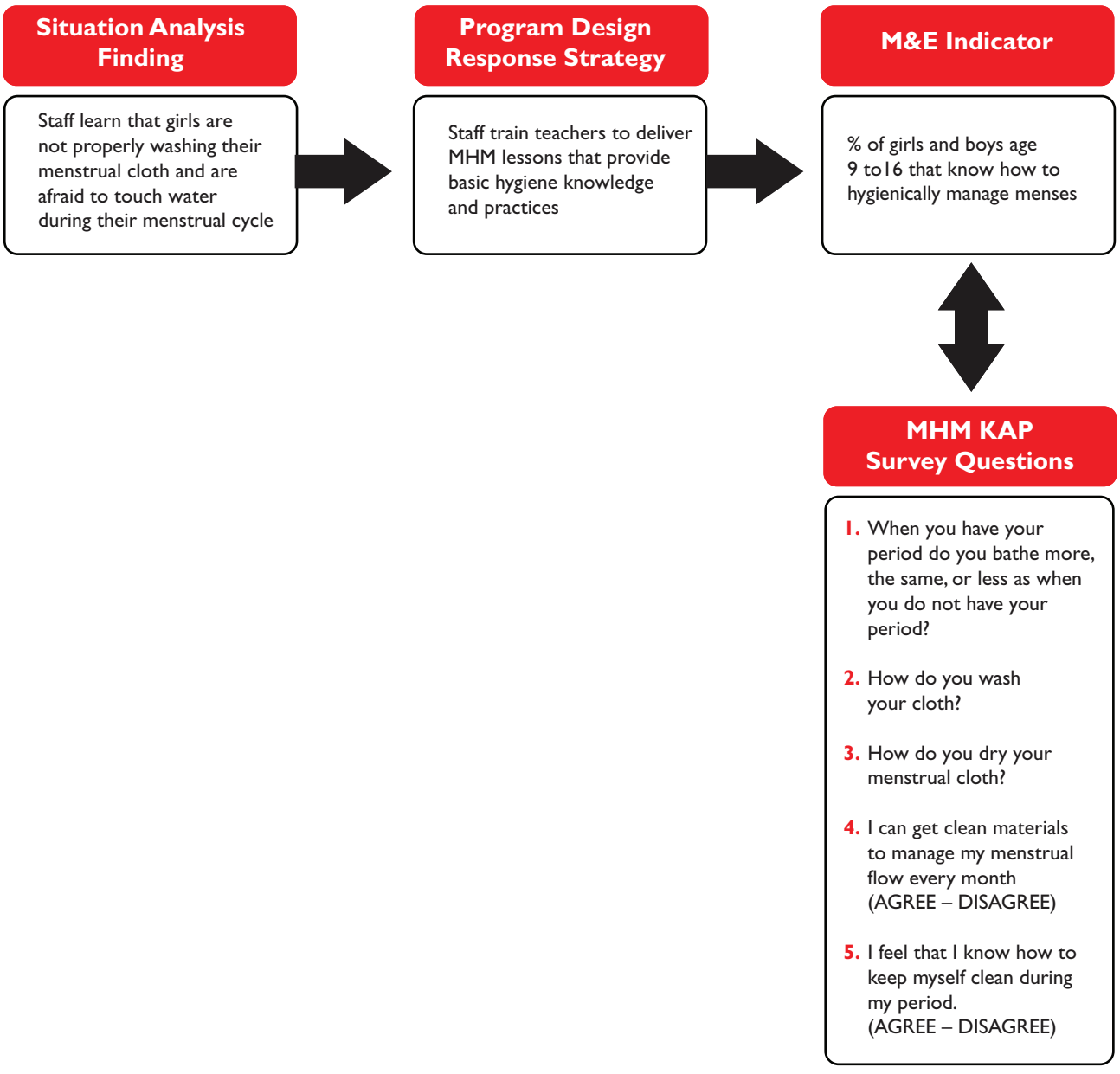
Refer to Appendix N for creative ways to design Basic Facts KAP questions. An MHM program my aim to expand beyond this list of facts, but at a minimum all MHM programs must impart this knowledge to stakeholders and all MHM KAPs must measure this knowledge.

[7] If the situation analysis suggests that girls in your impact area wear homemade menstrual cloth to manage menses, this question must be included. If all girls use sanitary napkins, it can be removed.

IV. Getting from indicators to KAP questions

The figure below provides an example of the connection between situation analysis findings, program design, M&E and designing KAP questions. M&E indicators and questions should reflect the MHM challenges found during the situation analysis and MHM program strategies developed address those challenges.

Figure 3: Linking Situation Analysis findings to Program Design, M&E and MHM KAP Survey Questions



MHM KAP Questions and Adaptation

KAP questions must be contextualized to measure the achievement of specific program interventions (Figure 3, above), but also adapted for the age group being assessed. While there is a menu of potential MHM KAP questions, remember that youth cannot typically withstand surveys longer than 45 minutes, therefore, only select survey questions that will provide relevant information for program monitoring and evaluation.

Determine which KAP questions (document #19, Planning & Implementation Resources folder, flash drive) feed into the relevant program indicators. The WASH infrastructure and observation survey and the teacher interview (document #2, p. 28, Planning & Implementation Resources folder, flash drive) provides school-level assessments for program indicators.

When developing the MHM KAP tool, consider simpler ways to word questions, acceptable probes for each question and whether the entire survey should be conducted in the local language or language of instruction. Additionally, the situation analysis should provide the team with the MHM context to add or adapt questions and probes, such as common beliefs and practices surrounding menstruation and puberty, including common words and phrases that are familiar to girls and boys.

Using familiar local words to describe menstruation will help children understand the questions (e.g., saying "first period" instead of "menarche" or "period" instead of "menstruation"). Hire enumerators that speak the local language and can switch between languages, when required.

Adding Contextually-relevant Survey Questions

The KAP questions provided in the MHM KAP document are a starting point, but questions can and should be added if they reflect a unique practice or particular belief that your program hopes to change.

For example, did participants talk about any of the following practices during FGDs or interviews?

- Reducing bathing or other changes in hygiene
- Douching
- Social isolation and self-exclusion from peers, men and boys
- Changing eating behaviors or restricting food consumption
- Incorrect fertility tracking or increased fertility during menses

If these harmful or incorrect beliefs were prevalent during the situation analysis findings, and the MHM program aims to educate girls, boys and communities about them, then KAP questions that measure these beliefs should be added.

Appendix O contains an example of a Likert Scale response format that can be used to have children demonstrate their beliefs in a quantitative way.

V. Enumerator sensitization and training on sensitive topics

Enumerators should be carefully trained on the KAP survey and other tools they are administering. Enumerators should understand the purpose of each question, be familiar with the skip patterns and know which probes are appropriate. Similar to the situation analysis, enumerators should also be trained on discussing sensitive topics with children and receive guidance from a child protection specialist. Save the Children staff must have a plan in place should the responses to any of the KAP questions indicate that girls or boys are experiencing abuse, bullying or other child protection issues. Several of the KAP questions below suggest that enumerators follow up on a child's response with the question "why?" In these cases, if children feel they can trust the adult, they may reveal information that needs further investigation. Save the Children should refer to the Child Safeguarding Policy. Enumerator training and child safeguarding mechanisms must be explicit in the M&E protocol.

Appendix L
Pointers for Designing and Piloting Data Collection Tools

Information adapted from the *Monitoring Reading Assessment in Literacy Breakthrough Countries: Instrument Development and Administration Handbook* and *The Save the Children Evaluation Handbook*.

1. Always pilot test the instruments in the population in which the KAP will be implemented.
2. Practice the entire survey administration process, including student selection, conducting the survey and data entry.
3. If travel to the target area is not feasible for the pilot, select a school in an alternate site that shares the same location type (urban v. rural), socio-economic status and home language with the target area.
4. By working through the KAP tool with several children each, the assessors will build their level of familiarity and capacity in using the tool. All enumerators should work through the full assessment on at least two children at each school during this pilot. Their work to survey children in the pilot will enhance their skills and reliability during the data collection process.
5. Select a team leader from the enumerators (suggestion) before going to the first pilot school. This would be enumerators that have demonstrated leadership qualities, such as concern for the understanding of their fellow trainees, and who understand the tool best. They should also be respected by their fellow teammates.
    a. Upon arrival at the pilot school, the team leaders liaise with the school/headmaster/teachers and find a place to assess the children. They are in charge of sampling the children and overseeing their allocation to the other enumerators.
    b. They answer assessor questions when they come up.
    c. The team leader will conduct the teacher/headmaster interview and school WASH observations.

From The Save the Children Evaluation Handbook (p. 38)

- Make sure that you engage children in the pre-testing of data collection tools. Children will often have the commitment and capacities to be involved in data collection. You will need to ensure that they receive appropriate training to assist them in this role.
- When designing and testing your data collection tools, make sure you base them on the evaluation objectives and questions set out in the design phase.
- Use participatory exercises for the questionnaire design, involving thematic advisers/managers and other stakeholders.

- Make sure that you only collect the data you need (based on the defined scope of the evaluation or the indicators under investigation).
- Make sure the data collection tools you want to use allow you to disaggregate data if need be; for instance, by sex or age group. Certain tools will be more appropriate for different sexes and ages.
- Translate, back-translate and field test tools in selected communities or among selected beneficiaries. The level of effort required for this depends on the context (e.g., if the evaluation is replicating a Baseline Survey, the questions should be the same as those used in the baseline questionnaire, so not much work should be needed for subsequent evaluations). You may also be able to use external human resources to do this (e.g., university students or interns).
- Tools will need to be translated into local languages to enable data collectors and participants to use them properly.

Appendix M
Randomly Selecting Students for the KAP

Scenario:

- You want to sample 10 girls and five boys from grade five in one primary school.
- On the day you come to conduct the survey, there are 200 girls and boys in grade five present (75 girls and 125 boys) at school.
- On the official school roster, there are 215 girls and boys enrolled (80 Girls and 130 boys).

Below are three strategies for randomly selecting the survey participants.

1. Ask the teacher for a class list that marks which children are present on that day. Divide the list by gender and then divide the total number of present girls or boys by the total number of girls or boys you want to sample. Round up to the next whole number. This number is your counting number.

    a. If there are 75 girls in grade five and you want to sample 10 girls from that grade, then 75/10=7.5. Round 7.5 up to 8; your counting number is 8.
    b. Begin at the top of the list and mark each eighth girl's name. You may have to cycle back to the beginning to reach the total number of girls you need. This will give you a list of the girls to be assessed.
    c. Repeat this process for the boys as well. 100 boys in grade five and you want to sample five boys. 100/5 = 20. Begin at the top of the list and mark each 20th boy's name.
    d. Call girls and boys out of class when it is their turn to be assessed. There is no need for them to miss class while waiting their turn.

2. If there is no class list, ask all the girls in grade five to form a line. Divide the total number of girls in the line by 10 and round up to the next whole number. This number is your counting number. Again, if there are 75 girls in the grade, then 75/10=7.5 and the counting number is 8. Go to the back of the line of and begin counting at 1; ask every eighth girl to step out of line, and with the teachers' or a fellow researcher's assistance, create a list of children to be assessed. Repeat this process with the boys.

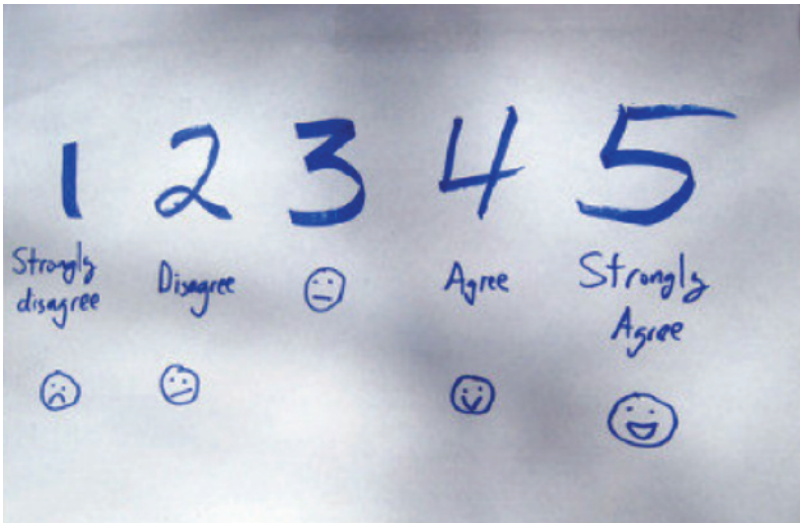
3. Both examples 1 and 2 can be replicated with stickers, marbles or colored pieces of paper. Put enough marbles in a bag so that every girl in grade five can select a marble. If you only want to sample 10 girls, make sure there are 80 marbles in the bag but only 10 blue marbles in the bag. Allow each girl in grade five to pull a marble from the bag without looking in. Ask every girl with a blue marble to step out of the line, and with the teachers' or a fellow researcher's assistance, create a list of children to be assessed. Call girls out of class when it's their turn to be assessed. Repeat this process with the boys.

Appendix N
Creative MHM KAP Questions for Basic Facts

Instruction: write Martha or Maria in the 'Answer' column to indicate the sentence that the girl considers to be true.

#	Questions		Answer	Directions
	I am going to read you some sentences between two people who are fighting and you have to tell me whose sentence is correct. One girl is named Maria and other is named Martha. Sometimes Maria is correct and sometimes Martha is correct. You have to pay attention to tell me who is telling the truth and who is making a mistake.			
	Maria	**Martha**		
1	Menstruation is something dirty that comes out of the body.	Menstruation is the lining of the uterus and blood leaving the body. It is not dirty.		
2	The pain is normal; it happens because the uterus is contracting.	The pain is dangerous		
3	Menstruation can happen as soon as you turn 13 years old.	Menstruation can start between 10 and 15 years of age.		
4	Menstruation ends between 45 and 55 years old.	Girls will menstruate until they die.		
5	Menstruation happens every month on the same date.	Menstruation happens every 25 to 35 days, depending on the woman.		
6	Menstruation is normal.	Menstruation is an illness.		
7	Having menstruated means a girl has already had sexual relations with a man.	Menstruation is a sign that a girl can get pregnant if she has sexual relations with a man.		
8	A girl can bathe without worry if she is menstruating.	Bathing is bad for you if you are menstruating.		
9	A girl who is menstruating can wash her hands but not her genitalia.	You have to wash your vulva (the area around your vagina) at least once a day when you are menstruating.		
10	The inside of the vagina is self-cleaning and does not need to be washed.	Menstrual blood makes the inside of the vagina dirty and it should be washed after menstruating.		
11	You have to change your sanitary pads or menstrual cloth once a day.	You have to change your sanitary pads or menstrual cloth 3 to 6 times a day		
12	If a girl uses menstrual cloth, she has to wash them with detergent and dry them in the sun.	The menstrual cloth should never see the sun, you have to wash them under other clothes to hide them.		

Appendix O
Visual Likert Scale options



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