

Institutional Survey on Menstrual Hygiene Management

May, 2019



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Cover Photo:

A health worker explains the proper use of sanitary napkins during the repatriation at a transfer center in Monzombo, DRC / UNHCR / J. Ose / July 12, 2005

Glossary

Menstrual hygiene management (MHM) interventions: can include any of the following: distribution of menstrual materials or menstrual supplies; education or awareness on menstrual health targeting boys/girls or women/men; design/construction of MHM friendly infrastructure (e.g. school, WASH, etc.).

Menstrual materials: refers to the materials used to catch blood during menses. This could be a pad, piece of cloth, tampon, cup or any other preferred method.

Menstrual supplies: refers to the other supportive items needed to support the management of menstruation (e.g. soap, bucket, underwear, and clothesline)

Executive Summary

Amongst all the persons of concern (PoCs) as of the end of 2017 there were an estimated 12.3 million girls and women of reproductive age for which menstrual hygiene management is a day to day issue and another 8.3 million girls who will experience menarche in the coming decade¹. UNHCR has made a commitment to empowering displaced women and girls to ensure that they have equal access to and control over management and provision of core relief items and cash based interventions including **sanitary materials and supplies** for menstrual hygiene management. However, this is only one aspect of comprehensive programming for menstrual health and hygiene. What is also fundamentally important in the healthy and dignified management of menstruation, is ensuring **safe access to adequate infrastructure** such as toilets and washing facilities and also **access to menstrual hygiene information and education**. These three aspects are the pillars of comprehensive MHM programming. Menstrual health is NOT just about sanitary pads or cash to buy sanitary pads.

- As part of the operationalization of the Age, Gender and Diversity policy, UNHCR is working to better understand how it is addressing the MHM needs of its persons of concern globally and to support country operations in planning for and responding to those needs. To facilitate this, on MHM Day 2018 the Assistant High Commissioner for Operations announced a global survey of MHM programs. This survey was circulated at the end of 2018 and the results are summarized in this document. The key findings of the survey include:
- 84 respondents provided information for the survey, while only 45 locations had MHM programming. UNHCR is the lead agency in coordinating the MHM response in the majority of situations captured by the survey.
- Protection, WASH, and Supply are the units primarily involved in MHM programming, however at the field level many units are involved.
- Needs assessments were only carried out in two thirds of those locations where UNHCR or partner programming included MHM. This is in stark contrast to the ADG policy which states that “At a minimum, country operations will employ participatory methodologies at each stage of the operations management cycle, to incorporate the capacities and priorities of women and girls.”
- On average only 55% of female PoCs of reproductive age (as targeted by the operation) had their needs met with regards to menstrual materials (e.g. sanitary napkins, tampons) and soap and much less in terms of underwear (37%). Looking beyond the average figures, operations tended to either do well (meeting a high percentage of needs) or very poorly.
- Monitoring is most commonly focused on Pillar 1 indicators (i.e. materials and supplies) with inadequate attention to support infrastructure (Pillar 2) and information and education (Pillar 3).
- Monitoring is almost exclusively tied to program funds, and therefore if no UNHCR expenditure is made on MHM, no data is collected.
- Regardless of whether cash based interventions or in-kind interventions are used, post distribution monitoring was not systematic.
- Distributions of materials and supplies were often insufficient with inconsistencies across locations in terms of the items included in the distributions.
- In one third of locations there are no feedback mechanisms for PoCs. This is in stark contrast to the AGD policy that stipulates “At a minimum, all UNHCR operations will establish and promote feedback and response systems, including for confidential complaints.”

¹ Data taken from ASR table 3, however gender disaggregated data was only available for approximately 42 million persons of concern. Therefore this data was extrapolated proportionately to the full 68.5 million PoCs.

- Support infrastructure is often not meeting the minimum targets, both in terms of the quantity of facilities (e.g. minimum standards for number of female toilet facilities in schools) and also in terms of quality. Very few WASH facilities were designed to be “female friendly” (e.g. hook, shelf or mirror in facility, menstrual waste collection, sufficient lighting, space, etc.).
- Just over half the locations include training as part of the interventions, however not all trainings is tailored to the unique needs (e.g. young girls) and boys/men are very rarely provided any education on these topics.
- A large number of respondents stated that no MHM programming was taking place in their operation (39/84), and of those that provided more detailed information (19) there were very few (3) collecting data on the needs of PoCs.
- A 2010 study looking at MHM materials and supplies only (Pillar 1) found that 42% of girls and women had needs met for menstrual materials (as compared to 55% in this study). Consultation with women and girls occurred in 61% of cases in 2010 versus 66% in 2018. Budget and difficulty in accessing PoCs remain the key challenges.

Considering these survey findings, and building on the global institutional knowledge within DIP and DPSM on MHM, the following recommendations are put forward:

1. **Ensure that MHM is integrated to the relevant global strategies and existing results frameworks** including the new Global Public Health Strategy. To effectively track progress on MHM programming, as part of the on-going review of data systems and the update to the RBM, there should be an effort to assess the extent to which MHM outcomes can be tracked, and the necessary adjustments made to those systems.
2. **Harmonize programmatic approaches to MHM:** UNHCR should continue to work with partners at the global and country level to harmonize programmatic approaches to MHM. These approaches should utilize participatory process and should include specific guidance on how to identify and address needs of vulnerable groups (e.g. disabled, very poor, unaccompanied minors, orphans, and minority groups) among the wider female population. In addition, there should be a more concerted effort to reach a key demographic- adolescent girls, with information and education on MHM. These approaches should also include “location appropriate” targeting (age range) for general distribution of MHM materials and supplies, while maintaining mechanisms for girls and women outside of this range to obtain assistance if necessary. This will ensure financial efficiency by avoiding unnecessary distributions, while also ensuring protection concerns are addressed. In addition there should be greater investment by UNHCR and its partners to understand how MHM response evolves over time, from emergency onset through to protracted phases.
3. **Develop a technical brief on MHM programming for use by field staff:** This brief should outline the key steps to ensuring an integrated MHM response which address aspects for each of the three key pillars. This technical brief should also direct staff and partners to the existing practical guidance and tools that can be used. This is especially important as UNHCR moves to CBI and the delivery of MHM materials and supplies through multipurpose cash grants. Materials and supplies are only one of the three key pillars to successful MHM programming, and this needs to be clearly articulated to field staff.
4. **Identify key indicators related to MHM and systematically track in all operations.** Currently data are not available to be able to systematically track the MHM well-being of PoCs. Each relevant sector should assess the opportunity to collect relevant data on MHM. These data should be regularly collected, collated in the RBM and/or WASH Monitoring System and included in UNHCR’s annual Age, Gender and Diversity accountability report and other relevant publications.
5. **Conduct a financial analysis to inform planning and budgeting** A thorough analysis of expenditures on MHM materials and supplies should be conducted to better understand the unit costs of adequate MHM programming. This information will assist operations in planning and

budgeting and lay the groundwork to ensure financial efficiency and programmatic effectiveness. This analysis should also take stock of the experiences from livelihoods and vocational skill building as related to the production of MHM materials by PoCs. If appropriate, these analyses should be linked with the concept of gender budgeting. Such analyses will also assist in targeted funding raising for MHM, as budget was identified as one of the main bottlenecks to effective programming.

6. **Ensuring supportive infrastructure to facilitate MHM** Increased efforts are needed to ensure appropriately designed and located sanitation facilities as well as acceptable and appropriate menstrual waste collection, transfer and disposal systems. Specific focus should be made on MHM supportive facilities in institutions (e.g. schools, health care facilities, public spaces). UNHCR's education unit can play a leading role in disseminating the existing checklists and technical guidance on female friendly facilities- particularly in primary schools.
7. **Providing access to age and gender appropriate information, education, and communication:** Only two thirds of sites carry out education or training for women of reproductive age. The goal should be to ensure universal access to MHM education and training for both girls and women. In addition, separate and uniquely designed education should be provided to boys and men to help combat negative and potentially damaging stereotypes and stigma surrounding menstruation. UNHCR should work through the Division of Resilience and Solutions (Education) to review available IEC materials and ensure that MHM messaging is appropriate. This work can build on the gender and education consultancy which is already being programmed for 2019.
8. **Conduct research on effectiveness of cash based interventions and MHM:** As part of UNHCR's scale up of cash-based programming, there is a need for evidence to inform the most effective way to implement CBIs while ensuring optimal outcomes in regards to MHM and other core protection issues. There are substantial gaps across the existing evidence base for effective interventions to improve MHM in humanitarian contexts. UNHCR should work with partners to evaluate the data which is now being collected through the post distribution monitoring (PDM) toolkit rolled out in 2019. Case studies could be done with data coming in (e.g. Chad) to understand how MHM earmarked funds are actually being spent.
9. **Address the human resources issues related to MHM:** To effectively address many of the above recommendations will require the creation of a MHM technical working group composed of formal MHM focal points identified from existing staff within all relevant sections/units at HQ (e.g. WASH, Cash, SGBV, Reproductive Health, Youth, Education, Supply, etc.) as well as representatives from the Bureaus. As a number of the above recommendations are one-off activities and may require specific expertise, it is recommended to hire a consultant or staff on a temporary appointment to carry out the bulk of this work. More broadly across the organization, a capacity assessment should be conducted of the staff primarily engaged with the MHM response. The objective of this assessment will be to identify gaps in knowledge and specific needs in terms of training and capacity building. An online learning on MHM programming (based on the technical brief) could be developed.

Background

Amongst UNHCR's 68.5 Million persons of concern (PoCs) there are approximately 12.3 million girls and women of reproductive age for which menstrual hygiene management is a day to day issue. During their lifetime these women will be menstruating for approximately 3,500 days, or over one decade (WSSCC, 2013). Often this natural process of menstruating is subjected to taboo and stigma and the result is that menstrual needs are often overlooked or neglected.

UNHCR has made a commitment to empowering displaced women and girls to ensure that they have equal access to and control over management and provision of core relief items and cash based interventions including **sanitary materials and supplies** for menstrual hygiene management. However, this is only one aspect of MHM programming. Equally as important in the healthy and dignified management of menstruation is **safe access to adequate infrastructure** such as toilets and washing facilities and also **access to menstrual hygiene information and education**. This information includes: basic menstrual health education (especially for pubescent girls), practical information on wearing, washing and disposing of sanitary materials, and information which addresses harmful cultural or social norms related to menstruation. These three components represent the pillars of a comprehensive MHM response.

On May 28th, 2018 for the first time, UNHCR marked Menstrual Hygiene Day with a call to revitalize UNHCR's commitment to providing women and girls of concern with access to sufficient sanitary material and supplies, appropriate facilities and adequate information. This is necessary to safeguard their rights and improve their well-being and that of their families. This support is also in alignment with UNHCR's Age, Gender and Diversity (AGD) Policy and the commitments to Accountability to Affected Population (AAP). As part of the operationalization of the AGD policy, UNHCR is working to better understand how it is addressing the MHM needs of its persons of concern globally and to support country operations in planning for and responding to those needs.

To gain a global view of the way operations are currently addressing the MHM needs of our PoCs, the Division of International Protection (DIP) and the Division of Programme Support and Management (DPSM), developed a survey to gather information from all field operations at branch office and field/sub-office levels. This report summarizes the results of that survey.

Survey Limitations

The survey was developed online and was disseminated through an all staff email. The instructions included in that communication requested that only one representative from each site/location should complete the survey and that responses should include both activities conducted with UNHCR funds (i.e. through direct implementation or implementing partners) and operating partner funds. In some cases there was confusion about who should submit the survey, and some survey participants were unable to obtain partner information. However, the completion rate (79%) and response rate (20%) is in alignment with expectations for an online survey. As is the case with all online surveys, nonresponse bias is a risk (e.g. locations where the designated individual is unwilling or unable to participate). A number of respondents explicitly stated that they were unable to gather the required information from operational partners. Furthermore, the survey mainly involved multiple choice or limited response questions, which is not always conducive to large scale operations covering multiple populations. This is best explained by the feedback from one participant: "For the urban population, it is very difficult to provide some of the numbers. It would have been helpful to change the survey design so that it does not just ask for numbers but provides space to explain the answer to certain questions." Considering these limitations the survey data is presented to derive qualitative key messages and general recommendations moving forward.

Survey Findings

Menstrual Hygiene Programming

A total of 84 responses were received². This represents a rough response rate of 20%, when considering those offices which have operational activities³. This response rate is within the expected range for online surveys. Of the 84 responses, 45 (54%) stated that there were MHM related activities for the persons of concern (PoCs) that are covered by their office. A disaggregation of the responses is provided in Figure 1.⁴

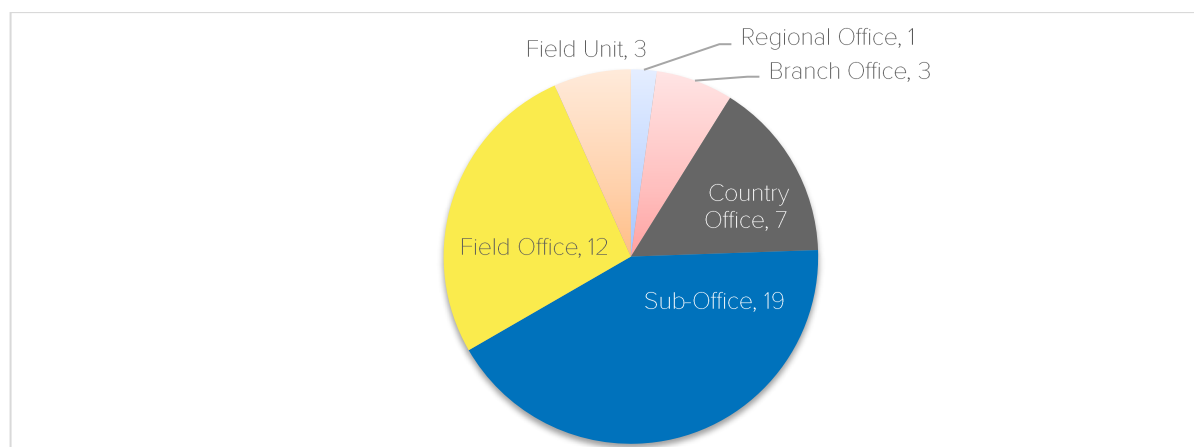


Figure 1 Designation of the office represented by the survey response.

. In most cases UNHCR is the coordinating agency either directly (n=35) or jointly through the protection cluster which is co-lead in (at least) one country.

Table 1 Response to: Which agency is responsible for the coordination of the overall MHM response for the PoCs in your site?

Agency	Count	Percent
UNHCR	35	78%
Protection Cluster	1	2%
Government	1	2%
NGO	4	9%
Other UN Agency	2	4%
No coordinator	2	4%
Grand Total	45	100%

Of the 45 responses only 34 provided information on budget for MHM: either the UNHCR expenditure (i.e. UNHCR direct implementation or partnership agreements with implementing partners)

² 106 surveys were submitted, however for 22 surveys the respondents stated that there WERE menstrual health management related activities for the persons of concern covered by the office, however they DID NOT complete any of the subsequent question and were therefore eliminated from analysis.

³ A list of all UNHCR offices worldwide (475) has 436 which are considered to have operational expenditures. These include Regional, National, Country, Sub, and Field Offices and Field Units.

⁴ The regional office of Panama provided information on operational activities in Panama.

or the expenditures made by operating partners. In addition, two respondents of the 34 did not provide information on the target population. A breakdown can be found in Table 2.

Table 2 Disaggregation of the responses provided to the MHM survey

	Count	Percent
NO MHM related activities reported	39	46%
MHM related activities reported	45	54%
Expenditure Not Reported	11	13%
Expenditure Reported	32	38%
Expenditure Reported but Target Population Not Reported	2	2%
Total number who completed the survey	84	100%

For those that reported both expenditure and population (n=32), the minimum per capita expenditure on all MHM programming was stated to be \$0.20 per person per year, while the maximum was over \$52 per person per year. The average was \$14.40 per person per year.

There are multiple different units within UNHCR operations, which are involved in MHM programming. Most commonly MHM is led by protection, WASH and supply. However, as you get closer to the field there are additional units involved in programming.

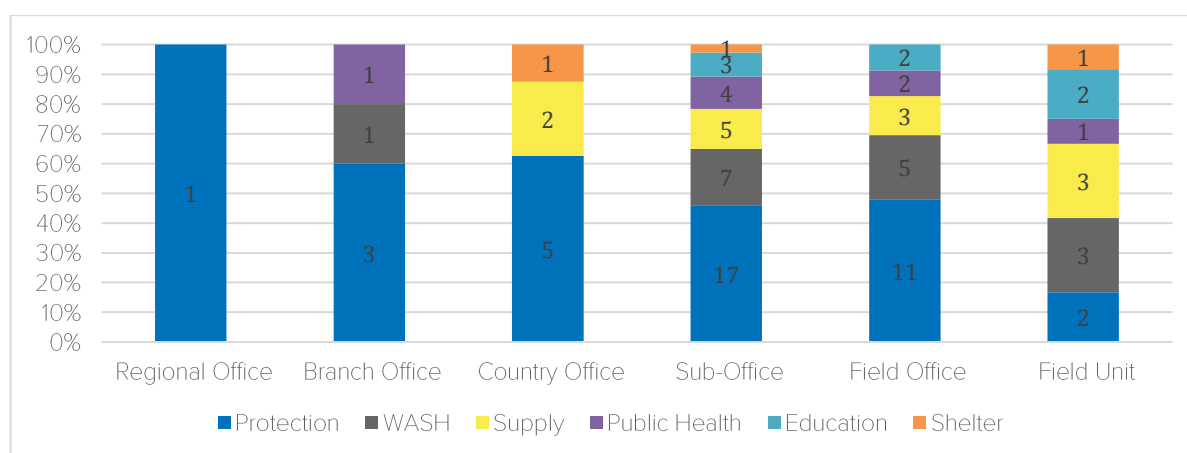


Figure 2 Units within UNHCR that are involved in menstrual hygiene programming.

Market and Needs Assessments

A “market assessment” (i.e. review of the available products and supplies in country) was done in 22 of the 45 locations. An assessment of the needs of the persons of concern was performed in 30 of the 45 locations with the most common approach to needs assessments being focus group discussions. A summary of the techniques used is shown in Figure 3.

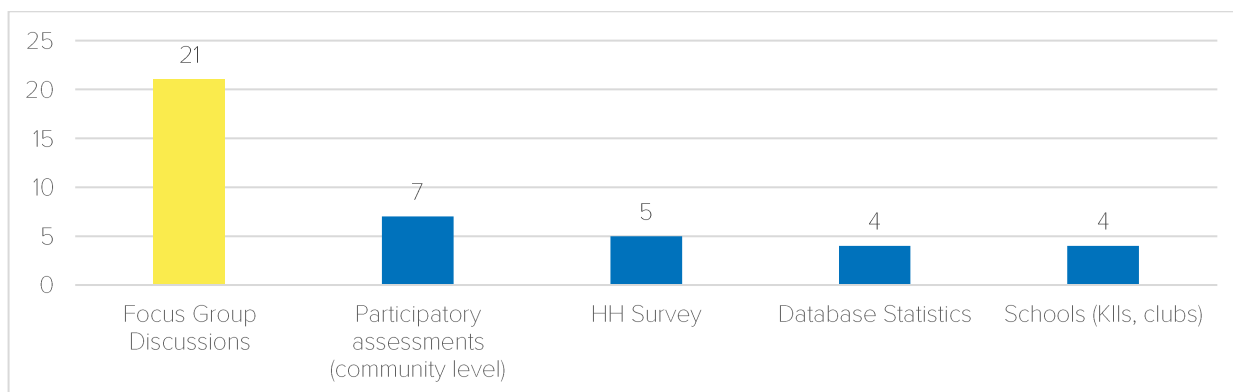


Figure 3 Various approaches used for assessing MHM needs of UNHCR's persons of concern

Targeting

Although the age of menarche (occurrence of first period) and menopause, can vary from country to country, the average age globally is 13 years and 49 years respectively (Thomas et al, 2001). In the survey, the most commonly cited age range targeted was 12 to 49 years of age. However eleven respondents stated that they were targeting girls as young as 8-10 years old and ten respondents stated that they were targeting women as old as 50-60 years. In one case, the specific age range was limited to girls between 16 and 18 years.

Feedback mechanisms and monitoring

Approximately two thirds of the respondents (n=34) said that there are mechanisms to gather feedback from women and girls on the approaches, materials, supplies, disposal, knowledge, attitudes, concerns related to MHM. The most commonly cited method was through focus group discussions (n=14), however post distribution monitoring surveys and home visits by hygiene promoters were also mentioned. (Figure 4)

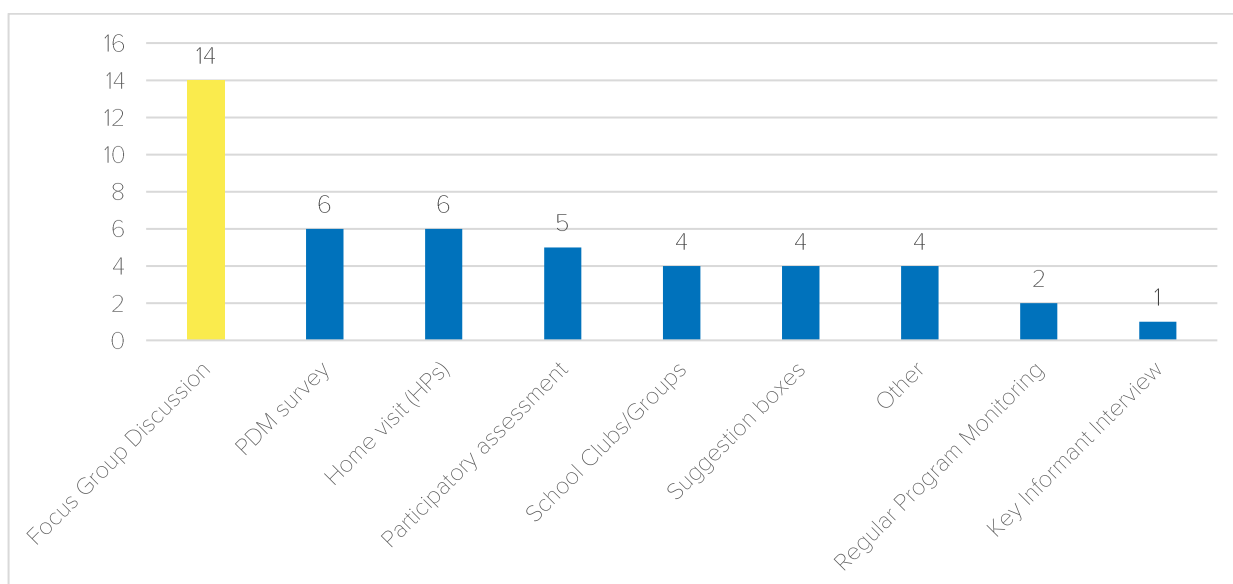


Figure 4 Mechanism for gathering feedback from persons of concern

UNHCR has identified a number of common indicators which can be used to understand the quality of MHM programming. These indicators are listed in Figure 5 along with the frequency with which the respondents said they are using them.

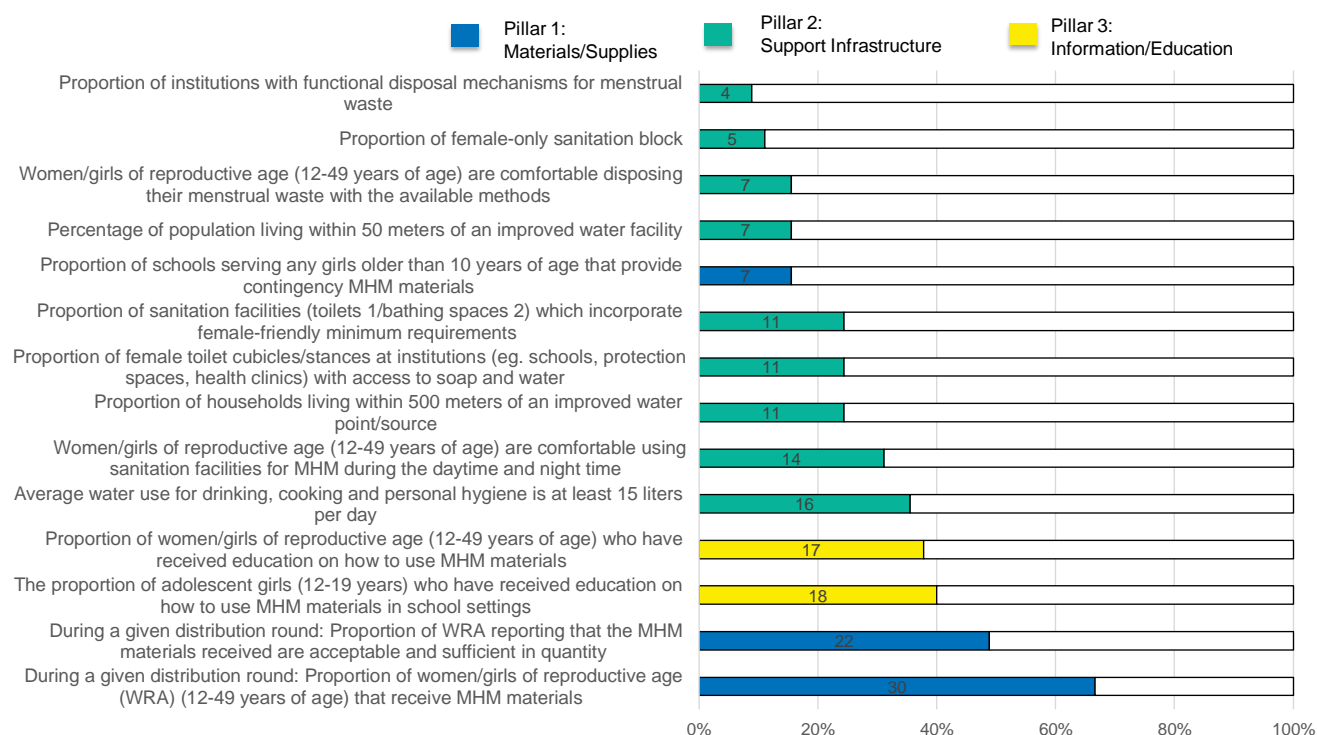


Figure 5 Indicators related to MHM and the frequency that they are used

Respondents were asked what percentage of the PoC's needs are met with regards to menstrual materials, soap, and underwear. Considering the budgets that were reported, the respondents reported that only 37-55% of the persons of concern covered by their office had their needs met (see Table 3 and Figure 6 for more information).

Table 3 Estimate of the % of PoCs whose needs are met in terms of MHM materials and supplies.

Menstrual materials (e.g. sanitary napkins, tampons)	Underwear	Soap
55%	37%	55%

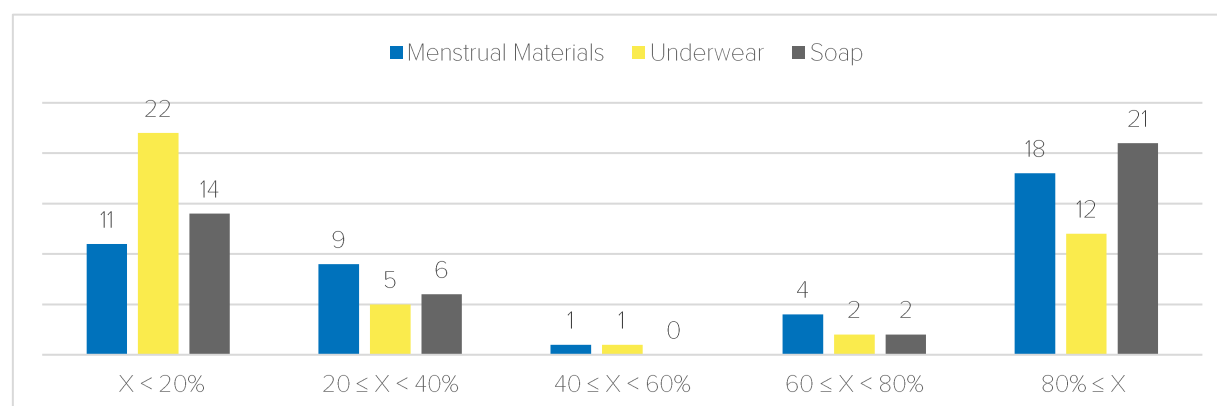


Figure 6 Percent of the population with needs met in regards to MHM materials, underwear, and soap

Pillar 1: Materials and Supplies

The first pillar to effective MHM programming is the availability and accessibility of materials and supplies. Menstrual materials refers to the substance that is used to catch the blood (e.g. pad, piece of cloth, tampon, cup, etc.). Menstrual supplies are the broader group of items that are needed to support the management of menstruation.



Figure 7 Range of items that are needed by girls and women for managing menstruation.
(Source: MHM in Emergencies Toolkit)

Cash-based interventions

Cash-based interventions (CBI) as an approach to delivering assistance has rapidly expanded and is being embraced across humanitarian sectors with aims of improved efficiency and sustainability, and to support dignity and choice amongst beneficiaries. UNHCR operational guidelines for CBIs in displacement settings describe two types of CBI: cash transfers (unrestricted) and vouchers (restricted).

According to the survey results, of the 45 respondents to the survey only four locations in three operations (Ukraine, Armenia, and Chad) are using cash as a mechanism for delivering MHM materials and supplies. In all cases the cash intervention is unconditional and unrestricted. The monetary value that is provided is between \$20 and \$65 per person, as a one off and is supposed to be used for all related menstrual hygiene supplies and materials.

Overall in 2018, approximately \$500 Million was channelled through cash programming. However, very little was allocated explicitly for MHM. According to Global Focus there are eleven countries which have CBI expenditures explicitly targeting menstrual hygiene supplies.⁵ The total expenditure for menstrual hygiene items in these countries was \$1.1 Million USD, or 0.22% of overall CBI programming. The majority of cash programming is done through multiple purpose cash, with 60% (approximately \$308 million USD) earmarked in Focus as “CBI cash assistance to beneficiaries for basic needs (multipurpose).” These multipurpose cash grants (MPG) were carried out in 94 countries. It is unknown the full extent to which MHM materials and supplies are included in the minimum expenditure baskets (MEB) which are used to as part of the analysis for targeting support to PoCs. However, in March 2018, the Cash unit in DPSM carried out an informal assessment of the MEB’s for the operations planning

⁵ There are a total of 19 countries which have expenditures corresponding to the account code 612560 Cash Assistance to Beneficiaries: Hygiene and Sanitation needs”, however a detailed review of the “budget line descriptions” found that only eleven countries had explicitly detailed menstrual hygiene materials or supplies. These are found in Annex 2.

MPGs. Fourteen operations, representing a total MPG programming budget \$91M, responded to that questionnaire. The findings showed that the MEBs included:

- ☐ MHM materials and MHM supplies/hygiene items(6 operations)
- ☐ MHM supplies/hygiene items only (3 operations)
- ☐ No MHM or hygiene items included (1 operation)
- ☐ MEB contents were unclear from documents available (4 operations)

The MHM materials and supplies represented between 1-7% of the total MEB for these operations, representing (\$0.44-\$9.94/person/month) No data were available on the actual expenditures on MHM made by beneficiaries. Furthermore it is unclear what complementary programming is being done in areas where MHM materials and supplies are monetized and delivered through CBIs (restricted/unrestricted or conditional/unconditional).

There have been no rigorous evaluations of the effectiveness of CBIs for menstrual hygiene. Even in non-emergency low income contexts, there are very few high quality studies that have looked at the impact of menstrual product provision and education. These studies are almost exclusively focused on improving MHM for school attendance amongst adolescent girls. A global review of MHM in emergencies noted that whilst there has been increased acknowledgement of MHM needs, technical guidance and evaluations of programming remain limited (Sommer et al., 2016).

In-Kind Distributions

According to Focus, there were 23 operations that had expenditures for output “sanitary materials provided” which would correspond to in-kind distributions. Total in-kind distributions were valued at \$23 Million USD.

For the MHM survey of the 45 responses, 41 are delivering menstrual hygiene materials and supplies through in-kind distributions. These were in a total of 22 operations. Figure 8 has a breakdown of the types of in-kind distributions which are made. In a number of locations, the distributions include multiple types of materials (so total adds to more than 41).

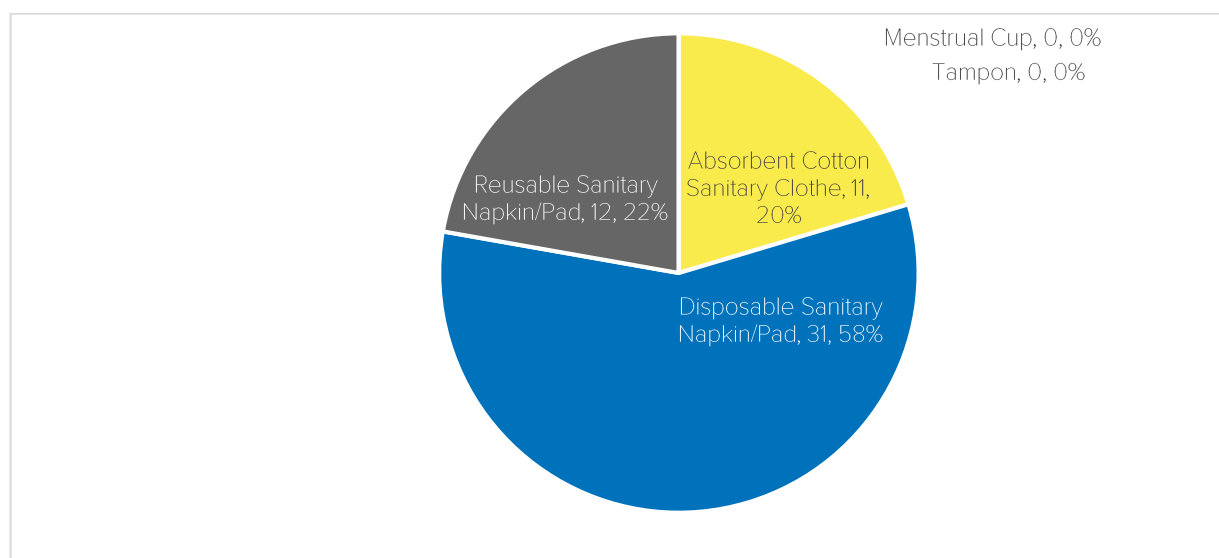


Figure 8 Breakdown of the types of in-kind MHM that are distributed to the PoCs.

Cotton Flannel

Beneficiaries were involved in the selection of the material, either through focus group discussions or through key informant interviews. However in at least two cases the choice was made because that was what was available in the UNCHR warehouse or because of the perceived religious and cultural

practices as determined by UNHCR staff. Distributions were most often made on a biannual or annual basis (see table 4 below)

Table 4 Frequency of distribution of cotton flannel

Frequency	Count	Percent
Monthly	1	9%
Quarterly	2	18%
Twice annually	3	27%
Annually	3	27%
Needs basis (with NFIs)	2	18%
Grand Total	11	100%

Of the 11 responses, 8 locations are pre-cutting the cloth into individual napkins with an average size of 39 cm x 32 cm. In only 2 of the 11 responses is the quantity of sanitary cloth distributed in alignment with UNHCR's minimum target of 4 sq. meters per person per year. Nine of the 11 are providing instructions for the use of the cotton cloth.

Disposable Sanitary Napkin

In the majority of cases the decision to use disposable sanitary napkins or pads was done through consultation with the refugees or PoCs. However in 8 responses the choice of disposable pads was dependent on what the donor wanted (or would provide in-kind)-(3 responses), what the partner proposed (1 response), or what was determined by UNHCR staff (4 responses).

On average, 15 pads are distributed to women/girls (median = 13 pads) per distribution. However, the range pads distributed was wide (minimum was one pad per distribution and the maximum number distributed was 72 pads per person per distribution. Additionally, and most importantly, the frequency of distribution varied widely (table 5).

Considering the number of pads per distribution and frequency of distributions a comparison was made to see if the absolute quantity of sanitary pads was sufficient to meet the UNHCR target of 12 disposable pads per person per month. In eight of the 26 responses, the quantity was sufficient, meaning that over two thirds of operations where sanitary napkins are distributed the quantity is insufficient.

Table 5 Frequency of distribution of disposable sanitary napkins

Frequency of Distribution	Count	Percent
Monthly	11	42%
Every other month	1	4%
Quarterly	5	19%
Twice annually	2	8%
Annually	2	8%
Needs basis (with NFIs)	5	19%
Grand Total	26	100%

In the majority of instances (88%) instructions were provided on the use of the pads, but less often did these instructions include information on the proper disposal (73%). In the majority of cases the respondents selected that “sanitary napkins are managed in the same way as all other solid waste” (69%). In the remaining instances (31%) separate consideration for the disposal was made, however in all but one case the special consideration was disposal in the latrine. Disposal of non-biodegradable materials such as sanitary napkins or diapers is inappropriate as it will cause latrines to fill up faster, can interfere with the degradation of waste, and can make desludging and eventual treatment of the sludge very problematic.

Reusable Sanitary Napkin

Distribution of reusable sanitary napkins or pads was very limited amongst survey respondents. The choice for using reusable pads was made with consultation of refugees in 3 out of the 4 instances, with the remaining response being cost effectiveness of reusable pads over alternatives. Reusable pads are distributed quarterly (1), twice annually (2) or as part of a project/*ad hoc* (1). Instructions were provided in all cases. As with the cloth and disposable sanitary napkins the number of sanitary pads distributed was not sufficient in all cases. The quality of the reusable pad will dictate the lifespan, however in two of the instances women were provided with an insufficient number of reusable pads to even manage a single menstrual cycle.

Disposal of menstrual materials is an issue regardless of the type of material used (cotton, disposable, reusable, etc.). Improper disposal can pose a risk to human health, but it also can indirectly impact on other functions in the camp. For example one respondent said that a 2017 household survey reported that 79% of women/girls interviewed use cloth to manage their menstruation (either provided by UNHCR or partners). 85% of these women disposed of the cloth in the latrine after each use. This increased the needs for costly (and hazardous) desludging by double or triple.

Table 6 Additional MHM-related items that were distributed

Item Distributed	Count	Percent
Underwear	25	56%
Soap	38	84%
Clothesline	4	9%
Pain medication	2	4%
Bucket or basin for washing/disinfecting sanitary materials	23	51%
Carrying case for items	5	11%
Carrying case for soiled MHM materials	4	9%
Other (please specify)*	10	22%
Total Answered	45	100%

*respondents listed various other hygiene items (tooth brush, comb, nail clippers, etc.).

Of the locations distributing underwear the majority are distributing it once a year and only half of the locations are meeting the suggested target of 6 pairs per person per year. Of the 36 locations that are distributing soap, two thirds are providing at least the recommended 250 grams per person for exclusive use for menstrual hygiene, separate from soap distributed for other uses. Of those respondents where operations are also providing soap for uses other than MHM approximately two thirds are meeting the targets of at least 200 g/p/month for laundry and 250 g/p/month for personal hygiene.

Table 7 Distribution of soap to PoCs

	Soap for MHM	Soap for Laundry	Soap for Personal Hygiene
Standard	(250 g/p/month)	(200 g/p/month)	(250 g/p/month)
Does not meet standard	12 (33%)	6 (21%)	6 (21%)
Meets standard	24 (66%)	23 (79%)	23 (79%)
Total	36 (100%)	29 (100%)	29 (100%)

Soap distribution is most often done on a monthly basis followed by quarterly and annually. Table 8 has a disaggregation of the responses.

Table 8 Frequency of soap distribution to PoC

Frequency	Count	Percent
Annually	7	18%
Twice annually	1	3%
Quarterly	6	15%
Every other month	2	5%
Monthly	21	54%
Need basis	2	5%
Total	39	100%

Post Distribution Monitoring

Roughly one-third of respondents said that there is no post distribution monitoring taking place at all in their locations. This was regardless of the approach (in-kind or cash) for materials and supplies

Table 9 Post distribution monitoring as reported in the survey

Post Distribution Monitoring	Count	Percent
Yes, regular PDM is carried out	12	26%
Yes, some PDM is carried out but it is only one time or irregular	20	43%
No PDM is carried out	15	32%
Total	47	100%

Pillar 2: Supportive Infrastructure

Equally as important as menstrual materials and supplies, is the supportive infrastructure such as sanitation and handwashing facilities, which allow girls and women to safely, privately, and effectively manage their menstruation. Supportive infrastructure is particularly important in public spaces such as schools, health care facilities, markets, etc.

For those locations where information was reported on school sanitation (n=29), the majority of respondents stated that the infrastructure does not meet the UNHCR standards in terms of the pupil to toilet ratio. A higher number of respondents (n=16) stated compliance with the standard for water supply.

Table 10 Standards of school water and sanitation facilities

	Overall number of pupils per toilet/drop hole	Girls per toilet/drop hole	Boys per toilet/drop hole	Number of Pupils per usable tap
Standard	Less than 50:1	Less than 30:1	Less than 60:1	Less than 200:1
Meet Standard	9 (30%)	7 (24%)	13 (45%)	16 (55%)
Do Not Meet Standard	21 (70%)	22 (76%)	16 (55%)	13 (45%)
Total	30 (100%)	29 (100%)	29 (100%)	29 (100%)

Respondents were also asked if the public facilities (schools, health care, and other public facilities) in their location met the general criteria for MHM-supportive infrastructure. The results are shown in Table 5 below.

Table 11- Status of the schools, health facilities, and other public places

	Schools	Health Care Facilities	Other Public Places
Safe access to these sanitary facilities (e.g. location identified by users, doors have inside locks, etc.).	82%	95%	72%
Access to water	92%	100%	90%
Access to soap	41%	69%	31%
Adequate Privacy (e.g. walls are not translucent, no cracks to see through, etc.).	77%	72%	51%
Facilities gender segregated	82%	85%	64%
Acceptable and appropriate menstrual waste collection, transfer and disposal system	23%	36%	18%
Provision of light source to ensure accessibility at all times	36%	56%	31%
Water access inside the cubicle	33%	38%	23%
Hook or shelf inside the cubicle	10%	15%	13%
Mirror inside the cubicle or facility	13%	18%	10%
Facilities accommodate disabled persons or other special needs users	26%	44%	15%
Unisex facilities or facilities which could be accessed by transgender people	5%	0%	3%

Pillar 3: MHM and Health Education

Equally important, and often forgotten in programming, is the need to carry out menstrual health education and menstrual hygiene promotion with adolescent girls and women. These activities should be integrated in to the existing hygiene promotion and health education and awareness activities and should cover topics such as:

- ☐ Education and demonstration on hygienic practices for managing menstruation (cleaning, changing, washing)
- ☐ Hygienic disposal of menstrual materials
- ☐ Education on puberty and menstrual cycles

There are many opportunities to engage in this education: health outreach or clinics, NFI distributions, and health education in schools.

From the UNHCR survey, twenty-seven of 42 locations (64%) said that they provide general education or training women of reproductive age. The topics that are covered in this training include: what menstruation is, how to handle it in a safe and hygienic way, including how to use MHM materials. A slightly lower number (25 of 42 respondents) said that the in the past year there was education or training provided specifically to adolescent girls on how to manage their menstruation in a safe and hygienic manner. In 22 locations these trainings for adolescent girls were conducted in schools, and in total over 38,000 refugee girls were trained on how to manage their menstruation. The number varied by location with an average of 1,800 girls trained per location. In nearly all cases this training was linked to sexual and reproductive health education programs. Only 8 out of 42 locations were also targeting boys or men in training programs. This represents a significant opportunity lost, in order to address harmful taboos or cultural beliefs related to MHM, it is necessary to capitalize where and when possible on opportunities to engage and educated boys and men.

Locations with no MHM activities

Although a total of 39 respondents said that there were no MHM activities at their location, only 19 completed the related sections to describe more about their context. Considering these 19 locations, the number of refugees covered by these areas was estimated by the respondents to be 1,010,158 people. There were four main reasons cited why MHM activities are not occurring in these locations (See Figure 9).

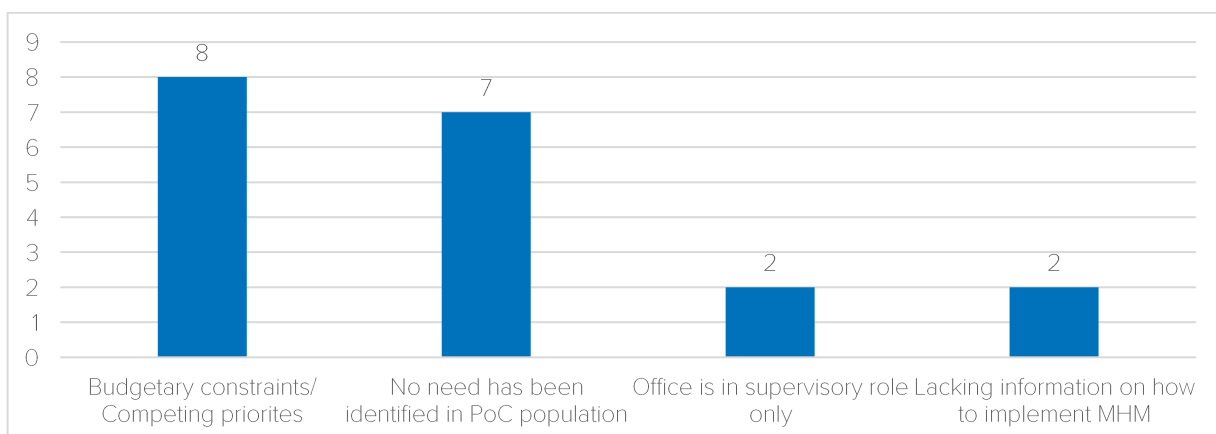


Figure 9 Reasons cited for why there are no MHM programs at the respondent's site.

Only 3 of the 19 locations were collecting information on the MHM needs of the female PoCs.

General Comments and Challenges:

At the conclusion of the survey, respondents were given the opportunity to provide additional feedback. Respondents cited numerous challenges to implementing menstrual hygiene programming with the most common being budgetary constraints. The second most commonly cited difficulty was in reaching mobile populations and PoCs outside of camps/settlements. In a number of cases the provision of “non-essential” or non-lifesaving support to PoC who are outside of camps or settlements managed by UNHCR or its partners was not possible because of the political implications of such support. In one case it was suggested that government refusal to permit distributions was based on the assumption that such support outside of camps could facilitate/motivate refugees to leave the camps.

Finally, a number of male respondents suggested as a male staff member it was difficult to answer questions or was, in fact, not their responsibility to know about MHM. These responses appear to be made regardless of the professional responsibilities or job description, which may include the need to be knowledgeable about the MHM response.

Conclusions and Recommendations

Under the AGD Policy published in 2018, UNHCR has the commitment to ensure the safety and well-being of women and girls. This includes their needs in regards to menstrual health and hygiene. The recent MOPAN evaluation of UNHCR found “There is strong strategic commitment within documentation to the addressing of gender issues corporately and operationally, but documentation does not provide evidence that UNHCR has the key elements required to systematically address gender concerns, including programme quality control systems, gender architecture and gender equality capacity building”

The following recommendations result from an assessment of the internal survey and consideration of the work being done by DIP and DPSM.

1. Ensure that MHM is integrated to the relevant global strategies and existing results frameworks

To effectively track progress on MHM programming, as part of the on-going review of data systems and the update to the RBM, there should be an effort to assess the extent to which MHM outcomes can be tracked, and the necessary adjustments made to those systems.

Given the limited survey response, additional research should be carried out to effectively characterise MHM programming globally and inform the creation of resources to better integrate MHM into UNHCR’s programming.

MHM should be integrated in to the new Global Public Health Strategy and

2. Harmonize the general MHM programming approach within UNHCR’s response

Global reviews have recognised the need to narrow the gap between MHM policy and practice. (Van Leeuwen, C. & Torondel, B., 2018).

According to the survey UNHCR is most often the lead agency in MHM response and furthermore considering UNHCR’s mandate, it should continue to work with partners at the global and country level to harmonise programmatic approaches to MHM.

Participatory processes should be used through the programme, this includes: conducting needs assessments to see what refugee needs and preferences are; including refugees in the selection of materials and supplies; ensuring that there are structured and universally and easily accessible mechanisms for PoCs to provide feedback. This is a critical step to ensuring compliance with the Grand Bargain commitment of 100% operations with feedback and response mechanisms by 2021.

Ensure that programming approaches provide guidance on how to identify and address needs of vulnerable groups (disabled, very poor, unaccompanied minors, orphans, and minority groups) among the wider female population.

Identify the “location appropriate” targeting age range for general distribution of MHM materials and supplies through participatory processes. Maintain a mechanism for girls and women outside of this range to obtain assistance if necessary. This will ensure financial efficiency by avoiding unnecessary distributions, while also ensuring protection concerns are addressed.

3. Develop a technical brief on MHM programming for use by field staff:

To facilitate harmonisation of MHM programming approach and address the issues raised in the recommendation above, a technical brief should be written.

This brief should outline the key steps to ensuring an integrated MHM response and provide guidance on tools that can be used- specifically linking to those tools that already exist. This is especially important as UNHCR moves to CBI and the delivery of MHM materials and supplies through multipurpose cash grants. Materials and supplies are only one of the three key pillars to successful MHM programming, and this needs to be clearly articulated to field staff.

4. Identify key indicators related to MHM and systematically track in all operations.

UNHCR has a clear mandate to ensure the well-being of girls and women, but currently data is not available to be able to systematically track the situation with regards to MHM well-being.

Collate this information and include in UNHCR’s annual Age, Gender and Diversity accountability report and other relevant publications.

5. Conduct a financial analysis to inform planning and budgeting

Although budgetary restrictions are a reality, there is a very real issue of whether provision of MHM materials and supplies is prioritized or what “calculus” is used to consider girls and women’s MHM needs against the overall needs.

A thorough analysis of expenditures on MHM materials and supplies should be conducted to better understand the unit costs to assist with planning/budgeting but also to facilitate the most efficient use of resources.

In addition, there should be additional analysis or stock taking of the experiences from livelihoods and vocational skill building as related to MHM. This should consider both the cost efficiency of these initiatives but also the impact on MHM related outcomes.

If appropriate these activities should engage linked with the concept of gender budgeting

6. Ensuring supportive infrastructure to facilitate MHM

Effective menstrual hygiene programming must address the needs of PoCs in regards to MHM materials and supplies, but it also must address any deficiencies in infrastructure or services related to MHM. This includes appropriately designed and located sanitation facilities as well as acceptable and appropriate menstrual waste collection, transfer and disposal systems.

7. Providing access to age and gender appropriate information, education, and communication

Only two thirds of sites are carrying out education or training women of reproductive age. Most of the training is targeting girls in schools and is linked to sexual and reproductive health training, which is a good first step. However, the goal should be to ensure universal access to MHM education and training in all situations for both girls and women but also for boys and men.

UNHCR should work with partners to ensure access to appropriate information, education, and communication materials. This will require collaboration and knowledge sharing with relevant actors in a humanitarian response.

8. Conduct research on effectiveness of cash based interventions and MHM

UNHCR's policy on CBIs is to scale up cash, doubling the amount of funds by 2020 and "seizing on every feasible opportunity to use CBIs where they contribute to realizing protection and solutions objectives."

The shift to CBI has not included MHM, but it is unclear why this is the case.

Recognising the general benefits of cash programming, the increased emphasis on cash programming will need to be tempered with evidence which informs the most effective way to implement CBIs while ensuring optimal outcomes in regards to MHM and other core protection issues. There are substantial gaps across the existing evidence base for effective interventions to improve MHM in humanitarian contexts. This will include; rigorous evaluation of the impact of CBIs for MHM, understanding barriers and facilitators to effectiveness and implementation, and by providing the first quantitative data on the menstrual experience of women and girls in refugee camp settings.

9. Address the human resources issues

Conduct a capacity assessment of the staff primarily engaged with the MHM response to identify gaps and specific needs. Linked to this will be the development of training materials and the identification of training opportunities.

Create a MHM technical working group composed of formal MHM focal points identified from existing staff within all relevant sections/units at HQ (e.g. WASH, Cash, SGBV, Reproductive Health, Youth, Supply, etc.).

If appropriate, hire a consultant that can take the lead to address these recommendations.

References:

Sommers, M., Schmitt, M., Clatworthy, D., Bramucci, G., Wheeler, E., & Ratnayake, R. (2016). What is the scope for addressing menstrual hygiene management in complex humanitarian emergencies? A global review. *Waterlines* 35(3).

Thomas, F., Renaud, F., Benefice, E., De Meeus, T. & Guegan, J (2001) International Variability of Ages at Menarche and Menopause: Patterns and Main Determinants. *Human Biology*, 73(2) pp 271-290.

WSSCC (2013). Celebrating Womanhood: How better menstrual hygiene management is the path to better health, dignity and business. Water Supply & Sanitation Collaborative Council, London.

Annexes:

Annex 1: Reasons why no MHM activities are carried out

Below is a list of the reasons provided by respondents as to why UNHCR or its partners are not carrying out MHM related activities for the PoC in their site. The responses have been modified to ensure the anonymity of the respondent. These are divided into four main categories:

1. Insufficient budget or not a priority

Operation is focused on protection/border monitoring, ensuring provision of basic medical and psychological support, free legal aid.

Operational activities relating to direct assistance do not include MHM

Project partner did not include MHM in their proposal

We are a relatively new office with limited staffing resources, combined with a number of very serious protection issues (for example: refoulement, lack of access to asylum, vulnerabilities due to lack of documentation and no work authorization), which have led to other activities, like MHM, being deprioritized.

In the previous years, UNHCR through the implementing partners have conducted many activities related to MHM. Currently the operation is facing a great budget challenge and enormous gap regarding each area of basic need assistance. For this matter any NFI regarding MHM have not been purchased this year.

Distribution of MHM materials and supplies was not budgeted for.

Reduced budgets has resulted in the discontinuation of distribution of dignity kits

2. MHM interventions are not needed:

Refugee population is mostly comprised of male individuals

We had not identified it as a need in our operation. We have mostly urban PoC and give CBI (which does not include MHM)

Refugees and asylum-seekers are able to access sanitary material.

Girls and women have access to menstruation materials although sexual education is restrictive.

Refugees have access to all services of centres for social welfare same as citizens, including MHM.

Upon arrival those asylum-seekers who meet the vulnerability criteria, are accommodated at the Reception Centre where they are provided with monthly allowance during their stay. Both refugees and asylum seekers are eligible to apply to the relevant State authority for medical/social assistance in case they face financial constraints. All the hygienic materials are available in the country and they can be purchased by the PoCs. Thus, given the situation that the hygienic means are available and financially vulnerable PoCs are assisted by the government.

3. No information available

Lack of information about MHM in the operation.

4. Not our responsibility

Responsibility for PoCs rests with the Government

Annex 2: Detailed budget lines from Focus which include MHM

The below table has a list of all the operations which have expenditures corresponding to the account code 612560, "Cash Assistance to Beneficiaries: Hygiene and Sanitation needs". However, out of these 19 operations, looking at the "budget line descriptions", there are only 11 operations had explicitly detailed menstrual hygiene materials or supplies (highlighted in yellow below).

Operation	Budget_Line_Description	Total
Algeria	kits hygienique pour femme, lait et couche bébé	\$10,614
Cameroon	Assurer la distribution mensuelle des Kits hygieniques via le CBI ou le voucher aux femmes en age de procreer du	\$149,977
	Frais de suivi des transactions liés au CBI	\$8,991
	Frais liés aux diverses transactions CBI-MTN	\$19,499
Chad	Urgence - Achat de bassines pour tous les sites	\$81
	Urgence - Bidon Vide de capacité 20 litres (les 2 équipes)	\$108
	Urgence - Chaise pour clinique mobile (5 sites, 10 chaises par site)	\$1,124
	Urgence - Savon pour l'hygiène au niveau des sites	\$755
Democratic Republic of the	Assistance en cash pour renouvellement des kits Nfis aux PBS	\$3,000
	CBI - Achat materiels locaux et frais main d'oeuvre pour construction latrines/douches individuelle / 1272 nouveaux	\$71,232
Djibouti	Markazi: Procurement of Family Hygiene kits for the new arrivals (250 kits)	\$10,169
Ethiopia	Cost of Sanitary pad provision under CBI	\$17,560
	Cost of Soap provision under CBI	\$84,914
	Cost of Woman underwear provision under CBI	\$56,100
	Cost of Men underwear provision under CBI	\$56,100
India	Provision of sanitary napkins and hygiene kits for a year for 1500 girls and women in the refugee settlements for 8	\$10,862
Jordan	NRC: Hygiene - camp population (1 round per quarter @ 5 JODs per HH of a total of 16,600 HH @100%)	\$468,927
	NRC: Hygiene - UNHCR Recommendations - 5 JODs per person for 310 b/f per month	\$26,271
	NRC: Replenish expired items in hygiene kits for new arrivals	\$46,610
Kenya	CBI for procurement of latrine materials	\$4,651
	Provision of Cash to PoCs for procurment of latrine materials	\$4,341
Niger	achat Savons pour le camp de Sayam	\$23,737
	Seances de salubrite (JM Salubrite)	\$1,618
Nigeria	provision of sanitary materials to 50 women of reproductive age	\$506
RO Pretoria	Multi-purpose cash/voucher (Sanitary Materils)	\$717
Rwanda	REQ# 0002 • Delivery of cash for soap and sanitary pads for 3,717 families (19,790 persons) living in Kigeme camp	\$173,020
Saudi Arabia	(blank)	\$10,000
Uganda	Monthly Incentives for 30 community based hygiene promoters	\$11,003
Venezuela	Kits de higiene	\$15,000
Zambia	Construction 50 sanplats	\$1,296
Grand Total		\$1,232,68

Annex 3: Survey Form

Survey can be downloaded [here](#).

Annex 4: Countries that responded to survey

Row Labels	Are there any MHM related activities for the persons of concern that are covered by your office?
Afghanistan	3
Algeria	1
Armenia	1
Belarus	1
Cameroon	4
Chad	2
Cuba	1
DJIBOUTI	1
DR Congo	1
ETHIOPIA	1
Indonesia	1
NIGER	1
Panama	1
Russian Federation	1
Rwanda	1
Somalia	6
South Sudan	1
Sudan	5
Tanzania	4
Uganda	4
Uganda	1
Ukraine	2
Zimbabwe	1
Grand Total	45

Annex 4: In-Kind Distributions of Menstrual

Below is a table of the operations which have listed expenditures in Focus for 2018 for Output 418AG “Sanitary materials provided”. Countries are ranked by the expenditure.

#	Operation	MSRP_Operation	Total
1	Ethiopia	ETH ABC	\$4,353,119.69
2	Somalia	SOM ABC	\$4,072,652.20
3	Islamic Republic of Iran	IRN ABC	\$3,328,564.33
4	Uganda	UGA ABC	\$2,961,674.67
5	Kenya	KEN ABC	\$1,980,143.33
6	Yemen	YEM ABC	\$1,892,086.49
7	DRC	COD RO ABC	\$1,245,014.44
8	South Sudan	SSD ABC	\$742,977.03
9	Jordan	JOR ABC	\$733,648.17
10	Malawi	MWI ABC	\$285,917.52
11	India	IND ABC	\$254,662.07
12	Zambia	ZMB ABC	\$245,469.81
13	Burkina Faso	BFA ABC	\$187,148.80
14	Sudan	SDN ABC	\$167,484.03
15	Indonesia	IDN ABC	\$153,466.97
16	Ghana	GHA ABC	\$138,142.09
17	Rwanda	RWA ABC	\$121,152.50
18	Saudi Arabia	SAU ABC	\$94,646.90
19	Zimbabwe	ZWE ABC	\$68,784.06
20	Congo	COG ABC	\$50,000.00
21	Cameroon	CMR ABC	\$37,141.39
22	RO Pretoria	ZAF RO ABC	\$30,345.44
23	RO Dakar	SEN RO ABC	\$2,717.00
	Grand Total		\$23,146,958.93

Institutional Survey on Menstrual Hygiene Management