**CONCEPT NOTE PROPOSAL**

**On**

**MENSTRUAL HYGIENE MANAGEMENT (MHM) OF RURAL GIRLS IN ETHIOPIA**

1. Introduction

Ethiopia is one of the signatory countries for MDGs/SDGs; which the member states of the UN agreed on during the Millennium Summit in 2000, are important guiding principles for the policy on development co–operation. They are quantitative goals, which must be achieved by the efforts of governments of both developing and developed countries within a period of 25 years. In recognition of this; Ethiopia has formulating and implementing National Strategy on Water, Sanitation and Hygiene (WASH) towards ensuring Sanitation for Dignity and Health. Among the priority action in the ESDP IV; School Water, Sanitation and Hygiene (WASH); Gender and Education and School Health and Nutrition are included and the Key outcome targets to decrease the drop-out and repetition rates for both boys and girls throughout primary education (G1-8) .This will expected decrease to 1.0% and at least 70% of number of drop outs and repetition in primary education in all grade levels in all subjects and all type of assessments and exams will score at least 50% and at least 20% of the students will score 75% .

Although often not acknowledged, it is clear that measure to adequately address menstrual hygiene and management will directly contribute to SDG-7 on environmental sustainability. Additionally, due to its indirect effects on school absenteeism and gender discrepancy, poor menstrual hygiene and management may seriously hamper the realization of SDG-2 on Universal Education and SDG-3 on Gender Equality and Women Empowerment. However, the attention on this issue is far from sufficient. Even the literature on gender mainstreaming insanitation sector is silent on the issues of menstrual management.

The total population of Ethiopia in 2013 is estimated more than 86,225,821 of these, 43,506,492 (50.5%) are males and 42,719,328 (49.5%) which is projected from 2007 Census). The population of Ethiopia grew at an average annual rate of 2.6% between 1994 and 2007 and Ethiopia is the country of young population. In Ethiopia 84% of the population are living in the rural areas and only 16% of the population are living in the urban areas. Ethiopia is among the African countries showing progress in achieving economic growth and development. Ethiopian Health and Education policy aims to access the population with Universal Primary Health Care and Primary Education coverage with particular emphasis to the rural areas.

The goal of the Education Policy is Education for All and improvement in student achievement through a consistent focus on the enhancement of the teaching/learning process. Transformation of the school into a motivational and child-friendly learning environment is among the plane of the Education Sector Development Program (ESDP) IV The main goal of the ESDP is to improve access to quality basic education in order to make sure that all children, youngsters and adults, with particular emphasis on females, acquire the competencies, skills, values and attitudes enabling them to participate fully in the social, economic and political development of Ethiopia.

According to the ESDP IV the current enrolment stands at 83% of primary school aged children and ESDP IV will be a historic landmark in making free primary education compulsory in order to give a major boost to education and to reach the remaining 17%, the most vulnerable children who are still out of school. Although the 17% is not disaggregated by sex, it is clear that majorities are girls and it may also include victims of MHM which needs special attention.

By 2021, the total number of school going pupils in Ethiopia was 28,700,000 out of which 14,500,000 were girls and 15,200,000 were boys. School girls of puberty age were about 12,300,000. Approximately 84% of these girls attend primary schools in rural areas where access to standard sanitary pads is very limited and expensive option that is will not be indicted as part of their family monthly expenses, which is further complicated by women and girls lack of control over resources and limited discussion about menstruation between girls and their father the decision maker and who controls over household resources. These leave the adolescent school girls to use unhygienic pieces of old cloths which can expose them to genitourinary tract infections and or stay home during menstruation.

The goal of the Health Policy of Ethiopia is ‘Health for All’; and it focuses on providing quality services. Health Care services in an accessible and equitable manner to reach all Ethiopian through accelerating expansion of Primary Health Care Coverage; and the Health Extension Program (HEP) are the pillars of the universal access to Primary Health Care in Ethiopia. The Health Extension Program contains sixteen packages; seven of them are about Hygiene and Environmental Sanitation (but not included MHM); and five of them are about Family Health and the remaining are about disease prevention and control. The Health Extension Program has included promoting gender equality in accessing health services as one of its objectives. However, neither in the Personal Hygiene and Environmental Health nor in the family Health components; menstrual hygiene is clearly included; hence without the inclusion of MHM achieving the Health Extension program objectives as well as the Universal Access to Primary Health Care is never will be complete.

Among the priority action in the ESDP IV; Water, Sanitation and Hygiene(WASH) in School, Gender and Education and School Health and Nutrition are included and the Key outcome targets the drop-out and repetition rates for both boys and girls throughout primary education (G1-8) that will intend to decrease to 1.0% and at least 70% of students in all grade levels in all subjects and all type of assessments and exams will score at least 50% and at least 20% of the students will score 75% .Unless the problems related to menstruation is treated within the school intervention; and HRW reducing the dropout rates and improving performance of girls might not be feasible, these objectives can only be achieved by including menstrual Hygiene Management in the school plan and budget.

Different studies were conducted by different agencies and professionals like, SNV, UNICEF and other international, and the studies established among other things that, primary school girls in rural areas who have reached puberty like their counterparts elsewhere suffer for lack of proper menstrual care, i.e. water, appropriate toilet facilities, appropriate sanitary wear, and guidance from school teachers or parents during their monthly menstrual cycle.

As per the study conducted by SNV Netherlands Organization in Ethiopia (2011) at 27 schools surveyed (4 secondary, 23 primary); 90% of the schools did not have adequate toilet and hygiene arrangements – ranging from no toilet or washing facilities to combined toilets for boys and girls, no privacy (e.g no doors) or at most very dirty latrines. Approx. 38% of girls do not attend school during menstruation. Absenteeism leads to critical loss of learning time. On average about 3-4 days per month can be lost for girl students. These girls are from poor communities where access to sanitary resources are limited, the purchase of sanitary pads is simply too expensive. They use unclean pieces of clothes which expose them for health risks including urinary and reproductive system infections.

Ethiopia, like other developing countries, is to reduce morbidity and mortality caused by exposure to agents of disease and exacerbated by environmental hazards. Priority areas include water supply and sanitation, solid waste management and hygiene education. Better excreta disposal facilities benefit men, women, girls and boys. They offer privacy, convenience and safety. But most sanitation programs necessarily do not mention the special needs of women and adolescent girls who use latrines to manage menstruation. It's a need that has been excluded from latrine design/construction as well as hygiene education packages. Hence, reproductive and preventive health programs in developing countries like Ethiopia often do not address the issue and moreover they focus mainly on the reproductive functions of married women. Menstruation, though a natural process, has often been dealt with secrecy in many parts of Ethiopia. Hence, knowledge and information about reproductive functioning and reproductive health problems amongst the adolescent is poor. A great deal of women’s and girls' scant knowledge is informed by peers and female family members.

The gender unfriendly schools and infrastructure, and lack of adequate menstrual protection alternatives and / or clean, safe and private sanitation facilities for female girls and teachers, undermine the right of privacy, which results in fundamental infringement of the human rights of female students and teachers. Even in the homes, a culture of shame forces women to find well hidden places to dry the rags. These places are often damp, dark and unhealthy. Rags that are unclean can cause urinary, vaginal and perinea infection. Very often serious infections are left untreated and may sometimes lead to potentially fatal toxic shock syndrome.

Menstrual Hygiene Management is yet to be integrated effectively in overall hygiene promotion interventions in Ethiopia. Evidences from the field are imperative to emphasize the issues. Thus, this Baseline Survey on MHM in School will be focused on the current WASH status in schools and how menstruation hygiene is being managed in view of collecting information that will form basis for future programming and current Programme implementation.

1. **Justification/Rationale of the Study**

People often find it embarrassing to talk about menstruation, the monthly period when the unused lining of a woman’s uterus, rich in blood to feed and protect a fertilized egg, is discharged. However, methods of sanitary protection are extremely important for health and dignity. Women and girls need to change their sanitary protection around three or four times a day during the period of menstruation[[1]](#footnote-1)**.** In the Ethiopian context, what is available to them in terms of sanitary protection often varies according to their income. Poor women are likely to use a variety of inexpensive, reusable materials. In some rural areas of Ethiopia found that to purchase sanitary protection at market prices cost around a tenth of a poor family’s monthly income – equivalent to the cost of enough paraffin for a month – which is prohibitively expensive.

As per the assessment conducted by TCECA/CARE in Ethiopia (2012) on MHM in Amhara Regional State; Female Teachers are also face challenges due to inadequate sanitation facilities in schools. Many schools do not have adequate toilet facilities for men and women, and lack sanitary bins to dispose of sanitary products. In many social events; menstruation is associated with uncleanness which restricts the behavior of women at these times. Such taboo could reinforce a woman’s sense of shame or low self-image. Hence, menstruation often causes physical discomfort, cramps, tiredness and nausea[[2]](#footnote-2). As a result of this; menstrual hygiene of girls and women has been insufficiently acknowledged as a problem. In several cultures of Ethiopia there are (cultural and or religious) taboos concerning blood, menstruating girls and women and menstrual hygiene. There is also structural gender inequality, which continues to exist through the widespread preservation of (sex–tied) preconceptions, stereotypes and cultural patriarchal attitudes, because of which the position of women as independent actors is being undermined daily[[3]](#footnote-3).

Furthermore, lack of attention to this issue is striking. Most of the Ethiopian women know from their own experience how important good menstrual hygiene is to be able to function optimally during menstruation. Yet this is hardly realized by in particular politicians, programmers and policy makers. This is also surprising in view of the explicit relation of this issue to water and sanitation and distribution of all kinds of diseases due to poor menstruation hygiene, which can be reduced considerably by good hygiene[[4]](#footnote-4). As per this assessment on MHM; the following facts were obtained:

* Few social-entrepreneurs have actively engaged in developing alternative and affordable sanitary pads to manage MHM issue although it has crossed many a mind in passing;
* Expert from the Health (Water & Sanitation) sector equally were amazed at the absence of MHM issue from both technical and rights based discourses, but unable in most cases to point out in the direction of substantive work on these issues;
* The study on gender mainstreaming in Water & Sanitation sector, is silent on MHM adequacy of water for washing and bathing, availability of hygienic materials and solid waste management of disposables. Interventions in this area are restricted to very small pilots, with extremely minimal follow-up and limited dissemination of results;
* Although poor sanitation is correlated with absenteeism and dropping-out of school girls in Ethiopia, efforts in school sanitation to address MHM issue have ignored menstrual management in educational curriculum, latrine design and construction. Wider aspects of MHM issue such as privacy, water availability and awareness-raising amongst boys and men remain largely unexplored by advance initiatives;
* Limited hygiene promotion efforts have recently started focusing on this area but mainly on the software aspects i.e. telling girls and women about correct practices. These efforts do not currently target men and adolescent boys, nor do they systematically inform infrastructure design;
* Absence of effort that has led into production and social marketing of low-cost sanitary pads, reusable materials, research into bio-degradable sanitary pads, etc. Research and development efforts have been limited to commercial ventures that even today are unable to market products that are affordable for the poorest of the poor.
* MHM issue on the package of washing of soiled materials and environmentally friendly disposal of sanitary pads is absent from waste management training, infrastructure design and impact evaluation;
* Need to have menstrual management as a priority in wash in schools. This seems to be relegated at the expense of water and toilets; and
* In short, Menstrual Management is missing from the literature and practical actions whether it is manuals to sensitize engineers to gender needs or technical manuals on latrine design, sanitation for secondary schools, solid waste issues, composting, bio-degradable materials or even simple training modules for health and sanitary workers.

On the other hand; in sub-Saharan Africa, adolescent girls’ participation in school is generally very poor. Even in contexts where gender parity is achieved in the early grades, by late primary school (Grades 4 or 5) the numbers of girls in school has dropped significantly. In reviewing education data, enrollment rates are important. Yet retention and successful completion rates provide a stronger test of Education for All (EFA) achievements and more particularly of achievement of the SDG 2. In an International Rescue Committee study of primary schools in Guinea, although girls represented almost 50% of students in early grades, they made up only 34% of those who complete the cycle at Grade six[[5]](#footnote-5). Such drops in girls’ participation can be attributed to multiple factors, including the lack of female teachers, and therefore successful role models, curriculum content that is irrelevant to girls’ lives, and the poor quality of schools, both the facilities and the instruction. Another under-explored factor, and hence the subject of this article, are the linkages between the onset of menarche, girls’ response to sexual maturation, and the subsequent impacts on their educational access and experience. Anecdotal evidence from a number of countries suggests that a main reason the onset of menses disrupts schooling are familial expectations that a post-pubescent girl will marry and move to her new husband’s home, thereby removing her from her school. In some societies, ‘menarche’ may be seen as shameful if occurring in unmarried girls due to beliefs that its onset is somehow linked to sexual intercourse[[6]](#footnote-6).

On the other hand, insufficient or inadequate sanitary protection can be very embarrassing for a girl attending school during her monthly Menstruation. This is made worse if her school clothing is flimsy, worn and/or too small for her. Soiled uniforms can provoke ridicule from boys as well as from other girls, putting her at great risk of experiencing stigma and discrimination. For girls who cannot afford to buy washing soap, regular cleaning of her uniform or school clothes may not be easy. This situation means that for many girls and young women it is preferable to stay at home during menstruation and not to attend school at all. At home they do not have to worry as much about sanitary protection, nor about having adequately concealing clothing. Few of the girls’ mothers attended school and so they do not have experience to share with their daughters as to how to manage menstruation away from home. Regular absence from school for several days a month can – even in the short term - have a negative impact on a girl’s learning and therefore on her academic performance in school[[7]](#footnote-7)**.**

Poor sanitary facilities in schools also affect women teachers’ experiences. Outside of Nepal where, as mentioned, there are cultural taboos operating which discourage women from teaching during menstruation, it is very likely that women teachers elsewhere are frequently absent during menstruation due to the inability of the school infrastructure to meet their health and hygiene needs. Given the unavailability of substitute teachers due to teacher shortages all over the developing world, this means that teachers’ instruction time in school will be reduced by 10-20%[[8]](#footnote-8). Therefore, these absences inevitably impact on the quality of children’s education. They may also contribute to shaping children’s attitudes about menstruation.

Where girls are able or determined to attend school throughout menstruation, the insufficient facilities and sanitary protection may nevertheless create discomfort for girls in the classroom and an inability to participate. For example, menstruating girls may hesitate to go up to the front of the class to write on the board, or to stand up as is often required for answering teachers’ questions, due to fear of having an ‘accident’ and staining their uniforms. The very short skirts worn by girls in many African schools may add to these feelings of self-consciousness. This discomfort is augmented when male teachers and students show insensitivity to the challenges girls face in managing menstruation. Male teachers, for example, do not always understand a girl’s urgent need to go to the bathroom, and may insist that she wait until the end of class. Worse still are the situations where male teachers and boy students tease the girls[[9]](#footnote-9)**.** This teasing may be fueled by the lack of knowledge about normal biological and maturational processes, and reinforced by local cultural myths or beliefs about menstrual blood.

In recognition of the above and other related problems on MHM; TCECA works in Amhara, Oromia, SNNP and Tigray regional states in the three global priority components such as WASH, Agriculture and Energy. TCECA is dedicated to build the capacity of local actors to increase access to safe water, sanitation and hygiene. One of the areas of the capacity development support is school WASH program. An inquiry undertaken in pilot schools of some TCECA supported District/Woredas on management and use of school latrines revealed that adolescent girls find the school latrines inappropriate for providing the required sanitation and hygiene during menstruation periods. The latrines are poorly designed and lack of privacy, water is unavailable, there is limited guidance and support on how to hygienically manage menstruation.

**3. Objective of the Study**

The overall objective of this baseline survey on MHM was to undertake a comprehensive assessment on menstrual hygiene in school through collecting, analyzing and documenting important information based on the verifiable and measurable data collecting tools and identify baseline information against which future changes due to the project intervention. The specific objectives of this baseline survey were to:

1. Assess the prevailing knowledge and sources of information about MHM of school girls;
2. Elaborate the experiences and factors that determine the prevailing practices of school girls vis-à-vis MHM practices;
3. Identify key factors that have been contributed to poor MHM; and this baseline survey on MHM will intend to identify and assess approaches, strategies and key activities that would be helped for the achievement of girls’ education; and
4. Propose specific measures to improve Menstrual Hygiene Knowledge and Management of school girls.

**4. Organization of Baseline Report**

The baseline survey report on MHM in School will be arranged into four sections. *Section one* presents introduction, background, objectives, rational and review of related literature. *Section two* provides an insight into the overall survey methodology that has been so far employed. *Section three* presents baseline survey findings and discussions. Finally, section four presents conclusion and recommendations based on the findings from this baseline survey and other related studies have been undertaken earlier.

**5. Scope of the Work**

*Tiret Community Empowerment for Change Association (TCECA)*, the Researcher will undertake baseline survey on MHM through addressing all relevant information that demonstrates the social, economic, cultural and environmental aspects of the study population. To this end, it will perform the following key activities but not limited to:

* Develop data collection tools, refining them in consultation with SNV and field testing of tools;
* Translate close-ended questionnaires, in-depth interview guides, FGDs checklist and informed consent forms into Amharic;
* Establish database template for data entry using SPPS software;
* Enter quantitative data into computer software, cleaning and analyzing;
* Compile and analysis of quantitative and qualitative data; and
* Analyze baseline results, writing and submitting draft report, and producing final report after incorporation of feedback from stakeholders.

**6. METHODOLOGYOF THE STUDY**

**6.1. Study Areas, Population and General Considerations**

The study will be carried out at six Woredas (Sodo, Sebeta Hawas, Tole, Bure, Machakel and Meskan) selected purposefully on primary and secondary schools. A total of 12 primaries and six secondary schools (two primaries and one secondary school per woreda) selected from TCECA intervention Project Areas. This represents around 45% out of the total number of 40 TCECA supported schools. The sample size per woreda is aimed at 128 closed-ended questionnaires in total, out of which, 41, 43 and 44 questionnaires will be distributed (for each woreda) to Grade 7-8, Grade 9-10 and Grade 11-12 (Precatory) respectively. About 30 open ended questions were also distributed for Focus Group Discussions (FGDs). The respondents will select from each Grade by using *Cluster Sampling* as groups, not individuals, are randomly to be selected. Since, all the respondents of the population groups from each Grade have similar characteristics on menstruation issues.

The target populations for this baseline survey are school girls, boys, teachers, parents and other key informants. Relevant respondents at school level for this baseline survey will be identified in consultation with Woreda Education Offices and necessary arrangement has made to get information as relevant. Close- ended questionnaires, open-ended questions for Focus Group Discussions, and structured questions for in-depth interview for key informants were prepared for this baseline study. The contents of the data collection tools were based on standard questions on MHM KAP. These questionnaires prepared in English, and translated into Amharic for easy reference for data respondents and collectors.

Both primary and secondary data will be collected for this baseline survey. Secondary data will obtain by reviewing relevant documents while primary data was analyzed through conducting quantitative data (close-ended questionnaires) and qualitative data (FGDs and key informants interview) methods. This study will analyzed based on descriptive cross-sectional in which mixed methods (quantitative as well qualitative) that will be applied. A self-administered close-ended questionnaire survey (quantitative), and FGDs, and structured interviews (qualitative) will be applied to collect the information on MHM in school. The school girls participated in the close-ended questionnaire within each school will be selected based on cluster random sampling selection from adolescent school girls in the primary, secondary and precatory schools, most of whom have experienced with periods. The senior women teachers will be facilitated the close-end questionnaires and school girls FGDs at each school.

**6.2. Determination of Sampling Size**

With regards to the calculations of the sample size population of 768; it will use the following formula in order to estimate the population study. Since there is no prior information about the Population (P) study; it was obtained a conservative estimate of the required sample size is calculated by considering as:

P=Q=1/2, i.e. P=Q=1-P. Thus, n= Z\*2PQ, whereas ‘ME’ is Margin of Error;

**(ME)** 2

Since, it is not known the size of P or Q; by taking the formula P=Q=1/2, i.e. P=Q= 1-P; it is calculate the size of the sample population.

Therefore, by taking 95% of Confidence of Interval, ‘n’ is calculated as follows:

|  |
| --- |
| N = Z\*2PQ = Let Value of Z = 1.96 and Value of ME=0.05  (ME) 2  **N = (1.96)**2  **(0.5)(0.5) = 3.84\*0.25 = 384**  **(0.05)**2 **0.0025** |

**Note**: As per the above calculation, the exact sample size population for this study is 384. However, in order to make more representative sampling and minimize high errors in the filling of close-ended questionnaires by respondents, it was multiplied by two this sample size population i.e. ***384 \* 2 = 768***. Therefore, this sample size was intentionally made double in order to obtain optimum results from the larger number of respondents.

**6.3. Study Tools and Population Study Categories**

These schools are selected in consultation with Woreda Education Offices using convenient and purposeful sampling technique. The sample population included students above Grade-7 (girls and boys), parents (male and female), community leaders, Woreda WASH Team, HEWs, School Directors, senior women and male teachers. *Cluster random* sampling technique was employed in the selection of school girls from Grade-7 and above (Grade 7 to 12) at both primary and secondary schools. Girls who were staying in the nearby homes surrounding the school and were willing to participate in the study were also included. *Convenient sampling technique* was used in the selection of boys, parents, and teachers for FGDs as well as their willingness to be involved in the study. *Purposive sampling technique* was also used in the section of key informants including School Directors, HEWs, WWT, Community Leaders, and Shop Keepers for in-depth interview depending on their availability, willingness and readiness to participate in this study.

**6.3.1. Close-ended Questionnaires**

Three (3) schools selected from each woreda which comprises; two Primary School (Grade 7-8) one from rural and one from peri-urban; and one Secondary School (Grade 9-10 and 11-12) from urban. These schools were chosen based on purposeful and convenience method to represent different terrains as well as rural-urban areas of the project site, and also to keep it within SNV Netherlands Development Organization project area. Experienced facilitators and enumerators assigned for the conducting of close-ended questionnaires; and Focus Group Discussions (FGDs). This data was analyzed by using computer software of SPSS version-20.

**6.3.2. FGDs Participants and Key Information**

About 30 FGDs to be selected (5 FGDs for each woreda); of which 12 FGDs for school girls and 12 FGDs for boys; and six(6) FGDs for parent and teachers were conducted; and a total of 300 participants (140girls, 120 boys and 40 teachers) were attended in the Focus Group Discussions (FGDs). Besides, 32 key informants, of which 6 School Directors, 5 WWT, 6 HEWs, 7 Community Leaders and 8 Shopkeepers, were interviewed during the baseline survey.

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***June 20/2022***

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4. TCECA-CARE Ethiopia: Assessment Report ed.al. 2012. [↑](#footnote-ref-4)
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7. UNICEF et.al.2006 [↑](#footnote-ref-7)
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