The United Republic of Tanzania
Ministry of Health

NATIONAL MENSTRUAL HEALTH AND HYGIENE GUIDELINES

FIRST EDITION | 2025

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FOREWORD

Menstrual health and hygiene (MHH) is critical for girls' and women's health and their well-being, mobility, education and economic empowerment and to ensure gender equality and preserve their dignity. In Tanzania, there are 15 million menstruating girls and women out of the population of 61.7 million. In order to manage their menstrual experiences safely and with dignity, it is imperative that women and girls have access to reliable, accurate and comprehensive information, adequate water, sanitation and hygiene facilities, protective materials of their choice, and care and supportive environment at school, community, workplaces, public places and in humanitarian settings.

The Tanzanian government through the Ministry of Health (MoH) has been at the forefront of improving menstrual health and hygiene conditions in collaboration with development partners and other stakeholders at all levels in the country. Over the last decade, many measures, such as mobilizing stakeholders, strengthening regulations on the safety of menstrual materials, addressing economic incentives, increasing access to menstrual materials and products, improved facilities, capacity building and social and behaviour change, have been successfully implemented. However, more needs to be done to bridge the prevailing gaps in MHH services and to address the negative sociocultural norms, leaving no one behind.

Menstrual health and hygiene is an important component of gender-responsive health services and an integral part of the National Health Policy goals and National Development Vision 2025 . Now that we have a foundation that has allowed us to learn, research and pilot the initiatives, these guidelines provide us with a stepwise guidance on how stakeholders from national, subnational and community levels across sectors should deliver MHH-responsive programmes and services that are inclusive and sustainable.

This is an exciting moment for women and girls of Tanzania to excel, and it is time for boys and men to join hands and support them. Indeed, investing in MHH is a responsibility and opportunity to provide transformative change towards equitable society for sustainable development.

I therefore urge all the stakeholders to adopt and make use of these guidelines in their respective settings and invest in the provision of female-friendly services that will meet the menstrual health and hygiene needs of all women and girls in Tanzania.

Dr. Seif A. Shekalaghe

PERMANENT SECRETARY

ACKNOWLEDGEMENTS

These guidelines were developed using a participatory approach, involving key ministries including the President's Office – Regional Administration and Local Government; Ministry of Water; Ministry of Education, Science and Technology; Ministry of Community Development, Gender, Women and Special Groups; and Ministry of Industry and Trade. Other stakeholders involved in the preparation were development partners, higher learning institutions, research agencies and civil society organizations, to mention a few, who provided their technical expertise across five major pillars of MHH and committed their time to reading and reviewing various chapters of the guidelines.

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Finally, the Ministry would like to appreciate the efforts of all those who participated in every step of developing the guidelines and toolkits, which will help to improve the quality of MHH services holistically in the country.

Dr. Grace E. Magembe

CHIEF MEDICAL OFFICER

GLOSSARY OF TERMS

Term	Definition
Pre-puberty	The two- to three-year period preceding puberty, that is, 8 to 10 years of age. It is a good period to prepare the boys and girls for puberty.
Puberty	The natural physiological process that boys and girls undergo to become sexually mature. In essence, this is the period a child's body matures into an adult body, capable of sexual reproduction. It involves a series of physical, emotional and social changes, in both boys and girls, that lead to the development of secondary sexual characteristics, including full development of the male or female reproductive organs.
Adolescence	The phase of life between childhood and adulthood, from the age of 9 to 19 years. It is a unique stage of human development and an important time for laying the foundations of good health.
Menarche	Menarche is defined as the first menstrual period in a female adolescent. Menarche typically occurs between the ages of 10 and 16 years, with the average age of onset being 12.4 years.
Menopause	The time in a woman's life when her menstrual periods stop and she is no longer able to have children. A woman is considered to have reached menopause when she has not had periods for over a year. It often happens between the age of 45 and 55 years, but it can occur earlier or later. Menopause is not an event but rather a process that is preceded by physiological changes referred to as perimenopause.
Perimenopause	The perimenopause is the period leading up to the menopause that can last for more than 10 years. It involves hormonal fluctuation, which can cause various symptoms in a woman, including heavy flow during menstrual periods.
Hygiene	Conditions and practices associated with the prevention of the spread of diseases and preservation of good health. It consists of behaviours related to the safe management of human waste, such as handwashing with soap, or the safe disposal of used menstrual products and materials. Good hygiene involves keeping oneself and one's surroundings clean, to prevent illness or the spread of disease. Hygiene therefore represents cleanliness relating to good health.
Hazardous waste	Waste that poses a potential threat to public health and the environment. It can be in solid, liquid or gaseous forms. Hazardous waste is classified into infectious waste, highly infectious waste, sharps waste, pathological waste, pharmaceutical waste, genotoxic waste, chemical waste and radioactive waste.
Infectious waste	All materials suspected to contain pathogens (bacteria, viruses, parasites or fungi) in sufficient concentration or quantity to cause disease in susceptible hosts. This category includes waste contaminated with blood or other body fluids.
Menstrual cycle	The menstrual cycle is the series of changes a woman's body goes through every month in preparation for the possibility of pregnancy. Each month, one of the ovaries releases an egg in a process called ovulation. If ovulation takes place and the egg isn't fertilized, the lining of the uterus sheds through the vagina. A cycle is counted from the first day of a period to the first day of the next period. The average menstrual cycle is 28 days long. Cycles can range anywhere from 21 to 35 days.

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Menstruation	A biological process resulting in the periodic flow of blood as a discharge from the uterus, usually on a monthly basis, from the onset of puberty until menopause, except during pregnancy. A natural part of the reproductive process that occurs to prepare a woman's body for pregnancy. If a woman does not become pregnant, the uterus sheds its lining. This shedding is called menstruation and is evidenced by the flow of blood through the uterine canal.
Menstrual health	A state of complete physical, mental and social well-being, not merely the absence of disease or infirmity, in relation to the menstrual process (Hennegan 2021).
Menstrual hygiene	The (i) articulation, awareness, information and confidence to manage menstruation with safety and dignity using safe hygienic materials; together with (ii) adequate water and space for washing and bathing with soap and (iii) disposal of used menstrual products and materials with privacy and dignity.
Menstrual health and hygiene	Menstrual health and hygiene (MHH) encompasses both MHM and the broader systemic factors that link menstruation with health, well-being, gender equality, education, equity, empowerment and rights. These systematic factors have been summarized by UNESCO as accurate and timely knowledge, available, safe and affordable materials, informed and comfortable professionals, referral and access to health services, sanitation and washing facilities, positive social norms, safe and hygienic disposal and advocacy and policy.
Menstrual health and hygiene-friendly facilities	Water, sanitation and hygiene (WASH) and facilities for disposing of menstrual materials in institutions, workplaces, public spaces and private households that are designed and maintained in ways that are responsive to the specific needs and desires of the menstruating women and girls.
Menstrual health and hygiene education	Age-appropriate, culturally relevant information about MHH provided in institutions, community and public places through various media and related channels, with the aim of increasing knowledge, inculcating correct practices and changing the perception and attitudes towards menstruation and its management.
Menstrual materials/ products	Any material that girls and women use to absorb or soak up menstrual blood during menstruation. These can include disposable pads, reusable pads, tampons, cotton wool, menstrual cups and pieces of cloth.
Menstrual products and materials/sanitary waste	These are used menstrual absorbents that contain blood, which may consist of used diapers, sanitary towels, napkins, tampons or menstrual cups, which need to be disposed of safely.
Modern reusable pads	These are reusable pads, which are certified and use approved materials/ fabrics to make them.
Public place	The centre of contemporary social life such as street parks, commercial centres, bus stops and marketplaces that accommodate the public in different ways (*The Journal of Public Space 2016, Vol.1, no. 1*).

ACRONYMS

ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
ASRH	Adolescents' Sexual Reproductive Health
BDM	Behaviour Driver Model
BRELA	Business Registration and Licensing Agency
CIMB	Contraceptive-Induced Menstrual Bleeding
CSO	Civil Society Organization
CHW	Community Health Worker
DI	Destination Inspection
DPO	Organization of People with Disability
EPZA	Export Processing Zone Authority
FBO	Faith-Based Organizations
GBV	Gender-Based Violence
IPC	Interpersonal Communication
IPOSA	Integrated Programme for Out-of-School Adolescents
LGA	Local Government Authority
MHH	Menstrual Health and Hygiene
MIT	Ministry of Industry and Trade
MoCDGWSG	Ministry of Community Development, Gender, Women and Special Groups
MoEST	Ministry of Education Science and Technology
MoF	Ministry of Finance
MoH	Ministry of Health
MoW	Ministry of Water
MSME	Micro, Small and Medium-Size Enterprises
NBS	National Bureau of Statistics
NIMR	National Institute of Medical Research

PMS	Premenstrual Syndromes
PPE	Personal Protective Equipment
PO-RALG	President's Office – Regional Administration and Local Government
PVoC	Pre-verification Certificate of Conformity
PwD	People with Disability
RS	Regional Secretariat
SBC	Social and Behaviour Change
SBCC	Social and Behaviour Change Communication
SEM	Social Ecological Model
SEQUIP	Secondary Education Quality Improvement Programme
SIDO	Small Industry Development Organization
SME	Small and Medium Enterprise
SRWSSP	Sustainable Rural Water Supply and Sanitation Program
STI	Sexually Transmitted Infection
SRH	Sexual and Reproductive Health
SWASH	School Water, Sanitation and Hygiene
TBS	Tanzania Bureau of Standards
TFNC	Tanzania Food and Nutrition Centre
TIC	Tanzania Investment Centre
TIE	Tanzania Institute of Education
TIN	Tax Identification Number
TMDA	Tanzania Medical Device Authority
TTCIH	Tanzania Training Centre for International Health
UNFPA	United Nations Population Fund
UTI	Urinary Tract Infection
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Chapter 01

INTRODUCTION

1.1. Background

Menstruation is a physiological process that occurs monthly among adolescent girls and pre-menopausal adult women. Regular menstrual periods point to a healthy and functioning reproductive system in a woman. Menstruation affects girls and women psychologically, emotionally and physically, shaping their fertility, sexuality and broader social life. Menstruation brings about additional needs such as access to menstrual materials, secure and dignified space for personal hygiene and supportive social environment that are necessary for their optimal health and well-being. While menstrual experience may be a source of pride and prosperity, girls/women deprived of essential needs face psychosocial stress and reproductive health challenges that may be a barrier to their health, education and development potential.

An estimated 1.8 billion girls and women from around the world are actively menstruating, of whom 300 million observe menstrual periods on any given day (UNICEF 2019; World Bank 2022). Based on the 2022 national census, 15 million people in Tanzania are women and girls of reproductive age, actively involved in reproduction and societal development. However, a significant number of these women are constrained in managing their menstruation and reaching their potential due to lack of knowledge, limited access to water, sanitation and hygiene (WASH) facilities, appropriate menstrual materials, medical care and supportive social atmosphere. Improving menstrual health and hygiene (MHH) is hence vital to ensuring the health and well-being of women and girls, supporting gender participation in economic development, developing positive social norms and social integrity and attaining improved standards of living.

Improving MHH creates an enabling environment for women and the community to flourish socially and economically, a key factor for accelerating the attainment of the National Development Vision 2025. MHH is also central for the country to achieve a number of global development goals. By managing discomfort and complications and improving sexual and reproductive health, it promotes health and well-being in line with Sustainable Development Goal (SDG) 3. Through increased access to adequate WASH services and products, preserving women's dignity and abolishing menstrual-related shame, the aims of the SDG 6.2 can be met. By creating favourable conditions for learning, allowing adolescents and older girls to effectively engage in education and limiting absenteeism, thereby improving quality, the SDG 4 is fulfilled. Moreover, among adolescent girls, peri- and pre-menopausal women in communities and workplaces, MHH leads to empowerment, enhanced participation, increased access and reduced gender inequality to accessing opportunities, thus accelerating the realization of several other SDGs, notably SDGs 5, 8, 11, 12 and 15.

Notwithstanding the progress made, the gaps in MHH services remain high in the country, where 83 per cent of schools are without girl-friendly facilities, 72 per cent of school-going adolescent girls lack the right knowledge and negative socio-cultural norms remain evidently prevalent in communities according to recent survey report (NIMR 2021). Considerable investment will be required to address these gaps. This requires political will, commitment, coordination and accountability. Therefore, these guidelines define the purpose and scope of MHH management and provide technical guidance using which efforts can be made to improve MHH programming for broader socio-economic development.

Studies extrapolating the situation in schools, workplaces and humanitarian communities revealed the MHH challenges that the communities face. The challenges that adolescents face in and out of school are significant compared to the other issues. NIMR (2021) and Sommer et al. (2018) have highlighted the negative socio-cultural norms that place significant limitations to progress of women of all ages. This includes non-supportive MHH conditions in workplaces (USAID 2022). Limited access to material and associated reproductive and family health effects affect women of reproductive age, across the age ranges. Poor sanitation infrastructure in homes and communal areas, including widespread limited access to clean and safe water, impairs the well-being of adolescents and adult women.

1.2. Rationale for the MHH guidelines

Despite having policies, strategies, guidelines, frameworks and ongoing programmes in WASH and other related sectors, the provision of MHH services has not been addressed comprehensively and coherently, thus limiting availability, affordability and access to most appropriate MHH information, services and products. It is therefore imperative to have comprehensive guidelines that will guide multi-sectoral stakeholders on the provision of equitable and inclusive MHH services, facilitate effective coordination, holistic planning and budgeting, technical guidance, implementation, monitoring and evaluation both in development and humanitarian settings.

1.3. Objective of the guidelines

The objective of the MHH guidelines is to provide a stepwise guidance on how stakeholders at the national, subnational and community levels, across sectors, should deliver MHH-responsive programmes and services that are inclusive and sustainable to achieve the health and well-being of girls and women in Tanzania.

Specifically, the guidelines focus on the following:

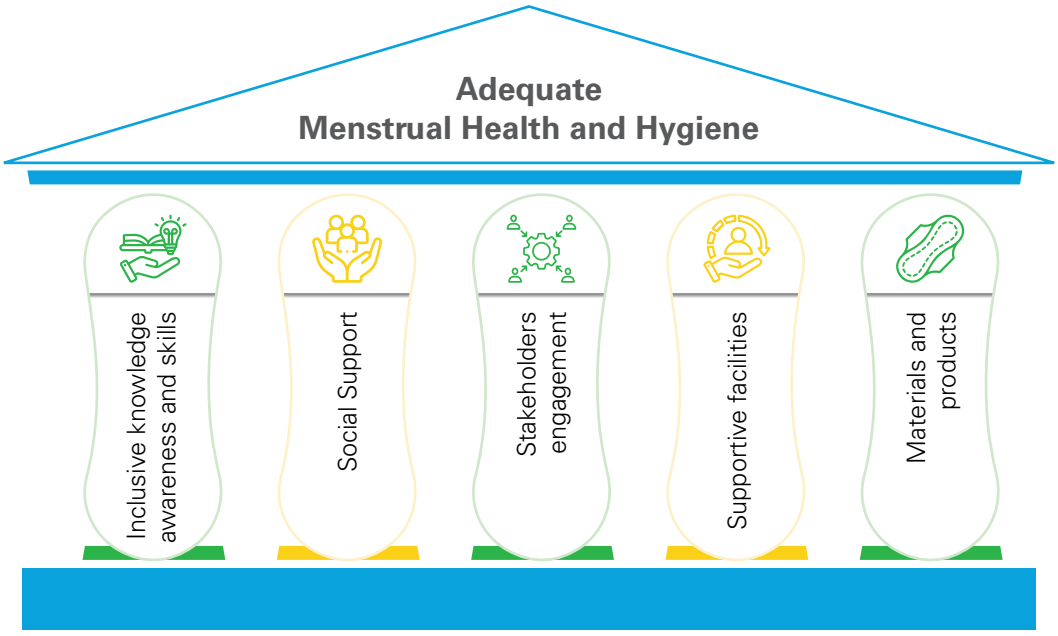
1. Guide appropriate content for MHH education and social behaviour change and delivery approaches for different target groups.
2. Describe forms/types and designs of appropriate materials, health requirements and specifications, production and trading rules.
3. Provide technical guidance and specifications on essential infrastructure, facilities and amenities, including used menstrual products and materials management requirements in institutions and communities.
4. Describe the governance and coordination systems and mechanisms that facilitate stakeholder coordination, planning and budgeting, and monitoring and evaluation of MHH programmes at all levels.

1.4. Scope of the guidelines

These guidelines cover five key pillars as shown in Figure 1.1 that cater to the MHH needs considering the needs of women and girls with different kinds of disabilities and other vulnerabilities in institutions, workplaces

and communities and in- and out-of-school adolescents in public places and development and humanitarian settings. It also addresses cross-cutting issues of the legal and institutional framework, monitoring and evaluation and sustainability plan.

Figure 1.1: Pillars of adequate menstrual health and hygiene services



The five pillars depicted in Figure 1.1 are interlinked and embrace a holistic approach to providing adequate menstrual health and hygiene considering people with different kinds of disabilities and vulnerability as detailed below:

Inclusive knowledge, awareness and skills: This pillar entails the inclusion of MHH in education and health programmes to build knowledge and skills for boys, girls, women, men and the entire community.

Social support: This pillar entails the provision of social support through public advocacy, social mobilization and interpersonal communication for positive behavioural transformation at home, institutions and communities.

Quality materials and products: This pillar entails support and increased sustainable access to acceptable menstrual materials and products in an equitable and inclusive manner.

Supportive infrastructure and facilities: This pillar stresses on access to inclusive and gender-responsive WASH facilities, sustainable supply of water and hygiene amenities, safe disposal of MHH waste, and the operation and maintenance of facilities.

Effective stakeholder engagement and planning: This pillar requires the identification of stakeholders, defining their roles and responsibilities and instituting collaboration and coordination mechanisms for effective engagement in MHH programming.

1.5. Users of the guidelines

Considering MHH is multisectoral, these guidelines are intended to be used by all actors, including policymakers and decision-makers from sectoral ministries, regional secretariats (RS), local government authorities (LGA), development partners, Organization

of People with Disabilities (DPO), non-government organizations (NGOs), civil society organizations (CSOs), private sector, research and development institutions, learning institutions, schools, community and those with interest on MHH. The guidelines are complemented by five toolkits that provide details on the implementation of MHH interventions within the framework of the five pillars, as described in Table 1.1.

Table 1.1: Details of the documents on MHH interventions

S/No	Document	Description	Users
1.	MHH Guidelines	These are the main guidelines that provide guidance based on five key MHH pillars and standard requirements for effective MHH services in Tanzania.	Stakeholders involved in MHH from national to subnational level
2.	Toolkit on Menstrual Health and Hygiene Training of Trainers	The toolkit is divided into nine modules that address key intervention areas related to MHH training and skills development: **Modules 1:** Necessity, concept and components of MHH **Module 2:** Biology of menstruation, menstrual cycle and reproduction process **Module 3:** The menstrual hygiene, care and health **Module 4:** Safe disposal options for used menstrual products and materials **Modelue 5:** Nutrition for healthy menstruation **Module 6:** The role of boys and men in MHH **Module 7:** Inclusion of persons with disability in MHH **Module 8:** Teaching and learning MHH in schools, institutions, workplaces, community, humanitarian settings and emergency response **Module 9:** Myth and taboos for various regions and tribes in Tanzania **Module 10:** Training skills,methods and evaluation	Trainers tasked with building capacity for cascading the MHH knowledge and skills
3.	Toolkit on the Integration of Menstrual Health (MH) into Sexual and Reproductive (SRH) Education and Service Delivery	This toolkit is designed to empower the implementers of SRH programmes on integrating menstrual health into the implementation of SRH education and services provision in institutions (schools and health care facilities), communities, emergency response and humanitarian settings.	SRH programme developers and implementers, including schools, communities, health service providers, non-government organizations, faith-based organizations and others

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S/No	Document	Description	Users
4.	Toolkit on MHH Social and Behaviour Change (SBC)	The toolkit provides a step-by-step description concerning SBC for MHH for stakeholders seeking to address socio-cultural limitations to MHH.	Programmers, project staff members and supervisors addressing the behaviour change aspect of MHH
5.	Toolkit on MHH Products and Materials	This toolkit is designed to empower trainers, MHH enterpreneurs, institutions and other individuals to provide knowledge and skills about MHM material and product safety, material types and standards, compliance measures and management of MHH products and materials at the individual and institutional levels as well as describing methods and steps to local production including sewing of reusable pads.	MHH trainers from government and private sectors, including CSOs, FBOs, Organization of People with Disabilities (DPO), MHH entrepreneurs, caregivers and individuals who may wish to educate themselves and increase their knowledge on MHH products
6.	Toolkit on MHH Facilities	The toolkit describes the key technical aspects of the construction of MHH-friendly facilities in practical terms and identifies acceptable designs and related technical standards for female-friendly WASH and disposal facilities for girls and women, including those with special needs and considerations of operation and maintenance.	The government and its institutions, NGOs and private sector addressing WASH and related infrastructure and services at all levels
7.	Toolkit on MHH Monitoring and Evaluation	This toolkit is designed to break down the implementation of the national guidelines in practical terms. It describes how monitoring and evaluation (M&E) activities are drawn from MHH projects from planning to the implementation stage. The toolkit provides model tools for MHH data collection. The toolkit also demonstrates how the M&E indicators outlined in the guidelines are to be put into operation in real-life programming.	Those involved in designing and implementing MHH projects and programmes within the government, NGOs and partner organizations, individuals and groups

1.6. Organization of the document

This document has a total of 10 chapters. The first four chapters cover the general issues on background, the current MHH situation, policy and legal framework and stakeholder coordination. The subsequent six chapters (Chapters 5 to 10) focus on the specific pillars of MHH, which are inclusive knowledge awareness and skills, social support, materials and products, facilities and services, monitoring and evaluation, and the sustainability framework.

Chapter 02

THE CURRENT SITUATION

2.1. Global and regional perspective

Many women and girls worldwide do not have the knowledge and skills, or access to services and products, or support to ensure their well-being during menstruation. Globally, 500 million women and girls out of 1.8 billion lack access to adequate facilities and products they need to manage menstruation (WB 2022). At the same time, there is evidence that ensuring good menstrual health and hygiene (MHH) contributes to the health and well-being of women and girls and promotes gender equality.

Africa has a population of 1.43 billion people, of whom 371 million (26 per cent) are menstruating women and girls (UNFPA ESARO, 2022). Across Africa, only 29 per cent of health care facilities have improved basic sanitation facilities, which include provision of menstrual health and hygiene facilities. Furthermore, 46 per cent of health care facilities have basic water services, and 40 per cent have basic health care waste management services, whereas only 54 per cent of schools across Africa have basic sanitation and 38 per cent have basic hygiene services (WHO 2022).

Good nutrition is crucial for psychosocial development, for which dietary and lifestyle habits need to be established that continue into adulthood. Girls need additional, more than twice the amount of iron when they start to menstruate and will continue to need it well into adulthood to prevent anaemia (FAO, 2004; WHO, 2006c). The prevalence of anaemia remains high in sub-Saharan Africa, affecting 36 per cent of adolescent girls (Public Health Nutrition 2021). Thus improving nutrition with double uptake of iron for adolescent girls is vital to eliminate the burden of anaemia and malnutrition, thereby securing their menstrual health.

The disposal of used menstrual products becomes complicated, given strong cultural beliefs around menstrual blood. In some contexts, girls and women have undisclosed fears about the risks of infertility or diseases from the burning of used menstrual products. The absence of proper disposal options leads many girls and women to discard the used menstrual products via burying, burning or dropping them directly into toilets.

According to WASHDEV (2022), informal disposal practices can create environmental hazards or reduce toilet capacity, including clogged pipes and difficulties in emptying pit latrines, cesspits and septic tanks.

Notebox 2.1: WHO statement on menstrual health and hygiene

WHO statement on menstrual health and calls for three actions (WHO, 2022)

Recognize and frame menstruation as a health issue, not a hygiene issue – a health issue with physical, psychological and social dimensions, and one that needs to be addressed from the perspective of a life course – from before menarche to after menopause.

Recognize that menstrual health means that women and girls have access to information and education about it; to the menstrual products they need; water, sanitation and disposal facilities; to competent and empathic care when needed; to live, study and work in an environment in which menstruation is seen as positive and healthy not something to be ashamed of; and to fully participate in work and social activities.

Ensure that these activities are included in the relevant sectoral workplans and budgets and their performance is measured.

2.2. The national status

Menstrual health and hygiene campaigns in Tanzania started in 2010 when UNICEF, a handful of NGOs and researchers started to raise awareness of MHH within their implemented programmes. In 2015, the MHH campaigns went public through WASH programmes and by engaging more stakeholders, including key ministries, development partners, private companies, media, NGOs, research institutions, individuals and MHH entrepreneurs, leading to increased MHH awareness and funding.

Among the ongoing Tanzania WASH programmes that integrate MHH services, the following are important: Sustainable Rural Water Supply and Sanitation Program (SRWSSP) Payment for Results (PfR) programme under the Water Sector Development Programme (WSDP) implemented in rural districts throughout the country, Secondary Education Quality Improvement Programme (SEQUIP) and BOOST programmes under the President's Office – Regional Administration and Local Government (PO-RALG). In addition to those efforts, several studies have been undertaken on MHH, which revealed a number of gaps in different areas of the MHH pillars, including limited coordination, lack of coherent approach in delivering MHH education, limited access to MHH products, inadequate water and sanitation facilities and disposal options for used menstrual products and materials.

Recently, National Institute of Medical Research (NIMR), in collaboration with UNICEF Tanzania, conducted a study on the MHH situation among school girls in Tanzania, which revealed several challenges, including inadequate knowledge (72 per cent), unaffordable commercial menstrual products (40 per cent), inadequate hand washing facilities (70 per cent), lack of effective disposal solutions (75 per cent), lack of changing rooms with basic amenities (83 per cent) and nearly 17 per cent of girls reporting missing school for at least 48 days of school every year. Consequently, the authors reported a lower proportion of essential infrastructure for MHH among rural schools compared to the urban schools: 16 per cent of the rural schools had special rooms for girls compared to 22 per cent of the urban schools and 60 per cent rural schools had latrines compared to 65 per cent urban schools. More girls from rural schools and marginalized communities reported using reusable pads and homemade menstrual materials compared to those from urban schools. The main reasons were limited access to menstrual products and misconceptions about the use of modern menstrual products in rural areas (NIMR 2021).

Acknowledging the above mentioned deficiencies, the Government of Tanzania

has set strategies to address the MHH gaps, which include reviewing the toilet designs for school girls to accommodate MHH rooms with necessary amenities, as well as developing guidelines for health care facilities that address the needs of women and girls and people with disabilities.

The Government's efforts to address the gap on the availability and affordability for MHH products on 1 July, 2018 through the Parliament removed VAT from all sanitary pads, although it was reinstated a year later in 2019.

The Government, however, approved an incentive on corporate tax (5 per cent) for local MHH products manufacturers. Furthermore, in 2024 the Government removed the import duty for local manufacturers on raw materials used to produce MHH products. To address the accessibility gap the Tanzania members of Parliament, through own efforts, managed to raise funds and construct a demonstration school with appropriate MHH facilities in Dodoma "Bunge Girls High School".

Chapter 03

POLICY AND LEGAL FRAMEWORK FOR MENSTRUAL HEALTH AND HYGIENE IN TANZANIA

3.1. Overview

In the Constitution of the United Republic of Tanzania (1977), menstrual health and hygiene rights are implied from a human rights point of view, specifically under public health rights. Article 9(a) and (f) provide that *"the state authority and all its agencies are obliged to direct their policies and programs towards ensuring (a) that human dignity and other human rights are respected and cherished... (f) that human dignity is preserved and upheld in accordance with the spirit of the Universal Declaration of Human Rights."* These rights, including public health rights, are established and protected under Articles 29 and 30 of the Constitution.

MHH is linked to "economic, social, and cultural rights" in the National Human Rights Action Plan (2013–2027). The right to education, the right to employment, the right to clean, safe water and sanitation, and the right to highest attainable standard of physical and mental health are all vital requirements for attaining dignified menstrual health and hygiene. MHH also concerns the rights of "groups (of girls and women) with special needs" . Since poor menstrual health and hygiene affects women first-hand, this issue should be considered a part of the explicitly stated 'gender rights', including rights against social discrimination.

3.2. International agreements

Tanzania is a signatory to several regional and global instruments that guarantee the rights of women and girls and are an integral part of universal human rights to ensure dignity, health, well-being and safety. These include the Convention on the Rights of the Child (1990) and the Vienna Declaration and Programs of Action, adopted by the World Conference on Human Rights (1993). This reaffirmed that human rights of women and girls are an integral and indivisible part of universal human rights. The International Conference on Human Rights, in 1993, also reaffirmed that the human rights of women and the girl child are an integral part of universal human rights and that the full and equal enjoyment of all human rights and fundamental freedoms by women and girls is a priority for governments and the United Nations and is essential for the advancement of women. Other international agreements of relevance to MHH include the Program of Action of the International Conference on Population and Development (1994) and the United Nations Convention on the Rights of Persons with Disability (2008), the Platform for Action, developed at the United Nations Fourth World Conference on Women (1995), the Millennium Development Goals (2000–2015), the Maputo Plan of Action (2007–2010) and UN Sustainable Goals (2015–2030) and the Ngor declaration for Sanitation and Hygiene, adopted by the African ministers responsible for sanitation and hygiene 2015 at AfricaSan4. Furthermore, to show global commitment to supporting women and girls, menstruation was declared as a basic human right, based upon the statement of the High Commissioner for Human Rights at the 50th session of the United Nations Human Rights Council on 21 June 2022.

3.3. Related sectoral national policies and guidelines

The national policies of the various sectors highlighted have a broad enshrined commitment to promote reproductive health and gender rights. These rights are directed well around menstrual health and hygiene. However, none of the constitutional and policy documents explicitly address the question of menstrual health and hygiene. The comprehensive guidelines on menstrual health and hygiene hence present a timely and needy opportunity to integrate MHH rights into the country's policies across sectors. Table 3.1 stipulates the levels of contributions of national policies to MHH.

Table 3.1: National policies and guidelines related to menstrual health and hygiene in Tanzania

S/No	National policies and guidelines	Contribution to MHH
1.	The National Health Policy, 2007	❖ Section 5.3.5 defines the national commitment to address reproductive health through family planning, prevention of sexually transmitted diseases and counteracting threats to reproductive health, including harmful socio-cultural norms and practices, like female genital mutilation, particularly among youths. ❖ Section 5.3.5: The government commits to prepare guidelines, strategies and to coordinate activities designed to foster sexual and reproductive health among all gender groups, including people with special needs, women and girls. It aims to reduce deaths due to reproductive causes and the impact of poor reproductive health on pregnant women. ❖ The government commits to ensuring hygienic conditions of people through environmental hygiene interventions. ❖ The policy requires the provision of gender-responsive health services to groups including women and people with special needs. ❖ The policy emphasizes management of health care wastes at all levels.
2.	The National Education Policy, 2014, Version 2023	❖ Commitments to ensure equitable access to education for all children. ❖ Section 1.1.3: Government commits to provide education without discrimination, including on the basis of gender or disability. ❖ Section 3.2.1 affirms that meeting the right to education requires assurance of equity by addressing gender-based limitations. ❖ Section 3.2.1.1: Government commits to address gender equality in education.

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S/No	National policies and guidelines	Contribution to MHH
3.	National Youth Development Policy 2007	❖ The youth development policy envisions having empowered, well-motivated and responsible youth capable of participating effectively in social, political and economic development. ❖ Section 3.4: The policy statement in this section commits to the promotion of equitable access to resources with an emphasis on gender equity in economic development and productivity involvement. Menstrual health and hygiene is an essential component of gender empowerment and enhancement of female youth's involvement in productivity and development.
4.	National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing (NAIA-AHW) 2021/22–2024/25	❖ NAIA-AHW addresses the improvement of the health of children and adolescents as a prerequisite for achieving national and global development goals. The Agenda is designed to address six pillars, namely, preventing HIV; preventing teenage pregnancies; preventing sexual, physical, and emotional violence; improving nutrition; keeping boys and girls in school; and developing meaningful employment opportunities. The agenda is anchored in empowering adolescents as they transition into adulthood. ❖ Section 1.6 on supply suggests identifying the existing gaps in essential infrastructure and supplies that impact girls' menstrual health and hygiene and related gender and developmental impact. ❖ Under Intervention 5.2 (annex), the strategy establishes interventions to improve MHH, setting out a budget for countrywide actions.
5.	The National Water Policy, 2002	❖ Section 4.8 defines 'gender sensitivity' in water supply service through. ❖ Institutionalizing participation of women in water supply programmes. ❖ Bringing up female priorities for water, in planning and service delivery.
6.	The National Environmental Policy, 2021	❖ Provides a framework for mainstreaming the environment, including environmental health, into the planning and implementation framework of the government institutions, in an integrated manner. ❖ Also specifies the major environmental problems facing the country. ❖ Provides the context for improved environmental health, hygiene and sanitation to protect public health and promote social well-being.

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S/No	National policies and guidelines	Contribution to MHH
7.	The Community Development Policy, 1996	❖ Recognizes that sufficient clean and safe water and clean and healthy environment are critical elements for community development. ❖ Centred at empowering people to recognize their own potential to identify their own problems and devise solutions to resolve their challenges, increase their income and build better lives for themselves. ❖ Responsibility for building people's capacity is to remove people's obstacles to development at any level of development, i.e., individual, family, institutional and others. Some obstacles are gender-related. ❖ Poor menstrual health and hygiene is a subtle hindrance to development among women and girls.
8.	The National Trade Policy, 2003	❖ The policy targets raising efficiency and widening linkages in domestic production and building a diversified, competitive export sector as the means of stimulating higher rates of growth and development. ❖ A prerogative for attaining and sustaining high rates of economic growth is the establishment of attractive, stable and predictable macroeconomic environment for increased flow of investment and trade. ❖ The government realizes that measures to increase gender equality, apart from their social and distributional implications, have considerable potential in inducing growth acceleration. ❖ Tanzania attaches great importance to the growing need to protect and conserve the environment and has consistently upheld environmental conservation measures.
9.	The National Policy on Disability, 2004	The policy is geared towards removing obstacles that infringe on the right to accessing services and development and participation in the development and decision-making among people with disability linked to two main public health issues of concern: ❖ Lack of access to good hygiene services because of different disabling conditions, emphasizing the need to strengthen preventative education, environmental management and nutrition. ❖ Requirements for health personnel to institute programmes that address menstrual health needs among people with disability.

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S/No	National policies and guidelines	Contribution to MHH
10.	National Transport Policy 2003	❖ The goal of the National Transportation Policy is to improve the capacity and quality of urban road infrastructure to accommodate the ever-growing road traffic. ❖ The policy recognizes the various efforts undertaken to improve social services, particularly health, nutrition, water and sanitation urging the need to address these fundamental social services for effective economic development (Section 3.2.2). ❖ In so doing, the policy commits that the pursuance of transportation policy goals would be done in tandem with key national and sectoral policies including the National Health Policy (Section 3.7.1) and that those responsible for transportation policy implementation would coordinate with responsible persons in the sector or departments (in this case the health sector) where development programmes are implemented (Section 6.9.2.2). ❖ The Transportation Policy therefore emphasizes the need for collaboration with the health sector to improve public health, which implies promoting menstrual health and hygiene along with the provision of essential WASH facilities in transport routes.
11.	The National Guidelines for Water, Sanitation, and Hygiene in Health Care Facilities 2017	❖ The guidelines aim to ensure minimum requirements for WASH provisions and services are met for quality and safe health care and minimize the risk of infection in HCFs. ❖ Section 4.4.6: The guidelines stress on the importance of providing female-friendly WASH infrastructure and services requiring HCFs to adhere to infrastructural and waste management provisions for menstruating women. ❖ The guideline emphasizes the need for addressing not only the presence but also the quality of WASH services that include essential hygiene amenities.
12.	National Guidelines for Water, Sanitation and Guidelines, for Tanzanian Schools 2014	❖ The guidelines were the first policy tool to document the relevance of menstrual health and hygiene services in Tanzania. ❖ Section 7.5 describes the importance of menstrual health and hygiene management for schoolgirls and its linkage with broader sanitation and hygiene education. It highlights the need for coordination between schools and health services personnel in this regard. It describes the objectives of MHH education and how it needs to be done. It also outlines the different types of services to be provided to schoolgirls and the education of boys. ❖ The guidelines are accompanied by toolkits, which define the various sanitation services and facilities required to support menstrual health and hygiene for schoolgirls and lay down basic facility standards for girls in general and schoolgirls with disability.

3.4. Related legislations and regulations

The following are the national legislations related to MHH and can be used to guide or enforce compliance with the standards on this subject.

Table 3.2: Legislations and regulations related to menstrual health

S/No	Legislations and regulations	MHH relevance
1.	The Environmental Management Act, 2004	❖ Recognizes the right to a clean, safe and healthy environment for all citizens in the various public elements or segments of the environment for recreational, educational, health, spiritual, cultural and economic purposes.
2.	The Public Health Act, 2009	❖ Emphasizes issues that are of public health concern, including sanitation and hygiene, management of hazardous wastes and infection prevention and control (IPC). ❖ Stipulates that public buildings should be equipped with sufficient sanitary facilities.
3.	The Industrial and Consumer Chemicals (Management and Control) Act, 2003	❖ Control of production, importation, exportation, transportation, storage of and dealing in chemicals.
4.	The Local Government (District and Municipal Authorities) Act, 1982 as amended on 30 June 2000	❖ Spells out the requirements for the sanitation of buildings and the cleanliness of yards or compounds and on the construction and maintenance of toilets and other sanitary structures. ❖ Assigns local government authorities (LGAs) to "build, equip and maintain, or grant sums of money towards the establishment, equipment and maintenance of hospitals, health centres, maternity clinics, (and) dispensaries."
5.	The Tanzania Occupational Health and Safety Act, 2003	❖ Stipulates among other things, health and welfare provisions, specifically related to the supply of drinking water, sanitary conveniences for people with special needs and the provision of washing facilities in public places.
6.	The Finance Act Supplement No. 8, 2019	❖ The supplement to the 2019 act introduced amendments to Tanzania Food, Drugs and Cosmetics Act (cap. 219) and name change from TFDA to TMDA including: • Transferred the key role to regulate manufacturing and importation of sanitary pads in the country. • Provided economic incentives (in terms of tax reduction) for local manufacturers of sanitary pads through performance agreement with the Government of the United Republic of Tanzania.

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S/No	Legislations and regulations	MHH relevance
7.	Standards Act, 2009 (No. 2 of 2009)	❖ The 2009 act provides for the promotion of the standardization of specifications of commodities, infrastructure and services. ❖ Sections 6, 8, and 9 address the powers to inspect, issue licence and register premises that may include production facilities and factories for menstrual health and hygiene material and products.
8.	The National Industries (License and Registration Act), 2002	❖ Registration of industries. ❖ Operation of industrial licences.
9.	The Law of the Child Act, 2009 (Revised, 2019)	❖ Section 5: Provision against child discrimination, including gender-based. ❖ Section 8: Duty to maintain the child's right to (i) access to education, immunization, food, clothing, shelter, health and medical care or any other thing required for their development. ❖ Section 83: Prohibitions against exposing a child to sexual exploitation.
10.	The Persons with Disabilities Act, No. 9 of 2010	❖ The Act is aimed at making provisions for health care, social support, accessibility, rehabilitation, education and vocational training, communication, employment or work protection and promotion of basic rights for persons with disabilities and to provide for related matters. ❖ Section 26 provides that "Every person with a disability shall have the right to enjoy the attainable standard of health care services without any discrimination." ❖ Section 26(2): Every health facility, whether public or private, shall not deprive a person with disability the right to health care service and shall take all reasonable and necessary measures to ensure access for such person to health services. ❖ Section 26(5): A person with disability shall be entitled to receive appropriate information related to health in the accessible formats. ❖ Section 27(1): Persons with disabilities of all ages and gender shall have the same rights to education and training. ❖ Section 27(4): A child shall be provided with appropriate disability-related support services or other necessary learning services from a qualified teacher or a teacher assigned for that purpose.
11.	The Water Supply and Sanitation Act, 2019	❖ Establishes RUWASA for ensuring water supply is provided for rural communities. With the powers and duties of the Water Supply and Sanitation Section.
12.	The Water Resources Management Act, 2009	❖ Provides for the institutional and legal framework for sustainable management and development of water resources. This legislation is particularly relevant for institutions opting to develop their own water sources, such as drilled boreholes.

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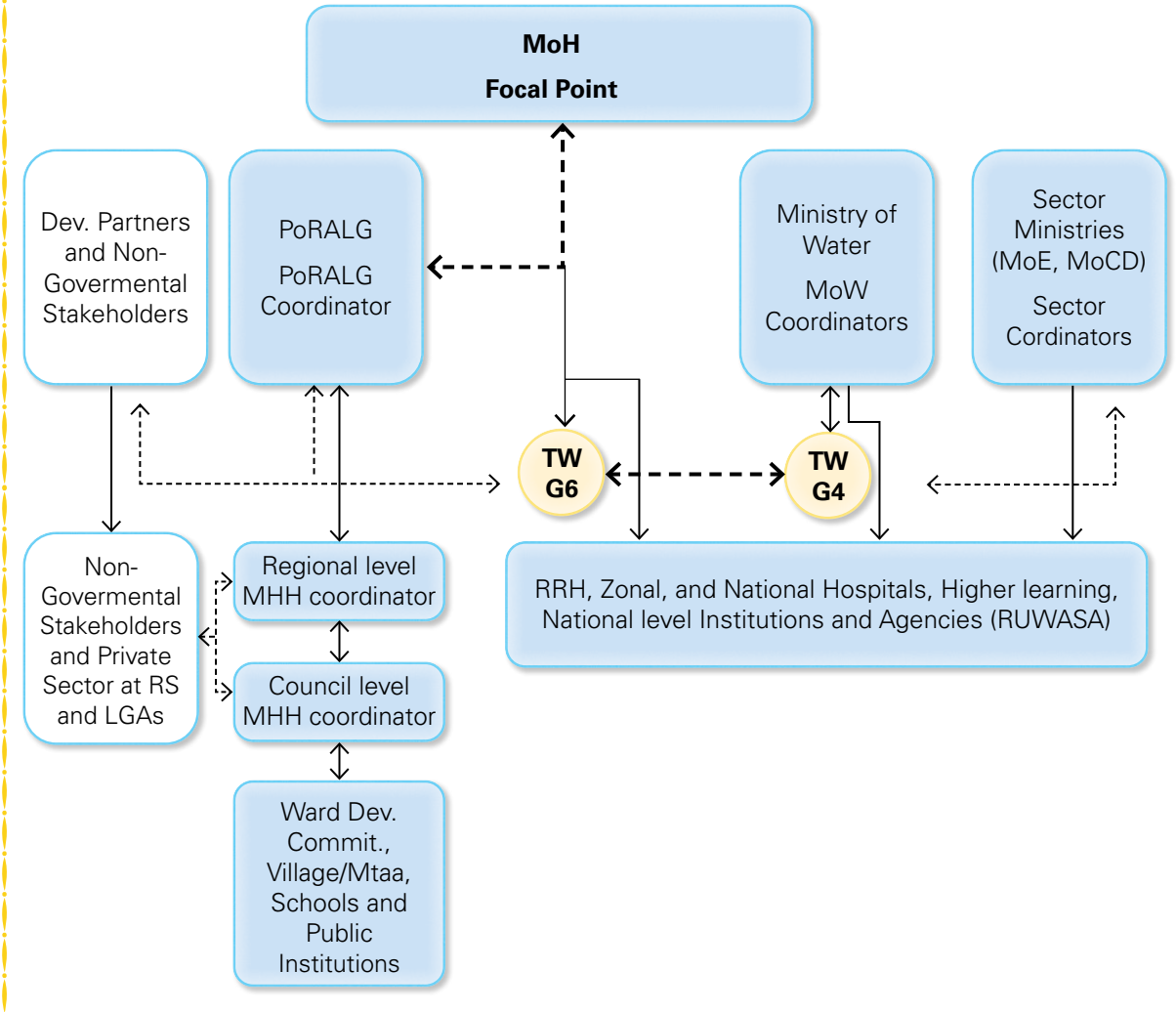
S/No	Legislations and regulations	MHH relevance
13.	The Energy and Water Utilities Regulatory Authority Act, 2001	❖ Regulation of the provision of water supply and sanitation services by a water authority, or other person, including the establishment of standards relating to equipment and tariffs chargeable for the provisions of water supply and sanitation services in the country.
14.	The Environmental Management (Solid Waste Management) Regulations, 2009	❖ The regulations detail the requirements and responsibilities for managing solid waste in Tanzania. They highlight waste minimization and cleaner production principles, alongside the duty to safeguard public health and the environment from adverse effects of solid waste; and they also explain permitting requirements for collectors, transporters, waste depositors or managers of the transfer of wastes.
15.	The Environmental Management (Hazardous Waste Control and Management) Regulations, 2020	❖ The regulations describe the requirements and procedures for the classification, handling, management, in-country and trans-boundary transportation, treatment, recovery, reuse, recycling or disposal and facility/sites for hazardous wastes, including health care wastes.

Chapter 04

MENSTRUAL HEALTH AND HYGIENE STAKEHOLDERS COORDINATION

Menstrual health and hygiene is a multisectoral coordination of players and a clear distribution of roles is paramount for adequate and smooth delivery. The institutional framework aims to describe the roles of key sector bodies and describes how the different entities are interlinked in the provision of MHH and related services. It forms the basis for guidance as to how the players should work together to address this central cross-cutting issue with great efficiency and harmony (Figure 4.1).

Figure 4.1: Framework for supporting national and sub-national level MHH coordination



Organogram description: *The coordination structure for MHH Identifies national-level players featuring four sector ministries, namely Health, Water, Education and Community Development and the ministry responsible for regional administration and local government, development partners and stakeholders. It also presents the position of subnational level entities including government, non-governmental, private sector entities and communities. It highlights the main coordination structures, notably the technical working groups at the Ministry of Health (TWG6) working closely with its counterpart in the Ministry of Water (TWG4) while introducing a national MHH focal point at the Ministry of Health (MoH) and sector-specific MHH coordinators as the drivers of sector roles. At the subnational level, the coordination is led by the MHH coordinators at the regional secretariat (RS) and local government authority (LGA). The solid and dotted lines respectively illustrate direct and indirect power relations between the various partner entities.*

The key sectoral players for MHH are public health, education, water, community development, industry and trade. Each named sectors represent governmental and non-governmental entities, who play crucial roles in the creation of an enabling environment for MHH.

4.1. Stakeholder's roles and responsibilities

Menstrual health and hygiene is the concern of multiple stakeholders at various levels. The provision of adequate MHH services in the country requires strong support and collaboration among key actors and stakeholders. The various roles of key MHH stakeholders are described in Table 4.1. The Ministry of Health is the leading actor, owing to its natural mandate to provide public health services.

Table 4.1: Roles and responsibilities of multisectoral MHH stakeholders

S/No	List of stakeholders	Roles and responsibilities
1.	Ministry of Health	❖ The Ministry of Health is the technical lead actor responsible for spearheading the attainment of the desired state of health and well-being related to menstrual health and hygiene and reproductive health. ❖ Takes the lead in the multisectoral coordination of stakeholders: • Chair of the Multi-Sectoral Technical Working Group responsible for menstrual health and hygiene coordination. • Facilitates menstrual health research and management for use across sectors and stakeholders. ❖ Responsible for the development of MHH standards and guidelines. ❖ Takes the lead in advocacy for supportive policy, resource mobilization, governance and sustainability of MHH among the high-level country leadership. ❖ Responsible for monitoring of menstrual health and hygiene.

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S/No	List of stakeholders	Roles and responsibilities
2.	President's Office – Regional Administration and Local Government	❖ Leading party in the implementation of the guidelines from regional to LGA level. ❖ Responsible for leading the planning and implementation of MHH interventions at the regional and LGA levels. ❖ Tasked with coordination and harmonization of programmes and operations across sectors and between government and non-governmental actors at the implementation level. ❖ Mobilize financial and other resources for MHH programmes in community, schools and out of schools at regional and LGA levels ❖ Have to ensure adherence to set standards through supportive supervision and enforcement. ❖ Monitors the performance of LGAs and other actors in WASH.
3.	Vice President's Office Division of Environment	❖ Oversight of environmental protection and climate change with respect to the management of waste menstrual materials in households, public areas and communities.
4.	Prime Minister's Office, Ministry of Labor, Youth Employment and People with Disabilities – Occupational Safety and Health Authority (OSHA)	❖ Oversight and supervision of occupational safety and health requirements pertaining to menstrual health and hygiene and gender-friendly working environments. ❖ Oversight of MHH requirements for people with disabilities or other special needs.
5.	Ministry of Finance/ Planning	❖ Priority development, mobilize and facilitate financial resource acquisition, and lead in the national budget and plan development for all the ministries and MDAs, including providing for MHH. ❖ Monitoring implementation of plans and fiscal policy management for ministries and MDA s, including those linked with MHH. ❖ Leading the planning and implementation of national-level monitoring and evaluation for MHH through country survey programmes.
6.	Ministry of Water	❖ Responsible for water sector resource mobilization and technical backstopping, particularly concerning MHH. ❖ Facilitate the development of sustainable water resources for hygiene uses: • Ensure the supply of adequate water supplies for personal hygiene, including MHH in homes, schools, institutions, workplaces, public places and communities. • Ensure adherence to appropriate water quality standards. ❖ Facilitate monitoring and evaluation of MHH services through water-related indicators – coordination of water sector development activities, concerning sanitation and hygiene.

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S/No	List of stakeholders	Roles and responsibilities
7.	Ministry of Education Science and Technology	❖ Leads in the formulation and enforcement of MHH policy for young learners, schools and other education institutions. ❖ Coordinates planning and budgeting of MHH in special schools at national level and higher learning education institutions. ❖ Takes the lead in monitoring the implementation and coordination of MHH in schools and other educational institutions: • Takes the lead in the supervision of quality assurance of MHH for education institutions. • Coordinates MHH education programmes (for teachers/trainers and learners) within schools and education institutions. ❖ Facilitates MHH education and behaviour change communication programmes for key change agents, including parents, community leaders and cultural custodians. ❖ Develops and reviews policy guidelines for school WASH, in collaboration with the MoH, MoWI , PO-RALG and CSOs.
8.	Ministry of Community, Development, Gender, Women and Special Groups	❖ Leads in the development and oversight of community programmes addressing socio-cultural norms and practices that result in good menstrual health and hygiene in communities. ❖ Ensures the integration of MHH in community development programmes, as part of gender-responsive and inclusive programming for workplaces, public places, schools and communities. ❖ Facilitates behaviour change communication for MHH, particularly among out-of-school youth and community change agents. ❖ Supports specific efforts to increase access to MHH knowledge and services for people from particularly marginalized, vulnerable or disadvantaged groups, including people with different kinds of disabilities.
9.	Ministry of Industry and Trade	❖ Stimulates the industrial scale production of MHH-related products, among essential health and gender-transformative commodities. ❖ Develops industrial capacity for processing locally available raw materials and technologies for the manufacturing of MHH products of acceptable quality standards. ❖ Regulation of MHH management material to ensure adherence to quality, health and safety requirements, as well as controlling product prices at levels reachable by a range of consumers of differing incomes. ❖ Enables equitable access to MHH management materials through broader, as well as targeted (pro-poor, youth, people with special needs and other marginalized groups) price controls and other incentives, which ensure the sustainable supply of this essential commodity.

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S/No	List of stakeholders	Roles and responsibilities
10.	Ministry of Transport	❖ Provision of transportation, infrastructures and facilities around healthcare service areas and communities. ❖ Adheres to the public health standards and recommendations concerning infrastructure and services in transportation vessels, infrastructure and facilities, including ensuring the provision of female-friendly WASH facilities and services such as cleaning and waste management in transportation systems. ❖ Foster provision of health and behaviour change messages in collaboration with the health sector. ❖ Mobilize financial and other resources for provision of gender-friendly WASH services and infrastructure along transportation routes and vessels.
11.	Development partners including UN agencies and International NGOs	❖ Provide technical backstopping, financial and in-kind resources for MHH and WASH programme implementation. ❖ Engage in advocacy and MHH programme activity implementation. ❖ Support further learning, research and capacity building, related to good practices of MHH. ❖ Support specific efforts to increase access to MHH knowledge and services for people from particularly marginalized, vulnerable or disadvantaged groups, including people with different kinds of disabilities.
12.	Regional Secretariat	❖ Supervision and monitoring of LGAs on the efficiency and effectiveness of use of resources related to MHH. ❖ Provision of technical advice to LGAs for the implementation of MHH interventions.
13.	LGAs	❖ Advocate at the national and council levels for equitable and adequate resources, regarding different MHH interventions in institutions and communities. ❖ Coordinate local MHH service providers. ❖ Ensure correct and cost-effective design and construction of MHH facilities in institutions and communities. ❖ Ensure correct and cost-effective maintenance of WASH facilities in schools, institutions, public places, and households. ❖ Mobilize and solicit funds to support MHH at LGA levels.
14.	Organization of People with Disabilities (DPOs), CSOs, FBOs, private sector and individual interested parties	❖ Promote safety, dignity, privacy, MHH education, social support and access to MHH-friendly infrastructure and facilities and access to menstrual products and supply chains. ❖ Advocacy and MHH programme activity implementation. ❖ Support further learning, research and capacity building, related to good practices of MHH.

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S/No	List of stakeholders	Roles and responsibilities
		❖ Support specific efforts to increase access to MHH knowledge and services for people from particularly marginalized, vulnerable or disadvantaged groups, including people with different kinds of disabilities.
15.	Industries/ manufacturers Banks/ companies	❖ Local production and import of menstrual products. ❖ Provision of MHH services and products and an MHH-friendly work environment, including private and accessible WASH and disposal facilities for female employees.
16.	Ward development committees and village councils	❖ Planning and budgeting of village funds for MHH and WASH in institutions and communities. ❖ Promotion of awareness and action on MHH in communities. ❖ Mobilize the communities' contributions for the O&M fund for actions in MHH. ❖ Implement monitoring and follow-up for MHH at community and institution levels. ❖ Ensure that the poorest members of the communities and people who may be the most vulnerable, marginalized or disadvantaged, including people with disabilities, have adequate access to knowledge and products to manage their menstruation.
17.	Religious leaders and other key influencers (tribal groups, cultural, custodians like Kungwis Nyakanga and others, age groups like young adults, elders)	❖ Religious teachings on myth, beliefs and norms towards menstruation. ❖ Preserve and promote cultural values related to menstruation, reproductive health, hygiene and rights issues. ❖ Contribute to the propagation of positive social norms and may serve to educate for good and breaking of negative social norms. ❖ Provide guidance to girls and boys and youth on positive adulthood manners. ❖ Actively participate in education and knowledge dissemination as well as social and behaviour change communication (SBCC) for shaping the culture.
18.	Parents and communities	❖ Learn about good practices in supporting children in MHH and in sharing knowledge. ❖ Contribute to the construction, rehabilitation and O&M of MHH materials and facilities, in cash or in kind, as and when needed. ❖ Actively participate in WASH facility development (planning, selection of appropriate technical options, construction supervision, quality control, fund raising, etc.).

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S/No	List of stakeholders	Roles and responsibilities
19.	Public institutions such as schools	❖ Make sure hygiene education is part of school teaching activities. ❖ To ensure provision of security to protect WASH facilities in schools. ❖ Ensure the facilities are correctly used and maintained. ❖ Facilitate pupils to participate in MHH extracurricular activities and serve as a catalyst for the promotion of sanitation and hygiene in and out of the school.
20.	Public institutions such as health care facilities	❖ Boards have the capacity to decide and mobilize resources to strengthen WASH services including MHH. ❖ Provide governance and oversight of health services related to MHH. ❖ Coordinate and manage WASH activities at each HCF.
21.	Academic institutions	❖ Carry out research and learning regarding MHH and WASH. ❖ Scale up knowledge and skills on MHH and WASH.

Over the last decade, advocacy for MHH has been intensified and stakeholders are coordinated through the National MHH Coalition of Tanzania, an informal coordination mechanism, uniting both the government and non-governmental players across sectors. The coalition formed a voluntary secretariat, which spearheaded planning and provided a forum for sharing and dissemination of key updates on MHH. It is imperative that formal guidance is provided for a harmonized and sustainable coordination of all MHH stakeholders at all levels.

4.1.1. Coordination of national-level MHH stakeholders

1. Coordination of MHH at the Ministry of Health aligns with the Health Sector Strategic Plan and the Sector Wide Approach (SWA) for health coordination, or future official updates to it. A focal point will be established at the environmental health section (MoH), which will be the overall multisectoral coordinator.
2. The focal point will take the lead in the coordination of the multisectoral MHH agenda at the TWG6 for all programmes within the government sectors and for non-state actors.
3. Key sector ministries will be coordinated by the Technical Working Group, responsible for Environmental Health and Health Promotion, current (TWG6) or an appropriate sector-wide committee (in case of a change of this arrangement). The composition of TWG6 will be expanded to include the Commissioner of Education from the Ministry of Education Science and Technology (MoEST), the Director of Water Supply and Sanitation from the Ministry of Water and an appropriate representative from development partners and non-state actors including representatives from DPOs.
4. Key sector ministries (MoEST, Ministry of Community Development, Gender, Women and Special Groups (MoCDGWSG), MOW, MoIT) and PO-RALG should designate MHH sector coordinators, who should also liaise with the focal point to strengthen multisectoral coordination through dialogue.

5. Development partners and non-state actors should be effectively represented at the respective sector TWGs and TWG6 at the MoH and in stakeholder forums at all levels.
6. Non-state actors should indicate their role for MHH in their plans and present memorandums of understanding (MoU) documentations with sector ministries and LGAs to facilitate recognition and follow-up actions.
7. An inclusive multisectoral MHH secretariat will be formed at the focal point to spearhead national MHH programmes.

4.1.2. Coordination of subnational-level MHH stakeholders

Strong coordination must be maintained throughout the service delivery continuum. To this effect, subnational-level coordination should follow the guidelines as given below:

1. Designate the overall coordinator for MHH at LGA and RS level from the health department, preferably the environmental health officer. He/she should provide oversight of the related programmes, ensure MHH integration and engage in progress monitoring and evaluation, working alongside the relevant departments.
2. Designate two sector coordinators from education (preferably school water, sanitation and hygiene (SWASH) coordinator) and community development departments to lead the MHH planning and service provision in education institutions and communities, respectively.
3. Facilitate the compilation and sharing of MHH progress reports for discussion in the council health management team, social service committee and eventually to the full council within the LGAs, including providing updates on non-state actors' performance and contributions, actively engaging the representatives of people with different kind of disabilities and other marginalized groups within their jurisdiction.
4. Effectively coordinate between health, education, community development, water and industry and trade departments and non-state actors in planning, supervision, programme execution, monitoring, evaluation and in stakeholder forums for MHH.

Chapter 05

GUIDELINES ON INCLUSIVE KNOWLEDGE OF AND SKILLS IN MENSTRUAL HEALTH AND HYGIENE

Right information, knowledge and skills are paramount for understanding the biology of menstruation and the provision of care and support to girls and women for addressing physiological, psychological, emotional change and health complications prior to and at the onset of menstruation and throughout the reproductive life cycle. It is also essential for dispelling myths and misconceptions from the community with respect to safe and hygienic practices on menstruation and safe use of MHH-friendly facilities and disposal options.

This chapter provides guidance on the holistic approach to the dissemination of knowledge and imparting skills related to MHH at all levels in Tanzanian society covering schools, communities, workplaces, public places, emergency responses and humanitarian settings as well as nutrition needs for menstruating women and girls and the link between MHH and SRH. Figure 5.1 provides information on MHH education in Tanzania as per NIMR (2021), Norris et al. (2021), Stoilova et al. (2022), MoH (2018) and Sommer et al. (2018).

Figure 5.1: The current status of MHH education in Tanzania

Knowledge information and skills

- Inadequate knowledge on MHH among school girls
- Teachers having limited capacity to teach adolescents on MHH
- Limited role school training on behavioural practices

Taboos, myths, and misconceptions

- Restrictive norms limits girls from participation in productive and socio activities
- Secrecy prohibits girls from seeking support and solutions to challenges associated with menstruation
- Myths and beliefs damage self worth and inflict fear

Stigma and steriotyping

- Boys often tease menstruating girls when accidentally stained or prompted by odour
- Boys not understanding the idea of menstruation for girls and how to be good to towards them

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Missing school

- Significant proportion of girls miss school due to menstruation related reasons
- Menstrual related pain and discomfort a major reason for girl's absenteeism

Nutritional needs

- Nutritional deficiency due to inadequate micronutrients and insufficient uptake of diversified food groups
- Anaemia due to reduced update of iron, folic acid, and folate among menstruators

Emergency and humanitarian situations

- Challenges in preserving dignity and comfort related to menstruation without education and socio support
- Limited guidance on essentials and preparedness needs

5.1. Holistic approach to MHH education

In delivering MHH education, a holistic approach[1] should be adopted based on three components illustrated in Figure 5.2, which involves breaking the silence, safe hygienic practices on menstruation and safe use of inclusive MHH-friendly supportive facilities and disposal options. For effective implementation of MHH education programmes,

MHH Training of Trainers (TOT) Toolkit is provided to build the capacity of implementers for each component. The details for each component are presented below:

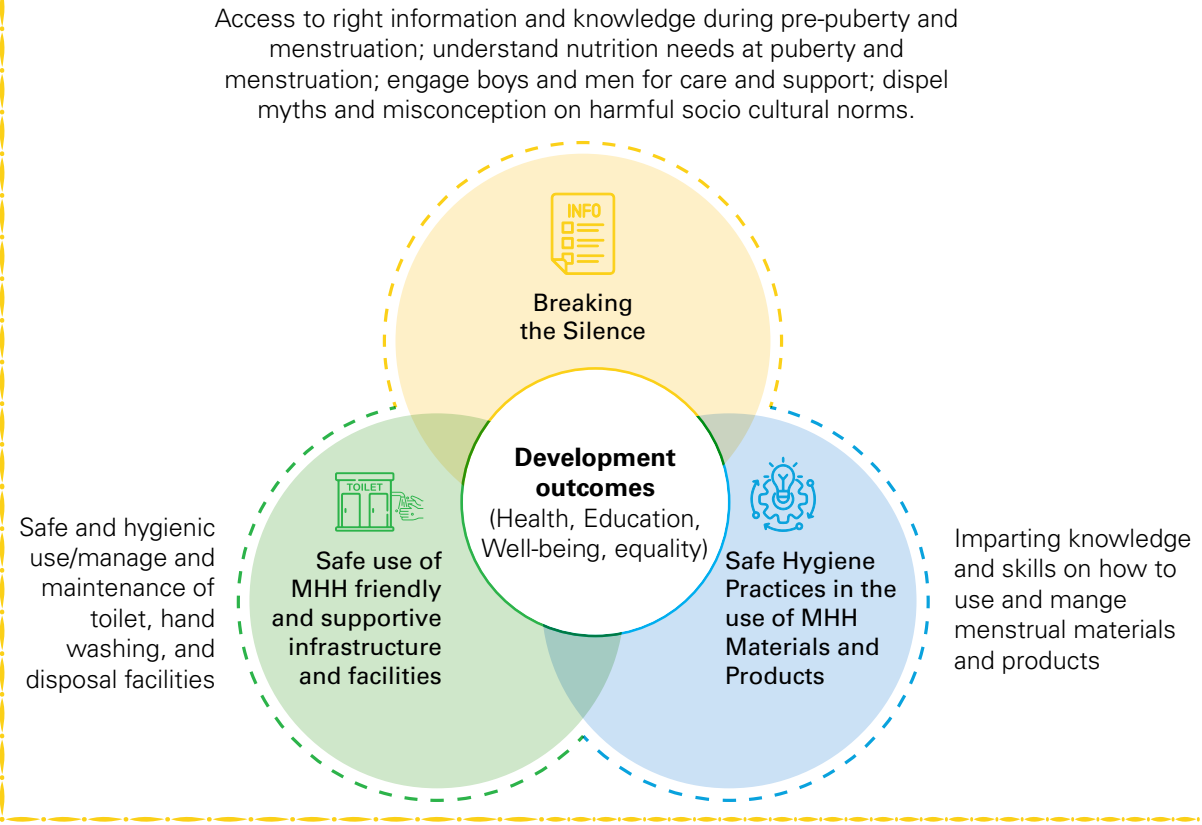
(a) The first component is breaking the silence, which requires knowledgeable and competent trainers at all levels who will deliver appropriate information and disseminate MHH education to learners that dispel myths and misconceptions on menstruation. Learners should also understand basic facts about pre-puberty, puberty, menstruation, the menstrual cycle, nutrition requirements during puberty and in the menstrual period and the management of pain and discomfort. Engagement of boys and men will enhance the care and support of adolescent girls and women during their menstrual period.

(b) The second component is safe hygienic practices on menstruation, which entails the provision of knowledge and skills on the use of clean menstrual materials that absorb menstrual blood and can be changed timely, as often as necessary for the whole duration of the menstrual period and washing the body with water and soap, with dignity and comfort, without fear or stigma.

1 Holistic MHH education entails three main components: (a) breaking the silence; (b) safe menstrual hygienic practices and (c) safe use of inclusive MHH-friendly supportive facilities (safe toilet with privacy, water and soap for washing the body and sustaining the general cleanliness of the toilets and safe and convenient options for disposal of used menstrual products and materials (adapted from WSSCC 2013 and The World Bank 2022)

(c) The third component is the safe use of inclusive MHH-friendly supportive facilities, including disposal options that entails provision of knowledge and skills on the proper use of water and sanitation facilities. This concerns information on access to a safe toilet with privacy, water and soap for washing the body and to sustain general cleanliness of the toilets and safe and convenient options for the disposal of used menstrual products and materials.

Figure 5.2: Holistic approach to MHH education



Source: Adapted from WSSCC (2013) and the World Bank (2022).

5.2. Nutrition needs for MHH

Healthy eating is vital for adolescents because this is the second window of opportunity for rapid physical growth. At the age of 10–19 years, adolescents experience rapid physical growth and development, which require them to eat a diversified diet with all six food groups[2] that provide energy and nutrients (MoH 2023; WHO 2021; UNICEF 2021; FAO 2004). Improving the nutrition and health of adolescent girls can eliminate the burden of malnutrition, help maintain healthy menstrual cycle and reduce symptoms of premenstrual disorders. Menstruation reduces the iron levels in the body and therefore requires double intake of iron for adolescent girls and women. High-energy foods help reduce fatigue resulting from menstruation. Nutritious foods lead to healthy menstruation by reducing inflammation and supporting the function of hormones. It is important that trainers and learners in the public acquire knowledge and skills on healthy menstruation. The relevant guidelines for this aspect are as follows:

2 MoH (2023). The six food groups include cereals, starchy roots, tubers, plantains and green bananas; vegetables; fruits; pulses/legumes, nuts and oily seeds; animal-source foods; and healthy fats and oils.

1. The Ministry of Health in collaboration with the Ministry of Education, Science and Technology will promote nutrition education and counselling of adolescent girls with inclusion of disability in schools on nutritional requirements for proper puberty growth and healthy menstruation for the prevention of menstrual complications.
2. The Ministry of Agriculture in collaboration with President's Office – Regional Administration and Local Government should design and promote programmes geared at increasing access to essential nutrients from locally available foods for growth and development among adolescents including healthy menstruation for girls.
3. The Ministry of Health, in collaboration with the Ministry of Community Development Gender Women and Special Groups (MoCDGWSG), will integrate education on nutritional requirements for healthy menstruation into adolescent-friendly services for out-of-school youth at the health facility and other points of care.
4. All the implementing partners who engage in developing teaching and learning materials for MHH education on nutritional requirements for adolescents and women have to seek approval from authorized entities, such as the Tanzania Institute of Education of the Ministry of Education, Science and Technology and Content Review Committee of the Ministry of Health.

5.3. MHH knowledge and skills in schools and colleges

An accurate and timely access to information and knowledge about menstruation helps girls prepare for puberty and menarche. This includes their subsequent safety-appropriate hygienic practices using menstrual products and materials, the use of toilets with privacy and access to soap and water. Also, the provision of knowledge on timely referral for girls with serious menstrual problems to health care facilities, for diagnosis and further supportive treatment of menstrual cycle disorders will reduce health complications related to menstruation. These forms of support reduce absenteeism from school and contribute to improved educational performance. The primary audience for knowledge and skill-building activities are girls and women. The secondary audience are: (a) peers, including pre-adolescent and adolescent boys; (b) teachers, parents/guardians and caregivers; (c) community and religious leaders; (d) public servants working on education; (e) civil society organizations; (f) private sector; and (g) research and development institutions and academia. The following are guidelines on improving knowledge and information-sharing in schools and teachers' training colleges:

1. Head teachers, health teachers and matrons should be well oriented to be knowledgeable about holistic MHH education to promote and cascade inclusive MHH knowledge and skills to girls and others.
2. MoEST should facilitate the incorporation of holistic MHH education in science and biology teacher training curriculums at all levels of education.
3. The Tanzania Institute of Education should prioritize updating the school science and biology books for primary and secondary schools according to the revised science and biology syllabus of 2023, emphasizing menstrual education and make them available to all schools.
4. Extra-curricular activities should be promoted in schools through debates, drama, songs, poems, games, quizzes, role play and the use of multimedia channels. These should be used as means to inform, create awareness and sensitize stakeholders within schools on various components of holistic MHH education by forming WASH, Environment and MHH clubs.
5. The government, in collaboration with MHH stakeholders, should integrate menstrual health and hygiene agenda into national

and international events across ministries to enhance public awareness and sharing of appropriate information on MHH.

6. The management of schools and teachers' training colleges should create a space or sick bay for adolescent girls to lie down, rest temporarily and train matrons/caregivers to assist them relieve or cope with menstrual pain when the need arises.

7. The school management should maintain an accessible first aid kit with the required painkillers, which are to be managed with the support of a health professional. The head teacher, health teachers and matrons should be oriented on the dosage and frequency of the use of painkillers (MoEST 2016).[3]

8. The school management and staff of health care facilities should design a referral pathway in which referral forms from schools are given to nearby health care facilities to care for, support and provide access to appropriate medication in order to relieve menstruation pain for adolescent girls in schools.

9. MoEST should ensure the inclusion of an indicator for the use of health referral forms in the school monitoring checklist.

10. MoEST, in collaboration with President's Office – Regional Administration and Local Government, should allocate at least one female teacher from marginalized schools to support adolescent girls to address menstruation-related challenges and reduce their absenteeism during menstruation from schools.

11. MoEST, in collaboration with President's Office – Regional Administration and Local Government, should create a supportive environment for female teachers working in marginalized schools so that they can help adolescent girls tackle their menstruation challenges.

5.4. MHH knowledge and skills in communities

A comprehensive understanding of menstruation offers the best means of addressing myths and taboos in the community and ensuring the adoption of proper menstrual health practices. Accurate information about and knowledge of MHH that is age-specific, content and culturally appropriate should be conveyed to menstruating girls and women through trained key influencers who possess knowledge on holistic MHH education . The key influencers include parents/guardians, community health workers, community and religious leaders, CSOs, FBOs and Organization of People with Disabilities (DPOs). The following are guidelines for improving knowledge and information sharing in the community:

1. The trained key influencers on holistic MHH education should champion the dialogue and delivery of appropriate information on menstruation to adolescent girls and women in the community (WSSCC 2013; UNICEF 2019; The World Bank 2022).

2. MoCDGWSG should ensure the integration of MHH knowledge and skills through on-job training programmes for community development, social welfare officers and health promotion coordinators to support the delivery of MHH knowledge and skills in the community.

3. MHH stakeholders, in collaboration with LGAs, should use age-appropriate and context-specific approaches during the delivery of MHH education to initiate conversation on menstruation in girls and women by engaging boys and men as detailed in the MHH ToT toolkit.

4. Implementing partners, in collaboration with LGAs, should develop materials for creating awareness and educating the community on handling, segregation, transportation and end disposal of used menstrual products.

3 URT, MoEST (2016). National Guidelines for Water, Sanitation and Hygiene for Tanzania Schools.

Notebox 5.1: Handling and transportation of used menstrual products and materials in public waste stream

Used menstrual products and materials collection should be segregated at source and collected in clearly marked containers, with a biohazardous sign.

Once collected, it should be transported hygienically in a designated vessel from the collection point to final disposal.

Treatment and disposal should be undertaken as per hazardous/biomedical waste standards.

In urban areas, where onsite disposal of domestic waste is discouraged, permitted arrangements should be made to facilitate safe handling till the disposal of used menstrual products and materials.

Used menstrual materials should be grouped as clinical or infectious waste (in accordance with Article 12 of The Environmental Management (Hazardous Waste Control and Management Regulations, 2020)).

Hazardous waste management regulations should be applied for managing used menstrual products and materials unless more specific regulations or bylaws apply.

5.5. MHH knowledge and skills in workplaces

Formal and informal workplaces that do not have MHH-friendly facilities hinder the ability of girls and women to manage their menstruation. This affects their health and well-being and can result in poor work attendance. The failure of women to participate in income-generating activities can lead to reduced earnings and negative economic outcomes. It is therefore vital to educate leaders and decision-makers on creating MHH-supporting environment in workplaces. The supportive environment should include having access to a toilet, which provides privacy, space, water and soap, emergency menstrual materials and products and elaborate used menstrual products and materials disposal systems. It should also include a workplace culture that cares for and supports girls and women. The following are the guidelines for best MHH practices in the workplace:

1. MoH, in collaboration with OSHA and workplace employers and other stakeholders, will integrate MHH requirements for workplaces in relevant training packages for occupational health and related concerns, including meeting MHH standards for persons with disability.
2. Employers both in formal and informal sectors should adhere to set standards for WASH facilities at workplaces to ensure there is provision of an MHH-friendly environment, emergency MHH materials and products and safe disposal options for used menstrual products.
3. MoH, in collaboration with OSHA and other stakeholders, will develop education and awareness programmes to promote the proper use and maintenance of WASH facilities and build a supportive culture at the workplace through the workers' committee.

5.6. MHH knowledge and skills in emergency responses and humanitarian settings

Humanitarian and emergency conditions compound the menstruation-related challenges, as MHH is often overlooked in response efforts. However, the need for appropriate MHH materials and supplies, supportive facilities and information remains basic for menstruating women and girls despite their conditions and location. The leaders of sectors working in emergency responses and in humanitarian settings should

be cognizant of the MHH needs of women and girls, including persons with disability so that they can plan ahead of emergency situations for preparedness, response and recovery to ensure adolescent girls and women can manage their menstruation with dignity, privacy and comfort. Figure 5.3 explains the three essential components of MHH response. The following are the guidelines for MHH in emergency and humanitarian settings:

1. MoH, in collaboration with stakeholders, should ensure that all the operation staff in sectors related to humanitarian and emergency response are well equipped with knowledge and skills to address the MHH needs for displaced women and girls, including persons with disabilities.
2. MoH and humanitarian agencies should develop education and communication materials on the proper use and maintenance of WASH facilities and build a supportive culture detailing the basic roles and responsibilities of both men and women, including persons with disabilities.
3. Humanitarian agencies should develop or update the standard operating procedures to ensure that the staff possess proper skills on the use of essential items in emergencies, including dignity kits and sanitation cubicles, and that used menstrual products and materials disposal options are in stock during the preparation for emergency.

Figure 5.3: Three essential components of MHH response

MHH materials & supply

- Appropriate menstrual materials (pad, cloths, underwear)
- Additional supportive materials (e.g. soap, bucket) for storage, washing and drying
- Demonstration on how to use MHM materials

MHH supportive facilities

- Safe and private toilet and bathing facilities with water for changing, washing and drying menstrual meterials
- Convenient and private disposal options for used menstrual products and materials
- Waste management system in place for used menstrual products and materials

MHH information

- Basic menstrual health and hygiene promotion and education
- Basic menstrual health eduction (especially for pubescent girls)
- Address harmful cultural or social norms related to menstruation

Source: adapted from Sommer et al., 2017

5.7. MHH knowledge and skills in public places

The experience of public toilet facilities based on their maintenance of general cleanliness determines if girls and women would be able to use them in a safe, hygienic and dignified manner during menstruation. As public toilets have a high influx of users from diverse cultures possessing inadequate knowledge and awareness of unclean environment and health risks, insufficient toilet facilities without basic amenities, including water supply and soap, lack of privacy, lack of access to emergency menstrual products and materials, high production of used menstrual products and materials without supportive facilities for collection, lack of right equipment and skills of the service providers for emptying, transportation and their end disposal could prove detrimental to the health of the community members who use these facilities (SNV Tanzania 2018).

Adherence to good menstrual health and hygiene and maintaining the general cleanliness of public toilets with access to basic amenities for menstruation would preserve dignity, reduce psychological stress and reduce health risks related to reproductive and urinary tract infections (UTIs) for girls and women. In cases where girls and women do not wash their hands, before or after changing menstrual products, due to lack of handwashing facilities, water and soap, it can lead to a spread of infections, such as UTIs and hepatitis B. The following are proposed guidelines for public places, such as bus stops, ports, marketplaces, railway stations, beaches, open space gardens, religious and spiritual centres, highways and heritage sites:

1. MoH, in collaboration with PORALG, implementing partners and the private sector, will provide training to the management teams of public places so that they are able to use age-appropriate and content-specific information for all users of the public places, including people with disabilities.
2. LGAs, in collaboration with implementing partners and the operators of public places, should design tailor-made menstrual health and hygiene reminder messages in an artistic and colourful manner through posters, stickers and voice messages delivered through loudspeakers for public place users. These should focus on maintaining general cleanliness of toilets, safe personal hygiene practices during menstruation, safe handling and collection of used menstrual products and materials through designated covered bins with liners by menstruating women and girls.
3. The management of the public places by LGAs, in collaboration with CSOs and the private sector, should adhere to set standards for WASH facilities at public places to ensure the provision of MHH-friendly facilities, emergency MHH materials and products (kiosks, vending machines, pad box) and safe collection options for used menstrual products and materials. This will enhance positive health outcomes for users, especially menstruating girls and women.

5.8. Integration of menstrual health (MH) into sexual and reproductive health (SRH)

The impact of poor menstrual health on the psychosocial well-being of women and girls (e.g., stress levels, fear and embarrassment, and social exclusion during menstruation) should not be underestimated. The risk of infection (including sexually transmitted infection) is higher than normal during menstruation because the plug of mucus normally found at the opening of the cervix is dislodged and the cervix opens to allow blood to pass out of the body. Poor MHH practices such as using unclean menstrual products/materials, prolonged use of the same material, douching and like can introduce or support the growth of bacteria, which may lead to infections that would eventually cause pelvic

inflammation diseases, which might lead to infertility.

The risk of transmitting or contracting blood-borne diseases such as HIV, viral hepatitis or hepatitis B through unprotected sex increases during menstruation (Reichelderfer et al. 2010) owing to the fact that the highest concentrations of HIV and hepatitis B virus are found in blood compared to other body fluids (CDC, 2010).

Studies have shown that adolescent girls engage in transactional sex, often unprotected, to obtain money and sanitary pads. Furthermore, lack of knowledge of menstrual cycle lowers the ability of girls to prevent unwanted pregnancies. This places them at the risk of harassment and sexual assault. These practices are also linked to gender-based violence, early marriages and negative sexual reproductive health outcomes, including unplanned pregnancies and sexually transmitted diseases.

Despite the importance of menstruation, global health practitioners have often overlooked its value. Consequently, girls and women do not receive appropriate education about their menstrual cycle and fertility, contributing to a lack of confidence and failure to own their own bodies, which are essential elements to make informed decisions throughout their sexual and reproductive health journeys. An integrated approach that incorporates MHH is thus paramount for a comprehensive sexual and reproductive health programming.

This section elaborates on the link between menstrual health and SRH, including the association between MH and teenage pregnancy, maternal morbidity, mortality, transactional sex, gender-based violence and economic deprivation.

5.8.1. Sociocultural links between MH and SRH

Social determinants of both MH and SRH have an impact on healthy lifestyle and health-seeking behaviours among women and girls. The following are selected social determinants that shape the integration of MH and SRH:

1. **Menstrual knowledge and SRH:** Studies consistently demonstrate a lack of menstrual knowledge and widespread misconceptions about menstruation among girls and women. Lack of knowledge of the ovulatory cycle is associated with misconceptions about SRH components like fertility, which impacts family planning. This also contributes to menstruation-related stigmatization and discrimination by boys and men.
2. **Menstruation and gender-based violence:** Several forms of gender-based violence (GBV) are directed against adolescent girls and young women (AGYW) and women, specifically because of their menstruation status. Bullying or teasing girls in school settings or women in the workplace due to menstruation is a common occurrence. Early marriage, an important gender issue in Tanzania, is intimately related to MH and SRH. Menarche is simultaneously considered a sign of readiness for marriage and a starting point for pre-marital relationships (Santhya, 2011, Girls Not Brides, 2018; Raj et al. 2015). Early marriage is a major concern for SRH. It is also related to initiation rites associated with the onset of menstruation. Consequences of early marriage include discontinuing education and early childbearing, which have adverse implications for the health and well-being of young women, at times with dire outcomes such as maternal mortality . Adolescents marrying prematurely are common victims of gender inequity, affecting their right to health, education and access to resources.

Child and early forced marriages are internationally recognized by law as a form of gender-based violence and violation of human rights.

3. **Age at menarche and SRH outcomes:** In addition to child and early forced marriage, early menarche is associated with early pregnancies and some sexually transmitted infections (STIs). These linkages present a clear opportunity to integrate MH and SRH programmes and services to support the needs of adolescent girls, especially young adolescents. However, many SRH programmes and services primarily target adolescents aged 15 years and older.

4. **Menstruation, psychosocial well-being and SRH:** One of the most consistent findings across studies and settings is that menstruation is associated with feelings of shame, fear and distress, including anxiety, low self-esteem and depression throughout the life cycle. Gender inequalities deeply influence SRH and MH, shaping whether people have access to information, as well as the type and depth of information received, access to essential services (health, nutrition, education, psychosocial support), control over their decisions, lives as well as GBV and discrimination (Sen et al. 2007, Wilson et al. 2018).

5. **Transactional sex, gender-based violence and SRH:** Multiple studies have found that adolescent girls engage in transactional sex, often unprotected, to obtain money and sanitary pads. This places them at risk of harassment and sexual assault. These practices are also linked to significant SRH outcomes, including unplanned pregnancies and sexually transmitted diseases.

5.8.2. Biological links between MH and SRH

1. **Experience of puberty and menarche:** The onset of menstruation or menarche is considered the most definitive sign of puberty in girls and marks the start of a girl's MHH and SRH journey.

2. **Contraception, family planning and MH:** MH intersects with contraception in many ways. One link is that hormonal contraception is among the first-line treatment to alleviate abnormal uterine bleeding and dysmenorrhoea. Linkages between schools and health care facilities, particularly SRH programmes, could facilitate access to care for adolescent girls (aged younger than 15 years) and those who are not seeking family planning services. It is important for users to be educated when contraceptives need to be used for pain alleviation or purposes other than family planning to avoid negative consequences that may arise from misunderstanding their use.

The second intersection relates to contraceptive-induced menstrual bleeding (CIMB), referring to changes in bleeding patterns resulting from the use of hormonal contraception, which includes amenorrhea, irregular spotting or bleeding and heavy bleeding. These changes call for extra menstrual health needs such as emergency menstrual materials and products, additional products and materials to manage heavy bleeding and demand for supportive physical and social environment-related menstrual changes.

Linking SRH programmes with menstrual product suppliers and other supportive agencies could help meet the need for menstruation-related challenges.

A third link relates to contraceptive use during perimenopause. Although fertility levels decline with age at around 45 years, approximately half of all women are still fertile; therefore, access to contraception is essential since irregular bleeding patterns during this time pose the risk of unintended

pregnancies. However, the current disconnect between menstrual health and hygiene and contraceptive use and care has resulted in missed opportunities to enhance females' menstrual and reproductive experiences, as well as to improve upon programmatic approaches and delivery of MH and SRH services.

3. **HIV and MH:** HIV/AIDS can affect the menstrual cycle of people living with this condition. A global meta-analysis found that women living with HIV were at higher risk of a menstrual disorder known as amenorrhea (missing three or more consecutive periods in the absence of pregnancy) than women without HIV (King et al. 2019). People living with HIV who experience menstruation need support to manage menses safely to avoid infections associated with unhygienic practices, which can further compromise their immune system.

4. **Urinary tract infections (UTIs) and urogenital infections and MH:** Poor menstrual health and hygiene practices are associated with urinary tract infections, which might lead to infertility and increase the risk of ectopic pregnancies.

5. **Maternal health and MH:** Menstrual bleeding and anaemia have a significant impact on maternal health. Anaemic women are at increased risk of maternal mortality resulting from peripartum haemorrhage. Limited knowledge of MH predisposes girls and women to unwanted pregnancies and increased risk of maternal mortality and morbidity.

6. **Menstrual disorders and sequelae:** Menstrual irregularities, including dysmenorrhoea and abnormal uterine bleeding (fibroids, endometriosis and ovarian cyst), are directly linked to aspects of SRH and can significantly affect the quality of life of adolescent girls and women. Studies show that pain, discomfort and premenstrual symptoms are not uncommon among adolescent girls.

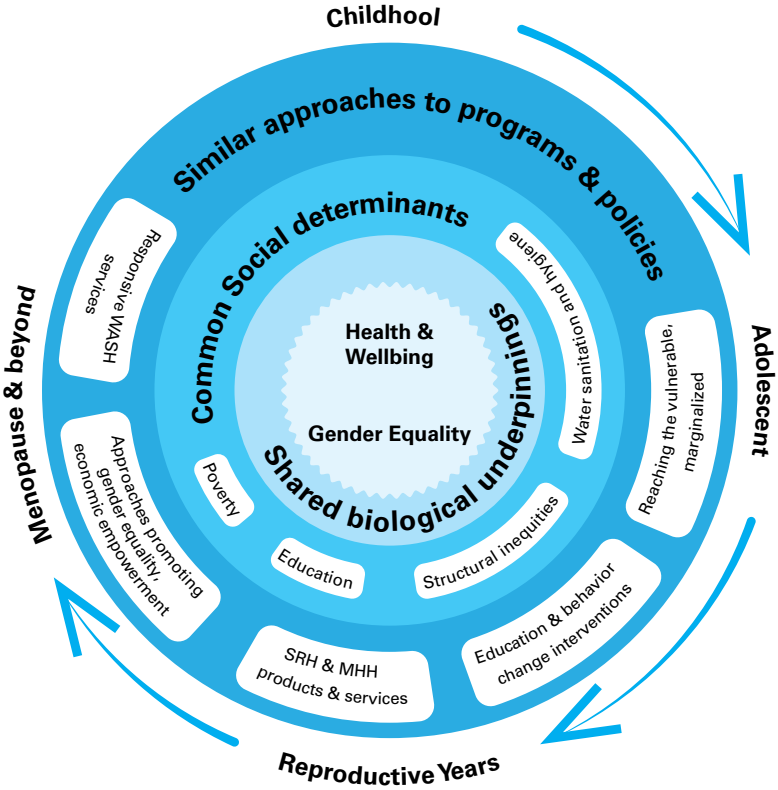
7. **Perimenopause and menopause:** Perimenopause is the phase during which the body transitions into menopause and is also referred to as the menopausal transition (Santoro 2016). Perimenopause and menopause are rarely discussed because they are often marked by silence, shame and misinformation. However, understanding this phase of the reproductive life cycle and the impact of hormonal changes on the body, including on menstruation, are critical to prepare for and manage the symptoms of any disorder. Understanding women's experience of perimenopause and menopause across socio-economic strata will help address these issues from a health promotion perspective.

8. **MH and mental health:** Some women experience symptoms of premenstrual syndromes (PMS), a combination of physical and emotional symptoms that arise a week or two before the menstrual period. On the other hand, contraceptive users are reported to experience mood changes that may cause mental stress and reactions. As many as 43.6 per cent of oral contraceptive users are reported to experience mood changes as a side effect (Martell et al. 2023). While menstrual health-related manifestations occur naturally, they are also contributed by SRH interventions; hence there is a need for SRH programmes to address menstrual-related mental health challenges.

5.8.3. Foundations for the integration of MH and SRH

Figure 5.4 shows all the phases of life that are relevant for MHH and SRH and striking commonalities: the shared biological underpinnings, the key social determinants affecting both MH and SRH, the common programmatic approaches from MH and SRH that can be leveraged to strengthen integration action across the life course, with the ultimate goal being the integration of MH and SRH to accomplish health, well-being and gender equality (Global Menstrual Collective, 2023).

Figure 5.4: Shared foundational interventions and outcomes of MHH and SRH



Source: adapted from Global Menstrual Collective 2023

Integrating MH and SRH can lead to the following benefits:

1. Strengthen the understanding of shared biological processes, sexual and reproductive health events across the life course
2. Harness efforts to address shared social determinants that adversely affect outcomes, and amplify beneficial multi-sectoral actions
3. Leverage programmatic similarities to enable positive outcomes for all, across the life course, and at scale
4. Advance achievement of common goals related to health and well-being, education, water and sanitation, and gender equality.

5.8.4. Integration of MH into SRH

The following guidelines therefore are aimed at linking MH and SRH:

1. MoH will ensure implementers of SRH programmes use the integration of MH into SRH tool kit in delivering interventions to build knowledge and skills for the management of abnormal periods, pains and discomforts including complications associated with pre-menopause and menopause.
2. MoH will ensure the SRH programmes develop strategies to build and strengthen in-house knowledge and skills among practitioners (doctors, midwives/nurses and community health workers).

3. MoH will develop programmes addressing and dealing with MH challenges associated with social-cultural barriers impacting SRH for adolescents and older women at the national and subnational levels.

4. MoH will ensure SRH clinics (Reproductive and Child Health, Adolescent and Youth friendly and Outreach Services) expand the horizon of services to reach AGYW, adolescent boys and young men (ABYM), men and women at the pre-menopause and menopause stages.

5. MoH, in collaboration with SRH stakeholders, will foster economic empowerment interventions, psychosocial and menstrual material support to address period poverty and related outcomes, including transactional sex, early pregnancies, early marriage and GBV challenges to reduce sexually transmitted diseases among vulnerable girls and women.

6. MoH, in collaboration with SRH stakeholders, will ensure SRH programmes promote hygienic practices, including the use of clean and improved MHH materials, washing the body with clean water and soap, avoidance of use of chemicals and other potentially harmful substances to decrease the risk of UTI and ensure healthy reproduction. The guidance on MHH management in a hygienic manner is explained in detail in MHH TOT Toolkit, Module 3: The Menstrual Hygiene, Care and Health.

Chapter 06

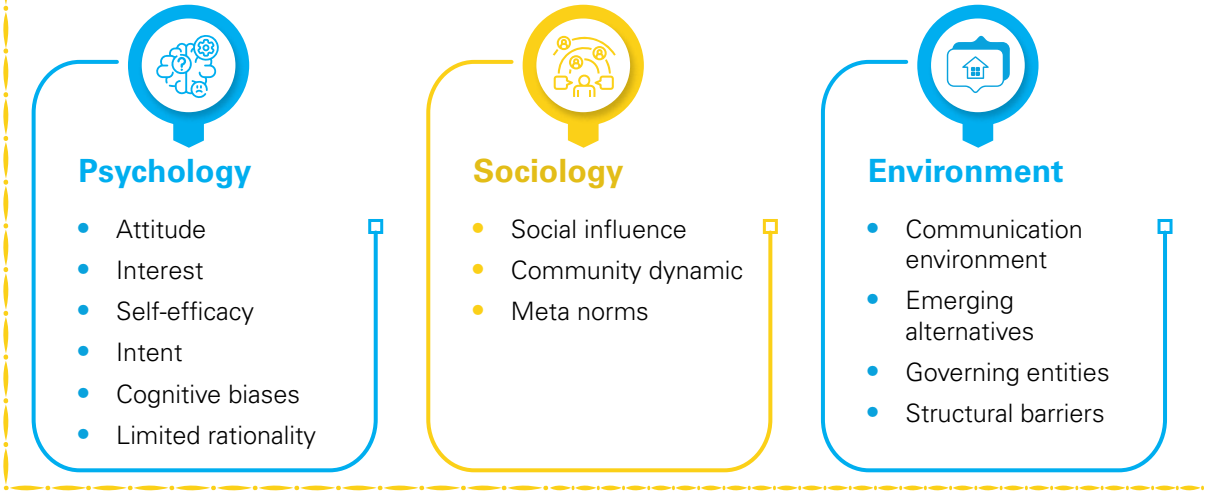
GUIDELINES ON SOCIAL SUPPORT

Menstruation remains a taboo, not discussed openly, and also shrouded in imprudent social and cultural norms that contribute to discrimination, stigma and limited access to menstrual health information and services (World Bank 2022). Negative attitudes towards menstruation can lead to communication barriers and limited access to information and resources on MHH, which, in turn, contributes to poor MHH practices and health challenges among girls and women (Lund University 2018). Stress and shame associated with menstruation can negatively affect their mental health, while the use of unhygienic sanitation products may predispose girls and women to reproductive tract infections. Awareness of menstruation should be created among girls and women so that they are able to manage their periods safely and without being shamed or subjected to discrimination.

Socio-economic dimension determines women's access to essential MHH services, including menstrual materials, water, sanitation and personal hygiene services. Women's empowerment is truly achieved only when they have the ability to participate in the labour market, earn an income and have access to financial resources. It encompasses a wide set of issues, notably control over their own time, lives and bodies, and meaningful participation and representation in economic decision-making processes at all levels – ranging from within the household to the highest economic and political positions (UNWomen 2020). As a result, women remain deprived of their ability to make choices and create a supportive social environment to meet their MHH needs. Consequently, in households, men are decision-makers and hold the purse strings, it makes it difficult for them to provide for the MHH needs, including social and financial support, to their daughters and other female dependants (NIMR, UNICEF 2021).

The Social Institutions and Gender Index Country Report for Tanzania revealed that 63 per cent of working-age women are in the labour force and 58 per cent are employed, compared to 75 per cent and 69 per cent of men, respectively (OECD 2022).

Figure 6.1: The behaviour driver model



The Tanzania MHH study (NIMR, UNICEF 2021) showed that the prevailing social norms and taboos related to MHH confine girls to rely on trusted groups in society (mothers and female family members) for emotional support, knowledge and skills in handling menstruation, and on provision of menstrual materials and products, whereas fathers form the least trusted group by girls on sharing information related to menstrual needs despite their control and ownership of family financial resources. This is because males are socio-culturally conditioned not to be concerned with menstruation. Consequently, the notion of secrecy surrounding menstruation in society has resulted in restraining women and girls from social engagement, exercise and touching a few things and related practices during menstruation.

The social support MHH pillar focuses on improving the supportive social environment for sustained positive MHH practices. It aims to end stigma and discrimination against menstruating girls and women by promoting positive social norms during menstruation.

6.1. Behaviour change models for MHH

In addressing the MHH situation, social and behaviour change (SBC) strategies to address the social norms and disparities between communities and individuals are guided by the behaviour driver model (BDM) and social ecological model (SEM). The behaviour driver model encompasses psychology (attitudes, interests and biases), sociology (reference groups, social influences and meta norms) and environment (services, large-scale institutions and frameworks that communities operate in). Under the SEM, five levels should be addressed, which encompasses society (looking at policy, traditions and cultural beliefs), environment (looking at water, sanitation, menstrual products, safe disposal facilities and other services), interpersonal (looking at relationships with family, teachers and peers), personal (looking at knowledge, skills and beliefs) and biology (looking on age, menstrual flow and cycle). In programming SEM for MHH packages of interventions, there are four areas suggested that lead to behaviour changes namely social support, knowledge and skills, facilities and services and materials.

Figure 6.2: The socio-ecological model

Gathering social support for MHH requires SBC strategies to realize change at individual and community levels by addressing behavioural determinants that affect menstrual health and hygiene practices. Grounded in the socio-ecological model, social support aims to ensure that adolescent girls and women receive the necessary support from all levels to influence the individual and collective community behaviours. The socio-ecological model (Figure 6.2) emphasizes multiple levels of influence and supports the idea that behaviours are affected by a complex interplay between individual, family and friends' relationships, community and societal factors.

The guidelines on the delivery of social support services on MHH at different levels are as follows:

6.1.1. Individual

This level targets individuals, that is, adolescent girls and boys, women and men.

1. MHH stakeholders should develop inclusive and easily accessible, interactive and age-

appropriate, accurate and context-specific MHH information content for dissemination through different channels to address socio-cultural barriers on MHH.

2. MHH stakeholders should design interactive activities/programmes in institutions and within the community to address individuals' (girls, boys, women and men) concerns and misconceptions related to menstruation.

6.1.2 Interpersonal

This level targets families, caregivers, peers, stakeholders and family members.

1. MHH stakeholders should primarily map context-specific reference group members of the target audience (i.e., heads of households, caregivers, friends, influencers) and equip them with relevant MHH knowledge and an understanding of their roles to effectively support girls and women on MHH.
2. MHH stakeholders should engage men and boys to gather MHH information on interpersonal and societal factors on care and support to inform the design of targeted inclusive communication materials and products for them to become the source of MHH solutions.
3. MoH will collaborate with stakeholders to integrate MHH in capacity-strengthening programmes for peer educators and community health workers (CHWs) to enable them to deliver interpersonal messages that address MHH-related taboos.
4. MoCDGWSG, in collaboration with PORALG and MoEST, should make use of the existing programmes such as safe space, children council and SWASH clubs to support and promote parent–child communication, community dialogue and positive peer discussion on MHH issues.
5. MHH stakeholders should hold guided dialogues where men and women feel free to ask questions and discuss MHH without judgement by encouraging the consideration of personal values and biases that may affect the programme.
6. MHH stakeholders should use interpersonal communication (IPC) to deliver MHH counselling and guidance on available MHH services and support and provide information related to pain management and menstrual irregularities through the already existing mechanisms (safe space, gender desk and SRH clinics).

6.1.3. Community

This level targets community leaders, community influencers, religious leaders, professionals, community support groups, socio-cultural groups, social networks, sports teams and volunteer groups in their neighbourhoods, schools, places of employment and worship.

1. MHH stakeholders should collaborate with social welfare and community development officers to understand the existing community engagement structures and platforms prior to the delivery of SBC activities on MHH. They should also ensure that their engagement initiatives are inclusive of people with disabilities and of the last mile.
2. MHH stakeholders should forge strong partnerships with community leaders, key local influencers and religious and traditional leaders as strategic entry points to enhance community ownership of SBC programmes on MHH.
3. MHH stakeholders should engage with and build the capacity of key influential leaders (political, religious, traditional, elders and tribal chiefs) to convey appropriate and sensitive information on MHH during dialogues and on community leader platforms.
4. MHH stakeholders should train teachers, health care workers and other trusted community network groups and platforms

to effectively support girls and boys on MHH education aimed at changing the negative behaviours, practices and attitudes.

5. MHH stakeholders should integrate their MHH programmes with the existing community groups such as VIKOBA (credit and serving groups), in- and out-of-school groups, elders council groups, parent groups, caregivers, counselling and guidance associations, community influencers, youth groups, men's groups, informal community gatherings, football groups and family prayer groups (JUMUIYA) to facilitate dialogue to inculcate positive social norms around MHH.
6. MHH stakeholders should conduct community campaigns to promote positive social norms around MHH including the use of tailored MHH tents, dialogue-stimulating approaches and rallies/road shows.
7. MHH stakeholders should engage community groups and key influencers in the community to dispel community myths, misconceptions, taboos and social stigma around menstruation.
8. The heads of households and other household members should be engaged and empowered with information to address the MHH needs of girls and women living in their households.
9. The development of messages for SBC should be participatory and inclusive tailored to the needs of different community audiences, such as girls and boys, women, men, parents, caretakers, counselling and guiding teachers, religious leaders, traditional leaders, chiefs, and elderly groups and people with disabilities (PwDs).
10. MoH, in collaboration with other key sector ministries and MHH stakeholders, will ensure that MHH is integrated with other major symbolic days such as World Toilet Day, World AIDS Day, Global Handwashing Day and Water Week.

6.1.4. Organizations and institutions

This level targets organizational leaders, decision makers and staff who are responsible for social and behaviour change for MHH at different institutions. The following guidelines apply to them:

1. MHH stakeholders should conduct formative research to understand the organizational structure and challenging social behaviours on MHH.
2. MHH stakeholders should facilitate high-quality designing of SBC messages targeting institutions and workplaces beginning with behaviour prioritization, a step that ensures the efficient use of resources for lasting impact.
3. MHH stakeholders should devise an SBC communication strategy to provide a road map to ensure SBC interventions for MHH. This includes the development of materials and approvals by relevant authorities.
4. MoH, in collaboration with relevant sectors and agencies, will adopt MHH provisions as part of regulatory requirements for the enhancement of female worker's social welfare and productivity.
5. MHH stakeholders should prepare mental health quality and psychological support programmes to solve mental problems occurring in menstruating women and girls in society.

6.1.5. Advocacy for influencers and decision-makers

The following guidelines target individuals in leadership roles, including policymakers, law makers, programme planners, the governing bodies such as key ministries and ministerial departments and agencies. The use of these guidelines will advocate for upgrading the existing policies, redefine public perceptions, social norms and procedures and influence funding decisions for specific MHH initiatives.

1. Stakeholders involved in MHH advocacy should develop a joint advocacy strategy by using a SMART advocacy approach that outlines key advocacy issues, targeted primary audiences, the right messages and the right messenger to deliver the message including opportunities and entry points and outline roles and responsibilities of partners involved in influencing decisions.
2. Stakeholders should ensure that all advocacy initiatives are evidence-based to persuade the key decision-makers.
3. Stakeholders should identify and engage appropriate influential individuals and groups as MHH champions for MHH advocacy.
4. Stakeholders should utilize specific MHH-related advocacy events to create awareness and solicit commitment among decision-makers.
5. Stakeholders should advocate for the integration of MHH in national-level programmes and plans including WASH, SRH, education, gender, women, youth and other relevant sectoral programmes.

Chapter 07

GUIDELINES ON MENSTRUAL HEALTH AND HYGIENE MATERIALS AND PRODUCTS

Menstrual health and hygiene products and materials are fundamental to the dignity and well-being of girls and women. When girls and women have access to safe and affordable menstrual materials and products to manage their menstruation, it improves their ability to participate in socio-economic activities while lowering the risk of infections, which can have a domino effect on overall sexual and reproductive health.

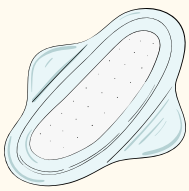
This chapter provides information and guidelines on MHH products commonly available in Tanzania, as well as types, compositions and characteristics of materials that can be used to produce modern reusable pads, disposable pads and menstrual cups. It also provides information on the related regulations, certifications and compliance of MHH products, materials and small and medium enterprises (SMEs). The suggested types, composition and characteristics of MHH materials and products are in accordance with the national, East African and international regulatory standards.

Tanzania recognizes that there are different new technologies of MHH products that are used in other places. However, due to social context and availability of hygiene services, use of menstrual cup should be carefully managed to avoid any complications that may arise in handling, cleansing and sterilizing.

7.1. Types of MHH products

There are different types of MHH products that accommodate diverse needs and choices of menstruating women and girls, regardless of their social, physical and financial status. The common available MHH products in Tanzania are highlighted in Table 7.1.

Table 7.1: Types of MHH products

S/No	Type of product	Description
1.	Disposable pads 	These are also known as sanitary napkins or disposable menstrual pads. They are thin/thick pads, made of absorbent materials that absorb the menstrual fluid during menstruation and are meant for single use only. Ideally, they should be changed every six to eight hours, depending on the menstrual flow and the quality of the product. Used pads should be safely disposed.

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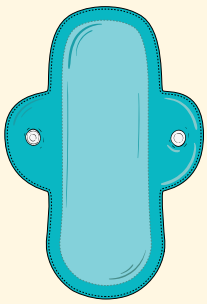
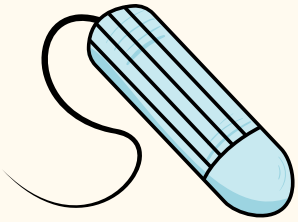
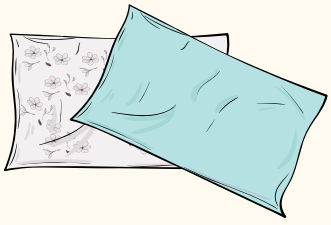
S/No	Type of product	Description
2.	Modern reusable pads 	These are also known as commercial reusable pads. They are made of special fabrics. They absorb menstrual blood and should be changed every four to six hours depending on the menstrual flow and the quality of the product. After use, the pad needs to be washed with soap and clean cold water, dried in a clean ventilated place for its reuse. Users need at least three reusable pads for a day to allow for the washing of the soiled pads and drying them. About eight modern reusable pads are required per person every two years depending on the quality of the materials.
3.	Tampons 	These are small cylinders, made of cotton or other materials, which a woman/girl inserts into vagina to absorb menstrual blood. Once inserted correctly, it expands as it soaks up menstrual blood. These are meant for single use only. They should be changed every six to eight hours, depending on the menstrual flow and the quality of the product. These should be safely disposed of after use.
4.	Menstrual cups 	These are small, funnel-shaped cups made up of rubber, thermoplastic elastomer (TPE), or silicone, which a woman/girl inserts into her vagina, to collect menstrual blood. They should be removed, rinsed and re-inserted into the vagina every 8 to 12 hours, depending on the menstrual flow and the quality of the product. After completion of that particular cycle, they should be boiled, wiped and stored in a clean dry place and be reused in the next cycle. The user needs to buy a new menstrual cup, at least every five years depending on the quality of the product. Hygiene of the hands and the cup are very important to prevent infections.
5.	Home-made menstrual materials/products 	There are a wide range of home-made menstrual materials/ products. The majority of these are made with pieces of old clothes or cotton wool. If old clothes were to be used, they should be soft fabrics, such as polyester fleece or cotton flannel. Such materials should be clean, soft, free from lumps, lightweight and absorbent. Home-made menstrual materials should be changed regularly, at least every three hours depending on the menstrual flow and the quality of material used. Rough cotton towel should not be used next to the skin without another layer on top. After use, menstrual materials need to be washed, dried under the sun or in a clean ventilated place and ironed before they can be reused. If you are using cotton wool, never reuse it. NB: Home-made menstrual products/materials are commonly used in rural Tanzania or less privileged communities. These MHH products/materials carry a lot of potential health risks since they are not regulated by any authority compared to the above four types.

7.2. Materials for making MHH products

The continued advancement of technology has encouraged innovations around menstrual materials and contributed significantly to a wide range of menstrual products in the market. This subsection will elaborate on various menstrual materials and their relevant regulatory standards.

7.2.1. Modern reusable pads

Special fabrics made of fibre, filament, non-woven, terry, microfibre or other materials of similar properties are recommended to be used. These materials should have three different types of layers, where each layer has its own function, characteristics and composition. The production of modern reusable pads should adhere to the types of these layers and their characteristics, adhering to the national regulatory standards as stipulated by the Tanzania Bureau of Standards (TBS), TZS 1659:2014 (first edition) or updates thereof as appropriate. For more details on types, composition and characteristics of raw materials for making modern reusable pads, refer to Annex 1.

7.2.2. Disposable pads

Disposable pads are formed by four different layers of materials: (a) the cover stock, (b) acquisition and distribution, (c) absorbent core and (d) back sheet layer. The main raw material is cotton; however, with the advancement of technology, synthetic materials, including rayon, non-woven fabrics, pulp and others, are used as the raw material (Barman et al. 2018; Mazharul Islam Kiron 2012). The production of disposable pads should adhere to the types of these layers and their characteristics and observe national regulatory standards as stipulated by TBS, TZS 279:2021 (third edition) or updates thereof as appropriate. For more details on types, composition and characteristics of raw materials for making disposable pads, refer to Annex 2.

7.2.3. Menstrual tampons

Tampons are made from natural or regenerated fibre, such as viscose, rayon, non-woven fabrics or cotton. The production of menstrual tampons should adhere to the types of raw materials and their characteristics, adhering to the procedures and regulations as stipulated by the Tanzania Bureau of Standards.

7.2.4. Menstrual cups

Menstrual cups are made from three different substances, namely silicone, natural rubber and thermoplastic elastomer (TPE). With advancement in technology, there might be more raw materials invented in future (MeLuna USA 2018). The production of menstrual cups should make use of the types of raw materials and their characteristics adhering to the procedures and regulations as stipulated by the TBS. For more details on types, composition and characteristics of raw materials for making menstrual cups, refer to Annex 3.

7.3. Regulations, certifications and compliance

Regulation, certification and compliance are a very crucial component aiding in creating harmony and fairness in the MHH business ecosystem. There are different levels of compliance, regulations and procedures for MHH products, materials and enterprises. All MHH products are required by the governed law in Tanzania to be certified by Respective Regulatory Authority currently TBS and TMDA at the port of entry or production premise before being distributed or donated.

7.3.1. Regulations, certification and compliance procedures for MHH materials

Companies, organizations or individuals who wish to locally manufacture or import MHH materials should comply with the country's regulations and quality standards and adhere to the following guidelines.

7.3.2. Locally produced menstrual materials

The Tanzania Bureau of Standards is responsible for the regulation, testing and certification of menstrual materials and the TBS staff visit the manufacturer and sample the materials through laboratory tests. If the tested materials conform to the regulatory standards, the respective test report, or licence, is issued to the manufacturer, depending on the aim or nature of the inspection.

7.3.3. Imported menstrual materials

The TBS-approved representatives, such as Intertek and SGS (Societe Generale de Surveillance), are responsible for certification by visiting the manufacturer at the country of origin and sampling of materials for laboratory tests. If the tested materials conform to the regulatory standards (EAS 220:2018), the Pre-verification Certificate of Conformity (PVoC) is issued. At the port of entry, TBS shall verify the issued PVoC and stamp it before allowing those materials to enter or cross the Tanzania border.

Another option is for imported materials to be tested directly by TBS when they arrive at the port of entry and a Destination Inspection (DI) report is issued. In the case that the tested materials do not conform to the national regulatory standards, the whole consignment shall be recalled, seized or disposed under TBS supervision.

Note: Due to the possibility of amending or changing regulations and compliance procedures, it's vital for the importers to regularly update and familiarize themselves with these regulations before importing MHH materials to avoid unnecessary complications.

7.3.4. Regulations and conformity requirements of MHH products

The primary objectives of the MHH product regulations are to ensure companies and producers comply with the laws and operate fairly in the marketplace and provide consumers with safe, good quality and regulation-compliant products. Regulations help to remove substandard menstrual products in the marketplace and protect consumers from any potential risks caused by the use of those products.

TMDA and TBS are the primary and secondary regulators of MHH products, respectively. The manufacturers and importers should not produce or import any product likely to be counterfeit or which has omitted the country of origin.

Any individual, institution, company or organization that wishes to sell or donate MHH products should adhere to the requirements set by these regulatory authorities.

For more details on specifications and conformity of MHH products, refer to Annex 4.

7.3.5. Regulations, certifications and compliance procedures for MHH enterprises: micro, small, medium and large-scale enterprises

All businesses are required to be registered by the Business Registration and Licensing Agency (BRELA), whether they are individual businesses, partnerships or corporations before they acquire the business licence from the local government authority. Societies, NGOs or cooperatives, which are interested in engaging with MHH products or and materials business, should be registered by BRELA (refer to Table 7.2).

Apart from formally registering with BRELA, there are additional compliance requirements, including obtaining a business licence, Tax Identification Number (TIN), business bank account, occupational health and safety compliance and respective industry standards, such as TBS and TMDA (Netherlands Enterprise Agency 2022; World Bank 2023).

Table 7.2: Regulations, certifications and compliance procedures for MHH enterprises

S/No	Category	Compliance requirements
1.	Micro, Small, Medium and Large-scale MHH Enterprises – Importers and Distributors	1. Apply for TMDA import permit every time you ship MHH products into the country. 2. Subject MHH products to PVoC or DI tests before shipping them to the country, or before clearing them from the port of entry. 3. Submit PVoC, or DI test reports, to TBS for final verifications and approval. 4. Have an active TMDA business licence. 5. Store MHH products in a TMDA-registered warehouse.
2.	Micro and Small-scale MHH Enterprises – Local Manufacturers	1. Subject MHH materials (raw materials) to DI or PVoC tests, depending on where you procure the materials or request your supplier to provide you with those certificates. 2. Register with Small Industry Development Organization (SIDO). 3. Produce MHH products in TMDA-registered production premises. 4. Have an active TMDA business licence.
3.	Medium and Large scale MHH Enterprises – Local Manufacturers	1. Subject MHH materials (raw materials) to TBS tests. 2. Produce MHH products in TMDA-registered production premises. 3. Subject MHH products to TBS tests. 4. Have an active TBS licence to use the mark of the Bureau. 5. Have an active TMDA business licence. 6. Register with Tanzania Investment Centre – only for large-scale enterprises. 7. Obtain an Industrial License, class A, from BRELA.

The Small and Medium Enterprise Development Policy, issued in April 2003, defines micro, small and medium-size enterprises (MSME), according to sector, employment size and capital investment in machinery, as shown in Table 7.3 (Decide Project 2019; IGC-SIDO 2016).

Table 7.3: Classification of businesses in Tanzania

	Microenterprise	Small enterprise	Medium enterprise	Large enterprise
Staff headcount	1–4	5–49	50–99	100 and above
Capital assets/ investment in machinery	Less than TZS 5 million	TZS 5–200 million	TZS 200–800 million	Above TZS 800 million

7.4. Existing support and infrastructure provided by the government to support local investors and SMEs

The government plays a crucial role in supporting local investors and SMEs through supportive policies and economic incentives. The list of existing support and infrastructure, provided by the government, is shown in Table 7.4.

Table 7.4: Existing support and infrastructure provided by the government

S/No	Name of the institution	Support provided
1.	Small Industry Development Organization (SIDO)	❖ Facilitate SMEs' innovative capacity, access to technology, infrastructure and technical services. ❖ Facilitate business development skills for SMEs' growth and competitiveness. ❖ Facilitate SMEs' access to market, finance and information. ❖ Provide consultancy and extension services.
2.	Tanzania Industrial Research and Development Organization (TIRDO)	❖ Promote and carry out applied research, designed to facilitate the evaluation, development and the use of local materials in industrial processes. ❖ Research into local and foreign industrial techniques and technologies and evaluation of suitability for adoption and use in industrial production. ❖ Provide technical services for industrial development. ❖ Promote and provide facilities for training personnel for carrying out applied scientific and industrial research.
3.	Export Processing Zone Authority (EPZA)	❖ Facilitate investment information and services. ❖ Issuing licence. ❖ Provision of special economic zones or export processing zones infrastructure.
4.	Tanzania Investment Centre (TIC)	❖ Investment promotion and facilitation agency in attracting quality investments for sustainable economic development. ❖ Coordinate, promote and facilitate investments in Tanzania and advice the government on policy matters to create a competitive, attractive and sustainable investment climate.

7.5. Import requirements for MHH products and materials

All importers (companies, organization or individuals) should always familiarize themselves with government laws and regulations before importing any menstrual materials and products into the country. The requirements are the relevant requirements (TFDA, May 2015).

7.5.1. Requirements for the import of commercial MHH products

1. Importers and producers of MHH products should register with TMDA and obtain a TMDA business license, unless given special approval by TMDA or the Ministry of Health.
2. All import of MHH products should be done by importers whose premises are duly registered by TMDA.
3. All importers should import MHH products and materials through the authorized ports of entry.
4. All imported menstrual materials should be subjected to Destination Investigation (DI) or Pre-shipment Verification of Conformity (PVoC) tests, which will be approved by TBS at the port of entry.
5. Authorized importers intending to import MHH products should apply to the Director General of TMDA by filling the online application form to obtain the Import Permit.
6. All imported and locally produced menstrual products should bear the following information on the label:
    a. Trade or brand name of the product
    b. Name and the address of the manufacturer
    c. Batch or lot number
    d. Direction of use, disposal instructions, and or sign, size and number of units
    e. Manufacturing and expiry date
    f. Labelling information shall be in English and or Swahili and shall be expressed in a legible, permanent and prominent manner that can easily be understood by the intended user
7. All local manufacturers and importers of MHH products should not engage in producing counterfeit or import substandard products.

7.5.2. Requirements for the import of donated MHH products

MoH, through TMDA, will track the import of donated MHH materials and ensure the key requirements are adhered to by importers as listed below:

1. All donations should be in accordance with the recipient's needs and should comply with the existing government health policies, laws, guidelines and administrative arrangements.
2. Donations should comply with acceptable standards.
3. Any person, institution or organization, intending to import MHH products for donation purposes, shall be required to apply for import permit at TMDA by filling out an online application form.
4. Donated MHH products should have a shelf-life of not less than 12 months (where applicable).
5. The permit issued for the import of donated MHH products shall be valid for six months only.
6. All donated MHH products shall be imported through the authorized port of entry and should be accompanied by all necessary documents.

7.6. Supply and distribution of MHH products

The supply and distribution of MHH products is a crucial component in ensuring women and girls have freedom to access MHH products of their choice at affordable prices regardless of their geographical location.

Suppliers and distributors of MHH products must ensure MHH products that they supply or distribute has TBS and TMDA approval certificates before engaging in this activity, and should be fair in setting prices for their products and always accommodate incentives such as subsidies or tax exemptions whenever availed.

The ministries responsible for trade, finance and planning, should regulate MHH product prices in the marketplace, especially when the government provides tax incentives and subsidies. The following are guidelines on supply and distribution of MHH products:

7.6.1. Supply and distribution procedures for free MHH products

1. MoH, in collaboration with PORALG, will develop criteria and procedures for the distribution of free menstrual products based on socio-economic status (less privileged and marginalized).
2. Local government authorities should involve community development officers, social workers, WASH officers and education officers to contextualize the set criteria, determine the needs of the desired groups and mechanism of distribution.
3. Any person, organization or institution that wishes to donate free MHH products to schools or communities should go through the respective LGA to obtain permission and follow the instructions on how to carry out that activity. Any free distribution that will bypass LGA should be subjected to disciplinary actions decided by the respective LGA.
4. Donated MHH products should be TMDA (and/or TBS) certified; LGAs are responsible for ensuring that non-certified products are not distributed by any person, organization or institution in their area of jurisdiction.
5. The list of beneficiaries, the quantity donated, frequency of distribution, address and the name of the donating organization, person or institution should be presented to the respective LGA and to the department responsible for MHH programming at the Ministry of Health.
6. Distributors of donated MHH products should give priority to less privileged rural women and girls including persons with disability. They should also provide all necessary information on how to use, dispose and manage the distributed MHH products.

7.6.2. Supply and distribution procedures for commercial MHH products

1. The distributors of MHH products should adhere to TMDA procedures and TBS standards TZS 279:2021 (third edition) and TZS 1659:2014 (first edition).
2. Expired and damaged MHH products should be removed from the shelves and never be distributed.
3. The distributed MHH products should be stored in a ventilated and dry warehouse/ room and not be exposed to sunlight.

7.6.3. Supply and distribution procedures for MHH products to people with disabilities

1. All suppliers and distributors of MHH products should consider the diverse needs of the recipients based on the kind of disability.
2. For recipients who totally depend on caregivers to manage their menstruation such as those with (a) intellectual disability, (b) disabilities of the arm or (c) no upper limbs, the distribution of MHH products should be through their caregivers. These caregivers should be trained on how to support persons with disability on the management of menstruation with privacy and dignity. Any menstrual products that require insertion should not be distributed

to this particular group to reduce potential risks of violence.

3. For girls and women with Albinism, who have very delicate skin, may face challenges with friction while girls and women with autism may face challenges in wearing specific textures against their skin. They should receive more MHH products depending on the suggested frequency of change to avoid friction or allowed to test and prioritize appropriate materials. Their recommendations should be non-negotiable.
4. Caregivers of persons with blindness and visual impairment should observe essential safety information including expiry date and clear direction of use for effective support and protection of the vulnerable groups.
5. Tactile tools should be used for teaching persons with blindness and visual impairment, deaf and hearing impairment on the use of distributed MHH products and they should be engaged in the process of developing training strategies and materials.
6. In any circumstances where deaf or persons with hearing impairment are engaged in MHH intervention, they should be provided with a minimum of two sign language interpreters.

7.7. Menstrual health and hygiene kit

Institutions, organizations or individuals who wish to distribute MHH kits should adhere to the supply and distribution procedures for MHH products (refer to section 7.6).

The composition of MHH kit should consider the recipient's needs and the socio-cultural and environmental context. The kit should consist of the following basic items:

1. Three pairs of well-fitting cotton underwear.
2. In case the selected MHH products are disposable pads, they should be enough for at least three menstrual cycles, and a re-supply plan for when they run out of stock should be in place.
3. In case the selected MHH products are modern re-usable pads, they should be enough for at least one year and provide a strong polyethylene zip-lock bag for temporarily carrying soaked pads and a bucket with a well-fitted lid for soaking soiled pads and washing.
4. In case the selected MHH products are menstrual cups, provide a metal pan for boiling the cup after completion of the cycle to ensure safety.
5. A leaflet needs to be issued with information on the direction of use, management and disposal. The leaflets should accommodate persons with blindness or visual impairments.
6. Always give a piece of soap for hand washing.

For advanced MHH kits, the following items should be included:

1. Four pairs of well-fitting cotton underwear.
2. Selected MHH products must comply with the recipient's needs. In case the selected MHH products are disposable pads, they should be enough for at least six menstrual cycles, and a re-supply plan for when they run out of stock should be in place.
3. In case the selected MHH products are modern re-usable pads, they should be enough for at least one year and provide a strong polyethylene zip-lock bag for temporarily carrying soaked pads and a bucket with well-fitted lid for soaking soiled pads and washing.
4. In case the selected MHH products are menstrual cups, provide a metal pan for boiling the cup after completion of the cycle to ensure safety.
5. A leaflet with information on the direction of use, management and disposal. The leaflets should accommodate persons with blindness or visual impairments.
6. Shaving blades.
7. Bar soap/detergent for washing.
8. Hand sanitizers.
9. Body oil.

Notebox 7.1: Additional material and safety requirements for adolescent girls and women under special circumstances

1. Recipients who totally depend on caregivers to manage their menstruation must receive two MHH kits per recipient to accommodate caregivers as well.
2. In emergency responses and humanitarian contexts, an advanced kit should be provided with a regular supply of MHH products, additional soap, underwear, washing line and pegs. Solar light should be provided in and around female toilets to increase girls' and women's safety and security at night.

7.8. Handling and disposal of used MHH products and materials

The Tanzania National Health Policy (2007) recognizes the importance of health care waste management at all levels. Improper management of health care wastes contributes to increased public health risks, as well as environmental pollution.

Used menstrual products and materials are hazardous and need safe handling during collection, transportation, treatment and final disposal. Disposal mechanisms for MHH products

Table 7.5: Disposal mechanisms for MHH products

S/No	Category	Disposing mechanism
1.	Handling and disposing of MHH products and materials at the individual level	❖ Wrap the used MHH products into a piece of paper, ensuring there is no opening. ❖ Have a separate disposal bag, which will only store used menstrual products. ❖ Dispose of the bag into a waste bin with a lid, placed in a toilet or bedroom. Make sure the bag is tied tight to keep odour and insects away. ❖ In the case of using reusable MHH products, the water used for cleansing/washing should be properly poured into the toilet or soak-away pit. ❖ Open burning is strictly not allowed for this type of waste in urban areas. Reuse methods are explained in chapter 8.
2.	Handling and disposing of MHH products and materials at the household level	❖ Make sure there are functional waste bins with lids in the toilets and bedrooms all the time. ❖ Observe and adhere to the waste collection schedule in your area. ❖ When emptying these waste bins, make sure you hand them to the licensed waste collectors or place them in LGA-designated MHH waste collection and disposal sites. ❖ For the households in rural areas, used menstrual products and materials can be buried or disposed of in a pit latrine. ❖ Burning of used menstrual products and materials at the household level in urban areas is strictly not allowed unless the household has a qualified biomedical incinerator.

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S/No	Category	Disposing mechanism
3.	Handling and disposing of MHH products and materials at institutions, such as health facilities and schools and in markets and bus stands	❖ Make sure there are functional waste bins with liners and lids in all toilets as well as standard equipment for waste collection. ❖ Display a pictorial poster/reminder in every toilet that has instructions on the proper disposal of used menstrual products. ❖ Provide appropriate personal protective equipment (PPE) for toilet facility operators. ❖ Ensure the availability of soap and water at all times for hand-washing and cleaning. ❖ Ensure periodic emptying of bins from toilets to keep the environment clean. ❖ The collected used menstrual products should not be left even temporarily, anywhere other than at the designated area. ❖ Used menstrual products can either be treated, medically incinerated, buried or handed over to licensed waste collectors. ❖ Fly and bottom ash of these wastes from incineration is generally considered to be hazardous; therefore, for larger disposal volumes, they should be disposed of in centralized sites designated for hazardous wastes. ❖ In the absence of designated disposal sites, a standard ash pit within or offsite of the facility premises should be constructed. ❖ Transportation of these wastes on public roads should only be conducted by licensed waste collectors (chapter 8).
4.	Handling of MHH products and materials in emergency and humanitarian settings	❖ The authority should use appropriate health care waste management practices. ❖ Appropriate disposal options and procedures must be followed including interim minimal disposal practices. ❖ Open dumping of these wastes should be avoided. ❖ Functional waste bins with lids must be provided in each female toilet. ❖ Waste shall be collected regularly, at least twice a week. ❖ All infectious waste shall be managed in strict compliance with the national protocols and, in their absence, should comply with the global WHO protocols. Transporting this waste creates additional risks and it is highly recommended that medical waste is therefore managed and disposed of on-site using simple methods (UNHCR 2017).

Chapter 08

GUIDELINES ON MENSTRUAL HEALTH AND HYGIENE FACILITIES

Adequate inclusive and functional WASH facilities and used menstrual products and materials management systems are important to ensure adolescent girls and women, including those living with different kinds of disabilities, are safe and secure at all levels and locations. This includes institutions, public places, workplaces and emergency response and humanitarian settings. A MHH study conducted in Tanzanian schools (NIMR, UNICEF 2021) revealed that 70 per cent of schools have inadequate hand washing facilities, 75 per cent lack a disposal solution, while 83 per cent of schools lack changing rooms with basic amenities. They also reported a lower proportion of essential infrastructure for MHH among rural schools compared to the urban schools, whereas 16 per cent of rural schools had special rooms for girls compared to 22 per cent urban schools, and 60 per cent rural schools had an adequate number of latrines compared to 65 per cent urban schools. These data show the magnitude of the problem and therefore calls for action to invest in infrastructure catering to the needs of girls.

Breaking barriers in MHH necessitate the provision of a safe environment and preserving the dignity and confidence of women and girls. The construction of dedicated changing rooms should ensure users' privacy and safety, allowing them to change the used menstrual products; safely dispose of used menstrual products with regular collection procedures; practice personal body and hand wash with water and soap easily; and provision of a location to put their pads and hang their clothes when changing their pads. These construction requirements address gender equity and inclusion needs as stipulated in the National SWASH Guidelines 2016.[4]

This chapter therefore provides key requirements for managing MHH, which are adequate clean and safe running water, sanitation, hygiene and safe disposal facilities in all situations in institutions, public places, households and in emergencies and humanitarian settings. It also provides guidance on operation and maintenance.

Notebox 8.1: Sanitation facility provisions for effective MHH management

1. Ensure separate toilets for girls/women and boys/men in institutions, workplaces and public places, according to national standards with full privacy, fitted with lockable doors from inside and outside. The male and female units must be separated by distance or screens to ensure security.

Continued

4 Basic amenities for MHH room are pad box, soap, emergency pads, hanger or hook, water supply, emergency skirts and underwear.

Continued

2. Toilet facilities for people with different kinds of disabilities (PwD) in all situations should include important features such as ramps, handrails, seats, signs indicating male or female toilets (in big fonts/images) and sound to guide the users and caregivers to access the facility.
3. Make provision of a separate special room with basic amenities to cater to menstruating girls in schools for ensuring their privacy, safety and dignity.
4. Toilets should be considered functional and adequate for MHH only when they have basic requirements such as easy access to a constant supply of adequate clean and safe running water, soap, bucket and a container for anal cleansing and separate bucket for cleaning the used menstrual materials.
5. There should be a suitable mechanism to ensure a sustainable supply of MHH materials such as pad box, vending machine and a kiosk run by a private vendor in toilet facilities in institutions and public places.
6. All female toilets in institutions and public places should have red-coded collection bins with liners for used menstrual materials and ensure a safe disposal mechanism.
7. Toilets in institutions, workplaces and public places should be provided with accessible handwashing facilities with soap and adequate clean and safe running water.
8. There should be special drainage arrangement to a soak pit, which is discrete, for draining water from bathrooms, where water may be stained with blood.
9. Toilets for women and girls at all levels should be provided with adequate light to allow them to manage their menstruation with dignity.

8.1. Water supply needs for MHH management

For provision of MHH services, adequate clean and safe running water and sustainable services are fundamental at all levels (in schools, at home, in other institutions, such as health facilities and care homes, public places and workplaces).

1. Water supply from improved sources (from utilities, boreholes, protected springs, rainwater harvesting (RWH)) should be accessible in all places where women and girls receive MHH services.
2. Female toilet facilities in institutions and public places should be provided with adequate and sustainable water supply (at least 20 litres per user per day) to meet the gender needs of menstruating women and girls (self-cleansing, cleaning soiled clothes, bathing and handwashing).
3. Special/changing rooms for adolescent girls should be provided with adequate and sustainable water supply to be functional (allowing self-cleansing, cleaning soiled clothes, bathing and handwashing).
4. A room to cater to the needs of girls and women with disabilities in all settings should be provided with user-friendly water supply facilities and fittings.
5. In the workplace, public places (markets, bus stands, bars, highway facilities), health care facilities and in emergencies and humanitarian settings, toilets for women and girls should have adequate and sustainable water supply with functional water taps.
6. Showers in schools, institutions, health care facilities and public places should be provided with adequate and sustainable water supply for the management of

personal body cleanliness for menstruating women and girls.

7. Quality of water system fittings, especially water taps that are frequently used in institutions, like schools and public places, should be strong, durable and of good quality and user-friendly for people with disabilities and must be regularly maintained for regular use.

8.2. Sanitation and hygiene needs for MHH in public places and institutions

The provision and use of improved toilets are essential to ensure safe and secured MHH service for girls and women at all levels to enhance their dignity:

1. Toilets in institutions (other than schools) should be sex-specific and separated by distance or screens to ensure the convenience and safety of users (girls and boys, women and men).
2. Toilets for women and girls should have a washable but non-slippery floor, maintained very clean to avoid poor sanitation and prevent urinary tract infections, a hook to hang their clothes and bags, a mirror and a pad box.
3. Toilets in public places and institutions should be provided with mechanisms to access emergency sanitary pads, such as vending machines, privately managed kiosks with diverse MHH products and other related products such as soap, toilet paper, sanitizer and wipes.
4. Toilet facilities should always be well maintained with general cleanliness and ensuring availability of cleaning aids and agents, PPE and reminders for guiding the usage.
5. Toilets and bathrooms should have adequate light for users' visibility during the day and night and good ventilation.
6. In all female toilets, there should be a foot-operated receptacle bin with a lid lined with a plastic bag for the disposal of sanitary pads.
7. Handwashing facilities should be positioned outside the toilet to allow immediate action after the girl/woman leaves the toilet, and include soap and water at all times.
8. A full-length mirror (700 mm × 400 mm fixed at 200–300 mm from the floor level) should be provided in female toilets or special rooms to allow women and girls check stains on their clothes.

8.3. Design criteria for MHH facilities

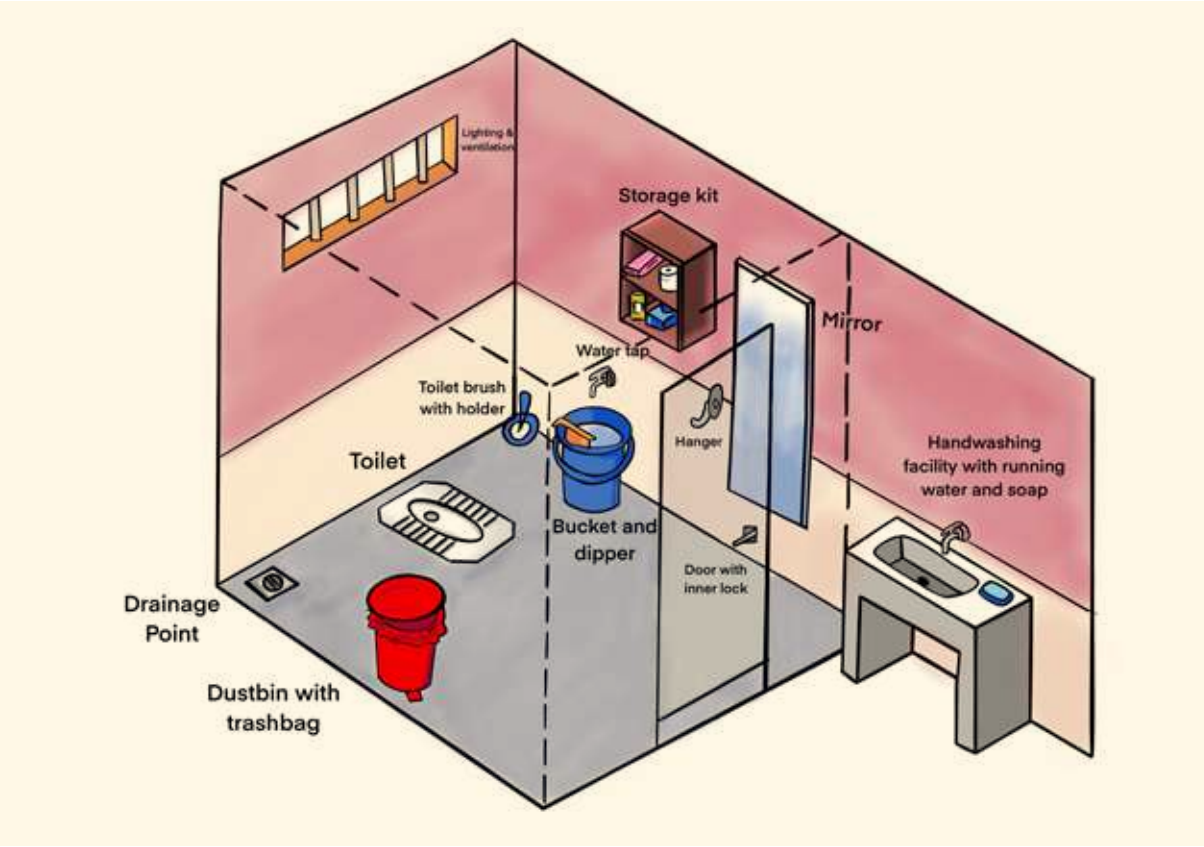
This subsection describes technical specifications for designing MHH facilities. For more details, refer to the toolkit on MHH facilities.

1. Girls' changing room should have the dimensions 1500 mm × 1800 mm inside, including other basic amenities, such as a water facility, tap, shower, handwashing basin, waste collection bin with a lid and liner, pad box, hooks for hanging clothes, a long mirror (700 mm × 400 mm, fixed at 200–300 mm from the floor) and space for comfortable movement in the room while using the facility.
2. The minimum dimensions for female toilets in institutions and public places should be 1200 mm × 1800 mm.
3. Toilets for girls and women with disabilities should also be provided with facilities to cater to their MHH needs, including a waste bin and a pad box for emergency pads.
4. Women and girls should be involved from the early stage of design and construction of female toilets.
5. The room should have windows (600 mm × 1200 mm) to allow light and ventilation and lockable door from inside and outside for privacy.

6. For the attached burning chamber with chute, there should be an airtight cover to prevent smoke.
7. A separate burning chamber should be positioned in such a way girls can access it easily. Planning for its position should take into account the wind direction.
8. Handwashing basin can be fixed inside the MHH room or outside the room depending on resources available and the convenience of users.

Figure 8.1(a) and (b) summarize facilities and basic amenities for the MHH room in accordance with revised SWASH facility designs by MoEST and PORALG (2022). The sketches (a) and (b) are 3D illustrations of facilities and basic amenities with and without the hand wash basin in the MHH room, respectively.

Figure 8.1 MHH room with handwashing basin located outside the room



8.4. MHH facilities for people with disabilities

All institutions and public places should have at least one toilet designed to be fully accessible to women and girls with disabilities. Necessary provisions include ramps, with handrails and clear signage, pedestal flush toilet with splash guard, adequate space within the toilet unit for manoeuvring a large/long wheelchair, a wider door, easy access to water, handwashing facility and used menstrual products and materials disposal facilities, proper lighting for the poor-sighted people (MoEST and PORALG revised design).

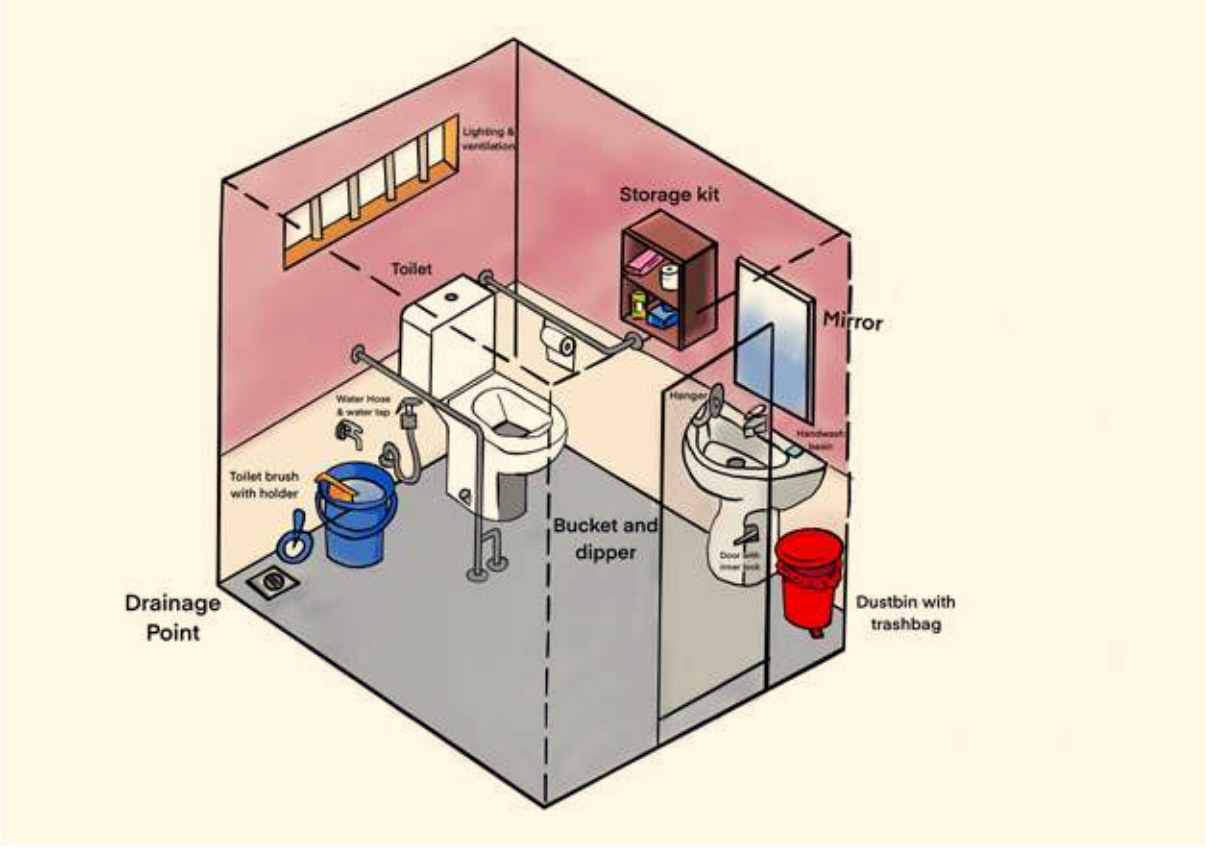
A room to accommodate people with disabilities should have dimensions of 1800 mm × 2050 mm as stipulated in the revised design provided by MoEST in collaboration with PORALG (2022). Special provisions include raised toilet seat, a wider and lockable

door, window, ramp and rails at two levels, both on the pathway and inside the toilet, as well as other signals for people with low vision and stickers in Braille for visually challenged people. Menstrual health amenities should be placed in accessible low shelves and hooks should be available for hanging clothes.

Different provisions should be made where users' needs vary, such as wheelchair holders versus those who crow. In such cases, toilet seat levels should be adjusted accordingly. Specially designed seats made of wood or other appropriate materials should be used to cater to the needs of people with disability in extreme water scarcity or other challenging circumstances.

MHH room: Generally, the MHH room is constructed following the revised designs by MoEST and PORALG for schoolgirls' toilet facility. The sketch illustrates all necessary facilities and amenities in the MHH room. The room provides for sitting/pedestal ceramic with shattaf for cleansing the rear, walls with tiles, window to allow ventilation, drainage point and added amenities as shown in Figure 8.2.

Figure 8.2: Basic MHH room requirements for people with disability



8.5. MHH facilities in humanitarian settings and emergency response

MHH needs for girls and women remain the same regardless of their situation. The provisions for ensuring MHH such as toilet and bathing unit should be safe and private, with continuous supply of water for personal body cleanliness, anal cleansing, handwashing and washing of menstrual materials. They also need to include features, such as a hook and also a full-length mirror in toilet units. A bin with a lid should be provided in each female toilet unit with a sustainable safe collection and disposal process for used menstrual products. The associated cleaning and personal preventive equipment should be provided for people engaged in cleaning and waste collection and disposal. The basic criteria for managing menstruation in humanitarian settings, which need to be fulfilled, are indicated in Box 8.2:

Notebox 8.2: Basic criteria for managing menstruation in humanitarian settings

Dignity: Harmful cultural norms are addressed; a supportive environment ensured; access to information about puberty and reproductive health; engagement with boys and men, as well as girls and women

Privacy: Ability to privately manage menstruation, including to wash, dry and/or discretely discard the disposable materials

Safety: A secure environment; ability to access facilities of choice, throughout the day and night

Facilities: Private female-friendly toilets and washrooms, ideally at home/shelter levels, and separated for each gender by either screens or distance in case of shared toilets or public toilets and in institutional spaces

Information: Practical information should be provided, on wearing, washing and disposing of menstrual materials

Basic materials and supplies: Pads, underwear, a bucket with fitted lid for storage of soiled pads and washing the pads, a rope and pegs and additional washing and body soap should be provided.

Adapted from the Global Toolkit for Integrating MHM in Humanitarian Responses by Sommer et al. (2017).

Care must be taken to ensure that any solution to support women and girls in an emergency response or humanitarian situation involves prior consultations to understand the needs, preferences and appropriate designs of facilities.

In any emergency situation, when designing and setting health facilities, isolation centres, schools, child-friendly spaces, women and girls' safe spaces and other community-related spaces, MHH amenities and supplies should be accommodated.

Although emergency shelters may be temporary, toilet facilities for girls and women should be planned and provided to ensure the safety of users against gender violence, privacy and preservation of dignity. Female toilets, separated from those of males, should have adequate interior space to allow movement and installation of amenities.

Implementers should establish used menstrual products and materials disposal needs during the emergency. It is important to consult with girls and women to inform the selection of systems for managing used menstrual products and materials, as there may be cultural norms, which relate to its collection and disposal that vary by community (Sommer et al. 2017).

8.6. Facilities for the management of used menstrual products

Used menstrual products by nature are highly infectious and therefore its handling, such as collection, storage, transportation and disposal, should be safely managed. However, girls and women often do not prefer others to see their used menstrual products, thus limiting the usefulness of collection, transportation and disposal systems. Disposal mechanisms must be discreet if they are to be used and consultation with girls and women is essential to achieving an effective waste management system (Sommer et al. 2017).

Facilities for the disposal of used menstrual products should adhere to the requirement of health care waste management guidelines, including, in particular, large volumes of soiled sanitary materials (MoH 2018).

8.7. Collection and storage of used menstrual products

The criteria for collection and storage of used menstrual products vary depending on volumes of waste generated in all the settings.

In public places, the commonly used facilities for collection and storage should include bins or closed containers. These should be provided with red-coloured liners and a well-fitted lid and a provision of personal protective equipment for the collection, transportation and disposal. The bin should be clearly labelled. In institutions, a stand-alone bin may be used or a direct drop/chute to the disposal system. Waste collectors/handlers should be trained, medically examined and vaccinated after six months to ensure their safety.

Figure 8.3: Collection and temporary storage bins for used menstrual products and materials

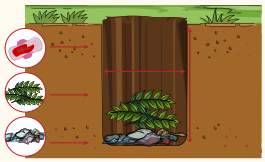
8.8. Transportation and disposal of used menstrual products

This stage is important to ensure the environment is clean and safe. Segregation of waste should be encouraged from the point of collection to transportation and disposal.

The operators of waste collection should have separate containers to keep used menstrual products safely and dispose them of at the designated place or link with health care facilities for incineration.

The disposal options for used menstrual products vary from traditional to high-tech. It is encouraged to use eco-friendly and affordable technologies for treatment and disposal of used MHH materials and products. Different options are provided in Table 8.1, with the recommended use for each option. For wastewater from washing of MHH materials and bathing, there should be a protected or closed drainage to the soak pit to reduce the health risk associated with contaminated water.

Table 8.1: Disposal facilities for used menstrual products

Disposal options	Specification/features	Applicable area			
		Household-level rural setting	Household-level urban setting	Institutions	Public places
Deep burial 	For used cloths and/or sanitary napkins (pads), except for deodorized products: Size of the pit 0.5 m wide x 0.5 m long x 1 m deep. A pit can serve for two years and once filled, another pit can be dug and used. A pit should be dug a minimum of 7 metres from the water source, including hand pumps, tube wells, open wells, ponds, reservoirs and rivers.	✓	✗	✗	✗
Composting 	Improved method over deep burial: size of a pit 0.5 m wide x 0.5 m long x 1 m deep. Deposit the waste (used pads and cloth) along with leaves, other wet biomass and dung slurry. Additional materials should be added every time it is used when cloths and napkins are disposed of. Cover the material with a layer of soil.	✓	✗	✗	✗

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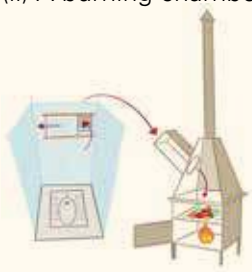
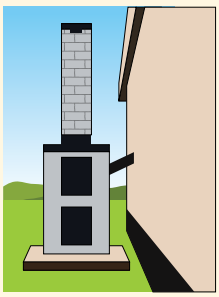
Disposal options	Specification/features	Applicable area			
Incineration/burning (i) Burning in a customized drum 	Burning can be done in a customized metallic drum with holes to allow more effective burning. The drum may undergo wear and tear; therefore, it should be monitored and changed.	✗	✗	✓	✓
(ii) A burning chamber 	Could be constructed as an integral part of the toilet, so the napkins can be dropped directly from inside the toilet. The disposal place should be secured to avoid any possible injury for people. Design options have been provided in the Facility Toolkit.	✗	✗	✓	✗
(iii) A burning chamber harmonize with revisions in toolkit on facilities 	A burning chamber, detached from toilet block with a chute connection to the toilet building, for dropping of used MHH materials. Burning is done in the chambers outside.	✗	✗	✓	✗

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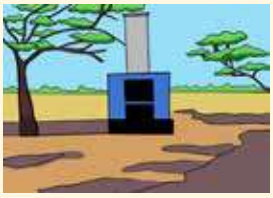
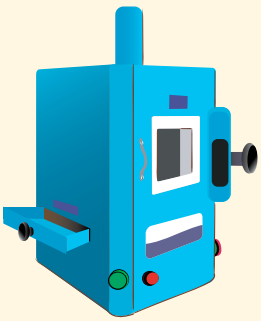
Disposal options	Specification/features	Applicable area			
(iv) A burning chamber attached to the building 	An option of a burning chamber, attached to the toilet block with an airtight opening from inside the toilet for dropping of used MHH materials. Burning is done in the chambers outside	✗	✗	✓	✗
(v) A stand-alone burning chamber 	An option of a standalone burning chamber. The waste has to be carried in a collection bin from the toilet for burning.	✗	✗	✓	✗
Disposal chute and composting pit 	This is a simple model. It is used for schools with an unlined pit. The design uses a steep 60-degree chute, made from a six-inch PVC pipe, leading from the hole in the cubicle to a pit.	✗	✗	✓	✗
Electric incinerators 	These can be adapted for girls' hostels, training centres and women's association centres, depending on the number of women and girls residing in or working in the location. There are more innovations of high-tech incinerators for the disposal of used menstrual products.	✗	✗	✗	✓

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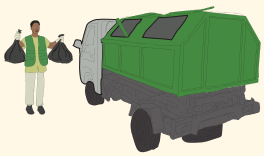
Disposal options	Specification/features	Applicable area			
Offsite disposal 	This is a commonly used method, where collection is done with other waste by service providers, often in urban areas. Another example is from workplaces. In this case, the waste should be transported as a hazardous waste stream and disposed of at hazardous waste treatment facilities.	✗	✓	✓	✓

8.9. Operation and maintenance

The operation and maintenance (O&M) of MHH facilities cannot be separated from the general management of WASH facilities for the entire system. The O&M includes routine maintenance, minor repairs and corrective maintenance. There are key considerations to ensure continued functional MHH services, such as the following:

1. Have a monthly/quarterly checklist for institutions to ensure a thorough inspection, unblocking and repairing all parts of the sanitation system, disposal facility and water systems, which may be damaged.
2. There should be a maintenance fund, such as for latrine cleaning equipment, buying soap, disinfectants, cleaning materials, PPE and menstrual products.
3. In public places and institutions, caretakers should be trained, guided and supervised on the proper maintenance of facilities and provided with PPE.
4. Use a loudspeaker to guide and remind users, especially in public places, on the proper management of facilities and disposal of used menstrual products.
5. Provide visibly displayed posters to remind users on proper practices (such as flush the toilet and leave it clean after use, handwashing with soap and not to drop pads into the toilet).

Chapter 09

MONITORING AND EVALUATION

Monitoring and evaluation (M&E) aims to track progress, identify challenges and institutionalize practical solutions to encourage evidence-based decision-making for MHH services. The M&E for MHH is intended to make the most use of the existing frameworks to capture and process information from diverse sectors and stakeholders in order to minimize the need for new investments and in line with the Health Information System Guidelines 2018. Monitoring processes are streamlined through various operational levels, from national and regional secretariats, local government authorities, institutions and communities.

The M&E framework identifies the common indicators and describes data management processes for the five MHH pillars: (i) inclusive knowledge and skills; (ii) social support; (iii) quality materials and products; (iv) supportive infrastructure and facilities; and (v) effective stakeholder engagement. The implementation aspects of the M&E framework including putting indicators into operation are explained in the Toolkit for Monitoring and Evaluations of menstrual health and hygiene, which is complementary to the guidelines.

9.1. Existing monitoring and evaluation frameworks supporting MHH

The relevant national-level M&E frameworks are identified in Table 9.1, outlining the opportunities to mainstream MHH monitoring into the existing frameworks. The focal point and coordinators should examine the systems and understand the requirement for supporting MHH monitoring, avoiding the creation of parallel structures. Working with organs and persons responsible, the coordinators should facilitate the selection of indicators, describe data analysis and data sharing.

Table 9.1: Existing monitoring and evaluation databases of the key sectors

S/No	Sector	Existing monitoring and evaluation frameworks
1.	Health	1. Health Management Information System (HMIS). 2. National Sanitation Management Information System (NSMIS). 3. Unified Community System (UCS). 4. Afya Supportive Supervision System (Afya SS).
2.	Education	1. Education Management Information System (EMIS). 2. Basic Education Management Information System (BEMIS). 3. School Information System (SIS).

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S/No	Sector	Existing monitoring and evaluation frameworks
3.	Water	1. Routine System for Data Management (RSDM). 2. Water Information System (MAJI-IS).
4.	Industry and Trade	1. Tanzania National Business (TNBP) portal. 2. Online (Business) Registration System (ORS).
5.	Cross-cutting financing system at PORALG	1. Facility Financial Accounting and Reporting System (FFARS). 2. National e-Procurement System of Tanzania (NeST).
6.	Community development	1. NGO Information System.

9.2. Guiding principles on MHH: Monitoring and evaluation at the national level

For harmonization and complementarity of the MHH monitoring and evaluation framework across the sectors, the following guidelines need to be adhered to:

1. MHH indicators (at least three: (i) access to approved menstrual materials, (ii) presence of acceptable female-friendly toilet facility and (iii) availability of running water and soap) should be incorporated into relevant national surveys, particularly the DHS , to facilitate national-level and SDG-related progress monitoring. Planning and M&E departments in sector ministries, national programmes/projects and LGA levels should facilitate the inclusion of MHH indicators into the respective M&E systems working alongside user departments.
2. Water supply databases from respective rural and urban water supply authorities (CBWSO, RUWASA, WSSAs) should be harmonized to facilitate data sharing and segregation of specific institutional water users, such as schools, hospitals, commercial and other public institutions, for monitoring of water access and water usage by user categories in rural and urban areas.
3. An appropriate information management system (preferably the NSMIS) should be used to set up a sector-wide dashboard for MHH. This should be supported by within-sector and across-sector data-sharing mechanisms for collective analysis and sharing through the dashboard.
4. MHH focal points and sector coordinators at the national and LGA levels should work with the respective planning departments and national programmes to identify and ensure the incorporation of relevant indicators to the sector's database.
5. Ensure that multisectoral stakeholders working on MHH coordinate with and share M&E data with the Ministry of Health.

9.3. Monitoring and evaluation functions of MHH focal point and coordinators

The MHH focal point is also responsible for the coordination of M&E activities at the national level, working closely with the central M&E division at the MoH. The sector coordinator at the national level in the same way should coordinate M&E functions at the sector ministry levels in collaboration with the respective M&E sections. Subnational-level coordinators are to coordinate the M&E activities for subnational-level programmes, keep record and relay data for use at the national level. The following functions should be undertaken as part of M&E depending on the level of implementation:

Sample M&E activities for the national level

1. Develop electronic and manual MHH data collection and reporting tools for routine M&E.
2. Develop routine monitoring plan and monthly, quarterly, semi-annual and annual reporting templates.
3. Coordinate process evaluations, midterm evaluations and impact evaluations for MHH and related projects and programmes.
4. Conduct consensus-building on the national MHH indicators and variables for data collection.
5. Coordinate documentation of best practices and production of reports, technical briefs and publications at the national and international levels.

Sample M&E activities for all levels

1. Conduct situational analysis to determine the status of MHH practices and facility situations in the country and set the baseline.
2. Align the MHH M&E framework with funding and implementing partner programmes.
3. Coordinate training on MHH data management.
4. Coordinate quarterly MHH progress review events at the district, regional and national levels, linking the government, implementing partners, CSOs, funding agencies, research and academia and leaders.
5. Provide guidance on the supervision of responsible staff members from public health, education, community development, water, trade and others, health care facilities, schools and institutions, including care centres (like orphanages), workplaces, village and ward level officers, leaders and key influencers and communities and facilitate related data collection, information sharing, planning and decision-making.

9.4. MHH monitoring indicators

A selection of MHH indicators is identified to guide the attention of planners and practitioners on designing, budgeting and implementing M&E programmes for MHH. The use of these indicators will facilitate a comparison between programmes at the same time and ensure that the M&E programme is implemented in a holistic manner, as they are designed to cover a whole range of MHH domains, which can be applied to varieties of programmes.

The indicators provided here are generic and can be applied to different managerial levels such as institutions, communities, district to national levels and in diverse programme setups like government, small-scale projects and in regional or country-level programmes.

Table 9.2: Comprehensive list of indicators for MHH monitoring and evaluation

S/No	MHH pillar	Setting	Indicator
1.	Knowledge	School	1. Per cent of students (boys/girls) who have ever been taught about menstruation in primary and secondary school. 2. Per cent of girls who know about menstruation prior to menarche. 3. Per cent of girls with correct knowledge of the menstrual cycle. 4. Per cent of students that are aware of nutritional needs for adolescents.

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S/No	MHH pillar	Setting	Indicator
			5. Per cent of girls with right knowledge about pain and discomfort associated with menstruation. 6. Per cent of girls who report that they were able to reduce their menstrual (abdominal/ back/) pain when they needed to during their last menstrual period. 7. Per cent of schools where education about menstruation is provided for students from age 9. 8. Existence of pre-service or in-service teacher training on MHH at the primary or secondary level. 9. Per cent of schools that have at least one teacher trained to educate primary/ secondary students about MHH. 10. Per cent of schools that have teacher training guide/manual on menstrual health and hygiene education at the primary and secondary level. 11. Presence of training curriculum covering menstrual health and hygiene education at the primary and secondary level.
		Public places and institutions	12. Per cent of workplaces/institutions with the identified leader responsible for female workers affairs related to menstruation. 13. Per cent of workplaces/public place/ institution with leader oriented/trained on MHH. 14. Per cent of workplaces/institutions with educational and behaviour change materials covering MHH.
		Communities	15. Per cent of women of reproductive age that are aware of the existing menstrual products and materials management facility/arrangement in the community.

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S/No	MHH pillar	Setting	Indicator
2.	MHH materials and supplies	School	16. Per cent of girls who reported having enough menstrual materials during their last menstrual period. 17. Per cent of schools with menstrual materials/products available to girls in case of an emergency.
		Institutions/public places	18. Per cent of institutions/public places with the mechanism to provide access to emergency menstrual/product materials.
		Communities	19. Per cent of menstruators who reported having enough menstrual materials/ products during their last menstrual period. 20. Per cent of menstruating girls/ women who have access to approved menstrual materials/products within the communities. 21. Distance from the nearest point where women and girls can access approved type of menstrual materials/products. 22. Number of points of sale within walking distance from the household.
		Project/programmes	23. Number of menstruating women who have gained access to approved menstrual materials/products as a result of project/ programme interventions. 24. Number of menstrual materials/products registered by regulatory bodies (TBS and TMDA). 25. Type of materials/products approved by regulatory bodies (TBS and TMDA). 26. Number of menstrual materials/products produced at the community/LGA level. 27. Number of entities importing menstrual materials/products. 28. Number of approved menstrual products/ materials imported.

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S/No	MHH pillar	Setting	Indicator
3	Emergency and humanitarian support		29. Presence of national guidance/standard operating procedure (SoP) incorporating MHH in the list of essential humanitarian needs for all emergency and humanitarian services. 30. Presence of educational and SBC materials on the MHH for temporary settlements.
			31. Physical presence of dignity kits among the emergency and humanitarian stocks in national relief programmes. 32. Per cent of girls/women that have received dignity kit or other form of menstrual health and hygiene support in humanitarian settings. 33. Presence of improved sanitation facilities that are single sex, ensure safety and privacy at the time of the survey. 34. Per cent of girls/women who would feel comfortable, safe and dignified using sanitation facilities during menstruation in a humanitarian setting. 35. Presence of clear arrangement for management of used menstrual products (collection, transportation, treatment or disposal) facilities. 36. Presence of disposal mechanisms for used menstrual products.
4	Infrastructure	School	37. Per cent of schools with special rooms for girls. 38. Per cent of schools with special rooms for girls with disability. 39. Per cent of schools that have special room with basic amenities for MHH (including running water, pad box, mobility room, lockable door and waste collection bins). 40. Per cent of schools with used menstrual products and materials management systems (collection, transportation, treatment, or disposal). 41. Per cent of schools with accessible handwashing facility with running water soap.

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S/No	MHH pillar	Setting	Indicator
		Institutions/public places	42. Per cent of institutions/public places with separate toilet facilities for men and women. 43. Per cent of institutions/public places with friendly facilities for people with disabilities. 44. Per cent of institutions/public places with basic amenities in female toilets. 45. Per cent of institutions/ public places with used menstrual products and materials management system (collection, transportation, treatment or disposal).
		Communities	46. Per cent of households in urban/rural with mechanism for the management of used menstrual products and materials (segregation, collection and disposal). 47. Per cent of households with closed drainage/soak pit for ablution water. 48. Per cent of urban communities with acceptable centralized hazardous waste disposal facility and elaborate system for safe handling and transportation of used menstrual products and materials to disposal point.
		Project/programmes	49. Per cent of institutions/public places that have gained access to acceptable types of menstruation-friendly infrastructure and amenities as a result of project/programme interventions. 50. Per cent of institutions/public places that are meeting minimum standards for female-friendly WASH infrastructure and basic amenities. 51. Per cent of institutions/public places with acceptable infrastructure/arrangement for the safe disposal of used menstrual materials.
5	Practices and behaviours	School	52. Per cent of girls who changed their menstrual materials/products at school in a MHH room that was clean, safe and with during their last menstrual period.

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S/No	MHH pillar	Setting	Indicator
6	SRH integration		53. Presence of SRH practitioner's guideline covering MH facilitation topics. 54. Per cent of women with correct knowledge of the menstrual cycle. 55. Per cent of females attending RCH programmes who received MH education and information from attending the respective programmes/sessions. 56. Per cent of females accessing MHH materials as part of their participation in sexual and reproductive health programmes.
7	Supportive social environment		57. Per cent of girls who knows whom to contact in case they need help with menstruation-related issue while at school. 58. Per cent of girls who would feel comfortable seeking help for menstruation problems at home/in their community. 59. Per cent of girls who would feel comfortable seeking help for menstrual problems from male parent/guardian/ teacher. 60. Per cent of girls/women who would feel comfortable engaging in education, work or other developmental activity during menstruation. 61. Per cent of girls/women who would feel comfortable attending social or developmental gatherings during menstruation. 62. Per cent of girls/women who would feel that menstruation is not something that they are stigmatized for or that they need to feel ashamed about in their communities. 63. Per cent of public toilets with visual reminders on correct usage of MHH facilities including used menstrual products and materials segregation.

Continued

Continued

S/No	MHH pillar	Setting	Indicator
8	Nutritional needs, Disorder/ Discomfort		64. Per cent of schools with school-to-health care facility referral forms (including for menstruation-health related complications) for pupils and or students available. 65. Per cent of schools with records indicating the usage of school-to-health care facility referral of students and or pupils. 66. Per cent of girls and women with correct knowledge on nutritional needs during pre-menstrual and menstrual period. 67. Per cent of girls and women who report that they were able to manage menstrual pain as a result of knowledge gain.
9	Policy		68. National and subnational budgets allocated to menstrual health and hygiene. 69. Budgeted funds are disbursed to schools and last miles in communities. 70. Per cent of communities with legal instruments directing right handling, transportation, and disposal and prohibiting indiscriminate disposal of used menstrual products and materials.

9.5. Data analysis, data usage and sharing

National programmes and projects should develop appropriate monitoring systems from the designing stage and in accordance with the health information system guidelines (MoH 2019). They should select appropriate indicators from the list (Table 9.2) to ensure comparability (model M&E forms, data analysis tools and templates are provided in the national M&E toolkit). Programmes should optimize their monitoring tools, including data collection forms (e.g. questionnaires and checklists) and data capture tools, like electronic spreadsheets, with the recommended national tools.

Coordinators and stakeholders responsible for monitoring should adhere to the following guidance to ensure effective data collection, analysis, sharing and usage:

1. Standardize categorization and accurately capture monitored entities by their categories, such as gender groups of male, female, adolescents and adults and types of institutions like schools, markets or churches.
2. Obtain administrative and community identifiers from lower levels, that is, village/ mtaa and wards to facilitate operational level data analysis and interpretation.

3. Strengthen capacity and provide tools to LGA staff responsible for M&E to facilitate lower-level (village, ward and institutional group) data analysis and learning. Note: Data aggregation for national programmes is to be done from the council to national levels.
4. Facilitate operationalization of data analysis, data display, as well as data sharing (see section 9.2 (4)), with relevant stakeholders and decision-makers from council levels.
5. Ensure that non-state actors incorporate M&E components in projects from the designing stage and share information through the national and subnational level government mechanisms for sustainability.

Chapter 10

SUSTAINABILITY

Menstrual health and hygiene programmes should be part of ongoing planning and budgeting for gender-supportive development at all levels. This is necessary to ensure that the goals of providing for and improving the well-being of girls and women are not only met but also sustained at all administrative levels and in communities. Therefore, MHH programmes should embrace the sustainability aspects provided as part of guidelines here.

10.1. Governance

Leaders need to understand the subtle role of menstruation in the health and welfare of girls and women and embrace it among the priority agendas for development. With that in mind, they should work with communities to plan and execute developmental activities in a way that will ensure access to sustainable MHH services for the well-being of women and girls. The principles that guide strengthening the governance for MHH are as follows:

1. Build awareness and advocate for the inclusion of MHH as a priority development agenda, among political leaders, decision-makers and influential persons.
2. Identify and document key sectors and programmes where the inclusion of MHH is most relevant, such as in schools and adolescent/youth services, health care facilities, care institutions, sanitation and hygiene programmes and public offices.
3. Outline key intervention areas where government or community budgets can be directed to improve MHH status at their respective levels.
4. Ensure M&E outputs on MHH and other progress reports are presented at decision-making forums, including parliament, technical working groups (TWGs), full council and management meetings of the government entities and stakeholder groups.

10.2. Planning and budgeting

Menstruation needs are not only central to health and reproduction but also linked to multiple development sectors including Environment, Water and Sanitation, Trade and Industry and broader community development. Thus menstruation-related needs have to be planned and provided to unleash the immense development potential that girls and women possess. The guidance on planning and budgeting for MHH at different levels is as follows:

1. The focal point at the Ministry of Health should work with the planning departments to establish MHH as a priority gender and welfare package for budgeting and mainstreaming to the related programmes.
2. National and subnational level officials, addressing MHH-related aspects such as WASH, education, sexual and reproductive health, social welfare, community development and environment, should develop annual plans and commit resources to cover various MHH components for health and social well-being, including:

a. Education, to include the development of training curriculum for trainers and trainees, teaching materials and textbooks for learners.

b. Socio-behaviour change activities, such as media campaigns, development of information, education, communication materials and other communication aids, as well as community outreach programmes.

c. Advocacy for resource commitment in parliament and high-level government.

d. Incentives and promotion of the production of acceptable menstrual materials at various capacities, including vocational training of local producers and local processing of raw materials, small-to-large scale importers and local manufacturers at the national, local government and community levels.

e. Increase access to acceptable MHH services for all, leaving no one behind. This should entail meeting the needs of people with different kinds of disability, economically disadvantaged and the marginalized.

f. Provision of gender-friendly WASH services in schools, workplaces, public facilities and in households.

g. Provisions for the collection, transportation and safe disposal of used menstrual materials, from communal areas and urban locations, where onsite treatment and disposal may not be feasible.

h. Innovation, research and development for improvement in various areas and sharing of good lessons.

i. Capacity strengthening and sensitization of national, regional, LGA and community (ward and village) level officials and field workers, like those involved in monitoring and members of CSOs, FBOs and others.

j. Monitoring and evaluation, supervision and audit including data-sharing activities for planned and implemented MHH programmes at different levels.

3. Sensitize parents and guardians to plan and provide for female adolescents, whether they are in school or out of school. School and parenting programmes should be used to promote parental support to adolescent girls. An example arrangement is provided in Notebox 10.1.

Notebox 10.1: Model approaches to increase access to MHH in schools and workplaces

Approaches to encourage parents to provide for their adolescent girls

Outlining menstrual health requirements in the list of students' personal items.

Bulk procurements of menstrual materials for students, as prepaid by parents.

Making MHH essentials and pad box available at retail shops, within or near schools.

Include MHH training in targeted training for parents in puberty education and parenting.

4. LGAs should budget for and allocate resources equitably, targeting people with different kinds of disabilities and deprived communities or families, exploiting social support mechanisms, including TASAF and direct contributions from stakeholders to meet the last mile to an estimated amount of TZS 40 million per year (see calculations in Notebox 10.2).
5. National government and local government authorities should prioritize MHH in school budgets as per the SWASH Guidelines, 2016. Where school sources, such as the capitation grant, are limited, councils should consider providing additional funding from their own sources on as-needed basis.
6. Schools (primary and secondary, public and private) should allocate a budget for emergency menstrual pads, estimated at 10 reusable or disposable pads per 100 girls per month, to be made available in case of emergency every day, with the addition of bar soap, underwear, three skirts of varying sizes and pain relief medications. The cost of these amenities with the exception of water supply bills are estimated at TZS 150,000 per 100 girls population per year in primary schools and TZS 300,000 per year in secondary schools.
7. Authorities should ensure that employers in offices and factories maintain gender-supportive working conditions by providing MHH supportive facilities, materials and culture, including planning and budgeting for MHH needs such as material procurement and disposal and presence of secure toilets with water and other hygiene amenities.
8. Council-level coordinators should encourage stakeholders' contributions towards MHH and supervise workplace and institutional-level services.
9. Councils should also set aside mechanisms to manage non-state actors' contributions for MHH materials and operational contributions in schools for equitable allocation of limited resources to target those in need.

Notebox 10.2: Estimating emergency MHH needs for schools

Estimating minimum budget requirement for emergency MHH needs in school

1. **Number of girls menstruating every day**

   Girls/women menstruate for 5 days in a month (roughly 5/30 days)

   Hence, out of 100 post-menarchal girls, 17 are actively menstruating on any given day

2. **Chances of an adolescent girl experiencing emergency menstrual event in a month**

   Chance of unexpected start of menstrual period (in an emergency), assuming 10 menstrual events with 3 occurrences = 0.3

   Chance of a girl experiencing a menstrual emergency during her cycle is 1 in 5, and emergencies typically occur on the first day of menstruation out of an average five-day period = 0.2

   Number of emergencies in a day = 17*0.3*0.2 =1

   The chances of occurrence of menstrual emergency for 17 girls actively menstruating in a day = 1

3. **Number of emergency pads per day per 100 menstruators**

   A minimum of 1 menstrual pad per day for a population of 100 girls

   Inferring a minimum of 30 pads per month per 100 girls

Continued

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Estimated annual budget for emergency personal MHH needs for girl students

Basic personal items	Unit	Daily requirement	Monthly needs	Annual needs	Unit cost (TZS)	Total cost (TZS)	Cost for primary schools (TZS)	Cost for secondary schools (TZS)
Factor							**0.6**	**0.8**
Menstrual pads	Pad	1	30	300	450	405,000	243,000	324,000
Bar soap	PCs	1	5	50	3000	450,000	180,000	360,000
Skirt	PCs	3	1	3	15000	180,000	72,000	144,000
Underwear	PCs	1	1	12	2000	72,000	28,800	57,600
Oil or lotion	PCs	1	1	12	2000	72,000	28,800	57,600
Painkiller	Tablet	2	60	600	100	180,000	72,000	144,000
Total						**1,359,000**	**624,600**	**1,087,200**
Per child per year						13,590	6,246	10,872
Per child per month						1359	624.6	1087.2
Rounding up							600	1000

Assumptions

- In a population of 100 post-menarchal girls, 17 will be actively menstruating in any given day
- Post-menarchal girls constitute about 30 per cent of primary school girls with higher chance of emergencies doubling the proportion to 60 per cent (factor 0.6 in the table)
- Post-menarchal girls constitute about 80 per cent of secondary school girls (factor 0.8)
- These estimations present conservative minimum needs which can be improved based on resource availability

Estimating annual cost of emergency MHH needs for economically deprived and marginalized individuals in a council

Note: The budget estimate covers pads only for last mile which could be distributed via appropriate channels such as TASAF.

Annual budget = number of last mile menstruators* annual cost of materials

Assumptions

- Average council population based on census 2022 = 335,885.9
- Percentage of population on abduct poverty = 2.5 per cent
- Proportion of menstruators in community = 24 per cent
- Annual cost of emergency modern reusable pads per person TZS 20,000
- Estimated emergency budgetary requirements for last mile/marginalized individual per council per year = TZS 40,000,000

10.3. Guidance on estimating cost of emergency MHH needs for girls in schools

Recommended emergency MHH needs for girls should be made available all the time in school, they include the following items:

- Menstrual products such as disposable or modern reusable pads
- Soap for personal hygiene including hand washing
- Emergency underwear (not for sharing)
- Skirt or wrapper (khanga) that can be shared after laundry
- Skin care oil or lotion
- Basic painkiller medications

Estimated cost for emergency MHH needs for primary and secondary schools

The estimated costs of emergency menstrual pads are based on the assumptions and calculations detailed in Notebox 10.2. These estimations have taken many factors into consideration, including the probability of emergency menstrual events and the difference in proportion of post-menarche girls in primary and secondary schools, and reflect the cost for MHH needs as listed in the introduction. For practical reasons, the estimations are applicable to groups rather than individual girls. Hence, it is provided for groups of hundred students in secondary and primary schools as detailed in Table 10.1.

Table 10.1: Budget estimation for emergency menstrual pads in primary and secondary schools

S.no.	Number of girls	Monthly budget estimate (TZS)		Annual budget estimate (TZS)	
		Primary school	Secondary school	Primary school	Secondary school
1.	1 – 100	60,000	100,000	600,000	1,000,000
2.	101 – 200	120,000	200,000	1,200,000	2,000,000
3.	201 – 300	180,000	300,000	1,800,000	3,000,000
4.	301 – 300	200,000	350,000	2,000,000	3,500,000
5.	401 – 300	220,000	380,000	2,200,000	3,800,000

Note: *This discussion covers estimated costs for essential MHH materials, specifically emergency supplies for school girls. Summary description of estimated costs of basic menstrual materials required for a girl's or woman's regular monthly needs is provided for context and practical reference. Accordingly, the total annual cost of disposable pads per school girl is estimated at* ***TSh 30,250****, with costs ranging from* ***TSh 22,000*** *in rural areas to* ***TSh 38,500*** *in urban areas, based upon a recent analysis report.*[5]

5 **Hyasintha Ntuyeko,** Examining the Market for Female Sanitary Pads in Rural Tanzania, *OIKOS & WORLD BANK report pg. 65., 2023 (Draft Report)*

REFERENCES

1. Barman, Anuradha, S.D. Asagekar and Pooja Katkar, *Natural and Sustainable Raw Materials for Sanitary Napkin and Textile Value Chain* , 2018.

2. Benki, S., S.B. Mostad, B.A. Richardson et al., 'Cyclic Shedding of HIV-1 RVA in Cervical Secretions During the Menstrual Cycle'*, Journal of Infectious Diseases,* vol. 189, no. 12, 2004, pp. 92–201.

3. CDC, STD *Treatment Guidelines: Evidence-based recommendations for the treatment and prevention of STDs*, CDC, Atlanta, GA, 2010, <www.cdc.gov/std/treatment/2010/default.htm>

4. Decide Project, *Business Formalization in Tanzania*, 2019.

5. FAO, *Nutrition Factsheet*, FAO Publications of the United Nations, Rome, 2004.

6. Girls Not Brides, *Child Marriage and Sexual and Reproductive Health and Rights,* November 2018, <www.girlsnotbrides.org/documents/873/PO47765-Girls-Not-Brides-5.-Child-Marriage-and-SRHR-lr.pdf>

7. Global Menstrual Collective, *The Power of Integration* , 2023, 22 pp.

8. IGC-SIDO, Joshua Chipman and Jed Silver, *Impact Evaluation Scoping Visit,* Report and comments, F-40406-TZA-1, October 2016.

9. International Labor Office, *Gender Equality at the Heart of Decent Work,* International Labor Conference, 98th Session, 2009, Report VI, International Labor Office, Geneva, 2009.

10. King, Elizabeth M., Arianne Albert and Melanie C.M. Murray, 'HIV and Amenorrhea: a meta-analysis', AIDS, vol. 33, no. 3, 2019, pp. 483–491, doi: 10.1097/QAD.0000000000002084.

11. Lund University, *Towards Sustainable Menstrual Health Management in Tanzania,* Policy brief, Lund University Centre for Sustainability Studies, 2018, <www.lucsus.lu.se/sites/lucsus.lu.se/files/policy_brief_mhm_saragabrielsson.pdf>, accessed 6 August 2023.

12. Maji Safi Group, *Period Poverty in Tanzania: Menstruation issues and sanitation,* 2020, 23 December.

13. Marino, D.D. and J.C. King, 'Nutritional Concerns During Adolescence', *Pediatric Clinics of North America,* 1980, vol. 27, no. 1, pp. 125–139, doi: 10.1016/s0031-3955(16)33824-x.

14. Martell, S., C. Marini, C.A. Kondas and A.B. Deutch, 'Psychological Side Effects of Hormonal Contraception: a disconnect between patients and providers', *Contraception and Reproductive Medicine,* vol. 8, no. 1, 2023, p. 9.

15. MeLuna USA, Menstrual Cup Materials, *Menstrual Hygiene Management Kit,* 2018.

16. Ministry of Drinking Water and Sanitation, Republic of India, *Menstrual Hygiene Management National Guidelines,* 2015.

17. Ministry of Education and Sports, Republic of Uganda, *Menstrual Health and Hygiene Management Guidelines for Schools and Education Institutions in Uganda,* 2021.

18. Ministry of Industry and Trade, United Republic of Tanzania, *The Tanzania SMEs Development Policy,* 2003.

19. Ministry of Education, Republic of Zambia, *Menstrual Hygiene Management National Guidelines,* 2016.

20. Ministry of Education Science and Technology, United Republic of Tanzania, *Draft Facilitator Guideline: MHH education for primary, secondary school and teachers' college in Tanzania,* 2020.

21. Ministry of Education Science and Technology, United Republic of Tanzania, *National Guideline for Water, Sanitation and Hygiene for Tanzania Schools* .

22. Ministry of Health, United Republic of Tanzania, *The Tanzania National Health Policy*, 2017.

23. Ministry of Health, Community Development, Gender, Elderly and Children, United Republic of Tanzania, *National Policy Guidelines for Healthcare Waste Management in Tanzania,* 2017.

24. Ministry of Health, Community Development, Gender, Elderly and Children, United Republic of Tanzania, *The National Guidelines for Water, Sanitation and Hygiene in Health Care Facilities,* 2017.

25. Ministry of Health, Community Development, Gender, Elderly and Children, United Republic of Tanzania, and TFNC, *Mafunzo Jumuishi ya Lishe na Afya ya Jamii kwa Watoa Huduma ya Afya Ngazi ya Jamii-Mwongozo wa Mwezeshaji, 2018, <www.lishe.org>*

26. Ministry of Health, Community Development, Gender, Elderly and Children, United Republic of Tanzania, *National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing,* 2021/22–2024/5.

27. Ministry of Health, United Republic of Tanzania and TFNC, *Maternal Infant and Young Child and Adolescent Nutrition (MIYCAN),* 2022.

28. Ministry of Health, Community Development, Gender, Elderly and Children, United Republic of Tanzania, *National Catalogue for Healthcare Waste Management Equipment, Supplies, Treatment and Disposal Methods,* 2018, 2023 .

29. Ministry of Health, Community Development, Gender, Elderly and Children, United Republic of Tanzania, *National Communication Strategy for Health Promotion,* 2021–2026.

30. MoW , United Republic of Tanzania, *Design, Construction Supervision, Operation and Maintenance (Dcom) Manual,* Fourth Edition, Volume I: Design of water supply projects, 2020, doi: 10.1186/s40834-022-00204-w.

31. Netherlands Enterprise Agency, Ministry of Foreign Affairs, *A Guide to Doing Business in Tanzania,* 2022.

32. NIMR and PHL IdC, *Menstrual Health and Hygiene Among School Girls in Tanzania,* Research Report, National Institute of Medical Research, Dares-salaam, Tanzania, June 2021, ISBN 978-9976-88-975-81.

33. NIMR and UNICEF , *Menstrual Health and Hygiene Situation in Tanzania,* Report on Myths, Beliefs and Social Cultural Norms Impacting MHH in Tanzania, 2021.

34. Norris, Shane A., Edward A. Frongillo, Maureen M. Black et al., 'Nutrition in Adolescent Growth and Development', *The Lancet*, vol. 399, 2021, pp. 172–184, <https://doi.org/10.1016/S0140-6736(21)01590-7>

35. Nyampundu, Kepha, William J.S Mwegoha and Walter C. Millanzi, *Sustainable Solid Waste Management Measures in Tanzania,* 2020.

36. OECD, *SIGI Country Report for Tanzania, Social Institutions and Gender Index,* OECD Publishing, Paris, 2022.

37. Reichelderfer, P.S., R.W. Coombes, D.J. Wright, et al. *AIDS,* vol 14, no 14, 2000, pp. 101–107.

38. Santhya, K.G., 'Early Marriage and Sexual and Reproductive Health Vulnerabilities of Young Women: A synthesis of recent evidence from developing countries', *Current Opinion in Obstetrics and Gynecology,* vol. 23, no. 5, 2011, pp. 334–339.

39. Santoro, N., 'Perimenopause: From research to practice', *Journal of Women's Health,* vol. 25, no. 4, 2016, pp. 332–339. doi: 10.1089/jwh.2015.5556.

40. SNV Tanzania, Formative Research, Arusha City Council and Shinyanga Municipal Council with SNV Tanzania WASH SDG, 2018.

41. Sommer M., S. Chandraratna, S. Cavill et al., 'Managing Menstruation in the Workplace: An Overlooked Issue in Low- and Middle-income Countries', *International Journal for Equity in Health,* vol. 15, 2016, article number 86.

42. Sommer, M., M. Schmitt and D. Clatworthy, *A Toolkit for Integrating Menstrual Hygiene Management (MHM) into Humanitarian Response* (first edition), Mailman School of Public Health and International Rescue Committee, Columbia University, New York, 2017.

43. Sommer M. et al. 'Pilot Testing and Evaluation of a Toolkit for Menstrual Hygiene Management in Emergencies in Three Refugee Camps in Northwest Tanzania', *Journal of International Humanitarian Action,* vol. 3, 2018, article number 6, <https://doi.org/10.1186/s41018-018-0034-7>

44. Sommer, M., *A Toolkit for Integrating Menstrual Hygiene Management (MHH) into Humanitarian Response.*

45. *Tanzania Demographic and Health Survey and Malaria Indicator Survey* (TDHS 2015–2016), Final Report.

46. TFDA, *Guidelines for Importation and Exportation of Medical Devices Including In Vitro Diagnostics,* May 2015.

47. The World Bank, *Menstrual Health and Hygiene Brief,* 2022, <www.worldbank.org>

48. UN Women, *Gender Equality & Water, Sanitation and Hygiene,* Report of the Expert Group Meeting, 2020.

49. UNHCR, *Hygiene Promotion Guidelines,* 2017.

50. UNICEF, *Guidance on Menstrual Health and Hygiene,* First edition, Programme Division/WASH 3, United Nations, New York, 2019, <www.unicef.org>

51. United Republic of Tanzania, *The National Solid Waste Management Strategy,* 2018.

52. USAID, *Engaging Men to Improve Menstrual Hygiene Management in the Workplace*, 2022.

53. Wahl, R. 'Nutrition in the Adolescent,' *Pediatric Annals,* vol. 28, no. 2, 1999, pp. 107–111. doi: 10.3928/0090-4481-19990201-07.

54. Wilson, L.C., K.H. Rademacher, J. Rosenbaum et al. 'Seeking Synergies: Understanding the evidence that

links menstrual health and sexual and reproductive health and rights', *Sex Reproductive Health Matters,* vol. 29, no. 1, 2021, p. 1882791. doi: 10.1080/26410397.2021.1882791.

55. World Bank, *Financial Aspects of MHH Products in Tanzania,* April 2023.

56. World Health Organization, *Knowledge Translation for Health Decision Making,* 2021, <www3.paho.org/hq/index.php?option=com_content&view=article&id=9682:knowledge-translation-for-health-decision-making&Itemid=41010&lang=en>

57. WSSCC, *Menstrual Wheel*, Water Supply and Sanitation Collaborative Council, 2000.

58. WSSCC, *WASH and Health for MHH, Training of Trainers Manual v1.0,* Water Supply and Sanitation Collaborative Council Learning Series Menstrual Health Management, 2013, <www.wsscc.org>

ANNEXURES

Annexure 1: Guidelines on types, composition and characteristics of materials for making modern reusable pads

S/No	Type	Composition	Characteristics
1.	Top layer	The recommended materials to be used for the top layer are fleece or non-woven fabrics. These materials are made with polyester, cotton, wool or rayon fibres. Other materials with similar characteristics can be used as a top layer.	1. Does not hold onto the liquid and dries quickly when wet 2. Very soft 3. Lightweight 4. It doesn't fray easily 5. Breathable 6. Does not keep stain 7. Less likely to itch
2.	Middle layer	The recommended materials to be used for the middle layer are microfibres. These materials are known as terry, staple fibre or filaments. They are made with at least two or all of the following fibres: acrylic, polyamide, nylon, rayon and polyester. Other materials with similar characteristics can be used as a middle layer.	1. Excellent ability to absorb moisture 2. Breathable 3. Easy to clean 4. Resistant to bacterial growth 5. Hypoallergenic 6. Resist wrinkles and lumps 7. Retains its original shape after washing
3.	Bottom layer	The recommended materials to be used are fabrics which are coated or laminated with waterproof materials like rubber, polyvinyl chloride (PVC), polyurethane (PU), silicone elastomer, fluoropolymers and wax.	1. Excellent capacity to resist water absorption 2. Resistant to mould and mildew growth 3. Lightweight. 4. Breathable

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Continued

S/No	Type	Composition	Characteristics
		Other obtained materials with similar characteristics can be used as a bottom layer.	5. Resistant to shrinkage when washing or drying
4.	Packaging materials	The packets shall be packed in a carton, preferably lined with a polyethylene bag inside. Marking on the package should be included as per the standards.	1. Excellent capacity to resist moisture, stain, dust or any other foreign particles 2. Easy to use and manage 3. Legally compliant

Annexure 2: Guidelines on the type, composition and characteristics of raw materials for making disposable pads

S/No	Type	Composition	Characteristics
1.	Cover stock layer	Cotton, non-woven, synthetic fibres, rewetting agents	1. Must be lighter 2. Must be soft and offer good protection of the skin 3. Must rapidly pass the fluid through to the core of the pad 4. Must restrict the passage of the fluids, back through in the reverse direction 5. Must maintain a dry surface for the skin
2.	Acquisition and distribution layer	Thermal or air-bonded composites, non-woven/ cotton materials	1. Must be able to imbibe/absorb the fluid 2. Must be able to draw away the fluid from the point of discharge 3. Must be able to laterally distribute the fluid and hold it for the core to absorb
3.	Absorbent core layer	Wood pulp, air-laid pulp, superabsorbent polymers (SAP) or cellulosic pulp	1. Must absorb and hold fluid 2. Must not retard the flow-in of the subsequent additional fluids 3. Must not block the pores of the structure, due to swelling
4.	Back sheet layer	Polyethylene (PE) film	Must prevent leakage

Annexure 3: Guidelines on types, composition and characteristics of materials for making menstrual cup

S/No	Type	Composition	Characteristics
1.	Menstrual cups raw materials	Menstrual cups can be made from either of the following substances: silicones, thermoplastic elastomers (TPE) and natural rubber.	1. The substances must not damage organisms in the vagina. 2. The biological surroundings of the vagina must not affect the material properties of the substance. 3. The substances must not cause any allergies. 4. The substances must not leach or release any harmful materials to the body.

Annexure 4: Guidelines on the regulations and conformity requirements of MHH products

(a) Disposable pads

Specifications				Conformity
Descriptions Pad size (mm)	**Pad size (mm)**			This is in Medical Devices, Class 1 – Personal Hygiene Device It is regulated by TBS, TZS 279: 2021 The above standard automatically complies with EAS 96-1:2018 standard
	Regular	Large	Extra large	
Length	200 ± 20	240 ± 20	280 ± 20	
Width excluding wings	70 ± 5	70 ± 5	70 ± 5	
Thickness	15 ± 2	15 ± 2	15 ± 2	
Absorption capacity	40–60 ml	40–60 ml	40–60 ml	
Firmness	The bottom layer must have firm glue underneath	The bottom layer must have firm glue underneath	The bottom layer must have firm glue underneath	
Intended user	This is for users with a light flow	This is for users with a normal flow	This is for users with a heavy flow	

(b) Menstrual tamponas

Specifications				Conformity
Descriptions	Pad size (mm)			This is in Medical Device, Class 1 – Personal Hygiene Device It is regulated by TBS, TZS 1659: 2014 The above standard is automatically complying with: EAS 96:2008 standard
	Regular	Large	Extra large	
Length	200 ± 20	240 ± 20	280 ± 20	
Width excluding wings	70 ± 5	70 ± 5	70 ± 5	
Thickness	15 ± 2	15 ± 2	15 ± 2	
Absorption capacity	30–35 ml	30–35 ml	30–35 ml	
Firmness	Must have buttons	Must have buttons	Must have buttons	
Intended user	This is for users with a light flow	This is for users with a normal flow	This is for users with a heavy flow	

(d) Menstrual cups

Specifications				Conformity
Descriptions	**Cup size (mm)**			This is in Medical Device class 2 – Personal Hygiene Device It is regulated by ISO 13485 or 9001 It must also comply with the following safety and standards ISO 10993-1 ISO 10993-3 ISO 10993-5 ISO 10993-10
	Small/mini	Medium	Large	
Diameter of the rim	36–40	41–44	45–48	
Length of the cup excluding pull-out stem	40–50	45–55	48–58	
Cup capacity	15–25 ml	20–30 ml	30–40 ml	
Length of pull-out stem	15	15	15	
Diameter of air holes	1	1	1	
Cup wall thickness	2 (± 0.3)	2 (± 0.3)	2 (± 0.3)	
Firmness	Soft to medium	Soft to medium	Medium to hard	
Intended user	This is for users with a light flow or a low cervix position. This type can be used by young women/girls.	This is for users with a normal flow or medium cervix position. This type can be used by adult women.	This is for users with a heavy flow, high cervix position or women/girls who already have kids (vaginal delivery); this type can be used by adult women.	

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