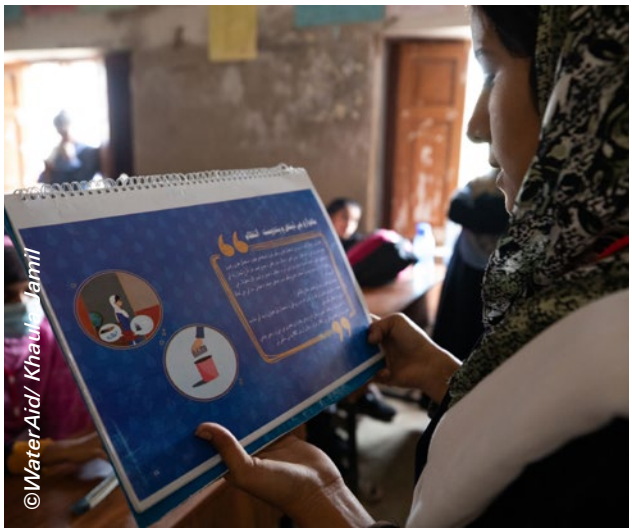
Rolling out the priority indicators for monitoring menstrual health and hygiene nationally – lessons learned



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Contents

Cover photos, clockwise from top-left:

Bangladesh
Hashi at her school in Gaibandha, Rangpur, Bangladesh.

Nigeria
(L–R) Dorcas, 14, Veronica, 14, and Mary Ann, 15, at their school, Agidingbi, Nigeria.

Pakistan
Moomal, 14, has taken a leading role in educating her female classmates on personal hygiene at a government school in Badin, Sindh, Pakistan.

Jordan
Suzan, 14, takes part in a session on sustainable water, sanitation and hygiene practices as part of the Climate Action Club's activities at her school.

Introduction

Globally, there has been more attention – and some evidence of progress – on turning an ambition for improved menstrual health and hygiene (MHH) into a reality for all. We can celebrate the efforts many countries have made to: boost access to information and education; improve the supply of materials; provide menstrual health supportive water, sanitation and hygiene (WASH) services and disposal facilities in schools and public places; and create a stigma-free environment. These changes make it easier for those who menstruate to participate in work and social activities (Amaya, Marcatili and Bhavaraju, 2020), as shown by the personal testimony of women and girls.

Monitoring might not immediately appear critical to securing better MHH outcomes for women, girls and other people who menstruate. But there is still a lack of evidence on the global scale of unmet menstrual-related needs. Understanding what the status of MHH is and where the gaps are in different countries across the world is essential (Hennegan, et al., 2023). Assessments (such as that in East Asia and Pacific by Head, et al., 2023) highlight the need for greater investment in comprehensive solutions that reach all those who menstruate. Comprehensive solutions require comprehensive data. Investment in collecting, analysing and disseminating data is vital to improve the effectiveness of the approaches and models currently used by policy makers and development practitioners. It is also essential to fill any gaps that are identified. Achieving ambitious global and country priorities and targets requires the data needed to inform effective decisions and action and track progress for accountability.

To support standardized monitoring of MHH for adolescent girls, the Global MHH Monitoring Group[1] undertook a review of the existing indicators and conducted an expert consultation to develop the Priority Indicators for National Monitoring of Adolescent Girls' Menstrual Health and Hygiene (2022). These 21 indicators cover seven domains: materials, WASH, knowledge, discomfort/disorders, supportive social environment, menstrual health impacts, and policy. While these indicators focus on girls, given the extent of existing evidence gaps certain indicators can be adapted for monitoring MHH for adult women (which has been done for the 2024 Multiple Indicator Cluster Survey (MICS) module[2]). Using standardized indicators

Maida uses the sanitary pad disposal point inside the girls' toilet at her school, Gazipur, Bangladesh.

WaterAid/ Drik/ Farzana Hossen

"In the newly built girls' toilet, we now have everything we need for keeping ourselves fit, healthy and fine. In addition to running water and handwashing facilities in each toilet, the menstrual hygiene provisions include somewhere to wash and dry used cloths, proper disposal facilities, and a dispenser for sanitary napkins. Now when we have our periods it's nothing to worry about. We have our own private space where we can change, clean and rest whenever we need to. We also do not have to buy pads anywhere else, we can just get them here by ourselves."

– Maida

1 The Global MHH Monitoring Group includes MHH experts from Burnet Institute, Columbia University, Emory University, Liverpool School of Tropical Medicine, London School of Hygiene and Tropical Medicine, Save the Children and WaterAid.

2 Other indicators are also available for monitoring MHH for adult women (Caruso, et al., 2021).

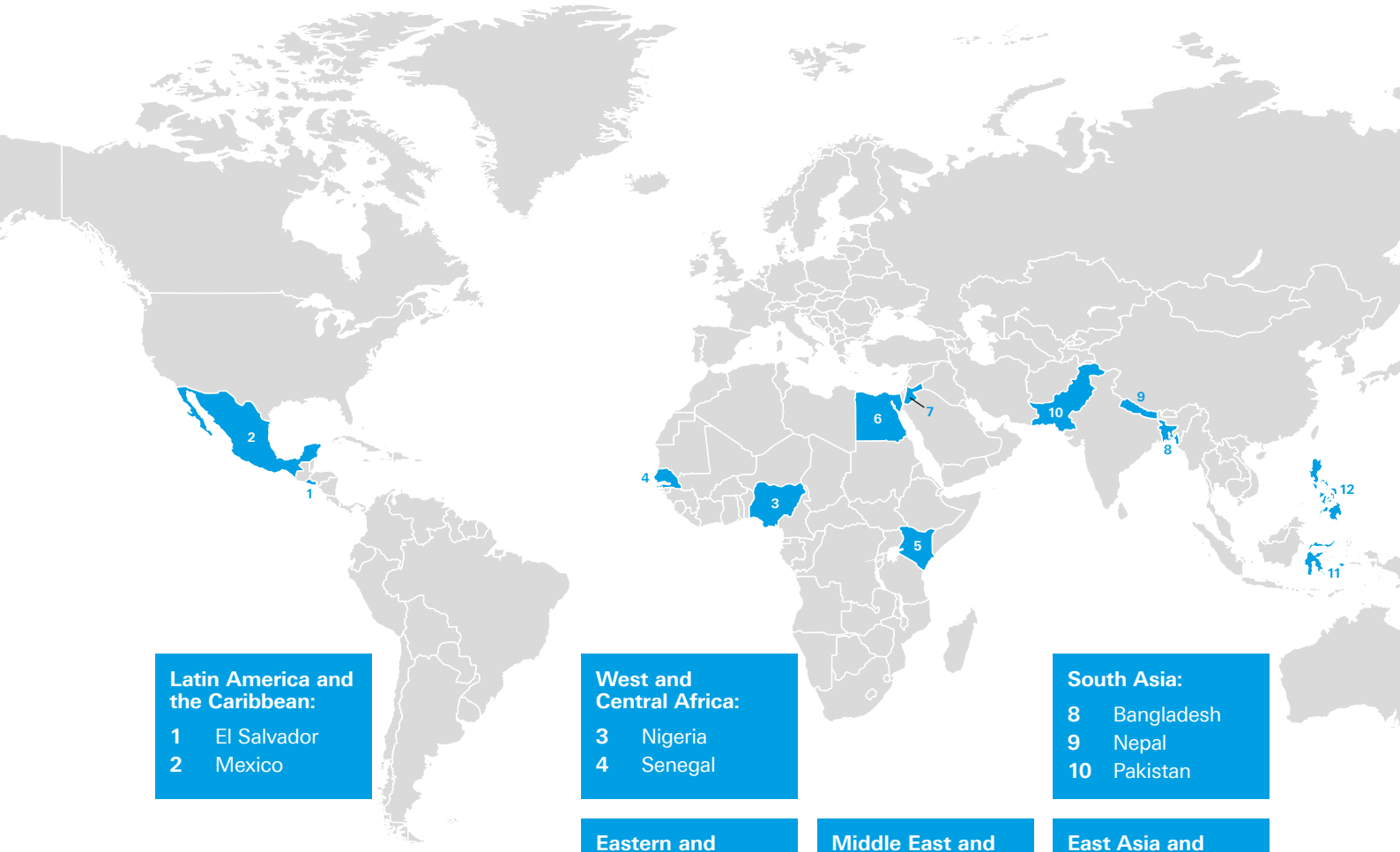
means a country will be able to consider its progress on MHH relative to other countries, demonstrate it has made progress relative to its own position in the past, and compare progress between different populations within the country.

This brief shares the experiences of the Global MHH Monitoring Group and collaborators, including national governments, UNICEF and country stakeholders, in rolling out the indicators in 12 countries and the lessons learned from initial efforts to promote uptake in national monitoring systems. Based on a cross-portfolio analysis of efforts, it outlines:

1. the process for getting started to promote uptake in new countries.
2. common themes or ingredients of success.
3. pathways for how strengthened monitoring can support improved MHH for women, girls and other people who menstruate.

The brief concludes with further resources for those who want to undertake similar initiatives to strengthen MHH in their country. It has been written to support the work of national and local governments, development partners and others engaged in the topic.

Map of the countries engaged in the roll out of priority indicators for national monitoring of MHH



Latin America and the Caribbean:
- **1** El Salvador
- **2** Mexico

West and Central Africa:
- **3** Nigeria
- **4** Senegal

South Asia:
- **8** Bangladesh
- **9** Nepal
- **10** Pakistan

Eastern and Southern Africa:
- **5** Kenya

Middle East and North Africa:
- **6** Egypt
- **7** Jordan

East Asia and Pacific:
- **11** Indonesia
- **12** Philippines

Note: This map is stylized, and it is not to scale. It does not reflect a position by UNICEF or WaterAid on the legal status of any country or territory or the delimitation of any frontiers.

The process: supporting multi-actor ownership of monitoring from the outset

The Global MHH Monitoring Group started working with three exemplar countries in 2021 (Bangladesh, Kenya and Philippines). These countries informed the development of the priority indicators and the group has continued to engage with all three on uptake. In the most recent phase (2023–24) WaterAid and UNICEF expanded these efforts to perform scoping activities in four countries (Egypt, Jordan, Nigeria and Pakistan) in collaboration with stakeholders. WaterAid also supported a scoping engagement and consultation in Nepal and Save the Children performed a similar exercise in four countries (El Salvador, Indonesia, Mexico and Senegal). Our work to date reveals some similarities in the prioritization of indicators – materials, WASH, and knowledge are more likely to be monitored. So far there are fewer examples of national data collected on discomfort/disorders, supportive social environment, and menstrual health impacts.

From our experience of collaborating with stakeholders to carry out these assessments, the following process has been developed to identify the current status, priorities and opportunities for uptake. These steps can be adapted and applied by others (governments, development partners and/or other national stakeholders) seeking to undertake similar initiatives.

- **Stakeholder analysis:** Winning broad support for and contributions to the initiative is key. Therefore a stakeholder analysis of in-country MHH actors is necessary to map who is doing – and monitoring – what on MHH and identify champions and spoilers across the public, private and civil society spheres. Noting the staff positions with heavy turnover as opposed to those with greater continuity is crucial for sustaining momentum.
- **Onboard country leadership:** First identify national organization/s to lead and coordinate the consultation process (e.g. government ministries or departments, MHH platforms). Involving external (non-government) actors, such as UN agencies and/or other development partners, as facilitators can make space for reflection which is often elusive in day-to-day work and establish collaborative dialogue. However, the process should ideally be owned by the relevant government department or ministry as the primary stakeholder driving MHH policy and programming. Such a ministry would also be best placed to include indicators in government-owned management information systems (MIS) or government-led household surveys. Ensuring government approval and review at every step encourages buy-in and links to national policies or action plans where these exist.

National organization/s to lead and coordinate the consultation process

In Philippines the Department of Education (DepEd) benefitted from the support of several key partners – GIZ, Save the Children and UNICEF – as contributors in the National WASH in Schools Technical Working Group (TWG). Although orchestrating the support from several sources was a challenge, DepEd was able to successfully create the synergy that expedited the implementation and monitoring of an integrated WASH in Schools (WinS) and MHH programme. TWGs (such as the National Menstrual Health and Hygiene Management Technical Working Group in Nigeria) and MHH platforms (such as in Bangladesh and the MHM (Menstrual Hygiene Management) Partners' Alliance in Nepal) provide a coordination mechanism that can support prioritization, harmonization and the uptake of indicators.

- **Convene and orient national actors:** These include government, the UN, development partners, academic institutions, and MHH working groups, to launch the initiative and identify relevant stakeholders that will contribute to the following steps. Present a snapshot of the existing data on MHH and recent experiences on measuring MHH. Brief stakeholders on the priority indicators. Discuss the collaboration opportunity with country teams and partners. Ideally, this would be led by national stakeholders.

- **Context analysis:** It is crucial that MHH monitoring is anchored in the local context. To ensure this, undertake a thorough context analysis of the institutional and political context, existing data collection efforts, and current indicators. Carry out a desk review of existing legal and policy frameworks related to MHH, available data on MHH, existing large-scale programmes or interventions, staff capacity, and formal monitoring systems. Surveys, focus group discussions (FGDs) and interviews with stakeholders can identify local priorities, enablers, barriers and opportunities for collecting additional data.

- **Validation workshop:** Share the results of the context analysis with stakeholders in a validation workshop and use group work to identify and prioritize indicators for monitoring and next steps, depending on which MHH Indicators most resonate. Consider if indicators need to be adapted to the country context, selecting the priority domains/indicators and identifying which partners will perform the monitoring through what processes.

- **Agree next steps:** Multi-actor action planning is necessary to develop a roadmap or next steps for improved MHH monitoring. These may include further scoping and orientation, activities, responsibilities, budgets, logistics, connecting with statistics departments, sector MIS (e.g. education, health), and/or other monitoring activities. Provide follow-on support where possible, with continued consultation and advocacy through MHH platforms to provide the necessary expertise to support momentum and the implementation of roadmaps and agreed actions.

Resourcing the process

Resources (in-country resources where available), particularly in terms of people, are required:

- researcher/s to undertake the analysis and prepare outputs (reports/presentations)
- facilitator/s for convening meetings/ consultations
- funds to cover cost of meetings/consultations
- further resources to implement roadmaps and agreed actions

Lessons learned on improving national MHH monitoring

Below are nine common themes that have emerged from our 12-country cross-portfolio learning on planning and implementing improved national MHH monitoring. These themes have contributed to some of the early wins achieved so far and may provide practitioners, policy makers and decision makers with insights to effectively address complex MHH issues.

1. Don't forget the people behind the data. Monitoring is the means not the end. MHH data is only useful when it helps to capture people's experiences and reveal where efforts to support MHH can be enhanced. Data responsibility means there must be a plan for safe and ethical data collection as well as a plan to use the data in programmes and decisions. Women, girls and other people who menstruate should have a part to play in how data about them is gathered, understood and used.

2. Bring together the right stakeholders at the right time in the right ways. MHH is a multi-faceted issue that intersects with sectors such as health, education and WASH. In our experience, it was essential to mobilize different actors and organizations across sectors and government departments – some at the political level and some at the technical – and to foster relationships between them. The risk in involving all relevant stakeholders in monitoring is having too many parties involved in decision making, with a lack of clarity on how a final decision will be reached and who will make it. Therefore roles should be clarified upfront to avoid confusion and delays.

3. Shine a light on monitoring systems. It is important to be aware of what is currently being measured and by whom. Data can be seen as the sole preserve of planning, monitoring and evaluation (PM&E) teams. Those working on monitoring have an important role in providing access to the data and information required and are often the gatekeepers of monitoring in programming. Yet they are often not involved in advocacy, national consultations or policy processes around MHH. To demystify the monitoring system, it is important to take time to explain the national monitoring processes (across different sectors) so that MHH decision makers understand them (e.g. how and when new indicators are incorporated, who collects what data at the different levels and time frames, and how the data collectors are resourced). Sensitization is needed on both sides; monitoring and evaluation (M&E) leads need to be engaged to include MHH, and MHH experts need to be involved to think about monitoring. Understanding the MHH data needs of governments and development practitioners can help convince such actors of the usefulness of monitoring, for instance in terms of the potential linkage to their policies as well as to improve the efficiency and effectiveness of their MHH strategies and programmes. Mechanisms must be in place to support the building and strengthening of multi-sector collaborations to facilitate sharing, for instance between government bodies collecting data. At the district/local level (e.g. in health centres and schools) joined-up systems must be in place to collect and make available MHH data.

4. Understand and address stigma and taboos.
Shame and stigma can undermine the success of MHH monitoring, affecting people's willingness to ask or answer questions. Tackling stigma is essential for strengthening monitoring systems and improving the quality of data collection. Train and build the confidence of data collectors and ensure data is collected sensitively (e.g. by female enumerators). Navigating political sensitivities where these exist allows for monitoring even in regions where MHH is considered highly taboo.

Addressing stigma and taboos in MHH monitoring

In the AMEHC (Adolescent Menstrual Experiences and Health Cohort) study, implemented by Burnet Institute, BRAC James P Grant School of Public Health (JPGPH) and WaterAid Bangladesh, researchers found that some girls had reached menarche but did not report it during the baseline survey due to stigma and shame (Hennegan, et al., 2024). To feel confident to answer openly, girls required reassurances of privacy and confidentiality. In Pakistan data collectors reported being too embarrassed to ask the questions. Using the government's preferred terminology in Jordan and Kyrgyzstan – 'girls' personal hygiene' instead of 'menstrual health and hygiene' supported the uptake of monitoring. In the long term, monitoring may help catalyse transformative change by breaking the silence.

5. Start small and grow.
Focusing on national priorities is a good place to start. Rather than promoting the uptake of all 21 priority indicators at the outset, start by focusing on those indicators that align with issues ministries are already working on. Current government MHH priorities and workplans can be an entry point or opportunity to plug in indicators for monitoring. Over time, additional indicators can be added to build the complete picture across all domains. Research and advocacy may be required to make the case for other indicators to be incorporated. Recognize that countries are at different stages and have different resources, so some may be able to go further than the 21 indicators.

Identifying entry points for national MHH monitoring

In Indonesia MHH indicators on WASH in Schools (WinS) are embedded in the National School Health Policy. As more ministries engage with MHH there are new opportunities for monitoring. For example the Ministry of Education, Culture, Research and Technology is committed to integrate MHH into the Healthy School Movement (Gerakan Sekolah Sehat/GSS) in 2,000 pilot schools. A baseline is planned to gather data on myths and taboos, adolescent girls' experiences during menstruation, how girls feel about MHH and WASH, and menstrual health impacts on absenteeism. In Nepal the National Planning Commission has incorporated two priority indicators for MHH into the 16th Five Year Development Plan, which was being finalized at the time of the monitoring consultation in Nepal. Other opportunities to integrate indicators are being considered for Nepal's WASH MIS, MICS and Demographic and Health Survey (DHS).

6. Leverage existing processes.
Harnessing global monitoring processes is vital to support MHH data collection. The WHO/UNICEF Joint Monitoring Programme (JMP) provides country, regional and global estimates of progress on WASH. Recent JMP reports provide an exciting juncture for MHH monitoring, with a gender-focused report including a dedicated chapter on MHH (2023) and an MHH in schools report (2024) that is structured around the priority indicators and domains, providing, in effect, a baseline on the priority indicators for MHH. The importance of gathering reliable data has also been elevated by the inclusion of selected indicators in global periodic surveys, such as the new MICS module that includes an adapted subset of the priority indicators. While national surveys will continue to be important to provide MHH data, diversifying and expanding the type of data collected is also necessary. Trends indicate national data must increasingly be combined (in a 'data sandwich') with data from other more unconventional sources, such as crowd-sourced data or online polls. Monitoring by non-governmental organizations (NGOs), international non-governmental organizations (INGOs) and researchers, in collaboration with government and UN agencies, offers

valuable supplementary, and higher frequency, data complementing national systems. For instance, UNICEF has launched a U-Report (digital community for young people) poll in several countries on aspects of MHH, including awareness, challenges, use of materials, strategies to manage the menstrual cycle, and the significance of speaking openly about the subject. U-Report data is not representative of the participant countries' populations but can identify important insights that can be further validated and triangulated with other data sources. Research is also important for monitoring.

Research to support national MHH monitoring

In Bangladesh the AMEHC study led by Burnet Institute in partnership with BRAC JPGPH and WaterAid Bangladesh has incorporated all the indicators into its survey tools (Hennegan, et al., 2024). And in Jordan the Gender and Adolescence: Global Evidence (GAGE) Survey (2015–2024) was a mixed-methods longitudinal research programme with MHH questions targeting adolescent refugees, adolescents with disabilities, those out of school, married girls and adolescent mothers.

7. Use policy processes.
Given that MHH indicators are often measured through schools, school health and nutrition (SHN) policies can be a vehicle for MHH indicator uptake. Bangladesh, Indonesia, Kenya, Nepal, Pakistan and Philippines have very strong SHN policies. These provide a platform for working with the Ministry of Education and Ministry of Health (possibly together) on WinS and provide a route to education management information systems (EMIS). In Bangladesh the launch of the National MHM Strategy was a relevant moment to consider monitoring. In Nigeria the (draft) National Strategic Framework on Menstrual Health and Hygiene Management (2022–2026) requires the development of an M&E framework. In Mexico there are two specific laws that address MHH and several states adopting them as well as a National Survey on Sexual and Gender Diversity (ENDISEG) which could support the adoption and uptake of the indicators. In Indonesia, as part of the National School Health Programme/Usaha Kesehatan Sekolah dan Madrasah, the Ministry of Education, Culture, Research and Technology launched the Healthy School Movement (Gerakan Sekolah Sehat/GSS) in 2022 to improve nutrition, physical health, immunization, mental health, and environmental health. Currently MHH indicators are integrated into physical health, nutrition (iron tablet consumption), and mental health (feeling depressed/no energy during menstruation).

8. Ensure staff have sufficient capacity and resources for monitoring.
Initiatives for scaling up MHH monitoring can be complex and time consuming, sometimes requiring more resources than allocated. Likewise opportunities for change may be too time-sensitive for the resources available. Where MHH monitoring focal points have their roles in addition to their regular work, they may be unable to provide sufficient time or have the necessary decision-making power to make the changes required. Success relies on the ability of decision makers to understand how the data relates to their work and how they can implement it, meaning training might be needed on how to use data to make evidence-based decisions. It is of crucial importance to ensure national statistical offices/systems have a skilled data-collection workforce with clear roles and knowledge for data processing, display/presentation, and use. For instance in Philippines capacity building, including coaching, online courses and technical assistance, for schools (supported by national government and development partners) and sub-national level offices helped to improve monitoring in WinS and MHH programmes. Part-funded appointments or secondments to ministries and local government could be another way to catalyse improved monitoring and uptake.

9. Use competition and incentives.
Change-minded officials and 'champions' within ministries can drive success even where the political leadership has yet to prioritize MHH monitoring. However, where shifting from the status quo meets resistance or where

intrinsic motivation is (initially) lacking, our experience highlights the benefits of using competition and incentives in the short term to create demand for monitoring and ensure the process does not stall at decision-making points. National government has incentivized local government to provide data through recognition, praise or the provision of resources for improvement (for those that are making efforts but may lack resources). This tends to inspire more effort leading to a positive effect on monitoring. An understanding of decision makers' pressure points can help in the design of appropriate incentives. Third party verification (especially when data is self-reported) may be needed to assure data quality.

Access to MHH data, from local to national levels

In Philippines the Department of Education (DepEd), UNICEF and key stakeholders are implementing the WASH in Schools Three Star Approach, which includes an MHH indicator (DepEd, 2023). They are using a range of strategies to incentivize schools and division offices to collect data and incorporate it into the EMIS. The type of incentive depends on the accomplishment (the number of stars reached). The highest recognition is a 'seal of excellence' provided by DepEd for schools that maintain their Three Star status for three years. Similarly in Sindh in Pakistan UNICEF in partnership with the Government of Sindh supports the implementation of the WASH in Schools plan in tandem with the Three Star Approach in the province (WaterAid and UNICEF, 2024). MHM indicators have been incorporated into its EMIS on the presence of MHM facilities within government schools. Making this data publicly available through the MIS creates an informal competition between the provinces. It also ensures data is available to those making decisions at the local level and provides a means for accountability to citizens.

Chioma washes her hands in the female-friendly school toilet, Agidingbi, Nigeria. ***©WaterAid/ Tom Saater***

Sandhya, 20, in the garden at her home after completing her final exam at college, Lahan, Nepal. ***©WaterAid/ Ram Saran Tamang***

Pathways from data to improved MHH

Experience to date reveals six practical pathways from improved MHH monitoring to enhanced services and programmes. These are practical and tangible ways to make the best use of data to inform policy and action. MHH is intrinsically a cross-sectoral issue. Focusing on the connections between these different pathways – and pursuing them simultaneously – will help to maximize impact for women, girls and other people who menstruate.

Pathway 1: **Advances in national policy environments** can be achieved through ensuring a supportive organizational culture, processes and systems, involving citizens and stakeholders in policy development, and providing the necessary resources and assets. With robust data government departments and other actors can develop MHH and related policies, strategies and guidelines; raise and allocate the necessary resources for their implementation; and track progress against them. This requires linkage and coordination between high-quality and accurate data and policy-relevant monitoring systems to deliver better outcomes.

Pathway 2: **Strengthened organizations and coordination** through increased capacity for the collection, production and interpretation of MHH data. Mandated agencies, with an identified focal person, must ensure their monitoring systems are fit for purpose and sufficiently resourced to produce high quality MHH data to inform decisions and approaches. This will also require consolidating data from across different sectoral monitoring systems to create a comprehensive picture of MHH that can be shared through cross-sectoral platforms to strengthen multi-sectoral approaches to MHH.

Pathway 3: **Targeted advocacy and communication** for the take-up of findings to inform MHH-responsive policies, the development of programming, and improving the effectiveness of MHH efforts. In particular, advocacy can highlight currently neglected areas of monitoring such as discomfort/ disorders, supportive social environment and menstrual health impacts.

Pathway 4: **Disaggregated data improves targeting** by enabling a better understanding of those populations who are not being reached or who require different programming approaches to address their MHH needs.

Pathway 5: **Communicating data improves uptake** by providing policymakers, practitioners and the private sector with information in clear and useful formats to catalyse policy making, investment and effective, scalable programming. Data should also be made accessible to those from whom it was collected and their organizations to support them to demand their rights and hold duty bearers accountable for MHH services.

Pathway 6: **Access to quality MHH programmes and services** through better quality MHH monitoring data that helps practitioners and stakeholders to understand 'what works' across different settings. Using this data they can improve the design, delivery and long-term management of MHH programmes and services.

Where do we go from here?

Mobilizing a greater level of effort, ambition and commitment towards MHH requires decision makers to use data to its full potential. Further resources (translated into multiple languages) available for those who want to undertake initiatives to strengthen MHH outcomes for women, girls and people who menstruate include:

- **MICS MHH module** https://mics.unicef.org/sites/mics/files/2024-07/Menstrual%20Health%20and%20Hygiene%207.1.2.zip

- **Guidance:** Priority List of Indicators for Girls' MHH: Technical guidance for national monitoring www.publichealth.columbia.edu/file/8002/download?token=AViwoc5e

- **Guidance summary:** Priority List of Indicators for Girls' MHH: Technical guidance for national monitoring www.publichealth.columbia.edu/file/14435/download?token=yEAM4U5C

- **Guidance:** Integrating MHH Indicators from the Short List into Research and Program Monitoring www.publichealth.columbia.edu/file/8206/download?token=b2FwDFH0

- **Green paper (2019):** Monitoring Menstrual Health and Hygiene: Measuring progress for girls on menstruation www.publichealth.columbia.edu/file/8207/download?token=ekilqOQ1

- **Article (2021):** How Addressing Menstrual Health and Hygiene May Enable Progress Across the Sustainable Development Goals, Global Health Action, 14:1 https://pmc.ncbi.nlm.nih.gov/articles/PMC8253211/

- **Article (2023):** Indicators for National and Global Monitoring of Girls' Menstrual Health and Hygiene: Development of a priority shortlist, Journal of Adolescent Health, 73:6 www.sciencedirect.com/science/article/pii/S1054139X2300383X

- **Training decks**

  - Uptake of MHH Indicators and Measures: Training to use the SCHOOL-LEVEL indicators www.publichealth.columbia.edu/file/14431/download?token=fFupnaKP

  - Uptake of MHH Indicators and Measures: Training to use the INDIVIDUAL-LEVEL indicators www.publichealth.columbia.edu/file/14430/download?token=RN_tI1Kn

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Annex

Priority List of Indicators for Girls' Menstrual Health and Hygiene

MATERIALS	*Individual*	1	% of girls who reported having enough menstrual materials during their last menstrual period.
	School	2	% of schools with menstrual materials available to girls in case of an emergency.
WASH	*Individual*	3	% of girls who reported changing their menstrual materials during their last menstrual period when at school.
		4	% of girls who changed their menstrual materials at school in a space that was clean, private, and safe during their last menstrual period.
	School	5	% of schools (primary/secondary) with improved sanitation facilities that are single-sex and usable (available, functional, and private) at the time of the survey.
		6	% of schools (primary/secondary) with improved sanitation facilities that are single-sex, usable (available, functional, and private), lockable from the inside, have covered disposal bins, and have discreet disposal mechanisms at the time of the survey.
		7	% of schools (primary/secondary) that have water and soap available in a private space for girls to manage menstruation.
KNOWLEDGE	*Individual*	8	% of students (male/female) who have ever received education about menstruation in primary and secondary school.
		9	% of females who know about menstruation prior to menarche.
		10	% of females with correct knowledge of the fertile period during the ovulatory cycle.
	School	11	% of schools where education about menstruation is provided for students from age 9.
		12	Existence of pre-service or in-service teacher training about menstruation at the primary or secondary level.
		13	% of schools that have at least one teacher trained to educate primary/secondary students about menstruation.
	Government / National	14	% of countries where national policy mandates education about menstruation at primary and secondary level.
DISCOMFORT/ DISORDERS	*Individual*	15	% of girls who report that they were able to reduce their menstrual (abdominal/back/cramping) pain when they needed to during their last menstrual period.
		16	% of girls who would feel comfortable seeking help for menstrual problems from a health care provider.
SUPPORTIVE SOCIAL ENVIRONMENT	*Individual*	17	% of girls who have someone they feel comfortable asking for support (advice, resources, emotional support) regarding menstruation.
MENSTRUAL HEALTH IMPACTS	*Individual*	18	% of girls who report a menstrual period does not impact their day.
		19	% of girls whose class participation was not impacted by their last menstrual period.
POLICY	*Government / National*	20	% of countries with policies or plans that include menstrual health and hygiene.
		21	National budget is allocated to menstrual health and hygiene; funds are dispersed to the schools in a timely and efficient manner.

Credit: Global MHH Monitoring Group, 2022.

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