Breaking the Cycle: Evaluating Period Poverty Policies and Their Impact on Girls' Education

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In this work I made use of generative artificial intelligence. Please see the appendix for the disclosure statement (Appendix 10.1).

Abbreviations List

CA – Capabilities Approach

DWYPD – Department for Women, Youth and People with Disabilities

e.g. – exampli gratia

GBV – Gender-based Violence

MH – Menstrual Hygiene

MHH – Menstrual Health and Hygiene

MHM – Menstrual Hygiene Management

MoE – Ministry of Education

MoH – Ministry of Health

NGO – Non-Governmental Organisation

SDF – Sanitary Dignity Framework

SDGs – Sustainable Development Goals

ToC – Theory of Change

UN – United Nations

UNESCO – United Nations Educational, Scientific and Cultural Organisation

UNICEF – United Nations International Children's Emergency Fund

VAT – Value-added Tax

WASH – Water, Sanitation, and Hygiene

WB – World Bank

WHO – World Health Organisation

Abstract

This thesis investigates the extent to which national menstrual health management (MHM) policies in Kenya and South Africa reduce educational inequality for menstruating pupils. Guided by the Capabilities Approach and Sommer's Theory of Change, the study evaluates whether policy frameworks enhance girls' educational opportunities and how implementation quality shapes outcomes. By using a deductive qualitative content analysis of policy documents, academic literature, and Non-Governmental Organisation (NGO) reports, the research compares the foundational elements, implementation activities, as well as outcomes and impacts of MHM policies in both countries. Findings reveal that Kenya and South Africa have made policy advances with several context-specific examples serving as best practices for MHM implementation. Nevertheless, the analysis reveals that persistent challenges remain. These mainly include infrastructural gaps, uneven implementation, and inadequate monitoring. The study concludes that, if comprehensive MHM interventions are effectively implemented, they show positive outcomes. Still, although national policies are necessary for promoting educational equality and menstrual dignity, their effectiveness is constrained by contextual barriers and insufficient data. The research highlights the need for more comprehensive, context-sensitive approaches, improved monitoring, and intersectional analyses. Ultimately, this thesis contributes to the academic and policy discourse by offering a comparative, theory-driven evaluation and by identifying priorities for future research and policy improvement in MHM.

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1. Introduction

1.1 Background and Context

Every day, countless girls miss school because they are not able to afford basic menstrual products, in fact, they are forced to choose between their education and managing a natural body function. This issue is not just about hygiene—it is about dignity, opportunity, and ending the inequality that prevents girls from reaching their full potential. For instance, "65% of women and girls in Kenya are unable to afford sanitary pads" (FSG 2016, 1), while in South Africa, nearly 30% of girls miss school due to a lack of access to menstrual hygiene products (MH Day 2023). The inability to manage menstruation traps these girls in cycles of poverty and inequality. Missing school leads to poor academic performance, fewer opportunities, and increased vulnerability to child marriage and violence. In Kenya and South Africa, the stigma, and the lack of support force girls to choose between education and basic human dignity — a violation of their human rights (Hennegan 2016).

Despite its significant impact on gender equality, education, and public health, the problem of period poverty has long been neglected by policymakers. Only a few governments implemented policies to address it. Some governments such as the Scottish government made menstrual products in public spaces (e.g. schools) freely available (Scottish Government, 2022). Other examples are countries such as Canada, Malaysia, or Nigeria have "lowered or scrapped taxes on menstrual products" (UN Women 2024, 2), nevertheless large-scale, systematic policies remain scarce.

At the international level, organisations like the UN acknowledge menstrual hygiene as a problem not just "about privilege or sex issues but about human rights" (Jaafar 2023, 5). Nevertheless, there are still few specific international frameworks for implementing policies despite this acknowledgment. There is no legally enforceable international agreement that requires governments to guarantee access to menstrual products and facilities, even while programs like UNICEF's Water, Sanitation, and Hygiene (WASH) in Schools program integrate MHM into public administration. Although "[p]eriod poverty is connected to the Sustainable Development Goals (SDGs) due to its impact on multiple goal areas" (Tohit & Haque, 2024, p.1), especially including SDG 3 (Good Health and Well-Being), SDG 4 (Quality Education), and SDG 5 (Gender Equality), the topic of menstruation health still receives little attention in public health and education conversations. Therefore, progress is dependent on local and national initiatives, which is resulting in notable differences in policy responses across the globe (Jaafar 2023).

In the academic world period poverty has gained increasing attention in recent years, even though the research remains not extensively studied in terms of formal policy evaluation. Research that has been done, mainly emphasises the negative effects of period poverty, especially on educational outcomes and school attendance. For instance, Crichton et al. (2013) investigate the connections between menstrual

stigma and access barriers, whereas Sommer et al. (2016) highlight how poor management of menstrual hygiene contributes to gender inequalities in education (particularly in low-income countries). Moreover, Van Eijk et al. (2019) present a systematic evaluation of menstrual health interventions, where they are noting both achievements and issues while Bobel (2019) examines the role of menstrual activism and its impact on pushing the topic to the political and public discourse.

Despite this expanding body of research, comparative studies evaluating the efficacy of policy options in addressing period poverty, particularly in the context of schooling and in South and East Africa, remain scarce. Moreover, it is challenging to find reliable data on the potential for adapting policies that have been implemented in other cases. By assessing different chosen policies and their effects on education, this study seeks to close this gap, to advance the academic discourse and policy creation on gender equality and menstrual health (MH). In addition, it underscores the urgency of addressing period poverty as a systemic health and human rights issue that leads to educational inequality.

1.2 Research Question and Sub-Questions

This research aims to find out to what extent national MHM is affecting the educational success of adolescent girls. Therefore, the research question is:

How do national policies addressing Menstrual Health Management and Period Poverty in Kenya and South Africa reduce educational inequality for menstruating pupils?

To be able to answer this question, it is helpful to work with Sub-questions which provide useful knowledge about the different elements combined within my research question.

SQ1: *What are the key menstrual health challenges affecting the education of pupils who menstruate in Kenya and South Africa?*

SQ2: *How do existing national policies and legal frameworks in Kenya and South Africa address menstrual health and its implications for education?*

SQ3: *What foundational elements and key components of the Theory of Change — including the implementation activities — can be identified in Kenya and South Africa's menstrual health policies, and how do they compare?*

SQ4: *In what ways have menstrual health policies in Kenya and South Africa influenced access to affordable menstrual products and MHM education—as well as broader impacts like school participation, educational engagement, and dignity in managing menstruation?*

The Explanatory Nature of the Research question enabled me to describe period poverty policies in Kenya and South Africa and further show the relation to educational outcomes by identifying the mechanisms and factors that influence this relationship. The Comparative Evaluative Part of my

question helped to assess the effectiveness of these policies in achieving their intended goals, such as reducing absenteeism for the affected pupils.

1.3 Structure of the Thesis and Research Approach

This research uses a deductive content analysis approach, systematically coding and analysing policy documents, academic literature, and NGO reports related to MHM in Kenya and South Africa. The analysis is guided by pre-defined categories derived from Sommer´s Theory of Change framework to identify and compare key policy elements and implementation strategies across both countries. The thesis is structured to first present the theoretical framework and methodology, followed by a comparative analysis of policy content and implementation in Kenya and South Africa, and concludes with a discussion of findings and an answer to the research question.

2. Theory

This comparative policy evaluation on MH policies in Kenya and South Africa draws on theories, concepts, and definitions from gender and development theories. Therefore, this part concentrates on naming and elaborating relevant concepts, as well as highlighting significant approaches my thesis is based on.

2.1 Conceptual Clarifications of Menstrual Health and Education

There is a wide range of terms across diverse cultures and languages, many of which are euphemisms, to name the natural biological process experienced by approximately half of the global population at some point in their lives, and central to this work. I refer to it as Menstruation, which is the:

"Periodic discharge of blood and mucosal tissue shed from the uterus and expelled through the vagina [which] Occurs approximately monthly (~28 days) from puberty to menopause in nonpregnant menstruating people" (Casola 2023, 67).

Menstruating people refers to "[a]ny person who experiences a menstrual cycle. This includes but is not limited to cisgender women and transgender men who retain physiologic ability to menstruate." (Casola 2023, 67). Much of the literature I engage with uses "girls" instead of menstruating people, which is not intended to be restrictive in this work. I will try to adopt a gender-inclusive language approach where possible while acknowledging the predominant framing of MH within the context of girls' education.

But Menstruation goes beyond the biological—it is a gendered social experience, shaped by stigma and cultural beliefs. Moreover, scholars examine it as "an issue of public policy" (Olson 2022, 2) as these social constructions influence how MH is prioritised, funded, and addressed in policy frameworks (Sommer 2021). The concept of Menstrual health and hygiene (MHH) or Menstrual Hygiene Management (MHM) "is used to describe the needs experienced by people who menstruate, including having safe and easy access to the information, supplies, and infrastructure needed to manage their periods with dignity and comfort […] as well as the systemic factors that link menstruation with health, gender equality, empowerment, and beyond". Thus, a term to describe the ability to manage menstruation safely, hygienically, and with dignity (Sommer 2015), which for instance includes the availability of menstrual products. In this thesis due to its limited reach, references to menstrual products primarily denote disposable sanitary pads, although it is acknowledged that a diverse range of products are available and relevant.

However, when individuals are unable to access menstrual needs, they experience what is termed period poverty – the "inability to obtain the quality or quantity of resources needed to manage a healthy, safe, and dignified menstrual cycle" (Casola 2023, 67). The term emerged in the early 2010s as scholars and

activists began to highlight the significant barriers that individuals face in accessing menstrual products and services. “Period poverty” was used to describe the intersection of gender, health, and economic disparities that prevent individuals from managing their menstrual needs with dignity (Hennegan & Montgomery, 2016) and has become a central concept to discussions on gender equality and public health. Therefore, it goes beyond the individual scope and is recognised as “one of the global challenges of our time” (Campbell 2020, 3).

Another central theme is educational inequality, which refers to the unequal distribution of academic resources, opportunities, and outcomes among different groups based on factors such as gender, socioeconomic status, ethnicity, and geography and “often reflect[s] and reproduce[s] broader social inequalities" (Connell 2008, 112). In the context of MHM, these inequalities are particularly gendered, as “systemic structures […] disadvantage girls, particularly in low-income contexts" (Unterhalter 2005, 113). According to UNESCO (2019), the lack of sanitary facilities in schools, gender discrimination, and stigma all contribute to absenteeism and, in certain situations even school dropout, which restricts educational attainment. Missing school not only affects immediate learning outcomes but also limits long-term opportunities for employment and economic independence (Sommer 2016). Therefore, I acknowledge the significant correlation between Education and Gender Inequality by seeing unequal access to quality education as both a consequence and a perpetrator of gender inequality (UNESCO 2019). Moreover, while gendered educational inequality encompasses a wide range of all these dimensions, this thesis primarily focuses on educational inequality in relation to key factors: access to menstrual products, awareness through MHM education, school participation, overall educational engagement, and the dignity of menstruating students in managing their hygiene.

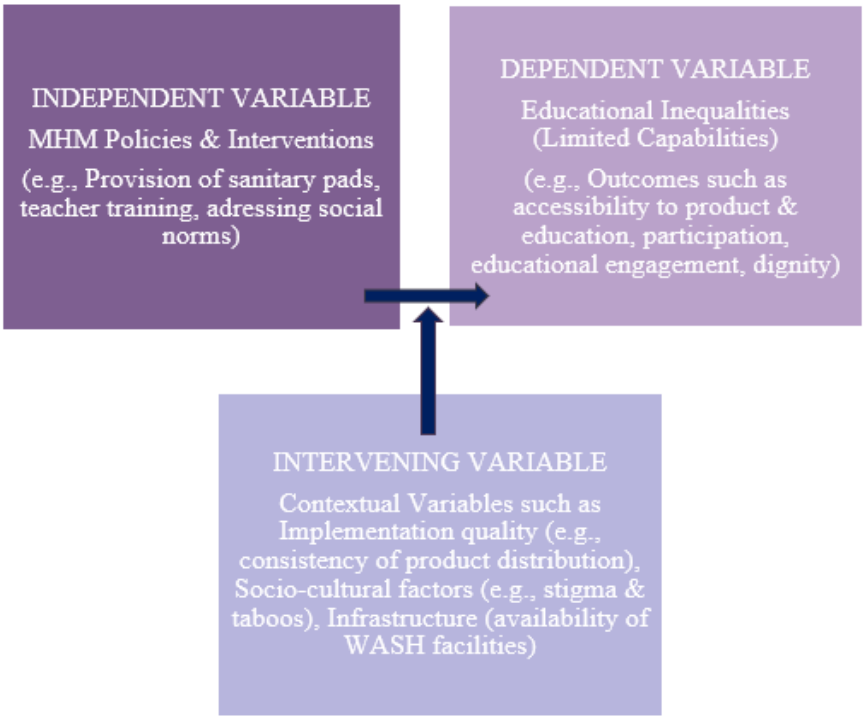

Figure 1: Conceptual Model of the Study

Figure 1 illustrates my conceptual framework and depicts how MHM interventions in Kenya and South Africa (independent variable) are expected to influence girls limited educational capabilities (dependent variable), with contextual factors such as implementation quality, socio-cultural norms, and infrastructure acting as intervening variables. While this model clarifies the pathways through which policy may affect educational outcomes, a key limitation is that the intervening variables cannot be fully integrated or measured within the scope of this qualitative research. As intervening variables are often hypothetical constructs and not observable or quantifiable, their precise impact on the relationship between policy and educational inequality remains partly theoretical and can only partly be systematically assessed.

2.2 Theories and Hypotheses

2.2.1 Capabilities Approach

In my thesis, I considered the capabilities approach (CA) as it applies to menstruating people in school. It is important to remember that it is not a full-developed theory but rather a comprehensive approach, which was introduced by Amartya Sen in the 1980s and later expanded by Martha Nussbaum and other scholars. It offers a framework for assessing well-being, social justice, and development beyond traditional economic measures. The philosophical approach is "based on a universalist account of central human functions, closely allied to a form of political liberalism" (Nussbaum 2000, 3). In his work, Sen redefines development as the expansion of people's real opportunities, as development should be seen

as *"*a process of expanding the real freedoms that people have" (Sen 1999, 36), emphasising that freedoms are tied to individuals' ability to choose a life they value. Hence, the "human capabilities, that is, what people are actually able to do and to be" (Nussbaum 2000, 5). In this research, development will therefore be understood as the achievement of those capabilities.

Building on this, scholars like Fukuda-Parr (2003) state that removing structural barriers is crucial to expanding human capabilities to foster development. This is especially relevant to structural barriers regarding gender equality. As Nussbaum highlights each person should be treated as an end, whereas women are "treated as mere instruments of the ends of others– reproducers, caregivers, sexual outlets" (Nussbaum 2000, 2). She highlights how Women's desired human capabilities are reduced and cannot be pursued due to unequal social and political instances (Nussbaum 2000). This is crucial "when poverty combines with gender inequality, [as] the result is acute failure of central human capabilities" (Nussbaum 2000, 3).

As highlighted above, period poverty is a direct intersection of this. The approach is relevant because MHH access is a capability that is limited due to period poverty–the inability to manage menstruation safely. Nussbaum's CA provides a valuable framework for understanding how period poverty restricts fundamental human freedoms. Among her ten central capabilities, five are particularly relevant to this study:

- Bodily Health – MH is a fundamental aspect of reproductive health. The inability to access MHM can directly harm physical well-being.
- Bodily Integrity – Reproductive health is related to bodily integrity. For instance, the lack of access to MH can limit mobility, especially when girls are forced to stay home from school.
- Senses, Imagination, and Thought – Education is central to human development, and barriers to attending school hinder intellectual growth.
- Affiliation – Discrimination related to menstruation undermines dignity and social inclusion and can lead to shame and exclusion from public life.
- Control over One's Environment – Equal access to MHM ensures agency over one's body and participation in education (Nussbaum 2000).

Within this framework, this study therefore argues that MH is a capability that must be supported through public policy, where a "government can aim to deliver […] the social basis of these capabilities (Nussbaum 2000, 81). Ensuring access to menstrual products, education about MHM, and enabling school participation and engagement, is essential for expanding freedoms and securing dignity in education (Sommer 2021). Thus, I expect that strengthening MHM policies removes barriers that restrict

the capabilities of girls, enabling them to participate more fully in education. A central hypothesis of this research therefore is:

H1: *National MHH policies (in Kenya and South Africa) significantly enhance adolescent girl´s capabilities in terms of fostering educational equality.*

However, the CA has limitations. For instance, the emphasis on individual agency may understate the role of deeply embedded social norms. Furthermore, while it recognises structural inequalities, it does not fully account for political and economic barriers that affect the implementation of policies, especially in the case of Kenya and South Africa. Nevertheless, it is still valuable and relevant for understanding how period poverty limits fundamental freedoms and supports my analysis as a theoretical foundation.

2.2.2 Theory of Change

To balance out these limitations and be able to assess the impact of policies and interventions more detailed, I further utilised the Theory of Change (ToC), which provides a structured approach to evaluate how initiatives can improve outcomes in various contexts.

The ToC probably emerged from evaluation theory and was then popularised by Carol Weiss in the 1990s to improve scientific evaluation and impact assessment (Funnell 2011). Since then, ToC has gained prominence, even though understanding and implementation remain inconsistent (Grantcraft 2006). The theory can be defined as "a method that explains how a given intervention, or set of interventions, is expected to lead to specific development change, drawing on a causal analysis based on available evidence" (UNDG 2017). It is a causal model that outlines how specific inputs and activities lead to outcomes and long-term impact, which is useful to this research as it can address development challenges which are "complex and are typically caused by many factors and layers that are embedded deeply in the way society functions" (UNDG 2017). Moreover, it can help to identify root causes, prioritise actions, and even provide adaption frameworks. In the MH context, the ToC therefore serves as a critical framework, which enables a holistic understanding of how interventions lead to improved schoolgirls´ education. To be able to do so, I looked at the following Components, as highlighted by Sommer:

1. Foundational elements: These cover a broad array of indicators selected to base understanding for the scale-up context, like putting together staff and systems executing the program.
2. Scale-up: These include indicators selected to document and measure the delivery of the program.
3. Outcomes: These include indicators selected to document and measure the immediate and intermediate effects of the program.
4. Impact: These indicators are used to measure the goal of the program.

(Sommer 2023a, 6)

Sommer further developed a general ToC "[b]ased on global lessons from MHH programmes" (UNICEF 2019). It utilises key elements for change to link interventions to desired outcomes and can be conceptualised differently, depending on the context (See Figure 2). This represents an ideal tool for evaluating the effectiveness of existing policies and identifying areas for improvement in MH initiatives. By building upon Sommer's ToC, I ensured my analysis is grounded in widely accepted methodologies. However, as it is a highly comprehensive framework, its extensive nature presented limitations in terms of fully applying it within the scope of my thesis. It was not feasible to address every component of the framework in depth. Therefore, I focused on key elements that are most relevant to my research question, as a complete application of the framework would require a more detailed study.

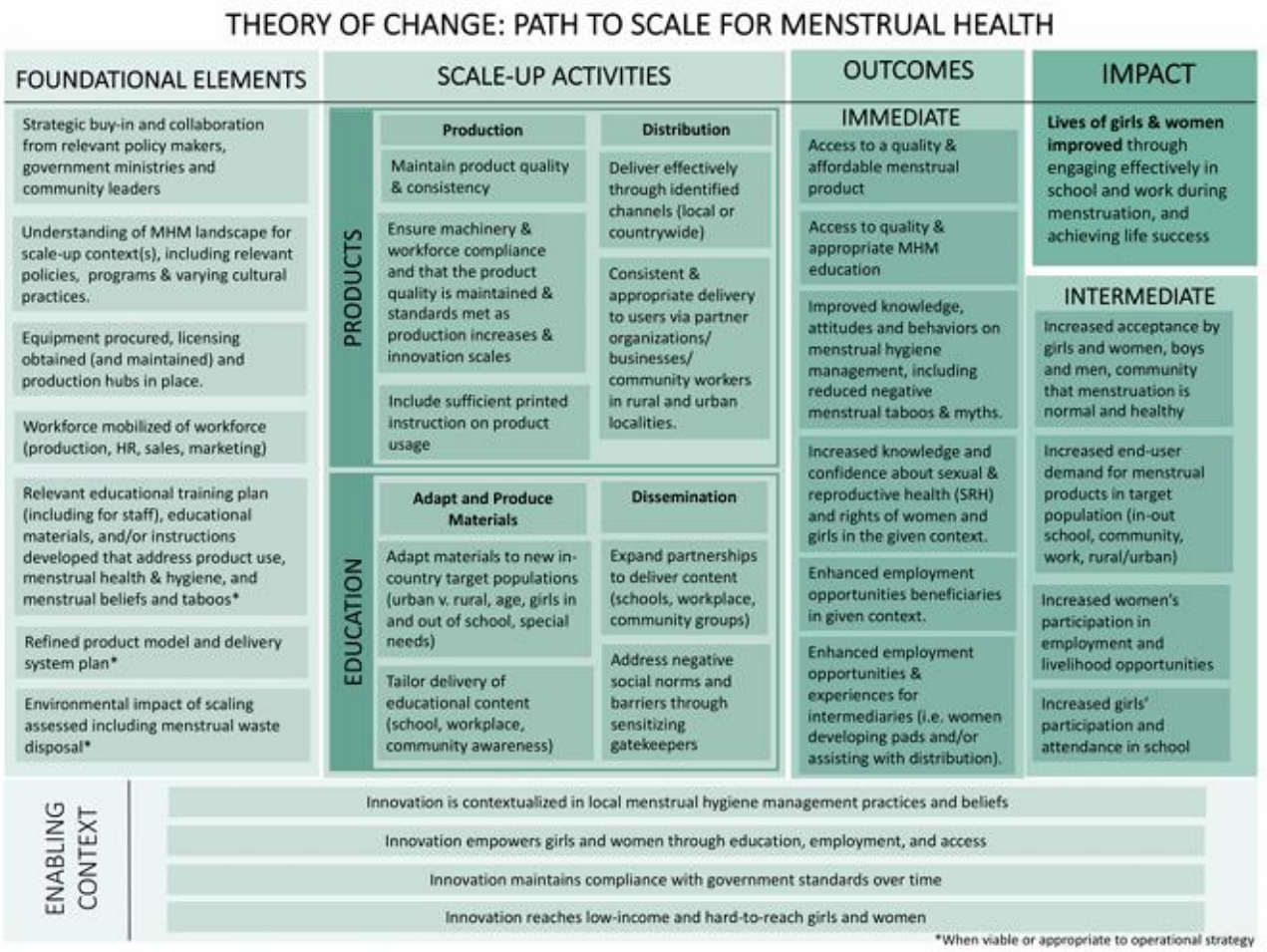

Figure 2: Sommer´s MHH ToC framework

Given the ToC's emphasis on mapping causal pathways and identifying critical points for intervention, I formulated a hypothesis around the implementation of MHM policies—specifically, that the effectiveness of these policies hinges on the quality of delivery, adequacy of infrastructure, and the

extent of teacher training. This focus is informed by the ToC's utility in unpacking complex, multi-layered challenges, and its ability to highlight where breakdowns or successes in policy translation are most likely to occur. Looking at these elements, the hypothesis therefore is:

H2: *The effectiveness of MHM policies is contingent upon the quality of their implementation at the school level, encompassing the adequacy of infrastructure, the standard of delivery, and the extent of teacher training.*

3. Research Design and Methodology

3.1 Research Design and Case Studies

This research aims to answer whether MH Policies help to strengthen educational outcomes for menstruating pupils (in the context of Sub-Sahara Africa). Therefore, the research design is a Comparative case study focusing on two Sub-Saharan countries – Kenya and South Africa. Both cases were selected through purposive sampling as they provide a compelling context for policy evaluation. They implemented MH policies, differing in scope and approach. Moreover, as influential countries in Sub-Saharan Africa with diverse social and educational contexts, they offer valuable insights applicable to the region and broader policy lessons. This comparative case study allowed an analysis of similarities, differences, and best practices in the implementation of MH policies and effects on educational outcomes for menstruating pupils. The cases were demarcated by focusing on the specific MH policies of each country and the context in which they were implemented.

The research focused on policy documents related to MH, as well as on secondary data such as reports from NGOs and academic publications. These texts were essential as they directly address the implementation, goals, and outcomes of MH policies (van Eijk 2019). A textual analysis of these documents allowed a detailed exploration of how policies are designed to improve educational outcomes (UNICEF 2023). This deductive approach was best suited to answer the research question as it enabled an in-depth understanding of policy impact through qualitative insights. The underlying methodological assumptions draw on social constructivism and interpretivism, recognising that MH "experiences are deeply embedded in their social and cultural contexts, making meaning-making a dynamic and interpretive process" (Finlay 2025, 65). The epistemology further aligns with critical theory in examining how power relations and policy structures influence capabilities and outcomes.

3.2 Method of Data Collection

Data in this research is qualitative, with a focus on policy documents and secondary data. The dataset for this study was compiled through systematic search and comprised significant Policy Documents like Kenya´s MHM Policy and South Africa´s Sanitary Dignity Policy. Key databases for Primary data entailed government websites, official publications, and international organisations portals. For Secondary Data, reports and studies from NGO websites, as well as academic databases such as JSTOR for publications regarding MH in schools were examined. Relevant data was selected from materials published between 2014 and 2024 to guarantee the accuracy, relevance, and validity of my findings. The policy documents provided insight into the theoretical concepts of educational capabilities and MHM policies. Secondary data supplemented the policy analysis and provided a broader understanding of

context and implementation challenges. Therefore, these data sources were appropriate for understanding the policy frameworks, implementation, and their impact on educational outcomes.

In addition to policy documents and secondary data, I aimed to include the voices of schoolgirls by examining school-based surveys (e.g., Studies across Secondary Schools). By integrating these perceptions, the research connected directly to the CA which emphasises the importance of individuals' agency and their ability to make choices that affect their own lives. Including these perspectives was essential to avoid overlooking those who are primary subjects of my thesis. A detailed data collection can be found in the appendix (Appendix 10.2). Overall, this wide literature range aimed to minimise bias and ensure validity, reliability, transparency, and replicability standards.

3.3 Method of Data analysis

For the data analysis, I employed qualitative textual analysis which is "a method for systematically analysing and interpreting textual data in order to identify patterns, themes, and meanings within the material" (Flick 2018, 485), while using Atlas.ti to analyse the policy documents and secondary textual data. The role of Atlas.ti in this process was to facilitate analysis of a large volume of textual data, by enabling systematic coding and theme identification. This method ensured transparency and consistency in the analysis and furthermore, helped identify patterns that contribute to understanding the relationship between MH policies and educational outcomes (Friese 2019). The theoretical lens then guided the interpretation of findings, ensuring that the analysis remained attentive to the enhancement of girl´s capabilities.

While the role of the CA was to provide an overarching lens focused on whether policies genuinely enhance girls' freedoms and well-being, the ToC offered a practical framework to analyse specific processes through which these outcomes are achieved. Hence, I operationalised the Sommer´s ToC framework (2023) by choosing the most relevant categories and indicators to answer my research question (guided by a reflection on core capabilities such as Bodily Integrity), as it is important to consider that:

"For logistical and financial reasons, it is not possible to measure everything included in the Theory of Change path to scale. Some may also be time consuming and costly to collect and analyse […] – many programs opt for indicators that are 'SMART': specific, measurable, attainable, relevant, and timely." (Sommer 2023b)

Therefore, I lay a specific focus on policy outcomes and impacts as they offer insights on the substantive expansion of girl´s capabilities. Furthermore, some indicators must be adapted or compromised due to limited scope and resources. Sommer highlights that "an alternative indicator […] can be used instead.

Indicators should be reviewed and used to make improvements during the project" (Sommer 2023b). Thus, I will only include the following categories:

ToC Element	Sub-Element	Category
1. Foundational Elements		1.1 Buy-in and collaboration from relevant stakeholders 1.2 Degree to which menstruation is addressed 1.3 Presence of Educational training plan, educational materials, and/or instructions that address MHH
2. Scale-Up activities	2.1 Products	2.1. Products: Distribution 2.1.1 Implementation of MHM policy guidelines for Delivery and Distribution to school
	2.2 Education	2.2.1 Adaption & Production of Materials 2.2.1.1 Tailor delivery of educational content to schools
		2.2.2 Dissemination 2.2.2.1 Presence of strategies that detail partnerships with schools for the delivery of MHM education 2.2.2.2 Addressing of negative social norms and barriers through sensitizing gatekeepers.
3. Outcomes	3.1 Immediate	3.1.1 Access to a quality and affordable menstrual product. 3.1.2 Access to quality and appropriate MHM education.
	3.2 Intermediate	3.1.1 Increased girls' participation and comfort in school
4. Impact		4.1 Improved educational engagement. 4.2 Increased dignity in managing menstruation.

Figure 3: Chosen Coding Categories

Thus, my coding scheme directly derives from theory and thereby enhances validity and transparency. The scheme entails a clarification of each Indicator and Type of Indicator, a Data Source, the Monitoring Process and Frequency, Reference point and Target change, as well as possible Biases of each category, which helps to strengthen replicability. This, as well as a detailed description of each category with its indicators, can be found in the Appendix (Appendix 10.4 & 10.5).

To further ensure consistency and reliability, I employed a double coding technique: selected segments of data were coded twice to verify the coherence of category application and reduce subjective bias. This reflexive approach strengthened the internal validity of the analysis and enhanced transparency in

the interpretation. Codes and emerging subthemes were cross-checked against the ToC indicators to ensure alignment with the framework while remaining sensitive to context-specific nuances in textual data.

3.4 Limitations and Ethical Considerations

Several limitations affected the methodology of my research. First, due to time and resource constraints, primary data collection (e.g., interviews) was not feasible. Even though school-based surveys are observed, there is a limited ability to fully capture lived experiences and nuanced insights directly from affected schoolgirls, educators, or policymakers. Secondly, the availability and accessibility of consistent and comparable data across both case studies posed a challenge. Some reports lacked recent updates, and data on educational outcomes specific to menstruating pupils were often context-specific or inconsistent. A key methodological limitation of this thesis moreover is its qualitative research design, which, while providing rich insights into lived experiences, does not allow for the systematic measurement or quantification of attendance rates, thereby limiting the ability to draw firm conclusions about the impact of MHM policies on school participation. Furthermore, the scope of the study had to be narrowed on selected elements of the ToC framework. This meant that some relevant sub-indicators were excluded or adapted to fit the qualitative design and time constraints. Intermediate and long-term outcomes (such as empowerment) could not be fully explored. As Sommer (2023) noted, many ToC indicators are logistically and financially demanding to measure and may require long-term engagement. Lastly, although a double-coding strategy was employed to enhance internal validity, the interpretation of qualitative data remains inherently subjective. Despite efforts to remain reflexive and grounded in the conceptual framework, personal bias may have influenced some analytical decisions.

4. Results: Context and Implementation of Menstrual Health Policies

This part of my thesis will present the coding results. The following abstract introduces contextual factors about the chosen case studies and aims to answer SQ1, namely:

What are the key menstrual health challenges affecting the education of pupils who menstruate in Kenya and South Africa?

4.1 Contextual Factors and Challenges

4.1.1 Kenya

Around 50.3% of the 55 million population are women (World Bank [WB] 2024), who will face menstrual struggles in their lives. Studies have indicated a great existence of period poverty, where up to 65% of women cannot afford sanitary pads. This is forcing women to use unsafe alternatives or depend on others to obtain menstrual products and can even lead further, as shown by the shocking number of 10% of adolescent girls in Western Kenya who resort to having sex for sanitary products (Phillips-Howard, 2015). Furthermore, deep-rooted cultural beliefs contribute to shame and limit access to information. The "'culture of silence' surrounding MHM stifles […] girls' ability to express their sexuality and hinders their participation which is a fundamental human rights principle" (Ministry of Health [MoH] 2019, 1). Thus, this underlines that Kenya faces severe challenges regarding the health of their menstruating population (MoH 2019).

Regarding the educational context within Kenya, about 4,059,000 of the student population in the around 28,300 primary and 8,600 secondary schools in Kenya are adolescents and likely to face challenges related to MHM. Moreover, schools struggle with Inadequate Facilities as only 32% of rural schools in Kenya have private places for changing menstrual products, and many lack proper disposal bins or access to water (MoH 2019).

4.1.2 South Africa

South Africa has a population of approximately 63 million, with women making up just over half of the total population (WB 2023). Of the estimated number of 22,85 million menstruating people in South Africa, a minimum of 13,7 million people do not have access to accurate MHM. This links to the fact that approximately 60% of households do not have proper access to water, which minimises the ability to manage menstruation in a dignified manner (Davidson 2023a, 2). Moreover, it leads to a higher vulnerability to Gender-based Violence (GBV) when accessing WASH facilities outside their homes. Qualitative studies revealed that women and girls report being raped when using public restrooms (Davidson 2023a). Furthermore, cultural taboos and stigma remain pervasive in South African

communities. Menstruation is shrouded in secrecy and shame, with girls frequently encouraged to conceal their cycles or be excluded from certain activities (Teti 2023).

The lack of WASH facilities further results in inadequate school infrastructure which is another major barrier to effective MHM. South African schools lack safe hygienic facilities to manage periods, with over 1,700 schools still using inadequate pit toilets and lacking reliable access to running water and proper disposal bins (Khamisa 2022). These infrastructural challenges disproportionately affect girls with disabilities and those in rural or low-income areas, further exacerbating educational inequalities (Khamisa 2022).

This context overview revealed significant challenges, tried to combat with legal frameworks. Thus, the following part aims to respond to SQ2:

How do existing national policies and legal frameworks in Kenya and South Africa address menstrual health and its implications for education?

4.2 Menstrual Health Policy Frameworks

4.2.1 Kenya

Kenya was the first country to remove Value-added Tax (VAT) on menstrual products in 2004, with other policies following onwards (Roussow 2021). This work focuses on the MHM Policy (2019–2030) which outlines Kenya's strategic approach to MHM equality. The policymakers describe their goal: "The focus of the MHM Policy is to guarantee all Kenyan women and girls' fundamental rights and freedoms including dignity, safety, participation, health, education, and decent work. […] This policy aims to break the silence around the biological phenomenon of menstruation" (MoH 2019, 3).

The MHM policy builds on existing policies such as health care rights in the Constitution from 2010 or the National Vision for 2030. More explicit policies like the Environmental Sanitation and Hygiene Policy (2016–2030) focus on the urgent need to promote good MHM (MoH 2019). The Basic Education Act (revised 2022) addresses the importance of access to menstrual products and thus, states that the government shall "provide free sufficient and quality sanitary towels to every girl child registered and enrolled in a public basic education institution" (Government of Kenya 2022, 16). Furthermore, the Kenya School Health Policy (2018) states that MHM is crucial for gender equality and outlines clear action points to achieve comprehensive MHM across schools. These and other policy pieces are enabling legislation that promotes health rights including sexual health. Additionally, Kenya has signed international agreements such as the SDGs, even though MHM is not included as an explicit (sub-)goal. Moreover, Period Poverty clearly is an obstacle to Human Rights, such as the Right to Education or other transnational agreements like the Human Rights of Women in Africa.

This abstract showed how Kenya made remarkable legislative efforts to address the complex intersection of MH, education, and gender equality, making it an influential example. For the purposes of this thesis, reviewing how these attempts translate into educational outcomes is crucial for determining if these interventions truly enhance girls' freedoms, as envisioned in both the CA and ToC.

4.2.2 South Africa

South Africa's legal framework for MHM is rooted in the country's constitution, such as section 9(2) which guarantees the full and equal enjoyment of all rights for all people and gender, and especially to protect those disadvantaged by unfair discrimination (Department for Women, Youth and People with Disabilities [DWYPD] 2019, 6). This foundational right is further operationalised through sectoral legislation regulating health, education, the environment, and human dignity, which all provide the legal basis for MHM policies (DWYPD 2019, 6).

The Sanitary Dignity Framework (SDF), published in 2019, is the first national policy to specifically address MHM (Davidson 2023a). Some provinces had programs to provide menstrual materials to pupils but without national coordination or standards. The SDF therefore is the first step to "place national norms and standards for expanding access to good MHH" (Davidson 2023a, 7). It aims "to promote sanitary dignity and to provide norms and standards in respect of the provision of sanitary products to indigent persons" (DWYPD 2019,15). South Africa is also a signatory to international agreements such as the SDGs, or the SADC Protocol on Gender and Development, which emphasises the rights of girls to health, dignity, and education (DWYPD, 2019).

This policy framework demonstrates that South Africa has made commitments—both constitutionally and through national and international policy—to advance MHM as a matter of dignity and human rights. The subsequent part will show how successfully they are implemented and whether they address educational inequality and comprehensive support for everyone who menstruates.

4.3 Implementation Frameworks and Scale-Up Activities

Using the ToC as an analytical lens, this section identifies and compares the foundational elements and scale-up activities—including implementation activities—embedded in each country's policy framework to answer the SQ 3:

What foundational elements and key components of the Theory of Change — including the implementation activities — can be identified in Kenya and South Africa's menstrual health policies, and how do they compare?

Stakeholder Input

The Results indicate that there is a high Input and buy-in from key stakeholders within the MHM landscape in Kenya. This includes policy makers and relevant government ministries such as MoH. The MoH takes a coordinating supervising role in the MHM implementation process and aims to „[e]nsure all government ministries and departments mainstream MHM in their policies and guidelines" (MoH 2019, 11). There is also a high (increasing) degree of NGOs entering Kenya and establishing MHM programmes (FSG 2016). For instance, one study in Nairobi found that NGOs sponsor 69.2% of MHM interventions in schools (Mokaya 2023). In South Africa, the DWYPD is a key player and "endeavours to partner with government partners and other key relevant stakeholders with the aim of achieving equity in sanitary dignity in the country" (DWYPD 2019, 5). NGOs have a high importance in South Africa as well (Chirambo 2019). Although the SDF further aims for the inclusion of diverse stakeholders such as "encouraging local business, women-owned business, youth and individuals with disabilities" (DWYPD 2019, 18), there seem to be challenges regarding coordination and distribution of resources.

Addressing of menstruation

Overall, the Results show a high Degree to which menstruation is addressed in health and education ministries in Kenya. Publications from 2016 already display: "There is growing national attention to MHM with the National Sanitary Towels Program for schoolgirls and development of national MHM guidelines" (FSG 2016, 1). In South Africa, "[t]he two most recent developments in national government policy regarding MHH are the issuing of the SDF and zero-rating menstrual pads for VAT" (Davidson 2023a, 2) However, before MHM was hardly addressed (even in Health and Education ministries) as "[p]rior government policy was fragmented at the provincial level and there was no national policy" (Davidson 2023a, 1).

MHM education plans and teacher training

In Kenya, Educational material is available for students and school staff as determined in the School Health Policy (2018). The MHM policy also states to mainstream MHM into the curriculum (MoH 2019). Furthermore, there is a MHM Handbook for Teachers, which outlines various learning tactics. There are several training instances such as the Ministry of Education which trains Teachers on usage and disposal (FSG 2016) or the Girl Child Network which educates teachers (FSG 2016) to "[i]ncrease the capacity of teachers, school management and public health officers on MHM" (MoH 2019, 12). In South Africa, MHM is included in "Life Orientation" which is part of the curriculum, and "in some instances, external NGOs provided education on menstruation in the schools" (Beksinska 2023, 11). Aside from that, there is no official, nationally standardised teacher training material on MHM.

Schools` implementation of guidelines on product distribution

Although the Basic Education Act obligates the government to provide sanitary towels in public basic education institutions, most schools only provide Pads in emergencies. Local and Regional Studies show differences and indicate that the quality and depth of implementation varies across the country (FSG 2016). A case study in Kibera, Nairobi found that 78,8% of Schools did not have a specific guide on MHM delivery (Mokaya 2024). Thus, this indicates issues regarding consistent delivery to intended users, which is hindering equitable access in both rural and urban settings. Earlier publications highlight underlying distribution challenges, and tailored delivery is prevented by issues as "corruption and collusion along the supply chain" (FSG 2016, 18).

Whereas in South Africa, the results show that a higher proportion of schools distribute products to intended users. In 2020/2021, "[a]ll provinces distributed menstrual pads, with every province spending at least some of its budget allocation" (Davidson 2023a, 13) Nevertheless, the distribution of menstrual products does not appear reliable and regular as "qualitative data demonstrated that the availability of sanitary towels was inconsistent across schools" (Beksinska 2023, 17) and dependent on NGOs.

Strategies for tailored delivery methods for schools

The MHM policy establishes a framework with no specific strategies for a tailored delivery to schools outlined. The implementation is therefore dependent on counties and municipalities. Migori County proposes strategies to foster the delivery methods for schools and introduces a clear division of tasks. For instance, it is the responsibility of the County Department of Education to generate "Data on the number of girls who have reached the age of puberty to facilitate the provision of free sanitary pads initiative" (Migori County Government [MCG] 2023, 22). But at present, Migori County is the only Kenyan county with a publicly available, official MHM policy document online. Most other counties have not yet published stand-alone MHM frameworks or plans accessible to the public (as of June 2025), though the national policy requires counties to develop such frameworks and integrate MHM into their County Integrated Development and Health Plans (MoH 2019).

The SDF indicates that there are specific delivery strategies in South Africa, as "[t]he Framework sets out clear functions for all committees" (Davidson 2023a, 10). Still, there is a lack of clarity regarding the distribution of menstrual products. Davidson states: "[T]he access to sanitary products section provides no clarity on how many products should be provided to recipients, how often they should receive these products or even what products should be provided" (Davidson 2023a, 8).

Strategies that detail partnerships for the delivery of MHM education

Kenya's policy document emphasises a coordinated, multi-stakeholder approach to disseminating MHH education, with strategies for engaging partners across government, civil society, and development sectors. This includes technical working groups, integration into existing programs, advocacy, and

county-level adaptation (MoH 2019). Nevertheless, the implementation is dependent on the 47 counties, which makes it difficult to track down specific strategies. Even though the analysis has shown that most girls receive MHM education in school as included in the curriculum, the lack of detailed specific strategies is demonstrated in its inaccuracy. For instance, a Study across Secondary Schools in Mbita Sub County points out that "there was no consistency in the provision of this service" (Misare 2024, 8).

The SDF shows different strategies to deliver MHM education, whether it is through the national curriculum or awareness campaigns. Moreover, there are partnerships mentioned that seem to detail MHM education for schools such as the Partnership with Care and Support for Teach and Learning Programme whose aim is "[e]nsuring sanitary dignity to girls and young women in schools, which includes […] menstrual education and awareness (DWYPD 2019, 14). On the other hand, "[t]he South African approach is however criticized as narrow considering that it only focuses on preserving girls' self-esteem through the provision of sanitary materials" (Chirambo 2020, 24), and thus to not include education delivery sufficiently.

Inclusion of strategies for engaging gatekeepers in addressing social norms

Kenya´s MHM policy objectives include "[t]o ensure that myths, taboos and stigma around menstruation are addressed by providing women, girls, men and boys access to information" (MoH 2019, 9) and therefore explicitly addresses stigma for men and boys. As this is crucial in the educational context, the school health policy addresses the "Cognizance of myths, stereotypes and taboos associated with menstruation" (Ministry of Health & Ministry of Education [MoH & MoE] 2018, 31) for a holistic understanding of MHM. Thus, "one of the policies that most extensively addresses the role of men and boys is the Kenyan MHM Policy" (Olson 2022, 16). Hence, Kenya´s MHM policy markedly fulfills the criteria of this indicator.

The SDF points out the importance of including gatekeepers in changing social norms: "Education on sanitary dignity must be extended to include educators, men and boys, families, communities and community leaders and civil society in general" (DWYPD 2019, 13). Despite this, policy evaluations of the SDF criticise that it does not include the demystification of menstruation and taboos comprehensive and context-specific enough (Davidson 2023a). The criteria for this indicator are therefore not sufficiently fulfilled.

To summarise, both countries embedded key foundational elements and scale-up activities (as in the ToC), yet with distinct emphases and structural limitations. In Kenya, there is strong policy commitment with the MoH taking a coordinating role. Implementation is decentralised, relying on county-level action. Notably, Migori County stands out as the only county with an available MHM document. This highlights significant gaps in policy development elsewhere, meaning despite robust national

frameworks, actual MHM support varies considerably across the country. In South Africa, the DWYPD leads MHM efforts. All provinces now allocate budgets for menstrual products, representing progress from previously fragmented policy efforts. However, distribution remains inconsistent and dependent on NGOs. MHM is included in the curriculum, but the approach has been criticised as narrow, focusing on product provision rather than education and stigma reduction. In contrast, Kenya has more comprehensive strategies for addressing norms and stigma. Overall, this comparison reveals that while national policies provide important frameworks, weak coordination, limited tailoring, and inconsistent education delivery in both cases reduce implementation quality.

5. Results: Educational Outcomes and Impacts

This part will concentrate on the Policy Outcomes and Impacts, and thus answer SQ4, namely:

In what ways have menstrual health policies in Kenya and South Africa influenced access to affordable menstrual products and MHM education—as well as broader impacts like school participation, educational engagement, and dignity in managing menstruation?

5.1 Analysis of Policy Outcomes

Access to quality and affordable menstrual products

Kenya´s Policy explicitly states to prioritise marginalised and disadvantaged groups in MHM Promotion (MoH 2019). For instance, "Huru International in collaboration with the Ministry of Health and local Ministry of Education offices has delivered an MHM programme for girls with disabilities" (Sommer 2021, 10), which indicates higher accessibility to MHM for disadvantaged girls.

However, these efforts remain limited as Low Accessibility is a multidimensional problem rooted in poverty and weak distribution systems. Socioeconomic status is a primary determinant of access, thus exacerbating existing inequalities (Roussow 2021). The indicator therefore shows a mixed picture in Kenya. The broader reality is that access remains low and unequal for most pupils, especially those in rural or low-income settings. While Kenya's policy environment and targeted programs show promise for improving access among specific groups, overall accessibility is deeply influenced by socioeconomic and geographic factors.

This issue becomes even more significant when looking at the financial accessibility of menstrual products. The MHM policy wants to "[e]nsure that women and girls have access to a range of MHM products that are acceptable, safe and affordable" (MoH 2019, 13). Low-cost sanitary pads "targeted at low-income urban and rural users, are entering the marketplace but still have limited reach" (FSG 2016, 11). This again highlights that efforts to increase accessibility tend to be constrained resulting in significant financial barriers (FSG 2016). Limited local manufacturing capacity (with only two domestic producers, whose products are considered low quality relative to price) forces enterprises to rely on imported pads "from overseas, most commonly China" (FSG 2016, 11).

The SDF in South Africa has the possibility to enable girls "especially those from lower socio-economic groups, to continue attending school throughout menses"(Beksisnka 2023, 17). However, this potential is not utilised as there still is low access to MHM products, especially for girls from poor communities, which leads them to "alternatively […] use cloth, grass or pieces of the mattress" (Chirambo 2020, 46). This concerns other marginalised groups such as girls with disabilities to similar or even greater extents (Siddiqui 2023). This problem connects to the limited reach of the SDF, whose "process of

implementation will focus on one target group at a time" (DWYPD 2019, 18). As Davidson highlights, "[t]he proportion of girls in the target group who benefited from the programme is fairly low across all the provinces" (Davidson 2023a, 20).

Regarding Financial Accessibility, the introduction of measures such as zero VAT on sanitary pads and student healthcare allowances demonstrates progress in reducing financial barriers (Chirambo 2020). Additionally, school-based distribution programs have become a key channel. For example, in Gauteng "one third of female learners (33.7%) reporting receiving products from school – either through a public sector school distribution programme or a NGO" (Tamaryn 2020, 6). Where programs are robust, girls benefit from reliable low-cost access to products. Despite these advances, disparities remain. Differences in procurement costs, packaging, and delivery logistics mean that not all girls receive the same level of support, and some regions experience irregular supply (Davidson 2023a).

Access to appropriate and quality MHM education

The school health policy aims to make MHM education accessible for every child and hence, outlines distinct strategies and objectives (Sommer 2021). The findings show that Kenya's school health policy and MHM frameworks set strong objectives for universal, age-appropriate, and factual MH education (MoH & MoE 2018). Furthermore, looking at the quality of education, there appears to be a comprehensive understanding of teaching about MHM which comprises important general lessons as "at least some trainings were not just [about] the product use, product disposal, product accessibility but also life skills" (Olson 2021, 12). This comprehensive understanding indicates a high quality of MHM education, as demonstrated in the Teacher Handbook (MoE 2020).

Nevertheless, the Results have shown that the access to MHM education in Kenya seems to be significantly low. Multiple studies highlight implementation gaps: teachers often skip or inadequately cover menstruation topics due to lack of training or embarrassment (Olson 2021). Educational materials are frequently unavailable, and comprehensive sexuality education is rarely delivered systematically. Following, many pupils lack accurate knowledge, such as "a study by Population Council found that only 1 in 5 girls in Nairobi's informal settlements can accurately pinpoint the time of the month that they are most likely to get pregnant" (FSG 2016, 7). A more recent study by Save the Children Kenya which "took place in eight schools in Central, Western, Northeastern, and Coastal regions, with a total of 420 participants […] showed that none of the schools guided girls on MHM, and no education materials were available" (Onbogo 2023, 71). Thus, while some cases demonstrate best practices, the overall picture is one of sporadic, insufficient, and reactive MHM education, which means that the indicator of access to appropriate and quality education is not accomplished.

Similarly in South Africa, the evidence for high access to appropriate MHM education is weak and inconsistent. While girls report receiving information about menstruation and pad use at school, this is often anecdotal and not representative of broader trends (Chirambo 2020). Additionally, the available evidence does not strongly support widespread access to quality MHM education. While data indicates a considerable number of girls knew about menstruation before menarche (Davidson 2023b), this alone does not reflect the depth or consistency of the education provided.

As opposed, multiple sources highlight that MHM education is not comprehensively delivered: Curricula focus on biological aspects, neglecting psycho-social and practical dimensions essential for effective MHM (Davidson 2023a). Furthermore, teacher preparedness and the quality of instruction vary widely, and several regions or schools only address menstruation reactively. A Student affirms: “They don’t always teach us about these things, they only do it when someone brings it us. But they do not usually come out and speak about it” (Chigome 2019, 99). In fact, studies highlight persistent gaps. Most girls still experience fear due to limited, inaccurate, or non-empowering information (Nomsenge 2024). For instance, a mixed-method study in senior primary schools in three provinces “found that fewer than two thirds of learners […] had been educated on their menstrual cycle and a third of those who had started menstruation did not know which passage the blood passes through” (Beksinska 2023, 2). These findings suggest that, while progress was made, access to quality education remains uneven and insufficient. The indicator is therefore not robustly met.

Girls’ participation and comfort in school and school-activities

It is challenging to find data on the proportion of girls able to positively enjoy school, and participate in school-activities during menstruation, as such indicators are rarely systematically measured. Still, the qualitative findings clearly illustrate that inadequate access to MHM leads to anxiety, reduced participation, and lower academic engagement (Misare 2024; Alexander 2016). These results suggest that when menstrual needs are unmet, girls are more likely to withdraw from class activities, experience concentration difficulties, and perform poorly academically (Sommer 2021). Context-specific evaluations of the Sanitary Towel Programme found that it “has impacted the girl’s educational access and participation through enabling them to be always in class, […] concentrate in study activities, […] and feel comfortable in class” (Mutune 2024, 5). Furthermore, Misare emphasises that the “[p]rovisions of sanitary towels have saved many of the girls not only dropping out from schools but also reduced the agency that hinders the girl child’s progress in curricular and co-curricular activities” (Misare 2024, 9). Her 2024 study in Mbita Sub County, further found a positive relationship between MHM and girls’ academic performance. The research showed that girls with better access to MHM resources demonstrated higher confidence and improved results in mathematics compared to those lacking

support, which “implies that indeed menstruation affects the girl’s academic performance” (Misare 2024, 9).

The results show that access to menstrual products not only enables girls to enjoy sports, lessons, and other activities during their periods but also enhances academic performance. Where targeted interventions are effectively implemented, there are clear improvements in comfort and participation. This suggests that while current policies have positive potential, their inconsistent reach is not letting all girls experience benefits.

In South Africa, the evidence does not support an increased girls’ participation and comfort in school and school-activities. Multiple sources highlight that girls remain uncomfortable while on their periods (Davidson 2023b). “The fear of possible leaks, body odour and related ridicule” (Nomsenge 2024, 67) disrupts their participation in class and school activities. Qualitative findings reveal that menstruating girls often become quieter, less active, and less attentive (Chirambo 2020). Research in selected KwaZulu-Natal schools found that “only 6% of the participants are comfortable going to school during menses” (Kgware 2016, 25), meaning the majority suffers discomfort. In another study across three provinces, girls who missed school due to menstruation also missed school-activities such as sports and drama, with up to 23 times in a single term (Beksinska 2023). This highlights that barriers remain significant. However, there are also positive signs: school distribution programs were “deemed to have had a positive impact on menstruating girls’ participation in activities such as sports, dancing, drama or playing with friends” (Beksisnka 2023, 16), with “[a] few girl learners felt they were able to participate in sports and other activities even when they were menstruating” (Beksinska 2023, 17). Nevertheless, while this demonstrates clear potential, the SDF outcomes remain limited, and most girls still face barriers to full participation when menstruating.

5.2 Analysis of Policy Impacts

Educational engagement: Completion Rates, Abseentism and Confidence

Generally, “[f]ewer girls (68%) in Kenya [and] enrolled in secondary school than boys (78%), and girls had a lower completion rate (39%), boys 46%” (Population Council 2022, 21). However, this attributes to a range of intersecting factors, including poverty, early pregnancy, child marriage, GBV, and inadequate school infrastructure. Still, these drivers intricately link to poor MHM and period poverty. For example, a lack of WASH facilities can lead to frequent absenteeism and dropout, as highlighted by a report by Dasra (2019), an organisation revealing that millions of girls leave school annually due to inadequate facilities (Mutune 2024). Additionally, period poverty can lead to “increased vulnerability to pregnancy or child marriage, with subsequent school dropout or expulsion” (Sommer 2021, 2). Given the complexity of factors influencing girls’ educational engagement, it is impossible to isolate the precise

proportion of girls who leave school solely due to poor MHM. Multiple, often interlinked reasons contribute to lower completion rates. Therefore, given the overlapping, mutually reinforcing nature of these obstacles, it is not possible to definitively evaluate this indicator. Instead, the evidence suggests that fighting poor MHM and period poverty helps to strengthen the broader landscape of educational advantages.

Dropout rates in South Africa are alarmingly high, "in 2013, only 40% of those learners who started school 12 years earlier passed Grade 12, while the following year, this figure fell by a further 4% to 36%" (Chigome 2019, 53), which indicates "that approximately 60% of South African learners are dropping out of the schooling system with no qualification" (Chigome 2019, 53). Over 75% of learners are from low socio-economic status and moreover "attend schools which offer poor sanitation-related services, poor quality education and thus perform poorly" (Chigome 2019, 53). It is these students and especially girls who are most vulnerable to dropping out. Similarly to Kenya, it is not possible to determine whether high dropout rates among female learners are specifically due to lack of access to sanitary products or inadequate facilities, as there is an insufficient level of research (Chigome 2019).

Regarding school attendance, Studies across Kenya show a high presence of Period Poverty with "girls from poor families miss[ing] 20% of school days in a year due to lack of sanitary towel" (Misare 2024, 10). This shows that the number and proportion of girls attending school during menstruation in Kenya are strongly influenced by MHM challenges. Moreover, other "[e]xisting data shows a close relationship between poor MHM and irregular school attendance" (MoE 2022, 1). However, this relationship is multidimensional and complex, and "because menstruation is limited to 0–5 days per month, absence within these few days may be hard to isolate in a high absenteeism context" (Benshaul-Tolonen 2019, 712). Thus, the complexity of this problem and the lack of policy monitoring make it demanding to identify precise statistics about absence. Presently, there are "large differences across contexts and studies" (Benshaul-Tolonen 2019, 704), and therefore due to significant variation, no definitive conclusions regarding the impact of the MHM policy on attendance rates can be provided.

Nevertheless, it is feasible to acknowledge context-specific research such as "cross-sectional surveys [that] found improved WASH reduced absenteeism among girls" (Alexander 2014, 1454) or a study from Benshaul-Tolonen 2019 in Siaya County reporting that the "Sanitary pad arm reduced absenteeism by 5.4 percentage point" (2020, 109). Hence, it is evident that MHM interventions can yield measurable improvements in school attendance within specific contexts, even though the broader realities of policy implementation demand more nuanced research about policy impact.

Studies in South Africa also show that providing sanitary products can significantly reduce absenteeism. For instance, "a study conducted in Eldorado Park, Johannesburg, showed 85% improvement in school

attendance with availability of sanitary products" (Siddiqui 2023, 125). A beneficiary of the sanitary pads program highlights: "As I'm saying, arrival of the supply of product helped us, they use to be absent from school a lot back in the days […] but now since they have been receiving it, they no longer miss school" (Beksinska 2022, 15). The provision therefore helps increase attendance, but the coding process also revealed that MHM-related absenteeism is not only dependent on products but also other implementation measures as "schools that offer free sanitary towels, gendered ablution facilities and water have less incidences of absenteeism by girls than those that do not have facilities to cater for girl children's needs" (Ngomane 2023, 305). However, this again shows that estimating the causal relationship is challenging, and "measuring absenteeism and the factors that drive it is difficult" (Davidson 2023a, 4), reinforced by the lack of nationally representative data.

The situation in South Africa therefore shows parallels to Kenya regarding data availability and policy impacts. Furthermore, it can be observed that while the provision of sanitary pads is important, reducing absenteeism requires an integrated approach that also addresses WASH infrastructure, menstrual pain management, stigma, and supportive school environments. Focusing on just one aspect—like product provision—will not fully resolve the issue.

The coding results highlight both the value and limitations of using self-reported confidence and motivation as indicators for educational engagement. In Kenya, much of the available evidence on girls' confidence and motivation during menstruation is based on small, qualitative, and self-reported studies, making "it difficult to generalise findings across different types of adolescent populations and diverse regions which have different cultural and socio-economic contexts." (FSG 2016, 1). On the other hand, there is qualitative evidence that the provision of sanitary towels directly contributes to increased school attendance, concentration, and academic performance, because of less anxiety and higher confidence (Mutune 2024, 4). This suggests a positive link between the MHM policy and girls' self-reported motivation and confidence to achieve potential in school, even if broader quantitative data is still lacking. In summary, self-reported confidence is a meaningful indicator, and available studies point to the empowering effects of adequate MHM support. But again, current research is limited in scope.

Similarly, targeted interventions in South Africa seem to show promise like "a study conducted in […] Johannesburg, […] showed a increase in self-esteem and confidence to attend school while menstruating" (Siddiqui 2023, 125). Still, these findings are context-specific, and more comprehensive data is needed to confirm widespread effects of policy efforts. This demonstrates that both Kenya and South Africa face similar issues regarding data availability and monitoring.

Dignity in managing menstruation

The findings indicate progress in reducing stigma and increasing dignity among adolescents in Kenya, particularly in urban areas like Kibera and Kisumu. The data from Mokaya (2023) show that 94,7% of school-going adolescents in Kibera, Nairobi City, view menstruation as a natural process, with only a small minority associating it with shame, curses, or disease (Mokaya 2024). Qualitative accounts from Olson (2022) and Onbogo (2023) further illustrate that open discussions involving both boys and girls, as well as engagement with parents and teachers (Olson 2022), have fostered a more supportive and less discriminatory environment. Teachers report that girls are increasingly comfortable discussing menstruation and that school communities are actively working to normalise the topic and help when needed. This suggests that policy interventions are having a tangible impact.

On the other hand, the limited scope of these studies shows that this impact can only partly be observed. While the MHM policy acknowledges stigma, it fails to translate this recognition into effective action, sometimes even reinforcing negative perceptions "by labeling menstruation as dirty and in need of proper hygiene" (Olson 2022, 11). Stigma persists in everyday schoollife, with teasing and humiliation after leaks, leading to absenteeism, dropping out or worse (Benshaul-Tolonen 2020). It still is a long way to overcome social taboos. Discrimination can go as far as the shocking suicide of 14-year-old schoolgirl Jackline Chepng'eno in Bomet County who took her life after being shamed by her teacher for soiling her uniform during her period (Misare 2024). This suggests that the indicator remains unmet in many contexts. While Kenya's MHM policy outlines objectives to address myths and taboos, implementation gaps mean that stigma and discrimination continue to affect girls' experiences.

In South Africa, the evidence does not support the indicator of increased dignity, as there are persistent reports of stigma, fear, and social exclusion. Studies show that „[m]ale teachers and learners featured prominently in reports about adolescent girls' experiences of menstruation and related fear and discomfort" (Nomsenge 2024, 67). Furthermore, deep-rooted sociocultural beliefs around menstruation continue to shape negative experiences for girls, despite increased attention and interventions in recent years (Nomsenge 2024). The fear of "being the object of public shame, ridicule, or disgust were commonly stated reasons for not wanting "to be seen by others" and therefore missing school" (Beksinska 2023, 15) exemplifies how significant barriers to dignity, social participation, and stigma reduction remain. The indicator is therefore not met, highlighting the need for more comprehensive, community-wide efforts to address cultural attitudes and ensure a supportive environment for all.

6. Interpretation and Hypotheses Discussion

6.1 Comparative Evaluation

This table compromises the most significant findings for both case studies, and enables a concise comparison, demonstrating strengths and challenges persisting. A more comprehensive comparative evaluation table can be found in the appendix (See Appendix 10.7)

ToC Element	Kenya	South Africa
Context	• Early adopter & strong policy • Ongoing challenges	• Later adopter • persistent stigma, poor facilities
Foundational Elements	• Broad stakeholder input • Comprehensive teacher training	• Coordination challenges • Limited teacher training
Outcomes	• Uneven/Weak • Limited access • Some education improvements	• Uneven/Moderate • Limited access • Persistent barriers for girls
Impacts	• Mixed, promising projects • Some attendance gains • Stigma reduction slow	• Weak overall • Dropout risk remains • Stigma largely unchanged

Figure 4: Qualitative Comparison Table- ToC Components

Comparing key aspects of the MHM policies, shows both countries face similar challenges like stigma, and poor school facilities. Although Kenya, as an early adopter, has stronger policy foundations and teacher training, it struggles with uneven implementation. This suggests that policy strength on paper does not automatically translate into meaningful impact without robust, context-sensitive implementation. South Africa has wider product distribution but relies heavily on NGOs and lacks clear strategies. Despite high demand, access and comfort remain limited in both countries. Overall, persistent barriers and inconsistent implementation reduce the policies' effectiveness in addressing educational inequality. The lack of systematic monitoring further prevents adaptive learning and long-term improvements.

6.2 Evaluating Hypotheses

These findings furthermore directly connect to my hypotheses. In the following, each hypothesis is discussed in relation to my evidence.

H1: *National MHH policies (in Kenya and South Africa) significantly enhance adolescent girls' capabilities in terms of fostering educational equality.*

The CA emphasises the importance of enabling individuals to live real freedoms and opportunities (Nussbaum 2000). In both case studies, national MHM policies are grounded in rights-based frameworks that aim to enhance dignity and equality for girls. The Kenyan MHM Policy and South Africa's SDF

both recognise menstruation as a barrier to educational equality and girls' capabilities and seek to address this through legislative and practical interventions.

Context-specific studies highlight that where MHM policies are strengthened and implemented, they can remove barriers that restrict the girl´s capabilities, to enable them to participate more fully in education. Still, their impact remains uneven. Persistent challenges such as inadequate school infrastructure, entrenched cultural taboos, and socioeconomic disparities continue to restrict the real freedoms of girls, particularly those in rural or marginalised communities. This indicates that the policies fail to fully remove structural barriers as proposed by Fukuda-Parr (2003).

Looking at Nussbaum´s central capabilities, the interventions primarily support *bodily health*, by addressing the physical dimension of MH. However, the broader framework of the CA highlights how MH intersects with multiple other essential freedoms. The lack of private, safe, and reliable sanitation facilities, especially in rural or under-resourced schools, directly restricts *bodily integrity*, as girls still stay home during menstruation due to fear of leakage or harassment. The inconsistent provision of MHM education further undermines the capability of *senses, imagination, and thought*, as girls miss learning opportunities and face stigma-related barriers to participation. Period poverty also impacts *affiliation*, as menstrual stigma fosters social exclusion and reduced self-esteem among menstruating pupils. Lastly, the unequal distribution of products and inadequate infrastructure compromise girls' *control over their environment*, particularly their access to MHM. Therefore, while national policies may initiate progress, their limited scope and uneven implementation can only expand one or two capabilities while leaving others fundamentally constrained—especially for girls with disabilities or those in marginalised communities.

To conclude, MHM policies in both countries have the potential to significantly enhance adolescent girls' capabilities and foster educational equality. However, structural and contextual barriers limit these capabilities. The evidence therefore only partly supports the hypothesis and shows that the current national implementation of the MHH policies is not sufficient to truly enhance girls´ capabilities.

H2: *The effectiveness of MHM policies is contingent upon the quality of their implementation at the school level, encompassing the adequacy of infrastructure, the standard of delivery, and the extent of teacher training.*

Sommer's ToC highlights that policy outcomes are not solely determined by their design but by the quality and level of their implementation. Both case studies demonstrate that the translation of policy intent into positive outcomes is highly dependent on effective school-level delivery. In Kenya, schools—especially in rural areas—lack reliable access to sanitary products, and adequately trained staff, leading to continued absenteeism and educational disadvantage. Similarly, in South Africa, the

SDF sets national standards, but its impact is reduced by fragmented implementation, insufficient infrastructure, and inconsistent teacher training. Some provinces have made progress, but many schools remain under-resourced, and girls continue to face stigma and practical barriers to managing menstruation.

The effectiveness of MHM policies is fundamentally shaped by the quality of school-level implementation. Where delivery is strong, characterised by adequate infrastructure, consistent product supply, and teacher preparedness, positive outcomes and impacts are more likely. Conversely, gaps in these areas undermine the intended impacts of national policies, reinforcing existing inequalities. Hence, the findings support the hypothesis based on the ToC.

6.3 Recommendations for Policy Improvement and Implementation

The results highlight the need for policymakers to systematically collect data and prioritise targeted actions, as there remains room for meaningful progress. To improve MHM policies scholars have articulated a range of actionable recommendations. Sommer (2016), for example, proposes the "MHM in Ten" Priorities for Action, which provides a globally recognised framework for strengthening MHM in schools. The Priorities are deliberately broad, but their significance lies in providing a comprehensive, strategic foundation for advancing MHM by engaging a range of stakeholders (such as NGOs, Researchers, or Education and Health ministries). They address the multi-dimensional nature of MHM challenges by emphasising not only the provision of products and infrastructure but also the importance of evidence, standards, advocacy, government accountability, and systemic integration.

Their five priorities emphasise the need to:

1. "Build a strong cross-sectoral evidence base for MHM in schools for prioritization of policies, resource allocation, and programming at scale. […]
2. Develop and disseminate global guidelines for MHM in schools with minimum standards, indicators, and illustrative strategies for adaption, adoption, and implementation at national and subnational levels. […]
3. Advance MHM in schools´ activities through a comprehensive evidence-based advocacy platform that generates policies, funding, and action across sectors at all levels of government
4. Allocate responsibility to designated government entities for the provision of MHM in school. […]
5. Integrate MHM and the capacity and resources to deliver inclusive MHM into the education system. […" (Sommer 2016, 4)

Figure 5: Research Priorities according to Sommer (2016)

Nevertheless, they require contextual adaptation, such as proposed by Davidson (2023a) for the case in South Africa, where a key first step (for the DWYPD) would be to conduct detailed, specific data, as "South Africa lacks detailed research into the extent and nature of poor MHM" (Davidson 2023a, 27). She recommends the next step should then be to redraft the SDF more evidence-based, drawing on a "clear implementation plan which outlines, in detail, a phased approach to achieving the overarching aims of the Framework" (Davidson 2023a, 27). This approach underscores the necessity of grounding MHM policy improvements in robust local evidence and tailored strategies.

Developing detailed, well-developed, and contextual recommendations for both countries would go beyond the thesis' extent and therefore is not possible. Nonetheless, the research priorities, as well as Davidson´s recommendations symbolise a baseline for rethinking the existing policies, to be able to adapt them and truly foster girls' capabilities.

7. Conclusion

7.1 Summary of Findings and Answer to Question

This part aims to answer my RQ, namely: *How do national policies addressing Menstrual Health Management and Period Poverty in Kenya and South Africa reduce educational inequality for menstruating pupils?*

The findings show that the policies have only limited contributed to reducing educational inequality for most menstruating pupils, as their effectiveness is constrained by several persistent challenges. However, if initiatives are correctly implemented, the results reveal positive effects on participation and engagement.

The systemic assessment with the ToC showed how both countries have made significant policy advances. Kenya's early adoption and strong stakeholder engagement have produced comprehensive plans and some best-practice cases, yet regional disparities, limited financial accessibility, and inconsistent delivery undermine widespread impact. South Africa, while a later adopter, has expanded product distribution, but efforts remain fragmented and lack sufficient MHM education and teacher training.

In both contexts, high rates of period poverty, stigma, and inadequate infrastructure continue to restrict access and comfort for girls, especially those from marginalised groups. Although targeted interventions have led to improvements in attendance and participation where implemented, overall progress is hampered by uneven reach, data gaps, and persistent social taboos. Thus, while both countries' policies emphasise rights, dignity, and supportive environments—their impact on educational engagement and menstrual dignity remains constrained, highlighting the need for more context-sensitive, integrated approaches to truly enhance capabilities.

7.2 Contributions to Research

A range of scholars have highlighted the persistent challenges for MHM across Sub-Saharan Africa. For instance, Phillips-Howard (2016) emphasises that, despite progressive policies, many girls still lack access to affordable products and adequate facilities, and stigma remains widespread. Similar observations are made by Davidson (2023a), who notes that policy frameworks like the SDF are important but require stronger evidence bases and clearer implementation plans.

My findings align with these studies in showing that, infrastructural gaps, uneven implementation, and cultural barriers continue to limit the effectiveness of MHM interventions. However, this thesis adds to the literature by applying both the CA and Sommer's ToC in a comparative analysis, linking policy design and implementation quality to educational and social outcomes for girls. Integrating my chosen

concepts and perspectives into the study of period poverty in South and East Africa not only enriches the academic discourse but also aims for more effective and equitable policy responses. By focusing on enhancing capabilities and employing structured methodological frameworks, we can better understand the multifaceted impacts of period poverty and develop interventions that uphold the dignity and rights of all individuals.

In line with recent calls from the Africa Symposium on MH (2023), my research underscores the need for more context-sensitive, integrated, and evidence-driven approaches—moving beyond product provision to address education, stigma, and monitoring. Thus, this study both confirms and extends the work of previous scholars by offering a nuanced, theory-informed perspective on what works and what still needs to be addressed in MHM policy and practice.

7.3 Final Remarks and Future Research Directions

This study highlights the considerable progress made in MHM policy in Kenya and South Africa but also underscores persistent gaps in implementation, monitoring, and evidence. As the results indicate, future research should prioritise more comprehensive data collection—particularly nationally representative and longitudinal studies—to better capture the lived experiences and educational impacts of menstruation.

It would further be interesting to research underexplored areas such as the use of menstrual cups, and adopt intersectional approaches that consider how disability, rurality, and socioeconomic status shape MH outcomes. There is a clear need to refine school outcome measures, for example as UNICEF suggests by developing measures for engagement, concentration, and accurate definitions of school absence, dropout, and re-enrolment (UNICEF 2019). Strengthening monitoring and evaluation systems will be essential for tracking progress and informing policy adjustments. Overall, advancing the field will require not only filling data gaps, but also ensuring that research is context-sensitive, inclusive, and capable of informing more effective and equitable MHM policies.

7.4 Limitations

In addition to the methodological constraints, this study faces several content-related and contextual limitations. Firstly, the study is subject to context-specific constraints that affect the generalisability of its conclusions. As highlighted by UNICEF (2024), “only a small number of countries routinely collect data on MH in schools, and indicator definitions vary widely which makes cross country comparison difficult” (UNICEF 2024, 44). This affects the depth and quality of the analysis and therefore is a significant limitation.

Adding on, the analysis did not comprehensively address important contextual variables influencing MHM and educational participation. This includes, for instance, the role of WASH facilities, menstrual

pain, or the exclusion of other products besides disposable sanitary pads. The non-consideration of the use of menstrual cups or eco-friendly products may therefore limit the applicability of findings to the full spectrum of MHM options. The omission of menstrual waste disposal from this analysis moreover overlooks environmental issues and critical ecofeminist concerns about simultaneously supporting girls' bodily autonomy and freedom while safeguarding the environment, underscoring the deep interconnection of menstrual and climate justice.

Furthermore, the research was conducted from a position of significant social and cultural distance from the lived realities of the populations studied. As a privileged outsider, I acknowledge that my understanding of the daily struggles faced by girls managing menstruation in Kenya and South Africa is inherently limited. While this thesis aims to contribute to the academic and policy dialogue on MHM, it can never fully capture or represent the complex, context-specific experiences of those most affected.

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Figure 1

Sommer, M., Zulaika, G., Schmitt, M. L., Khandakji, S., Neudorf, K., Gellis, L., & Phillips-Howard, P. A. (2023). Improving the impact of menstrual health innovations in low- and middle-income countries: A theory of change and measurement framework. *BMC Public Health, 23*(1), Article 12105. https://doi.org/10.29392/001c.12105

Figure 5

Sommer, M., Caruso, B. A., Sahin, M., Calderon, T., Cavill, S., Mahon, T., & Phillips-Howard, P. A. (2016). A time for global action: Addressing girls' menstrual hygiene management needs in schools. PLOS Medicine, 13(2), e1001962. https://doi.org/10.1371/journal.pmed.1001962

10.Appendix

10.1 AI Declaration

During the preparation of this work, the author used DeepL Write, PerplexityAI and ChatGPT3.0 to check for spelling and grammar mistakes. After using this tool, the author reviewed and edited the content as needed and took full responsibility for the content of the work.

10.2 Data Collection for Atlas.ti

A. Kenya

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10.3 Original Theory of Change Framework (Sommer 2023)

Evaluation Component	Sub-Component	Indicator
1. Foundational Elements		1.1 Strategic buy-in and collaboration from relevant policymakers, government ministries, and community leaders. 1.2 Understanding of MHM landscape for scale-up context(s), including relevant policies, programs & varying cultural practices. 1.3 Equipment procured, livelihoods obtained (and maintained), and production hubs in place. Workforce mobilised of workforce (production, HR, sales, marketing). 1.4 Relevant educational training plan (including for staff), educational materials, and/or instructions developed that address product use, menstrual health & hygiene, and menstrual beliefs and taboos. 1.5 Refined product model and delivery system plan. 1.6 Environmental impact of scaling assessed, including menstrual waste disposal.
2. Scale-Up activities ɛmentation)	2.1 Products	
	2.1.1 Production	2.1.1.1 Maintain product quality & consistency 2.1.1.2 Ensure machinery & workforce compliance and that the product quality maintained & standards met as production increases & innovation scales

		2.1.1.3 Include sufficient printed instruction on product usage
	2.1.2 Distribution	2.1.2.1 Deliver through identified channels (local or countrywide 2.1.2.2 Delivery to users via partner organisations / businesses community workers in rural and urban localities
	2.2 Education	
	2.2.1 Adapt & Produce Materials	2.2.1.1 Adapt materials to new in country target populations (urban v. rural, age, girls in and out of school, special needs) 2.2.1.2 Tailor delivery of educational content (school)
	2.2.2 Dissemination	2.2.2.1 Expand partnerships to deliver content (school) 2.2.2.2 Address negative social norms and barriers through sensitising gate keepers.
3. Outcomes	3.1 Immediate	3.1.1 Access to a quality & affordable menstrual product
	3.2 Intermediate	3.2.1 Access to a quality & appropriate MHM education 3.2.2 Knowledge attitudes and behaviours on menstrual hygiene management, including menstrual taboos & myths. 3.2.3 Knowledge and confidence about sexual & reproductive health (SRH) and rights of woman and girls in the given context 3.2.4 Employment opportunities beneficiaries in given context 3.2.5 Employment opportunities & experiences for intermediaries (i.e. Woman developing pads and / or assisting with distribution)
4. Impacts		4.1.1 Engaging of girls & women effectively in school during menstruation

		4.2.1 Acceptance by girls and woman, boys and men, community that menstruation is normal and healthy 4.2.2 End-user demand for menstrual products in target population (in school) 4.2.3 Woman's participation in school and livelihood opportunities 4.2.4 Girls' participation and attendance in school

5. Enabling Context		5.1 Innovation is contextualised in local menstrual hygiene managment practices and beliefs 5.2 Innovation empowers girls and woman through education, employment and access 5.3 Innovation maintains compliance with government standards over time 5.4 Innovation reaches low-income and hard-to-reach girls and woman

10.4 Definition of all Relevant Criteria

1. Foundational Elements

1.1 Strategic buy-in and collaboration from relevant policy makers, government ministries, and community leaders

The degree to which key stakeholders such as relevant policymakers, government ministries, and community leaders are engaged in menstrual health management (MHM) policy implementation. This includes their involvement in policy formulation, support for program sustainability, and participation in strategic planning, production, distribution, and monitoring of menstrual health interventions.

1.2 Understanding of MHM landscape for scale-up context(s), including relevant policies, programming & varying cultural practices

The degree to which menstruation is addressed across ministries (including education, health, and sanitation) to better understand the scale-up context. This can include the understanding of the cultural beliefs in Kenya and South Africa which can influence decision making at various stages of MHM innovation, production, and distribution.

1.3 Relevant educational training plan (including for staff), educational materials, and/or instructions developed that address product use, menstrual health & hygiene, and menstrual beliefs and taboos.

Explore if there is a developed educational training plan for orienting staff on the menstrual hygiene product, including its proper usage. Content should address relevant menstrual beliefs and taboos in the target communities.

2. Scale-Up activities

2.1 Products: Distribution

2.1.1 Consistent and appropriate delivery to users (at school) via partner organisations/businesses/community workers in rural and urban localities

Are the expanded distribution channels fulfilling appropriately forecast necessary quantities for target population based on a range of factors, including: target population size, product design limitations (including estimated lifespan of product), product loss, and the implications of product misuse (including reduced lifespan). These estimations should be reflected in the quantities distributed to minimise gaps in coverage and enhance consistent product usage and confidence. Expanded distribution methods should take into account that many girls and women may not be comfortable purchasing or receiving menstrual products and instructions in public or mixed gender settings given the taboos surrounding menstruation. Appropriate distribution methods should be introduced subsequent to consultations with girls and women, including hard-to-reach populations as their needs may differ. Considerations should include utilising venues that are private and female-only, the use of female distribution or sales staff and ensuring that the menstrual products are discreetly provided and/or packaged for personal transport (including storage) as this can reduce discomfort and anxiety about privacy and stigma in the target population (Sommer et al. 2023)

As this indicator is very comprehensive and it further does not include primary elements of my research question, I will lay a particular focus on the Distribution Accessibility to be able to evaluate whether menstrual products are consistently delivered to intended users in schools (elaborated further in Table 2).

2.2 Education

2.2.1 Adapt & Produce Materials

2.2.1.1 **Tailor delivery of educational content (school)**.

Different dissemination venues (schools, workplace, community centers) may require different approaches when providing MHM education. This can be influenced by the (1) venue location (including privacy considerations), (2) availability of resources like technology, sanitation, water and disposal facilities, and, (3) knowledge of the education approaches or resources already available, 4) who is doing the education (e.g. training of trainers or direct education delivery). Consultations with girls, women, staff, or community leaders at each type of location are useful for tailoring approaches, learning about pre-existing social resources and finding opportunities for expansion or growth. Consultations can also ensure that prior knowledge and social resources (e.g. existing forums, girls' clubs, or women's groups) are effectively engaged with and/or utilised for optimal or expanded product dissemination and uptake (Sommer et al. 2023).

To compromise, in my coding process, I will specifically assess how policy documents address the tailored delivery of MHM education in schools for schoolgirls to still be able to include this indicator without going beyond of the scope of the bachelor thesis.

2.2.2 Dissemination

2.2.2.1 Expand partnerships to deliver content (schools).

The range of partners involved in the provision of menstrual health and menstrual hygiene education. For example, engaging directly with organisations, schools, and community groups for the dissemination of this education can expand the range of audiences reached and promote sustainability. Furthermore, the engagement with a range of new partners can also help to build more informed and supportive menstrual environments via exposing workplace staff, community members and teachers to issues about menstruation, expanding their basic knowledge on the topic, and promoting consensus on the projects mission (Sommer et al. 2023).

As this is a very broad extensive category and not central to my research question, in my coding process, I aim to assess how policy documents include strategies to engage schools and relevant organisations (e.g., NGOs) for the dissemination of MHH education.

2.2.2.2 Address negative social norms and barriers through sensitising gatekeepers.

A range of actors can influence and/or hinder girls' and women's ability to manage their menstruation. It is important to identify the different types of gatekeepers (e.g. parents, men, boys, teachers, community elders) that may impact girls and women's ability to manage menstruation with confidence, comfort, and dignity. After identifying these gatekeepers, targeted outreach may be needed to ensure gatekeeper buy-in and sustainability of the product delivery approach, including sensitising gatekeepers on the rationale for supporting girls and women with their menstrual needs, and simultaneously addressing social taboos and myths. Sustained engagement and partnership with gatekeepers should be maintained overtime as this can enhance product utilisation and confidence by the target population, improve sustainability and decrease social taboos and stigmas around menstruation (Sommer et al. 2023).

To be able to assess this category in a qualitative way, I aim to evaluate how policy documents address the involvement of gatekeepers (e.g., parents, teachers, community leaders, men, and boys) in overcoming social taboos and barriers related to menstruation. For instance, this involves understanding whether the policies propose strategies for sensitising these gatekeepers and engaging them in promoting menstrual health awareness.

3. Outcomes

3.1 Immediate

3.1.1 Access to a quality and affordable menstrual product.

Assess degree to which this goal is reached: Target users are able to easily, comfortably, and regularly access and use a higher quality menstrual product. Factors such as cost, distance/geography, education, economic status, literacy-levels, product maintenance, and unfamiliarity with the product type should not pose barriers to usage (Sommer et al. 2023). To do so, I will primarily focus on Availability and Accessibility of menstrual products for targeted beneficiaries, especially marginalised groups, as well as on the Financial accessibility of the product.

3.1.2 Access to quality and appropriate MHM education.

Assess degree to which this goal is reached: Target users can easily and comfortably access and understand higher quality MHM education. This includes ensuring that factors such as distance/geography, language/dialect, educational and economic status, and literacy-levels do not pose barriers to access or comprehension (Sommer et al. 2023). My coding scheme focuses particularly on the access to MHM education, as well as the quality of the education provided.

3.2 Intermediate

3.2.1 Increased end-user demand for menstrual products in target population (in school, rural/urban).

Assess degree to which this goal is reached: Consumer demand, including both beneficiaries and organisations serving these populations (schools, workplaces, community organizations), remains high based on factors including awareness, acceptability, and affordability of the MHM innovation (Sommer et al. 2023).

I did so by assessing whether the target beneficiaries (e.g., schoolgirls) are purchasing menstrual products as intended by the policy. This includes measuring demand across different groups and identifying any barriers or factors influencing product purchase. However, this indicator had to be excludued from my analysis due to the limited scope of my thesis. This was justified as its exclusion because of its comparatively lower relevance to the core research objectives, allowed a more focused and coherent evaluation of the most critical factors influencing MHM and educational inequality.

3.2.2 Increased girls' participation and attendance in school

Assess degree to which this goal is reached: Adolescent girls have increased participation and engagement in the classroom due to increased confidence in the reliability of the menstrual product they are using. Improved product security may enhance girls' abilities to engage with teachers and peers in classroom activities by reducing fears about blood leaks on their clothing. There may also be a reduction in girls' menstrual-related absenteeism from school (Sommer et al. 2023).

4. Impact

4.1 **Improved educational engagement**.

Assess degree to which this goal is reached: Improved educational engagement can enhance the academic success and confidence of adolescent girls in addition to strengthening their school-based social networks. Ultimately this may impact their grade progression and school completion rates (Sommer et al. 2023).

4.2 **Increased dignity in managing menstruation**.

Assess degree to which this goal is reached: Girls and women may report experiencing reduced shame and stigma during their monthly menstruation, including describing perceptions of increased comfort from improved access to appropriate facilities and menstrual products, and diminished discrimination from boys, men and others in their communities (Sommer et al. 2023).

Sommer et al. proposed criteria are more numeric and very extensive. For my coding process, I will therefore focus on the presence of reported improvements in social participation and reduced stigma, or discrimination related to menstruation.

(Sommer 2023, Appendix S1)

10.5 Operationalisation of ToC

Evaluation Scheme

Cate-gories	Description	Indicator	Indicator Type	Data Source	Monitoring	Frequency	Reference point and target change	Biases
1.1	Input and buy-in from key stakeholders within MHM landscape in Kenya & South Africa, including policy makers and relevant government ministries.	Level of stakeholder engagement in MHM policy formulation and implementation	Qualitative (text-based content analysis, stakeholder mapping)	Official government statements, meeting records, policy documents, or ministerial reports.	One-Time assessment	One-Time data collection	Assess stakeholder In-Put of explicit commitments to MHM	Selective Reporting
1.2	Degree to which menstruation is addressed in health, sanitation education ministries to better understand the scale-up context	Degree to which MHM and Menstruation is addressed and included in relevant documents (highly or hardly).	Qualitative (text-based content analysis)	Policy documents from ministeries in Kenya & South Africa	"	"	Assess degree of which MHM is addressed in policy commitments	Reporting Bias (if policy documents do not reflect actual implementation)
1.3	Availability and quality of educational materials on menstrual health, hygiene, and product use for students and school staff	(a) Presence of an MHM education plan in schools (b) Inclusion of menstrual health in training materials for teachers	Categorial (present / absent)	School curricula, teacher training materials	"	"	Comparison with national education policies and guidelines on menstrual health education	Selective reporting in official materials

2.1.1	Distribution Accessibility: Evaluates whether menstrual products are consistently delivered to intended users in schools, ensuring equitable access in both rural and urban settings.	Proportion of schools (High or Low) implementing national MHM policy guidelines on menstrual product distribution.	Qualitative (Text-based analysis)	Ministry of Education reports, school implementation reports, NGO/government evaluations, and stakeholder interviews	“	“	Assessment of gaps in policy implementation at the school level	Inconsistent reporting from schools, policy implementation gaps not reflected in official records, reluctance to report challenges due to policy pressure.
2.2.1.1	Assess how policy documents address the tailored delivery of MHM education in schools. This involves reviewing whether the policies include specific strategies for adapting the content to the needs of schoolgirls.	Presence of specific strategies in policy documents that outline tailored delivery methods for schools	Qualitative (text-based analysis of policy content)	Policy documents, government reports, educational ministry guidelines	„	“	Finding out if Policies explicitly mention tailored delivery strategies for students	Potential bias from document selection (e.g., relying only on official versions or not including all relevant documents)

2.2.2.1	Assess how policy documents include strategies to engage partners for the dissemination of menstrual health and hygiene education.	Presence of strategies in policy documents that detail partnerships with schools for the delivery of MHM education	Qualitative (text-based analysis)	Policy documents, government reports, and implementation plans	"	"	To Examine if Policies identify key types of partnerships (e.g., schools, workplaces, community organisations) for MHM education delivery.	Potential bias in document selection or in over-representation of certain types of partnerships
2.2.2.2	Evaluate how policy documents address the involvement of gatekeepers (e.g., parents, teachers, community leaders, men, and boys) in overcoming social taboos and barriers related to menstruation. This involves understanding whether the policies propose strategies for sensitising these gatekeepers and engaging them in promoting menstrual health awareness	Inclusion of strategies in policy documents for engaging gatekeepers in addressing social norms and supporting girls' and women's menstrual health needs.	Qualitative (text-based analysis)	Policy documents, strategic frameworks, governmental reports on social norms, and education	"	"	Evaluate Strategies of including stakeholders to overcome menstrual stigmata and prejudices	Bias may arise from focusing only on formal gatekeepers (e.g., teachers, parents) and overlooking informal influencers (e.g., peer groups or local leaders)
3.1.1	Evaluate whether the policy ensures that the Innovative MHM Product is accessible and available to the intended beneficiaries, particularly those from different social groups, rural or urban settings,	(a) Availability and accessibility of menstrual products for targeted beneficiaries, especially marginalised groups. -> Explicit mention of distribution strategies, school-based supply	Qualitative (textual content analysis)	Policy documents, NGO reports, government distribution strategies	"	"	Assess the extent to which policies include accessibility measures for marginalised populations	Need for representative sampling from diverse beneficiary groups

	and marginalised or hard-to-reach populations.	programs, or government initiatives to improve access						
		(b) Financial accessibility of menstrual products for low-income individuals -> References to subsidies, tax exemptions, or government financial support mechanism					Identify affordability-focused interventions in policy design	
3.1.2	Evaluate whether MHM education, as outlined in the policy, is being provided to the right beneficiaries, including those from rural, urban, marginalised, and hard-to-reach populations. This involves determining if the educational content is reaching all target groups and is accessible to them	(a) Degree to which MHM education reaches marginalised and hard-to-reach settings.	Qualitative (text-based analysis)	Survey of institutions, curriculum records, NGO/government reports.	"	"	Target increase in education provision across different settings	Overrepresentation of urban/easy-access areas
		(b) MHM education quality: Presence of quality measures in education delivery; Level of Information received	Qualitative (evaluation reports, participant feedback)	Spot-check evaluations, FGDs with educators and students			Assess if education meets predefined quality standards	Variability in teaching standards, lack of standardised audit criteria

3.2.1	Assess whether the target beneficiaries (e.g., schoolgirls, rural/urban population) are purchasing menstrual products as intended by the policy. This includes measuring demand across different groups and identifying any barriers or factors influencing product purchase	Beneficiaries' reported interest or desire to purchase menstrual products because of the policy and available resources	Qualitative (Text-based)	FGDs, Interviews, NGO reports	"	"	Understand the shift in beneficiaries' expressed interest in purchasing menstrual products	Representation Bias in Document Selection
3.2.2	Provision of Innovative MHM Product, MHM Education enhances girls' ability to engage in school during menstruation	(a) Reports and proportion of girls able to attend and positively enjoy school during menses	Qualitative reports of girls fully engaging in school activity (sport, lessons)	School-based surveys, Interviews	"	"	Reach pre-determined measurable increase in number and proportion of girls enjoying specified activities during school; stratified by age, setting i.e. rural, urban, marginalised, disabilities, illiterate, etc	Representative of beneficiaries; stratified by different populations, rural/urban, hard to reach, disabilities etc.
		(b) Girls report menses no longer prevents them from enjoying sports, lessons and other activities or attending school during menses.	Qualitative description by girls they can fully engage and participate without fear of	FGD targeted schoolgirls, School-based surveys			Majority of girls report positive effect on engagement of school activities	

			menstrual issues arising during school activities				while having menses.	
4.1	Assess if MHM Policies enhances girls' confidence and ability to reach their academic potential.	(a) Reports and proportion of girls completing secondary school	Qualitative reports of girls completing school education	School-based surveys, NGO reports	"	"	Assess measurable data about increase and strengthening of schoolgirls' educational outcomes	Strong observational biases can occur with attendance/absence collection - poor collection through school registers, and reporting bias among girls' diaries etc (desirability effect bias)
		(b) Number and proportion of girls reporting attending school	Qualitative reports about Numbers and Proportion (Numeric, Quantitative)	"				
		(c) Reports and proportion of girls describe feeling confident and motivated to achieve in school	Qualitative description of ability to achieve potential in school	Qualitative (FDGs, Interviews)				
4.2	Evaluate whether access to menstrual health products and education improves the dignity and comfort of girls and women by reducing stigma, shame, and discrimination. This involves assessing if women and girls feel more confident and socially included during menstruation, with better access to appropriate facilities and menstrual products.	Presence of reported improvements in social participation and reduced stigma or discrimination related to menstruation (e.g., no longer feeling isolated, more comfortable at school)	Qualitative (Text-based)	FGDs or interviews with girls, school surveys, and reports from community-based organisations	"	"	Find out if policies managed for a majority of girls and women to report increased comfort and reduced stigma	

10.6 Coding Results – Findings Table

1. Kenya

Category	Code	Findings	Illustrative Quotes
1.1 Stakeholder Engagement	High	The Results indicate that there is a high Input and buy-in from key stakeholders within MHM landscape in Kenya. This is including policy makers and relevant government ministries such as Ministry of Health. For Instance, the MoH takes a coordinating supervising role in the MHM implementation process. Moreover, the MHM policy highlights the idea of a National and County MHH task force (MoH 2019). Furthermore, there is also high (increasing) degree of NGOs entering Kenya and establishing MHM programmes (FSG 2016) To illustrate, one Study in Nairobi found that NGOs sponsor 69.2% of MHM interventions in school (Mokaya 2023), e.g. UNICEF	„Ensure all government ministries and departments mainstream MHM in their policies and guidelines" (Ministry of Health [MoH] 2019, 11) "sector-wide approach to ensure there is multistakeholder and multisector involvement of relevant stakeholders in the county" (Migori County Government [MCG] 2023, 31)
	Low	An effective collaboration between key ministries involved in MHM in Kenya remains limited and problematic, even though there are strong efforts.	"Collaboration between various relevant ministries remains a challenge, although the Ministry of Health continues to invite other ministerial engagement (e.g. Gender, Environment and Water)" (Sommer 2021, 12)
1.2 Menstruation Adressed	Highly	The Results show a high Degree to which menstruation is addressed throughout different ministries such as health and education ministries, which helps to better understand the scale-up context. The high degree of addressing MHM is shown by the comprehensive MHM policy Furthermore, Kenya was a very early adopter and already removed VAT Tax on sanitary pads in 2004 (Misare 2024)	Early adopter as earlier publications highlight: "There is growing national attention to MHM with the National Sanitary Towels Program for school girls and development of national MHM guidelines" (FSG 2016, 1)
	Hardly	Even though, the government already addressed MHM a lot and is engaged in solving MHM related issues, there are still some gaps remaining (FSG 2016). Other ministries do not include MHM as extensive as the MHM policy proposes them to do.	/
1.3 a) Presence of MHM	Present Absent (0)	Comprehensive Educational material is available for students and school staff. For instance, the School Health Policy	"Incorporate reproductive health and menstrual hygiene into the curriculum in learning institutions for

Education plan		highlights the need to support girls during menses (2018). Furthermore, the MHM policy also states to mainstream MHM into the curriculum. Therefore, the criteria of this indicator is fulfilled, and a MHM Education Plan is present.	all relevant sectors (WASH, protection, health, community development.)" (MoH 2019, 17)
1.3 b) Inclusion of MH trainings plan for teacher	Included	*The coding process also reinforced the believe that "there is a statistically significance on the correlation between the percentage of menstrual knowledge of the adolescent girls and the percentage of trained teachers" (Mokaya 2024, 51). This shows the importance of trained staff in the school environment so that "the teacher acts as a coach and facilitates the learning" (Ministry of Health & Ministry of Education [MoH & MoE] 2020, 7).* There is a comprehensive MHM Handbook for Teachers, which outlines various learning tactics and schemes. Moreover, there are several training instances such as the Ministry of Education who trains Teacher on usage and disposal (FSG 2016) or the Girl Child network which educates teachers about MHM (FSG 2016). Thus, this indicator is met.	"Increase the capacity of teachers, school management and public health officers on MHM" (MoH 2019, 12) "the teacher should be able: 1. To gain knowledge […] to appreciate it as a normal biological process. 2. To advocate for change of attitude […] and view it as a normal biological process. 3. To gain knowledge on changes that occur during adolescence […]. 4. To describe to boys and girls' reproductive organs for the learner to appreciate the functional differences. 5. To dispel the myths, misconceptions and taboos around menstruation and be a change agent in the community" (MoH & MoE, 2020, 11)
	Not Included	A small-sample Study in Nairobi has shown education material varies a lot from one school to another that sometimes NGOs are mostly providing MHM education, which indicates that teachers are not well enough trained or do not feel confident enough to teach about MHM. However, this context-specific study is not very representative.	"[S]ome of their teachers had been certified to teach the girls on menstrual hygiene management while 61.5% (32) do not have any form of training on menstrual hygiene management or reproductive health" (Mokaya 2024, 37)
2.1.1 Proportion of schools implementing policy guidelines on menstrual product distribution	High	Originally, "the Basic Education (Amendment) Act […] obligates the government to provide free, sufficient and quality sanitary towels to every girl child registered and enrolled in a public basic education institution" (Government of Kenya 2022).	<
	Low	However, most schools only provide Pads in emergencies. Local/Regional Studies show differences and indicate that the quality and depth of implementation varies a lot across the country (especially a rural/urban contrast) (FSG 2016)	"Whether the government has a system for ensuring that schools impart knowledge on Menstrual Hygiene Management to the pupils in Primary schools the respondents indicated that there is no clear system" (Onbogo 2023, 77)

		For instance, a case study in Kibera, Nairobi found that 78,8% of Schools did not have a specific guide on MHM (Mokaya 2024). Thus, there seem to be issues regarding a consistent delivery to intended users in schools, which is hindering equitable access in both rural and urban settings. These results indicate that a rather low proportion of schools implemented the guidelines on product distribution.	
2.2.1.1. Presence of specific strategies in policy documents that outline tailored delivery methods for schools	Present	The MHM policy rather establishes a framework with no specific strategies outlined. The implementation is therefore dependent of the counties and municipalities. Migori County proposes different strategies to foster the delivery methods for schools. The county´s policy introduces a clear division of tasks.	For instance, Responsibility of Ministry of Education & County Department of Education to generate "Data on the number of girls who have reached the age of puberty to facilitate the provision of free sanitary pads initiative" (MCG 2023, 22)
	Absent	The specific implementation of tailored delivery methods is dependent on the counties 'implementation. At present, Migori County is the only Kenyan county with a publicly available, official MHM policy document online. Most other counties have not yet published stand-alone MHM frameworks or plans accessible to the public, though the national policy requires counties to develop such frameworks and integrate MHM into their County Integrated Development Plans (CIDPs) and County Health Strategic Plans. ➔ implementation plans are either still under development or not publicly accessible as of May 2025 The Beginning of the implementation of free sanitary pads already took place in 2011. However, earlier publications highlight underlying distribution challenges. The strategies are not outlined enough, and a tailored delivery is prevented by further issues such as corruption.	The "framework shall guide the Counties in developing their respective first five year County MHM Strategic and Investment Plans which shall be aligned with the respective County Integrated Development Plans and county sector plans" (MoH 2019, 15) "Smaller social enterprises are currently unable to access the best distributors, in part due to volume limitations. Additionally, safety remains an issue in certain pockets of the country "(FSG 2016, 19); "reports of corruption and collusion along the supply chain" (FSG 2016, 18)
2.2.2.1 Presence of strategies that detail partnerships with schools for the delivery of	Present	Kenya's MHM policy documents emphasise a coordinated, multi-stakeholder approach to disseminating menstrual health and hygiene education, with clear strategies for engaging partners across government, civil society, and development sectors. This includes technical working groups, integration into existing programs,	Case study from Kibera, Nairobi: "87.3 % (386) of the girls responded to have received general information on menstruation at school" (Mokaya 2023, 34) For Migori County Responsibility of Health & Sanitation Department

MHM education		advocacy, and county-level dissemination and adaptation. Nevertheless, the implementation is dependent on the 47 counties. Therefore, it is difficult to track down specific strategies. However, the coding process has shown that most girls receive MHM education in school as it is included in the curriculum. Moreover, NGOs play a role in the delivery of MHM education as well (FGD 2016).	"Coordinating for capacity building and training of MHM implementers from the county to the lower levels" (MCG 2023, 21)
	Absent	The lack of detailed specific strategies is shown in the inconsistency of MHM education. The indicator 2.2.2.1 is therefore not completely fulfilled.	A Study across Secondary Schools in Mbita Sub County showed: "only 20.9 percent of the respondents always received guidance and counseling services on Menstrual Hygiene Management. 28.2% of the respondents had never received guidance and counseling services on Menstrual Hygiene Management. The statistics show that there was no consistency in the provision of this service in secondary schools" (Misare 2024, 8)
2.2.2.2 Inclusion of strategies in policy documents for engaging gatekeepers in addressing social norms	Included	Kenya´s MHM policy objectives include "[t]o ensure that myths, taboos and stigma around menstruation are addressed by providing women, girls, men and boys access to information on menstruation" (MoH 2019, 9) and therefore explicitly addresses menstrual stigma especially for men and boys. As this is especially crucial in the educational context, the school health policy addresses the "Cognizance of myths, stereotypes and taboos associated with menstruation" (MoE, MoH 2018, 31) for a holistic understanding of MHM. The Policy document(s) therefore comprehensively include strategies for addressing social norms and stigma.	"[O]ne of the policies that most extensively addresses the role of men and boys is the Kenyan MHM Policy" (Olson 2022, 16) "Supporting initiatives that advance the reduction of menstrual stigma and discrimination" (MCG 2023, 22)
	Not Included	However, these strategies could be outlined more clearly, as shown by the results of indicator 4.2 (No Presence of reported improvement of discrimination)	
3.1.1 a) Access to quality	High Accessibility	The MHM Policy explicitly states to include marginalised and disadvantaged groups and research showed that MHM	"Vulnerable and disadvantaged sections of the community shall be given priority attention in Menstrual

menstrual product		programme for girls with disabilities were delivered.	Hygiene Management Promotion" (MoH 2019, 10) „In Kenya, Huru International in collaboration with the Ministry of Health and local Ministry of Education offices has delivered an MHM programme for girls with disabilities" (Sommer 2021, 10)
	Low Accessibility	Low accessibility of MHM products for schoolgirls in Kenya is a multidimensional problem rooted in poverty, high product costs, and weak distribution systems—especially in rural areas. Especially the socioeconomic status is a primary determinant of access to menstrual hygiene products among schoolgirls in Kenya, with economic affluence correlating positively with access, thus exacerbating existing inequalities. The indicator—access to quality menstrual products—shows a mixed picture in Kenya. However, the broader reality is that access remains low and highly unequal for most schoolgirls, especially those in rural or low-income settings. While Kenya's policy environment and some targeted programs show promise for improving access among specific groups, overall accessibility to quality menstrual products remains limited and deeply influenced by socioeconomic and geographic factors.	"Unsurprisingly, wealth itself is the biggest contributor to the overall wealth-related inequality in accessing sanitary pads in most countries." (Roussow 2021, 9) "The contribution of being in wealth quintile […] contributed significantly to inadequate access for the poor: […] 39%, contribution to the overall inequality in access to sanitary pads in […] Kenya" (Roussow 2021, 8) "MHM product availability is unreliable in rural and remote areas across Kenya" (FSG 2016, 13) "High costs and distribution challenges limit the accessibility of disposable pads to the majority of low-income girls and women, especially in rural areas" (FSG 2016, 1)
3.1.1 b) Access to affordable menstrual product	High Financial Accessibility	The MHM policy aims for affordable products for all women and girls, especially for marginalised groups such as rural or low-income population. This for example includes low-cost disposable sanitary pads.	"Ensure that women and girls have access to a range of Menstrual Hygiene Management products that are acceptable, safe and affordable" (MoH 2019, 13) "Low-cost disposable sanitary pads, targeted at low-income urban and rural users, are entering the marketplace but still have limited reach" (FSG 2016, 11)
	Low Financial Accessibility	Studies show that the high cost of disposable sanitary pads in Kenya renders them unaffordable for the majority of women and girls, particularly those from low-income households, resulting in significant financial barriers to menstrual hygiene management. Limited local	"High cost of disposable pads makes them inaccessible to the majority of women and girls" (FSG 2016, 13) "[T]here are only two manufacturers based in Kenya, which suppliers complain about the level of quality

		manufacturing capacity—only two domestic producers, whose products are often considered low quality relative to price—forces many enterprises to rely on imported pads.	for the price, and so the majority of these enterprises purchase higher quality, but still low-cost sanitary pads, from overseas, most commonly China" (FSG 2016, 11)
3.1.2 a) Access to appropriate MHM education	High MHM education access	The school health policy aims to make MHM education accessible for every child and hence, outlines distinct strategies and objectives. The findings show that Kenya's school health policy and MHM frameworks set strong objectives for universal, age-appropriate, and factual menstrual health education.	"Every child shall have access to relevant and factual health information, knowledge and skills that are appropriate for their age, gender, culture, language, context, and disability" (MoH & MoE 2018, 17) "The school health policy outlines clear action points, indicators and objectives to achieve comprehensive MHM across schools in Kenya." (Sommer 2021, 11)
	Low MHM education access	Nevertheless, the Results have shown that the access to MHM education in Kenya seems to be significantly low. This links to a limited availability of education materials, as well as no comprehensive sexual education. Multiple studies and reviews highlight significant implementation gaps: teachers often skip or inadequately cover menstruation topics due to lack of training, embarrassment, or competing curricular demands. Educational materials are frequently unavailable, and comprehensive sexuality education—including menstrual health—is rarely delivered systematically, especially in rural and low-income settings. As a result, many girls and boys lack accurate knowledge, with surveys revealing that only a minority of girls can answer basic questions about menstruation, and some schools provide no guidance or materials at all. For the indicator "Access to appropriate MHM education," this means it can not be statetd that the indicator is fulfilled.	"[G]irls and boys still have limited access to high-quality and comprehensive puberty education. A study by Population Council found that only 1 in 5 girls in Nairobi's informal settlements can accurately pinpoint the time of the month that they are most likely to get pregnant" (FSG 2016, 7) "A more recent 2018 survey by Save the Children Kenya shed further light on MHM practices. The survey took place in eight schools in Central, Western, Northeastern, and Coastal regions, with a total of 420 participants (212 boys and 208 girls). Findings showed that none of the schools guided girls on MHM, and no education materials were available" (Onbogo 2023, 71)
3.1.2 b) Access to quality MHM education	High MHM education quality	There appears to be a comprehensive understanding on teaching about MHM which is including important life skills for girls. This can be seen in the Handbook for teachers.	„In Kenya, at least some trainings were "not just [about] the product use, product disposal, product accessibility but also life skills because we realised that girls and also women going through menstruation face a lot of issues as

			far as their self-confidence comes in" (Olson 2021, 12)
	Low MHM education quality	Several case studies highlighted that MHM education is often only available on request, where it is not merely treated as an own important issue. Therefore, the indicator "access to quality MHM education" is not fulfilled at scale. While some schools and programs demonstrate best practices, the overall picture is one of sporadic, insufficient, and reactive MHM education. Most girls do not receive the consistent, empowering, and comprehensive menstrual health education needed to support their well-being and school engagement.	"lack of implementation, information that is only available upon request, and initiatives treated as add-ons all indicate missed opportunities to re-envisage menstrual education" (Olson 2021, 12)
3.2.1 Reports about End-user demand for menstrual products in target population		While there is clear demand and high usage of menstrual pads among schoolgirls in Kibera, the low proportion benefiting directly from government programs and the reliance on multiple sources for product access highlight persistent gaps in coverage and sustainability. Limited and localised data further restricts the ability to assess true population-wide demand and access, indicating a need for more comprehensive monitoring and program expansion.	Kibera Nairobi: "Approximately 17.3 % (9) of the informants reported to being beneficiaries of the Sanitary Towel Program rolled out by the Kenyan government" (Mokaya 2023, 46) "96,2% Percentage of accessibility of menstrual pads for the girls during Emergencies" (Mokaya 2023, 43)
3.2.2 Girls' participation and attendance in school	a) Reports of girls able to attend and positively enjoy school during menses	The findings reinforced the believe that a "lack of menstrual hygiene management (MHM) resources may affect girls' participation in school activities due to fear of leakage" (Alexander 2014, 6). However, it is challenging to find quantitative data on the exact number and proportion of girls able to attend and positively enjoy school during menstruation, as such indicators are rarely systematically measured. However, the qualitative findings clearly illustrate that inadequate access to MHM products and education leads to anxiety, reduced participation, and lower academic engagement among girls. These results suggest that when menstrual needs are unmet, girls are more likely to withdraw from class activities, experience concentration difficulties, and perform poorly academically. Context-specific Evaluations of the Sanitary Towel Programme found that it was able to enhance schoolgirls 'participation, as well as concentration in class.	"Another girl student added "When menstruation is not well managed the symptoms include lack of interest on the part of the girl student under menstrual period to class, lack of concentration during study hours, lack of concentration during co-curricular activities, nervousness when interacting with teachers, preferring to sleep day time, and difficulty in remembering contents studied leading to low performance in academic work."" (Misare 2024, 9) "This includes, for example, difficulty participating and engaging in the classroom, and thus achieving their potential, along with missed hours or days of school, and anxiety around menstrual accidents" (Sommer 2021, 2) "The study also concluded that the government sanitary towels initiative has impacted the girls educational access and participation through

			enabling them to be always in class, freely stand up and answer questions, mingled freely even among boys, concentrate in study activities, volunteer to dust the chalk-board and feel comfortable in class" (Mutune 2024, 5)
	b) Girls report menses no longer prevents them from enjoying sports, lessons and other activities or attending school during menses	It remains difficult to obtain precise quantitative data on how many girls report that menstruation no longer prevents them from participating in school activities, but the available evidence consistently demonstrates a strong link between the provision of sanitary pads and improved academic engagement. The results show that access to menstrual products enables girls to more fully enjoy sports, lessons, and other activities during their periods, thereby enhancing their academic performance and participation. However, this positive impact is highly dependent on the consistent and effective implementation of MHM interventions at the school level, including reliable product distribution, adequate facilities, and supportive education. There are reports from girls that states that the beneficiaries of the sanitary towel programme helped to stay in school and further to support the academic performance. Misare's 2024 study in Mbita Sub County, Kenya, found a significant positive relationship between MHM and girls' academic performance in mathematics. The research showed that girls with better access to MHM resources, such as sanitary pads and supportive school environments, demonstrated higher confidence and improved performance in mathematics compared to those lacking such support. This underscores that effective MHM interventions not only reduce absenteeism but also directly enhance girls' academic outcomes, particularly in key subjects like mathematics	"Provisions of sanitary towels have saved many of the girls not only dropping out from schools but also reduced the agency that hinders the girl child's progress in curricular and co- co-curricular activities." (Misare 2024, 9) "there was a significant relationship between the academic performance of girls students in Mathematics and Menstrual Hygiene Management. This implies that indeed menstruation affects the girls academic performance. In this respect Menstrual Hygiene Management as an intervention measure to enhance girl child academic performance is effective. In the absence of this intervention the girl child is bound to perform very poorly that is worse" (Misare 2024, 9).
4.1 Educational engagement.	a) Proportion and reports of girls completing	"Fewer girls (68 percent) in Kenya enrolled in secondary school than boys (78 percent), and girls had a lower completion rate (39 percent), boys 46%"	"2019 report by Dasra, a development organization, reveals that 23 million girls drop out of school every year due to lack of

	secondary school	➔ Population Council. (2022). *From advocacy to action: Lessons on girl- and youth-led systems accountability in India, Kenya, and Uganda*. New York: Population Council Kenya's lower secondary school enrolment and completion rates for girls compared to boys can be attributed to a range of intersecting factors, including poverty, early pregnancy, child marriage, gender-based violence, and inadequate school infrastructure. However, many of these drivers are closely linked to poor MHM and period poverty. For example, a lack of access to sanitary products and private, safe facilities can lead to frequent absenteeism, loss of confidence, and ultimately dropout, as highlighted by reports that millions of girls leave school annually due to inadequate MHM facilities (Sutune 2024, 2). Additionally, period poverty can increase girls' vulnerability to early pregnancy or child marriage, both of which are major contributors to school dropout and lower completion rates (Sommer 2021, 2). Studies from Kenya also show that poor MHM is associated with lower academic performance and reduced participation in both curricular and co-curricular activities, further compounding educational disparities (Misare 2024, 3).	proper menstrual hygiene management facilities" (Mutune 2024, 2) "increased vulnerability to pregnancy or child marriage, with subsequent school dropout or expulsion" (Sommer 2021, 2) „A survey conducted by Daraja Civic Initiatives Forum in Mbita Sub County found that up to forty eight percent of girls performed below average (Daraja, 2016). This study therefore sought to investigate the effect of Menstrual Hygiene Management on girl child's participation in secondary school education in Mbita sub-county in order to enhance performance and consequently raise academic standards" (Misare 2024, 3)
	b) Number and proportion of girls reporting attending school	The findings show that the number and proportion of girls reporting school attendance during menstruation in Kenya is strongly influenced by MHM challenges, and varies by context. There are "large differences across contexts and studies" (Benshaul-Tolonen 2019, 704). However, "[e]xisting data shows a close relationship between poor menstruation management and irregular school attendance, poor performance or school drop outs for girls who have reached puberty" (MoE 2022, 1). Some rigorous studies, including randomised controlled trials, have found that neither sanitary pad distribution nor reproductive health education alone or in combination was sufficient to significantly	Period Poverty: "Studies have shown that girls from poor families miss 20% of school days in a year due to lack of sanitary towel" (Misare 2024, 10) Study from Benshaul-Tolonen 2019: "Sanitary pad arm reduced absenteeism by 5.4 percentage point" (2020, 109) "cross-sectional surveys found improved WASH reduced absenteeism among girls" (Alexander 2014, 1454)

		improve school attendance at the national level. This is connected to the fact that "because menstruation is limited to 0–5 days per month, absence within these few days may be hard to isolate in a high-absenteeism context, […] and western Kenya" (Benshaul-Tolonen 2019, 712). Kenya's MHM policy and related programs have reduced school absenteeism for girls in some settings, particularly where comprehensive support (products, education, and facilities) is provided. However, national-level evidence shows that MHM interventions alone are not sufficient to significantly reduce absenteeism, as other socioeconomic barriers persist.	
	c) Reports and proportion of girls describe feeling confident and motivated to achieve in school	These citations highlight both the value and the limitations of using self-reported confidence and motivation as indicators for girls' educational engagement. The FSG (2016) report cautions that much of the available evidence on girls' confidence and motivation during menstruation is based on small, qualitative, and self-reported studies, making it difficult to generalise findings across diverse contexts. On the other hand, there is qualitative evidence that provision of sanitary towels directly contributes to increased school attendance, concentration, and academic performance, as girls feel less anxious about menstruation and more confident in class. This suggests a positive link between improved MHM and girls' self-reported motivation and confidence to achieve in school, even if broader quantitative data is still lacking. In summary, while self-reported confidence and motivation are meaningful indicators, current research is limited in scope, but available studies consistently point to the empowering effects of adequate menstrual hygiene support on girls' educational experiences.	"Current studies have small sample sizes, and they rely on qualitative, self-reported, or anecdotal data making it difficult to generalize findings across different types of adolescent populations and diverse regions which have different cultural and socio-economic contexts." (FSG 2016, 1) „Beatrice and Kibera (2019) in their study concluded that girls who benefit from the sanitary towels provision perform better academically compared to their colleagues who are not provided with the same. This is due to the fact that girls would not miss school due to menstruation and that they would concentrate better in class without fear of soiling their cloths and being mocked by fellow pupils" (Mutune 2024, 4)
4.2 Dignity in managing menstruation	Presence of reported improvements in social participation	These findings indicate significant progress in reducing stigma and increasing dignity around MHM among adolescents in Kenya, particularly in urban areas like Kibera and Kisumu. The data from Mokaya (2023)	Kibera, Nairobi City: Only 8,7% of school going adolecent perceive MHM as a shameful process. Only 2,3% believe it is a curse, 4,3% think it is a disease.

	and reduced stigma or discrimination related to menstruation	show that the vast majority of school-going adolescents now view menstruation as a natural process, with only a small minority associating it with shame, curses, or disease. Qualitative accounts from Olson (2022) and Onbogo (2023) further illustrate that open discussions involving both boys and girls, as well as engagement with parents and teachers, have fostered a more supportive and less discriminatory environment. Teachers report that girls are increasingly comfortable discussing menstruation, and that school communities are actively working to normalise the topic and help when needed. The indicator appears to be met in these contexts, suggesting that policy interventions are having a tangible impact.	94,7% perceive it as a natural process (Mokaya 2023, 40) "We talk to men, the fathers, we talk to the mothers, women, we talk to the children, both boys and girls and there's openness. And more often I have had fathers coming out to openly say that I wish I had someone telling me about these issues earlier" (Olson 2022, 8) Teacher in Kisumu County: „On attitude he said that girls are open to discussions, training is done in the assembly and boys were involved although a few girls are still shy and are sometimes embarrassed on issues of MHM. Most are aware and it has become a normal issue, teachers assist the girls when there is need and generally the attitude of girls and teachers towards menstrual hygiene is positive" (Onbogo 2023, 77)
	No Presence of reported improvements in social participation and reduced stigma or discrimination related to menstruation	These findings indicate that, despite policy recognition of menstrual stigma in Kenya, there is limited evidence of real progress in dismantling it at the community and school levels. While policies acknowledge stigma, they often fail to translate this recognition into effective action, sometimes even reinforcing negative perceptions by framing menstruation primarily as a hygiene issue and labeling it as "dirty". Stigma persists in everyday school life, with some girls experiencing teasing and humiliation after leaks, leading to absenteeism, dropping out or worse. It is still a long way to overcome social taboos and barriers related to menstruation. Discrimination can go far as the shocking suicide of 14-year-old schoolgirl Jackline Chepng'eno in Bomet County who took her life after allegedly being shamed by her teacher for soiling her uniform during her period (Misare 2024) This suggests that the indicator—presence of reported improvements in social participation and reduced stigma—remains	"Policies recognize stigma, but they do not contribute to dismantling it" (Olson 2022, 22) "In Kenya, one interviewee put it plainly: "Unfortunately, the hygiene aspect was in a way reinforcing the myths and the stigma itself" by labeling menstruation as dirty and in need of proper hygiene" (Olson 2022, 11) „In focus groups, some girls reported that being teased and humiliated after leaking led some girls to drop out of school" (Benshaul-Tolonen 2020, 713) "a suicide case of a girl who was allegedly embarrassed by her teacher after having her menses for which she had not prepared for" (Misare 2024, 1)

		unmet in many contexts. While Kenya's MHM policy outlines objectives to address myths and taboos, implementation gaps mean that stigma and discrimination continue to affect girls' experiences.	

2. South Africa

Category	Code	Findings	Quotes
1.1 Stakeholder Engagement	High	The SDF generally aims for a close collaboration with all relevant stakeholders. The Policy further envision the inclusion of diverse stakeholders (with a focus on minorities). The DWYPD serves as the key player in MHM in South Africa. The results further indicate a high importance of NGOs (Chirambo 2019)	"DWYPD endeavours to partner with government partners and other key relevant stakeholders with the aim of achieving equity in sanitary dignity in the country" (DWYPD 2019, 5) "focus on encouraging local business, women- owned business, youth and individuals with disabilities to participate in the menstrual health management value chain" (DWYPD 2019, 18)
	Low	However, even though there are efforts for a diverse and intense stakeholder collaboration, there seem to be challenges regarding coordination and distribution of resources. Hence, there is a need of a more comprehensive approach which really includes all stakeholders, and it cannot be stated that there truly is a high level of stakeholder Engagement.	"Comprehensive implementation of the Framework will require sustained coordination, effort, and allocation of resources by both national and provincial government bodies" (Geismar 2018, 10)
1.2 Menstruation Adressed	Highly	In recent years, South Africa has made notable policy advances to address menstruation and period poverty. The introduction of the SDF and the removal of VAT on sanitary pads are significant national policy steps aimed at improving menstrual health and accessibility for girls and women. These efforts mark a shift toward recognising menstrual health as a public and human rights issue, with explicit government commitment to tackling period poverty and promoting dignity.	"The two most recent developments in national government policy regarding menstrual health and hygiene are the issuing of the Sanitary Dignity Framework and zero-rating menstrual pads for Value Added Tax" (Davidson 2022a, 2)
	Hardly	Before these recent developments, menstruation was barely addressed at the national level. Government policy was fragmented, with little to no coordinated action from the Ministries of Health or Education, and no national policy framework in place. Menstrual health was often overlooked in both health and education sectors, leaving gaps in support and perpetuating stigma.	"Prior government policy was fragmented at the provincial level and there was no national policy" (Davidson 2022a, 1)

1.3 a) Presence of MHM Education plan	Present Absent	A MHM education plan is present, as MHM/Sexual Education is included in Life Orientation which is part of the curriculum. Nevertheless, it is questionable how comprehensive and detailed this education plan actually is.	"Respondents described that educators from Life Orientation/Life Skills and Natural Sciences classes provided education on menstruation and related topics. They described that Learner Support Assistants were available to assist with menses related queries. In some instances, external NGOs provided education on menstruation in the schools" (Beksinska 2023, 11)
1.3 b) Inclusion of MH trainings plan for teacher	Included (0) Not Included	There is no official, nationally standardised teacher training material on MHM produced specifically by the South African Department of Basic Education for all teachers. However, there are several relevant resources and training initiatives available in South Africa such as International and NGO-Developed Training Guides like WaterAid's "Menstrual Hygiene Matters" training guide	Reference (not in Atlas) Mahon, T., & Cavill, S. (2015). Menstrual hygiene matters: Training guide for practitioners. WaterAid
2.1.1 Proportion of schools implementing policy guidelines on menstrual product distribution	High	The results show reports about a high proportion of school distribute menstrual products to intended users in schools, which helps to ensure equitable access and supports families with socioeconomic struggles. Families and mothers seem to rely of the provision of sanitary pads through the school.	"The picture improves slightly in 2020/21 in various ways. All provinces distributed menstrual pads, with every province spending at least some of its budget allocation and four provinces spending their entire budget allocations" (Davidson 2022a, 13) "I buy the pads for my child but on a bad month I rest easy as the school provides them with a toiletry pack (Mother, School J)" (Tamaryn 2020, 8)
	Low	Nevertheless, the distribution of the menstrual products does not appear very consistent and regular. Moreover, there is a dependency on NGOs for the allocation of the pads. Hence, the results for this indicator show a mixed picture. It can therefore be said that the proportion of schools implementing the SDF guidelines seems to vary across the country, and that there is rather a low implementation.	"However, qualitative data demonstrated that the availability of sanitary towels was inconsistent across schools. Some schools had programmes for providing sanitary towels – although the source of the products varied (Government or NGO) according to school and region. In addition, the regularity of supply varied according to school and provider" (Beksinska 2023, 17)
2.2.1.1. Presence of specific strategies in policy documents	Present	South Africa's approach to menstrual product provision is anchored in national policy and standards, with government-led and NGO-supported delivery. The SDF indicates that there are specific delivery strategies.	"The Framework sets out clear functions for all committees except the inter-ministerial committee" (Davidson 2022a, 10)

that outline tailored delivery methods for schools			"Sanitary products must be distributed by the person or persons designated by the relevant programme implementation department. Municipal councils, schools, and clinics may be used as distribution centres of sanitary products to indigent persons and for this purpose." (DWYPD 2019, 23)
	Absent	There is a lack of clarity regarding the distribution of the menstrual products. Moreover, the actual availability of sanitary pads in schools seems to be inconsistent and limited.	"The plans, except for the procurement standards, lack detail. For example, the access to sanitary products section provides no clarity on how many products should be provided to recipients, how often they should receive these products or even what products should be provided" (Davidson 2022a, 8) "The regularity of supply varied according to school and provider" (Beksinska 2023, 19)
2.2.2.1 Presence of strategies that detail partnerships with schools for the delivery of MHM education	Present	The SDF shows different strategies on how to deliver MHM education, whether it is through the national curriculum or awareness campaigns. Moreover, there are partnerships mentioned that seem to detail MHM education for schools in South Africa.	"The recommended method outside the designated education curriculum includes but is not limited to education and awareness campaigns. Such campaigns should provide information on menstruation, sanitary dignity, sanitary products, and health aspects" (DWYPD 2019, 13) Partnership with Care and Support for Teach and Learning Programme: "Ensuring sanitary dignity to girls and young women in schools, which includes […] menstrual education and awareness (CSLT priority area of health promotion), fall within or would support the DBE package of non-negotiable minimum services that should be provided to South African schools." (DWYPD 2019, 14)
	Absent	Some researchers criticise that the SDF is not including education and awareness enough. Thus, this indicator is not fulfilled.	"The South African approach is however criticised as narrow considering that it only focuses on preserving girls' self-esteem through the provision of sanitary materials" (Chirambo 2020, 24)
2.2.2.2 Inclusion of	Included	The SDF points out the importance of including gatekeepers. Especially	"Education on sanitary dignity must be extended to include educators,

strategies in policy documents for engaging gatekeepers in addressing social norms		community leaders could play a crucial role in changing social norms.	men and boys, families, communities and community leaders and civil society in general. There are numerous myths and unsubstantiated taboos that have to be addressed" (DWYPD 2019, 13)
	Not Included	As highlighted in 2.2.2.1, the SDF is criticised for not including enough other aspects besides the provision of sanitary pads. Therefore, it can be said, this indicator is not fulfilled and strategies for engaging gatekeepers in addressing social norms are absent, as the SDF is not including the demystifying of menstruation and taboos comprehensive enough.	See 2.2.2.1 Absent
3.1.1 a) Access to quality menstrual product	High Accessibility	The Sanitary Towel Programme can enable girls from lower socio-economic backgrounds to go to school during their menstruation.	„They felt that access to the products would enable girls, especially those from lower socio-economic groups, to continue attending school throughout menses "(Beksisnka 2023, 17)
	Low Accessibility	However, there still is a low access to MHM products especially for girls from poor communities. Moreover, other marginalised groups such as disabled girls fight with the lack of sanitary products. The SDF is currently limited to specific target groups. Following, the policy is not accessible for all girls in need of free period products.	"These studies revealed that many girls, especially in poor communities' lack access to sanitary materials and alternatively they use cloth, grass, or pieces of the mattress. Often, girls from poor backgrounds lack access to sanitary material" (Chirambo 2020, 46) "The lack of sanitary products during menstruation is regarded as one of the major obstacles faced by under priv- ileged girls, including girls with disabilities and women in South Africa" (Siddiqui 2023, 126) Connected to the SDF Objective: „It is envisaged that the process of implementation will focus on one target group at a time. Targets groups and beneficiaries will be dependent on budget and provincial readiness to implement" (DWYPD 2019, 18) "The proportion of girls in the target group who benefited from the programme is fairly low across all the provinces" (Davidson 2022a, 20)

3.1.1 b) Access to affordable menstrual product	High Financial Accessibility	The introduction of measures such as zero VAT on sanitary pads and student healthcare allowances demonstrates significant progress in reducing the financial barriers to menstrual product access. Additionally, school-based distribution programs have become a key channel, with over a third of female learners receiving products through public or NGO initiatives. These policies and programs directly increase financial accessibility. Where programs are robust, girls benefit from reliable access to products and associated health education	"One of the achievements of this initiative has been the introduction of the Zero VAT rated sanitary pads and a health care allowance of R275 for students" (Chirambo 2020, 24) "Schools emerged as an important site for accessing products, with one third of female learners (33.7%) reporting re- ceiving products from school – either through a public sector school distribution programme or a NGO" (Tamaryn 2020, 6)
	Low Financial Accessibility	Despite these advances, disparities remain. As Davidson notes, the amount spent per beneficiary and the frequency and quality of product distribution vary significantly across provinces. Differences in procurement costs, packaging, and delivery logistics mean that not all girls receive the same level of support, and some regions experience irregular or insufficient supply. This inconsistency undermines the intended impact of national policies and leaves many girls still facing financial barriers to menstrual health management. These findings show that while policy interventions—such as tax exemptions and school distribution—have improved financial accessibility for many, the effectiveness of these measures is highly dependent on consistent, equitable implementation. Where implementation is uneven, financial barriers persist, perpetuating period poverty and its negative effects.	"the spend per beneficiary varies across the provinces. This indicates that what is received by beneficiary of each programme differs. The procurement prices similarly vary across the programmes, as some may include the packaging or delivery costs. Given that the provinces do not deliver the same number of times per year, delivery costs are likely to vary significantly across the provinces" (Davidson 2022a, 22)
3.1.2 a) Access to appropriate MHM education	High MHM education access	The evidence for high access to appropriate MHM education is weak and inconsistent. While some girls report receiving information about menstruation and pad use at school, this is often anecdotal and not representative of broader trends.	"From my primary school, there are people who came and told us about periods, what we should use, what we should do, how we should put our pads" (Chirambo 2020, 42)
	Low MHM education access	Multiple sources highlight that MHM education is not systematically or comprehensively delivered: many curricula focus only on biological aspects, neglecting the psycho-social and practical dimensions essential for effective menstrual	"It is important to note that this implementation plan does not cover access to accurate and timeous information on menstruation. This is an important aspect of menstrual health and hygiene not covered by

		management. Furthermore, teacher preparedness and the quality of instruction vary widely, and some regions or schools only address menstruation reactively, not proactively. As a result, while isolated examples of good practice exist, these do not constitute strong evidence for widespread or equitable access to quality MHM education. This indicator therefore remains unmet at scale, and policy implementation gaps persist, limiting the potential impact on girls' confidence, attendance, and educational outcomes	the Framework." (Davidson 2022a, 8) Western Cape: "They don't always teach us about these things, they only do it when someone brings it us. But they do not usually come out and speak about it" (Chigome 2019, 99)
3.1.2 b) Access to quality MHM education	High MHM education quality	The available evidence does not strongly support high or widespread access to quality MHM education. While some data indicate that a significant number of girls knew about menstruation before menarche, this alone does not reflect the depth, consistency, or empowerment value of the education provided.	"A significant number of girls reported knowledge of menstruation before menarche" (Davidson 2022b, 9)
	Low MHM education quality	In fact, several studies highlight persistent gaps: many girls still experience fear due to limited, inaccurate, or non-empowering information and learners in Gauteng report inconsistent and inadequate sexuality education. Survey results show that fewer than two-thirds of learners had received any education on the menstrual cycle, and a substantial portion did not understand basic biological facts. These findings suggest that, while some progress has been made, access to quality MHM education remains uneven and insufficient. The indicator—high access to quality MHM education—is therefore not robustly met, and policy efforts need to focus on ensuring comprehensive, accurate, and empowering menstrual health education for all learners.	"these studies also report that fear is experienced as a result of limited access to accurate and empowering information about menstruation" (Nomsenge 2024, 67) Gauteng: "All learners highlighted significant gaps in the quality and consistency of the delivery of sexuality education" (Tamaryn 2020, 11) „The survey found that fewer than two thirds of learners (61.1%; n = 203) had been educated on their menstrual cycle and a third of those who had started menstruation did not know which passage the blood passes through" (Beksinska 2023, 2)
3.2.1 Reports about end-user demand for menstrual products in target population		The results indicate that increased end-user demand for menstrual products in the target population is not strongly supported by the available evidence. Furthermore, while some participants report using sanitary pads throughout their menstruation this reflects individual access and preference rather than widespread, program-driven demand. Broader data show that access to products is still limited for	"According to Table 8, the majority of provinces saw a rise in the number of beneficiaries reached in 2020/21. However, this does not reflect improved performance, as four of these provinces reached no beneficiaries in 2019/20 so had not yet implemented the programme. Therefore, only two provinces reached more beneficiaries in the second year, while the remaining

		many girls, with distribution inconsistent and coverage gaps persisting Overall, these findings suggest that policy efforts have not yet translated into a substantial or equitable increase in demand or access for most girls, and the indicator is not robustly met.	three provinces reached fewer. The proportion of girls in the target group who benefited from the programme is fairly low across all the provinces in both financial years“ (Davidson 2022a, 20) “Participants mentioned that they use sanitary pads for the whole duration of menstruation. This is based on availability and personal preference” (Chirambo 2020, 45)
3.2.2 Girls’ participation and attendance in school	a) Number and proportion of girls able to attend and positively enjoy school during menses	The evidence does not support the indicator of increased girls’ participation and attendance in school during menstruation. Multiple sources highlight that many girls remain uncomfortable attending school while on their periods. Fear of leaks, body odor, and the risk of ridicule disrupts their participation in class and school activities. Qualitative findings reveal that menstruating girls often become quieter, less active, and less attentive, with some even leaving the classroom or lying on their desks due to pain or discomfort. Quantitatively, only 6% of surveyed girls reported feeling comfortable going to school during menstruation, indicating that the vast majority experience significant distress and barriers to full participation (Kgware 2016, 25).	„many girls report being uncomfortable coming to school while menstruating” (Davidson 2022b, 9) “The fear of possible leaks, body odour and related ridicule experienced by adoles- cents is said to interrupt participation in various aspects of schooling” (Nomsenge 2024, 67) “When asked how menstruation affects schooling, most girls reported that they become very quiet, and less active and attentive in class when they are menstruating. In most cases, girls lay on the desk or leave the classroom because of menstrual pains” (Chirambo 2020, 62) “In terms of the responses, only 6% of the participants are comfortable going to school during menses, meaning that the majority of the participants suffer a discomfort at school when they are menstruating” (Kgware 2016, 25)
	b) Girls report menses no longer prevents them from enjoying sports, lessons and other activities or attending	The evidence for the indicator is mixed and does not strongly support widespread improvement. In a study across three South African provinces, almost all girls who missed school due to menstruation also missed in-school activities such as sports and drama, with some missing activities up to 23 times in a single term. This highlights that menstrual-related barriers remain significant for many.	Study of 3 South African Provinces: “Learners were also asked about missing in school activities, for example sports and drama, due to MHM reasons and almost all (35/38) of those who reported missing school also said they had missed in-school activities. The range of activities missed in the last term was 1–23 times“ (Beksinska 2023, 13)

	school during menses	However, there are also positive signs: school sanitary towel programs have been reported to improve participation in activities for some girls and a few learners stated they could participate in sports and other activities during menstruation, either because they did not feel restricted or found ways to adapt. Overall, while targeted interventions show promise for some, most girls still face participation barriers during menstruation, indicating that this indicator is not yet achieved at scale.	"School sanitary towel programmes were deemed to have had a positive impact on menstruating girls' participation in activities such as sports, dancing, drama or playing with friends" (Beksisnka 2023, 16) "A few girl learners felt they were able to participate in sports and other activities even when they were menstruating. They did not feel restricted by, or were able to adapt to, their menses in order to continue with everyday activities. One group of girls stated it was better to keep active whilst menstruating" (Beksinska 2023, 17)
4.1 Educational engagement.	a) Reports and proportion of girls completing secondary school	The indicator cannot be supported by the current evidence. While dropout rates in South Africa are alarmingly high, with only 36–40% of learners completing Grade 12 and the majority coming from low socio-economic backgrounds and attending schools with poor sanitation and education quality, the direct link to menstrual health challenges is unclear. Chigome explicitly notes that there is insufficient research and data to determine whether high dropout rates among female learners are specifically due to lack of access to sanitary products or inadequate menstrual hygiene facilities. This means that, although poor school conditions—including those related to MHM—likely contribute to dropout risk, the evidence does not allow us to conclusively attribute low secondary school completion rates to menstrual health barriers alone. Comprehensive data and targeted research are needed to clarify the relationship between MHM access and educational attainment for girls in South Africa.	„The reality in South Africa is that, as reported in 2015, over 75 per cent of learners in the country are from families of low socio-economic status and attend schools which offer poor sanitation-related services, poor quality education and thus perform poorly (Spaull, 2015:37). Furthermore, it is these learners attending such schools who are at the highest risk of dropping out of school" (Chigome 2019, 53) „In 2013, only 40 per cent of those learners who started school 12 years earlier passed Grade 12, while the following year, this figure fell by a further 4 per cent to 36 per cent. The figures effectively indicate that approximately 60 per cent of South African learners are dropping out of the schooling system with no qualification" (Chigome 2019, 53) However,: "In South Africa there is insufficient research and data to indicate whether these high dropout rates, particularly amongst female learners, are a result of a lack of access to sanitary dignity products, and inadequate menstrual hygiene facilities being provided for female learners to manage their

			menses during menstruation" (Chigome 2019, 53)
	b) Number and proportion of girls reporting attending school	The coding process has shown that absenteeism among schoolgirls during menstruation is driven by a complex set of factors—not just the availability of sanitary pads, but also the quality of WASH facilities, pain management, sociocultural norms, and emotional factors like fear and stigma. While studies show that providing sanitary products can significantly reduce absenteeism (for example, an 85% improvement in attendance in one Johannesburg study and lower absenteeism where girls have enough products), other evidence highlights that schools with better WASH facilities—such as gender-sensitive toilets and access to water—see even greater reductions in absenteeism. However, measuring the exact impact of these interventions is challenging due to the lack of nationally representative data and the difficulty of isolating menstruation-related absences from other causes in high-absenteeism contexts. For instance, more than half of schoolgirls in some studies missed school due to a combination of these factors, not just product shortages. In summary, while the provision of sanitary pads is important, reducing absenteeism requires a holistic approach that also addresses WASH infrastructure, menstrual pain management, stigma, and supportive school environments. Focusing on just one aspect—like product provision—will not fully resolve the issue of menstruation-related school absenteeism.	„It is important to acknowledge that estimating a causal relationship faces many challenges. For example, measuring absenteeism and the factors that drive it is difficult. Another issue is the lack of detailed and nationally representative data on menstruation" (Davidson 2022a, 4) "A study conducted in Gauteng in 2018 showed that 46% of girls who did not have enough products for every period were more likely to miss school than those with sufficient products (22%)" (Siddiqui 2023, 125) "A study conducted in Eldorado Park, Johannesburg, showed 85% improvement in school attendance with availability of sanitary products" (Siddiqui 2023, 125) "As I'm saying, arrival of the supply of product helped us, they use to be absent from school a lot back in the days. You'd nd that a person would be scared to come to school because they don't have things to help them [sanitary products], but now since they have been receiving it, they no longer miss school" (Beksinska 2022, 15) "schools that offer free sanitary towels, gendered ablution facilities and water have less incidences of absenteeism by girls than those that do not have facilities to cater for girl children's needs" (Ngomane 2023, 305)
	c) Reports and proportion of girls describe feeling confident and motivated to achieve in school	The indicator—number and proportion of girls describing feeling confident and motivated to achieve in school—is supported by some evidence but remains closely tied to broader issues of absenteeism and academic performance. Davidson highlights that increased absenteeism and lower concentration due to	Connected to broader issue: „This increase in absenteeism and lower concentration levels at school at the individual level, often leading to poor academic performance34 and consequent lower grade retention – has broader societal costs. Grade repetition is estimated, by van der Berg et al. (2019), to have cost the

		menstrual challenges can lead to poor academic outcomes and significant societal costs, such as high rates of grade repetition. However, targeted interventions show promise: a study in Eldorado Park, Johannesburg, found that providing sanitary products led to a significant increase in girls' self-esteem and confidence to attend school during menstruation. This suggests that access to menstrual products can directly improve girls' confidence and motivation, positively impacting their educational engagement. Still, these findings are context-specific and more comprehensive data are needed to confirm widespread effects.	government approximately R20 billion in 2018 (based on a conservative estimate of 1 180 000 learners repeating in 2018)" (Davidson 2022a, 4) "A study conducted in Eldorado Park, Johannesburg, […] showed a significant increase in self-esteem and confidence to attend school while menstruating" (Siddiqui 2023, 125)
4.2 Dignity in managing menstruation	Presence of reported improvements in social participation and reduced stigma or discrimination related to menstruation	The evidence does not strongly support the indicator of increased dignity in managing menstruation, as there are persistent reports of stigma, fear, and social exclusion (See 4.2 No Presence of reported improvements).	
	No Presence of reported improvements in social participation and reduced stigma or discrimination related to menstruation	Studies show that male teachers and male students are often sources of ridicule and discomfort for menstruating girls, leading to heightened anxiety and a reluctance to attend school. Fear of being identified as menstruating and subjected to public shame or disgust remains a common reason for girls' absenteeism. Furthermore, deep-rooted sociocultural beliefs and taboos around menstruation continue to shape negative experiences for girls, despite increased attention and interventions in recent years These findings indicate that, while some progress may have been made in policy and awareness, significant barriers to dignity, social participation, and stigma reduction remain. The indicator is therefore not robustly met, highlighting the need for more comprehensive, community-wide efforts to address cultural attitudes and ensure a supportive environment for all menstruating girls.	„Male teachers and male learners featured prominently in reports about adolescent girls' experiences of menstruation and related fear and discomfort, with two studies identifying male learners as a source of ridicule for adolescent girls, leading to heightened anxiety and discomfort while at school" (Nomsenge 2024, 67) „Fear of being identied as menstruating and especially of being the object of public shame, ridicule, or disgust were commonly stated reasons for not wanting "to be seen by others" and therefore missing school" (Beksinska 2023, 15) "Qualitative research conducted in South Africa at the height of increased menstrual research and interventions globally has demonstrated that ideologies and sociocultural belief systems continue

			to pervade aspects of the experience of menstruation" (Nomsenge 2024, 73)

10.7 Comprehensive Comparative Evaluation Table

ToC Component	Kenya (MHM Policy)	South Africa (SDF)
Context	• Early Adopter • Strong legislative Framework • High Rates of Period Poverty • Challenges such as Stigma, Limited information, and Inadequate school facilities	• Late Adopter • Existing legislative framework • High Rates of Period Poverty • Challenges such as Stigma, A Lack of WASH facilities and Inadequate school facilities
Foundational Element	• High Stakeholder Input • Highly addressed throughout ministries • Comprehensive education plan & teacher training	• Stakeholder Input but Coordination Challenges • Starting to be addressed more frequently • No teacher training material
Scale-Up activities	• Low school implementation • Strong regional differences • No strategies for delivery (Counties responsible) • Multi-stakeholder Strategies for delivery of MHM education • Extensively addresses role of gatekeepers in changing social norms	• Higher school implementation distribution • Inconsistent distribution & Dependence on NGOs • Presence of Delivery strategies but lack clarity • Some partnerships but MHM education is generally not prioritised • Role of gatekeepers addressed but criticised for being too narrow
Outcomes	• Limited Accessibility (influenced by socioeconomic & geographic factors) • Low Financial Accessibility • Some best practice cases but overall sporadic and insufficient MHM education • High End-User demand but limited reach • Some improvements when interventions are effectively implemented (but Inconsistent reach of interventions)	• Limited Accessibility (especially for marginalised groups) • Progress in Enhancing Financial Accessibility but disparities across provinces • Access to MHM education remains insufficient • High End-User demand but limited reach • Some positive examples but Menstrual-related barriers remain high (girls still feel uncomfortable and tend to participate less)

Impacts	• Low girl´s secondary school completion rates interlinked to MHM challenges • Large-scale studies about absenteeism are missing but context-specific evidence supports improved attendance since MHM interventions • Some evidence of empowering effects of MHM on girl´s educational experiences • Some Progress in reducing stigma and but still a long way to overcome deep-embedded socio-cultural taboos	• Poor MHM conditions linked to dropout (especially for socio-economic disadvantaged girls) • Large-scale studies about absenteeism are missing but context-specific evidence supports improved attendance since MHM interventions • Reason for MHM related absenteeism difficult to isolate and measure • Issues regarding data availability but targeted interventions show promise • No real Progress in reducing stigma (persistent taboos)