MENSTRUAL HEALTH AND HYGIENE SITUATION AMONG SCHOOLGIRLS IN TANZANIA

Brief report on MHH situation among school girls with disabilities
Background

Menstruation is an integral part of a woman’s reproductive life, occurring naturally in pubescent girls and women. It is estimated that menstruation is experienced by about one-quarter of the global population. Women spend a significant proportion of their lives menstruating. However, despite being an important issue, MHH is often overlooked, especially in low-income countries due to limited resources and existing cultural factors, beliefs, myths and taboos. Millions of adolescent girls worldwide are denied the right to manage their monthly menstrual cycle in a dignified and healthy way. Girls with disabilities are even more affected during menstruation as compared to the rest of the population.

Methods

An exploratory study using quantitative and qualitative data collection techniques was conducted in 19 districts of the United Republic of Tanzania (URT) between February and September 2019.

Key findings related to girls with disability

Knowledge, attitude and practices towards MHH

Overall, the mean knowledge score on MHH among girls with disabilities in Tanzania was 66.1 per cent, with the majority of them demonstrating moderate level of knowledge (68.8 per cent, n=141). Almost three-quarters of these girls had a negative attitude towards MHH and over two-thirds were found to follow poor practices during menstruation. About 19.3 per cent (n=39) of the students with disabilities missed school due to menstruation in the past three months before our visit. Broadly, participants in the qualitative interviews agreed that menstruation reduces the academic performance of girls with disabilities through:

1. Reduced class attendance due to the advice from their school nurse in circumstances requiring rest, especially if these girls experience heavy menstruation and
2. Reduced attentiveness during lessons due to discomfort during menstruation such as severe abdominal pain and unavailability of durable sanitary pads which reduces comfort during lessons.

Sociocultural norms

While girls with disabilities did not emphasize religiously constructed norms, they were undoubtedly affected by socially constructed norms related to social engagement, exercise
and touching (SET) taboos during the menstrual cycle. Social engagement taboos include prohibitions from engaging with other members of the society during menstruation, for instance, not meeting with elder sisters. Immaturity was given as a justification to protect the girls with disabilities from learning bad manners and behaviours. Exercise taboos included avoidance of activities that involve energy consumption such as carrying out heavy work and walking for a very long time. Touching taboos include restrictions on touching cooking vessels, eating liquid foods like tea or porridge, touching leaves and vegetables, touching rainy water and water in boreholes during menstruation. Prohibitions on touching leaves and water in boreholes appear to be constructed around the beliefs that menstruation is a curse that will cause leaves to wither or borehole sources to go dry.

**Stigma related to MMH**

Girls with disabilities revealed in focus group discussions indicated that no negative attitude exists towards them in relation to menstruation. However, in-depth interviews showed that visually impaired girls sometimes face social stigma from other girls with disabilities in some special schools because of their unwitting tendency to contaminate the surroundings with menstrual blood as they cannot see. Boys with disabilities appear to be sympathetic towards girls with disabilities in not stigmatizing them during menstruation compared to boys with no disabilities.

**Gender role in menstruation**

Regarding gender roles, most girls with disabilities said that female friends, family members and some matrons as trustworthy circle of people with whom they can freely talk about menstruation. Male family members were not considered trustworthy in matters regarding menstruation. Furthermore, most parents, particularly fathers, were thought to be unreliable sources of information (compared to female figures – mothers, family members, female friends, and matrons). Being too busy, shying away from discussing menstruation issues with daughters, and untrustworthiness emerged as the reasons for some parents not talking to their daughters with disabilities.

**MHH materials**

The findings further indicated that a few girls with disabilities may have access to free pads in a school environment. However, reusable cloth emerged as the main type of MHM material used at home, while a few had sanitary pads for use at home. This is because some girls with disabilities requested additional sanitary pads to be used at home during school breaks.

**School water, sanitation and hygiene (SWASH) and MHH**

Similarly, few schools for girls with disabilities seem to have friendly WASH infrastructure despite many schools facing notable challenges. One of the key findings is the limitations girls face as a result of their disabilities. Navigating through the WASH infrastructure and inability to wash reusable clothes are barriers that girls with disabilities face. Further, they are impacted by unsustainable supply of sanitary pads and hygienic materials. This calls for continued support from all stakeholders to ensure adequate supply of sanitary pads and also offer support to girls with disabilities for using the WASH infrastructure.
The following broader recommendations are made to the government and all actors working to make sure girls in the country manage menstruation in a hygienic manner.

First, education programme and materials need to be produced with a provision for continued community education and sensitization to increase knowledge and awareness among girls with multiple disabilities so that they develop positive attitudes and adopt good practices towards MHH. SET taboos also need to be addressed as part of awareness through education. Boys and men also need to be sensitized about the challenges girls with disabilities face so that the latter are treated with empathy and dignity during their menstrual cycle.

Second, the government and stakeholders need to design and implement capacity-building strategies within schools to improve SWASH that are also user-friendly to girls with disabilities. SWASH facilities should be suitably designed to keep girls with multiple disabilities in mind so that they can adopt good MHH practices in school. Relatedly, on-the-job training has to be provided to male teachers and parents on how to better communicate with girls with disabilities during menstruation and cascading the trainer of trainer approaches to grassroot levels. This is because lack of awareness and education and sociocultural conditioning around menstruation were cited as major contributors to the male’s disengagement from menstruation generally.

Third, parents and teachers need to be equipped with the evidence-based skills to support and encourage girls with disabilities to continue with studies during menstruation. More specifically, sustainable access to safe and convenient menstrual materials has to be ensured for girls with disabilities through cost reduction, increased local production and mandatory provision of free emergency menstrual materials in schools.

Finally, MHH guidelines and curriculum need to be reviewed and modified to provide more weightage to MHH, especially keeping in mind girls with disabilities.