Vulnerabilities and Capacities in Menstrual Hygiene Management (MHM) and Menstrual Health: A Gendered Perspective

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Abstract
Menstrual hygiene management (MHM) is essential for those who menstruate because they have different needs during disasters and crises. Current MHM is focused on immediate needs instead of longer-term vulnerabilities and capacities. The purpose of this thesis is to examine how gendered vulnerabilities and capacities are considered in MHM policies and practice. The aim is to bring more focus to these vulnerabilities and capacities. This was done by conducting a document analysis with four chosen policies and five semi-structured interviews. A joint analysis was then done to contrast the policies and interviews. Lack of safety, privacy, and possibilities for upholding dignity emerged as a notable gendered vulnerability and community groups emerged as a notable gendered capacity in the contexts of development, disasters, and humanitarian crises. These are utilized in examining how vulnerabilities and capacities are considered in MHM currently. The main discussion in this thesis focuses on addressing root causes of vulnerabilities and the development of community groups further to fully utilize them as a capacity. In addition, the opportunities to make MHM policies and practice more inclusive of gender minorities are discussed. To improve current policies and practice, more focus needs to be put on vulnerabilities and capacities instead of immediate needs in the menstrual health field. More research needs to be conducted on the vulnerabilities and capacities as well as gender inclusion in relation to the menstrual health field.

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Summary

People who menstruate have particular needs during disasters, and thus menstruation hygiene management (MHM) is essential for them. Current MHM practices include for example providing kits, building latrines, and providing educational materials. Menstrual needs and their neglection increase menstruators' vulnerability in humanitarian crises and disasters. Some negatives arising from this are for example anxiety and absences from school. Women and gender minorities are argued to be more vulnerable during and after crises and disasters than men. This is mainly due to women's inferior socio-economic status stemming from cultural, social, and economic factors. The vulnerability of gender minorities on the other hand is a systematic issue due to the lack of research and awareness. Gender vulnerability in society follows a "progression of vulnerability" model; it builds up from root causes, dynamic pressures, and unsafe conditions. Although the notion is that women and gender minorities are more vulnerable, it does not mean that they do not have the ability to cope efficiently. They have skills and capacities that can be utilized in making menstrual hygiene management more successful, but these capacities are not currently utilized in neither MHM nor in wider disaster planning and management. In policy and practice there is still a significant focus on addressing needs rather than vulnerabilities.

This thesis looks at how gendered vulnerabilities and capacities are considered in MHM. It identifies the opportunities and challenges for decreasing vulnerabilities and increasing capacities in menstrual health policy and practice. Menstruation is still a taboo topic, but it has started to gain more attention in the past decade in the development, humanitarian, and disaster fields. The overarching aim is to bring more focus to the vulnerabilities and capacities, instead of the immediate needs that have received a great amount of attention for the past decades. The policies are contrasted with experiences and opinions from practitioners in order to find opportunities for improvement. This was done by conducting a document analysis with four chosen MHM policies and five semi-structured interviews with practitioners. Documents and interview transcripts were coded using NVivo. After the coding, a joint analysis was done to contrast the contents of the codes. Three limitations are addressed: the chosen policies only include ones that are publicly available online, the interview sample size is small and full saturation was not reached, and previous interview questions influenced answers for following questions.

The analysis in this thesis shows that one gendered vulnerability and one gendered capacity are central to MHM policies and practice. The former one is the lack of safety, privacy, and possibilities for upholding dignity and the latter one is community groups. Moreover, the analysis has identified the following challenges for decreasing vulnerabilities and developing capacities in MHM: context specific nature of taboos and beliefs as well as materials and practices, overall inclusion of gender minorities and men in MHM, and the lack of recognized capacities. The main discussion in this thesis focuses on addressing root causes of vulnerabilities and the development of community groups further to fully utilize them as a capacity. Both opportunities and challenges exist in addressing underlying causes of vulnerabilities in MHM policy and practice. Similarly, community groups could be utilized as an entry point to change the discourse on menstruation, but there are existing negative aspects that need to be addressed. Furthermore, there are opportunities to make MHM policies and practice more inclusive to gender minorities with a focus on vulnerabilities and capacities. Realizing these opportunities could contribute to the improvement of future policies and menstrual health and MHM response overall. In the future, more research needs to be conducted on the root causes of vulnerabilities, developing community groups as a capacity, and including gender minorities in menstrual health policies and practice.

Abbreviations

CADRI – Capacity for Disaster Reduction Initiative

CVA – Capacities and Vulnerabilities Assessment Framework

DRR – Disaster Risk Reduction

IFRC – International Federation of Red Cross and Red Crescent Societies

JMP – Joint Monitoring Programme

LGBT – Lesbian, Gay, Bisexual, and Transgender

MHH – Menstrual Health and Hygiene

MHM – Menstrual Hygiene Management

OCHA - United Nations Office for the Coordination of Humanitarian Affairs

PGI – Protection, Gender, and Inclusion

SRA – Social Research Association

UNICEF – United Nations Children's Fund

WASH – Water, Sanitation, and Hygiene

WHO – World Health Organization

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1 Introduction

Women, girls, and other people who experience menstruation have different needs during a disaster to those of who do not experience this (Ariyabandu, 2009). Menstruation needs are possibly the most evident difference when looking at immediate needs in humanitarian and disaster contexts. Menstrual hygiene management (MHM) is thus essential for those who menstruate (Sumpter & Torondel, 2013). Needs relating to menstruation include materials and their disposal, access to water and latrines, and information and education (Sommer, 2012). Neglecting these needs can lead to for example anxiety and fear, shame, reproductive tract infections, and absences from school (Winkler & Roaf, 2014; Sumpter & Torondel, 2013). Menstrual needs and their neglection increase menstruators' vulnerability in humanitarian crises and disasters (Sommer, 2012). While the inclusion of menstrual hygiene in response and recovery has gained attraction in the past few decades, there are still flaws and gaps in MHM policies that are reflected in practice, for example that MHM practices are not well integrated into immediate response activities (Sommer, 2012; Sommer et al, 2016).

MHM has historically been a neglected and overlooked need in preparedness and relief efforts. The main reasons for this according to Sommer (2012) are the following. Firstly, MHM has historically been perceived as a Water, Sanitation, and Hygiene (WASH) issue and has not had its own significant development separate from that. Thus, menstruation is also currently dealt with as a material and technical issue rather than a more holistic issue (Bobel, 2019). Secondly, the WASH sector has in the past been predominantly run by men who have, intentionally or unintentionally, ignored menstrual needs due to lack of personal experience. This clearly leaves out women and gender minorities who this issue concerns and who understand the extent of it. Thirdly, those who work in the field with immediate lifesaving needs might not have received training or orientation that would have regarded MHM in belonging to this category and have thus not considered it in their work. This has an implication for how menstrual health is not considered to be worthy of acknowledging vulnerabilities and capacities relating to it. Finally, the topic is often uncomfortable to discuss and ask about by all genders due to it being a taboo in many cultural contexts. Further, relating to the taboo nature of the topic menstruating persons are unlikely to ask for aid for menstrual needs without external prompting. Therefore, the acknowledgement that people experience issues relating to menstruation goes overlooked and makes it a low priority in the eyes of policy makers (Winkler & Roaf, 2014).

MHM is a concept applied in development, humanitarian, and disaster contexts. The policies regarding menstrual hygiene management are meant to offer guidance on MHM matters to practitioners in these contexts. In the past decade there has been a focus to create manuals specifically dedicated to MHM to guide menstrual hygiene management response possibly in an effort to address the past absence of MHM (VanLeeuwen & Torondel, 2018). More commonly, MHM has been and is included in WASH manuals as a separate section. Some common criticisms and gaps in policies regarding MHM include the lack of the following: external dissemination, guidance on timing for introducing MHM interventions, culturally adapted interventions, and designation of sectoral responsibility for leadership (Sommer et al., 2016). These can also be identified in the policies analyzed for this research. There has been a call for more evidence-based research to improve MHM guidelines (VanLeeuwen & Torondel, 2018). In practice, MHM is more recently tightly linked to Protection, Gender, and Inclusion (PGI) sectors, in addition to the already mentioned WASH sector connection (Sommer, 2012).

1.1 Background

Studies have shown that gender is a factor that directly affects people's vulnerability in humanitarian crises and disasters (Fothergill, 1996). In general, women and gender minorities are argued to be more vulnerable during and after crises and disasters than men (Ashraf & Azad, 2015; Gaillard, Sanz, Balgos, et al., 2017). Generally, women's increased vulnerability is due to cultural, social, and economic reasons that construct women's inferior socio-economic status (Ashraf & Azad, 2015). In more detail, Fothergill (1996) discusses women's heightened risk in disasters that stems from gender inequality and in consequence from their social roles, and lack of mobility. Gaillard, Gorman-Murray, & Fordham (2017) write about how the vulnerability of gender minorities on the other hand is systematic stemming from the lack of research and awareness and the absence of acknowledgement in disaster risk reduction (DRR) policies. They argue that gender minorities are more severely affected due to lack of access to same means of protection as men and women have.

Robert Stoller was one of the first researchers to separate sex from gender as a concept in 1968 and introduced the term 'gender identity' (Green, 2010). Although he acknowledged that gender identity is how people view and sense themselves while sex refers to biological parts, he was referring to gender identity in a binary fashion of men and women (Green, 2010). In current literature and research, gender is still often defined binarily as the social roles that women and men hold in society (Enarson & Chakrabarti, 2009). These roles are a social and a cultural construct shown in societies through gendered identities, perceptions, attitudes, and

status (Ariyabandu, 2009). This leaves out the current view of gender where gender identity is not binary. Gender minorities are defined as "Individuals whose gender identity (man, women, other) or expression (masculine, feminine, other) is different from their sex (male, female) assigned at birth" (CDC, 2019). In this thesis, gender is referred to as a wider concept, consisting of the social roles of men, women, and gender minorities. This is done to not contribute to the binary view of gender that is becoming more and more irrelevant in current society. Even though the focus of this thesis is not to discuss gender as a concept, this is important to understand when proceeding to include gender minorities who menstruate and discussing their vulnerabilities and capacities. When it comes to menstrual health and MHM, it is important to focus also on gender minorities because they include those who menstruate and require the same attention as women who menstruate.

The vulnerabilities and needs of women are overlooked before a disaster as well as during and after a disaster (Enarson & Chakrabarti, 2009). According to Enarson and Fordham (2001, as cited in Gaillard, Sanz, Balgos, et al., 2017), this issue has been addressed in the twenty-first century with strong advocacy for the vulnerability paradigm and incorporating and considering women in DRR policies and practice. Gender minorities face this same issue. Their vulnerabilities get overlooked and their needs go unmet (Gaillard, Sanz, Balgos, et al., 2017). There has been an uptick in highlighting the experiences of lesbian, gay, bisexual, and transgender (LGBT) people in disasters (Dominey-Howes, Gorman-Murray, & McKinnon, 2014, as cited in Gaillard, Sanz, Balgos, et al., 2017). Although these studies are extremely important in bringing attention to the negative effects of heteronormative DRR on non-heterosexual persons, Gaillard, Sanz, Balgos, et al. (2017) point out that this is not the complete picture of gender minorities in disaster situations. According to them, to better address the vulnerabilities of these groups, their participation should be fostered in DRR policies and practice.

A "progression of vulnerability" model that Wisner et al. (2003, pp.51,87) suggest is useful when analyzing vulnerability, gendered vulnerabilities included. They build up from root causes, dynamic pressures, and unsafe conditions (Wisner et al., 2003). When it comes to vulnerability, there are five dimensions that have been identified overall. These five dimensions are cultural, physical, political, economic, and social dimensions (Ariyabandhu, 2009; Enarson, 2012; Enarson & Chakrabarti, 2009; Fordham, 2003; as cited in Yumarni, 2014). McEntire (2001) adds a sixth category of technological dimension. Gender in itself, in addition to other organizing principles, is not disturbed by crisis or disasters; it remains operative during these

in times even if gender roles change (Alway et al., 1998). Thus, it can be concluded that gender-related vulnerabilities and capacities are also still present in crises and disaster situations.

Even though these vulnerabilities are somewhat considered in MHM policy and practice, there is still a significant focus on addressing the aforementioned immediate needs (VanLeeuwen & Torondel, 2018). This has been criticized by researchers, most notably Chris Bobel who wrote a book on MHM. Bobel (2019, p.10) writes: "What a girl needs most is not products (or education about products), but to be freed from the menstrual mandate." This refers to the MHM connection with WASH where the focus is on menstrual products. The focus needs to be shifted from the products to changing the current discourse on menstruation that Bobel (2019) refers to as the menstrual mandate. The change is necessary because the current discourse centers around shame, secrecy, and silence (Bobel, 2019).

According to March et al. (1999), the difference between vulnerabilities and needs is that needs are immediate necessities to survive or recover from a disaster while vulnerabilities exist already before disasters and are longstanding. Therefore, the ways to address these are different; needs are met with short-term and practical solutions while vulnerabilities require long-term and strategic interventions. When designing and implementing interventions for long-term change, capacities are considered because building on these strengths has the potential to achieve sustainable change and development and thus reduce immediate needs (March et al., 1999). Focusing on long-term qualities is a step towards changing the discourse on menstruation and menstrual health.

Although the notion is that women are more vulnerable, it does not mean that they do not have the ability to cope efficiently (McEntire, 2011). Women have skills and capacities that can be utilized in making menstrual hygiene management more successful, but these are not currently employed in neither MHM nor in wider disaster planning and management (Ariyabandu, 2009). Gaillard, Gorman-Murray, & Fordham (2017) discuss the same issue of unrecognized capacities of gender minorities in disaster risk reduction policies and practice. This is demonstrated by the fact that women and gender minorities are less represented in DRR practices, decision making processes, as well as in roles having to do with leadership and high-level emergency management (Ashraf & Azad, 2015; Fothergill, 1996; Gaillard Sanz, Balgos, et al., 2017). There is a consensus in current emerging DRR literature concerning this topic that women and gender minorities should not be just seen as powerless victims and should actually

be included in DRR practices and planning to create change and address power inequalities (Ashraf & Azad, 2015; Gaillard, Sanz, Balgos, et al., 2017; Ginige et al., 2014).

1.2 Purpose

This thesis focuses on the gendered vulnerabilities and capacities present in menstrual health and menstrual hygiene management in development, disaster, and humanitarian contexts. It is a topic that has started to gain more attention in the past decade, but it is still a taboo and a restricted subject. Thus, it is still important to raise more awareness about the topic and its challenges in the development, humanitarian, and disaster fields. The overarching aim is to bring more focus to the vulnerabilities and capacities rather than the immediate needs that have received a great amount of attention for the past decades. Focusing on vulnerabilities and capacities has the potential to create long-term change in terms of improved menstrual health in humanitarian and disaster contexts, as well as in terms of preparedness.

The purpose of the thesis is to investigate how gendered vulnerabilities and capacities are currently considered in both the policy and the practice side of MHM. The policies are contrasted with experiences and opinions from practitioners in order to find opportunities for improvement. This is crucial in developing better menstrual health policies and in consequence improving practices in the field. There is potential to take the menstrual health field forward in a more inclusive and sustainable way.

1.3 Research question

This thesis aims to answer the following research questions:

- *How are gendered vulnerabilities and capacities considered in MHM global policy and practice?*
- *What opportunities or challenges exist to decrease the vulnerabilities and develop the capacities in menstrual health policies and practice?*

2 Conceptual Framework

It is necessary to introduce some key concepts which are central to this thesis and will be discussed throughout the work. First, the concepts of menstrual hygiene management (MHM) and menstrual health are discussed. Secondly, the Capacities and Vulnerabilities Assessment Framework (CVA) will be used to present the concepts of gendered vulnerabilities and

capacities. Thirdly, social norms and the concepts of taboos, beliefs, and dignity will be explained.

2.1 Menstrual hygiene management and menstrual health

Efforts within the menstruation sphere are currently framed and measured in menstrual hygiene management (MHM), especially in the international development and relief fields (Sommer, 2012; Thomson et al., 2019). MHM reaches across all processes of the disaster cycle, and it has different definitions with varying amounts of detail and points of emphasis. The three main aspects identified in the different definitions are: sanitary materials, access to latrines, and means of disposal of used materials. As a fourth mention, education about menstruation is often included. Arguments have been made for the inclusion of more aspects into the concept, since the most widely used descriptions are lacking in some areas. The two possibly most used concepts are from the World Health Organization (WHO) and UNICEF's Joint Monitoring Program (JMP) (2019) and from Sommer (2012), full definitions can be found in Appendix 1. These descriptions of menstrual hygiene management are widely recognized in literature about MHM. Sommer's (2012) definition is more comprehensive than UNICEF's. It is expanded to include for example mentions of cultural and environmental appropriateness.

MacRae et al. (2019) proposed a new, more inclusive, definition for adequate MHM (see Appendix 1). The geographical context of their study is Odisha, India, but the suggested definition works universally (MacRae et al., 2019). The definition includes aspects missing from the UNICEF (2019) and Sommer (2012) definitions such as social support, pain management, and enabling sociocultural environment. However, even this definition is still not as inclusive as it could be. All three of these MHM definitions talk about "women and adolescent girls" leaving gender minorities out of the definition which is problematic when considering the implementation of policy that uses these definitions. This is a good example of the previously mentioned issue of excluding gender minorities in DRR policies, leaving them more vulnerable in crises.

To combat some of the issues, two other concepts have been created. The first alternative concept is menstrual health and hygiene (MHH) from UNICEF (2019), which is an attempt to include other "systematic factors" relating to menstruation such as health, education, empowerment, and rights (see Appendix 1). However, this concept — although adding some additional aspects — is still lacking. The second concept originates from an article published

in 2021 that gives a definition for the emerging concept of menstrual health, which had started to be used in advocacy, programming, research, and policy, but lacked a consistent definition (Hennegan et al., 2021). The full definition can be found in Appendix 1. It adds the need for "accurate, timely, age-appropriate information," "timely diagnosis, treatment, and care," "positive and respectful environment," and "decide whether and how to participate in all spheres of life" relating to and during the menstrual cycle (Hennegan et al., 2021, p.2). This concept expands what MacRae et al. (2019) attempted with the concept in their research paper. Hennegan et al. (2021) discuss why there is a need for new terminology to replace MHM. The reasoning touches upon similar criticisms presented in this thesis. It includes the elimination of the term "hygiene," which is connected to the idea that menstruation is something "dirty" or "polluting" discussed in section 2.3. The second reason is to include more than just the bleeding aspect of menstruation since there are social and psychological factors relating to the experience. The third reason is to incorporate gender-diversity into the field.

Due to this research taking place in the humanitarian, disaster, and development literature sphere, the widely spread term of menstrual hygiene management (MHM) is still used throughout wherever necessary. The reasoning for this is the familiarity and wide usage of this term in the past and present. For example, searching for the policies for analysis required the use of MHM. Further, MHM was used during interviews for the interviewee's assumed acquaintance and work history with the term. Menstrual hygiene is then used wherever appropriate and where the use of MHM is not justified.

2.2 Gendered vulnerabilities and capacities

This thesis utilizes the definitions of capacities and vulnerabilities offered in the Capacities and Vulnerabilities Assessment Framework (CVA) as presented in March et al. (1999). The concepts from the CVA are as follows (March et al., 1999). Capacities are defined as existing strengths that are constructed over a period of time by individuals and social groups. They are connected to material, physical, and social resources as well as attitudes and beliefs. Vulnerabilities are existing weaknesses of individuals or social groups. They are factors relating to physical, social, environmental, and economic qualities that hinder the ability to cope with disasters and emergencies and they make individuals and social groups more prone to disasters. Vulnerabilities have an effect throughout the whole timeline of a disaster — they are there before, they determine the severity of impact, they hinder disaster response, and remain afterwards (Wisner et al., 2003). Vulnerabilities have also been defined in a multitude of other ways, for example, they have also been described through capacities as McEntire (2011)

explains. He writes that they can be seen as the capacity to cope with, recover from, and adapt to exposure to hazards and external stress. In this interpretation, vulnerabilities and capacities are two sides of the same coin. This is an important view to understand the factor that vulnerable people have capacities and are not only powerless victims.

The CVA is a gender framework created by Harvard University in a research project called "*the International Relief and Development Project*" in 1989 and was intended to be used in humanitarian interventions and disaster preparedness (March et al., 1999). The framework has originated from the book which the research inspired called "*Rising from the Ashes: Development Strategies in Times of Disasters*" (Anderson & Woodrow, 1989, as cited in March et al., 1999), but the information for this thesis is compiled from a book "*A Guide to Gender-Analysis Frameworks*" by March et al. (1999), a collection of gender-analysis frameworks. The CVA is based on the idea that relief interventions should in the long-term reduce people's vulnerabilities and increase their capacities (March et al., 1999). According to the framework, capacities and vulnerabilities are a determinant in how people and social groups respond to a crisis and the impact of crisis on them (March et al., 1999).

Talking about gendered vulnerabilities and capacities refers to separating these based on gender. The reasoning for this in the framework — although done binarily — is the notion that people experience hazards differently based on gender roles and they possess different needs (March et al., 1999). This is crucial for understanding menstruation in humanitarian and disaster situations where those who experience this has different needs to those who do not, as mentioned previously. Thus, when looking at MHM and menstrual health policies and practice, it is important to recognize the vulnerabilities and capacities as gendered.

2.3 Social norms - taboos, beliefs, and dignity

Social norms affect the way menstruation is talked about and handled in societies. Social norms are defined as "Common standards within a social group regarding socially acceptable or appropriate behavior in particular social situations, the breach of which has social consequences" (Oxford Reference, n.d.-b). Some concepts relating to social norms and menstruation globally are taboos, beliefs, and dignity.

Taboo is defined by Cambridge Dictionary (n.d.-c) as "a subject, word, or action that is avoided for religious or social reasons." Belief is defined by Colman as "Any proposition that is accepted as true on the basis of inconclusive evidence. A belief is stronger than a baseless

opinion but not as strong as an item of knowledge. More generally, belief is conviction, faith, or confidence in something or someone" (2008, as cited in Oxford Reference, n.d.-a). Different taboos and beliefs about menstruation and hygiene are prominent in many cultures and communities and can be negative, positive, or neutral for effective menstrual health interventions (Gottlieb, 2020). Guterman et al. (2007) looks at what beliefs and taboos are associated with six major religions regarding menstruation. The common theme that they found is that each religion places restrictions on menstruating women. They also observe the consistent idea of impurity and pollution being attached to menstruation across religions. One of the most common practices that both Guterman et al. (2007) and Britton (1996) discuss is exclusion of menstruating persons, or sometimes voluntary seclusion. This is just one example from many practices stemming from taboos and beliefs related to menstruation. It must be mentioned that even though practices can be harmless, many practices related to taboos and beliefs are unsafe for those menstruating (Britton; 1996; Guterman et al., 2007; Thapa et al., 2019). For example, the aforementioned exclusion can be a positive time for relaxation, but its subsequent practices such as lack of hygiene practices can also lead to reproductive health problems (Gottlieb, 2020; Thapa et al., 2019).

In a book published in 1966, Mary Douglas writes about purity and pollution ideas regarding bodies and social interaction. As Guterman et al. (2007) observes, menstrual blood and the act of managing menstruation has widely been seen as a taboo and a polluting factor (Douglas, 1966). Douglas (1966, pp.36,41) defines pollution as "uncleanness or dirt which references matter that is out of place." Thus, the discourse on menstruation is tied to these concepts of dirt, uncleanliness, and mess when it crosses the boundary of the body and becomes "out of place" (Britton, 1996; Douglas, 1966). Taboos and beliefs take effect and certain actions are observed to occur to prevent the pollution from spreading. According to Douglas (1966), beliefs about pollution are used to influence other people's behavior and thus they reinforce social norms, as is the case with menstruation. Because of this, menstruation is kept undisclosed in public in many cultures. Karen Houppert (1999 as cited in Bobel, 2019, p.9) refers to this as "culture of concealment."

Dignity refers to a quality that can be possessed; the importance and value of an individual that demands respect from others and the person themselves (Cambridge Dictionary, n.d.-a). If possessing this quality successfully, one is meeting the social norms in a community and their treatment is based on this quality (Gilabert, 2019). The consideration of dignity in MHM interventions is contextualized when looking at the idea of dignity kits that are distributed as a

programming tool often to serve a larger protection purpose than MHM and hygiene kits (IFRC, 2018). Dignity is framed as the basis for all human rights (Gilabert, 2019). There are different challenges in upholding dignity when it comes to menstrual management such as the lack of adequate facilities and materials (Winkler & Roaf, 2014).

3 Methodology

This thesis was conducted by using a mixed method approach using two qualitative data research methods: a document analysis and semi-structured interviews. In theory, mixing two methods allows for a richer data set and the confirmation of results from the two different data outputs (Bowen, 2009). According to him, this allows for better credibility (Bowen, 2009). With both the document and interview analysis, it is possible to establish an idea of the relationship between policy and practice by contrasting and comparing how the written policy coincides or differs from practice.

3.1 Data collection

This section describes how the two qualitative data sets, documents and interviews, were collected. Additionally, the ethical implications of social research are discussed.

Documents

Policy is defined by Cambridge Dictionary (n.d.-b) as "a set of ideas or a plan of what to do in particular situations that has been agreed to officially by a group of people, a business organization, a government, or a political party." The document analysis was conducted using menstrual hygiene management policies. The aim was to find documents that cover guidance on how to conduct menstrual hygiene management actions and practices for practitioners in the humanitarian field globally. The global scope was chosen because context-specific policies often rely on or are influenced by the policies created by humanitarian organizations for wider use, much like practitioners do. In addition, it was an assumption that practitioners will have worked in multiple different contexts and are more familiar with the widely distributed policies created by large humanitarian organizations. The criteria for policies were the following:

- global scope,
- guidance on menstrual health and hygiene on a large scale,
- focusing on multiple aspects of the issue,

- MHM is the focus of the policy,
- include original text.

These policies were found and collected using Humanitarian library and ReliefWeb as main sources. Humanitarian library is a crowd-sourced and community-moderated platform where humanitarian knowledge is shared inter-agency and inter-sector (Humanitarian Library, n.d.). ReliefWeb is a platform provided by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) focusing on humanitarian information collected from over 4000 sources (ReliefWeb, n.d.). For initial searches in both platforms, the search words used were "menstrual hygiene management," "MHM," "menstrual health," and "WASH manual."

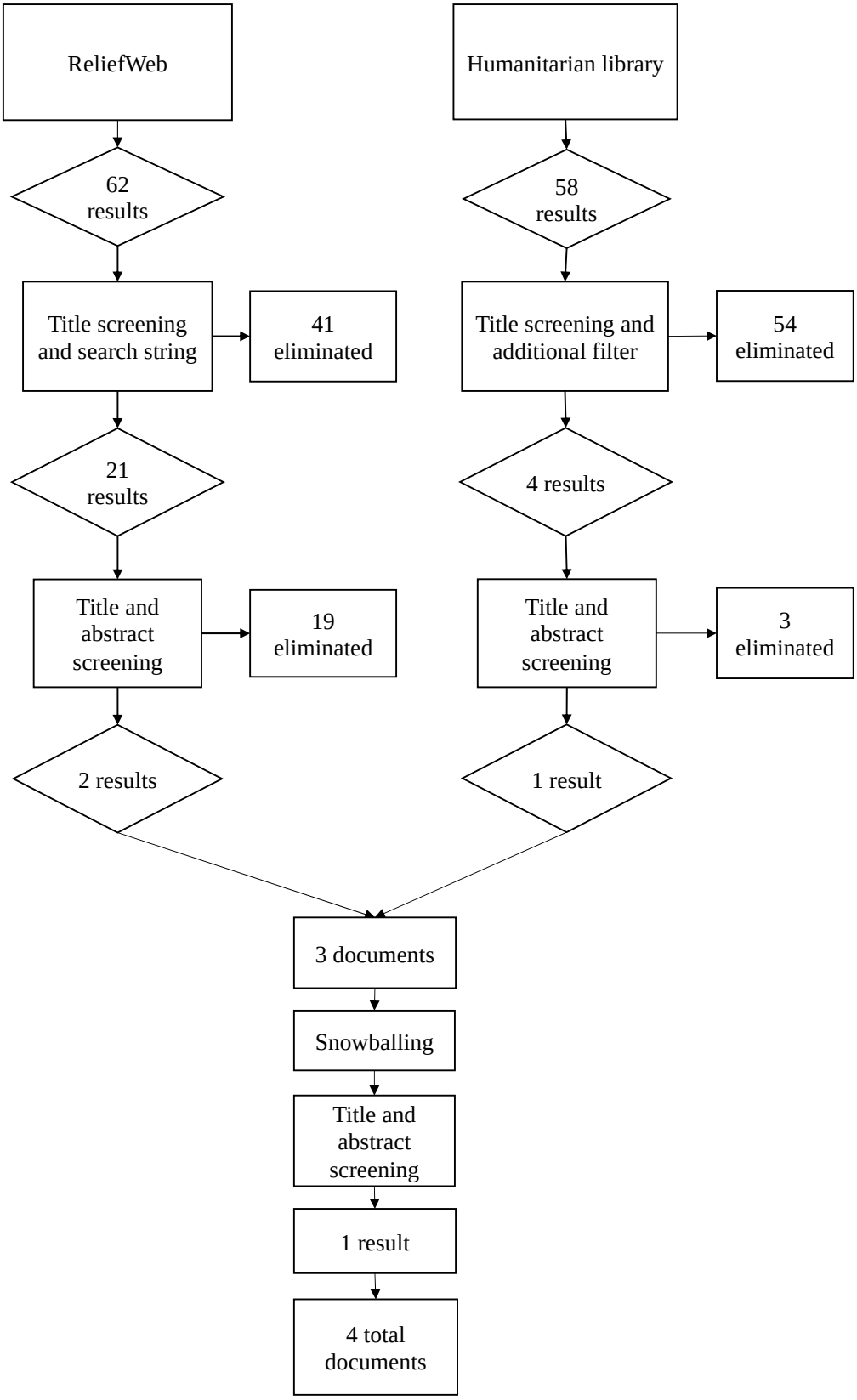

Figure 1. Policy selection process.

Table 1. Four chosen policies for document analysis.

Title	Author(s)	Publisher(s)	Year	Language
A Toolkit for Integrating Menstrual Hygiene Management (MHM) Into Humanitarian Response - The Full Guide	David Clatworthy, Margaret Schmitt, Marni Sommer	Columbia University, International Rescue Committee	2017	English
Addressing menstrual hygiene management (MHM) needs: Guide and tools for Red Cross and Red Crescent Societies.	IFRC	IFRC	2018	English
Guidance on Menstrual Health and Hygiene	UNICEF	UNICEF	2019	English
Menstrual Hygiene Matters - A Resource for Improving Menstrual Hygiene Management Around the World	Sarah House, Thérèse Mahon, Sue Cavill	WaterAid	2012	English

On ReliefWeb, the filters applied for the search were “Manual and guideline” for content format and “English” for language. The initial search with the search words totaled 62 results. A title screening was conducted for all search word results, which revealed that a large part of the search results were duplicates. In addition, it was apparent that the search word “WASH manual” did not show relevant results and thus it was left out of the next step. From this, a search string was created to get rid of the duplicates. The following search string was used: *"mhm" OR "menstrual hygiene management" OR "menstrual health."* This resulted in 21 results. After a new title screening and an abstract screening, two documents out of the 21 met the abovementioned criteria. The rest were eliminated on the basis that they did not fit the aforementioned criteria.

On Humanitarian library, the initial filter applied was “English” as language. With the same chosen search words a total of 58 results were shown. The search words were used separately because the use of a search string was not possible on the platform. After a title screening, the search word “WASH manual” was again deemed irrelevant. The search words showed duplicates, so the filter “policy and guidance” was applied for each search (disregarding “WASH manual”) to limit the number of results and be able to manually discard duplicates since the use of search strings was not possible. This resulted in a total of four policies. After a title and abstract screening, one document fit the criteria out of the four.

As the last step, the chosen three documents were examined in a snowballing fashion to identify new relevant policies from those that were cited or mentioned within the three policies (Palinkas et al., 2015). After doing title and abstract screening for the references found in these documents, one policy was found to be relevant and added to the analysis. The complete workflow is presented in Figure 1. This brought the total number of documents to four. The policies used for document analysis were limited to those that are publicly available online. In some cases, the guides reference the other guides in this group of four, but they still were largely

original in their information. The complete list of the four policies is in Table 1 and full references for the chosen documents can be found in Appendix 2.

Interviews

Five semi-structured interviews were conducted with practitioners in WASH and PGI fields who had worked with MHM to varying degrees. An interview guide (see Appendix 3) was used to guide and structure the discussion, but questions and discussed topics were not limited to the ones in the guide as per the definition of semi-structured interviews (Adams, 2015). The guide had three themes: manuals, MHM, and gender-based vulnerabilities and capacities. Opening and closing questions were included as the first and last sections. The interview guide was created with these criteria, following McNamara (2006):

- questions divided into sections based on their theme for structure and clarity,
- open-ended questions and possibility for follow-up questions,
- one question at a time,
- as neutral language as possible and staying clear.

The Capacities and Vulnerabilities Assessment Framework (CVA) was used as a guide to create the questions for the gender-based vulnerabilities and capacities theme. In the framework vulnerabilities and capacities are divided into three categories: physical/material, social/organizational, and motivational/attitudinal. These categories were utilized to categorize interview questions about vulnerabilities into digestible sections when creating the interview guide. The framework was not followed strictly, rather it was used more as a loose guide to organize and guide interview questions and thinking behind analyzing the policies. The framework was adapted for the thesis this way because the original format was not deemed fit for the chosen research methods. The framework includes examining a community when designing humanitarian interventions or disaster preparedness projects which is not done in this research (March et al., 1999). In addition, gender as a concept is used to mean men and women in the framework (March et al., 1999). This narrow view on gender does not fit the standards of the thesis and is thus changed to ask about beneficiaries. The framework has been adapted before, for example by Birks et al. (2016) who adapted it to focus on emerging problems and social issues rather than the disaster preparedness and humanitarian intervention context.

Interviews took place on Zoom and were recorded for the purpose of creating transcriptions for analysis. Length of interviews varied from 30 minutes to one hour. Three of the interviews lasted for 30 minutes, one lasted for 45 minutes, and one lasted for one hour. The snowball

method was used for sampling of the interviewees where the interviewee provided contacts for other relevant practitioners to interview (Palinkas et al., 2015). One of the interviewees was male and the rest were female. The only criterion for choosing the suitability of interviewees was that they had to have worked with or encountered menstrual hygiene management issues to some extent during the span of their careers. Most interviewees had over a decade of experience from the humanitarian field. All interviewees had worked in or with WASH projects and had encountered MHM through work in the WASH field. The interviewees were given pseudonyms to be referred to in the findings section.

Ethics

The Social Research Association (SRA) Ethical guidelines were used to guide the research through each step (Social Research Association, 2003). This was especially important during the interview conducting phase due to the sensitive nature of the topic. All the following information in this section is from the Social Research Association Ethical guidelines (2003).

The SRA clause 4.2 of obtaining informed consent was followed. Informed consent was obtained from interview subjects with a signed interview consent form (see Appendix 4). In the case the agreement form was not signed and received by the researcher before the interview, oral agreement was obtained during the beginning of the interview. The right to refuse or withdraw from the research was included in the interview consent form as per SRA clause 4.2. Informed permission to record the interviews was obtained before the start of the interview by email and orally before starting the recording. According to the SRA clause 4.7, preventing disclosure of identities, the interview subjects were informed that they would stay anonymous for the research and were given pseudonyms. Clause 4.6, maintaining the confidentiality of records, was followed when considering data security. Data security was mentioned to interviewees in the interview consent form and further explained if requested. All recordings and transcriptions were kept on the local device they were recorded on. They were also kept on the local device behind a password and downloaded into secure external memory.

Researchers need to be aware of personal bias, and thus the SRA clause 1.3 of pursuing objectivity was followed. The nature of the thesis topic is such that it awakens emotions and feelings as well as anecdotes of personal experiences. Due to this, objectivity was an especially important aspect when conducting the research and writing the final product. Personal anecdotes were shared during interviews by the researcher, but they were not considered in the analysis. This was done to avoid personal bias affecting the analysis.

3.2 Data analysis

NVivo was used to code and analyze documents chosen for policy analysis as well as the interview transcriptions. Policy analysis was started before the interview analysis. The two processes went hand in hand and influenced each other in terms of the codes and interview questions. Both the policies and interview transcripts can be analyzed by using the steps of document analysis. Bowen (2009) explains that the steps of document analysis have elements from content and thematic analysis. The first step in the analysis is to group information into different categories, which is typical for a content analysis. After the grouping, the next step is thematic analysis to recognize patterns in the data and perform coding. Full analysis process is visualized in Figure 2.

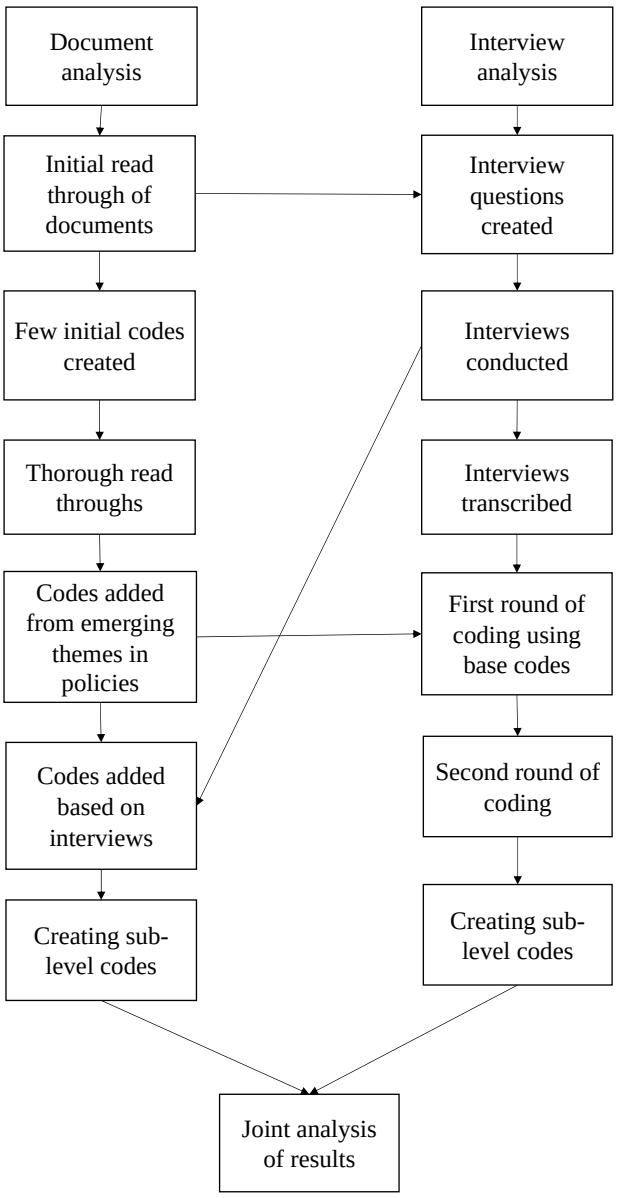

Figure 2. Policy and interview analysis process.

The coding for the policy analysis was started before interviews began. The start of the policy analysis was conducted in the data collection step where it was necessary to read through each document to see how suitable it was for the analysis. A few codes were created to act as guidance in the beginning of the coding process based on some of the sections found in each policy, such as key terms. During this first read through, common categories of information were identified based on which these initial codes were created for the policy analysis. This was also when most of the interview questions were composed based on the identified themes and information in the documents. More codes were added along the process based on the emerging and mutual themes in the documents after doing thorough read throughs. A few more

codes were added after the interview process had started and some new themes emerged. These first rounds of coding included placing the sections in top level codes. The second round of coding included going through the top-level codes and dividing some larger codes into sub-codes.

Interview transcriptions were coded using the same codes used for the document analysis. This was done to see how the themes that emerged in the document analysis were present in practice and thus being able to compare and contrast the two. Some additional codes were created for interview specific sections, such as the roles of the practitioners to keep this information easily available. However, other information and themes from the interviews fit under the already existing codes. After the first round of coding, a second round of coding was conducted for the interviews to pick up similarities and differences between the practitioner's views and the policy analysis. The next step was to break down the larger codes within the interview transcriptions to sub-codes according to the emerging themes within the higher-level codes.

Finally, the writing process was started, and codes were analyzed to answer the research question. The joint analysis process involved comparing and contrasting the code contents and sizes from both policies and interviews. Analyzing the contents and sizes of the codes was done to reveal what were the most prominent topics. These common topics and themes were identified in both analyses and compared. Analyzing the contents and sizes of codes also revealed what topics were less notable in both analyses. After the emerging common themes were identified, the contents were analyzed in more detail to find cohesive ideas within the themes.

3.3 Limitations

This research has some limitations to be addressed. For the document analysis, the policies chosen were all ones that are publicly available online. Organizations might have internal policies that are not published that could have filled the criteria but were missed due to the limited access. This limitation was addressed by doing a thorough search on the ones that are publicly available and acknowledging that some policies might have been missed due to limited access.

Interviewees were contacted by already established connections and snowball sampling. Due to time and resource limitations, the sample size was quite small and full saturation was not reached. This limits the ability to make generalizations from the data. However, the context for

this research is wide and thus full saturation would be near impossible to reach within the time limitation set for the thesis. In addition, the interviews provided contextualization of the policy and were able to be utilized in answering the research questions set for this thesis.

During the interviews a limitation that surfaced was the previous questions influencing some of the answers for the following questions. In some cases, it was hard for interviewees to think of a new example for the new question, so the same topic or issue would be discussed in multiple questions. This limits the scope, but also gives the opportunity to emphasize certain issues that are prominent in the field.

4 Results

This chapter presents the most significant findings of the analysis. First, the relationship between the interviewees and policy is discussed to understand how the practitioners view policies overall as well as more specifically MHM policies. This section validates further why analyzing the policies is important due to the impact they have on practitioners and therefore for the response and activities within MHM. After conducting analysis of the policies and interviews, one gendered vulnerability and one gendered capacity emerged as being considered in policy and practice, and these are utilized in discussing how the vulnerabilities and capacities are considered in MHM. Lack of safety, privacy, and possibilities for upholding dignity is discussed as a vulnerability and community groups are discussed as a capacity in the contexts of development, disasters, and humanitarian crises. Lastly, general findings that emerged from the research are presented. Quotes used from interviews in this section have been edited for clarity. Unnecessary repetition of words was deleted and filler words such as “um” were removed whenever they were not crucial for interpretation.

4.1 Relationship between interviewees and policy

Interviews included questions about guides and manuals in order to establish an understanding of the relationship between the interviewees and policies. Four out of the five interviewees had utilized manuals in their work to some capacity. All four had also used specific MHM guides and/or WASH guides with MHM included. One interviewee had been involved in revising guidelines to include protection, gender, and inclusion, when previously they had only contained protection aspects. The manuals that the four interviewees had used were both internal and external to their organizations. One interviewee said that they try to refer to internal

guidelines first, however they are often built upon the global guidelines. Three of the policies analyzed for this research can be seen as global since they are widely distributed within different organizations. Three interviewees said that they know their workplace has an MHM guide, while two interviewees were fairly confident their workplace has one.

The interviewees who had used an MHM guide or a WASH guide with MHM included were asked how the usage influenced their work or to give an example of the usage. Some common themes that emerged were the guidance they provide for planning, designing, implementing, monitoring, and evaluating MHM activities. The manuals offer steps to follow in a project and checklists which are helpful in making sure all aspects are considered. Further, they offer guidance on how to appropriately consider women's preferences, needs, and dignity. One interviewee mentioned that the manuals are helpful in offering guidance on the way MHM should be presented because it is a sensitive topic. Two interviewees remarked that the manuals contain useful training material for training others, but also training for getting ready to go to the field. Overall, the view on manuals and guides is positive and they are regarded as useful.

4.2 Lack of safety, privacy, and dignity as a vulnerability

What emerges in the analysis of policies and interviews as a widely discussed gendered vulnerability is the lack of safety, privacy, and possibilities for upholding dignity. In previous literature these topics have been framed as immediate needs or challenges, rather than gendered vulnerabilities to be addressed. Although safety, privacy, and dignity could be looked at as immediate needs, the underlying causes for the lack of these is a longstanding issue, which implicates that this is a vulnerability. This research aims to argue that framing them as vulnerabilities is beneficial for acknowledging the root causes and thus creating long-term change. This section discusses how the lack of safety, privacy, and dignity themselves are situated and considered in relation to MHM, and the lack of acknowledging their underlying causes is considered in the discussion chapter.

Based on the analysis, this is one of the largest vulnerabilities when it comes to MHM recognized by both policy and practitioners. Since menstrual health concerns largely women, girls, and gender minorities who menstruate, the lack of safety, privacy, and dignity is implied as a major gendered vulnerability. The need or desire for men and boys also to receive safe and private places for managing hygiene needs is not discussed in the MHM policies. Policies are more focused on safety and privacy, although dignity is also mentioned widely throughout. On

the other hand, during interviews dignity was a more prevalent concept while safety and privacy were mentioned less.

Safety is the main concern when use of latrines and access to them are mentioned in both policy and practice. Conditions around accessing spaces for menstrual management are assumed to be unsafe, and thus some solutions have been developed. The ideal safe female friendly toilet design is included in all four policies, originating from *A toolkit for integrating Menstrual Hygiene Management (MHM) into humanitarian response* (Sommer et al., 2017). This design includes nine aspects: adequate number of latrines for just females, safe and private toilets with an inside lock, clear signs for instructions of disposal, a shelf and hook for belongings, light inside and outside, easily accessible water (ideally inside), trash bins with lids, structure made of non-transparent material with no gaps or spaces, and some accessible units (Sommer et al., 2017). However, these requirements are not always filled and there are challenges in trying to implement them, as Interviewee 1 reported:

> *"We installed lights and it was stolen. Then they gave up so they gave them [the beneficiaries] these flashlights that they can carry. And imagine the whole family used that, so it was broken after a short time so they couldn't [use it anymore]. They didn't feel safe that they, adolescent girls, especially when they are on their period to go to the latrines during the night or after the evening. I mean, so imagine that they had to wait."*

A very similar account was told by another interviewee that also demonstrates the same issue:

> *"Residents right now in many of these places, especially as you get kind of closer to the equator, or in certain times of the year, it might be dark by 6:00 PM. And that means that after 6:00 PM, women just can't access latrines or access toilets in a way that's meaningful or safe for them. So, imagine you can't manage your period after 6:00 PM. I mean, my goodness, how, how are we allowing women to go on like this? So, I think we really have a responsibility to bear when it comes to safety."* (Interviewee 2)

Privacy is mainly referenced in both policy and practice when it comes to the way latrines are constructed and washing and disposing of materials when managing menstruation. The private management of aspects relating to menstruation, use of toilets, washing, drying, and disposing materials, and bathing goes hand in hand with the safety of facilities. Safety and privacy are also concerns when it comes to distributing MHM materials in the communities and

demonstrating their use. This can lead to those receiving aid being stigmatized and harassed due to the current shame and secrecy discourse on menstruation, which is why there are several recommendations and guidance to avoid unwanted consequences of bad MHM interventions. This includes recommendations such as using unbranded packaging for distributing menstrual materials and having women as the distributors.

Dignity is seen as stemming from successful safety and privacy, and all of these aspects go hand in hand. Dignity is often grouped together with the concepts of safety and privacy in MHM policies, and it is seen as one of the main pillars of menstrual hygiene management response and activities in the analyzed policies. According to the analyzed policies, taboos and beliefs linked to menstruation can hinder safety and privacy and in turn prohibit the preservation of dignity. Although these aspects are widely discussed in the guide documents, it is still clearly stated that they are largely lacking. From the analysis it emerged that women and girls as well as other menstruators are lacking private latrines in their homes and safe and private spaces outside of their homes which increases their vulnerability.

An aspect that was brought up in the interviews, but not in the documents is that some communities are currently entirely reliant on the humanitarian aid that is distributed to them. This practice is not seen as maintaining dignity, nor is it sustainable long term in reducing vulnerability. There is a wide agreement in the field that women prefer to be in charge of their own menstruation. This way they are able to choose the materials and practices based on their preferences. It was also mentioned by one interviewee that dignity is something that is hard to measure, which was not discussed in the documents. When asked about material and physical vulnerabilities of beneficiaries, one interviewee said the following:

> *"I think definitely access to means and right now particularly, we think about places like Bangladesh where we have this world's largest refugee camp and largest refugee population, and they're in a context where they cannot buy anything, they can't purchase anything. So, they rely entirely on aid being distributed to them and that's really challenging. That's not upholding dignity. I mean, nobody wants to be given their menstrual hygiene needs."* (Interviewee 2)

The policies mention severe consequences of the lack of safety and privacy. Some emotional responses to the lack of these mentioned in policy are anxiety, embarrassment, and stress when dealing with menstruation in these conditions. An interviewee mentioned that when people have

to publicly defecate out of necessity, they take themselves mentally out of the situation. This also demonstrates peoples' psychological desire for upholding their dignity. In some cases when people are forced to do this enough times, it becomes a normalcy, but the sanitation problem is still present to be addressed. In some contexts, this is the daily normal situation, and when a crisis or a disaster happens, it makes the situation even worse when people cannot access even a little of what they have in a normal situation. In contrast, there is a clear difference when women feel safe in the spaces created for them to deal with menstruation. One interviewee mentioned that they witnessed women hanging underwear and pads to dry in the shared spaces when they felt adequately safe and private, yet the current efforts are not enough:

> *"If you go into a women's shower you will see that they're hanging their underwear and their pads or whatever because it's a safe space for them to do that, so that's good, but we have to give maybe more space for that. We have to know that women need places outside of the home where men can't see, where they need to be able to hang their underwear without concern. And we don't create spaces like that right now."* (Interviewee 2)

The underlying causes associated with this topic are not acknowledged in policies. Instead, it is mentioned as self-explanatory that women and girls need additional safety and privacy — this is well represented in the following quote from the policy by Sommer et al. (2017):

> *"Women and girls require more privacy for sanitation than men and boys, especially when dealing with menstruation. Maintaining safety and dignity while accessing sanitation facilities remains a widespread challenge in humanitarian contexts."* (p.39)

Similarly, the interviewees acknowledged that managing menstruation can be unsafe or hard to do privately in the considered contexts, but it was not explicitly discussed why that is. One mention could be found about the fear of gender-based violence from the policy by UNICEF (2019). They remark sexual and gender-based violence as a cause for the need to provide adequate safe facilities. Other direct mentions of possible root causes could not be identified from policies or interviews. The root causes for the need for safety and privacy, and the lack of their acknowledgement in policies is mentioned in the discussion chapter.

4.3 Community groups as a capacity

Community groups, especially women's groups, come up in both the policies and interviews when examining capacities. Based on the analysis, community groups are one of the most substantial capacities that women and girls have when it comes to managing menstruation in development, humanitarian and disaster contexts. The policies recognize that the opportunity to support women's groups is great, which was also regarded by an interviewee. The same interviewee observed that the formation of these groups seems to be a natural occurrence:

> *"Oftentimes you find in these communities that women find each other. You know, I think this is something we, I think, observe as a species that women will often kind of seek out others and find help within each other. So, the opportunity to create things or support things like women groups is very high, generally within many of the communities in which we work. I don't want to say a blanket statement that it's always like that because it could be different. Humans are humans, but I think that the capacity for women to help each other is always quite high."* (Interviewee 2)

The policies also discuss women's groups and how they naturally exist within communities. The opportunity these groups hold to be utilized in education and promotion is discussed in the policy by Sommer et al. (2017):

> *"Existing girls' or women's community groups. Informal groups within communities usually exist prior to a crisis. These groups may continue to function during an emergency; or as communities are displaced new groups may form. Hygiene promoters can link with these existing groups and use them as safe spaces providing MHM promotion"* (p.59)

These community groups and community leaders often use storytelling as a means of educating the younger generations. Targeting community leaders, both formal and informal, when it comes to menstruation education and awareness has a positive effect and is endorsed in the guide documents as well as mentioned by interviewees. One interviewee mentioned grandmothers' committees as sources of information for younger girls as well as teachers. Tapping into the public narrative within community groups was mentioned as one of the tools to create long-term change by the interviewee. This was corroborated by another interviewee who also mentioned interjecting into the group's narrative about menstruation to spread messages is a way to make a long-term change. They mentioned that tapping into the

community group for quickly driving change or to spread messaging can be done by having contact with a woman with high social capital in the community.

In addition to spreading information, the common view is that community groups are great for women to be able to consult and discuss with each other and consult more knowledgeable women within the community regarding menstruation. Consulting more knowledgeable persons in the community comes out in policies as well as in interviews as something that happens frequently in communities. One interviewee regarded local knowledge and resources when discussing the topic:

> *"There are women, midwives who women turn to or elder women in the communities or even younger women with more education, who people can feel comfortable going to and getting advice on menstruation problems. I think there's definitely a lot of local knowledge and resources among women and girls' groups, especially I would say when there are midwives or health promoters or certain women who have a history in the community of giving either medical attention or advice to other women, they can be great resources."* (Interviewee 4)

There is a possibility for external aid to also utilize this consulting possibility. Since preferences on materials and practices are context specific, community groups can act as focus groups for external consultations. It was mentioned in interviews that finding out the contextual preferences, an already existing solution is to hold consultations with local communities and individuals. This demonstrates a way that community groups are already starting to be employed. One interviewee mentioned that in recent years there has been progress in holding consultations and asking women what they need through for example focus group discussions.

For women's groups to be able to reach their full potential, it is important to include also other groups in the communities in menstrual health activities. Raising awareness in the whole community, including caregivers, men and boys, and grandparents, is seen as beneficial by both the guide documents and interviewees because they can have a positive effect on how for example men and boys treat those who menstruate. Awareness sessions held with parents and caregivers was mentioned by one interviewee to be one of the best practices within MHM. An interviewee said that different groups in the community need to be targeted differently, which is also considered in the guide documents where guidance is given for how to include different

groups such as boys in menstrual education. The interviewee stated an important aspect — menstruation is not only a "girls' issue":

> *"[…] if we want to improve this, we need to work with our whole community, not just with the girls. So, I don't think it's a good practice keep doing it targeting just the girls. You have to raise awareness with their parents, with the males, and the boys, and everyone. So, this is also one of the conclusions that we need to target everyone differently of course but still, you can't just say it's a girls' issue."* (Interviewee 1)

Another interviewee highlighted the willingness to learn and curiosity about the subject as a capacity that menstruating persons and communities possess. Although the subject is still largely taboo, there is a certain openness to the topic amongst beneficiaries and willingness to take on projects concerning menstruation. This interviewee said that from their experience, especially boys are often eager to learn about the subject:

> *"I would say the training of teachers and students, and if it's acceptable, to include boys and men in the trainings because then that acceptance is longer in long-term. I've seen that in Ethiopia for example where boys had better results on some questions on MHM when there was a quiz because they really wanted to learn and get good results in school."* (Interviewee 5)

Community groups can also be trained in activities such as making reusable pads as a way to earn money. This was mentioned by an interviewee as something that works well in MHM currently. This type of activity has high potential to be successful, since it also came out in an interview that humanitarian organizations are keen on increasing localization agenda and equipping locally. The potential has been realized and is also included in the policy documents. For example, IFRC (2018) and UNICEF (2019) encourage supporting local markets in procuring menstrual products. There is also encouragement to support and establish groups that produce menstrual materials, usually reusable sanitary pads (House et al., 2012; IFRC, 2018).

Even though community groups are mostly seen as an existing capacity, they can also have a negative effect. One interviewee had encountered an issue with women's groups that started from girls going through the experience of genital mutilation together. The interviewee explained that this would create a bond between them and later in life they would be there for each other during other experiences such as getting married and having kids, much like siblings

do. However, these groups and bonds were built on the mutilation, which is something negative and traumatic, and thus it can create issues within the community. In this case the women would be advocates for the mutilation and have the mindset of "I went through it, so shall you" (Interviewee 3). This type of negative effect of continuing trauma in community groups was not discussed in any of the policies. The same interviewee explained that they wanted to find a positive alternative for the genital mutilation that would generate the same type of "sisterhood" and bonds as the mutilation had. Since the bonds themselves were something positive, they are an important part of the society and create a type of support system, they are important to hold on to according to the interviewee. As a solution they ended up providing information about sanitary pads and other options for MHM.

Another aspect of the community groups that can also be harmful is connected to the taboos and beliefs in that certain community. When the girls would get their information from the group leaders or other women in the group who believe in the taboos, beliefs, and myths, it gets put forward and the misinformation is spread. This risk was mentioned in policies, such as the IFRC (2018) policy:

> *"Trusted sources of information for personal health issues such as menstrual hygiene. Women and girls may trust information from coming from their mothers, aunties, teachers, or local health workers – rather than from agencies or government departments. Men may trust information coming from community or religious leaders, or health workers. It is important to understand where different segments of community get their information from, and which sources they trust. This is especially critical for effectively addressing cultural taboos, myths, and misinformation around menstruation."* (p.19)

This creates an additional issue that sometimes due to different taboos and beliefs, girls do not want to publicly identify themselves as menstruating due to the negative consequences of having to drop out of school and/or having a different status and expectations within the community. This also applies to other menstruating groups such as transgender and non-binary persons. They are in danger of being harassed, discriminated, and exposed to violence if identified (UNICEF, 2019). These factors make it hard to identify menstruating persons in the community and offer aid in the form of materials and education safely. This negative side of community groups was more prominent in the policies than in the interviews.

In brief, community groups can be good or bad initially, but with menstrual health activities it is possible to harness their positive potential. This requires abolishing the harmful taboos and beliefs as well as the examination of already existing groups and the basis of their existence. The implications of community groups being recognized as a significant capacity as well as their possible development are considered in the discussion.

4.4 Challenges and opportunities for decreasing vulnerabilities and developing capacities

Some general findings that emerged from the analysis of policies and interviews are presented next. These findings present some challenges and opportunities for decreasing vulnerabilities and developing capacities in MHM. The first challenge is the context specific nature of taboos and beliefs as well as materials and practices. This hinders the improvement of policies and practice. Second, the challenge of having a lack of recognized capacities is acknowledged. Lastly, some challenges and opportunities of overall inclusion of gender minorities and men in MHM is discussed.

There is a large focus on context-specific challenges found in the policies. Although taboos and beliefs around menstruation can be found globally, there are a variation of these found based on the location. Also, the implications of taboos and beliefs vary from place to place. This is also a reason why addressing these can be difficult in a generalized policy document. The context in which these are mentioned in the policies is the acknowledgement that a lot of beliefs and taboos are harmful and thus should be addressed. When these are harmful, they can increase gendered vulnerabilities, which is why understanding different taboos and beliefs is important for creating successful MHM interventions. This also allows for long-term change because the beliefs and taboos are often deep-rooted in the societies and communities. An interesting notion that an interviewee brought forward was the fact that even in places where menstruation is not as strong of a taboo as elsewhere, it is still weaponized. The interviewee noted that using menstruation as an insult and as a demeaning concept is fairly common and something that needs to change.

The challenge of a lack of recognized capacities exists in both policy and practice. Community groups as a capacity was by far the most mentioned one by interviewees. Only few other capacities were mentioned: the physical environment where a person lives and being able to find solutions if external aid fails. One interviewee mentioned climate as a capacity relating to

menstrual management. In colder and dryer climates it is easier to maintain adequate hygiene practices than in a humid and hot climate. This type of capacity is mostly to do with luck. Another interviewee said that women are able to find solutions for menstrual management if external interventions fail to provide culturally appropriate interventions. However, according to them, this does not mean that the found solutions are always upholding good hygiene. In addition, this capacity is tightly related to the capacity of community groups. Policies also focused strongly on community groups, and there are no other easily detectible capacities. Yet, interestingly, UNICEF (2019) includes capacity building in their programming principles and House et al. (2012) mentions building capacities quite extensively. The lack of other recognized capacities makes the community groups even more important, which is mentioned in the discussion chapter.

In line with the issues with the gender concept being viewed in a binary way presented in the introduction, many of the policies mostly use gender binarily to include only men and women. This comes out in the policies mentioning terms such as "sex-segregated toilets" and referring these to be provided for girls and women as can be found in UNICEF (2019). Some gender minorities that are included in the policies are transgender and non-binary persons. They are often counted in the vulnerable groups and included in the considerations when talking about heightened vulnerability. The major challenge with including these groups mentioned in the policies is the "do no harm" concept, relating to the fact that identifying and exposing them might cause more harm for these already vulnerable groups than help them. An interesting notion is that the UNICEF (2019) policy has a definition section for transgender and non-binary persons where they mention that it is estimated that these persons make up 0.3-1.2 percent of the population, meaning tens of millions of people around the world. Yet, from the analysis it emerged that they are not included in the policies comprehensively and it seems that there is not enough research done on the topic. In practice the situation is similar to policy. When asked from interviewees to what extent these groups are taken into account the answers varied: "very limited" (Interviewee 1), "I wouldn't really know" (Interviewee 3), "I don't think they are" (Interviewee 2), "there are protection concerns about singling them out" (Interviewee 4) and "they are a part of our work since we work inclusive, we have this definition of inclusive WASH with all" (Interviewee 5).

Despite these challenges, there is also an opportunity for increasing inclusion. The term "inclusive WASH" appeared in interviews, and it appears to be a trendy term currently to describe WASH practices and interventions. According to two interviewees, this includes

aspects such as building WASH facilities, having awareness sessions, and including vulnerable groups such as women and girls, and transgender and non-binary persons within WASH. Based on this, it references the inclusion of vulnerable groups and their needs in WASH as well as having a comprehensive intervention with multiple different actions included. This notes the concerning fact that these aspects have been excluded in the past in policy and practice. However, based on the interviews, the concept of inclusive WASH appears to be a good basis for increasing inclusivity.

Another opportunity and aspect of the comprehensive interventions is including men in MHM education activities. This is fairly widely discussed in policy and mentioned by four out of five interviewees to some extent. Including men and boys in menstrual education is seen as creating long-term change. One interviewee mentioned that just raising awareness is important for making a change, going into detail with them is not necessary. According to the policies, including men has a positive consequence of them being able to support their wives, sisters, and daughters in menstrual matters. In many contexts men are in charge of the finances and thus have the power to improve household level MHM (Sommer et al., 2016). Other positive effects mentioned is the decrease in harassment, bullying, and stigma when men possess the understanding of what menstruation entails. This type of change is important when it comes to the reduction of vulnerabilities and building capacities.

5 Discussion

Three main topics are considered in the following discussion. First, the opportunities to address root causes of vulnerabilities for the purposes of creating sustainable change. Second, the opportunities to develop community groups further to fully utilize them as a capacity. Both of these could contribute to the improvement of future policies, and menstrual health response overall. Finally, the inclusion of gender minorities in MHM practices and how policies and practice can be made more inclusive with a focus on vulnerabilities and capacities.

There is a call to improve policies to implement structural change to address the current issues in MHM and the menstrual health field (Winkler, 2020). Policy improvements should be done in a way to build more sustainable solutions and transition into more long-term thinking when it comes to menstruation (Tellier et al., 2020). Improving policies also has the potential to normalize discussion and create dialogue around menstruation (Aidara & Mbaye, 2020). Policy can then in turn affect practice and thus the discourse about menstruation can be changed

throughout the field. The key to doing this is to include activities that challenge social norms, beliefs, taboos, and stigma related to menstruation (Winkler, 2020). The following sections discuss the opportunities and challenges for improvement of MHM policies and practice.

5.1 Opportunities for addressing root causes of vulnerabilities

As argued by Bradshaw (2014) and Valdés (2009), disaster risk reduction, mitigation, response, and reconstruction need to include women and girls to lower disaster risk overall. However, to actually improve the current situation and change the position of women, DRR, development, and humanitarian fields need to address gender and social inequalities which are some of the root causes for women's heightened vulnerability (Bradshaw, 2014; Valdés, 2009). According to Bradshaw (2014), the way to reduce disaster risk is to address unequal power relations between genders during and after a disaster, but most importantly, before a disaster in development processes. This also refers back to the idea of treating women and gender minorities as part of the process, and not as a vulnerable group to be served (Ashraf & Azad, 2015; Gaillard, Sanz, Balgos, et al., 2017; Ginige et al., 2014).

The literature on MHM provide strong arguments for how poorly MHM has been addressed in the past (VanLeeuwen & Torondel, 2018; Sommer, 2012). The focus on post-disaster relief and meeting practical needs with the heavy focus on materials is what Bradshaw (2014) criticizes as not addressing women's strategic interests and the root causes. The issue with this is that treating the immediate needs will not address and get rid of the source of the vulnerability. In addition to the focus on materials, there is a strong argument made that MHM is not currently evidence-based enough and some claims made in policies are not backed up by research (Sumpter & Torondel, 2013). The focus on needs is apparent when looking at how the safety, privacy, and dignity aspects are handled in MHM. The lack of these aspects is discussed widely in all of the four policies and brough up by interviewees. It has also been mentioned by researchers who have comprehensively looked at MHM literature such as VanLeeuwen & Torondel (2018). Some solutions are presented and used to provide more safety and privacy, such as the previously discussed female friendly toilets. However, the root causes for the need for these solutions are not discussed comprehensively by researchers or policies.

The understanding of taboos and beliefs explains the need for more privacy for women, girls, and gender minorities. The prevailing ideas of menstruating bodies as polluted (Douglas, 1966) and the "culture of concealment" (Karen Houppert, 1999, as cited in Bobel, 2019, p.9)

are clear motives for menstruating persons to look for privacy when dealing with menstruation. When it comes to safety, as presented in the results chapter, there is an acknowledgement of the threat of sexual and gender-based violence being a reason for why there is a heightened need for safety when talking about menstrual management (UNICEF, 2019). However, past this one mention, the policies do not discuss these root causes. A separate study has been done by Sommer et al. (2014) about the threat of violence in relation to WASH activities, including menstrual management. The study reveals that girls and women are primarily the ones experiencing violence, making it a very gendered issue. It also identified that boys and men are often the committers of the violence. This demonstrates the existing power relations and inequalities between these groups. According to Sommer et al. (2014), managing menstruation increases the need for water and sanitation which can increase the threat of violence in the case of needing to leave the household to access facilities. They discuss that threat of violence is also a worry for minority groups. Addressing these underlying factors for increased vulnerability in policies is crucial for creating change and putting forward possible solutions. The policies could also be used as a basis to develop the already popular idea of including men in menstrual health activities even further. As mentioned about including men in MHM, educating them on the topic could decrease harassment around menstruation, but this opportunity could be utilized more in the policies.

Because of the reasons mentioned above, women, girls, and gender minorities require additional privacy and safety. This means that women, girls, and gender minorities need special attention in this section of MHM and WASH. However, there is no discussion about men and boys possibly also wishing for safety and privacy in sanitation facilities. In the end, it is a commonality that humans want to uphold their dignity, regardless of gender. For example, having adequate hygiene facilities concerns all. The attempt to make sanitation facilities safer and more private should not be limited to just MHM activities. Although menstruating persons have the extra layer of difficulty when dealing with menstruation, the desire for safety, privacy, and dignity is universal (Patkar, 2020). Thus, if all hygiene facilities were designed with the issues of safety, privacy, and dignity in mind both in everyday life and in disaster situations, the impact would be positive universally.

To have a more holistic approach to menstrual health, there are researchers who are calling for a rights-based approach as an answer to some of the issues associated with MHM and policy development (Thomson et al., 2019; Winkler & Roaf, 2014). According to Winkler & Roaf (2014), the rights-based approach means situating menstruation within the human rights frame

and would entail specifying the requirements for managing menstruation with dignity. They argue that this is beneficial because adequate hygiene practices relate to individual's rights to privacy, human dignity, gender equality, non-discrimination, and broader equality. They also argue that it is in these areas that the human rights perspective is the most useful in building understanding of menstrual management and for decision makers to prioritize menstruation. Taking the rights-based approach to menstrual health practices and response could address the issue on a larger level. Menstruation is linked to the right to water and sanitation, the right to education, the right to work, the right to health, and as discussed before, the right to non-discrimination and equality (Human Rights Watch & WASH United, 2017; Winkler & Roaf, 2014). The argument for taking a human rights approach to MHM is comprehensively discussed in a document published by Human Rights Watch and WASH United (2017). They mention addressing systematic problems and providing standards for holding practitioners and governments accountable as some of the benefits from the human rights approach. The three recommendations given in this document for indicators of good MHM are the same as the three main aspects historically required from MHM: menstrual management materials, adequate facilities and disposal, and knowledge of menstruation (see part 2.1). This indicates that the rights-based approach does not necessarily contribute anything new to the table regarding MHM policies.

There are also arguments against the human rights approach, for example by Bobel (2019) who presents a good example. He argues against the human rights approach to menstruation and preserving dignity because it might actually miss the mark due to failing to address the menstrual stigma. His argument is that the approach contributes into the secrecy about menstruation in society and trying to conceal it. He criticizes the overall framing of menstruation as a dignity issue. The main point Bobel (2019) brings up is that the core issue with menstruation is not the lack of ability to uphold dignity, but rather the view that women's bodies are devalued and sources of pollution. Although this is also what Douglas (1966) wrote about in 1966, the idea has not carried over fully to the field of MHM. As mentioned before, dignity is still discussed widely in policy and practice, and is seen as a main pillar in MHM. Bobel (2019, p.238) suggests tearing down the menstrual stigma and "remaking" the menstrual worlds to get rid of the shame, secrecy, and disgust. The time is right to move away from the attempts to find ways of assuring dignity is upheld in the menstrual health field and move onto changing the dirty and polluted discourse on women's bodies and menstruation.

Addressing the vulnerabilities and their root causes is the key to creating long-term change in the menstrual health field. Although the specific vulnerability of lack of safety and privacy in MHM is a gendered one, the solutions and developments can actually have a wider positive impact for everyone, including those who do not menstruate. Opportunities exist to include the underlying causes and solutions more into policy and practice in MHM, but it is not without challenges. It is agreed that taking a more holistic approach to MHM is needed, but the framing of menstruation remains as a core issue.

5.2 Developing community groups as a capacity

One way to reduce vulnerabilities is to develop capacities (Valdés, 2009). When including women in DRR, development, and humanitarian fields, existing community groups can serve as a starting point. Valdés (2009) argues for empowering and funding women's groups and developing their capacities. These groups often possess features such as insight, information, experience, networks, and resources, that are fundamental for strengthening capacities (Valdés, 2009). In relation to menstruation, Bhattacharjee (2020) argues that including communities in creating MHM and WASH solutions and frameworks is an opportunity to include women in disaster management planning and response. This chance should not go unrealized. The aforementioned opportunity of improving policies to change the discourse about menstruation is another reason to engage communities to create holistic change in how menstruation is viewed. Bobel (2019, p.10) condensed the topic well in his book by arguing: "Girls need to live, study, work, and play in communities where menstruation is no longer deployed as ammunition. […] To this end, everyone surrounding girls—boys, teachers, family members, religious leaders, policy makers, and so on—needs to challenge menstrual stigma. Girls need to be encircled in 360 degrees of body positivity."

All interviewees recognized community groups as a capacity, and only few other capacities were mentioned. Thus, it is even more important to fully utilize the positive potential of community groups as a realized capacity. As a result of the analysis, it is clear that groups hold a lot of potential for positive change and inclusion, but it can be debated whether it is being utilized to fullest extent or not. It came out that community groups can also be negative, which was not recognized in the policy.

The implication of having community groups as a recognized capacity is that there is great potential to perform successful capacity development. This was also recognized in the Honolulu

Call to Action in 2004, a workshop report on gender equality and disaster risk reduction, which recommends building capacity in women's groups and community-based organizations (Anderson, 2009). The four points to achieve this are listed as involving community at all levels, ensuring equitable power in partnerships, ensuring resources and funding, and addressing root causes of vulnerability (Anderson, 2009). As presented in the results, two of the policies discuss capacity building to an extent. However, the policies also had a hard time recognizing any other capacities relating to menstruation.

A comprehensive definition for capacity development is "a locally driven change process through which individuals, organizations and institutions obtain, strengthen, maintain, and adapt their capacities to set and achieve their own development objectives over time and learn from their efforts (Hagelsteen & Burke, 2016, p.44)." The Capacity for Disaster Reduction Initiative (CADRI, 2011) categorizes capacities into three categories: the enabling environment, the organizational level, and the individual level. Based on their categorization, community groups are put under the individual level while the underlying social norms and policies that affect menstrual management are under the enabling environment.

The enabling environment is where the environment for effective development of capacities, both individual and organizational is created. It also "sets the context for capacity development and determines the changes that may be necessary to ensure results – which may require a shift in values and approaches, in power dynamics and possibly even in power relations (CADRI, 2011, p.10)." When it comes to menstrual health and MHM, tackling the harmful social norms is a major concern and requires changes in power dynamics and relations. As discussed with the threat of violence, there is a need to change the power inequalities and dynamics. Engaging not only the women's groups or wider community, but also engaging community leaders is crucial as could be deduced from the analysis in this thesis. Further, including the men within these communities could also tackle some of the root causes for vulnerability while also building the capacity of community groups. In future policy improvement, the utilization of the full potential of community groups could be done on this level by shifting the values and the discourse on menstruation. In addition, other capacities relating to menstruation could be identified more strongly and researched.

In the CADRI (2011) categorization, the individual level encompasses the skills and knowledge possessed by individuals, groups, and communities which come from learning through education, training, doing, as well as coaching and mentoring. Further, this learning also

includes networks, communities of practice, and platform mechanisms. Education activities in MHM is a fairly popular activity based on the analysis. For example, in the attempt to engage different groups in the communities, practitioners utilize education activities. However, the main issue is changing the discourse on menstruation to make it more focused on openness rather than secrecy and shame. Educating the community groups on menstrual health can have this effect, but it needs to be acknowledged that only education about materials or healthy practices is not enough to change the discourse. In addition, utilizing existing knowledge and skills on menstruation in these communities could offer some long-term sustainable change unlike the unfamiliar materials and practices offered by external aid.

For successful capacity development to be possible, the negative side of community groups need to be acknowledged. The influence that social norms, taboos, and beliefs have on the discourse on menstruation can often be exacerbated by formal and informal community leaders and influential persons in the community. Erchull (2020) talks in an article about how patriarchal social structures are reinforced through the menstrual discourse of uncleanliness and pollution. According to the article, menstruation is used as a means to claim dominance by men and boys, starting from a young age. These can be challenges for developing community groups as a capacity successfully. Based on the analysis, tapping into the public narrative with factual information and involving everyone in education about menstruation is a way of diminishing harmful social norms, taboos, and beliefs within communities.

Another challenge can be the continuation of trauma in communities mentioned by an interviewee. As was seen with the example given about groups where genital mutilation was prevalent, this can be an issue. However, as that example proved, it is possible to offer alternatives and thus harness the bond into something positive with menstrual health activities. Menstrual health education also provides an opportunity to educate communities about other menstrual health related topics such as the harms of mutilation, gender-based violence, reproductive health and more. In conclusion, the potential of community groups to be employed as an entry point to change the discourse on menstruation is high. Although community groups are acknowledged as an existing capacity, the full potential does not materialize in policies or in practice. The dangers of harmful community groups need to be researched further and acknowledged more prevalently in policies.

5.3 Opportunities for more inclusivity in MHM

The gendered vulnerabilities and capacities also affect gender minorities. Thus, it is important to make sure that they are acknowledged in policy and practice. It is clear from the analysis that in practice the idea of inclusive WASH is more prominent and becoming more and more relevant than what can be deduced from the policies. Gender is just one of the multiple factors that affect vulnerability when it comes to menstruation. There are many factors that can overlap and create discrimination in menstrual matters making it an intersectional issue (Wisner et al., 2003). Some of the other factors are discussed in policies, such as disabilities and poverty.

The issue of MHM not being inclusive enough to gender minorities came out clearly in interviews. The topic is being discussed in policy to a certain extent but is very limited. According to the interview analysis, it is also limited in practice. The overall view is that it is still not sufficient in the field. The most significant acknowledgement of this issue was found in the newly released paper by Hennegan et al. (2021), who created a definition for menstrual health and mentioned the need to take into account the fact that there are other persons who menstruate in addition to just women and girls. This definition is meant to be used in policy, practice, and research (Hennegan et al., 2021). Integrating this definition more into the policies could guarantee an increase in the inclusion of these groups also in practice since it came out in the analysis that practitioners do find the MHM policies valuable and useful.

Interviewees largely focused on women and girls when talking about vulnerabilities, although the questions were framed to talk about beneficiaries. The binary thinking is still ingrained into practice and the language used by practitioners reflects that. Even though there is a clear awareness that there are minority groups who menstruate, their existence is not acknowledged in everyday language. Walby (2005) discusses gender mainstreaming as a way to improve policies, but in the more binary sense. However, relating to gender minorities getting mainstreamed, Elgström (2000, as cited in Walby, 2005) argues that new gender norms compete with the traditional norms because gender equality is prioritized over mainstreaming, and therefore new norms are hard to integrate into institutional thinking. In addition to gender mainstreaming, the aforementioned rights-based approach to menstrual health discussed by Thomson et al. (2019) and Winkler and Roaf (2014) could also address the right to non-discrimination and equality for women and girls but also for gender minorities if done successfully.

The prominent vulnerability of lack of safety and privacy definitely concerns gender minorities which was explicitly mentioned by two interviewees as well as discussed in the policies. A study done by Chrisler et al. (2016) found that secrecy about menstruation is important for the transgender community, especially in public spaces mainly for safety reasons. Their study found that avoidance of public latrines is common in the community unless they are single-toilet, gender-inclusive, and lockable. Thus, it can be concluded that these communities in countries and areas, where their identities are even less accepted, the desire for safety and secrecy is probably even higher. Further, the implications this has on disaster and humanitarian situations is not studied enough, which is apparent when looking at the lack of knowledge about the topic in the MHM policies.

Community groups as a capacity are not discussed in relation to gender minorities in policies or practice. It could be assumed that these groups have their own community groups as well, but possibly they are harder to track down due to safety concerns (Gaillard, Gorman-Murray, & Fordham, 2017). It is difficult to discuss how to develop this capacity in relation to these groups without existing research on what these groups look like and their impact in the menstrual health field. In brief, the previous discussions about root causes for vulnerabilities and the utilization of capacities within the menstrual health field concerns also gender minorities. However, there is still the additional step of making MHM more inclusive in policy and practice to better acknowledge and improve the menstrual experiences of these groups through policy development and inclusion in DRR activities (Gaillard, Gorman-Murray, & Fordham, 2017).

6 Conclusion

Menstruation remains a difficult topic to research and work with due to the social norms and stigma surrounding it. It is crucial to continue to bring the subject to light and change the way menstruation is talked about and handled in disasters, humanitarian crises, and development. However, just raising awareness is not enough. Continuous improvement of current policies and practice is crucial for freeing menstruators from the chains of the current shame, secrecy, and invisibility menstruation discourse. To improve current policies and practice, more focus needs to be put on vulnerabilities and capacities instead of immediate needs that have received majority of attention in the menstrual health field in the past.

This thesis aimed to focus on gendered vulnerabilities and capacities and how these are considered in MHM policies and practice. Although materials and education continue to be important and a basis for menstrual health activities, there needs to be a movement towards more long-term solutions to guarantee safety and privacy for menstruators as well as acknowledging other vulnerabilities. To be able to successfully reduce vulnerabilities, there also needs to be more focus on building existing capacities. The realized capacity of community groups should be better utilized and included in future policies and in consequence, practice. In addition to this, policies need to be updated to include more gender minorities and their existence should also be acknowledged better in practice. This is required for their vulnerabilities and capacities in relation to menstruation also get addressed and utilized.

The overall discourse on menstruation is the core issue which, if changed, could create a widespread change in the menstrual health field in both policy and practice. The view of menstruation as something dirty and polluting is prevalent and has created a world where menstruation is required to be concealed. Addressing the root causes of gendered vulnerabilities can contribute to creating a new, more open and accepting, discourse on menstruation. Further, developing the capacity of community groups and realizing their full potential can be employed for changing the discourse. A step towards a more open view is also including gender minorities in menstrual health policies and practice by also addressing their vulnerabilities and developing their capacities.

For future research it is recommended that more data collection is conducted on the topic because more research is needed in multiple aspects. First, the root causes for women's and gender minorities' increased vulnerabilities need to be researched more thoroughly and in consequence, addressed in policies and practice in a more distinct way. Second, more research should be done in how to develop existing community groups as a capacity and how to acknowledge and manage the hazards that might be associated with them. Lastly, there needs to be more research about including gender minorities in menstrual health policy and practice and more widely in disaster, humanitarian, and development contexts.

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Appendix 1: MHM, MHH, and Menstrual health definitions

MHM by UNICEF (2019, p.8)

"Menstrual hygiene management (MHM) refers to management of hygiene associated with the menstrual process. WHO and UNICEF Joint Monitoring Programme (JMP) for drinking water, sanitation, and hygiene has used the following definition of MHM: Women and adolescent girls using a clean menstrual management material to absorb or collect blood that can be changed in privacy as often as necessary for the duration of the menstruation period, using soap and water for washing the body as required, and having access to facilities to dispose of used menstrual management material."

MHM by Sommer (2012, p.83)

"Menstrual hygiene management (MHM) refers to the spectrum of interventions deemed necessary and appropriate to assure adolescent girls and women in various contexts can privately and safely manage their monthly menstrual flow. […] *an MHM approach is multi-faceted, and includes adequate numbers of safe and private latrines (including separate latrines for girls and women with locks inside the doors); easily accessible water (ideally inside a latrine facility); culturally appropriate sanitary materials (cloth, pad); socially and environmentally appropriate means of disposal of used sanitary materials (e.g. burning, burying) or private washing/drying for cloths); and pragmatic information on hygienic menstrual management for pubescent girls who are reaching menarche or newly menstruating."*

MHM by MacRae et al. (2019, p.16)

"Women and adolescent girls accessing and using a clean, comfortable, and reliable menstrual management material to absorb or collect menstrual blood, having access to private spaces for bathing, urination and defecation while menstruating, and for cleaning, drying, changing, storing, and disposing of materials, using easily available soap and water for washing the body and cleaning materials, clothing, and bedding as required, having access to private, safe, and separate facilities to dispose of used menstrual management materials, and receiving sufficient social support and pain management resources. They understand the basic facts linked to the menstrual cycle and how to manage it comfortably in an enabling sociocultural environment, with dignity and without discomfort, fear, worry, or unwanted disclosure of menstrual status."

MHH by UNICEF (2019, p.8)

"Menstrual health and hygiene (MHH) encompasses both MHM and the broader systemic factors that link menstruation with health, well-being, gender equality, education, equity, empowerment, and rights. These systematic factors have been summarised by UNESCO as accurate and timely knowledge, available, safe, and affordable materials, informed and comfortable professionals, referral and access to health services, sanitation and washing facilities, positive social norms, safe and hygienic disposal and advocacy and policy."

Menstrual health by Hennegan et al. (2021, p.2)

"Menstrual health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in relation to the menstrual cycle. Achieving menstrual health implies that women, girls, and all other people who experience a menstrual cycle, throughout their life-course, are able to:

- *access accurate, timely, age-appropriate information about the menstrual cycle, menstruation, and changes experienced throughout the life-course, as well as related self-care and hygiene practices.*
- *care for their bodies during menstruation such that their preferences, hygiene, comfort, privacy, and safety are supported. This includes accessing and using effective and affordable menstrual materials and having supportive facilities and services, including water, sanitation and hygiene services, for washing the body and hands, changing menstrual materials, and cleaning and/or disposing of used materials.*
- *access timely diagnosis, treatment and care for menstrual cycle-related discomforts and disorders, including access to appropriate health services and resources, pain relief, and strategies for self-care.*
- *experience a positive and respectful environment in relation to the menstrual cycle, free from stigma and psychological distress, including the resources and support they need to confidently care for their bodies and make informed decisions about self-care throughout their menstrual cycle.*
- *decide whether and how to participate in all spheres of life, including civil, cultural, economic, social, and political, during all phases of the menstrual cycle, free from menstrual-related exclusion, restriction, discrimination, coercion, and/or violence."*

Appendix 2: List of analyzed policies

House, S., Mahon, T., Cavill, S. (2012). *Menstrual Hygiene Matters: A Resource for Improving Menstrual Hygiene Management Around the World.* WaterAid. Retrieved January 24, 2022 from https://washmatters.wateraid.org/sites/g/files/jkxoof256/files/Menstrual%20hygiene%20matters%20low%20resolution.pdf

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Appendix 3: Interview guide

GENERAL

1. Can you introduce yourself briefly, your job title and how long have you worked in this position?
2. How would you describe your role and tasks in your place of work in your own words?
    - Have you worked with MHM issues in your past or present work?
    - Can you describe to what extent or give an example?

GUIDES/HANDBOOKS/MANUALS

3. Have you ever utilized any guides/handbooks/manuals relating to any topic in your work?
    - If yes, were they created by the organization you work for or were they external?
    - If no, why so?
4. Do you know if there is a MHM guide available in your current place of work?
    - If yes, to the best of your knowledge, to what extent is it used?
5. Have you ever used MHM guides/handbooks/manuals in your past or present work?
    - If yes, was the guide in question a WASH guide with MHM section included or a specific MHM guide?
    - If yes, can you describe how did the guide/handbook/manual influenced your work?
    - Can you give an example of the usage?

MENSTRUAL HYGIENE MANAGEMENT (MHM)

6. Based on your current knowledge, what would you say works well currently in MHM practices and response?
    - Can you give an example?
7. What would you say are the biggest challenges for MHM practices and response?
    - Can you give an example?
8. What would you like to see changed in MHM practices and response, if anything?
9. To the best of your knowledge, to what extent are other menstruating groups (such as non-binary persons, trans men etc.) considered in MHM practices and response?

GENDER-RELATED VULNERABILITIES AND CAPACITIES

10. Can you think of some physical or material vulnerabilities that the beneficiaries have that affect MHM?
11. For the beneficiaries, what to your knowledge are some social vulnerabilities relating to menstruation and MHM?
12. What to your understanding are some motivational or attitudinal (meaning cultural and psychological factors, that may be based on religion, community's history of crisis, or on their expectation of emergency relief) vulnerabilities relating to menstruation and MHM from the beneficiaries' perspective?
13. Can you think of capacities (physical or material, social, or motivational or attitudinal) that the beneficiaries have relating to MHM?

SUMMARY

14. Do you have anything you want to add?
15. Do you have any questions for me?
16. Can I email you with any follow-up questions or clarifications, if any?
17. Do you have any suggestions on other persons that would be beneficial for me to interview?

Appendix 4: Interview consent form

INTERVIEW CONSENT FORM

Working title of research: Gender-based vulnerabilities and capacities in menstrual hygiene management (MHM) response policies
Researcher: Inka Ovaska
Academic supervisor: Maja Svenbro

- I understand that my participation in this research study is voluntary, and I am free to refuse to participate and I am free to withdraw from the research at any time.
- I understand that I can refuse to answer any question without any consequences of any kind.
- I understand that all information I provide for this research will be handled confidentially.
- I understand that any material relating to me (consent form, recordings, transcript of interview) will be handled securely and in confidence.
- I understand that I will remain anonymous in any report of the research. This will be done by designating a pseudonym and disguising any detail that could reveal my identity or the identity of people I speak about.
- I understand that I am free to contact the researcher at any time to seek further clarification and information.
- By signing below, I am indicating my consent to participate in the research as it has been described to me. I understand that the data collected from my participation will be used for a thesis publication and I consent for it to be used in that manner.

Name of participant:

_____

Signature: **Date:**

_____ _____