MENSTRUAL HYGIENE MANAGEMENT: BEHAVIOUR AND PRACTICES IN THE KEDOUGOU REGION, SENEGAL

STUDY

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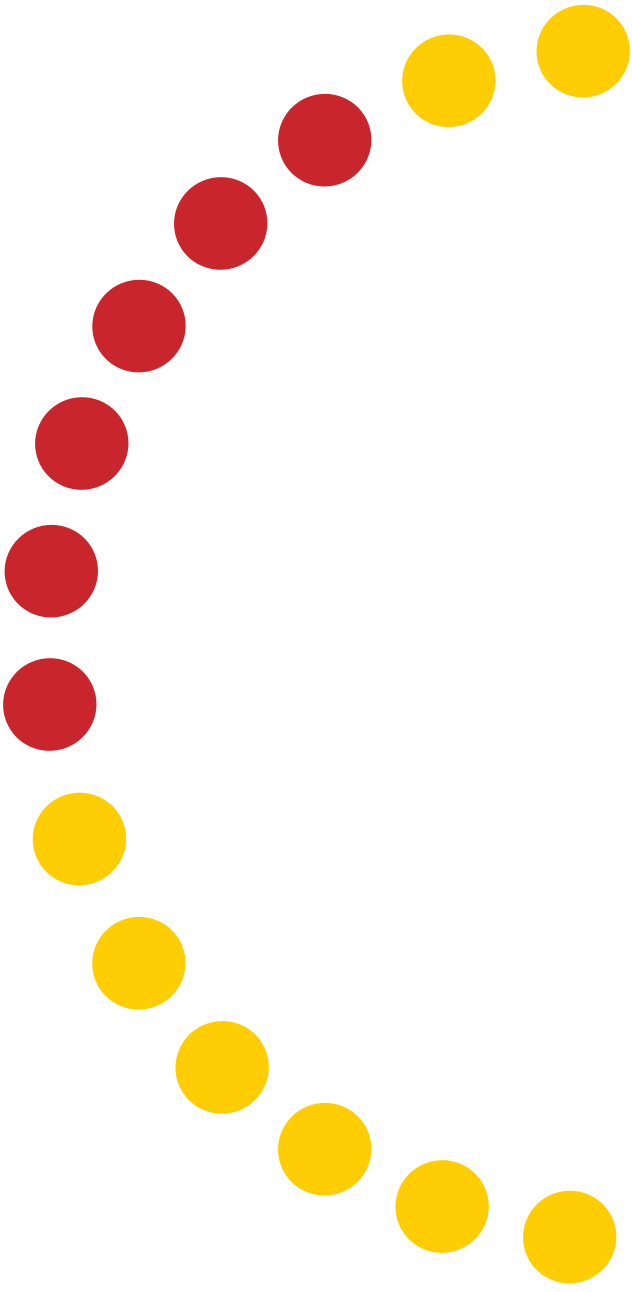
Cover photo: Woman walking through the local market in Kedougou with traditional calabash

MENSTRUAL HYGIENE MANAGEMENT: BEHAVIOUR AND PRACTICES IN THE KEDOUGOU REGION, SENEGAL

A report examining menstrua tion and its management from the perspective of women and girls in the Kedougou region of Senegal. These range from an inability to exercise their rights an d access services due to the silence and stigma that surround menstruation, to poor menstrual hygiene practices and waste management.



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ACRONYMS AND ABBREVIATIONS

AEMO
Action éducative en milieu ouvert (Open setting educational action)

AGETIP
Agence d'exécution des travaux d'intérêt public
(Agency for the Implementation of Public Works)

ANDS
Agence nationale de la statistique et de la démographie (National Agency for Statistics and Demographics)

EDS-MICS
Enquête démographique et de santé à indicateurs multiples (Multiple Indicator Demographic and Health Survey)

EIG
Economic Interest Group

ESPS
Enquête de suivi de la pauvreté au Sénégal (Senegal Poverty Monitoring Survey)

FCFA
CFA Franc

GEA
Gross enrolment rate

GEEP
Groupe pour l'étude et l'enseignement de la population
(Population Studies and Teaching Group)

GSF
Global Sanitation Fund

IGA
Income generating activities

Inh
inhabitant

KEOH
Kedougou encadrement orientation et développement humain
(Kedougou Guidance and Human Development Leadership)

MDG
Millennium Development Goals

MHM
Menstrual Hygiene Management

NGO
Non-Governmental Organization

PDEF
Programme décennal de l'éducation et la formation, Ten Year Education and Training Programme

PEPAM
Programme d'eau potable et d'assainissement du Millénaire (Millennium Drinking Water and Sanitation Programme)

PIC
Plan d'investissement communal (Municipal Investment Plan)

PNDS
Plan national de développement sanitaire (National Health Development Plan)

PNT
Programme national de lutte contre la tuberculose (National Tuberculosis Control Programme)

SCOFI
Scolarisation des filles (Education of Girls)

SDE
Sénégalaise des eaux (Senegalese Water Company)

SMART
Standardized Monitoring and Assessment of Relief and Transitions

SONES
Société national des eaux du Sénégal (National Water Company of Senegal)

STD
Sexually transmitted disease

STI
Sexually transmitted infection

TFP
Technical and Financial Partners

UNESCO
United Nations Educational, Scientific and Cultural Organization

UNFPA
United Nations Population Fund

UNICEF
United Nations Children's Fund

WAG
Women's Advancement Group

WASH
Water, Sanitation and Hygiene

WHO
World Health Organization

WRA
Women of Reproductive Age

WSSCC
Water Supply and Sanitation Collaborative Council

Dindefelo waterfalls in Kedougou

FOREWORD

Hygiene and sanitation are development issues that have long been overlooked by governments. However, as a result of sustained advocacy efforts, they are at the very top of the global and national agenda today.

Senegal has a fairly progressive national strategy that aims to improve gender parity in political representation, healthcare and education, access to drinking water and sanitation facilities and maternal and infant mortality among other priorities. These issues have a critical role to play in efforts to improve living conditions and support the country's social and economic development. Development can only be achieved by meeting the needs and improving the well-being of the population as a whole: both men and women.

Women make up half of Senegal's population. Between the onset of puberty and menopause, women menstruate for around 3000 days. What impact does menstruation have on their personal and working lives? Do they have access to reliable information about menstrual hygiene? Can they rely on medical assistance if they need it? This report lifts the lid on an issue that remains hidden, unspoken and somewhat taboo in many African societies.

This report examines menstruation and menstrual hygiene management. Perspectives range from women's inability to exercise their rights and access services due to the silence and stigma that surround menstruation, to poor menstrual hygiene practices and waste management.

Menstrual hygiene is complex, bringing together interrelated issues of personal hygiene and sanitation, water supply, health, education, the environment and gender. The Government of Senegal, represented by the Ministry for Water and Sanitation and the Ministry for Women, fully support the aims and objectives of the Joint Programme on Gender, Hygiene and Sanitation and the publication of this report, which we hope will inform future design, investment and decisions regarding hygiene and sanitation for women and girls in Senegal. We hope that it will inspire the region and the world as a whole.

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EXECUTIVE SUMMARY

This study on the management of menstrual hygiene in the region of Kedougou in southern Senegal complements an initial study conducted in June 2014 in the urban and semi-urban zone of Louga in the north of the country.

Its main objective is to establish a database of information on public policies, behaviours and practices with regard to menstrual hygiene management (MHM) and to analyse their impact on the living conditions of women and girls in this largely rural and impoverished, region.

To do this, it combines a literature review, direct observation and the collection and analysis of qualitative and quantitative data. The quantitative sample was randomly elected from 750 women and girls aged 11 to 63 years.

The Joint Programme on **Gender, Hygiene and Sanitation** is implemented in West and Central Africa with three pilot countries: Cameroon, Niger and Senegal.

Key results

The study showed that women are the *de facto* managers of water, sanitation and hygiene services in the household, and the community, but are excluded from the processes of decision-making, design, planning and implementation of WASH programmes.

Women are poorly represented or absent on decision-making bodies and NGOs and women's associations do not engage systematically with the design and delivery of WASH services. As a result, women have no forum to have their voices heard or make their needs known with regard to menstrual hygiene management.

Menstruation is a taboo issue in the community, marked by beliefs and myths that influence both its management and the daily lives of women and girls. Seen as an impurity or even a disease, menstrual blood is managed in secret. Mothers often do not discuss menstruation with their pre-pubescent daughters before they reach menarche.

When menstruating, women and girls are subjected to various prohibitions which may be religious (fasting, praying or going to holy places), food-related (ice cream, peanuts, lemon, sugar and gombo), domestic (doing laundry, going to the fields and braiding) or sexual (sharing the conjugal bed or having sexual relations).

While study participants demonstrated a basic awareness of menstruation, particularly the duration and the average age of menarche, **they could not explain why periods occur and had no knowledge of the links between the menstrual cycle and sexual and reproductive health**.

The silence on menstruation is mirrored in sectoral policy documents for health, education, sanitation, water and hygiene. A rapid review of these policies and guidelines reveals that services and facilities across sectors ignore girls' and women's menstrual needs. None of the toilet facilities visited by the study team had made provision for menstruating women to wash, clean themselves and change with privacy and in dignity. This observation applies equally to private multi-family dwellings, educational establishments, places of work (including markets, where women are present in large numbers), health centres and prisons. Just one of the toilets observed had soap and water.

Half the schools visited had no toilet facilities. For those that did have facilities, the toilets observed were poorly maintained and students did not use them. Of the markets visited, just one had toilets, which women did not use on account of their unsanitary condition and because they had to share them with men.

This **absence of adequate sanitation facilities** has a significant impact on the daily lives of women and girls. Over 40% of the girls surveyed said that they missed school for at least one day per month during their periods. And a **majority of economically active women said that they missed work during this period**, preferring to stay at home.

The absence of appropriate infrastructure greatly influences the way in which used absorbent material is managed. Women wash used cloth pads at home and dry them in the toilet or bedroom. Few women dry them outside in the sun out of discretion or due to fear of bad luck. Most girls and women throw menstrual waste, including cloth pads, in latrines.

Poor management of menstrual hygiene can cause infections and have a negative impact on women's reproductive health. M**ore than 90% of the women and girls interviewed in Kedougou had undergone female genital mutilation**. Nearly a quarter of them reported infections during their period suggesting a link between this practice and increased vulnerability to infections.

The lack of access to water in homes forces people to use the river for washing and cleaning (clothes, dishes, automobiles, livestock etc.)
Photo: Two women in Kedougou cleaning clothes

BACKGROUND

This report is the second in a series of studies initiated within the Joint Programme on Gender, Hygiene and Sanitation by the Water Supply and Sanitation Collaborative Council (WSSCC) and UN Women.

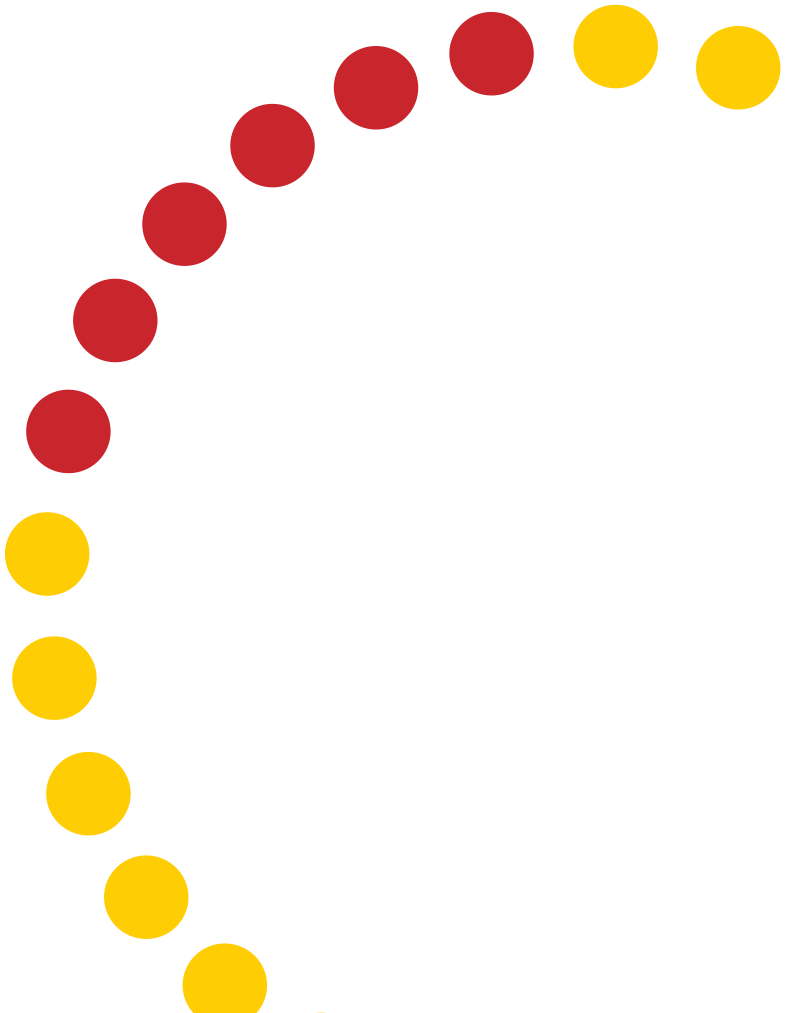
The Joint Programme on Gender, Hygiene and Sanitation combines the expertise and technical skills of two institutions with different but complementary mandates with the common goal of having women's voices heard in order to enable women and girls to achieve their human rights.

Implemented in Senegal, Niger and Cameroon in West and Central Africa, it aims to establish a framework within which all women and girls in this region will be able to benefit in a sustained manner from sanitation, hygiene and water (WASH) services.

The general goal of the Programme is to speed up policies and practices to promote fairness and the human right to water, hygiene and sanitation for the women and girls of West and Central Africa. The issue of menstrual hygiene is a powerful entry point to highlighting the different needs that women and girls have from men and boys in order to benefit from basic services.

Information on the issue of menstruation practices and services is insufficient and practices and behaviours in this area are little documented or not at all.

The two studies on menstrual hygiene management in Louga and Kedougou aim to contribute to filling this gap and raising awareness of this issue for policy and practice.



The study area

The administrative and economic situation of the region of Kedougou

Following the administrative reforms under Law 2008-14 of 18 March 2008, the region of Kedougou was formed from the division of the former region of Tambacounda. Kedougou occupies an area of 16,896 km2, has 151,357 inhabitants[1] and is the most mountainous region in Senegal.

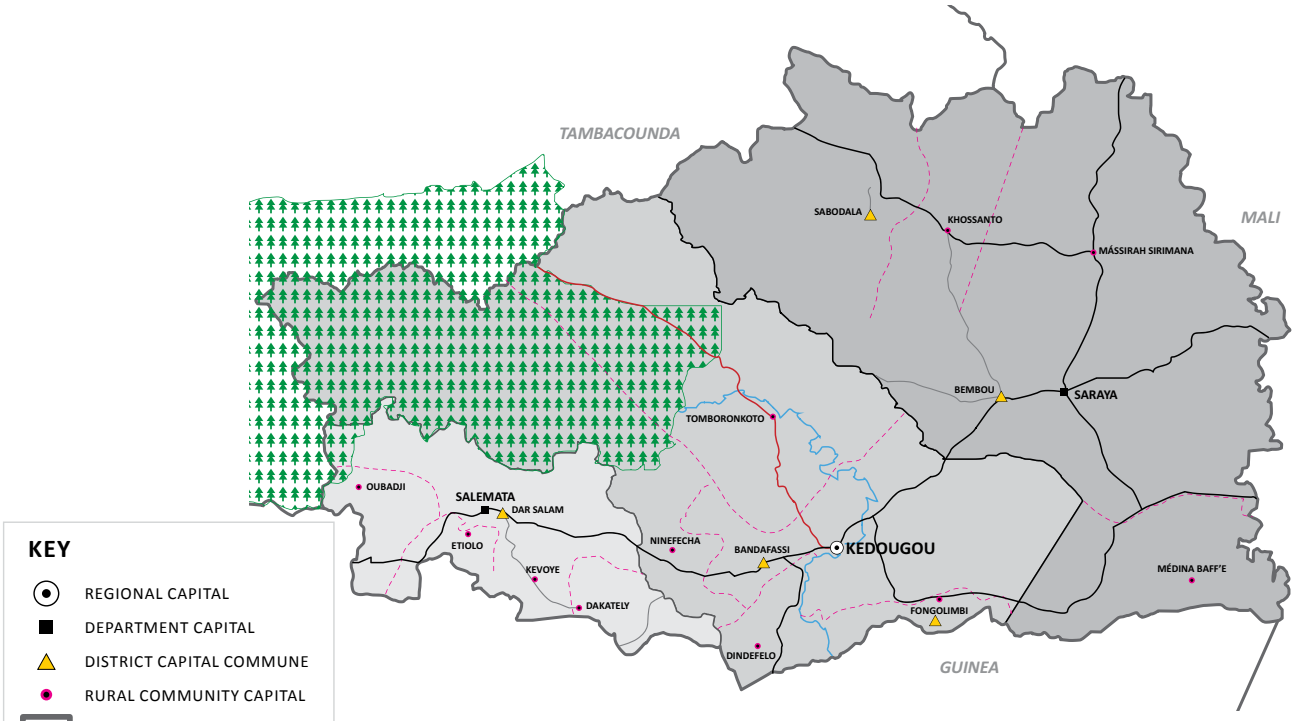
Kedougou is flanked on the west by the hills of Bassari country and Mount Assirik, which dominate Niokolo-Koba National Park; to the north by the district of Tambacounda; to the east by the Republic of Mali and to the south by the Republic of Guinea. It is traversed by the river Gambia, which rises in Fouta-Djalon in neighbouring Guinea, and by its tributaries such as the Niokolo Koba. It is a landlocked region located 710 km from Dakar, the capital of Senegal.

Administratively, Kedougou region is composed of three districts (Kedougou, Salemata and Saraya), six boroughs or provinces (Bandafassi, Fongolimbi, Dakatéli, Dar Salam, Bembou and Sabodala), 23 local authorities and 317 villages.

The region has significant mineral resources including gold. Incomes from traditional gold mining are very significant and, thus, attract numerous agricultural workers.[3] Nevertheless, agricultural activities still remain the main source of income for the farmers who represent more than 70% of the population.

The 2010-2011 Follow-Up Survey of Poverty in Senegal (ESPS II) reveals that the incidence of poverty in the region is 71.3%, that is, 7 out of 10 inhabitants.

The administrative division of Kedougou region[2]



1 According to the final report of the General Census of population and habitat, agriculture and animal husbandry in Senegal 2013, http://www.ansd.sn/ressources/RGPHAE-2013/ressources/doc/pdf/Rapport-definitif-RGPHAE2013.pdf Kedougou has a population of 151,357 inhabitants (see pp. 67 and 68 of the report). It is important to note that the sample of this study was constituted on the basis of a total population of 152,134 inhabitants in Kedougou in accordance with figures provided by the local government at the inception of the study.

2 Map available at http://www.ansd.sn/index.php?option=com_regions&view=region&id=9&Itemid=1223

3 This information is taken from the draft Regional Integral Development Plan document for Kedougou region, available from the Kedougou Regional Statistics and Demographics Service. The document notes the significance of gold-mining related income without giving specific figures.

Social situation

The town of Kedougou and surrounding urban areas have a strong voluntary sector including Economic Interest Groups, (EIGs), Women's Advancement Groups (WAGs) and women's associations.

Often constituted by an individual who then brings on various members of the family to hold different posts, these women's organizations are plagued by poor credibility. Even so, efforts are being made in the area of education of young women with the establishment of the Regional Centre for the Technical Education of Women (CRETF), which offers skills training in a range of areas such as tailoring, catering, hairdressing, dyeing, the processing of agricultural products, etc.

In general, women carry out household chores and income generating activities (IGA), combining productive, reproductive and women's community management roles, the latter two being predominant. Their main income generating activities are retail, market gardening, small-scale livestock rearing, processing agricultural and forestry products and dyeing. Nonetheless, according to the 2010-2011 EDS-MICS report, 59% of economically active women independently decide how to use their income, unlike the remaining 40% who have to gain their husband's approval.

In parallel with IGA, women organize outreach sessions in neighbourhoods on early marriage and pregnancy, schooling for children, especially girls, and their retention in education, reproductive health, sexually transmitted infections and diseases (STI and STD), etc.

Men make up the majority of members of community and state decision-making bodies. They exercise productive and political activities. The main activities in the area revolve around gold-mining. During the winter season, men also take part in agricultural activities.

Menstruation and MHM are remain a taboo in society in Kedougou, even within women. In the photo, Veronique and Leontine at Veronique's home in Indaar.

Data on girls' and women's education and literacy

The State of Senegal has committed to achieve schooling for all by 2015. In Kedougou region however, the education system remains characterized by under-schooling, and particularly that of girls. In 2013, the drop-out rate was 8.9% for boys and 11.2% for girls.[4] Thus, the retention of girls at school is a challenge.

Table 1
Gender parity index

Education (level)	Number of pupils		Girl/boy Ratio
	Girls	Boys	
Basic education	1,218	1,179	1.03
Elementary	12,409	13,782	0.90
Middle	3,419	5,449	0.62
Secondary	444	1,391	0.32

Source: Annuaire statistique national – Année scolaire 2012-2013.[5]
(National Statistical Yearbook - 2012-2013 School Year)

According to the Association of Teachers for the Education of Girls (SCOFI), girls' access to and retention in school conflicts with socio-cultural factors such as early marriage and pregnancy, responsibility for housework, poverty, incompatibility between the school and agricultural calendars, and also and especially, traditional gold-mining.

What is more, according to statistics from the Ministry of National Education for 2013, more than half of elementary schools had no sanitary facilities. Thus, 52% of schools had no toilets and 59% had no access to water. In the region as a whole, only 23% of schools had a handwashing facility. The lack of WASH infrastructure in schools is even more marked in middle and secondary education than in elementary.[6]

The literacy of the population is also a challenge. According to the National Agency for Statistics and Demographics (ANSD), the literacy rate in Kedougou is 35%. Thus, 65% of the population is illiterate. UNESCO data indicate that women account for 85% of this group.[7] There are few literacy classes in the region outside the town of Kedougou, the region's capital, which has a small number.[8]

4 Senegal Education National Statistical Yearbook 2013, Kedougou School Inspectorate.
5 Ministry of Education - Directorate of Education Planning and Reform, Office of Educational Statistics: http://www.education.gouv.sn/root-fr/upload_pieces/ANNUAIRE%20STAT%20EDUCATION%202012%202013.pdf
6 Annuaire statistique national – Année scolaire 2012-2013 (National Statistical Yearbook - 2012-2013 School Year), Senegal Ministry of National Education - Directorate of Education Planning and Reform, Office of Educational Statistics: http://www.education.gouv.sn/root-fr/upload_pieces/ANNUAIRE%20STAT%20EDUCATION%202012%202013.pdf
7 Women's and Girls' Literacy Project (PAJEF), UNESCO - Regional Office for Education in Africa (Dakar) http://www.unesco.org/new/fileadmin/MULTIMEDIA/FIELD/Dakar/pdf/Fiche_PAJEF_visite_DG.pdf
8 Information taken from the Kedougou Municipal Investment Plan (2012). However, this document does not provide precise figures.

Health data

The Kedougou Medical Region comprises the health districts of Kedougou, Salemata and Saraya. According to World Health Organization (WHO) recommended standards for health infrastructure coverage, the Kedougou Region presents a reasonably satisfactory rate (see tables 2 and 5).

Table 2
Main health infrastructure ratios

Infrastructure	WHO Standard (WHO 2005)	National Data (PNDS)	Kedougou Region Data
Hospital	1:150,000 inh.	1:150,000 inh.	1:141,846 inh.
Health centre	1:50,000 inh.	1:100,000 to 150,000 inh.	1:47,267 inh.
Health post	1:10,000 inh.	1:5,000 inh.	1:5,672 inh.

Source: Kedougou Health Centre (2011 data)

This apparently satisfactory coverage rate, however, masks many disparities and difficulties of access to health services. In fact, there is an unequal distribution of health infrastructure in the region, where mountainous terrain also makes access difficult for the population.

Outside Kedougou, no district level health centre has a cold chain storage. Medical imaging services in Saraya and Salemata health centres are also devoid of such technical equipment as radiology, ultrasound and odonto-stomatology, and do not have staff specialized in these areas.

The region has 176 basic healthcare centres, 46 (26%) of which are not operational. These facilities have just seen the addition of a private clinic and two private dispensaries in Kedougou town and a pharmacy in Saraya.

Table 3
Distribution of the population by distance from health facilities

Distance (km)	District		
	Kedougou	Saraya	Salemata
Under 5 km	45%	29%	42%
5-10 km	25%	33%	31%
Over 10 km	30%	38%	27%
Total	100%	100%	100%

Source: Kedougou Health Centre (2011 data)

Table 4
Condition of health facilities

District (Area covered by district)	Health Centres	Health Posts		No. of villages covered by district	No. of inhabitants covered by district (2013)
		Urban area	Rural area		
Kedougou (9 984 km²)	1	1	9	163	77,652
Salemata (1 970 km²)	1	0	5	70	23,248
Saraya (6 837 km²)	1	0	10	102	41,326
Total	3	1	24	335	141,846
		25			

Source: Kedougou Health Centre (2011 data)

According to figures for 2010-2011, there were 85 health personnel working in Kedougou region, including nine doctors, one dentist, 44 nurses and 31 midwives. Table 5 presents the health staff ratios for Kedougou region.

Table 5
Health staff ratios for Kedougou region

Staff	WHO Standard (WHO 2005)	National Data (PNDS)	Kedougou region data
Doctor	2.28-2.5: 10,000 inh.	1:10,000 inh.	1:12,890 inh.
Nurse	1:5,000 inh.	1:5,000 inh.	1:2,836 inh.
Midwife	1:3,000 WRA	1:3,000 WRA	1:1,352 inh.
Obstetrician/ Gynaecologist	1:1,000-1,500 pregnancies	1:1,500 WRA	00

Source: Kedougou Health Centre (2011 data)

These figures show that the region is still a long way away from WHO standards for numbers of doctors and midwives. Additionally, there is an absence of an obstetrician/gynaecologists. This lack of qualified staff contributes to the region's high maternal and child mortality rates.

Kedougou is also home to many migrants from the sub-region, attracted by gold-mining and related activities. The HIV/AIDS rate is 1.7% in the region, against 0.7% nationally. What is more, the geography of the region, characterized by mountainous terrain and an annual average rainfall of 1,300 mm over five months, combined with the presence of dense forest, promotes the development of vectors of malaria, arboviruses, etc.

These different elements could explain the poor performance recorded in the region's health subsector (see table 6).

Therese is toasting peanuts in the Bedik village of Ethiowar

Table 6

Performance indicators in the health subsector

Performance indicator	EDS-MICS V (2010–2011) Kedougou	EDS-MICS V (2010-2011) national average
Total Fertility Rate	6.1	5
Practice of excision	92%	25.7%
Participation of women in decisions concerning their own healthcare	23.7%	30.6%
% of people without medical cover (insurance)	W: 97.1%	W: 93.6%
	M: 95.3%	M: 91.7%
Contraceptive prevalence (modern method, women living in relationships)	6.1%	12.1%
Assisted childbirth	25.4%	65.1%
Fully vaccinated children	40.4%	62.8%
Underweight children (under 5 years)	15.7%	15.9%
Use of impregnated mosquito nets for children under 5 years	51.1%	30.8%
Prevalence of HIV	1.7%	0.7%
Neo-natal mortality	30%	29%
Infant and child mortality	154%	72%
Maternal mortality rate	628%	392%
Global acute malnutrition rate	8.6% (SMART 2012)	8.8% (SMART 2012)
Tuberculosis detection rate	21% (Medical region 2012)	55% (PNT[9] 2012)
TB cure rate	37% (Medical region 2012)	81% (PNT 2012)

Source: Kedougou Health Centre (2011 data, unless stated otherwise)

9 Programme national de lutte contre la tuberculose (National Tuberculosis Control Programme)

Water and sanitation data

Access to water

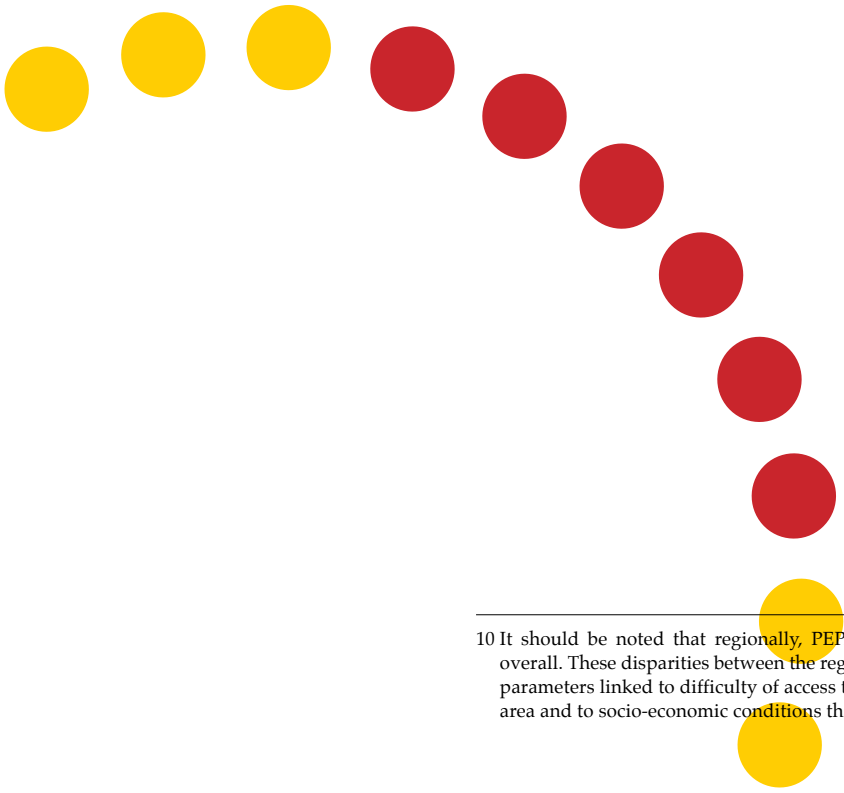
With regard to rural water, the region has a total of 515 boreholes with hand pumps and 24 powered boreholes. Of the latter, four are solar and 20 are operated by diesel engines. The flow rates of these boreholes vary from 1 to 15 m3 per hour, which is relatively low compared to the needs of people and livestock.

In Senegal, urban water is provided by SDE and SONES. In Kedougou, however, only Kedougou town, the region's capital, is served by the SDE network, while the districts of Salemata and Saraya are still supplied by the rural water method.

The three main modes of water supply in Kedougou are the Gambia River, wells and SDE. However, according to the Municipal Investment Plan (PIC), Millennium Development Goal (MDG) 7 on access to drinking water for all will not be achieved by 2015 in Kedougou town.[10] Despite being served by the Gambia and Faleme rivers, the town of Kedougou has water shortages during periods of extreme heat, due to insufficient supply, frequent breakdown of public standpipes and boreholes, and the rapid drying up of wells.

For financial reasons, some people prefer to use river and well water for household tasks and personal washing. Available figures do not give a precise indication of the percentage of the population that mainly uses river water. This situation may explain the proliferation of such diseases as diarrhoea, dysentery and schistosomiasis in the riverine areas. Even so, it should be noted that, according to the joint PEPAM Annual Sectoral Review for 2012, the MDG target for water has been met overall in Kedougou region, with a percentage of 94.4%.

Figures for Kedougou and Salemata for 2011 revealed that of 4,820 multi-family dwellings visited in Kedougou town, 18% were supplied by a private connection and/or public standpipe, 62% used water from unprotected wells and 20% used well and river water.



10 It should be noted that regionally, PEPAM data indicate that the MDG for water has been reached overall. These disparities between the region and the town are frequent and are explained by a number of parameters linked to difficulty of access to certain areas, to the living conditions of the inhabitants of the area and to socio-economic conditions that foster inequality of access.

Sanitation data

According to PEPAM data, 55.3% of households do not have latrines and practise open defecation.[11] Sanitation in Kedougou region is still embryonic from the viewpoint of both private and collective facilities. According to the EDS-MICS PEPAM survey of 2010-2011, the rate of access to sanitation is 9.2%. The coverage rate for households is 2.8% for self-ventilated improved latrines, 5.3% for latrines with slabs, and 35.5% for traditional latrines.

There is almost no system for the removal of waste and rainwater except for a two kilometre-long pipe in Kedougou town, running alongside national Highway 7. Some multi-family dwellings tip it out onto the road, and others use makeshift sumps. Pools of stagnant water, potential breeding sites for malarial mosquitoes, are particularly numerous during the winter.

Collecting water at a pump is a daily routine at location sometimes involving a walk of several kilometers. Photo: a water pump in Bandafassi

11 Millennium Drinking Water and Sanitation Programme, EDS-MICS/PEPAM 2010-2011

The issue

There is very little qualitative or quantitative data available on menstrual hygiene management in Africa, and in Senegal in particular. At regional level, there have been some recent studies on menstrual hygiene management in schools,[12] for example in Burkina Faso and Niger. It is much harder to find studies or research on how this affects women of all ages inside and outside schools, at the workplace and at home.

Menstrual hygiene information is not regarded as important in either health or education establishments in Senegal. Yet women and girls account for more than 50% of WASH service users and also have *de facto* responsibility for managing water, hygiene and sanitation services. It is indeed strange that these services fail to articulate or meet the specific needs of half of the population that has regular periods and requires access to information, water, soap and detergent, washing facilities and menstrual waste management options. Women and girls are forced to manage silently, without anyone knowing and are ill equipped to do so. This natural, biological function is shrouded in shame and silence. It is against this background that the Joint Programme on Gender, Hygiene and Sanitation emerged as an initiative between two United Nations bodies: UN Women and WSSCC.

The Programme's overall aim is to accelerate the development of policies and practices that promote equality and the human right to water, hygiene and sanitation for women and girls in West and Central Africa. The Programme focuses in particular on menstrual hygiene as an entry point to public policies, budgets and monitoring systems that better reflect the specific needs of women and girls different from those of men and boys. It aims to also improve practice on the ground so that facilities are more appropriately designed, constructed and maintained to respond to the needs of women and girls inside and outside the home.

Literature review

There is little literature on the management of menstrual hygiene. Most studies in this area are limited to schools and relate to girls.

Among these, the study conducted for UNICEF by Long J. and Caruso B on water, hygiene and sanitation in schools in Bolivia [13] reveals the fear and shame experienced by the pupils surveyed during their periods.These feelings are even manifested by a change in classroom behaviours. "They are less dynamic and do not have fun like they do in normal times." Teachers and mothers testified to girls' "well-behaved, calm" attitude at these times, admitting their difficulty in discussing this matter with their pupils/daughters.

In West Africa, as in Bolivia, girls face many difficulties over the management of their menstrual hygiene, including the use of absorbent materials. A study conducted by WSSCC and UN Women in the region of Louga, Senegal[14] shows that sanitary napkins and cloths are the most commonly used materials for the management of menstruation. Some women, mainly those living with disabilities, also use sponges (the stuffing of mattresses).

12 L'hygiène menstruelle dans les écoles de deux pays francophones d'Afrique de l'ouest : Burkina Faso et Niger, études de cas en 2013, UNICEF 2013 – WASH in schools empowers girls education in rural Cochabamba, Boliva – an assessment of Menstrual Hygiene Management in schools, UNICEF 2012.

13 WASH in Schools Empowers Girls' Education in Rural Cochabamba, Bolivia: An Assessment of Menstrual Hygiene Management in Schools, UNICEF, 2012.

14 Gestion de l'hygiène menstruelle : Comportements et pratiques dans la région de Louga, Sénégal. (Menstrual Hygiene Management: Behaviours and Practices in the Louga Region, Senegal.) WSSCC/UN Women, 2014.

From Latin America to Africa to the Far East, socio-cultural beliefs influence MHM practices. In Bolivia, some girls believe that they must not shower in cold water when menstruating, for fear of falling ill, of becoming infertile or of having their menstrual cycle shorten. Neither must they participate in sports or run, for fear of creating or increasing pain. Some foods, such as milk, are forbidden for fear of changing the colour of the blood. In China, women believe that they must not wash their scalp during their periods for fear of catching cold. In India and Nepal, menstruating women must not worship, cook or touch particular foods.

The Louga study reveals similar practices. Thus, a menstruating woman cannot make mayonnaise as it will not thicken properly or make homemade yoghurt, or even braid hair for fear of causing the braided person's hair to fall out.

The two studies reveal that sexual relations are not permitted during the menstrual period. In Louga, where more than 95% of respondents are Muslim, this is mainly because it is forbidden by the religion. In Bolivia, according to beliefs, sexual relations during menstruation would lead to pregnancy.

The two studies present similar results on infrastructure and access to good information. In both cases infrastructure for safe and dignified management of menstruation is inadequate, where it exists at all.

Other studies establish the link between the management of menstrual hygiene and a lack or inadequacy of infrastructure.[15] Thus, even in schools with toilets, these toilets never take account of the needs of disabled people.

In Niger, no school had separate toilets for boys and girls. In Burkina Faso, only 50% of schools had separate toilets.

WHO standards call for one toilet per 25 girls and one urinal per 50 boys. Keihas, on the other hand,[16] showed that the ratio was two toilets for 666 pupils (i.e. 1:333) in Niger and six for 470 pupils (i.e. 1:78) in Burkina Faso.

None of these schools had handwashing facilities. Handwashing facilities were found in 33% of schools in Niger and 60% in Burkina Faso, located outside the toilets making it difficult to manage menstruation in private. Thus, girls find it hard to wash either their re-usable sanitary pads or their hands, for fear of being seen.

According to these studies, the inadequacy of toilets has a negative impact on pupils' hygiene and on girls' attention and participation in school when they are menstruating. In addition, this discourages them from attending school during their periods.

The existing literature shows that menstruation remains a taboo subject and that it is not taken into account in planning, policies or budgets.

It should be noted, nevertheless, that none of the studies included in their sample women from a variety of age groups and social economic categories.

This study has been conducted with girls and women from the Kedougou region, including those living with disabilities, those in prison, girls attending school and not attending school, housewives, and lastly, women working in the formal and informal sectors.

15 Laura KEIHAS. L'hygiène menstruelle dans les écoles de deux pays francophones d'Afrique de l'Ouest, Burkina Faso et Niger. Études de cas en 2013. UNICEF. 2013.
16 Ibid.

A shared latrine in Bandaffasi

REVIEW OF EXISTING PUBLIC POLICIES RELATED TO MHM

The review of public policies included key policy documents and sectoral policies for water, sanitation, hygiene, health and education. These documents have been analysed and departmental heads, decision-makers and staff at national and local levels interviewed.

The Millennium Drinking Water and Sanitation Programme (PEPAM)

As emphasized in the sectoral policy paper on water and sanitation in urban and rural areas,[17] the National Millennium Drinking Water and Sanitation Programme (PEPAM) is the programmatic framework within which all actions carried out in Senegal to do with drinking water and sanitation in the urban and rural setting must fit and through which the government of Senegal intends to achieve related MDGs by 2015.

In the field of drinking water, the goal is universal access in urban areas and an 82% access rate in rural areas. For sanitation, Senegal has set itself the goal of a 78% access rate in urban areas and 59% in rural areas.

Funding requirements between 2005 and 2015 to achieve this are estimated overall at FCFA 274 billion for the rural component and FCFA 241 billion for the urban component.[18] For this, PEPAM has, in particular, the sectoral policy paper for drinking water and sanitation in the urban and rural setting, signed on 15 July 2005, which formalizes the programmatic approach of PEPAM and its strategic orientations. According to PEPAM, MDGs in the water subsector have been met overall in Senegal, while sanitation MDGs are out of reach.

Neither the sectoral policy paper nor the sanitation strategy address the issue of menstrual hygiene.

17 Sectoral policy paper on water and sanitation in urban and rural settings, Republic of Senegal (Ministry of Agriculture and Water, Ministry of Prevention, Public Health and Sanitation, Ministry of Planning and Sustainable Development, Finance Ministry), June 2005 http://www.pepam.gouv.sn/docs/lpsepa_fr.pdf

18 Ibid.

The Hygiene Code

Law 83-71 of 5 July 1983 on the Hygiene Code includes provisions defining hygiene rules for dwellings and hygiene rules for public roads. This law lists the tasks assigned to the National Hygiene Service, which include:

- educating the population on hygiene and public health;
- enforcing hygiene-related legislation and regulations in urban and rural areas;
- monitoring borders and maintaining sanitary requirements checks on the movement of people;
- seeking out and recording hygiene offences;
- assisting administrative authorities in the field of hygiene and public health;
- conducting vector control and prophylaxis against endemic and epidemic diseases.[19]

The Hygiene Code does not explicitly mention menstrual hygiene, even though this would technically fall within the purview of the National Hygiene Service, particularly with regard to educating people about hygiene and public health.

The National Health Development Plan

Health policy in Senegal is still based on primary healthcare and reflects health-related commitments made by Senegal at subregional, regional and world levels, among which appear the Millennium Development Goals (MDGs).

The National Health Development Plan (PNDS) 2009-2018[20] is the reference document for all actors in the health sector. It rests on a vision of Senegal where every individual, every household and every community has universal access, with no exclusion of any kind, to quality health services.

The PNDS 2009-2018 has four goals:

- reducing the burden of maternal and infant and child morbidity and mortality;
- increasing the sector's performance in the prevention of and fight against disease;
- strengthening the health system;
- improving the governance of the health sector.

Like the water, hygiene and sanitation sectors, the health sector does not explicitly include MHM even though a regular menstrual cycle is a sign of female health and vitality and proper hygiene prevents infections and poor self-esteem.

19 Law 83-71 of 5 July 1983 on the Hygiene Code, enforced as a law of the State. Passed in Dakar on 5 July 1983, signed by Mr Abdou Diouf, President of Senegal (www.sendeveloppementlocal.com/file/36018/)

20 National Health Development Plan 2009-2018, Republic of Senegal. Ministry of Health and Prevention. January 2009. Available at: http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Country_Pages/Senegal/PNDS2009_2018.pdf

Programme to Improve the Quality, Fairness and Transparency of Education (PAQUET) 2013-2025

The Programme to Improve the Quality, Fairness and Transparency of the Education and Training Sector (PAQUET-EF)[21] is the framework for implementation of Senegal's education policy for 2013-2025.

The Programme explicitly quotes the gender policy. Moreover, fairness and parity are among the objectives to be achieved. The document mentions that 9% of school drop-outs are due to early pregnancy and marriage.

The Programme does not mention the conditions for the management of menstruation in schools as a deterrent on the continued schooling of girls. Nevertheless, one of the results of the PAQUET programme, namely "Increased access to inclusive education", under the fair access component, could be a gateway for the management of menstrual hygiene in the sectoral policy.

Gender Equality and Equity Strategy (Sneeg) 2005-2015

Senegal has formulated a Gender Equality and Equity Strategy,[22] driven by the Ministry of Women, Family and Childhood.

The issue of menstrual hygiene is not mentioned anywhere in this strategy.

Emergent Senegal Plan

In February 2014, the Government of Senegal adopted a new development plan to accelerate its progress towards emergence. This plan, entitled Emergent Senegal Plan[23] (PSE), is the new benchmark for economic and social policy for the medium and long term. This document explicitly provides for the integration of gender in public policies.

The Emergent Senegal Plan and the issue of equity and gender equality

The PSE takes into account the needs, rights and contributions of women, following an integrated approach. In this area, the strategic objective is **to empower and promote women and girls** through building the capacities of institutions and local authorities to integrate gender into public policies, to improve the legal framework for the protection of women and girls, and to strengthen the leadership of women and their entrepreneurial capacities for inclusive growth.

Excerpt from chapter III, Theme 3 of the Emergent Senegal Plan, page 104

Analysis of sectoral policy papers on health, education, water and sanitation, the Gender Equality and Equity Strategy, and the Code of Public Hygiene, and interviews conducted with professionals in these sectors reveal that MHM does not appear in either the public policy documents or in the tools for implementing these policies.

21 http://www.gouv.sn/Programme-d-Amelioration-de-la.html
22 www.directiongenre.com/docs/sneeg.pdf
23 http://www.gouv.sn/Plan-Senegal-Emergent-PSE.html

Men building a hut in the mountains in Ethiowar village

OBJECTIVES AND METHODOLOGY OF THE STUDY

Objectives

The study's main aim is to establish a database of information on public policies behaviours and practices with regard to menstrual hygiene management (MHM) and to analyse their impact on the living conditions of women and girls.

In addition, the study has as specific objectives:

- to record the situation with regard to MHM behaviours and practices in the region of Kedougou, Senegal. This involves a situation analysis of existing infrastructure and public policies;
- to check the level of knowledge of women and girls about MHM and the information available in this sphere;
- to analyse the impact of the lack of information, and of existing policies and infrastructure on the health, educational level and employment of women and girls and their living conditions.

Methodology

A mixed research methodology was preferred to collect the information for this study. It combined a literature review, observations, and the collection and analysis of qualitative and quantitative data.

In total, the study was conducted with 785 people, 757 of whom participated in the quantitative sample and 28 in the qualitative sample.

Quantitative data

The sample used to collect quantitative data was selected at random from the total population of the Kedougou region and involved women and girls aged from 11 to 63 years, that is, a base population of 66,273 persons.[24] The target population consisted of all the girls and women aged 11 years and over who had had at least one period. Girls of 11 were included because they could have seen their first menarche. Women up to 63 were included in order to have the perspective of people who had lived through the entire menstrual period from puberty to the menopause.

Emphasis was placed on the 11-25 year age group, designated by the term "adolescents".

The target population was divided into strata using a two-level stratification: by district and by urban-rural classification.

- Level one: Administrative districts were chosen as primary units of stratification. Quotas were applied in each primary unit (stratum), while respecting the structure of the reference population. Thus, according to the Kedougou regional statistics and demography service, 52% of the population of girls and women aged 11 to 63 years were from the district of Kedougou, 35% from Saraya and 13% from Salemata.[25]
- Level two: within each administrative district a second stratification was made on the basis of the area being rural or urban. Some 46% of the women were from rural areas while 54% were from urban areas.

24 2011 data from the Kedougou regional statistics and demography service.
25 Kedougou regional statistics and demography service.

The prison population and people living with disabilities were included in the sampling. Thus, two inmates in Kedougou Prison (MAC, from Maison d'arrêt et de correction, house of detention and correction) and 21 persons with a motor or visual disability were also surveyed.

In total, the questionnaire was administered to 757 women and girls from the region.

Table 7
Questionnaire samples

Départements	Zone		Total
	Urban	Rural	
Kedougou	213	193	**406**
Saraya	128	121	**249**
Salemata	52	50	**102**
Total	393	364	**757**

Qualitative data

The quantitative data were complemented by qualitative data. These were collected through focus groups,[26] individual interviews or through interviews and observations.

In total, 93 people were involved in the qualitative sample; 65 women and girls took part in the various focus groups and 28 people were interviewed (21 at local level and 7 at central level).

Focus groups

Eight focus groups were organized. They contained between 3 to 10 women and girls each. In total, 65 women and girls took part in the different focus groups.

Table 8
Focus groups sample

District	Number of focus groups	Number of focus groups
Kedougou	4	37
Saraya	2	18
Salemata	2	10
Total	8	65

Local level interviews

The 21 individuals interviewed in Kedougou region included heads of decentralized services, local elected officials, dignitaries, traditional communicators, the managers of NGOs, the leaders of women's associations and associations for people living with disabilities, religious leaders, teachers and gold-miners.

26 Focus groups are restricted discussion groups made up of 6 to 8 women or girls, within which they are free to speak. The leaders of these groups invite participants to speak, share and learn about the management of menstrual hygiene.

Table 9
Local level interviews sample

Interviews	District			Total
	Kedougou	Saraya	Salemata	
Decentralized services – only men	6	-	-	**6**
Local elected officials – only men	-	-	2	**2**
Customary and religious leaders – only men	-	1	1	**2**
President of the Association of Traditional Communicators – man	1	-	-	**1**
Teachers – one man and one woman	2	-	-	**2**
Dignitaries – only men	0	1	1	**2**
Representative of the Kedougou Women's Association for Development (AFKD) – woman	1	-	-	**1**
President of the Association for people living with a motor or visual disability – woman	1	-	-	**1**
NGO manager – man	1	-	-	**1**
Gold-miners – two men and one woman	-	3	-	**3**
Total	12	2	4	**21**

The predominance of men in the interview sample is explained by their strong representation in decision-making bodies at both community and state levels. Thus there are only men at the head of decentralized services. Women occupy decision-making positions mainly in women's associations or in purely social institutions such as the Association for People Living with a Disability.

The Kedougou Guidance and Human Development Leadership (KEOH) NGO was chosen on account of its strong roots in the Kedougou region. It is, in fact, active in the three districts and is mainly involved in the prevention of early pregnancy and reproductive health issues.

Districts

The seven individuals interviewed included the Director of Hygiene, the focal point of the Agency for Implementation of the Global Sanitation Fund Programme in Senegal, two project managers from the Sanitation Directorate, one manager from the Water Directorate, the PEPAM coordinator, and a manager from the United Nations Population Fund (UNFPA), Senegal.

Observations

These concern WASH infrastructure, particularly latrines, water points, hygiene behaviours and the disposal of waste in various places where people live and work. In total, 12 dwellings, four schools, three markets, one health centre and Kedougou Prison were visited.

Data collection tools and interviewer training

a) Data collection tools

Tools were developed to collect information. They were all validated by the UN Women and WSSCC joint programme team. They included a questionnaire, interview guides for the conduct of interviews and focus groups, and observation grids.

- **Questionnaire:**
  The questionnaire addressed the following topics:
  - profile of respondents (educational level, marital situation, ethnic group and religion);
  - girls' and women's level of knowledge about menstruation;
  - management of menses (body and personal hygiene, washing and drying equipment, handwashing with soap, and management and disposal of waste);
  - social and religious considerations around menstruation;
  - impact of menstruation on girls' and women's living conditions;
  - the case of women and girls who have been subject to female genital mutilation;
  - girls and women who live with a disability;
  - girls' and women's recommendations for better management of menstrual hygiene.
- **Guide for interviews and focus groups:** The focus group discussions and in depth interviews mainly addressed issues of access to information on MHM, the behaviours and practices of girls and women, and beliefs about menstruation. They addressed the issue of the impact of menstruation on girls' and women's living conditions. The girls and women then formulated recommendations for the good management of menstrual hygiene.
- **Interviews with administrative and local authorities:** These addressed the issue of hygiene and sanitation policy, and the inclusion of MHM in their respective areas of responsibility and activity.
- **Observation forms:** The observation of water, hygiene and sanitation infrastructure in connection with MHM in multi-family dwellings, schools, places of work and prison focused on the spaces available, the presence of latrines, and the existence of soap, water and provision for disposal of waste. Photographs were taken as part of the observation.

b) Interviewers' profiles and training

To conduct the interviews in the three districts of Kedougou, Saraya and Salemata, 15 female interviewers aged between 28 and 46 years were recruited. They were chosen from community support workers. Ten were from Kedougou and five from Saraya. Women interviewers were used for this study in order to put interviewees at ease and allow them to talk openly about a taboo subject. Without these women interviewers, it would not have been possible to carry out this study in Kedougou region because of the strongly patriarchal culture.

All the interviewers spoke at least three local languages in addition to French.

They were trained for two days in survey administration techniques, on the content of the questionnaire, on the importance and significance of the study, and on research ethics.

Data collection

Data collection lasted 10 days. After a first day of training, a pre-test was organized on a sample of 30 questionnaires in the six major districts of Kedougou: Dinguessou, Lawol Tamba, Dandé Mayo, Togoro, Dalaba, and the Mosquée (Mosque) district.

Following this pre-test, the section of the questionnaire on girls' and women's expectations for better MHM was modified. This was because some closed questions made it impossible to collect relevant information.

In addition, the interviewers found it difficult to ask the question on the names used to denote women's menstrual periods in the local language. These questions as well as certain nuances around the levels of knowledge on menstruation were revised to make them more appropriate for the local context.

Questionnaires written in French were administered in local languages, including Fula, Malinke and Jahanka. In this region the dominant language among the local population is Malinke, followed by Fula and Jahanka.

Village and neighbourhood leaders were enlisted to mobilize women and girls in the target population for the survey. Respondents participated as volunteers and were free to stop the interview at any time.

Data capturing and processing

a) Quantitative data

Data was entered into the CSPro software package to ensure consistency checks between the different questions. Stata software was used for data processing in order to ensure checks, processing of missing values and correction of outliers. After correcting the data, PSS software was used to cross analyse the different variables.

b) Qualitative data

Most of the interviews with departmental heads were conducted in French and directly transcribed. Interviews with religious community leaders, dignitaries, village girls and women, traditional communicators and during focus groups were translated into French before being transcribed. Data transcribed was organized into categories according to the main research questions for coding and further analysis.

Limits to the study

Data collection was limited by the following:

- The inaccessibility of certain areas: the poor state of the roads, particularly in Salemata district made it impossible to reach some villages initially selected.
- Data collection took place during the full force of the Ebola epidemic in the sub region. Kedougou district has a border with Ebola-affected Guinea. As a result, it was not possible to visit some border areas originally selected for this study.
- The study was conducted during school holidays, which limited the collection of data from school authorities and observations of sanitation facilities in schools.

Aissatou has to carry water several times a day using a 15 litre or 20 litre container from the water pump to her home. Each litre of water weighs one kilogram.

OUTCOMES OF THE STUDY

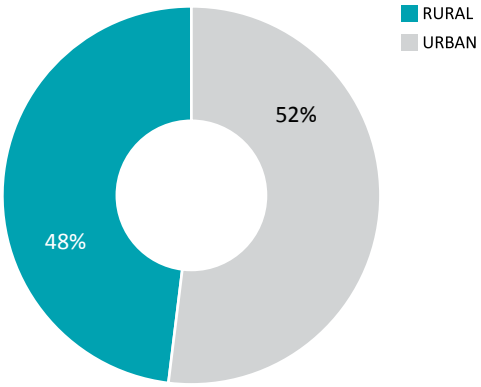
Profile of the population surveyed

The profile of the target population takes account of place of residence, age, marital status, profession or activities, religion and ethnic group in order to better make the links between these categories and respondents' practices with relation to the management of menstrual hygiene.

The population of Kedougou, the regional capital, is the largest, followed by Saraya. Salemata is the least populated district.

It should be noted that overall, rural households form the greater part of the region's population. The urban and rural populations differ in their levels of access to basic social services, such as education, healthcare, drinking water, commerce (shops or weekly markets) and roads (asphalt or unpaved). This disparity that gives the urban population advantages over the rural population may influence certain MHM behaviours and practices. Key factors include levels of knowledge and information on menstruation, access to sanitary pads in shops, access to a health post in the event of infection and personal hygiene.

Figure 1
Respondents' place of residence

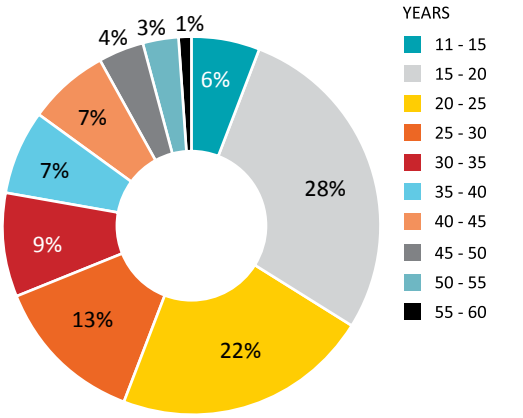


a) Age of respondents

The distribution of respondents by age group reveals that the population aged from 15 to 19 is in the majority, with 28.4%. This is followed by those aged 20 to 24 (22.3%) and girls and women aged 25 to 29, (13.5%). Women aged 30 to 63 constitute 30.3% of the sample.

In total, adolescents aged 11 to 24 represent 56.2%, while women aged 25 to 63 account for 43.8% of the sample surveyed. Women aged 50 to 63 represent 3.7% and younger girls (11 to 14 years) 5.5%.

Figure 2
Distribution of the population surveyed by age



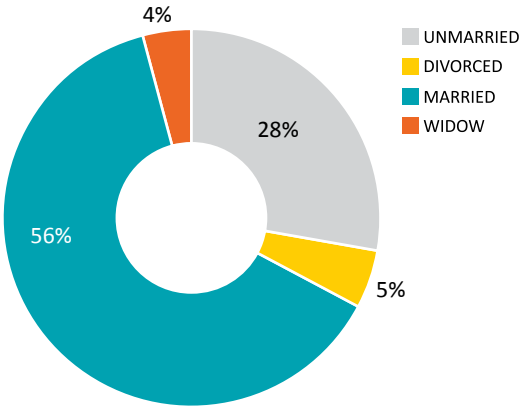
b) Marital status of respondents (polygamy, early pregnancy, fertility)

The data shows a preponderance of married women (62.35% of respondents). Cross-referencing the age and marital status variables revealed that among married women, those aged under 20 represented 22.4% and those aged under 15 represented 1.48%.

In total, women and girls aged 11 to 25 represented 51% of those married. This preponderance of married women in the region is due to a high rate of early marriage,[27] especially in rural areas, which account for 53% of those married, against 47% in urban areas.

Unmarried girls represent 28.13% of respondents. They are more numerous in urban areas (61%) than in rural areas (39%). The divorce rate is very low (5.2%), as is the percentage of widowed women (4.2%).

Figure 3
Marital status of respondents



27 Interview with a teacher member of the Association of Teachers for the Education of Girls.

Respondents living in a polygamous household represent 53.6% of the sample. This percentage reflects broadly practised polygamy in the region. This affects a greater proportion of women aged 20 and older.

The number of children per respondent varied from 0 to 12, with an average of 6.7 children per woman. This is due to the phenomenon of women's rivalry over procreation; those with the greatest number of children are held in highest esteem on account of the new workforce these children represent for agricultural work and other family activities.

Early pregnancies are also frequent in the region: respondents aged under 20 with at least one child account for 39.7% of the sample.

c) Female Genital Mutilation

More than 90% of respondents in this study had undergone female genital mutilation. Excision is a practice that takes its cultural justification from initiation rites and, in particular, young girls' passage from childhood to adolescence and adulthood in some communities.

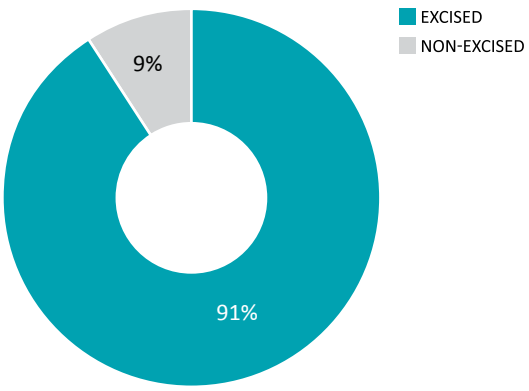
It includes four types of mutilation:[28]

- Type 1: Partial or total removal of the clitoris and/or prepuce (clitoridectomy);
- Type 2: Partial or total removal of the clitoris and labia minora, with or without mutilation of the labia majora;
- Type 3: Narrowing of the vaginal orifice and creation of a covering by the ablation and appositioning of the labia minora and/or labia majora, with or without mutilation of the clitoris;
- Type 4: All other harmful procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incision, scraping and cauterization.

According to demographic and health surveys (EDS 5), the most common type of excision in Senegal is Type 1. In ethnic groups where excision is a common practice, such as the Mandingo, the Fula, the Soninke and the Jola people, it is practised at a young age (under 5 years). Areas of high prevalence are Matam, Kolda Sédhiou, Tambacounda and Kedougou.

Excision is a widespread practice in the localities surveyed. Thus, 91.3% of girls and women surveyed reported having undergone genital mutilation. Excised girls and women are more numerous in the district of Kedougou (55.9%), followed by the district of Saraya (30%) and Salemata (14.1%). Excision is practised in both rural and urban areas.

Figure 4
Prevalence of excision among respondents



28 Ending female genital mutilation: Inter-institutional declarations by HCHR, WHO, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF and UNIFEM Geneva: WHO. 2008.

Box 1: Female genital mutilation and legislation in force in Senegal

Nationally, 28% of girls and women have undergone genital mutilation. Many measures have been taken to strengthen mobilization campaigns to totally end excision and a law forbidding the practice was adopted in 1999. A new action plan, the National Action Plan to Accelerate the Ending of Excision 2010-2015 was adopted in 2010.

Drawing lessons from the evaluation of implementation of the first action plan 2000-2005 and taking into account data collected for the first time by EDS-IV, the actions of the government and its partners were refocused around a number of guiding principles, including an holistic, multisectoral approach based on human rights, community empowerment, advocacy at national and international levels, efficient mechanisms for monitoring and evaluation, and improved coordination.

A study on the state of application of the law was published in 2011. It reveals that implementation remains limited. In fact, the law has led more to a fear of criminal sanctions. Consequently, excision is practised clandestinely and, in some cases, without medical assistance.

1 Gomis D. et Wone M.-M. Les mutilations génitales Féminines (MGF) au Sénégal : sens, portée et enseignement tirés de la réponse nationale. (2008). Dakar : UNICEF

d) Education

Some 28.8 % of the women and girls surveyed had received no formal education.

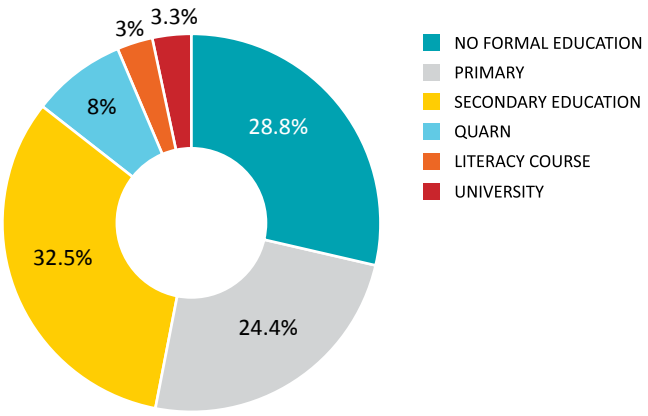
Female illiteracy is more pronounced in rural areas (62.84%) than in urban areas (37.16%). Nearly a quarter (24.4%) of girls and women reached the primary level, 53.5% of whom were in urban areas and 46.5% in rural ones.

32.5% of girls and women surveyed achieved secondary education, 58.94% of whom were in urban areas and 40.06% in rural ones. Girls and women reaching higher education represent 2.64% of the sample.

The majority (56.9%) of girls and women surveyed did not enter secondary education.

In addition, 8.32% of respondents received Quranic education, and 3% had taken literacy courses.

Figure 5
Educational levels of respondents



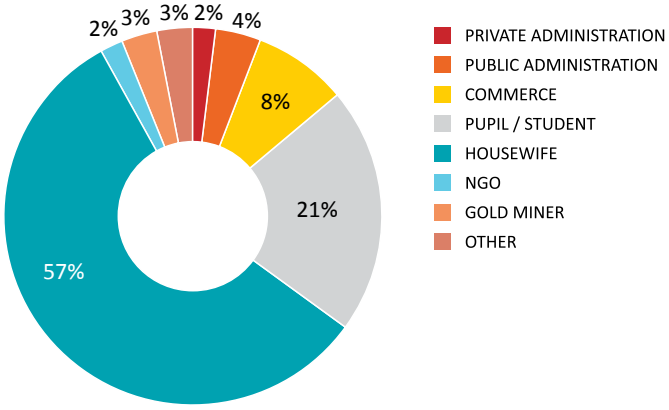
e) Income-generating activities carried out by women and girls

Overall, 77.8% of girls and women surveyed reported that they did not carry out any regular income-generating activity. The main occupations are housework, studying and retail.

Women describing themselves as housewives or home-makers make up the largest category (57.3%). They are followed by students (20.47%). The urban setting has more students than the rural setting. The majority of women describing themselves as housewives live in rural areas (56.2%, against 43.8% in urban areas).

Income-generating activities are retail (7.8%), public and private administration (5.67%), and gold-mining (3.43%). Other income generating activities include small-scale livestock rearing, and sewing or repairs, and represent 5.3%. The majority of women without an income-generating activity in rural areas help their husbands on family-run farms.

Figure 6
Population of girls and women by profession or activity



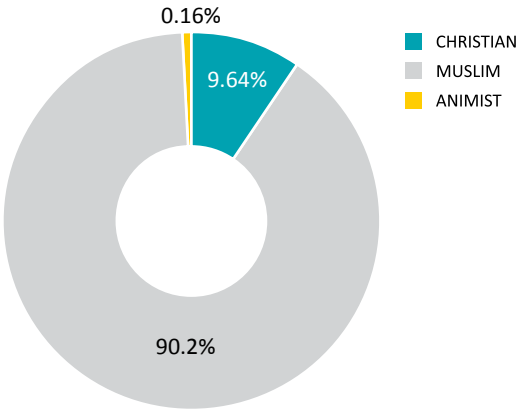
f) Religion

In the sample, 90.2% of the girls and women are Muslim. The proportion of Muslims is almost equal in urban and rural areas.

Christians represent 9.64% of the sample. Of them, 76.7% live in urban areas, against 23.3% in rural settings.

Animists represent a very small minority.

Figure 7
Respondents' religion

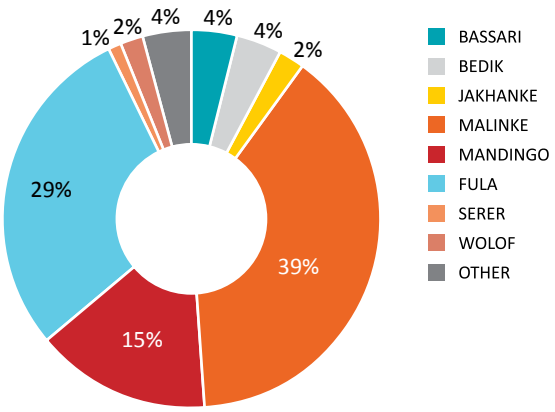


g) Ethnicity

The survey identified three main ethnic groups:

- The Malinke people, who represent 39.36% of the target population. More than half of them (52.6%) live in rural areas, against 47.4% in urban areas.
- The Fula people represent 28.9%. More than half (59.3%) live in urban areas, while 40.7% who live in rural areas.
- The Mandingo people represent 15% of the population. Of them, 69.2% live in rural areas, as against 30.8% in urban areas.
- The minority ethnicities are the Bassari (4.2%), the Bedik (3.96%), the Jakhanke (3.7%) and the Serer, the Wolof and Balanta people (3.5%). The Wolof people alone account for 1.5% of the population targeted by the study.

Figure 8
Ethnic distribution of sample



The influence of hierarchies and social norms on the management of menstruation

Menstruation is a taboo subject in the geographical area of the study. Thus, women find it very difficult to talk about menstruation, not only with men but also with their daughters and even with other women.

Relationships are very hierarchical in the Kedougou region, firstly between men and women, then in the home between parents and children and boys and girls. Households are headed by men. The wife is subordinate to her husband. This submission is sometimes extreme in rural areas, where the wife may not voice an opinion under any circumstances.

Men have no knowledge of the specific needs of women who are menstruating. This situation makes communication difficult within the couple, especially when the wife has to buy sanitary pads or go to hospital for a menstruation-related infection. It is the same for girls who, when they have specific needs during their periods, approach their mothers rather than their fathers. Mothers who have no income discourage their daughters from using commercial sanitary products and use plants, potions and talismans to deal with infections.

These relationships of subordination create communication difficulties between mother and daughter that persist throughout the girls' course of menstruation, as will be shown later.

Among the girls and women surveyed, 70% consider periods to be dirty. They give many reasons for this:[29]

- *"The smell is bothersome"*
- *"It is bodily waste"*
- *"It is a disease coming out"*
- *"It's all the filth from a woman's body coming out."*

It is largely accepted by the women and girls surveyed that periods are waste disposed once a month by the body. This would explain why women cannot pray during this period since they are considered to be unclean.

The term "I am not clean" is often used in local languages to denote that a woman is menstruating. In the Fula community the following term is used for having periods: *"mido woupoudé" (I'm doing the washing)*. Adolescents say *"mido yiidé Jack Bauer"*[30] *(I can see Jack Bauer)*, a more discreet expression that men, boys, grandmothers and even mothers cannot decrypt. Indeed the same communication difficulties between mother and daughter experienced at menarche continue every month so that girls often hide their menstrual status from their mothers.

The participants in focus groups and individual interviews gave different expressions and euphemisms to denote periods (see table 10).

29 Excerpts from focus groups in Kedougou, Saraya and Bandafassi.
30 A character in the American series "24", very popular among young people.

Table 10

Names for periods in local languages and expressions used to talk about menstruation without explicitly mentioning it

Names for periods in local languages
Malinke
Kooulo = to wash Moussouya = to be a woman Kharolédié = to be in the month Mboulo bédjioto = I've got my hands in the water Inté séniyaling = I am not clean
Fula
Farila = sacrifice Sunnay farila = sacrificial duty Woupougol = to do the washing Mido woupoudé = I'm doing the washing Ella = to wash
Jahanka
Farilo = sacrifice Khando = heat
Expressions used to talk about menstruation without mentioning it
To denote one's first period
– The Americans have landed – Time bomb – Red berets – The dog has arrived
To evoke the red colour of periods
– I'm going to Casamance[31] – I'm going to Dilobé[32] – I'm selling palm oil – The red birds are landing – You're with the red monkey – I'm going to the abattoir – Bantako[33]

31 Casamance is a region of southern Senegal.
32 Dilobé is a wholesale market specializing in palm oil in southern Senegal.
33 Bantako is located in the gold-mining area.

Ignorance of the menstrual cycle

The age of menarche is well known. Thus, in answer to the question, *"At what age does a girl have her first period?"* 66.6% of respondents replied that it was between the ages of 11 and 14, and 21.4% said it was from 15 to 18 years. The remaining 12% gave the following replies: at birth, before the age of five years, I don't know, over the age of 20 years, between six and nine years.

However, to the question, *"Where do periods come from?"* 88.2% of respondents said that periods were blood that originated in the woman's genitals or belly. In addition, 11.8% of respondents equated periods to a disease that women had to get rid of through their vaginas. No respondent mentioned the menstrual cycle, the biology of the female body nor the reproductive system.

This may be due to the poor level of education in the region and the fact that mothers and friends who have not learnt about the reproductive cycle are uneducated themselves and remain the main sources of information. In addition, the subject of safe and hygienic management of menstruation and the management and disposal of its waste products is not on school curricula. In some secondary schools, menstrual periods are briefly addressed, often after the age of menarche is attained and without going into detail.

If the issue is addressed neither systematically nor in detail, this is also because teachers avoid it, as evidenced by the statement in the box below:

Box 2: Testimony by a religious leader from the village of Dar Salam (Departement of Salemata)

My daughter stayed away from school for four days because she had her period. The day she returned to class, her teacher sent her with a request that we, her parents, go into school. I went to the school to respond to the request. Her teacher told me that my daughter had been away for four days without reason, when the school rules required a pupil's illness to be notified. My daughter had to provide a medical certificate.

I told the teacher that the clinic could not treat this illness (menstruation), because it was the will of God. All women experience menstrual periods.

I put the following question to the teacher: If my daughter was having her period, how could she sit down in class? I told him that this illness (menstruation) is treated at home by the old women, not at the clinic. For us, it is the old women who deal with this issue. Most girls hide their menstrual status at home.

If a girl is in the middle of her period, does the school have a solution? Nothing is provided for girl pupils. And if they have their period when they are at home, they stay home for four or five days and don't go to school. But how do you make up the time lost? Does the school have a solution? My questions received no answer.

Information collected about menstruation before the arrival of the first period

Nearly two thirds (65.2%) of respondents said that they had never asked anyone about menstruation. One mother taking part in a focus group in Bandafassi said:

> *"In general, we do not prepare our daughters for their first period. We wait for them to have it before we explain what it is."*

The women surveyed in the study found it very embarrassing to address this issue. According to another participant in a focus group in the village of Dar Salam, silence around menstruation is a tradition.

> *"Our ancestors did not mention menstruation. And we do not discuss it either. That is the tradition, and we respect it."*

> *"[...] I would like to add that menstruation is a taboo subject in our community. Few men know what it is, and women do not talk about it. Mums especially don't discuss it with their daughters, and this can lead to the daughters falling pregnant through ignorance [...]"* Excerpt from a men's focus group, testimony by a religious leader from the village of Dar Salam.

NGOs, who play an important role in information, disease prevention and social regulation, do not address the issue of menstruation either. Thus one NGO manager interviewed said:

> *"We are involved in reproductive health [...] but I've never heard anything about MHM."*

The interviews with the region's decentralized authorities involved in reproductive health show that practically no service (social action, open setting educational action (AEMO), the youth advice centre, health centres, the hygiene service, or the Association of Teachers for Girls' Education) had received any request for information from girls or women about MHM. Neither do these institutions organize training or information sessions on this subject.

According to a gynaecologist from the region,

> *"Periods are taboo in the region; girls and women only seek advice if their menstrual cycle is late or disrupted, and their concern is about issues to do with pregnancy. Important issues such as personal and genital hygiene are not brought up."*

At the youth advice centre, girls' enquiries are about HIV/AIDS and how to avoid pregnancy when having a period. This suggests that some women have sexual relations even during their periods, in spite of various social and religious restrictions.

Sources of information for women and girls

In response to the question, *"Had anyone talked to you about periods before your first period"*, 62.5% of girls and women answered 'yes'. Their mothers and female friends were the main sources of information for respectively 20.2% and 27% of respondents. Next, 15.8% were told about them by their sisters, 14.4% by their grandmothers, 11.6% at school, and 8.8% by other sources, such as the health centre, or cultural or religious ceremonies. It should be noted that 2.2% of girls and women had been told by their fathers.

The preponderance of friends as the main source of information is due to the fact that most mothers do not discuss menstruation with a daughter who has not yet started her periods. The exclusion of pre-pubescent girls from all discussion and information to do with biology, reproductive health and sexuality is a tradition that women maintain.

Ultimately, 85.6% of girls and women surveyed said they wanted more information about menstruation.

Menarche, fears and first advice

Girls having their first period feel fear above all. Thus, 40% of girls and women surveyed said they were afraid when they had their first period; 9.8% thought their genitals were injured and 2.8% thought they had got pregnant. In total, 52.6% of girls and women said they had no understanding of what was going on when they had their first period.

Recall that 62.5% of girls and women had, however, said that they had heard about menstruation before they started periods themselves. It appears that the information they gained at that time was not sufficient and did not properly prepare them.

Of the girls and women surveyed, 26.1% had talked with their mothers and 11% with their friends when they had their first period. Although mothers say they do not tell their daughters about them before their first period, they are still the first to help them when that first period comes. And generally, the first explanations given to the girl are, for one part, about the hygienic protection to absorb the blood and, for the other, about the risk of pregnancy. They ban their daughters from being in the company of men, for fear of them falling pregnant.

Here is the main advice from mothers to their daughters:

> *"The blood that comes out is called a period. When you see it, you need to protect yourself with a cloth. You are a woman now and you need to avoid boys."* (Statement by a pupil in a focus group in Saraya).

> *"It happened to me when I was your age. You need to protect yourself with a cloth and keep away from men. What you have is something every woman wants to have."* (Statement by a pupil at a focus group in Saraya).

> *"Protect yourself; get a cloth and put it in your knickers. I don't want to see you with boys anymore."* (Statement by a pupil in a focus group in Saraya).

> *"When my daughter has her period, I give her the following advice: this is a period, I showed her how to protect herself with a cloth and how to reuse it. I told her, your father and I are part of a respected, honoured family, my daughter, and I want no dishonour with my peers. Avoid boys; avoid men."* (Statement by a mother at a focus group in Kedougou).

Mothers and girls talking in Ethiowar

Restrictions and beliefs related to menstruation

Social, religious and food restrictions

Several restrictions begin with the arrival of the first period. They are social, religious and food-related. Some also aim to limit the activities of women and girls. Thus, 54.4% of respondents said they suffered restrictions when they were menstruating: they do not have the right to fast, pray or enter holy places (mosque or church). Often, they do not participate in religious or cultural ceremonies and cannot be in the company of boys or men.

During menstruation, married women do not share the conjugal bed. Often, they do not even share the conjugal bedroom, and sleep with their mother-in-law. Polygamy is widespread in the region and sexual relations are forbidden during menstruation because the women is considered to be unclean.

> *"Albinos and cursed children[34] are the result of sexual relations during menstruation."* (Kedougou focus groups).

> *"Men can die if they have sex during a period."* (Interview with a traditional griot).[35]

Girls and women are also subject to food restrictions. Certain drinks and foods are not consumed during menstruation. This applies to ice cubes or cold water, which would cause the menstrual blood to clot; peanuts and tea, which would increase the blood flow; gombo, which would lead to vomiting; and sugar, which would increase menstrual pain.

During this period, several communities prohibit women and girls from going to the fields, planting seeds in the garden, making canaris,[36] making traditional wine, doing the washing, cooking, braiding, or making traditional yoghurt or shea butter. There are various reasons for this (see table 11).

Beliefs related to menstruation

These restrictions are based on a set of beliefs generally respected within various ethnic groups and communities, and even beyond.

According to a *dioura man* (traditional gold-miner) from Bantako[37] who was interviewed, menstrual blood is highly sought-after by gold-miners because a belief persists that *"menstrual blood, used in a black magic potion attracts gold"*. Sometimes, gold prospectors offer a considerable sum of money to menstruating girls or women to have sex in the damas (the interior of a gold mine). It should be noted that on gold-mining sites, or *diouras*, most prospectors live on site, usually without their families, who have stayed in their home villages. These prospectors have multiple sexual partners and say that searching for gold means neither piety nor purity.

35 Difficult children, who have caused lots of problems or concerns for their parents throughout their lives, are considered cursed.
36 In the region, griots play an important role in the transmission of knowledge and the sharing of information in the community.
37 Canaris are terracotta pots or vases.
38 Gold-mining town.

Table 11

Social and religious beliefs about menstruation and associated restrictions

Social and religious beliefs about menstruation	Associated restrictions
Menstrual blood	
Periods are dirty or unclean	– Do not share one's husband's bed when menstruating – Do not pray or take part in religious activities
Blood flow increases when the woman is in a holy place (mosque, church etc.)	– Do not go to a place of worship
Menstrual blood can be used to cast a black magic spell to attract gold	– Do not throw used sanitary protection away without washing the blood off – Do not use single-use sanitary pads; use re-usable cloth – Do not dispose of used sanitary pads
Sanitary protection	
Single-use sanitary pads reduce fertility and cause disease	– In certain groups, single-use sanitary pads are not recommended
Sexual relations	
Albinos and cursed children are the fruit of having sex during menstruation	– Do not have sexual relations during a period
Domestic activities	
If a woman having a period touches seed, the harvest will not be abundant	– Do not go to the fields
If a menstruating woman does the washing, the clothes will be dirty	– Do not do the washing
If a menstruating woman braids another woman, the woman braided will lose her hair	– Do not braid
If a menstruating woman makes canaris, they will go unsold	– Do not make canaris
If a menstruating woman makes home-made yoghurt or shea butter, the products will not mix properly	– Do not make home-made yoghurt – Do not make shea butter
If a menstruating women makes local wine, it will be undrinkable	– Do not make local wine
Food	
Ice, water and other cold drinks clot menstrual blood	– Prohibited
Peanuts, hibiscus, tea and carbonated drinks (Coca Cola) increase menstrual blood flow	– Prohibited
Lemon, vinegar and bitter or acidic food reduce menstrual flow	– Prohibited
Gombo causes vomiting	– Prohibited
Sugar increases menstrual pain	– Prohibited
Religion	
Women are not allowed to pray or fast when menstruating Menstruating women who enter a holy place are liable to divine punishment	– Do not enter places of worship (mosques, churches, etc.) – Do not touch the Quran – Do not go to Mass

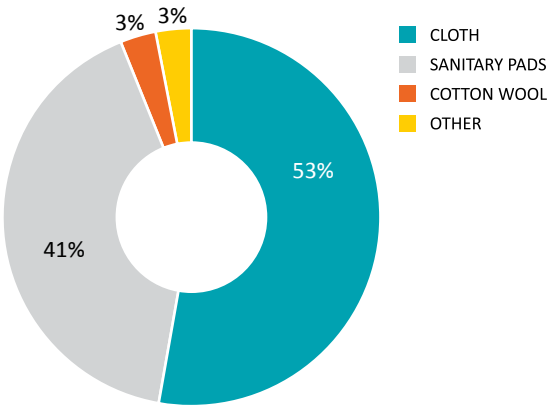
The management of menstruation

Main sanitary protection used

According to data collected, cloth fabric is the main protection used in the region. More than half (53.2%) of girls and women use cloth. Of these, 54.3% live in rural areas, against 45.7% in urban areas.

Sanitary pads are used by 41.2% of respondents. They are more numerous in urban areas (60.3%) than in rural areas (39.7%). In addition, 3% of girls and women wear several pairs of briefs or use cotton wool to manage their menstruation.

Figure 9
Sanitary protection used



The fact that most women and girls used fabric is not accidental. They state various reasons for this choice: cost, lack of knowledge about sanitary pads, and myths and beliefs about sanitary pads:

- Nearly half of those using cloths (49.9% of respondents) said that sanitary pads were expensive in light of low incomes. Thus, women using sanitary pads spend an average of FCFA 1,248.43 per month, or FCFA 14,981.24 annually. As seen, however, the region has a very high level of poverty (71.3%). That they choose fabric, often an old loincloth, is, therefore, easily explained.
- More than a quarter (26.7%) of fabric-users said they had not heard of sanitary pads. Girls who have just started their periods are informed by their mothers and grandmothers, who advise them to use fabric either because they themselves do not know of the existence of commercial sanitary pads or any other means of absorbing menstrual blood, or because they are perpetuating myths and beliefs around menstruation.
- 13.9% of girls and women use fabric because of beliefs about sanitary pads. They think that sanitary pads can make them ill or infertile. These same beliefs influence the behaviours of users of sanitary pads. Thus, it is a common practice in the region to wash sanitary pads before disposing of them.

In addition, in this poor region with porous borders, there are large quantities of counterfeit products in circulation,[38] raising concerns in women and girls about the quality of sanitary pads for sale in the region.

38 See Counterfeiting of medicines - Guinean lorry stopped by the gendarmerie in Rewmi [online], 30 June 2010 [Accessed 26 January 2015]. Available at: http://www.rewmi.com/contrefacon-de-medicaments-un-camion-guineen-arrete-par-la-gendarmerie_a28200.html

Care for sanitary protection

According to the data collected, women and girls wash their sanitary protection at least twice a day. This suggests, on the one hand, that the material used is not sufficiently absorbent and, on the other hand, that women change at least twice a day.

It is clear that the fabric used in the region for the management of menstruation (an old loincloth cut down) is not sufficiently absorbent. Respondents were not able to say what sort of fabric was used (cotton, synthetic, wool, polyester, etc.) However, many mentioned "Wax-print" fabrics, which are usually made of cotton or a cotton/synthetic mix. However, the use of any fabric other than cotton can cause infections.

Furthermore, none of the respondents mentioned fabric-based re-usable sanitary protection. Those sanitary pads made of re-usable fabric that can be made locally have not yet arrived in the region.

The girls and women who use fabric wash it at home: 96.3% said they washed it at home in the toilet, and 2.9% said in the river or stream.

It is important to note that 99.1% of girls and women said that they had never washed their fabric protection at their place of work, and of the pupils surveyed none had ever washed their fabric protection in school. This indicates that the activities of girls and women are reduced when they are menstruating. The social and religious constraints mentioned above also support this statement.

Reasons given by girls for not washing their sanitary protection or changing at school:

- *"The lack of a safe place to wash fabric protection."*
- *"The toilets are unsuitable and are shared with the boys: this is not discreet and there is no privacy."*
- *"There are no toilets in schools and, where there are, they are dirty and there is no soap or water."*

Testimonies from participants in focus groups in Saraya and Kedougou.

Once it has been washed, the fabric protection has to be dried. However, data show that it is rarely put out in the sun. Thus, of those using fabric, 45% dry it in toilets, 40% in bedrooms and 15% in the sun. In rural areas, however, the fabric protection is mostly dried in the sun.

Discretion and beliefs about periods are the main reasons behind people choosing to dry the fabric protection in bedrooms. At the focus groups, girls and women said that men must not see the fabric. They also think that sanitary protection fabric may be used by an enemy to cast an evil spell over the woman.

This was emphasized by one participant of a focus group organized at Bandafassi:

> *"I wash my fabric protection in the toilets, but I dry it behind my bedroom door. I have to dry it in a discreet place because, when I was 25 years old, someone cast a spell on me through my sanitary protection fabric. I went three months without a period. To find out the reason, my mother consulted a sorcerer who told her that I had been mystically attacked through my protective fabric."*

Stories like these are not uncommon. Such testimonies have repercussions on community practices and beliefs.

Figure 10
Place where sanitary material is washed

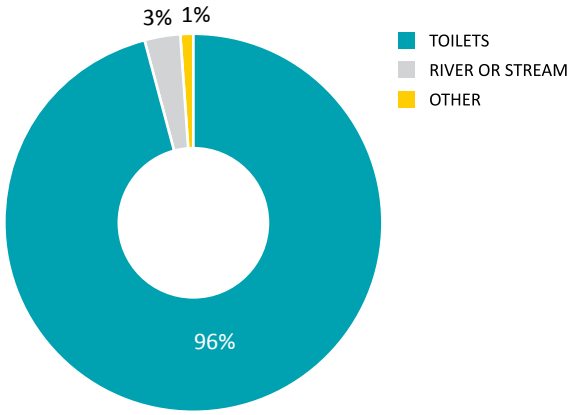


Figure 11
Place where sanitary material is dried

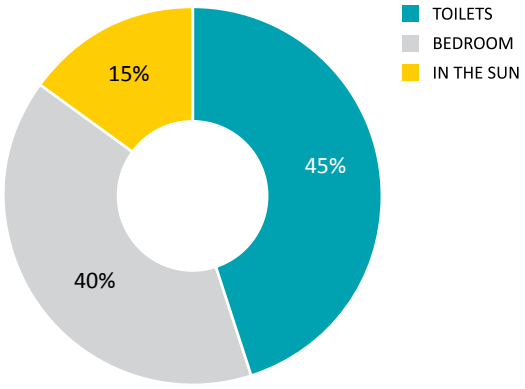
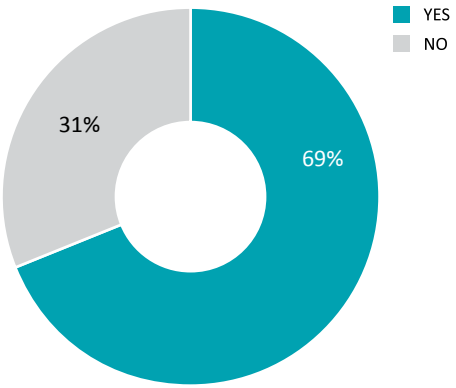


Figure 12
Access to a water point



Hygiene during menstruation

The questions, *"During your period, how many times to you bathe a day?"*, *"How often do you change?"*, *"Do you wash your hands with soap after changing your sanitary protection?"*, reveal good hygiene practices in both rural and urban areas. In detail:

- 94.1% of respondents said that they showered at least twice a day when they were menstruating. It should be noted that 69% of the girls and women said that they had running water at home.
- 93.9% of girls and women changed their sanitary protection and washed their private parts at least twice a day.
- 95.4% of respondents wash their hands with soap after changing their sanitary protection.

Management and disposal of waste

The management and disposal of waste is an acute problem in Kedougou. The region has no system for the collection of household waste and no system for removing waste and rainwater. Thus, the proliferation of unofficial waste dumps and the stagnation of rain water is common in the region.

The waste disposal methods used in multi-family dwellings are open-air incineration, with consequent air pollution, fly-tipping, burial, and discharge into abandoned wells. Household waste water is disposed of anarchically: some dwellings pour it out onto the public road and others use make-shift sumps.

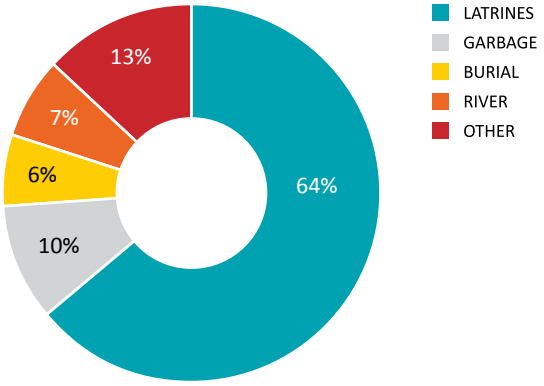
Above: Garbage near the river in Kedougou
Below: Women cleaning their clothes in the river

In parallel with households, other entities produce waste. This is the case of the Textile Fibres Development Company (cotton waste), the market and the hospital. The hospital has an incinerator. However, to care for the environment and prevent air pollution, this hospital equipment needs to adopt new technologies for the management of medical and biomedical waste.

The absence of a waste management system in the region has an impact on the disposal of menstruation-related waste. Thus, toilets are the most-used places for the disposal of this waste (64.1% of respondents). Almost 10% (9.9% of respondents) throw waste into dustbins, 7.1% get rid of their sanitary protection in the river or stream, and 6.1% bury it.

Beliefs and myths around menstrual blood explain why menstruation is managed covertly. Fabric is washed, rinsed and dried in the toilet. It is kept out of sight. Moreover, 12.8% of girls and women keep their old protective fabric. They never throw it away, because of mystical beliefs.

Figure 13
Method used to dispose of absorbent material



The management of menstrual hygiene by girls and women living with a disability

Girls and women living with a disability represent 2.51% of the sample. They mainly have two types of disability: a disability of the upper or lower limbs, or visual disabilities.

To the question *"Does anyone help you at home, at school or at work during your periods?"* 78.9% of respondents living with a disability said they had no help at home, at school or at work. They sort things out for themselves to manage their menstrual hygiene, facing the following difficulties:

- Keeping their sanitary protection in place: this is a difficulty for 36.8% of respondents living with a disability.
- Caring for the protection: girls and women living with a visual disability said that even if the fabric was properly washed, the fact that they could not see it worried them. They feel an increased need for help during this period.
- A difficulty in accessing and using toilets: toilets are not suitable. Respondents said they often fell down when toilets were tiled.

Thus, people living with disabilities said they significantly reduced their travel when they had their periods.

Management of menstrual hygiene by girls and women who have undergone genital mutilation

As the study reveals, more than 90% of respondents in this study had undergone female genital mutilation. And, 29.1% of girls and women who had been cut thought that their menstrual difficulties were inherent to their excision. Among the difficulties they encountered, they mentioned itching, redness, irregular periods, blood flowing out with difficulty, in small amounts.

Box 3: Testimonials on the management of menstruation in women who have undergone female genital mutilation

Excerpt from a statement given in an interview with an excised woman from Kedougou:

> *"When I get my period, it lasts for three days and then goes away, coming back seven days later. When I asked the doctor about it, he said it was because of the excision."*

Statement by a gynaecologist from Kedougou:

> *"Some practices of female circumcision, such as infibulation*, can have negative consequences on reproductive health, such as a loss of libido, difficult deliveries, and infections during menstruation."*

* An extreme form of excision, consisting of "closing the genital area".

Of the girls and women who had undergone genital mutilation, 24.3% had an infection. Most, 66.7%, use plants or preparations of traditional medicine to treat their infections.

Further studies would clarify if certain types of genital mutilation lead to more complications than others for MHM. This study has not addressed this issue. It simply notes that women and girls from the region, who are mostly excised, seem to be more prone to infections. These women and girls mostly use cloths and sanitary pads, but not tampons.

The management of menstrual hygiene by women in prison

At the time this study was conducted, Kedougou prison (MAC, from the French Maison d'arrêt et de correction, House of detention and correction) had two female inmates.

This penitentiary institution is a mixed-gender establishment. The men's wing is separate from the women's. All the prison warders and the head nurse are men. The head nurse is responsible for the primary healthcare of every inmate.

Of the two women interviewed, one had never had a period in prison as she had already passed the menopause. Women in prison must rely on the help of relatives or people visiting for menstrual hygiene management, because the prison does not provide sanitary pads or any other protective equipment.

According to inmates, the prison has a properly working running water supply, soap, and separate toilets. During our visit, however, there was no running water and no soap. Furthermore, the toilets did not have doors. Menstruation, therefore, could not be managed in private. As in any prison, everything is done in the presence of the warders who, in this case, are all men.

Girls grinding grain

ANALYSIS OF THE IMPACT OF MENSTRUATION ON THE LIVING CONDITIONS OF WOMEN AND GIRLS

Menstruation is a recurrent natural biological event in women's lives. According to data collected in this study, a majority of women, schoolchildren and women living with a disability reduce their activities when they have their periods, in part because of social and religious beliefs and ongoing social norms, and also because of the condition of the sanitary infrastructure.

The infrastructure issue, therefore, has an impact on the participation of women and girls in social, economic and cultural activities.

This section aims to describe the condition of the infrastructure in the region.

Toilet in the public school Tierno Salif Sidibe (578 students in 2014-2015) in Kedougou. Built in 1981, they are closed due to their bad state. Students therefore leave school to use a toilet.

The condition of infrastructure in the study area

Twelve multi-family dwellings, three markets, four schools, one health centre and one prison were visited. Water and sanitation infrastructure was observed in accordance with the protocol set down in the observation sheets and photos were taken.

The aim was to observe the condition of the infrastructure, to note if it was equipped with separate toilets for men and women and handwashing equipment, and if it had soap, water and other hygiene equipment.

For the multi-family dwellings, the task was to observe the relative positions of the washtub and the toilets, the type of toilets, and to ask if girls and women had access to the toilets. The task also included checking the drying arrangements.

a) WASH infrastructure in multi-family dwellings

Of the twelve multi-family dwellings visited, only two did not have latrines. Those living in the house observed in the municipality of Saraya (urban setting) used the latrines of neighbouring houses, while those living in the multi-family dwelling visited in village of Dar Salam (rural setting) practised open defecation.

Three types of latrine were observed:

- Improved, concrete latrines: observed in urban areas in the municipalities of Kedougou and Saraya;
- Traditional, self-ventilated latrines with a hole, with wattle or mud brick walls: observed in rural area;
- Self-ventilated, enclosed latrines with a slab: observed in the urban setting in the municipality of Salemata.

In every house, latrines were used by every member of the family and were located within the curtilage of the house.

The latrines and the shower were usually separated except for improved latrines, which sometimes included showers. Soap and water were not available inside the latrines at the time of observation. It is important to note that women in rural settings dried their fabric protection in the toilets in the fresh air, in the sun.

Shared latrines observed in a household in Ibel village

b) WASH infrastructure in schools

Four educational establishment, two of which were primary schools and two secondary schools, were visited. Two of them had no toilet facilities, a situation that disrupts school life.

Box 4: MHM at school

> *"Our secondary school has over 1,000 students. There are no toilets, and the students' union has been disrupting classes for two years to demand them."*

Interview with a teacher from one of the schools visited

In the other two schools, the toilets were not in operation. The toilets were dirty and the pupils did not use them. The schools visited had no running water at the time of the visit. The toilets seen were for girls only.

Of the pupils interviewed, none washed or dried sanitary protection in school. Nearly nine out of ten pupils do not dispose of their sanitary protection in school. It should be noted that pupils do not change at school due to the lack of appropriate spaces and infrastructure.

Tierno Salif Sidibe public school, Kedougou. Right: original toilets built in 1981 now closed due to poor maintenance. Left: Construction of toilets using private funds are suspended due to lack of continued funding and qualified workers. The project has not been finalized and toilets have never been used.

c) WASH infrastructure in markets

Three markets were visited: Kedougou central market, Saraya market, and Bandafassi market. Only Kedougou market had toilets and running water. The toilet manager told us, however, that women did not use them because they were mixed and dirty. Indeed, at the time of visit the toilets were not clean.

The issue of the maintenance of public toilets is a serious challenge for the Senegal Ministry of Water and Sanitation. PEPAM notes that this is a recurring problem in various localities. The Programme attempts to establish systems through local authorities and other decentralized services of the state, in order to ensure sustainable use of the facilities.

The lack of maintenance of toilets leads to their deterioration and, finally, their abandonment by users, as demonstrated by the case of Kedougou market. When establishing a system for the management of toilets, it is important to conduct a gender analysis to ensure that their maintenance does not fall to only women, while the profits from their operation go to only men.

Women buying fabric in Kedougou market

d) WASH infrastructure in health centres and prison

In Kedougou health centre, patients' toilets were shared by men and women. There are also toilets reserved for health gcentre staff. Soap and water were available in both toilets at the time of visit.

Women's toilets at a prison. There is no door, water nor soap.

The impact of inadequate WASH infrastructure observed on girls' and women's living conditions

In the Kedougou region, society remains patriarchal. The main roles of women are to reproduce and manage the community. They have no voice or space to demand services or rights.

The lack of information, the inadequacy of the infrastructure and the persistence of certain beliefs have a negative impact on girls' education, on women's and girls' health, and on their potential for economic empowerment.

Impact on girls' education

Some 40.64% of girls surveyed said that they had missed school for at least one day during their periods. Some stayed away for the entire duration of their periods.

According to the Association of Teachers for the Education of Girls, the absence of sanitary facilities adapted to girls' needs discourages them from attending regularly and has a negative impact on the promotion of gender equality in school.

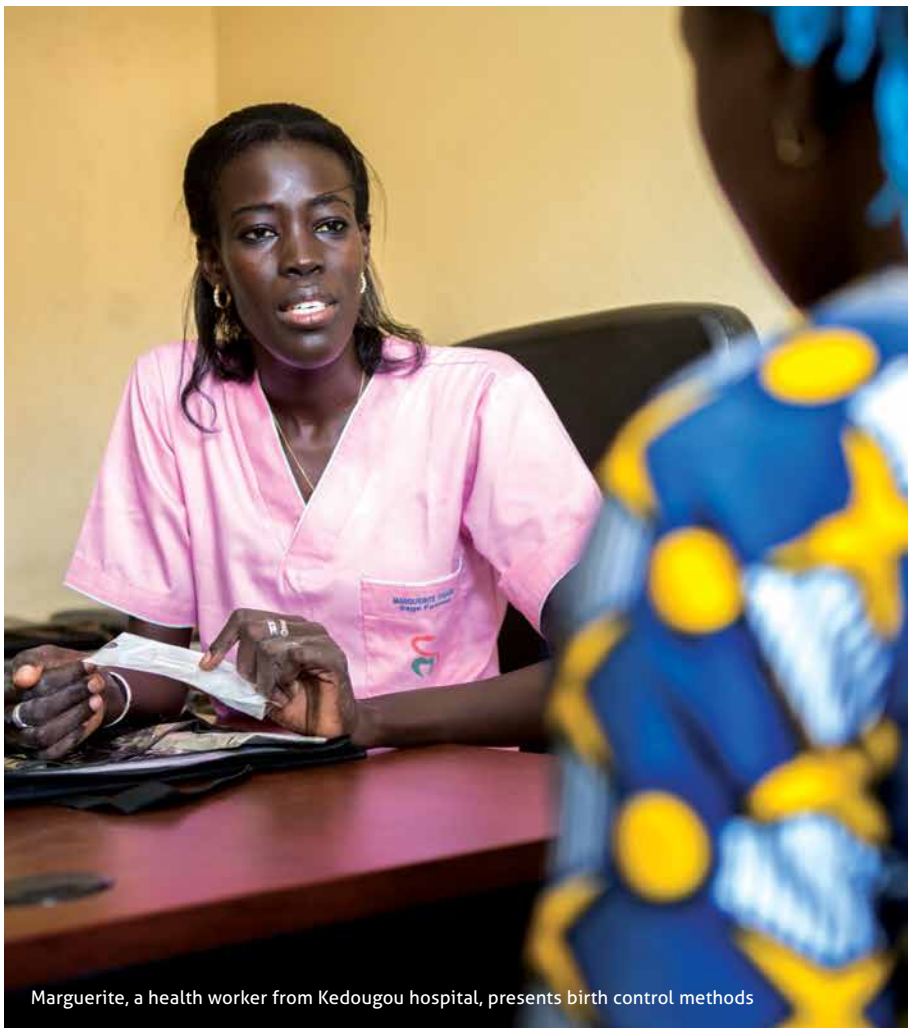
School of Ngari, 11 kilometres away from Kedougou

Impact on girls' and women's health

According to a gynaecologist from the region, a woman's body is most vulnerable to infections during the menstrual period. The fact is, blood acts as an excellent medium for the growth of bacteria. Poor personal and vaginal hygiene can lead to bacterial growth in menstrual blood and then in the female genital tract, before spreading to the rest of the body.

But this information barely reaches patients who only seek medical help in the event of a serious problem. The medical consequences are often infection, tubal obstructions, infertility, and the worsening of certain diseases. Some 23.5% of respondents said that they had experienced infections during their menstrual periods.

These health problems are further compounded by drying sanitary protection in dark places that expose them to bacteria and microbes. About 40% of girls and women surveyed dry their protective cloths in their bedrooms, away from the sunlight that kills germs.



Marguerite, a health worker from Kedougou hospital, presents birth control methods

Impact on the employment and activity of girls and women

Within the study, 96.4% of economically active women said that they did not regularly go to work during their periods. They preferred to stay at home because their periods made them weaker, because they experienced pain, stomach ache or cramps, or because in addition to that, they had nowhere to wash or to change their sanitary protection.

A group of women hurriedly walk for many hours to return home before dark

RECOMMENDATIONS

The management of menstrual hygiene is a potentially powerful entry point to addressing larger issues of fairness and gender equality in education, health, water and sanitation. Today this issue is largely absent from Senegal's public policies.

This study recommends a **review of these public strategies and policies and to explicitly include menstrual hygiene**, in order to enable women's and girls to access their fundamental human, economic, social and cultural rights.

The decentralized services of the state have a major role to play in this regard with appropriate policies, adequate financial resources and systematic monitoring. This study recommends to:

1. **Break the silence** on this taboo subject and remove obstacles and constraints based on superstitions and traditional beliefs that are harmful to women and girls.
2. Ensure that **infrastructure and school curricula** ensure knowledge and facilities include safe and hygienic management of menstruation.
3. **Ensure that systems for the safe disposal of menstrual waste** with privacy and dignity are provided at both domestic and public facilities and are integrated into planning.

A woman buying sanitary pads in a shop in Bandafassi. One small package of pads for 1.000 FCFA is equivalent to 2kg of rice.

The study also highlighted a need for information on the biology of menstruation and the management of menstrual hygiene. **Strengthening the capacities of health workers and teachers** is essential to address this issue in a professional manner with patients or pupils.

Including modules on the management of menstrual hygiene into training curricula for teachers, health schools and higher education institutions specializing in water, sanitation and the environment would be a first step in this regard.

Outreach and awareness-raising campaigns should also be conducted nationally and locally to demystify beliefs around MHM among the population. It is particularly crucial to explain the process of ovulation and the menstrual cycle, and to analyse and deconstruct the myths and taboos that hold back women's and girls' rights.

In parallel, we strongly recommend raising the awareness of religious and community leaders and the heads of decentralized services. These decision-makers have an important role to play in gender analysis and in taking account of the needs of women and girls. It is important that they become associated with locally-conducted activities in order to understand the issue and support the **participation of women** in discussions and decisions affecting their lives.

Finally, the issue of the **management of menstrual hygiene needs to be addressed as a priority by the prison administration**, taking account of international law and provisions on the treatment of those incarcerated.[39] According to these rules, "Women prisoners shall be attended and supervised only by women officers". This does not, however, preclude male members of the staff, particularly doctors and teachers, from carrying out their professional duties in institutions or parts of institutions set aside for women." Similarly, the prison doctor shall make regular inspections and advise the prison governor on the hygiene and cleanliness of the establishment and the detainees. Various options are possible, such as the provision of hygiene kits, staff training and the improvement of infrastructure.

Including the needs of specific groups of women such as those living with a disability and prisoners requires, in any case, the **collection of more information** in order to better identify their needs and provide a solution.

The study has also highlighted the **consequences of excision on menstrual hygiene and the health of excised women and girls**. This issue needs to be addressed in detail and should be the object of research specifically targeting girls and women who have undergone genital mutilation.

39 See all the Minimum Rules for the Treatment of Prisoners, adopted by the first Congress of the United Nations on the Prevention of Crime and the Treatment of Offenders, held in Geneva in 1955 and approved by the Economic and Social Council in its resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977, available at http://www.ohchr.org/FR/ProfessionalInterest/Pages/TreatmentOfPrisoners.aspx

Bandafassi plains viewed from the mountains in Ethiowar

CONCLUSION

Literature on the issue of the management of menstrual hygiene is still rare and the studies conducted so far on this issue have been limited to the school context and girls.

This study focuses more broadly on policy and on behaviours and practices with regard to women's and girls' management of menstrual hygiene. Conducted in the region of Kedougou, Senegal, it is one of a series of studies undertaken by the Joint Programme on Gender, Hygiene and Sanitation implemented by WSSCC and UN Women to document the specific hygiene and sanitation needs of women and girls in West Africa.

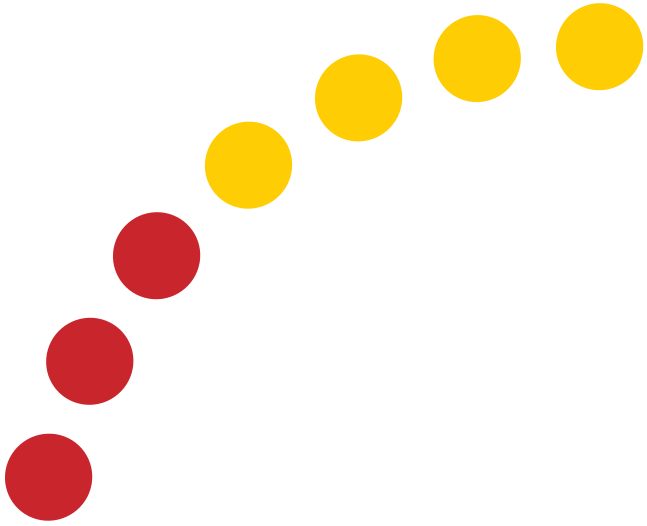
It follows on from a first study conducted in June 2014 in the region of Louga, Senegal, and is in conjunction with a third study conducted in Cameroon, in the regions of Kyossi in the Bantu and semi-Bantu Equatorial areas, and of Bafoussam in the Grass Fields area.

Like the work carried out in Louga and Cameroon, the approach adopted in the Kedougou region is holistic. Conducted with more than 750 women and girls, the study focused on every sector of the region's female population, with respect to age, educational level and employment.

It shines a particular light on MHM in rural areas, in a context of extreme poverty (70% of the population), where female circumcision is practised on a massive scale (over 90% of women and girls surveyed) and where women are particularly excluded from decision-making processes, including matters that directly affect their health and their economic, social and cultural integration.

The study, thus, provides a situation report on the response in terms of public policy and infrastructure to women's and girls' specific needs. It reveals the lack of knowledge and information on the menstrual cycle and the phenomenon of periods, and the persistence of beliefs and myths about this "bad blood" that is often likened to a disease. It also provides relevant information on the behaviours and practices relating to MHM and analyses the impact of the absence or inadequacy of existing infrastructure on women's and girls' living conditions.

The dissemination of the results of this study to the greatest number of people, including elected officials, policy-makers and professionals in the health sector, education, the environment and hygiene and sanitation must contribute to bringing about an evolution of policy and breaking the silence that surrounds the management of menstrual hygiene. This knowledge must encourage everyone to take up the challenge to take better account of the specific needs of women and girls and to respect their fundamental rights.



The motorbike is one of the most used vehicles for long distances in the Kedougou region

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UN WOMEN

In July 2010, the United Nations General Assembly created UN Women, the United Nations Entity for Gender Equality and the Empowerment of Women.

The main roles of UN Women are:

- To support intergovernmental bodies, such as the Commission on the Status of Women, in their formulation of policies, global standards and norms.
- To help Member States to implement these standards, standing ready to provide suitable technical and financial support to those countries that request it, and to forge effective partnerships with civil society.
- To hold the UN system accountable for its own commitments on gender equality, including regular monitoring of system-wide progress.

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- elimination of discrimination against women and girls;
- empowerment of women; and
- achievement of equality between women and men as partners and beneficiaries of development, human rights, humanitarian action and peace and security.

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