Appendix S1: Path to Scale: Menstrual Hygiene Management (MHM) Theory of Change Narrative

The purpose of the *Theory of Change* is to illustrate how activities undertaken by your MHM project can contribute to a chain of results which can then lead to the intended or observed outcomes and impact(s). This narrative is designed to be read in conjunction with the accompanying *Theory of Change* and the *Indicators Matrix*.

ENABLING CONTEXT

***Innovation is contextualized within local MHM practices and beliefs*.** A successful MHM innovation is largely dependent on its reception within the target community. A successful MHM innovation approach demonstrates respect, understanding, and adaptation to existing cultural practices, beliefs and community structures. Listening and learning directly from girls and women is an essential first step to developing an appropriate scaled innovation and educational platform that responds to their menstrual needs.

Innovation empowers girls and women through education, employment and access. A successful MHM innovation approach acknowledges the range of factors that influence girls and women's ability to actively participate in daily life when menstruating. The success of the innovation will depend on the active engagement of girls and women, particularly in the targeted communities, to provide critical insight and learning across all stages of the initiative. This is especially important in locations with strong taboos and negative social norms around menstruation. The innovation needs to be serve as a facilitator for girls and women to remain engaged and empowered, whether in school, at work, or conducting their daily activities within their communities.

Innovation maintains compliance with government standards over time. The sustainability of the MHM innovation relies on ensuring its dependability and accessibility to girls and women in the long term. In order to achieve this, government standards and regulations need to be routinely appraised and maintained over the course of operation.

Innovation reaches low-income and marginalized girls and women. The MHM innovation must utilize an equity approach in order to improve the lives of all girls and women. This includes tailoring the MHM innovation to specifically address the needs of low-income girls and other marginalized populations (including those that are out of school, displaced or disabled) to truly improve MHM access and facilitate regular use of these solutions.

FOUNDATIONAL ELEMENTS

Strategic buy-in and collaboration from relevant policy makers, government ministries, and community leaders. Gain input and buy-in from key stakeholders within your targeted context, including policy makers and relevant government ministries. Identify and engage community leaders to enhance uptake and sustainability within the targeted contexts. Commence multi-

level strategic engagement prior to scale up and sustain throughout production, distribution, delivery, monitoring and evaluation.

Understanding of MHM landscape for scale-up context(s), including relevant policies, programming & varying cultural practices. It is important to assess the degree to which menstruation is addressed across ministries (including education, health, and sanitation) to better understand the scale-up context. Understanding the cultural beliefs in target contexts throughout the country will inform the creation of educational materials and influence decision making at various stages of MHM innovation, production and distribution. Understanding existing MHM educational challenges along with existing taboos in order to identify potential barriers to uptake, including those related to the washing, drying and disposal of menstrual waste. This contextualized learning will inform targeted educational and outreach efforts.

Equipment procured, government licensing obtained & production hubs established. Obtain all relevant licensing prior to production, and consistently meet regulatory requirements in a timely manner, with careful documentation. Secure appropriate infrastructure for production efforts, and procure and install production equipment (as needed). Licensing will enhance legitimacy for scale up operations and enable the adherence to policies and regulations set by local and national governments.

Workforce mobilized (production, HR, sales, marketing). Provide production, human resource (HR), sales, and marketing teams with necessary resources to effectively perform daily tasks. Include technical training about various job expectations and associated tasks, along with sensitization to menstruation, MHM, and organizational mission. Ensure that all necessary physical resources and supplies, such as computers, educational materials, and product materials, are available and functioning.

Relevant educational training plan (including for staff), educational materials, and/or instructions developed that address product use, menstrual health & hygiene, and menstrual beliefs and taboos. Develop an educational training plan for orienting staff on the menstrual hygiene product, including its proper usage. Content should address relevant menstrual beliefs and taboos in the target communities. If educational outreach activities are planned, basic educational training resources should be developed for staff prior to scale up efforts.

Refined product model and delivery system plan. Prepare a refined product model for production and delivery that can feasibly be scaled. Adapt as needed to the expanded target population, their sanitation practices (including access to facilities, water, and washing and drying resources), and local cultural beliefs and norms.

Environmental impact of scaling including menstrual waste disposal. All menstrual hygiene products, whether single use or reusable, will one day need disposal. In addition to minimizing environmental harms during production of products, scale up efforts must consider the type of materials produced and the approach users will take for final disposal of these products. Optimal menstrual hygiene products are biodegradable and/or have clear instructions on the

appropriate means of disposal to minimize plumbing blockages, build-up of unsanitary conditions, or impacted waterways, forests, or agricultural areas. Additionally, products should work to limit any embarrassment for girls and women.

SCALE UP ACTIVITIES

Products

Production:

- ***Capacity to expand production.*** Support and build the capacity of the supply chain to meet anticipated demand. Analyze the value chain and identify leverage points for enhanced performance. This includes considerations related to the hiring availability for additional staff (or expansion of shifts for existing staff), procurement strategies for increased supplies or machinery to address demand needs and appropriate management/HR strategies to support production and workforce growth.

- ***Ensure machinery and workforce compliance and that product quality is maintained and standards met as production increases and innovation scales.*** All machinery needs to receive routine maintenance and oversight to ensure optimal operational efficiency and quality. This may require developing partnerships with outside contractors and companies capable of providing this technical expertise. The production line must ensure basic quality control procedures are in place to assure quality sources materials utilized, optimal product design is consistently replicated and maintained overtime.

- ***Include sufficient printed instruction on product usage****.* Consistently include printed instructions on the proper use and care of MHM product. These instructions should explain product use, disposal and hygiene care, and account for literacy levels, including images or visuals as needed. Field testing of the printed information materials can ensure instructions are appropriate for the target audience.

Distribution

- ***Deliver effectively through identified channels (local or countrywide*)**. A range of different channels can be used to ensure that expanded distribution of menstrual products reach the target population (e.g. schools, community groups, workplaces). It may be necessary to proactively identify hard-to-reach populations (e.g. out of school girls, girls and women with disabilities, low-income girls and women) and adapt distribution approaches as they may experience challenges in accessing distribution channels to harder-to-reach populations.

- ***Consistent and appropriate delivery to users (at workplace, school, community) via partner organizations/businesses/community workers in rural and urban localities*.** Expanded distribution channels should appropriately forecast necessary quantities for target population based on a range of factors, including: target population size, product

design limitations (including estimated lifespan of product), product loss, and the implications of product misuse (including reduced lifespan). These estimations should be reflected in the quantities distributed so as to minimize gaps in coverage and enhance consistent product usage and confidence.

Expanded distribution methods should take into account that many girls and women may not be comfortable purchasing or receiving menstrual products and instructions in public or mixed gender settings given the taboos surrounding menstruation. Appropriate distribution methods should be introduced subsequent to consultations with girls and women, including hard-to-reach populations as their needs may differ. Considerations should include utilizing venues that are private and female-only, the use of female distribution or sales staff and ensuring that the menstrual products are discreetly provided and/or packaged for personal transport (including storage) as this can reduce discomfort and anxiety about privacy and stigma in the target population.

Education

Adapt and produce materials:

- ***Adapt materials to new in-country target populations (urban v. rural, age, girls in and out of schools, special needs).*** To ensure the MHM educational messages and methods are appropriate for scale up, consider the full range of demographics being targeted. This includes exploring differences between urban and rural populations, adolescent girls and adult women, and girls in and out of school. Variation can exist within these populations, including in their existing menstrual knowledge, their menstrual practices, menstrual-related restrictions and other cultural beliefs.

  When adapting materials for girls and women with special needs, including those with physical or mental disabilities, it is important to consider caregivers as they may be responsible for directly supporting girls and women with special needs with their MHM, including changing menstrual products, washing and drying menstrual products, and disposing of menstrual waste. Caregivers, including males and females, may also need MHM education and should be considered when tailoring educational materials.

- ***Tailor delivery of educational content (school, workplace, community awareness).*** Different dissemination venues (schools, workplace, community centers) may require different approaches when providing MHM education. This can be influenced by the (1) venue location (including privacy considerations), (2) availability of resources like technology, sanitation, water and disposal facilities, and, (3) knowledge of the education approaches or resources already available, 4) who is doing the education (e.g. training of trainers or direct education delivery). Consultations with girls, women, staff or community leaders at each type of location are useful for tailoring approaches, learning about pre-existing social resources and finding opportunities for expansion or growth. Consultations can also ensure that prior knowledge and social resources (e.g. existing

forums, girls' clubs or women's groups) are effectively engaged with and/or utilized for optimal or expanded product dissemination and uptake.

Dissemination:

- ***Expand partnerships to deliver content (schools, workplace, community groups).*** During scale up activities, it is useful to expand the range of partners involved in the provision of menstrual health and menstrual hygiene education. For example, engaging directly with organizations, schools, and community groups for the dissemination of this education can expand the range of audiences reached and promote sustainability. Furthermore, the engagement with a range of new partners can also help to build more informed and supportive menstrual environments via exposing workplace staff, community members and teachers to issues about menstruation, expanding their basic knowledge on the topic, and promoting consensus on the projects mission.

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

OUTCOMES

Immediate outcomes:

- ***Access to a quality and affordable menstrual product.*** Target users are able to easily, comfortably, and regularly access and use a higher quality menstrual product. Factors such as cost, distance/geography, education, economic status, literacy-levels, product maintenance, and unfamiliarity with the product type should not pose barriers to usage.

- ***Access to quality and appropriate MHM education.*** Target users are able to easily and comfortably access and understand higher quality MHM education. This includes ensuring that factors such as distance/geography, language/dialect, educational and economic status, and literacy-levels do not pose barriers to access or comprehension.

- ***Improved knowledge, attitudes and behaviors on menstrual hygiene management, including reduced negative menstrual taboos and myths.*** Girls and women have increased knowledge on basic menstrual hygiene management in addition to improved attitudes around menstruation, and reduced negative menstrual taboos and myths.

- ***Increased knowledge and confidence about sexual and reproductive health (SRH) and rights of women and girls in given context.**** The SRH and rights education enhances girls' and women's understanding on the basics of SRH and their rights, including on available SRH services and support.

- ***Enhanced employment opportunities for beneficiaries in given context.*** Menstrual health innovation beneficiaries (product and education) are able to more consistently attend and complete their schooling or employment roles, thus enhancing their economic potential.

- ***Enhanced employment opportunities and experiences for intermediaries (i.e. women developing pads and/or assisting with distribution).*** Female staff hired by the menstrual health innovators have improved economic opportunities, coupled with exposure to menstrual hygiene management, and a gender-supportive work environment. In addition, staff have satisfaction that their leadership and organization are being operated in an ethical, gender-supportive and fiscally competent manner.

Intermediate Outcomes

- ***Increased acceptance by girls and women, boys and men, community that menstruation is normal and healthy***. Improved understanding and attitudes by girls and women, boys and men and community members on the basics of menstruation and its importance as an indicator of a healthy reproductive system. This also includes a reduction in negative social norms and taboos surrounding menstruation found at the societal-level.

- ***Increased end-user demand for menstrual products in target population (in-out school, community, work, rural/urban).*** Consumer demand, including both beneficiaries and organizations serving these populations (schools, workplaces, community organizations), remains high based on factors including awareness, acceptability and affordability of the MHM innovation.

- ***Increased women's participation in employment and livelihood opportunities.*** Women feel increased empowerment while at their place of employment/performing livelihood activities during their menstruation. This includes enhanced confidence that the menstrual product will protect from leaks on their clothing and that they are able to confidently and discreetly change, store and maintain the product (over time) while fulfilling their employment requirements.

- ***Increased girls' participation and attendance in school.*** Adolescent girls have increased participation and engagement in the classroom due to increased confidence in the reliability of the menstrual product they are using. Improved product security may enhance girls' abilities to engage with teachers and peers in classroom activities by

reducing fears about blood leaks on their clothing. There may also be a reduction in girls' menstrual-related absenteeism from school.

IMPACT

Lives of girls & women improved through engaging effectively in the school and work during menstruation and achieving life success.

- ***Improved educational engagement.*** Improved educational engagement can enhance the academic success and confidence of adolescent girls in addition to strengthening their school-based social networks. Ultimately this may impact their grade progression and school completion rates.

- ***Improved economic security/livelihood security.*** Employment opportunities gained through the MHM product and education initiatives may improve girls' and women's employment stability and potentially their financial literacy. Such initiatives may also enhance their lifetime earning potential, accruing benefits for themselves and their future families.

- ***Improved population heath.*** Girls' education improves population level health outcomes, such as by reducing fertility rates, increasing contraceptive usage, reducing the risk of becoming infected with HIV/AIDs and other sexually transmitted diseases, and positively impacts the health of girls' future families, such as increasing children's vaccine rates.

- ***Improved engagement by girls and women in society through the diminishment of taboos and social restrictions during their menstruation***. Girls and women may experience an increased capacity and confidence managing their activities of daily living during their monthly menstruation, including reduced menstrual related stress, improved ability to engage in school and work, and decreased social segregation from community, religious and household activities.

- ***Increased dignity in managing menstruation***. Girls and women may report experiencing reduced shame and stigma during their monthly menstruation, including describing perceptions of increased comfort from improved access to appropriate facilities and menstrual products, and diminished discrimination from boys, men and others in their communities.

**When viable or appropriate to operational strategy*

Appendix S2: Path to Scale: Menstrual Hygiene Management (MHM)
Monitoring and Evaluation Narrative of Framework

This is a narrative on the Monitoring and Evaluation (M&E) Framework for MHM Indicators. It is designed to be read in conjunction with the accompanying *Theory of Change* model and narrative. The *Theory of Change* illustrates how activities undertaken by your MHM project contribute to a chain of results leading to the intended or observed outcomes and impact/s. The narrative here describes which key Indicators you can measure and how, providing a detailed description of the M&E approach, with a broader array of Indicators, the rationale for each selecting each indicator, and how to measure these with rigor.

PREAMBLE

The success of every project requires evidence of progress made toward achieving its' aims and goals. The activities, outputs, and outcomes provided in the *Theory of Change* are coupled with indicators that describe the events and changes resulting from your intervention activities in observable terms. Indicators therefore link together the 'theory' with the project 'practice'. Indicators are defined before the start of the project to ensure monitoring and evaluation can plot progress and change over time. For logistical and financial reasons, it is not possible to measure everything included in the *Theory of Change* path to scale. Some may also be time-consuming and costly to collect and analyse. The best indicators are simple, precise, and measurable – many programs opt for indicators that are 'SMART': specific, measurable, attainable, relevant, and timely. The indicators provided here mostly cover measures that are more readily and accurately obtained outside research settings, with additional measures noted that can provide more rigorous (hard) outcomes should research be available to facilitate this. If certain outcomes in your project are not operationalized and cannot be measured, an alternative indicator which covers an outcome resulting from your intervention activities can be used instead. Indicators should be reviewed and used to make improvements during the project.

TYPES OF INDICATORS

Indicators can relate to any part of the project. They are often divided into 'input' (contributions going into a project; 'process' (number and types of activities and outputs, such as products and deliverables), and 'outcomes' (measures of expected change in the short intermediate or long-term). Here they are broken down into the same categories as the *Theory of Change* covering activities, outputs, outcomes, and impact.

Activities: Actions taken, or work performed, through which inputs, such as funds, technical assistance and other types of resources are mobilized to produce specific outputs.

Outputs: The products, capital goods and services which result from product development and can include changes resulting from intervention which are relevant to achieving outcomes.

Outcomes: The likely or achieved short- and medium-term effects of your project outputs.

Impact: Positive, negative, primary, and secondary long-term effects produced by the product intervention, provided directly or indirectly, includes both intended or unintended effects.

Indicators can be quantitative or qualitative. *Quantitative indicators* can be defined as measures of quantity, and are expressed as whole numbers, decimals, percentages, rates, fractions, and as a monetary value. *Qualitative indicators* are people's judgments or perceptions about a subject these types of questions give us information that indicates whether our work is leading to the changes in people's lives, power and rights that we want to achieve. While quantitative factors can always be expressed as a number, qualitative indicators are expressed as independent statements or in relative terms such as good, better, and best, and cover measures such as performance and satisfaction with service provision.

The following guide describes the indicators for (1) innovation; (2) foundational elements; (3) scale-up activities; (4) outcome indicators; (5) impact indicators. Each are aligned with the Theory of Change model.

For each indicator, this below document guides on indicator type and unit of measure, the data source/methodology required to capture it, the timing and frequency of measurement, how the measure is interpreted to infer change, and the type of biases that need to be considered and minimised to maintain rigor.

1. INDICATORS FOR INNOVATION

1.1 Innovation is contextualized within local MHM practices and beliefs.
Indicator: No

1.2 Innovation empowers girls and women through education, employment and access.
Indicator: No

1.3 Innovation maintains compliance with government standards over time.
Indicator: (see below government licensing)

1.4 Innovation reaches low-income and marginalized girls and women.
Indicator: No

2. INDICATORS FOR FOUNDATIONAL ELEMENTS

2.1 Strategic buy-in and collaboration from relevant policy makers, government ministries, and community leaders.
Indicator: No

2.2 Understanding of MHM landscape for scale-up context(s), including relevant policies, programming & varying cultural practices.
Indicator: No

2.3 Equipment procured, government licensing obtained & production hubs established.
Description: The product developed is reviewed and deemed high quality and fit for purpose, and competitively priced for retail, with adequate materials to guide safe effective use.
Indicator: The product passes quality control evaluation from a designated independent quality assurance auditor.
Indicator type: Categorical: pass.
Data source: National authority review, local bylaw mandate documentation.
Monitoring: Start of study.
Frequency: Initial testing, before scale-up (repeat if manufacturing process changes).
Reference point and target change: Prior to product marketing.
Biases: Knowledgeable and unprejudicial national, and independent assessors.

2.4 Workforce mobilized (production, HR, sales, marketing).
Description: Persons employed to produce materials and/or help delivery of Innovative MHM Product report system of production and delivery is viable and effective (efficient).
Indicator: (1) Number and proportion of workers reporting positive feedback (using scale e.g. Likert scale measure) on production and distribution of Innovative MHM Product (2) Worker perception that production and distribution system and workforce management is functioning well.
Indicator type: (1) Numeric (continuous) on workers (community, institution, rural/urban, hard to reach) who report positive systems in place; and rate (percentage) among same worker groups surveyed; (2) Worker group perception of production and/or delivery system, input into approaches used.
Data source: (1) Quantitative: cross-sectional survey; (2) Qualitative: FGD (Notes, 13) of specified workers.
Monitoring: Spot-checks.
Frequency: Occasional spot-checks, not pre-defined.
Reference point and target change: Benchmark pre-set target by the project (e.g. by 6 months of delivery 60% of workers satisfied; by 9 months delivery 85% satisfied by 12 months 95% satisfied or something to that effect.
Biases: Could be open to pressure, representative of workers across workforce needed, stratified by different locations; random selection of participants/informants by independent /research group. Avoid advance warning of spot-check to minimize interference. Qualitative - non-leading probe questions.

Training cadres on product (not in TOC narrative):
Below indicator monitors the training of cadres on providing correct information on product to beneficiaries.

Description: Number and proportion of trained cadres tested who correctly know how to demonstrate to beneficiaries the safe and effective use of the Innovative MHM Product (stratified by sex, cadre, urban/rural, types of beneficiaries, school, out-of-school and community outreach, occupational, shop/kiosks etc).
Indicator: (1) Number and proportion of intermediaries/cadres trained on use of MHM Innovative Product; (2) Number and proportion of intermediaries/trained cadres able to demonstrate knowledge of correct use of MHM Innovative Product.
Indicator type: (1) Numeric (continuous) on trained; and rate (percentage) on trained among all targeted for training; (2) Numeric (continuous) on trained care giving correct answers; and rate (percentage) of trained giving correct answers among all surveyed.
Data source: (1) Log of all trained, and estimate of total cadre pool in the locality; (2) periodic assessment of trained cadre.
Monitoring: Generation of data at pre-specified timepoints (.
Frequency: Beginning of scale-up; repeat at interim to identify if retraining needed.
Reference point and target change: (1) Pre-determined target increase set as a time-specified milestone in absolute number, and proportion of intermediaries/cadres trained; (2) Pre-determined target of number and proportion (e.g. 80% of cadre trained provide correct answer).
Biases: Accurate count of all trained; representative sampling among trained in survey; accurate questions used to demonstrate correct knowledge.

2.5 Relevant educational training plan (including for staff), educational materials, and/or instructions developed that address product use, menstrual health & hygiene, and menstrual beliefs and taboos.
Description: The MHM / SRH educational plan and materials developed and supplementary training materials are reviewed and attested correct and informative for trainee cadres.
Indicator: (1) Education plan in situ; (2) Pass quality control evaluation from independent MHM /SRH experts; (3) Feedback received from community and stakeholders.
Indicator type: (1-2) Categorical: present; pass; (3) Qualitative response
Data source: Expert review, documentation.
Monitoring: Start of study.
Frequency: Inspection before training, re-review until positive outcome.
Reference point and target change: Prior to training.
Biases: Knowledgeable and unprejudicial independent assessors.

See also Indicator 3.3

2.6 Refined product model and delivery system plan.
See Indicator 3.4

2.7 Environmental impact of scaling including menstrual waste disposal.
Indicator: No

3. INDICATORS FOR SCALE UP ACTIVITIES

Product Outputs

Production:

3.1 Capacity to expand production.
Indicator: No

3.2 Ensure machinery and workforce compliance and that product quality is maintained and standards met as production increases and innovation scales.
Indicator: See 2.3 and 2.4

3.3 Include sufficient printed instruction on product usage.
Description: MHM / SRH Education materials (brochures/inserts) reach the specified standard for delivery to differing beneficiary groups, taking literacy level into account with visuals if needed; translation into local dialects if needed.
Indicator: (1) MHM / SRH Education materials (brochures, inserts) pass a quality control audit, evaluating content.
Indicator type: (1) Aggregate numeric score on all necessary components (purpose, use, hygiene care, safety, disposal), with pass above specified threshold.
Data source: (1) Evaluation checklist of content of materials, threshold score must be attained
Monitoring: Pre-marketing, and annual audits.
Frequency: Occasional spot-checks not pre-defined.
Reference point and target change: (1) Pass evaluation audit.
Biases: Review by independent representatives of different Educational programmes, regulators.

Distribution:

3.4 Deliver effectively through identified channels (local or countrywide).
Description: Number of units of the Innovative MHM Product manufactured and distributed to retailers/vendors, with milestones specified in delivery systems plan.
Indicator: (1) Number of units (packs) of Innovative MHM Product manufactured per month; (2) Number of units (packs) of Innovative MHM Product distributed by location[country/area], vendor type.
Indicator type: (1) Number (continuous) of packs/month manufactured; (2) Numeric (continuous) of packs/month by location and by vendor type.
Data source: (1) Company manufacturing logs; (2) Vendor stock-check, and/or manufacturers' company distributor logs.
Monitoring: Continuous monitoring.
Frequency: Monthly or quarterly; summarize annually.
Reference point and target change: (1) Pre-determined target of number of units (packs) manufactured per month specified in delivery system plan as a time-specified milestone; (2) Pre-determined target of number of units (packs) reaching distributers/vendors as a time-

specified milestone specified in delivery system plan; change measured as annual growth compared with previous year; comparison to pre-determined targets
Biases: Auditing (spot-checks) of manufacturing and distribution logs also required to ensure quality of reporting.

Ensure distribution of menstrual products expanded to reach the target population (e.g. schools, community groups, workplaces). It may be necessary to proactively identify hard-to-reach populations (e.g. out of school girls, girls and women with disabilities, low-income girls and women) and adapt distribution approaches as they may experience challenges in accessing distribution channels to harder-to-reach populations.

3.5 Consistent and appropriate delivery to users (at workplace, school, community) via partner organizations/businesses/community workers in rural and urban localities.

See Indicator 2.6

Education

Adapt and produce materials:

3.6 Adapt materials to new in-country target populations (urban v. rural, age, girls in and out of schools, special needs).
See Indicator 3.3

Caregivers, including males and females, may also need MHM education and should be considered when tailoring educational materials.

3.7 Tailor delivery of educational content (school, workplace, community awareness).
Description: Number and proportion of trained cadres tested who correctly know factual information on MHM / SRH Education (stratified by sex, cadre, urban/rural, types of beneficiaries, school, out-of-school and community outreach, work health departments, shop/kiosks etc).
Indicator: (1) Number and proportion of intermediaries/cadres trained; (2) # and % of intermediaries/trained cadres who correctly answer a basic set of questions regarding MHM / SRH Education (key questions can be listed).
Indicator type: (1) Numeric (continuous) on trained; and rate (percentage) on trained among all targeted for training; (2) Numeric (continuous) on trained care giving correct answers; and rate (percentage) of trained giving correct answers among all surveyed.
Data source: (1) Log of all trained and estimate of total cadre pool in the locality; (2) Periodic assessment of trained cadre.
Monitoring: Generation of data at pre-specified timepoints.
Frequency: Beginning of scale-up; repeat at interim to identify if retraining needed.

Reference point and target change: (1) Pre-determined target increase set as a time-specified milestone in absolute number, and proportion of intermediaries/cadres trained; (2) Pre-determined target of number and proportion (e.g. 80% of xxx trained provide correct answer)
Biases: Accurate count of all trained; representative sampling among trained in survey; accurate questions used to demonstrate correct knowledge.

Dissemination:

3.8 Expand partnerships to deliver content (schools, workplace, community groups).
Indicator: No

3.9 Address negative social norms and barriers through sensitizing gatekeepers.
Note the indicator below focuses on trained cadre rather than gatekeepers

Description: Number and proportion of trained cadres tested who correctly disagree with common myths and taboos (stratified by sex, cadre, urban/rural, types of beneficiaries, school, out-of-school and community outreach, occupational, shop/kiosks etc).
Indicator: (1) Number and proportion of intermediaries/cadre trained on myths and taboos; (2) Number and proportion of intermediaries /trained cadres who correctly disagree on a basic set of questions regarding myths and taboos.
Indicator type: (1) Numeric (continuous) on trained; and rate (percentage) on trained on myths and taboos; (2) Numeric (continuous) on trained giving correct answers on myths and taboos; and rate (percentage) on trained giving correct answers on myths and taboos among all surveyed.
Data source: (1) Log of all trained and estimate of total cadre pool in the hard to reach locality; (2) Periodic assessment of trained cadre.
Monitoring: Generation of data at pre-specified timepoints.
Frequency: Beginning of scale-up; repeat at interim to identify if retraining needed.
Reference point and target change: (1) Pre-determined target increase set as a time-specified milestone in absolute number, and proportion of intermediaries/cadres trained; (2) Pre-determined target of number and proportion (e.g. 80% of xxx trained provide correct answer).
Biases: Accurate count of all trained; representative sampling among trained in survey; accurate questions used to demonstrate correct knowledge around sensitive topics involving local myths and taboos.

4. OUTCOME INDICATORS

Immediate outcomes:

4.1 Access to a quality and affordable menstrual product.

Factors such as cost, distance/geography, education, economic status, literacy-levels, product maintenance, and unfamiliarity with the product type should not pose barriers to usage.

4.1.1 Access (reported by beneficiaries)

Description: The Innovative MHM Product is shown to be available and accessible for purchase and use by the right beneficiaries targeted (by social group, rural, urban, marginalized and hard to reach populations).
Indicator: (1) Beneficiaries caregivers (by social group, rural, urban, marginalized populations) report that Innovative MHM Product is accessible to them; (2) Number and proportion of beneficiaries' caregivers (by social group, rural, urban, marginalized and hard to reach populations) reporting: Innovative MHM Product is available and accessible for their purchase and use.
Indicator type: (1) Numeric (continuous) of beneficiaries, caregivers (by social group, rural, urban, marginalized populations) reporting product is available in their community, vendors; and rate (percentage) of beneficiaries, caregivers (by social group, rural, urban, marginalized and hard to reach populations) able to access and use.
Data source: (1) Quantitative: Survey of beneficiaries and caregivers documenting MHM product is available and accessible to them in their community, vendors.
Monitoring: Spot-checks and surveys, generated at prespecified time-points.
Frequency: Annual measure showing permeation.
Reference point and target change: (1) Pre-determined target increase set as a time-specified milestone in absolute number, and proportion of target population reached with available accessible product, stratified by target group including hard to reach; comparison to pre-determined targets; aggregate increase over time; compare with another area.
Biases: Representative of beneficiaries; stratified by different target populations, girls, women, in-out of school, occupation, rural/urban, hard to reach.

4.1.2 Access (reported by vendors)
Description: The Innovative MHM Product is shown to be accessible for distribution and purchase by an accepted number and proportion of the reported target channels to reach the right beneficiaries targeted (including hard to reach areas).
Indicator: (1) Number and proportion of local shop/kiosks/community groups who have stocks of the Innovative MHM Product among total targeted (including hard to reach areas) (2) supplies stocked in schools (free, subsidized depending on business model).
Indicator type: (1) Numeric (continuous) of vendors (by type, location) with stock for public purchase; and rate (percentage) of vendors (by type, location) with stock among all vendors.
Data source: (1) Quantitative: number of vendors broken down by type, and location (including hard to reach communities); mystery shopper verification; vendor sales data.
Monitoring: Spot-checks and surveys, generated at prespecified time-points.
Frequency: Annual measure showing permeation.
Reference point and target change: (1) Reach pre-determined measurable increase in number and proportion of vendors with Product stocked for public [or freely available at specified institutions] as time-specified milestone; stratified by type, location; comparison to pre-determined targets; aggregate increase over time; compare with another area.
Biases: Representative of vendors who serve intended beneficiaries; not solely 'easy access' includes survey in hard to reach areas.

4.1.3 Affordable (reported by beneficiaries)

Description: Targeted beneficiaries/caregivers report that the Innovative MHM Product has been priced at an affordable amount for their purchase and use.
Indicator: (1) Community (vendors; beneficiaries) perception that Innovative MHM Product is affordable; (2) Number and proportion of beneficiaries reporting: Innovative MHM Product is competitively priced for their purchase and use.
Indicator type: (1) Group consensus perception of affordability of Innovative MHM Product; (2) Categorical (ordinal) on affordability (willingness to pay); and rate (percentage) agreeing affordability.
Data source: (1) Qualitative: FGD vendors; FGD targeted beneficiaries (2) Quantitative: Vendor exit survey of targeted beneficiaries 'willingness to pay'; vendor sales data.
Monitoring: Generation of data at prespecified timepoints.
Frequency: FGD at scale up, and after one year; vendor exit survey after one year.
Reference point and target change: (1) Marketing consensus of beneficiary groups of correct pricing; (2) Increase in number and proportion of beneficiaries reporting willing to pay for Product, reaching a predetermined proportion (e.g. 50%) in a given time-frame as milestone.
Biases: Representative of vendors who serve intended beneficiaries, and representative of targeted beneficiaries; includes stratification of hard to reach; avoid biased questions on cost.

4.2 Access to quality and appropriate MHM education.

4.2.1 MHM education access (by venues)
Description: MHM / SRH Education is provided to the reported target number of beneficiary groups (including hard to reach areas and marginalized populations).
Indicator: (1) Number and proportion of venues (schools, community groups, workplaces) received MHM / SRH Education sessions among total targeted (including hard to reach areas).
Indicator type: (1) Numeric (continuous) of venues (by type, location) with MHM / SRH Education curricula listed; and rate (percentage) of venues (by type, location) among all targeted venues.
Data source: (1) Quantitative: Survey of venues documenting MHM / SRH Education on curricula (including hard to reach communities).
Monitoring: Initial and spot-checks.
Frequency: Annual measure showing permeation.
Reference point and target change: (1) Pre-determined target increase set as a time-specified milestone in absolute number, and proportion of target population trained; stratified by target groups including hard to reach.
Biases: Representative of venues who serve intended beneficiaries; not solely 'easy access' includes survey in hard to reach areas, or marginalized populations that may be missed.

4.2.2 MHM education access (by beneficiaries)
Description: MHM / SRH Education is shown to be available and provided to the right beneficiaries targeted (by social group, rural, urban, marginalized and hard to reach populations).
Indicator: (1) Beneficiaries caregivers (by social group, rural, urban, marginalized populations) report that MHM / SRH Education is provided to them; (2) Number and proportion of

beneficiaries' caregivers (by social group, rural, urban, marginalized and hard to reach populations) reporting MHM / SRH Education is provided to them; (3) Beneficiaries/caregivers describe positive response to education sessions, across different groups.
Indicator type: (1) Numeric (continuous) of beneficiaries, caregivers (by social group, rural, urban, marginalized populations) reporting MHM/SRH education is provided to their community; (2) Rate (percentage) of beneficiaries, caregivers (by social group, rural, urban, marginalized and hard to reach populations) provided; (3) qualitative feedback.
Data source: (1) Quantitative: Survey of beneficiaries and caregivers documenting MHM / SRH Education is provided to them in their community, settings; (3) Qualitative: FGD targeted beneficiaries/caregivers.
Monitoring: Initial and spot-checks.
Frequency: Annual measure showing permeation.
Reference point and target change: (1) Pre-determined target increase set as a time-specified milestone in absolute number, and proportion of target population trained; stratified by target groups including hard to reach.
Biases: Representative of venues who serve intended beneficiaries; not solely 'easy access' includes survey in hard to reach areas, or marginalized populations that may be missed.

4.2.3 MHM education quality
Description: MHM / SRH Education is provided to specified standard to the beneficiary groups (including hard to reach areas and marginalized populations)
Indicator: (1) MHM / SRH Education sessions pass a quality control audit, evaluating teaching delivery and quality of education.
Indicator type: (1) Aggregate numeric score including each component, with pass above specified threshold.
Data source: (1) Evaluation checklist of education delivery, threshold score must be attained
Monitoring: Initial and spot-checks.
Frequency: Occasional spot-checks not pre-defined.
Reference point and target change: (1) Pass evaluation audit.
Biases: Representative of different Educational programmes, includes spectrum of educational levels and settings, including in hard to reach populations.

4.3 Improved knowledge, attitudes and behaviors on menstrual hygiene management, including reduced negative menstrual taboos and myths. Girls and women have increased knowledge on basic menstrual hygiene management in addition to improved attitudes around menstruation and reduced negative menstrual taboos and myths.

Description: MHM Education has increased knowledge on MHM, healthy behaviors, and reduced taboos and myths among beneficiaries-- note this could be broken down into separate indicators for specific areas (hard to reach, rural, urban etc).
Indicator: (1) Number and proportion of beneficiaries (schoolgirls, out-of-school girls, women) correctly responding to puberty and menstrual practices questions; (2) Beneficiaries demonstrate knowledge of correct practice and disagree with common myths and taboos.

Indicator type: (1) Numeric (continuous) of beneficiaries who report correct answers and disagree with common myths and taboos; and rate (percentage) among same beneficiary groups surveyed; (2) Beneficiary groups knowledge, practices and attitudes to MHM reflected, with dispelling of common myths and taboos.
Data source: (1) Quantitative: cross-sectional survey [household; and/or institutional] of targeted beneficiaries; (2) Qualitative: FGD targeted beneficiaries.
Monitoring: Generation of data at different timepoints.
Frequency: Consider rolling survey e.g. biannually; FGD annual.
Reference point and target change: (1) Pre-determined target increase in absolute number, and proportion of targeted population responding correctly to set of MHM questions as a time-specified milestone; (2) Majority of informants demonstrate knowledge and disagree with myths and taboos; compare against baseline observations if available.
Biases: Representative of beneficiaries; stratified by different target populations, girls, women, in-out of school, occupation, rural/urban, hard to reach. Qualitative - non-leading probe questions.

4.4 Increased knowledge and confidence about sexual and reproductive health (SRH) and rights of women and girls in given context. *
Description: SRH Education has increased knowledge on SRH, women's rights, and where beneficiaries can go to seek health advice on SRH service access -- note this could be broken down into separate indicators for specific areas (hard to reach, rural, urban etc).
Indicator: (1) Number and proportion of beneficiaries (schoolgirls, out-of-school girls, women) able to answer basic SRH questions, women's rights, and identify local SRH service and how to access; (2) Beneficiaries demonstrate knowledge on rights to SRH services and care, and how to access.
Indicator type: (1) Numeric (continuous) of beneficiaries who report knowledge of SRH, women's rights, and where services are available; and rate (percentage) among same beneficiary groups surveyed; (2) Beneficiary groups knowledge, practices and attitudes on SRH and access to services.
Data source: (1) Quantitative: cross-sectional survey [household; and/or institutional] of targeted beneficiaries; (2) Qualitative: FGD targeted beneficiaries.
Monitoring: Generation of data at prespecified timepoints.
Frequency: Consider rolling survey e.g. biannually; FGD annual.
Reference point and target change: (1) Pre-determined target increase in absolute number, and proportion of targeted population responding correctly to set of SRH questions as a time-specified milestone; (2) Majority of informants demonstrate knowledge of rights and services; compare against baseline observations if available.
Biases: Representative of beneficiaries; stratified by different target populations, girls, women, in-out of school, occupation, rural/urban, hard to reach. Qualitative - non-leading probe questions.

4.5 Enhanced employment opportunities for beneficiaries in given context.

Menstrual health innovation beneficiaries (product and education) are able to more consistently attend and complete their schooling or employment roles, thus enhancing their economic potential.
Description: Provision of Innovative MHM Product, MHM Education enhances women and girls' ability to continue school and work-life during menstruation.
Indicator: (1) Number and proportion of girls attending school during menses; (2) Number and proportion of women attending work during menses; (3) Beneficiaries report menses no longer prevents them from attending school or work.
Indicator type: (1, 2) Numeric (continuous) and rate (percentage) on girls and women attending school and work; (3) Beneficiary groups report ability to attend.
Data source: (1) Quantitative: cross-sectional survey [household; and/or institutional] of targeted beneficiaries; (2) Qualitative: FGD targeted beneficiaries.
Monitoring: Generation of data at prespecified timepoints.
Frequency: Consider rolling survey e.g. biannually; FGD annual.
Reference point and target change: (1,2) Reach pre-determined measurable increase in number and proportion of girls and women attending school and work as time-specified milestone; stratified by group, rural, urban (3) Majority of informants' report ability to attend.
Biases: Representative of beneficiaries; stratified by different target populations, girls, women, in-out of school, occupation, rural/urban, hard to reach. Qualitative - non-leading probe questions.

4.6 Enhanced employment opportunities and experiences for intermediaries (i.e. women developing pads and/or assisting with distribution).
Description: Improvements are made in the environment and employment work conditions experienced by intermediaries.
Indicator: (1) Number and proportion of women intermediaries who manufacture or provide MHM Product and/or educations report work hours and work conditions have improved employment; (2) Women intermediaries report beneficiaries report quality of employment has improved.
Indicator type: (1) Numeric (continuous) and rate (percentage) of women reporting employed, and positive work conditions (2) Intermediaries describe good quality work environment, opportunities for work, and employment rights.
Data source: (1) Quantitative: cross-sectional survey [household; and/or institutional] of intermediaries; (2) Qualitative: FGD in representative of different intermediaries
Monitoring: Generation of data at prespecified timepoints.
Frequency: Annually; end of project.
Reference point and target change: (1,2) Reach pre-determined measurable increase in number and proportion of intermediaries as time-specified milestone; stratified by employment, rural, urban (3) Majority of informants' report enhanced employment.
Biases: Representative of intermediaries; stratified across differing employment sectors rural/urban, hard to reach. Qualitative - non-leading probe questions, representative.

Intermediate Outcomes

4.7 Increased acceptance by girls and women, boys and men, community that menstruation is normal and healthy.

Description: Provision of Innovative MHM Product, MHM Education in community increases acceptance of menstruation as normal and healthy

Indicator: (1) Number and proportion of community members (boys, men, leaders, teachers, employers, other [as well as girls and women] who report menstruation is normal and healthy; (2) High proportion of above describe menstruation as normal and healthy, with no myths and taboos.

Indicator type: (1) Numeric (continuous) and rate (percentage) of different community members agreeing that menstruation is normal and healthy; (2) Qualitative description by community members that menstruation is normal and healthy; and that myths and taboos no longer limit girls and women's activities.

Data source: (1) Quantitative: cross-sectional survey in community representing differing groups; (2) Qualitative: FGD targeted groups.

Monitoring: Generation of data at prespecified timepoints.

Frequency: Annually; end of project.

Reference point and target change: (1) Reach pre-determined measurable increase in number and proportion of community, stratified by education, gender, setting i.e. rural, urban, illiterate, marginalized, etc (2) Majority of community members dispel myths and taboos and comment on menstruation as being healthy and normal; compare against baseline or comparison populations.

Biases: Representative of different populations, avoid leading questions.

4.8 Increased end-user demand for menstrual products in target population (in-out school, community, work, rural/urban).

Description: The Innovative MHM Product is demonstrated to be purchased by the targeted beneficiaries -- note this can be further broken down into separate indicators for specific target populations (schoolgirls, delivery through schools; community out-of-school girls; women in the community through outreach workers, availability in the workplace; access in hard to reach populations, slum dwellers etc).

Indicator: (1) Number and proportion of beneficiaries or caregivers who report purchase of Innovative MHM Product in the previous 3 months; (2) Beneficiary / caregivers perception that community peers are purchasing Innovative MHM Product in previous 3 months (3) number of beneficiaries reporting desire to purchase product.

Indicator type: (1) Numeric (continuous) of beneficiaries (by age, location [school, office, community], rural/urban, hard to reach) who report purchase of Innovative MHM Product in past 3 months; and rate (percentage) among same beneficiary groups surveyed; (2) Beneficiary group perception of purchasing among peers in past 3 months.

Data source: (1) Quantitative: cross-sectional survey [household; and/or institutional] of targeted beneficiaries; (2) Qualitative: FGD targeted beneficiaries; vendor sales data

Monitoring: Generation of data at prespecified timepoints.

Frequency: Annually, end of project.

Reference point and target change: (1) Pre-determined target increase set as a time-specified milestone in absolute number, and proportion of targeted population purchasing MHM; compare against baseline or comparison population Product; (2) Majority of informants know of beneficiaries who have purchased MHM Product.
Biases: Representative of beneficiaries; stratified by different target populations, girls, women, in-out of school, occupation, rural/urban, hard to reach, marginalized, illiterate etc. Qualitative - non-leading probe questions. Note also concerns that this indicator could be prone to perverse incentives - so care is needed not to create false reporting (or obligation for false reporting)

4.9 Increased women's participation in employment and livelihood opportunities.
(Note - some overlap with Immediate indicator 4.5)
Description: Provision of Innovative MHM Product and/or MHM Education enhances women ability to participate and contribute to work and employment while menstruating.
Indicator: (1) Number and proportion of women able to actively participate in full work activities during menses; taking a lead role in work activities (2) Women report they are able to lead in work activities throughout their menses without fear or risk of any menstrual issues arising.
Indicator type: (1) Numeric (continuous) and rate (percentage) of women reporting they fully engage while at work, without worrying about their menses; (3) Qualitative description of enhanced status and engagement at work.
Data source: (1) Quantitative: cross-sectional survey [household; and/or institutional] of targeted beneficiaries; (2) Qualitative: FGD targeted beneficiaries.
Monitoring: Generation of data at prespecified timepoints.
Frequency: Consider rolling survey e.g. biannually; FGD annual.
Reference point and target change: (1) Reach pre-determined measurable increase in number and proportion of women fully engaged in work as time-specified milestone; stratified by group, rural, urban (2) Majority of informants' report ability to attend.
Biases: Representative of beneficiaries; stratified by different target populations, women, employment settings, rural/urban, hard to reach. Qualitative – non-leading probe questions.

4.10 Increased girls' participation and attendance in school.
(Note - some overlap with Immediate indicator 4.5)
Description: Provision of Innovative MHM Product, MHM Education enhances girls' ability to engage in school during menstruation
Indicator: (1) Number and proportion of girls able to attend and positively enjoy school during menses; (2) Girls report menses no longer prevents them from enjoying sports, lessons and other activities or attending school during menses.
Indicator type: (1) Numeric (continuous) and rate (percentage) of girls fully reporting they engage in school activity (sport, lessons); (2) Qualitative description by girls they are able to fully engage and participate without fear of menstrual issues arising during school activities.
Data source: (1) Quantitative: cross-sectional survey in school of range of schoolgirls representing differing vulnerabilities; (2) Qualitative: FGD targeted schoolgirls.
Monitoring: Generation of data at prespecified timepoints.

Frequency: Consider rolling survey e.g. biannually; FGD annual.
Reference point and target change: (1) Reach pre-determined measurable increase in number and proportion of girls enjoying specified activities during school as time-specified milestone; stratified by age, setting i.e. rural, urban, marginalised, disabilities, illiterate, etc (2) Majority of girls report positive effect on engagement of school activities while having menses.
Biases: Representative of beneficiaries; stratified by different populations, rural/urban, hard to reach, disabilities etc. Qualitative – non-leading probe questions

5 IMPACT INDICATORS

Health impact indicators commonly describe the impact of interventions on mortality, morbidity, or lives improved. Due to the limited research and programme evidence-base on the generation of standardized health impact indicators using robust and cost-effective methods, grantees are expected during scale-up of MHM products to define indicators most closely aligned with these, that are feasible to measure. The following are examples, of which an attainable selection can be included in grantees monitoring and evaluation plan.

Lives of girls and women improved through engaging effectively in the school and work during menstruation and achieving life success.

5.1 Improved educational engagement and achievement.

Improved educational engagement can enhance the academic success and confidence of adolescent girls in addition to strengthening their school-based social networks. Ultimately this may impact their grade progression and school completion rates.
Description: Provision of Innovative MHM Product, SRH / MHM Education enhances girls confidence and ability to reach their academic potential.
Indicator: (1) Number and proportion of girls completing secondary school; (2) Number and proportion of girls reporting attending school; (3) Number and proportion of girls describe feeling confident and motivated to achieve in school.
Indicator type: (1, 2) Numeric (continuous) and rate (percentage of girls completing school education; (3) Qualitative description of ability to achieve potential in school.
Data source: (1,2) Quantitative - cross-sectional surveys; (3) Qualitative; FGD before, and after study among different beneficiaries.
Monitoring: Generation of data at prespecified timepoints.
Frequency: Annual, after completion of project, permeated over time.
Reference point and target change: (1) Reach pre-determined measurable increase in number and proportion of girls completing school as time-specified milestone; stratified by group, rural, urban (2) Reach pre-determined measurable increase in number and proportion of girls attending school as time-specified milestone; stratified by group, rural, urban (3) Clear step change in girls attitudes and ability to achieve described, compared with baseline or comparative population.
Biases: Strong observational biases can occur with attendance/absence collection - poor collection through school registers, and reporting bias among girls' diaries etc (desirability effect bias).

5.3 Improved economic security/livelihood security.
Description: Provision of Innovative MHM Product, SRH / MHM Education enhances women's' ability to succeed in the workplace, with improved employment and financial independence
Indicator: (1) Number and proportion of women employed in community in formal sector; (2) Wages of women employed
Indicator type: (1) Numeric (continuous) on women employed in specific sectors targeted; (2) Numeric (continuous) mean income of women employed.
Data source: Quantitative - work databases, employment statistics.
Monitoring: Generation of data at prespecified timepoints.
Frequency: Occasional, e.g. every 5 years.
Reference point and target change: (1) Reach pre-determined measurable increase in number and proportion of women working as time-specified milestone; stratified by population, rural, urban; (2) Measurable rise in income generation among women.
Biases: Biases with work records possible; extraneous political and social factors may influence measures.

5.4 Improved population heath.
Description: Provision of Innovative MHM Product, MHM Education enhances women and girls' health (selection: fertility, contraceptive use, HIV/AIDS, STI, gender-violence)
Indicator: (1) Number and proportion of girls and women reporting contraceptive used/HIV-negative; STI-negative; no gender-violence in past 12 months (2) Beneficiaries report healthy life-style; (3) Health facility statistics records show downward trend in HIV, STI, violence.
Indicator type: (1) Numeric (continuous) and rate (percentage) of girls and women reporting contraceptive used/HIV-negative; STI-negative; no gender-violence in past 12 months; (2) Beneficiary groups report health; (3) Rates (percentages of health events in area.
Data source: (1) Quantitative: cross-sectional survey [household; and/or institutional] of targeted beneficiaries; (2) Qualitative: FGD targeted beneficiaries; (3) health facility statistics records with denominators for area to calculate rates.
Monitoring: Generation of data at prespecified timepoints.
Frequency: Occasional, e.g. every 5 years.
Reference point and target change: (1) Reach pre-determined measurable decrease in number and proportion of women with health events as time-specified milestone; stratified by population, rural, urban; (2) Measurable rise in women exhibiting healthy behaviors.
Biases: Biases with health records possible; extraneous political and social factors may influence measures.

5.5 Improved engagement by girls and women in society through the diminishment of taboos and social restrictions during their menstruation.
Description: Provision of Innovative MHM Product and/or MHM Education enhances women and girls' ability to participate in activities previously denied (religious festivals, etc).
Indicator: (1) Number and proportion of girls and women report they can attend previously denied social activity (2) Beneficiaries report menses no longer prevents them from attending.

Indicator type: (1, 2) Numeric (continuous) and rate (percentage) on girls and women attending denied social activity; (3) Beneficiary groups report ability to attend.
Data source: (1) Quantitative: cross-sectional survey [household; and/or institutional] of targeted beneficiaries; (2) Qualitative: FGD targeted beneficiaries.
Monitoring: Generation of data at prespecified timepoints.
Frequency: Consider rolling survey e.g. annually.
Reference point and target change: (1,2) Reach pre-determined measurable increase in number and proportion of girls and women attending social activity as time-specified milestone. stratified by group, rural, urban (3) majority of informants' report ability to attend.
Biases: Representative of beneficiaries; stratified by different target populations, girls, women, in-out of school, occupation, rural/urban, hard to reach. Qualitative – non-leading probe questions.

5.6 Increased dignity in managing menstruation.

Girls and women may report experiencing reduced shame and stigma during their monthly menstruation, including describing perceptions of increased comfort from improved access to appropriate facilities and menstrual products, and diminished discrimination from boys, men and others in their communities.

Description: Provision of Innovative MHM Product and/or SRH/MHM Education enhances girls and women's day to day lives, self-esteem, and ability to participate socially.
Indicator: (1) Number and proportion of girls and women reporting stress related to MHM in school, or the workplace; (2) Number and proportion of girls and women reporting no longer segregated from sleeping. arrangements, religious or community events; (3) Beneficiaries report improved social life and reduced isolation.
Indicator type: (1) Categorical (ordinal) on degree of CHANGE in stress related to MHM in school, or the workplace in beneficiaries; and rate (percentage) among same beneficiaries surveyed; (2) Categorical (ordinal) on degree of CHANGE in segregation from sleeping arrangements, religious or community events; (3) beneficiaries report improved social life and reduced isolation.
Data source: (1) and (2) Quantitative: repeat survey before, during (interim), end-survey MHM Innovation and/or MHM /SRH Education stratified by beneficiary groups; (3) Qualitative; FGD before, interim, end of study among different beneficiaries.
Monitoring: Generation of data at prespecified timepoints.
Frequency: Consider rolling survey e.g. annually.
Reference point and target change: (1) Pre-determined target decrease in absolute number, and proportion of targeted population reporting stress as a time-specified milestone; (2) Pre-determined target increase in absolute number, and proportion of targeted population reporting no segregation; (3) Majority of beneficiaries report positive change in social life
Biases: May have strong desirability effect; need to capture data on representative populations.

**When viable or appropriate to operational strategy.*