MENSTRUAL HYGIENE MANAGEMENT: THE EXPERIENCE OF NOMADIC AND SEDENTARY POPULATIONS IN NIGER

STUDY

UN WOMEN

WSSCC
WATER SUPPLY & SANITATION COLLABORATIVE COUNCIL

Menstrual hygiene management: the experience of nomadic and sedentary populations in Niger

Regions of Maradi, Tahoua, Tillabéri and Zinder

UN WOMEN

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UNIVERSITY OF YAOUNDÉ II

TRAINING AND DEMOGRAPHIC RESEARCH INSTITUTE (IFORD)

This study was undertaken as part of the Joint Programme on Gender, Hygiene and Sanitation. It is the result of beneficial collaboration between WSSCC, UN WOMEN and IFORD. WSSCC and UN Women do not share responsibility for the data which were collected by the team at IFORD.

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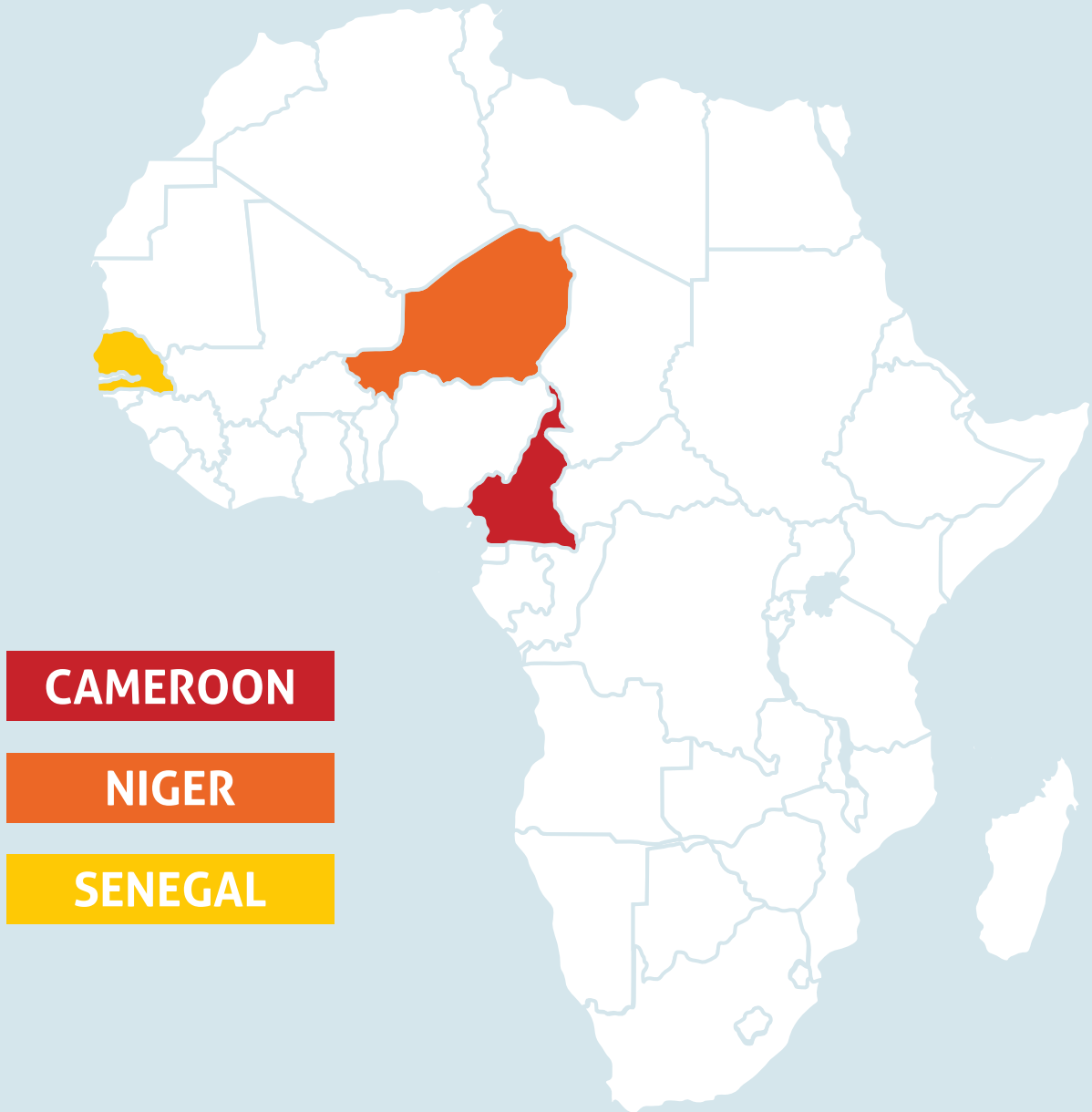
The Joint Programme on Gender, Hygiene and Sanitation is being implemented in three pilot countries of West and Central Africa: Cameroon, Niger and Senegal.



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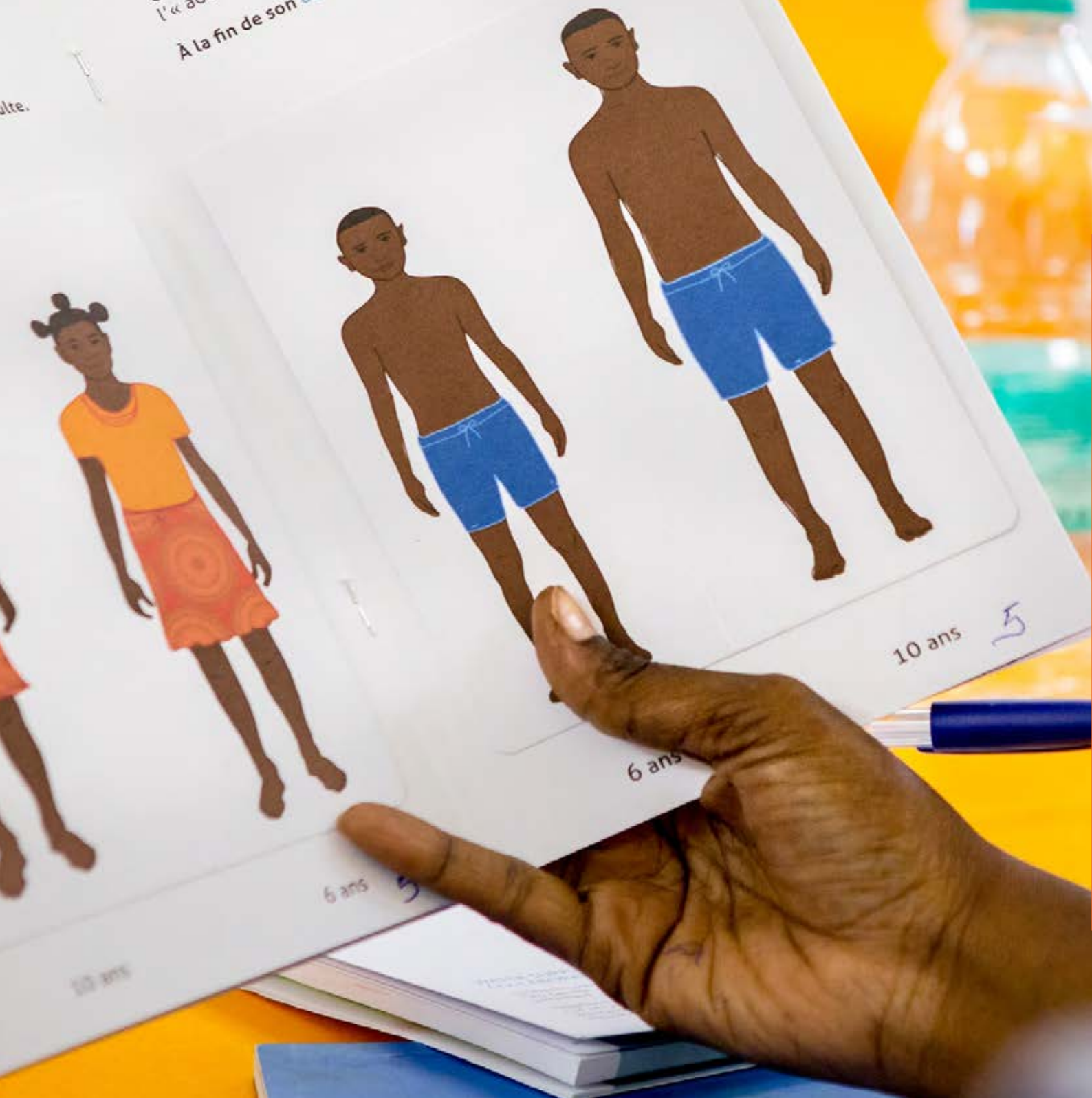
Garçon

Lorsqu'un garçon grandit, son corps se développe et des changements se produisent. Ces changements prennent place entre 9 et 19 ans.

Cette étape de la vie des garçons s'appelle l'« adolescence ».

À la fin de son adolescence, il sera devenu adulte.



EXECUTIVE SUMMARY

This study on menstrual hygiene management (MHM) was conducted in Niger, and focused on four regions: Maradi, Zinder, Tahoua and Tillabéri. It was carried out under the Joint Programme on Gender, Hygiene and Sanitation in West and Central Africa, implemented by the Water Supply and Sanitation Collaborative Council (WSSCC) and UN Women. The main objective of the study is to examine and analyse behaviours and practices related to menstrual hygiene management and their impact on the living conditions of sedentary and nomadic women and girls in Niger. It also looks at MHM in public policy.

Data were collected from regional and local leaders and from the general population, using a mixed research method that combined quantitative and qualitative approaches. The sample used for the quantitative data was randomly drawn from women and girls aged 12 to 49 years and men aged between 15 and 49 years. A total of 1,310 people took part (868 women and 442 men) in the research.

In terms of major results, we note that:

- menstruation is a taboo subject in Nigerien society, strongly influenced by beliefs and myths that affect its management. Regarded as impure, menstrual blood is handled with considerable discretion;
- those participating in the study have a basic understanding of menstruation, particularly its duration and the average age of menarche. Nevertheless, and particularly among women and girls from rural areas, they are not able to explain why women have periods. They do not, moreover, have any knowledge of the relationship between the menstrual cycle and reproductive health;
- during their periods, (i) women and girls observe nutritional, sexual and religious restrictions; (ii) men and boys are not much involved and offer women and girls little help in the management of their periods;
- poor menstrual hygiene management practices are seen more among nomadic women (98%) in comparison with sedentary women (49%). In all the regions studied, the proportion of women with poor menstrual hygiene management is higher than 50%. It is even more pronounced in the region of Maradi (73%);
- pads are the most common type of protection used during menstruation. They are considered safe and hygienic. The washing of reusable sanitary products is generally done with soap and hot water. A few women use salt for washing. They represent 17% in Tahoua and 14% in Maradi;
- the level of access to and use of WASH facilities in the communities remains insufficient – lower in nomadic communities as opposed to sedentary groups – with poorly cleaned toilets which are often non-functional and unsuitable for good menstrual hygiene management;
- the WASH facilities are also insufficient at the household level – both nomadic and sedentary – with some variations in Tahoua and Zinder, as opposed to Maradi and Tillabéri. Toilets and latrines are generally overused, poorly and irregularly cleaned and not very discrete. In addition, there is a lack of tools for the collection of and management of menstrual waste.
- field observations reveal that WASH infrastructure in different settings – secondary schools and universities, workplaces and markets, where large numbers of women are present – do not address women's and girls' needs during menstruation. None of the toilets visited would allow women to wash properly because they were either unhygienic or not secure.
- this lack of appropriate WASH infrastructure also has a negative impact on women's participation in economic, learning and social activities. Most women report that their days are disrupted during their periods. Their mobility and level of activity is restricted and nearly 40% of girls surveyed said that they took time off school at least once a month during their periods.
- the lack of appropriate WASH infrastructure impacts on the way sanitary protection is used. In most cases, women wash their sanitary protection at home and dry it in their bedrooms, or in another room inside the house. Once worn out, sanitary protection is either buried in the ground or thrown into latrines.
- overall, there is poor menstrual hygiene management at both the individual and community level which can lead to infections and thus have a negative impact on Nigerien women's and girls' health. The fact that nearly a quarter of women and girls reported an infection during menstruation points to a link between the inefficient management of periods and vulnerability to infections.
- Sectoral policy documents on water, sanitation and hygiene, health and education rarely mention women's

and girls' menstruation in Niger. Poorly represented in decision-making bodies, women have no forum to make their voices heard or demand a response to their needs in relation to menstrual hygiene management.

At the end of the study, the following recommendations for decision makers were made:

- intensify interventions for the promotion of good MHM in rural and nomadic environments while strengthening the upkeep and maintenance of existing infrastructure;
- intensify awareness-raising campaigns on MHM aimed at nomadic populations, especially in the regions of Tahoua and Zinder, where the study revealed poor menstrual hygiene management;
- conduct awareness-raising campaigns aimed at women in formal and informal schools including Koranic schools;
- respond to boys' requests for better information on MHM which will aid the reduction of stereotypes that reinforce gender inequalities;
- strengthen the building of separate latrines in educational establishments;
- develop modules on MHM in secondary and higher curricula and further disseminate existing ones;
- involve men in MHM-related interventions;
- strengthen action research activities to inform political decision makers and practitioners in the field of MHM;
- strengthen evidence-based advocacy to promote the integration of MHM into public policies and national and local development strategies;
- carry out a complementary study in the regions of Agadez and Diffa to further reflect and address the needs of nomadic groups in Niger;
- undertake an analysis of the obstacles and barriers to the acquisition of toilets and latrines by communities.


La roue des menstruations
WSSCC

GENERAL INTRODUCTION

1. BACKGROUND TO AND JUSTIFICATION FOR THE STUDY

Water, hygiene and sanitation, are serious development issues faced by many African countries. While collective hygiene and public sanitation matters have been increasingly debated and taken into account by governments in their development policies, the same cannot be said for menstrual hygiene. Defined as a set of practices related to cleanliness that, when applied, protect our bodies and the people around us from disease, individual hygiene involves the washing of hands, feet, the scalp, the mouth, teeth and many other parts of the body such as the face, nose, ears and genital organs (Frioux, 2015).

Therefore, individual hygiene also includes menstrual hygiene management which refers to women's ability to stay clean and in good health during menstruation as well as to the way they use and dispose of menstrual products (Reed and Shaw, 2008). The care of genital organs requires rigorous hygiene due to their sensitivity and increased vulnerability to disease, more so in women than men. Because individual hygiene is critical to fight sources of infection and to reduce the vehicles of transmission, it is now part of national and global priorities.

West Africa is an arid region, and Niger in particular, experiences a shortage of drinking water, which can be a threat for menstrual hygiene management (Mitullah et al., 2016; United Nations, 2015). And yet, despite constituting a very important part of women's lives, menstruation is a subject that is rarely discussed in public (Perrot, 1984) and a few studies only are available on this topic. The one conducted by Long and Caruso in Bolivia revealed the fear and shame experienced during their periods by the school pupils surveyed. These feelings are particularly manifested by a behaviour change in classroom.

Studies show that menstruation is still a taboo. Girls are ashamed at the onset of menarche and negative perceptions are persistent (House et al., 2012; UNESCO, 2014).In West Africa, a study conducted by WSSCC and UN Women in the region of Louga, Senegal, shows that sanitary napkins and cloths are the most commonly used materials for the management of menstruation. Some women, particularly those living with disabilities, also use sponges – bits of sponge from mattresses to manage their periods. In Niger, the results of the qualitative research conducted by Souley (2016), in schools, show that the topic remains somewhat taboo and that there is no communication between parents and children. Therefore, knowledge about menstruation is limited. As for perceptions, they seem to be quite negative among girls, highlighting an ambivalent conception of periods, which are considered both a clear sign of fertility and a potential risk for unwanted pregnancy. This summary literature shows that menstruation remains a taboo subject that is not taken into account in public health policy planning or budgeting. It should also be noted that none of these studies targeted every category of women.

Even if periods symbolize the maturity of the ovum, form part of a normal phase in girls' growth and consequently give them the power to be mothers one day, girls and women are often ashamed of their periods. This shame, and the practice of hiding the materials used during menstruation, can put girls and women at risk of catching certain diseases related to poor hygiene during menstruation. In a community context characterized by the lack of gender-specific toilets and the shared use of the toilet, this study raises the difficulties related to menstrual hygiene management.

Furthermore, women's and, especially, girls' difficulties can prevent their success in the workplace. For this reason, it is important to discuss menstruation and to have a proper understanding of the challenges associated with this social, cultural, normal and natural phenomenon.

This study is also justified because it is not only about girls in schools as was the case in previous studies carried out in Niger, but on another segment of the population: pastoral and sedentary girls and women. Differences may exist between these two strata of the population in terms of access to information and menstrual hygiene practices. This factor explains why this is a comparative study in which the resulting data will highlight any differences in MHM between nomadic and sedentary girls and women.

2. OBJECTIVES OF THE STUDY

2.1 General objective

The general objective of this study is to examine and analyse behaviours and practices for the management of menstrual hygiene and their impact on the living conditions of sedentary and nomadic women and girls in Niger, as well as looking at MHM in public policy.

2.2 Specific objectives

Specifically, this study aims to:

- assess the knowledge, attitudes and perceptions of women and men in relation to MHM;
- collect information on beliefs and cultural and social practices related to women's menstrual hygiene management;
- identify physical, social, economic and environmental barriers to good menstrual hygiene management among women;
- report on the state of MHM-related practices and behaviours;
- identify good practices that encourage good menstrual hygiene;
- report on the state of infrastructure and existing public policies on MHM;
- formulate recommendations for decision makers, to take better account of MHM in policy making.

3. EXPECTED OUTCOMES

Expected outcomes of the study include:

- information on women's and girls' knowledge of MHM will be captured and made available;
- women's and girls' perceptions of MHM will be measured;
- information will be captured on social and cultural practices related to menstrual hygiene management among nomadic and sedentary women and girls in Niger;
- a report will be drawn up on MHM practices and behaviours, infrastructure and public policies;
- good practices favourable to good menstrual hygiene will be identified;
- policy briefs will be developed for the attention of Niger's decision makers, to enable better account to be taken in public policies of the menstrual hygiene of nomadic and sedentary women and girls.

4. METHODOLOGICAL ASPECTS

4.1 Definition of key concepts

Puberty: puberty refers to the period of physical and emotional change that occurs during the growth and development of the child. It is one of the key steps in the development of the human body towards adulthood, with the most rapid growth since the prenatal and neonatal periods. Hormonal changes result in the first ejaculation (semenarche) in boys and the first menstruation (menarche) in girls (Brooks-Gunn, 1988).

Menarche: name given to a young woman's first period. It usually occurs around 12 years of age (Caruso et al., 2013).

Menstrual cycle: a biological and, therefore, natural phenomenon that occurs in the female reproductive system over a period of 28 days on average. Each month, tissues of the wall of the uterus build up in preparation for ovulation. If the ovule is fertilized, the uterus walls provide nourishment for the embryo and the cycle stops until the woman gives birth. If the ovule is not fertilized it disintegrates with the outer layers of the uterus walls and is expelled from the vagina with blood. It is this release phase that is called menstruation (Kirk and Sommer, 2006).

Menstruation: also called period, this is the monthly elimination of the surplus uterus wall by women of reproductive age. On average, it occurs every 28 days and the bleeding usually lasts 5 to 7 days. The average blood loss in this period is 35 ml (Caruso et al., 2013).

Menstrual hygiene: this refers to the conditions or habits that promote the protection of health and the prevention of disease, with particular focus on women's cleanliness during their periods (Tjon Ten, 2007).

Menstrual Hygiene Management (MHM): this is the sum of hygiene strategies used by women during their periods. In other words, it is the way in which women keep clean and healthy during their periods and how they acquire, use and dispose of products that absorb the blood (House et al., 2012).

Sanitation: according to WHO, sanitation is the provision of facilities and services enabling the risk-free disposal of urine and faeces. It is also used to designate the maintenance of hygienic conditions, by means such as services for the removal of wastewater and solid waste (domestic and/or industrial waste) (WHO, 2014).

Collective sanitation: generally found in urban areas or where homes are grouped together, wastewater is first collected in a sewerage network which is then transported to a treatment plant. There are many types of collective sanitation: urban treatment plants, more modest capacity treatment plants and lagoons (WHO, 2014).

Individual or independent sanitation: this is used in areas where homes are dispersed: a sanitation system is set up for each home or for each group of homes within a defined perimeter. Setting up this type of sanitation is the responsibility of individuals. Located close to the house, the system typically comprises a wastewater collection device and a septic tank to provide anaerobic pre-treatment, a sludge spreading treatment system and a system for disposal by scattering on the land (WHO. 2014).

Latrine: a latrine is a place arranged in such a way that human beings can relieve themselves of their bodily excrement, including by defecation (Franceys et al., 1992) They are sometimes associated with toilets since, in addition to being used as a place of defecation, they also serve as a place of bathing. Latrines have a lower technology and may be divided into two broad categories:

- *Improved latrine/toilet:* these are constructions built in accordance with certain rules: a hole covered with a slab of concrete or wooden planks with a superstructure made of solid walls with ventilation holes. This category includes the ventilate latrine (VIP), the pit, ventilated latrine (VIP), double pit latrine, EcoSan latrine, manually flushed toilet, pit or double pit and mechanically flushed toilet (WHO/UNICEF, 2016; Pickford, 1995).
- *Unimproved latrine:* an unimproved latrine is a traditional latrine with no concrete slab and made with a flimsy superstructure. This category includes the drilled hole or simple pit latrine (WHO/UNICEF, 2016; Pickford, 1995).

Knowledge (on the subject of menstrual hygiene): public health knowledge is defined as a set of information acquired by people on a given aspect of public health (Goutille, 2009). This information, which enables individuals to identify their degree of vulnerability to the health issue in question, concerns their ability to define the concept studied and to identify its different components, such as prevention, transmission and treatment. In the context of MHM, knowledge refers to accurate information on cognitive abilities to understand menstruation in its scientific and sociocultural dimension and to identify the educational needs and precise materials needed for remediation.

4.2 Area of study and target populations

The survey was conducted in the four intervention regions of the UN Women and WSSCC programme: Tahoua, Maradi, Zinder and Tillabéri (Map 1). These regions contain one of the highest rates of population growth (3.9% per year between 2001 and 2012). This rate of population increase accentuates the weight of the challenges that the country must meet to be part of a sustainable development process. With regard to the economy, the pace of growth of the Nigerien economy has been characterized by high volatility in recent years. Thus, Niger's growth fluctuated from 2.3% in 2011 to 10.8% in 2012, then 4.1% in 2013, which places the country in last place of the UNDP Human Development Index ranking. Poverty leads to a low standard of living and highlights the importance of issues related to social sectors such as education and health. Data from different surveys conducted since 1990 show limited improvement in the living conditions of Niger's households and people. In 1998, the gross enrolment ratio in Niger's schools was 32% for the country overall and 25% for girls. The estimated literacy rate in 2008-2012 was 28% overall.

With regard to health, it was estimated in 2007 that there was one doctor per 40,000 inhabitants at the country level (one doctor per 100,000 inhabitants in the region of Tillabéri); WHO standards give one doctor per 10,000 inhabitants. Infant and mortality rate was 63% (UNICEF, 2012) and the child vaccination coverage rate around 70% depending on the vaccine (UNICEF, 2012). Taking all regions together, the rate of access to safe drinking water is 49% in rural areas, against 100% in urban settings; the rate of access to sanitation is at 5% in rural areas and 38% in urban settings (JMP, 2015). All indicators denote the precariousness of the Nigerien people's living conditions, especially in rural areas.

On a different topic, that of early marriage, this phenomenon is a source of concern due to its frequency and scale and the consequences arising from it. While it is a very widespread phenomenon in Niger (77% on average), its prevalence is higher in the regions of the south of the country, more specifically in the regions of Diffa (89%), Zinder (88%), Maradi (87%) and Tahoua (83%), where the issue of early marriage is particularly urgent (UNFPA, 2012; Zabeirou, 2010).

Once married, very few of these girls (4.3%) use contraceptives and they manage their menstrual hygiene less (Zabeirou, 2010). A sample was drawn from all the households identified. As the general objective was to analyse different practices and behaviours around MHM and their

Map 1
Regions surveyed

Source: Shutterstock

impacts on nomadic and sedentary women's and girls' living conditions, the survey was conducted on a representative sample of the two social categories targeted, the nomadic and sedentary populations. In each of the sample households, either all the girls and women aged 12-49 who had had at least one period but no men were surveyed, or all the girls and women aged 12-49 who had had at least one period and all the men aged 15-49 were surveyed to answer the questionnaire.

4.3 Type of study

In view of the objectives, triangulating methods made it possible to optimize results. Indeed, this study consisted of two components that were conducted jointly: the statistical survey consisting of the administration of individual questionnaires was complemented by a qualitative component conducted through interviews and targeted focus group discussions (FGDs).

4.3.1 Quantitative component

Criteria for the selection of households: the study was conducted among nomadic and sedentary households containing women or girls of reproductive age who had had at least one period. Occasionally the study also included men aged 15 to 49.

Sampling: the sampling frame was made up of all households in the various regions. Households were referenced by their assigned census (or structure) numbers and the surname(s) and forename(s) of the heads of household. This sampling frame was sorted by area, residence setting and by order in the counting zone (ZD, in French).

Sample size: the calculation of the number of individuals using appropriate mathematical formulas resulted in the selection of 868 women. In addition, 442 men, a little over half the number of women, were selected in order to capture the views of men on the subject.

Data-collection tools: the collection tools were designed to suit the target group and the nature of the information being sought. These tools are as follows:

- the "community" questionnaire, developed to identify the infrastructure and facilities in the commune, locality or village/district. This identified ratios such as the number of women of reproductive age who had had at least one period;
- the "household" questionnaire, designed to determine how many women of reproductive age (12-49) there were in each household. It was built around several areas of interest and questions relating to the sociodemographic, sociocultural and socioeconomic characteristics of members of the household;
- the "individual woman" questionnaire, developed for women and girls of reproductive age who had had at least one period (aged 12-49);
- the "individual man" questionnaire, for men aged 15 to 49 years.

These latter two tools explored questions of MHM-related knowledge and practices, and also the availability of infrastructure for women's hygiene and its specific role in good menstrual hygiene practices.

Technique and personnel used for data collection: as our data collection technique, we opted for direct interviews (in the Hausa, Zarma or Fula languages depending on the respondent) via the administration of questionnaires to women of reproductive age who had had at least one period (12-49 years) and men aged 15-49. Regarding the data collection team, given the secrecy that surrounded this subject and for respondents to be comfortable with answering questions, preference was given to women as interviewers. The data collection team was originally established as having 3 supervisors and 12 interviewers, of whom 12 were women and 2 were men. Due to certain cultural considerations, however,[1] we added 2 more men, so that each region team had one male interviewer to administrate the men's questionnaires. We recruited 20 interviewers (15 women and 5 men) for training, of whom we selected 12 female interviewers and 4 male interviewers for the actual collection.

Processing and analysis of data: quantitative data were processed using CSPro 6.3 software. They were then exported for processing and analysis using SPSS 20 and Stata 12 for Windows. To meet the objectives of the study, the statistical methods used for data analysis were essentially descriptive methods, reflecting the frequency distributions of the variables analysed.

4.3.2 Qualitative component

To better understand the management of menstrual hygiene among nomadic and sedentary girls and women in Niger, it was deemed necessary to deploy appropriate qualitative techniques (individual semi-directed interviews and FGDs). Indeed, going beyond the figures obtained by the quantitative component, it was essential to understand the perceptions, practices, attitudes and social representations built up around menstrual hygiene management by girls and women (of reproductive age) in Niger. Thus, the techniques mentioned above were used to understand and explain the symbolic and observable practices and personal experiences of these social actors. This option has deepened analysis and, as Bourdieu said (1984: 32), *"to fully explain what statistics only show"*.

Target populations: in the two regions selected for the qualitative component (Maradi and Zinder), the qualitative survey focused on: (i) girls and women aged 15-49; (ii) officials responsible for health issues, particularly mayors or their deputies at the local level, and some senior officials within the Ministry of Health at national level; (iii) programme managers and staff working in the WASH sector; and (iv) programme managers and staff working in the health, environment and education sectors.

Sampling techniques: the sample was constructed on the basis of "rational choices". Each element of the sample was selected for its actual ability to provide the information we sought. At the end of each interview, the "snowball" technique was used to access the next interviewee. Technically, this consisted of the person who had just been interviewed identifying another person in the community who met the same requirements as him or her for the survey. Table 1 below shows the size of the sample in this study.

Qualitative data-collection tools: three main collection tools were used in this research (see annex 2): (i) The observation grid to highlight the outstanding elements that were immediately apparent, without the aid of the interviewee; (ii) the guides for semi-directed or semi-structured individual interviews with municipal officials and officials in charge of health and education issues and (iii) the FGD guide designed to facilitate group discussions with the persons selected (nomadic or sedentary men and women) who had freely consented to take part.

1 It turned out that it would have been difficult or impossible for a female interviewer to ask men questions about an area that is so sensitive and so surrounded by taboos.

Collection techniques: three data-collection techniques were chosen:

- *The semi-structured interview:* these consisted of "giving the floor" to local social actors so that they could share their feelings and perceptions on hygiene issues in general in their localities (access to water, etc) and particularly on questions related to MHM. This technique gathered quite rich information and opened new avenues for reflection.
- *The Focus Group Discussion:* as noted above, FGDs were conducted on both study sites in Niger. Directed group discussions were used to correct or go deeper into individual interviews. Indeed, certain themes and opinions that were not mentioned in the individual interviews were introduced in the group discussions. In addition, the interactions arising from this technique were of such a nature as to enrich the data, helping achieve a deeper knowledge of MHM-related sociocultural practices in these regions of Niger in nomadic and sedentary girls and women.
- *Direct observation:* To draw up an inventory of infrastructure (used by nomadic populations and sedentary populations), we used the technique of direct observation to identify and assess their condition.

Processing and analysis of qualitative data: the qualitative data gained from the interviews and group discussions were transcribed. These transcriptions were made by the interviewers who collected the data. These qualitative data were later subjected to a socio-anthropological analysis by the social anthropologist on the research team.

Document review

The document review was mainly carried out on documents related to public policy and the establishment of community-level water and sanitation infrastructure to address menstrual hygiene management.

Table 1

Distribution of persons targeted by qualitative survey technique

CATEGORY OF STAKEHOLDER TARGETED	SEMI-DIRECTED INDIVIDUAL INTERVIEW (SDIS)	FOCUS GROUPS DISCUSSIONS (FGDS)	REGION
Programme managers and staff working in the WASH/health sector	6 WASH: 3 (men and women) Health: 3 (men and women)		MARADI AND ZINDER
Nomadic and sedentary women and girls		5	
Nomadic and sedentary men and boys		5	
Municipal officials and officials responsible for health and education issues	6 Health: 2 (man and woman) Education: 2 (man and woman) Municipal officials: 02 (man and woman)		
TOTAL	12	10	

5. CHALLENGES ENCOUNTERED

While conducting this study, the team encountered the following challenges:

- **Insecurity:** a climate of insecurity still reigns in much of Niger. This is the case in areas of Tillabéri and Maradi that, at the time of our visit, were the scene of armed attacks and kidnappings. This led us to adjust our survey and sampling plan and to limit one of our target groups (the nomads) to just two localities, Dakoro and Sarki Yama.
- **The sensitivity of the topic of the study:** MHM remains a taboo subject within the communities surveyed. Customs and practices dictate that questions related to this topic are not addressed in either the domestic or public arenas. For this reason, whole swathes of questions were not answered in the questionnaires or discussed at FGD sessions, and many cases of refusal were recorded.

6. STRUCTURE OF THE REPORT

This report is structured into eight chapters. The first chapter presents the characteristics of the people surveyed. The second analyses the state of functionality of WASH infrastructure in communities and households. The third covers the population's general knowledge of menstrual hygiene management. The fourth chapter deals with practices, attitudes and behaviours related to menstrual hygiene. The fifth considers social and cultural barriers to good menstrual hygiene management. The sixth chapter is dedicated to health problems and people's use of health care during menstruation. The seventh examines the impact of menstruation on women's lives. The final chapter evaluates the extent to which public policy takes account of menstrual hygiene management.

CHAPTER 1

PROFILE OF THE PEOPLE SURVEYED

This chapter focuses on the distribution of the people surveyed according to their demographic, economic and sociocultural characteristics. This univariate analysis enables the description of individuals within households.

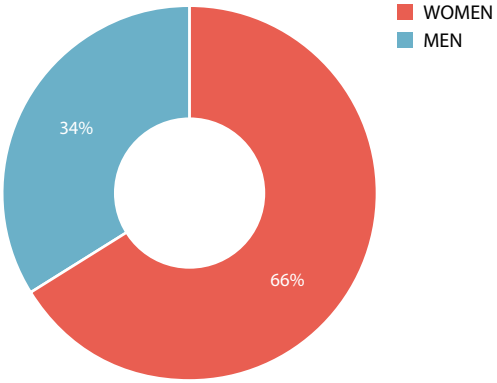
1.1 Demographic and economic characteristics

1.1.1 Preponderance of females

As the main target population of the study is women, they are over-represented in the sample, justifying the proportion of 66.3% represented by them (Graph 1.1). It must be said, however, that despite this consideration linked to the study objectives, the Nigerien population is composed of more women than men. There are 5,543,703 women, against 5,516,548 men (INS, 2011).

Graph 1.1

Total sample distribution by sex

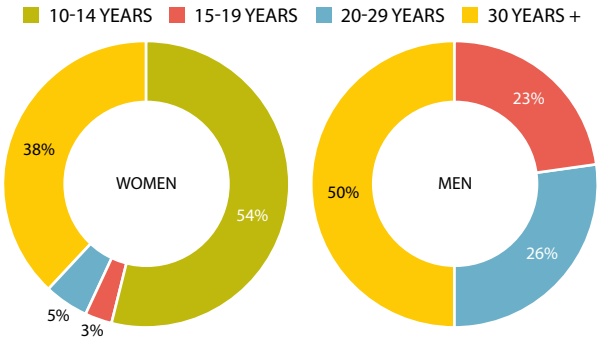


1.1.2 Preponderance of young people and young adults

The breakdown by age reveals a bimodal distribution of the population surveyed (Graph 1.2). The first modal group is made up of adolescents (10-14 years) and adults (30 years and over), and the second group has a near equal proportion of men and women, young people close to the age of majority (15-19 years) and young adults. Taken overall, this is a young population that reflects Niger's age pyramid, the broad base of which shows the youth of the population.

Graph 1.2

Distribution by age group of total sample

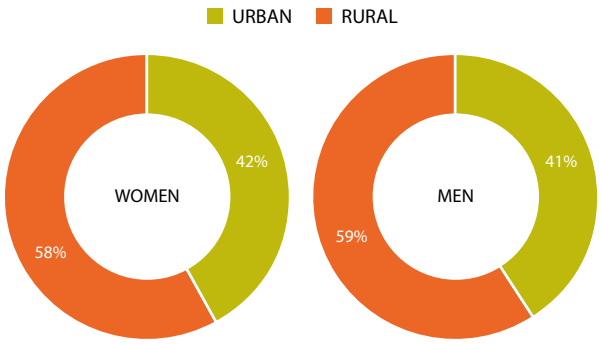


1.1.3 Mainly rural respondents

More than half of the respondents live in rural areas (58% of women and 59% of men), reflecting the low level of urbanization in Niger.

Graph 1.3

Distribution of respondents according to residential setting

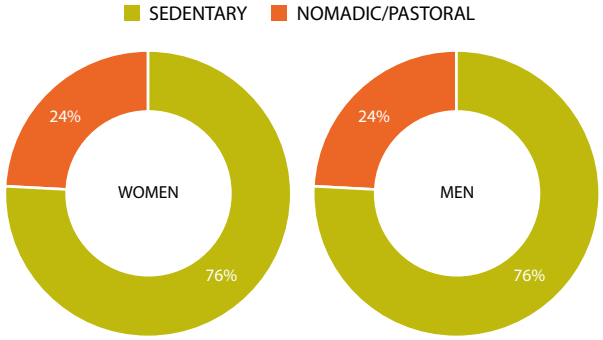


1.1.4 A population more sedentary than nomadic

Three quarters of respondents, both male and female, are members of sedentary households. This reflects the reality of Nigerien society which is characterised by a high proportion of sedentary households.

Graph 1.4

Distribution of respondents by residence type

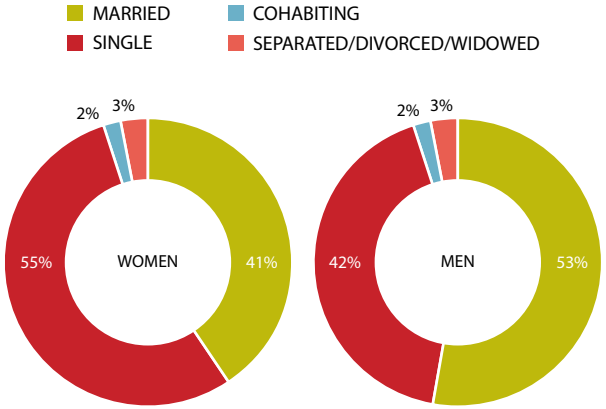


1.1.5 Respondents are mainly single

Households living as couples form half of the sample; the other half are single people with a slight preponderance of women (55%).

Graph 1.5

Distribution of respondents by marital status

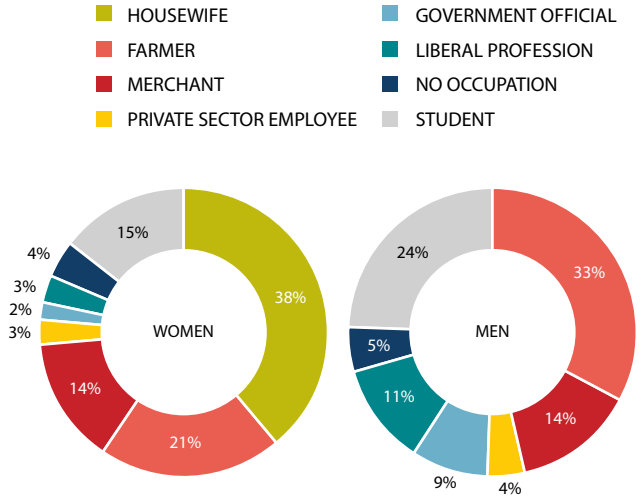


1.1.6 Respondents working in the primary sector

Discounting school pupils and students, who are generally economically inactive, most respondents work in the primary sector (agriculture and livestock) and the tertiary service sector (retail). A majority of women (nearly 38%) are housewives.

Graph 1.6

Distribution of respondents by occupational level



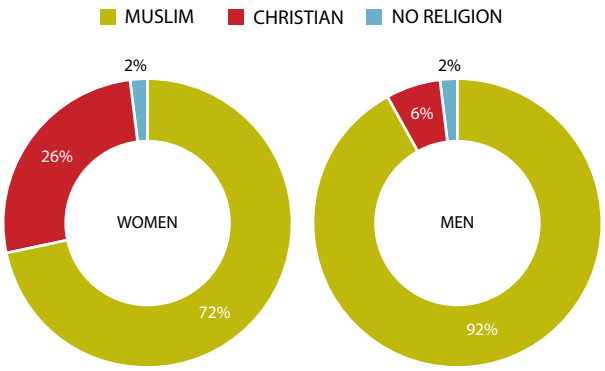
1.2 Sociocultural characteristics

1.2.1 Large majority of respondents are Muslims

Taking both sexes together, the majority of respondents are Muslims and a minority are Christian. This is hardly surprising as the Nigerien landscape is largely dominated by Muslims (nearly 90%), the remaining 10% being followers of Christianity and a few who are non-religious.

Graph 1.7

Distribution of total sample by religion

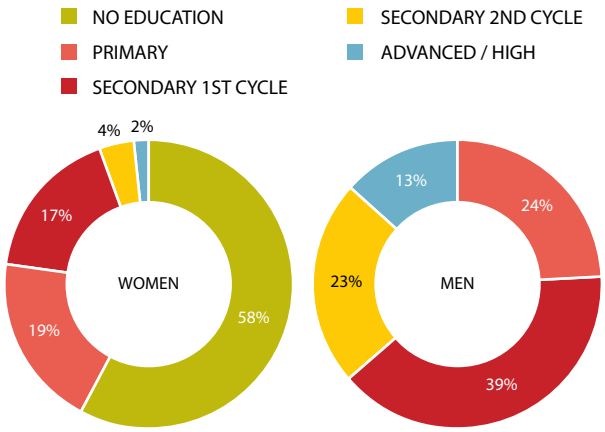


1.2.2 Low school enrolment rates

With regard to schooling, a majority of interviewees only completed primary and the first cycle of secondary education. There was a high proportion of people with no education, especially women. As shown below, the reasons for the absence or low level of schooling is likely to be linked to early marriage and to poverty.

Graph 1.8

Distribution of respondents by educational level



Broken down by category for the target population, the following tables provide the detail for each group (Tables 1.1 and 1.2).

Table 1.1

Distribution of men surveyed by educational level and residence

EDUCATIONAL LEVEL	TYPE OF RESIDENCE	
	SEDENTARY	NOMADIC
	FREQUENCY (%)	FREQUENCY (%)
No educational level completed	0	0
Primary	26	10
Secondary, 1st cycle	35	73
Secondary, 2nd cycle	24	17
Higher	14	0

Table 1.2

Distribution of women surveyed by educational level and residence

EDUCATIONAL LEVEL	TYPE OF RESIDENCE	
	SEDENTARY	NOMADIC
	FREQUENCY (%)	FREQUENCY (%)
No educational level completed	72	8
Primary	13	39
Secondary, 1st cycle	9	48
Secondary, 2nd cycle	4	3
Higher	2	2


WEST
24

CHAPTER 2

ASSESSMENT OF WASH INFRASTRUCTURE

One of the purposes of this study is to conduct an inventory of the infrastructure from a gender perspective, especially with regards to menstrual hygiene management to evaluate if the context in which girls and women live – both in the home and in public places – is suitable for their needs and conducive to good menstrual hygiene. This chapter analyses the existence of facilities needed for MHM in the two types of environment mostly frequented by girls and women: in the community and at home.

2.1 Limited infrastructure in community settings

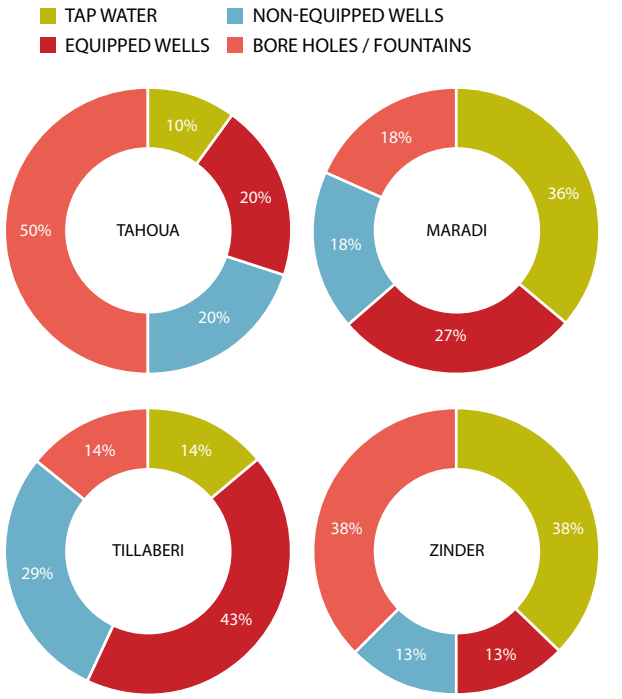
In the paragraphs below, the community level refers to the scale of observation, that is, either the village or the district. In these settings, the places visited were schools, high schools, universities, bus stations and markets.

2.1.1 Relatively high use of bores and wells

Of the four sources of water supply, Graph 2.1 demonstrates that the majority of respondents use bores and wells, albeit at different levels from region to region. Tahoua stands out in terms of using supplies from bores and public standpipes (50%), while Tillabéri comes first for use of protected or unprotected wells (29% and 43%). Zinder is the region where households mainly used tap water (38%).

Graph 2.1

Distribution of respondents by main source of water supply

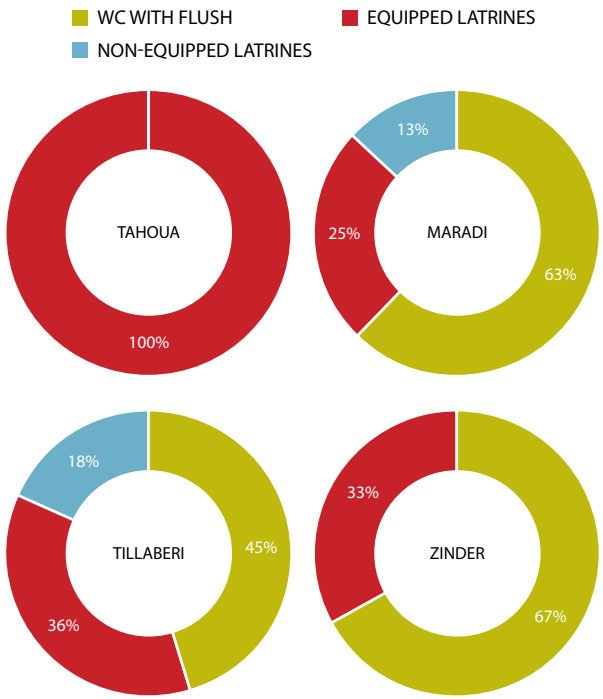


2.1.2 Latrines as the most common sanitation facility

A majority of respondents reported using latrines, including unimproved latrines, particularly pit latrines and dry toilets that consist of a hole dug in the ground, above which there is a rudimentary wooden structure. In Tahoua, users of this type of latrine reached 100%. The prevalence of this type of toilet denotes the low rate of access to sanitation in Niger where one notes the current practice of open defecation at the high rate of 79% (JMP, 2012).

Graph 2.2

Types of toilet and latrine



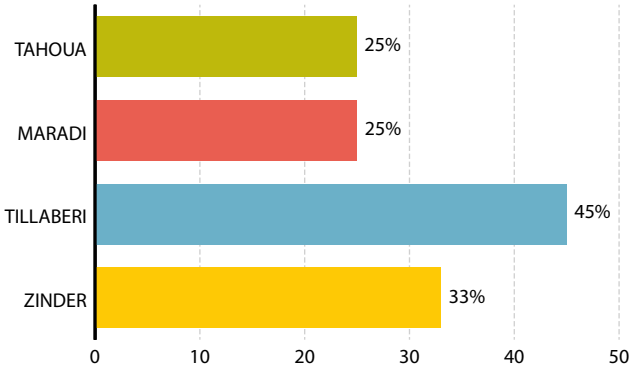
2.1.3 Relatively operational sanitation facilities

Whether improved toilets (WC with flush) or latrines (Photo 2.1), data show that more than 50% (Graph 2.3) of them are not functional.

Tillabéri is the only region where the level of functionality of toilets and latrines approaches 50%. This can be explained by its proximity to Niamey, the political capital, from where the advantages of an urban setting spread to nearby places.

Graph 2.3

Function of toilets and latrines



2.1.4 Poorly cleaned toilets and latrines

The toilets and latrines visited were poorly cleaned. Indeed, the level of cleanliness (assessed on the basis of the presence of waste on the floor, flies, smells and faeces on the edges of the hole) is largely below average, ranging from 20% in Maradi to 36% in Tillabéri (Graph 2.4). In rural areas, more than 90% of the population still practises open defecation, which has a direct impact on the health of young people and contributes greatly to the mortality rate of children aged under five years (UNICEF, 2011).

Graph 2.4

Cleanliness of toilets and latrines

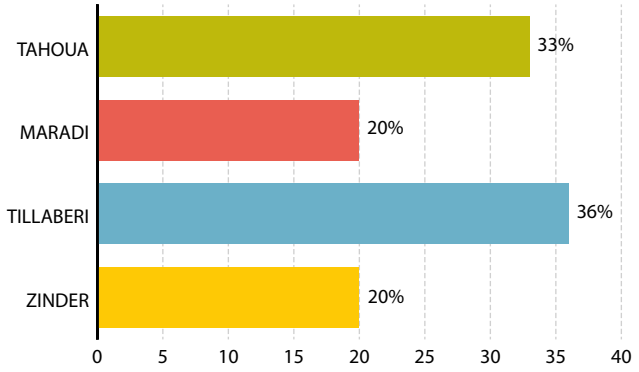


Photo 2.1
Improved toilet with flush

Photo 2.2
Improved toilet; no flush, but wet

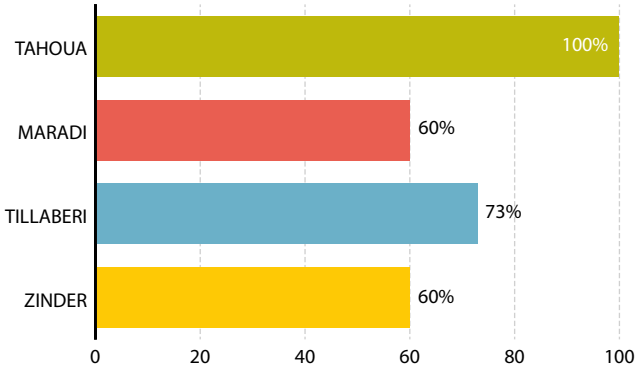
Photo 2.3
Improved pit latrine block

2.1.5 Widespread respect for privacy

Although they are poorly cleaned, toilets and latrines are built with respect for the privacy of users in mind. Thus, the majority, ranging from 60% in Maradi and Zinder to 73% in Tillabéri and even 100% in Tahoua, evidence separation between women and men (Graph 2.5).

Graph 2.5

Separation of male and female toilets and latrines



2.1.6 Signs of security

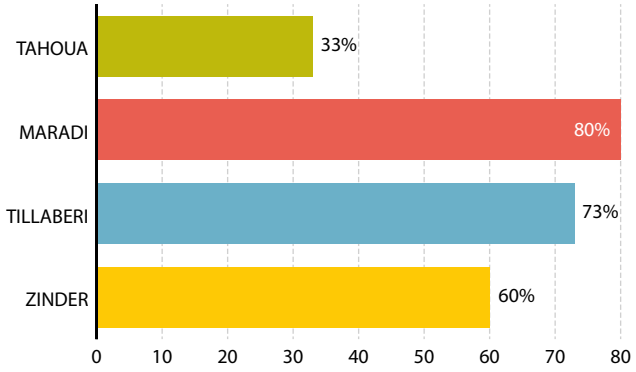
The above toilets and latrines show signs of security, since nearly all of them have doors (Graph 2.6) and some have devices to secure them shut from the inside. Nonetheless, this is not common to all four regions. Although every toilet and latrine in Maradi is equipped, none of the facilities in Tahoua are (Graph 2.7).

Photo 2.4

Improved and gender-separated toilets in Zinder

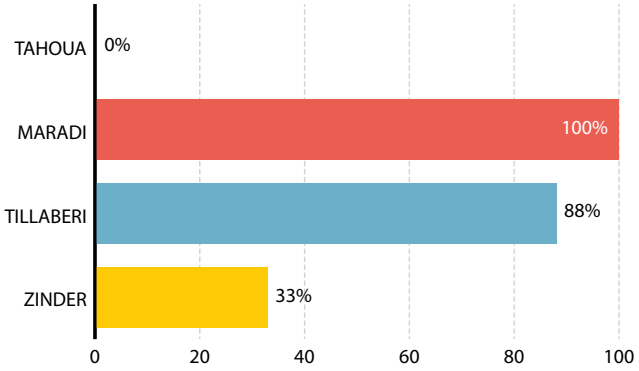
Graph 2.6

Presence of door on toilets and latrines



Graph 2.7

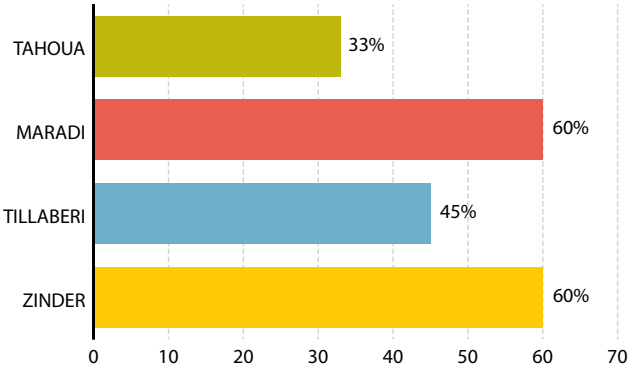
Presence of means to secure doors from the inside



These security measures are unevenly provided across the four regions studied (Graph 2.8).

Graph 2.8

Security of toilets



2.1.7 Remoteness of toilets as a reason for insecurity

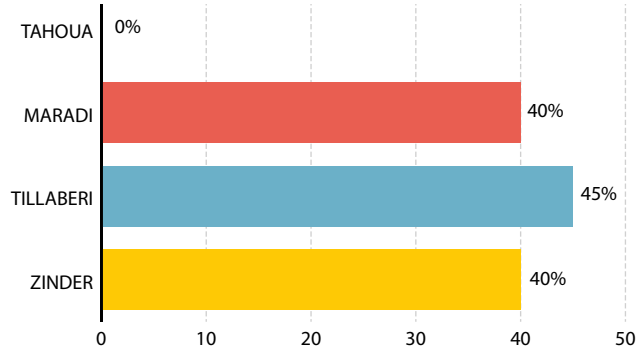
Respondents who feel a sense of insecurity when using these toilets express distance from their homes as the main reason (Table 2.1).

2.1.8 Toilets ill-equipped for effective MHM

Here, functionality refers to the availability of soap and water. In the opinion of respondents, soap for hand-washing after using the toilet is rarely available (40% in Maradi and Zinder) or totally absent from toilets in Tahoua (Graph 2.9).

Graph 2.9

Availability of soap after use of the toilet



Moreover, they lack bins where women can dispose of used sanitary protection (Graph 2.10).

Graph 2.10

Presence of waste bin for used sanitary products

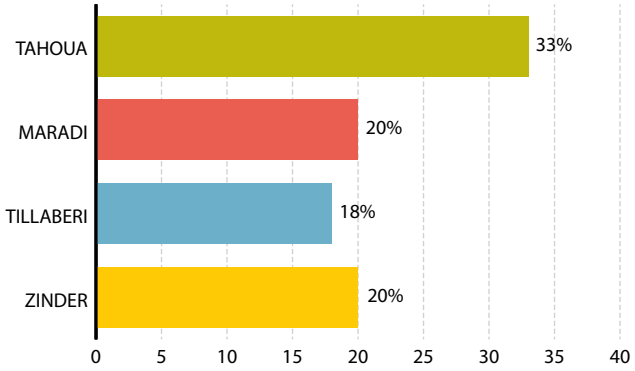


Table 2.1

Reasons for insecurity of toilets and latrines according to users

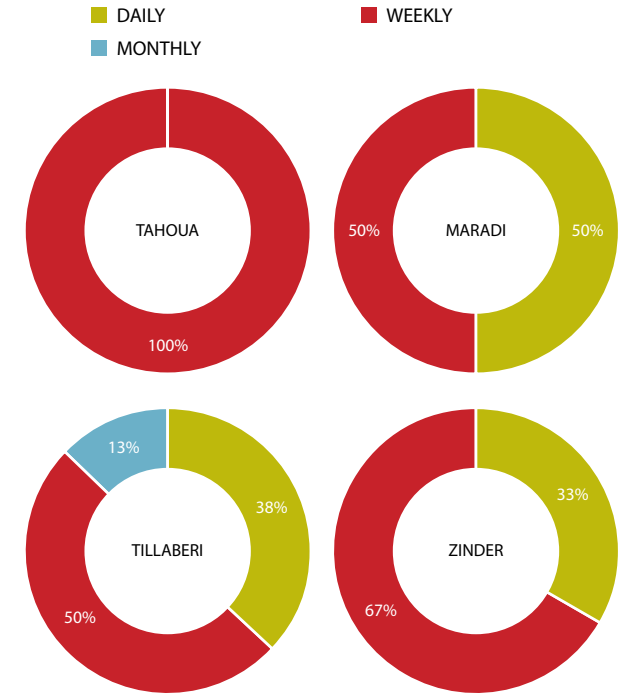
REASONS FOR INSECURITY OF TOILETS FELT BY USERS	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Remoteness of toilets	50	100	67	0
Risk of rape	0	100	67	50
Infrastructure unsuitable for persons with reduced mobility	0	100	67	50
Poor quality of construction materials	0	100	83	50
Health hazards	0	100	83	50
No gender separation	100	50	50	50
Lack of ventilation	0	50	50	100
Lack of light	0	0	83	100

2.1.9 Toilets insufficiently cleaned and maintained

The communities do not pay much attention to the cleaning of their toilets. According to the respondents, on average, toilets are cleaned only on a weekly basis though some are cleaned daily (Graph 2.11). Cleaning consists of tipping water to remove excrement from the walls of the hole and using chemicals such as waste oil or disinfectant to reduce the volume of human excreta (Graph 2.12).

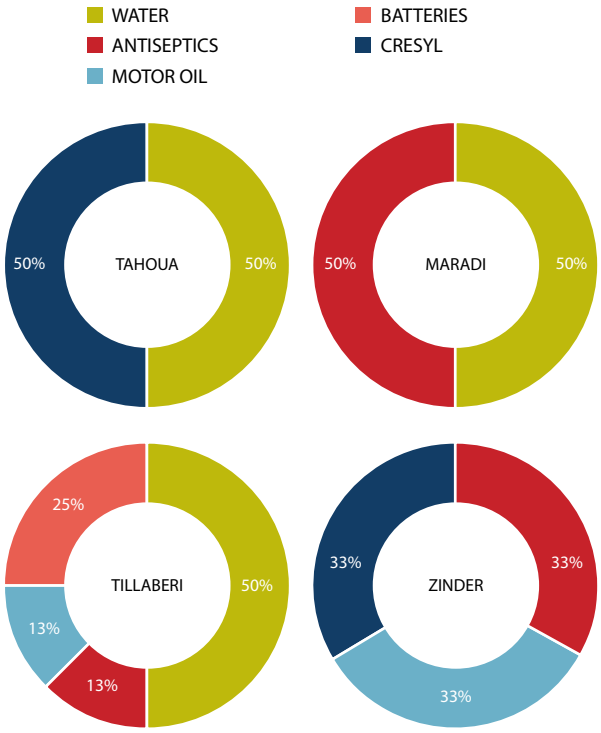
Graph 2.11

Frequency of toilet cleaning



Graph 2.12

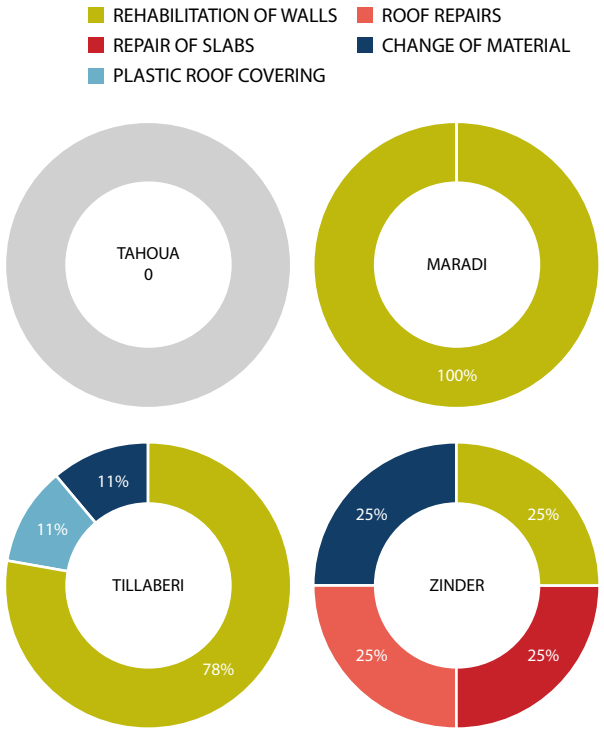
Products used to disinfect toilets



Maintenance seems to be limited to refurbishing the walls and, to a lesser extent, the slab. Regional disparities can be seen in this maintenance, with no maintenance carried out in Tahoua and some, albeit partial, in Maradi and Zinder (Graph 2.13).

Graph 2.13

Type of maintenance of toilets



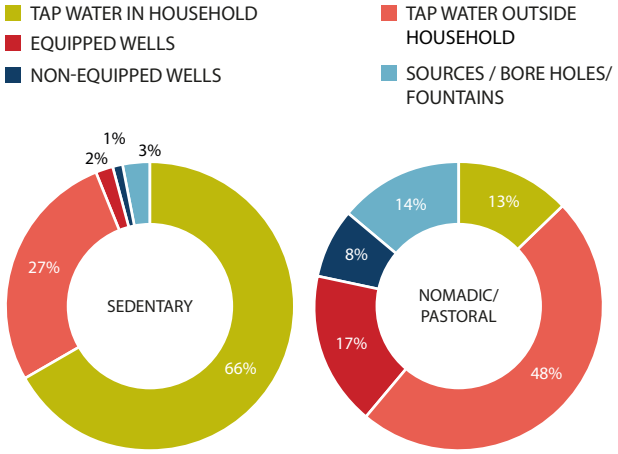
2.2 Insufficient WASH infrastructure in homes

2.2.1 A range of water supply sources

Households in the areas surveyed use two main types of water supply: modern sources (tap) and traditional sources (wells, springs and rivers). Graph 2.14 reveals that sedentary households use modern sources more often, while nomadic households are more likely to use traditional sources.

Graph 2.14

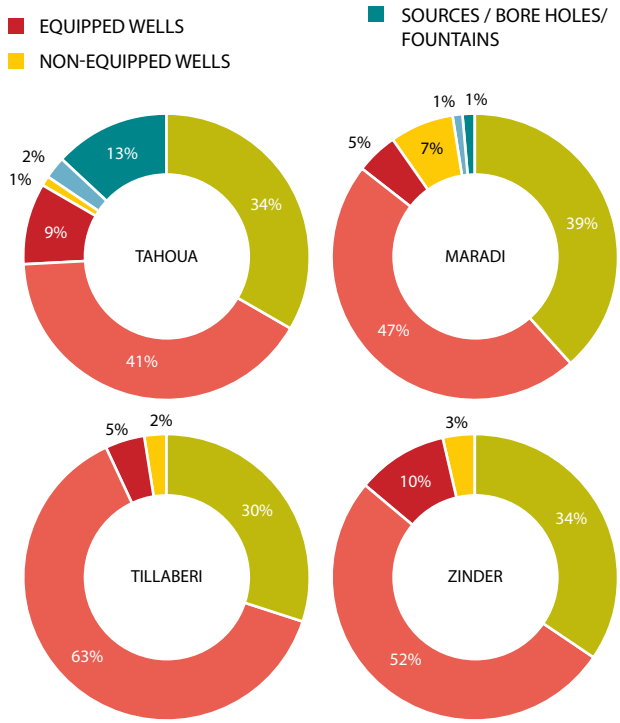
Sources of water supply according to type of residence



In sedentary households, taps are the predominant modern water source used, particularly taps located outside the household. Tahoua, a mostly rural region, is where the use of traditional water sources (Graph 2.15) is the most marked.

Graph 2.15

Sources of running water

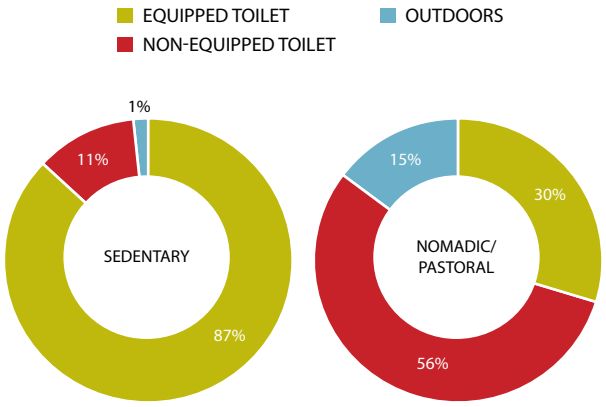


2.2.2 Varying use of toilets and bathing facilities

In general, in Niger, a single infrastructure item is used as both latrine and place of bathing. Also in this paragraph, the term 'toilet' refers therefore to the place of bathing that is also the place of defecation (the latrine). That said, analyses reveal that households use several types of places of bathing or toilet, with a strong variation depending on whether the household is sedentary or nomadic (Graph 2.16).

Graph 2.16

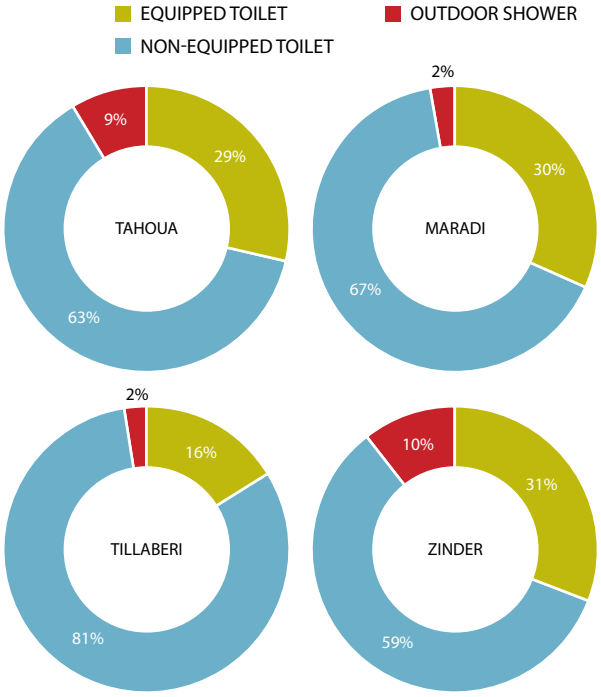
Usual place of bathing by type of residence



It is noted that households mainly use unimproved toilets for bathing, in mostly equal proportions across all the regions studied: 59% in Zinder, 63% in Tahoua, 67% in Maradi, and 81% in Tillabéri. Improved toilets come second, finally followed by outdoors, also in broadly similar proportions between the regions.

Graph 2.17

The main place of routine bathing for households

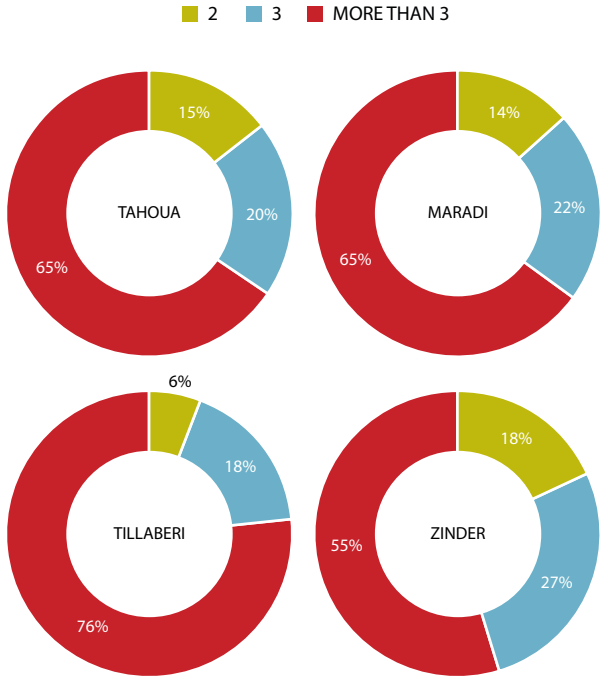


2.2.3 A high number of users per toilet

Nigerien households are large, as each household is composed of an average of 6.1 persons (ESDN-II of 1998). However, this average was 5.9 persons in 2011 (INS, 2011) Graph 2.18, below, shows that regardless of type of residence (sedentary or nomadic) toilets are overused. Indeed, in the majority of cases, up to 3 households (i.e. 18 persons, on average) use the same toilet. This can be observed in equal proportions in Tahoua (65%) and Maradi (65%), slightly more in Tillabéri (76%) and less in Zinder (55%).

Graph 2.18

Number of households per toilet

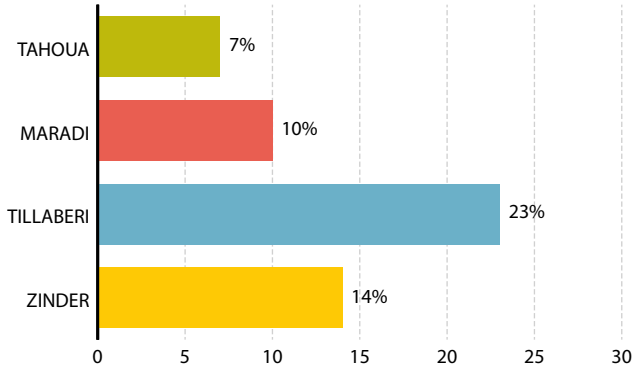


2.2.4 Toilets are unsanitary and lack privacy

Overall in the households surveyed, the level of cleanliness of toilets is very low, ranging between just 7% in Tahoua to 23% in Tillabéri, the region with the highest cleanliness rate (Graph 2.19).

Graph 2.19

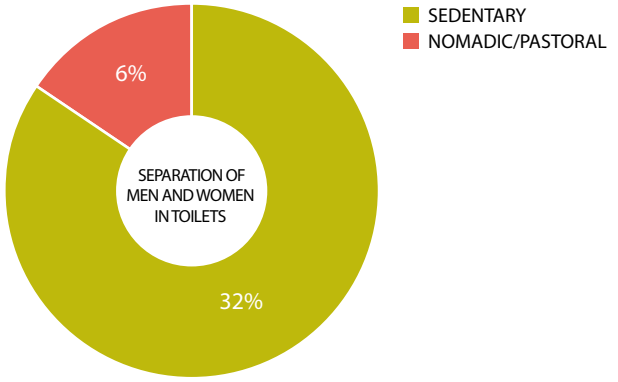
Cleanliness of toilets



In addition, and depending on whether the setting is sedentary or nomadic, toilets are used by both men and women (Graph 2.20), which means users have no sense of privacy.

Graph 2.20

Percentage of separate toilets for men and women by type of residential setting

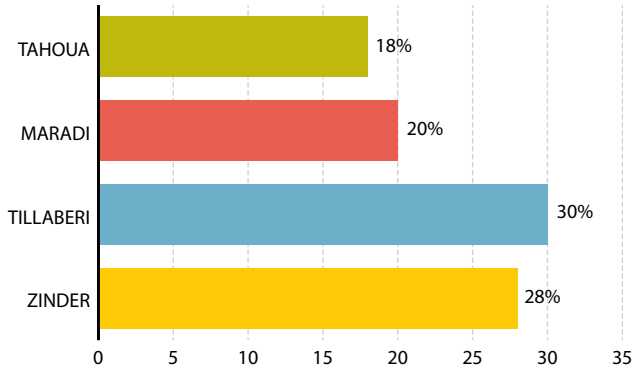


2.2.5 Few toilets have doors or systems for locking from the inside

In most settings generally, (sedentary and nomadic), a majority of toilets do not have doors. Only 18% do in Tahoua, against 28% in Zinder and 30% in Tillabéri (Graph 2.21) Those few toilets that do have doors lack a means of securing them shut from the inside (Graph 2.22).

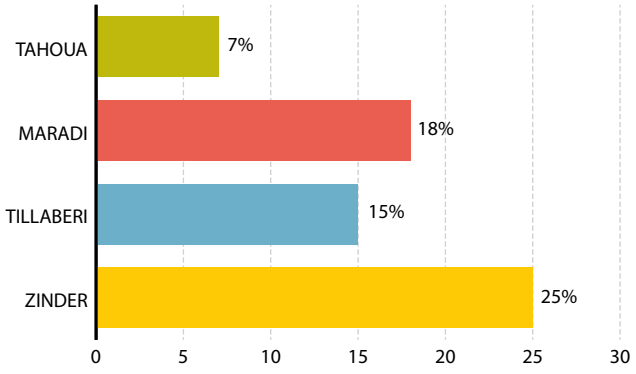
Graph 2.21

Presence of toilet doors



Graph 2.22

Doors with a device to secure them shut from inside

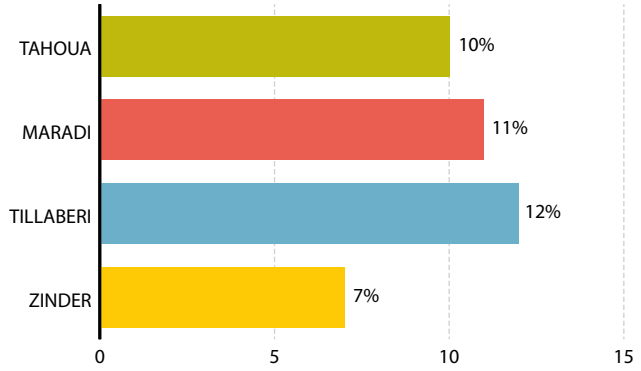


2.2.6 Toilets provide only minimal level of security for users

As toilets rarely have doors or systems for locking them from the inside, the vast majority of household users do not feel secure when using facilities. Only 7% felt secure in Tahoua and 12% in Tillabéri (Graph 2.23).

Graph 2.23

Sense of security when using the toilets



2.2.7 A range of reasons behind toilet users' sense of insecurity

In the opinion of respondents, the toilets do not provide a sense of security. Various reasons were given, in nearly equal proportions from one region of the study to another. They include a lack of light and ventilation, the use of unsuitable and poor quality construction materials, the distance from the home and the absence of separate toilets for men and women (Table 2.2).

2.2.8 Toilets equipped with soap

Unlike the situation observed in the community setting, toilets in households are equipped with soap, regardless of a sedentary or nomadic type of residence (Graph 2.24) or region studied (Graph 2.25).

Graph 2.24

Availability of soap after toilet use, by type of residence

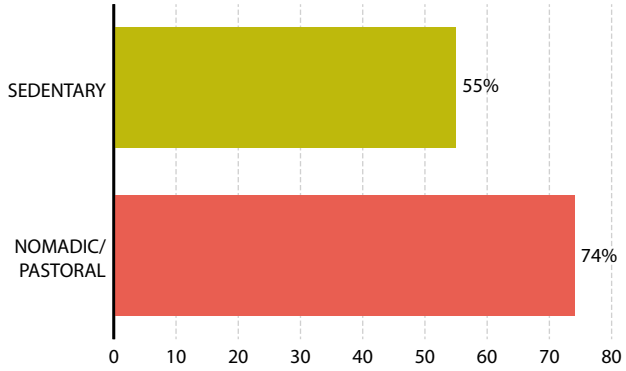


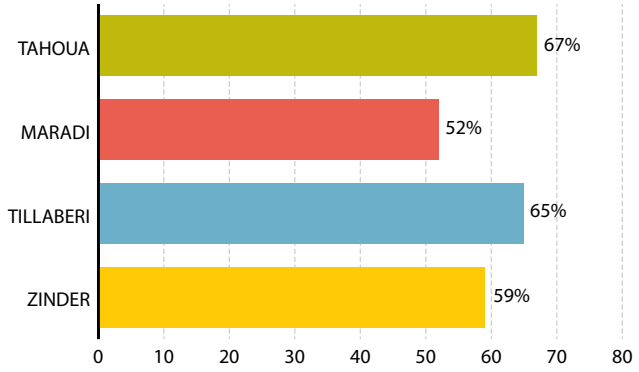
Table 2.2

Reasons behind sense of insecurity when using toilet facilities

REASONS FOR HOUSEHOLDS' INSECURITY FEELING IN TOILETS	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
No gender separation	91	96	89	93
Infrastructure unsuitable for persons with reduced mobility	85	93	82	89
Lack of light	84	80	82	85
Poor quality of construction materials	80	57	63	67
Health hazards	78	69	74	81
Remoteness of toilets	64	84	66	89
Lack of ventilation	62	70	76	78
Risk of rape	51	62	63	74

Graph 2.25

Availability of soap after toilet use

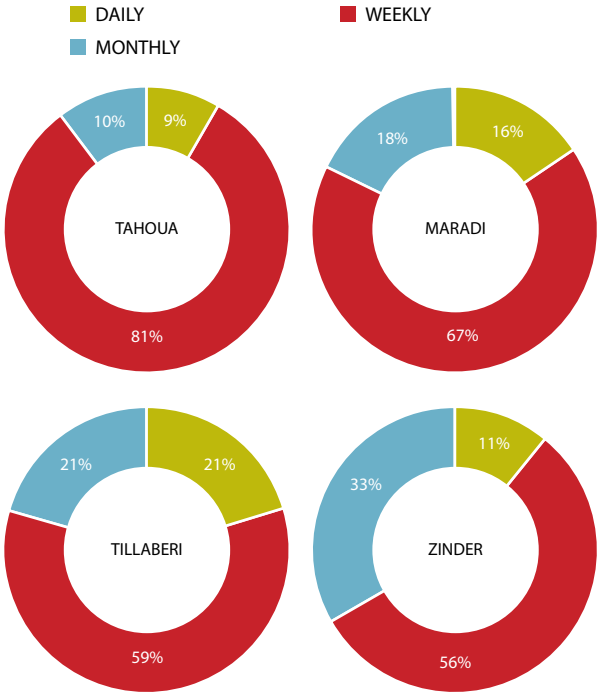


2.2.9 Toilets mostly cleaned on a weekly basis

Household toilets are mostly cleaned once a week, with no real disparity between the regions studied with the exception of Tahoua (81%) (Graph 2.26). Products used to clean toilets are mostly water and disinfectants (Graph 2.27).

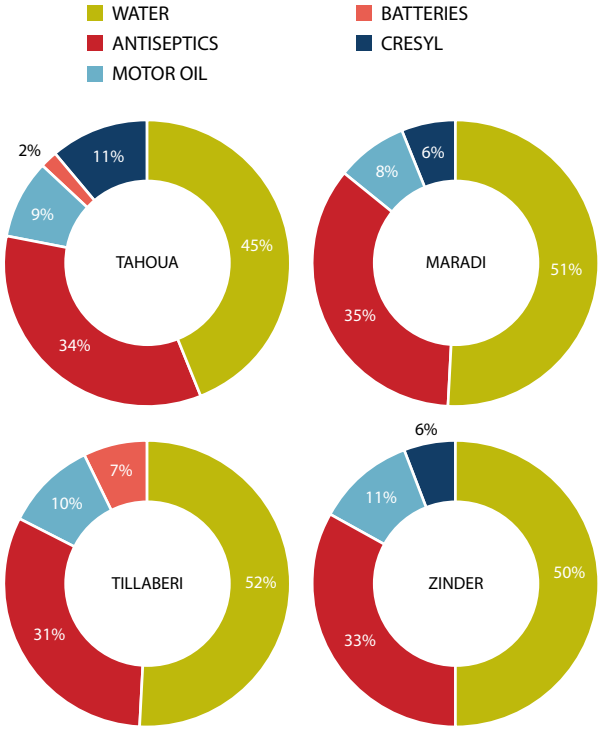
Graph 2.26

Frequency of cleaning of toilets



Graph 2.27

Products used to clean toilets

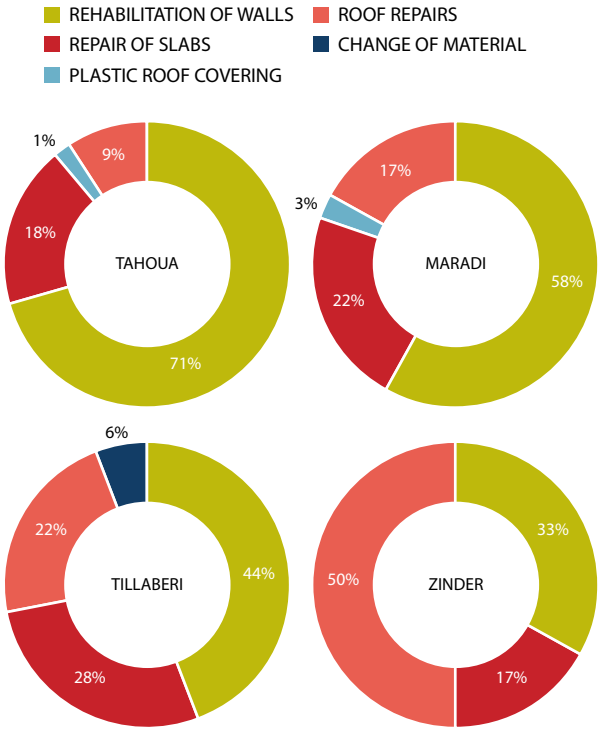


2.2.10 Maintenance of toilets

Toilet maintenance is effective at the household level in all four regions studied. This maintenance mainly includes the repair of walls and roofs, the slabs placed over the hole and the tarpaulins that are either placed around the toilet or used as doors (Graph 2.28).

Graph 2.28

Type of toilet maintenance

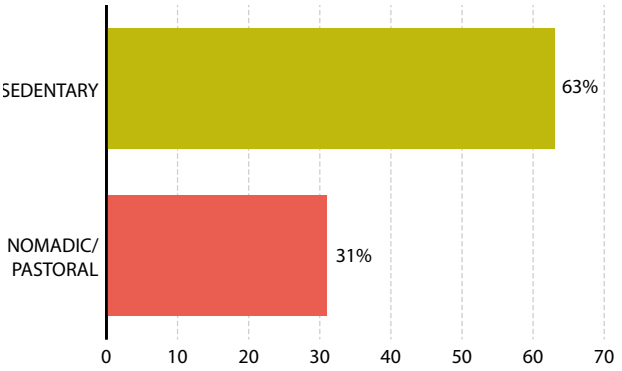


2.2.11 Severe shortage of equipment for collection and management of menstrual waste

There is a severe lack of household bins for collecting non-reusable sanitary towels or other domestic waste used in the management of periods (Graph 2.29). The lack of bins is notable across all regions.

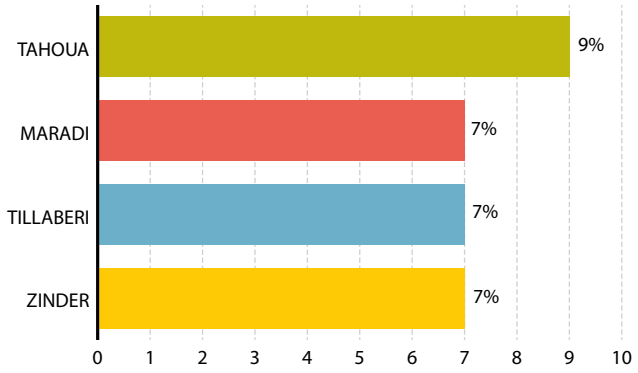
Graph 2.29

Presence of bins for sanitary towels/waste, by type of residence



Graph 2.30

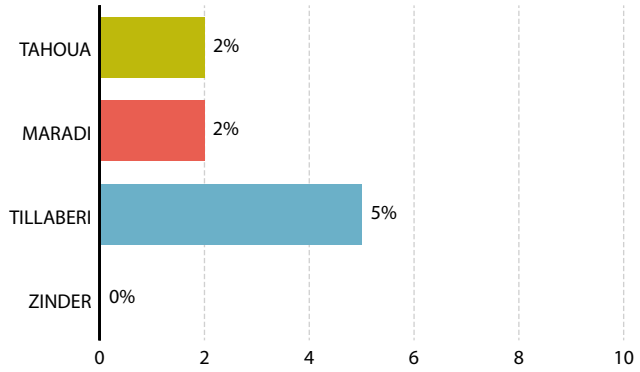
Presence of bins in each region



Furthermore, there is a lack of service providers – often small and medium enterprises – for the recycling and disposal of domestic as well as sanitary waste. The offer is particularly limited in Tillabéri (5%), Maradi (2%) and Tahoua (2%), but almost none in Zinder (Graph 2.31).

Graph 2.31

Existence of sanitation infrastructure



The study found that there was WASH infrastructure in both households and communities but it was not always operational. What is more, most toilets used in households and the community were not very clean and were not sanitized. In short, they do not meet standards for WASH facilities, particularly in respect of security, cleanliness, provision, regulation, control etc[2]. The consequence is that these toilets are not conducive to good menstrual hygiene.

2 The minimum standards in water, sanitation and hygiene promotion are the practical expression of the principles and rights embodied in the Humanitarian Charter. This charter covers the most basic requirement needed to preserve life and dignity. The standards state that there must be 250 persons per community water point, 1 washing-station per 25 people, and a maximum of 5 people per toilet/latrine. The use of toilets is to be organized per household and separate toilets for women and men are to be available in public places (markets, distribution centres, health centres, etc). Shared or public toilets are to be cleaned and maintained in such a way that they may be used by all intended users. Toilets are to be located a maximum of 50 metres from dwellings and are to be used in the most hygienic way possible; children's faeces is to be immediately and hygienically removed. All toilets constructed that use a flush or hydraulic syphon are to be adequately and regularly supplied with water. Pit latrines and cesspools (for most ground types) are to be at least 30 metres from any source of groundwater (ground source) and the bottoms of latrine pits shall be at least 1.5 metres above the water table. Drainage or spillage from defecation systems must not flow in the direction of a surface water source or a shallow groundwater source. Persons shall wash their hands after defecation and before eating or preparing food. Households shall have tools and equipment for the construction, upkeep and cleaning of their own toilets. Women and girls who are having their periods shall have access to appropriate articles for the absorption and disposal of menses, etc. (Oxfam/Sphere Project, 2004).

CHAPTER 3

GENERAL KNOWLEDGE OF MENSTRUAL HYGIENE MANAGEMENT

This chapter will look at the extent to which girls and women are adequately informed about the biological changes associated with periods and the menstrual cycle. A composite indicator called "good knowledge of MHM" has been designed in order to assess people (men and women) who have a good knowledge of MHM.

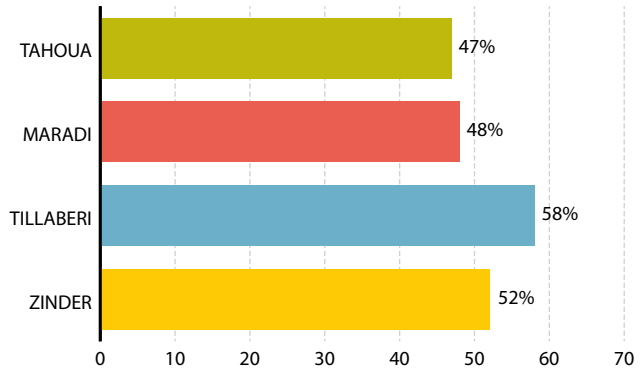
3.1 Knowledge of MHM amongst Nigerien women

3.1.1 Knowledge of the menstrual cycle and awareness of periods

In this study, knowledge of the menstrual cycle refers to knowledge of what the menstrual cycle is and knowledge of one's own individual cycle. Taking the sample as a whole, roughly half of respondents say that they know what the menstrual cycle is, albeit with variations from region to region (Graph 3.1).

Graph 3.1

Knowledge of the menstrual cycle

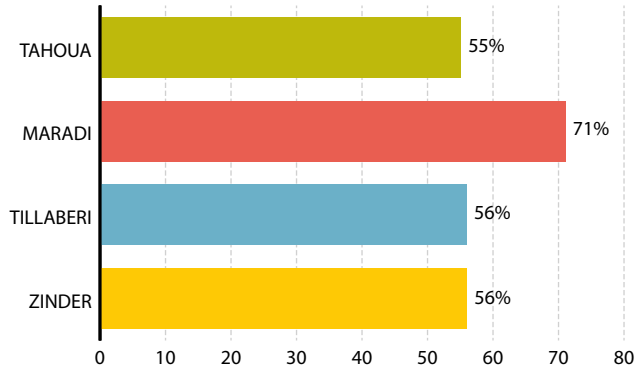


3.1.2 Knowledge of menarche and awareness of periods

A relatively high number of women in all regions studied know about menarche (Graph 3.2). However in-depth knowledge about the onset of periods, at least first periods, is mostly lacking, with the exception of women in Maradi (Graph 3.3).

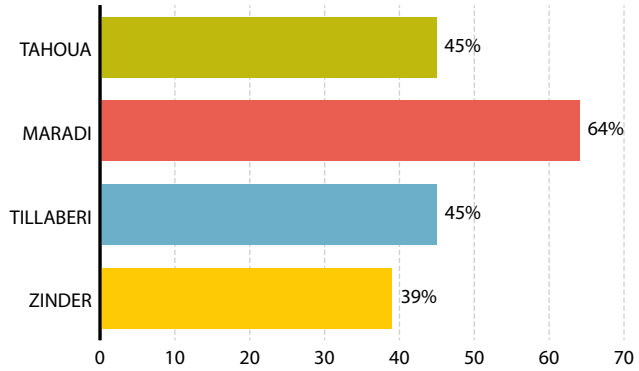
Graph 3.2

Information about first period



Graph 3.3

Awareness of the occurrence of periods



3.1.3 Emotions experienced during first period

Taking all the regions together, a range of emotions was felt at the onset of menarche and, overall, these were feelings of sadness. Only 5% of respondents said that they experienced positive emotions (Table 3.1).

3.1.4 Sharing information before and after menarche

Table 3.2 below shows that the family circle and awareness-raising sessions organized by non-governmental organizations are the foremost spheres of women's communication about menarche. In the family circle, communication is more fluid with persons of the same sex (mother, sister and grandmother). The second circle includes health staff and teachers or classmates. It is noted that communication about menstruation is difficult with men and boys, be they husbands, fathers or brothers.

The same trend can be observed after the first period. The only difference is that there are fewer discussions with awareness-raising personnel and slightly more with peers and friends (Table 3.3).

Table 3.1

Emotions experienced at time of first period

FEELINGS DURING FIRST PERIOD	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Fear	73	67	62	46
Indifference	61	41	14	16
Disgust	11	15	21	30
Unhappy	26	18	41	14
Happy	0	0	0	5

Table 3.2

People with whom women have had discussions before their first period

PEOPLE SPOKEN WITH ABOUT PERIODS BEFORE FIRST PERIOD	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Mother	96	77	86	73
Sister	89	72	84	79
Female friend	75	76	76	67
Awareness-raising	73	62	71	58
Health employee	53	28	53	52
Teacher/classmates	51	56	80	55
Other female family member	48	31	4	73
Father	17	13	0	15
Grandmother	15	10	8	85
Brother	2	2	4	24
Other male family member	2	3	0	42

Table 3.3 :

People with whom women have had discussions after their first period

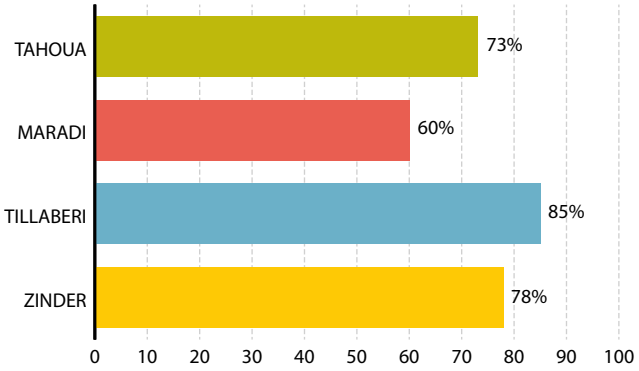
FIRST PEOPLE WOMEN SPOKE TO AFTER THEIR FIRST PERIOD	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Mother	38	36	38	38
Sister	36	30	30	32
Female friend	20	22	20	14
Other female family member	3	7	8	8
Grandmother	0	2	1	3
Brother	1	1	0	3
Father	0	1	0	0
Other male family member	1	0	0	0
Awareness-raising professional	0	0	0	0
Health employee	1	1	3	3
Total	100	100	100	100

3.1.5 Increased awareness of periods

Many women have attended or are attending awareness-raising sessions. The proportion is significant, ranging from 60% in Maradi to 78% in Zinder (Graph 3.4)

Graph 3.4

Attendance at awareness-raising sessions on menstruation



3.1.6 Participation in awareness-raising sessions and advice received

The organizers of awareness-raising sessions on menstruation for women in Niger are mainly the United Nations and international NGOs. The communities in which these women live are less involved and the Government seems to be less concerned about the issue.

Regardless of where respondents live, the advice received during these awareness-raising sessions is extensive and varied (Table 3.5), and contributes to a good understanding of MHM among women.

3.1.7 Understanding of the origin of periods

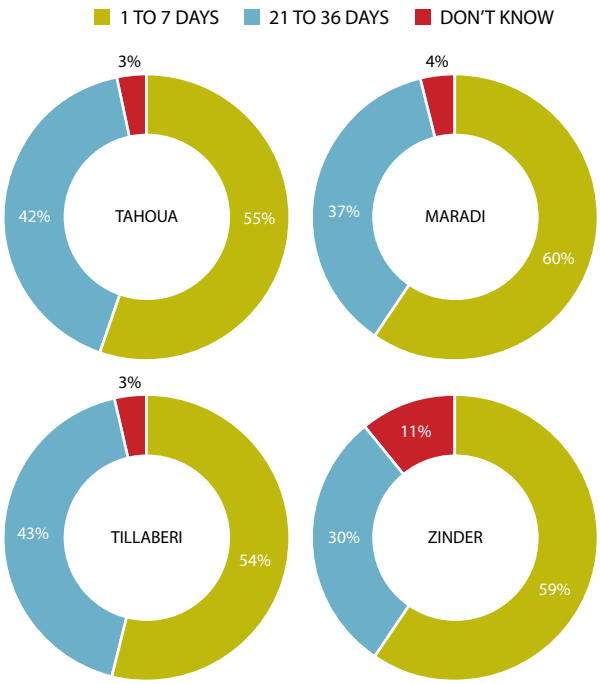
A good proportion of respondents consider that periods are a natural phenomenon (69% overall) that occurs at puberty (62%). Very few associate the onset of periods with irrational phenomena such as curses or sin.

3.1.8 Good knowledge of the actual duration of periods and of the menstrual cycle

An equally high number of women know the actual duration of periods. Regardless of the region of residence, the proportion is above average (Graph 3.5). The monthly regularity means they ultimately become aware of the normal length and also know the length of a menstrual cycle (Graph 3.6).

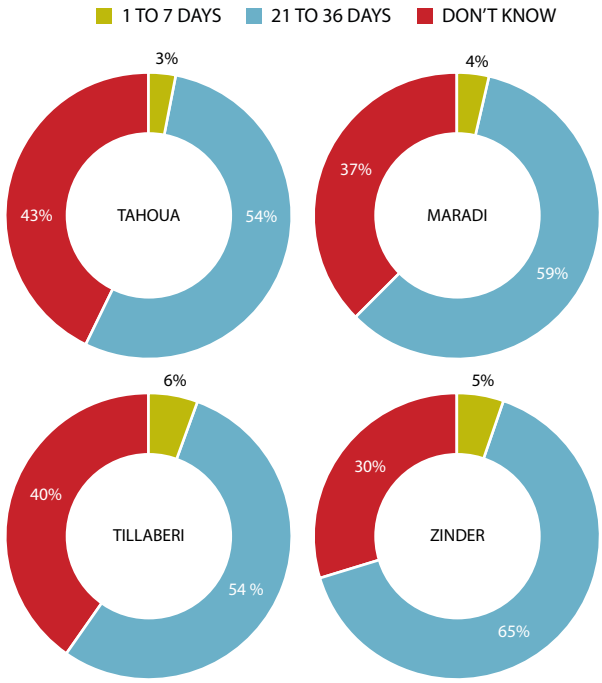
Graph 3.5

Knowledge of the normal length of periods



Graph 3.6

Knowledge of the length of the menstrual cycle

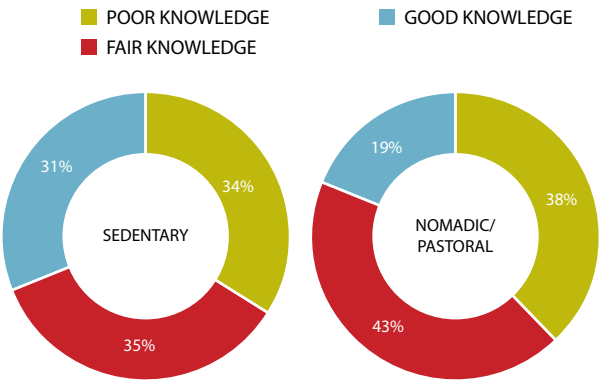


3.1.9 Overall, women have an average level of knowledge of MHM

While it is certainly true that respondents displayed an adequate level of knowledge of the length of periods and menstrual cycle, when one takes into account the *Knowledge of MHM*[3] indicators, it becomes clear that the general level of knowledge of MHM is low to average (Graph 3.7).

Graph 3.7

General level of women's knowledge of MHM by type of residence



3 The Knowledge of MHM indicator contained the following questions: Why do girls and women have periods? Have you ever heard of the menstrual cycle? How long do periods normally last? Do you know how to count the days of a menstrual cycle? How long is your cycle?

Table 3.4 :
Main organizers of sessions to raise awareness about first periods

ORGANIZER OF AWARENESS-RAISING SESSIONS	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
United Nations	75	60	69	72
Humanitarian NGO	62	63	66	55
Government body	9	18	35	45
Host community	0	15	3	55
My community	0	4	0	48

Table 3.5 :
Advice received during awareness-raising sessions on first periods

ADVICE RECEIVED DURING AWARENESS SESSION	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
How to manage periods	80	65	82	86
Equipment to be used	62	53	78	72
How to keep clean	70	54	73	76
How to manage pain	48	31	57	55
Not being ashamed of periods	60	35	69	86
Things/activities to avoid	35	34	35	55
What to do with used sanitary protection	46	60	58	59

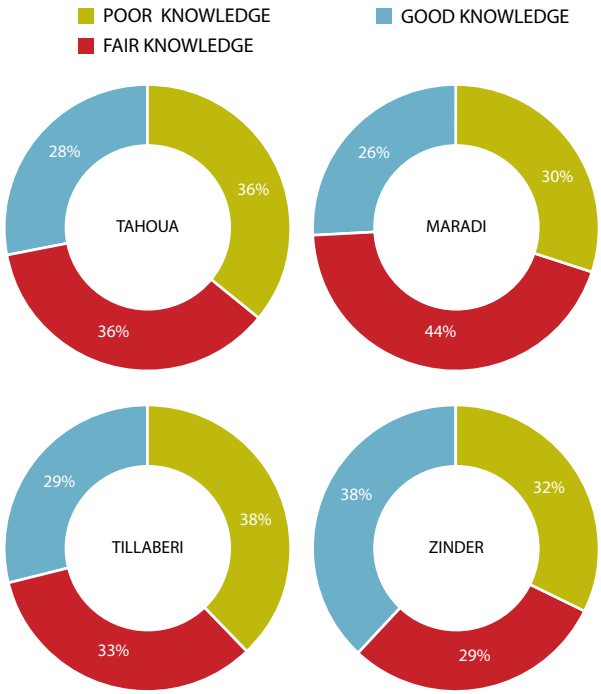
Table 3.6
The reasons why women have periods

THE REASONS WHY WOMEN HAVE PERIODS	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Natural phenomenon	68	65	68	76
Puberty / biological maturity	60	63	63	62
Don't know	21	21	28	22
Hormones	4	39	66	41
Sin	0	1	6	11
Curse	1	1	3	3

The level of knowledge is consistent across the regions studied.

Graph 3.8

Women's general level of knowledge of MHM by region



Ultimately, in the localities visited as part of this study and given the socio-anthropological data obtained, women's knowledge of menstrual hygiene management can be evaluated in terms of the definition that women give to menstruation, the age of menarche and the significance of menarche for women.

For the definition of periods, women obviously mention blood. *"Periods are the blood that comes out of a woman's vagina"*, said one women from the locality of Rougga Marrini. They also gave the different terms for periods in their communities. In Fula hamlets, for example, periods are called "wanki" and "hayla" (Women's FGD, Rougga Marrini).

The meaning given to periods directly associates them with the ability of women to procreate. For them, *"It is thanks to periods that women have children. Women who do not get periods cannot have children."* In other words, periods appear as the sine qua non for a woman to fulfil her femininity and, especially, motherhood. Indeed, in this context where girls usually marry early, from the age of puberty. *"Married girls get their first periods from the age of 14 years"*, said one female informant who added that a girl who has her first period while still living with her parents catches the eye of the community and, therefore, spreads shame on her family.

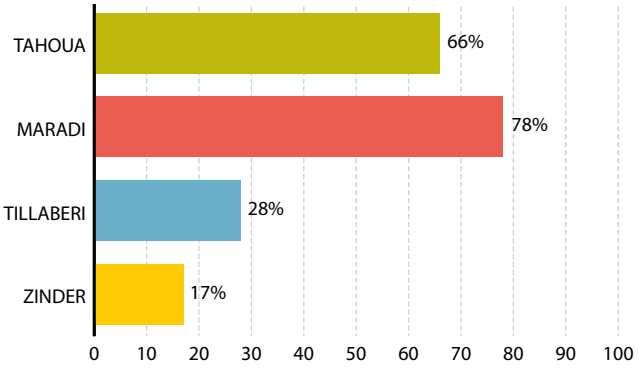
3.2 Summary of men's knowledge about MHM

3.2.1 Knowledge about periods and seeking knowledge/advice about the subject

Although this is a phenomenon associated with women, the issue of periods also very much interests men. Many men in Niger, with some differences from region to region, (Graph 3.9) are interested in periods and have even received information about them (Graph 3.10).

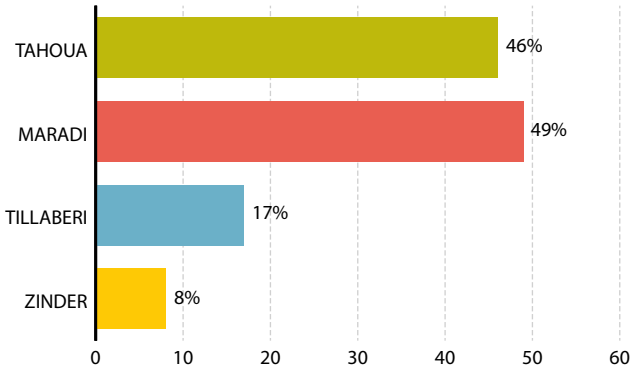
Graph 3.9

Knowledge of menstruation among men



Graph 3.10

Men who have received information on women's menstruation



3.2.2 Types of advice or information received on women's menstruation

During awareness-raising sessions attended by men their attention has been drawn to aspects related to the management of periods and activities to avoid (Table 3.7).

3.2.3 Sharing information on women's menstruation

The table below shows that the health care staff, schoolmates, colleagues, friends and the organizers of awareness sessions are the first people that men talk to about women's menstruation, followed by their wives or girlfriends (Table 3.8).

Table 3.7

Advice women received during awareness session

ADVICE RECEIVED DURING AWARENESS SESSION	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Equipment to be used	95	85	0	0
How to manage periods	86	83	30	0
How to keep clean	86	87	30	100
Things/activities to avoid	79	79	0	0
Not being ashamed of periods	65	83	30	0
Management of used sanitary protection	61	83	90	100
How to manage pain	1	58	60	50

Table 3.8 :

People with whom women have had discussions before their first period

THE FIRST PEOPLE WITH WHOM ONE DISCUSSED PERIODS	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Awareness-raising	32	75	50	100
Teacher/classmates	46	61	63	100
Female friend	16	48	31	0
Health employee	13	67	19	0
Mother	0	73	0	0
Sister	0	55	0	100
Grandmother	0	51	12	0
Other female family member	3	42	0	0
Brother	1	54	31	0
Father	0	48	31	0
Other male family member	0	52	6	0

Table 3.9
Reasons why girls have periods

REASONS WHY GIRLS HAVE PERIODS	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Natural phenomenon	88	69	71	100
Puberty / biological maturity	73	74	50	100
Hormones	2	66	47	100
Curse	0	29	38	54
Sin	0	36	38	54
Don't know	0	15	36	0,

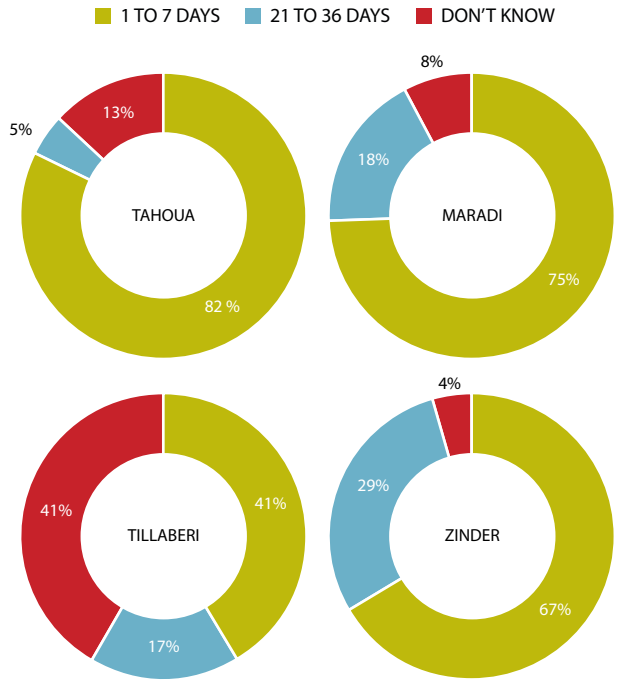
3.2.4 Reasons why women have periods

Taking all regions together, men think that women's periods are a natural phenomenon (100% in Zinder, 70% in Tillabéri and 88% in Tahoua). Even so, in three out of the four regions, the onset of menstruation in women is also associated with curses and sin.

3.2.5 Reasonable knowledge of the length of periods and the menstrual cycle

Across the sample, with the exception of Tillabéri (41%), more than half the men surveyed in the regions of Tahoua (82%), Maradi (75%) and Zinder (67%) say that they know the normal length of a woman's period.

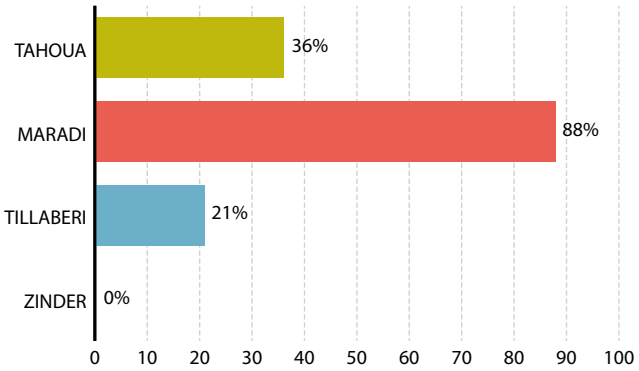
Graph 3.11
Knowledge of the normal length of women's periods



Only three out of the four regions discussed the issue of the menstrual cycle, with very different results (Graphs 3.12 and 3.13).

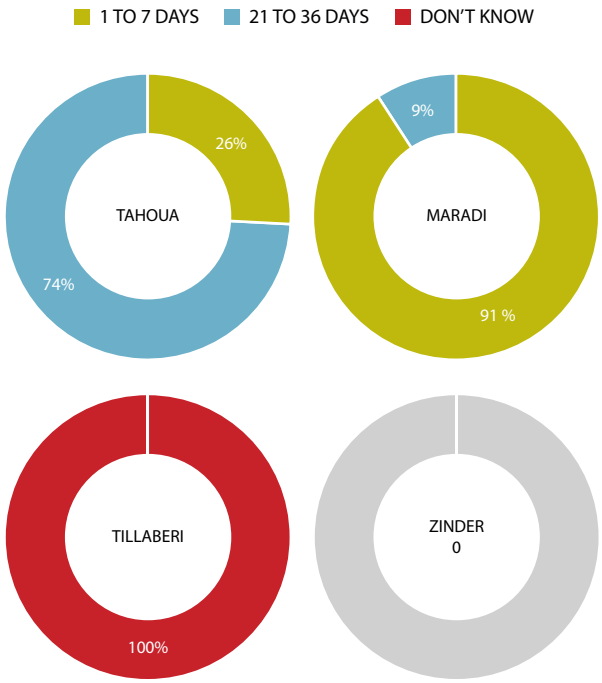
Graph 3.12

Knowing how to count the days of a woman's menstrual cycle



Graph 3.13

Length of a woman's cycle



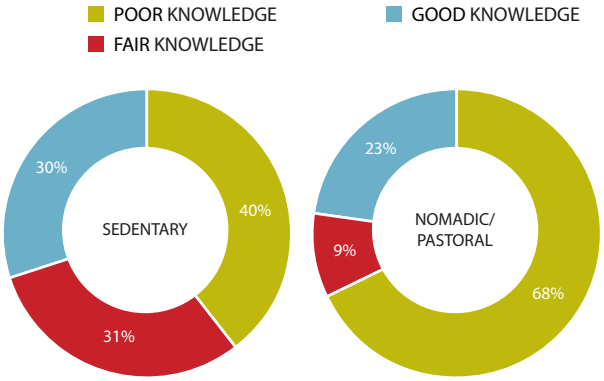
3.2.6 Men have limited knowledge of MHM overall

While male respondents showed good knowledge of the length of periods and a degree of interest in the subject of the menstrual cycle, when the *Knowledge of MHM* indicators[4], are considered, their level of general knowledge remains low (Graph 3.14).

4 The Knowledge of MHM indicator contained the following questions: Why do girls and women have periods? Have you ever heard of the menstrual cycle? How long do periods normally last? Do you know how to count the days of a menstrual cycle? How long is your cycle?

Graph 3.14

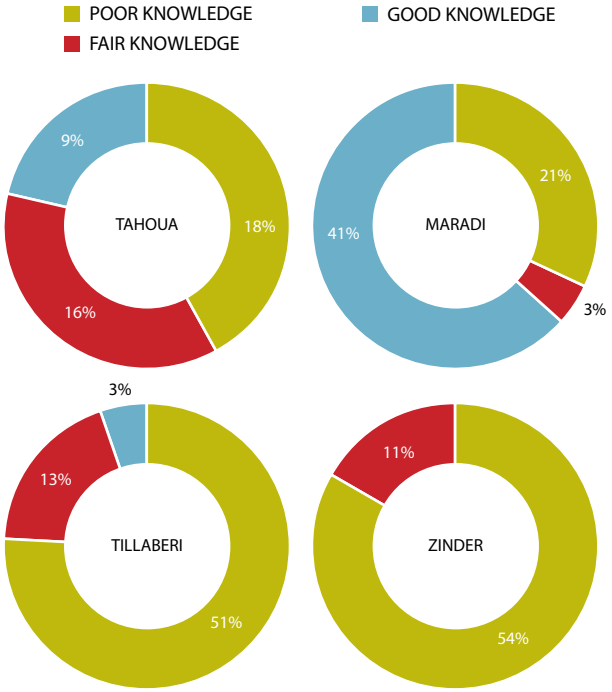
General level of men's knowledge of MHM by residential setting



Over the regions as a whole, the level of knowledge is average, though on the low side.

Graph 3.15

Men's general level of knowledge of MHM, by regions studied



These quantitative analyses are complemented by the qualitative analysis, the main results of which show that men, and especially boys, surveyed in communities in Niger have certain beliefs about menstruation. The ideas that circulate in male circles are very often out of step with reality. For example, the definition boys give for a period makes them sound like a disease. During a group discussion with unmarried boys, one of them defined periods in this way:

"A disease during which women bleed every month or at the end of the month for 3 to 7 days. Some women have their periods once every 3 months. This involves girls and women aged 14 to 50 years." [5]

The information given about the age at which girls have their first period is quite different from that given elsewhere by other respondents. As for the meaning that boys ascribe to menstruation, periods are seen as the driver of a girl's social maturation. Differing meanings were given by different respondents: *"Periods are a sign of 'Balaga', girls' maturity"; "This explains that she needs a man"; "She is ready for sexual relations with men,"* etc.

3.3 Profiles of women and men who have knowledge of MHM

3.3.1 Profile of women who have low or average knowledge of MHM

Analysis in Figure 3.1 highlights the group of women with a low or passable knowledge of MHM.

This group is composed of unmarried nomadic women from Maradi. They live in rural areas and have first cycle secondary schooling at most. They are non-religious or Christian, housewives or working in agriculture or pastoralism.

3.3.2 Profile of men with limited knowledge of MHM

In Figure 3.2, we can categorize men who have limited knowledge of MHM.

This group is composed of nomadic men from Tahoua. They live in rural areas and are non-religious or Muslim. In addition, they work in agriculture and pastoralism.

5 FGD for unmarried boys, Kouran Daga, November 2016.

Figure 3.1
Factorial plot showing the categorization of women according to selected characteristics

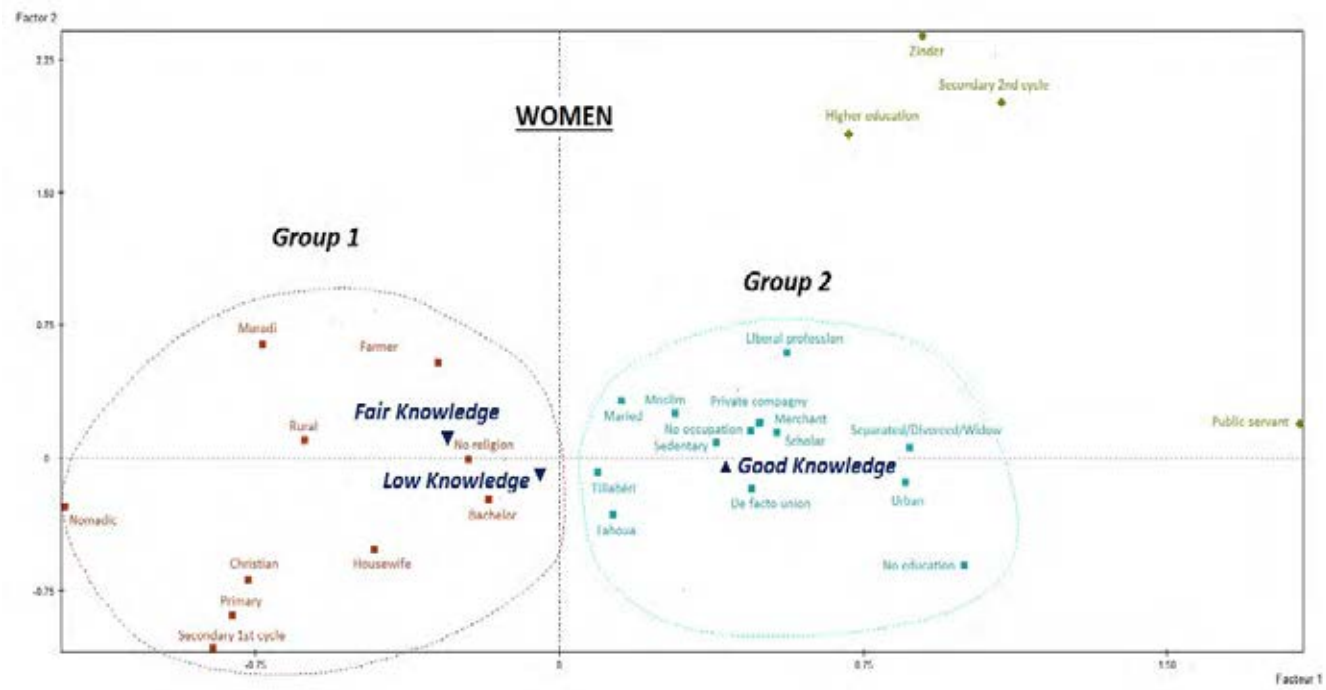
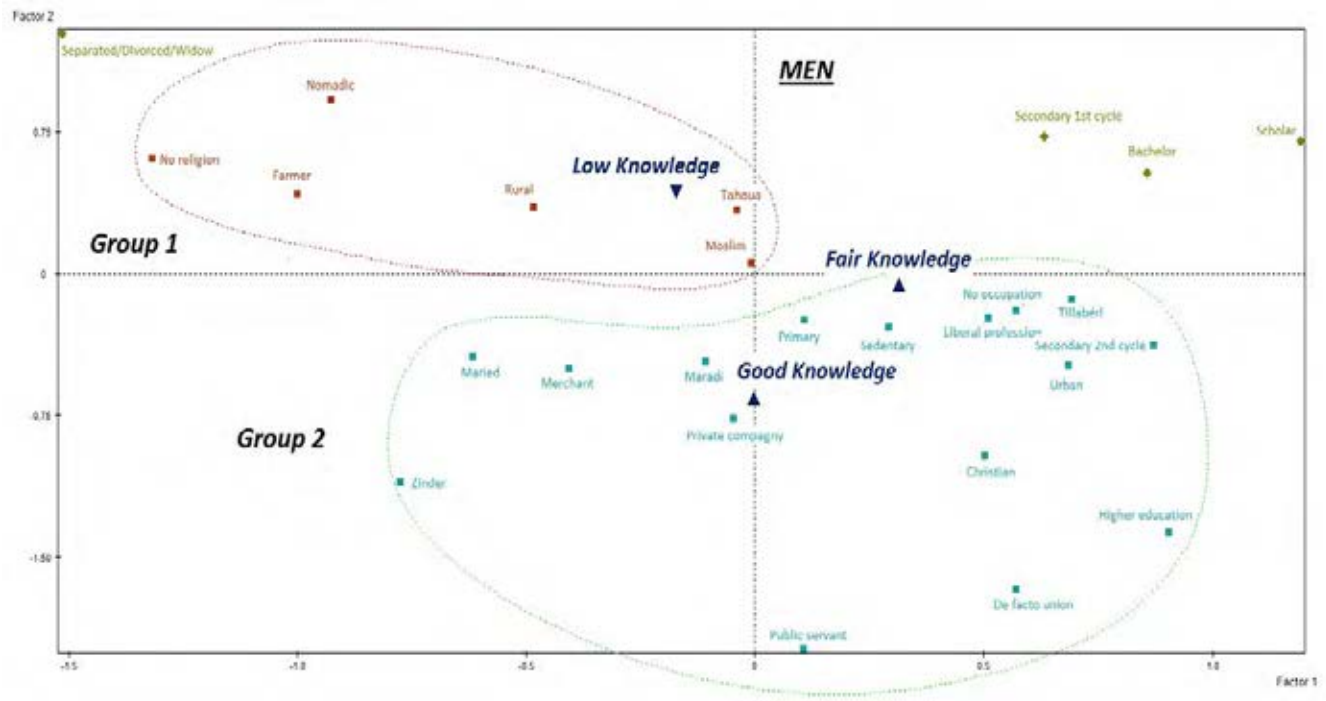


Figure 3.2
Factorial plot showing the categorization of men according to selected characteristics



CHAPTER 4

PRACTICES, ATTITUDES AND BEHAVIOURS RELATED TO MENSTRUAL HYGIENE

In line with one of the objectives of the study, this chapter sets out practices, attitudes and behaviour related to menstrual hygiene. These practices enable an analysis of the causes of health problems linked to poor management of menstrual hygiene.

4.1 Menstrual management and waste disposal practices to be improved

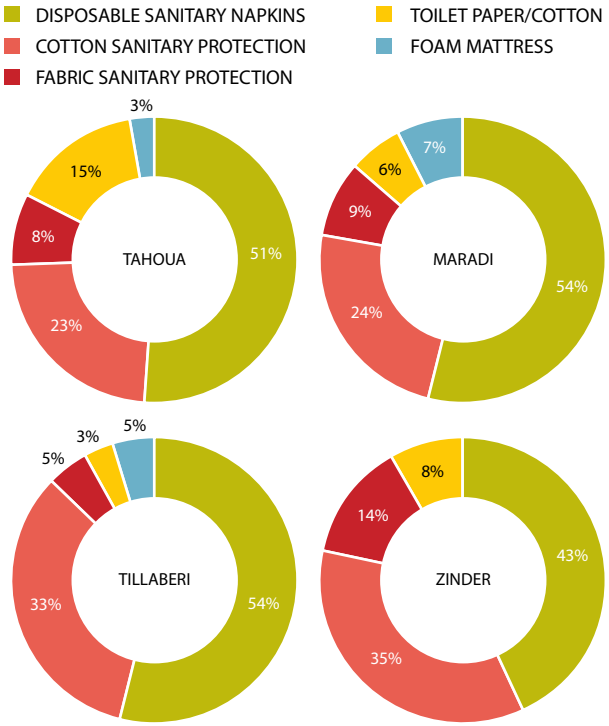
4.1.1 Various sanitary products but dominated by disposable sanitary pads

Whether for their last period or routinely, many respondents reported using disposable sanitary pads, particularly those living in Tillabéri (54%), Maradi (53%) and Tahoua (51%). Other sanitary protection products are, in broadly descending order and for all regions, those made of cotton, cloth, toilet paper and mattress foam (Graph 4.1). As there is no local production of sanitary pads in Niger, they are all imported from abroad. They are therefore sought by more affluent girls residing in urban areas. Most rural girls use pieces of fabric and occasionally absorbent cotton as sanitary protection during their periods.

However, they do not dry the pieces of fabric in the sun (which would kill germs) because they do not want others to see their sanitary protection. Periods are supposed to remain secret and completely hidden from others.

Graph 4.1

Types of sanitary protection used during periods



4.1.2 Soap and water to wash reusable sanitary products

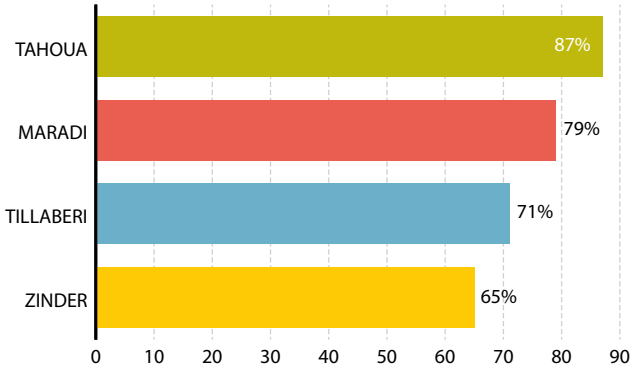
Women who reported using reusable sanitary protection products such as pieces of fabric and cotton mostly use hot water and soap to wash them.

4.1.3 Hand-washing: a widespread practice when changing sanitary protection

The majority of girls and women said that they washed their hands with soap before and after changing, regardless of whether they used disposable pads or pieces of fabric as sanitary protection.

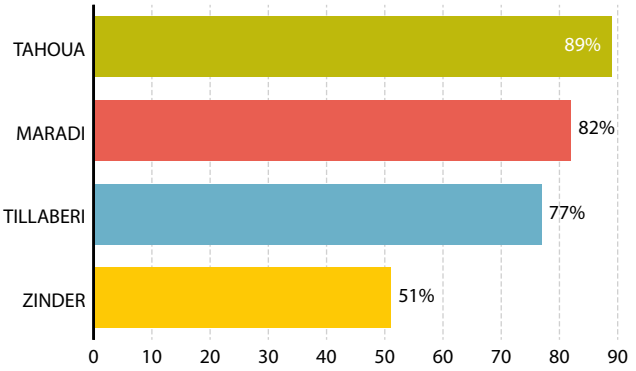
Graph 4.2

Hand-washing before changing protection



Graph 4.3

Hand-washing after changing sanitary protection



4.1.4 Soaking fabric and cotton sanitary protection: a common practice

The majority of girls and women said that they regularly soaked their fabric sanitary protection in soapy water before washing. Zinder is the region where this practice is most common (80%), compared with Tillabéri where it is the least common (50%). The length of time the fabric is soaked (more than 20 minutes) is the same in all four regions studied.

Graph 4.4

Soak fabric sanitary protection

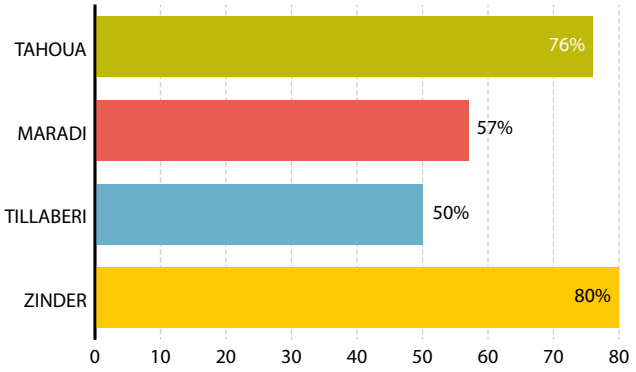


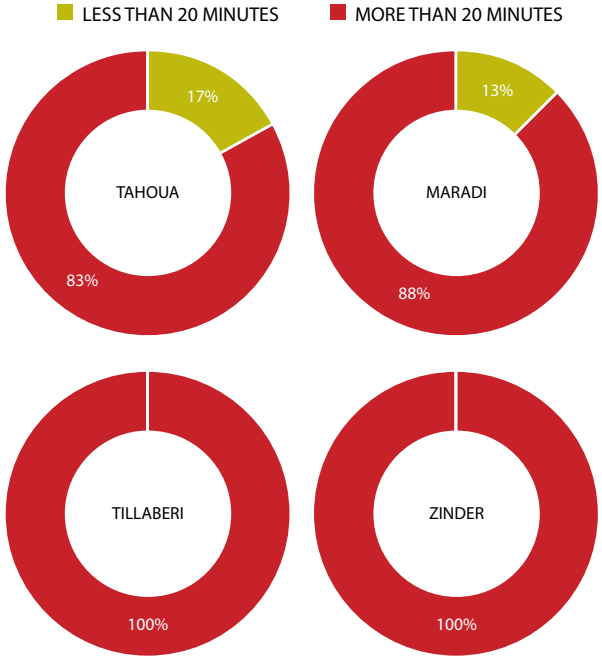
Table 4.1

Products used to wash fabric sanitary protection

PRODUCTS USED TO WASH FABRIC SANITARY PROTECTION	REGION			
	TAHOUA *Frequency (%)*	**MARADI** *Frequency (%)*	**TILLABÉRI** *Frequency (%)*	**ZINDER** *Frequency (%)*
Soap	100	100	100	100
Hot water	80	64	50	80
Cold water	20	36	50	20
Salt	17	14	0	0
Hot water / soap / salt	15	14	0	0

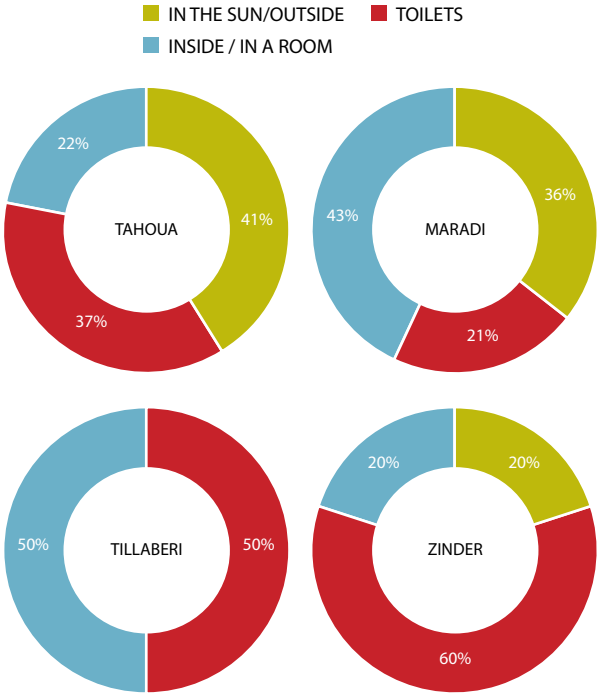
Graph 4.5

Length of time protection is soaked



Graph 4.6

Place where fabric protection is dried



4.1.5 Toilets and other rooms inside houses are the preferred place to dry sanitary protection

Once they are washed, fabric and cotton sanitary protection has to be dried. However, the data show that sanitary materials are rarely exposed to sunlight (which would kill the germs). Of those who use fabric sanitary protection, 60% in Maradi, 50% in Tillabéri, 36% in Tahoua and 21% in Zinder dry the materials in the toilet; 50% in Tillabéri, 43% in Maradi, and nearly 20% in Tahoua and Zinder dry them inside the house or in their bedrooms. In rural areas, however, fabric sanitary protection is mostly dried in the sun.

4.1.6 Discretion and beliefs around drying fabric and cotton protection

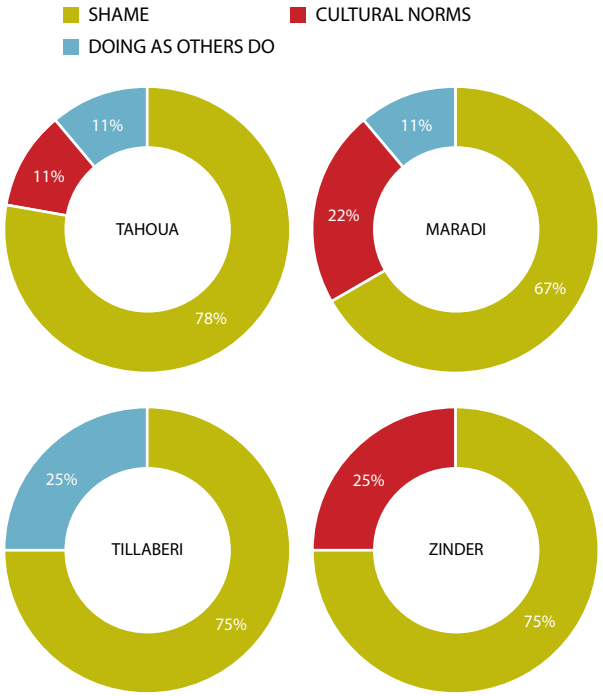
Shame and cultural constraints surrounding periods are the main reasons for choosing to dry fabric protection in bedrooms or toilets in Niger. In the focus groups, girls and women from all study regions said they would fear the shame and mockery of men if they were to dry sanitary materials outside in the sun. For this reason, they hide their fabric protection in a secret place to avoid unwanted attention and suggestive comments. They also think that sanitary protection can be used by enemies to cast evil spells on women. This was emphasized by one focus group participant in Zinder.

> *"I wash my fabric protection in the toilets, but I dry it behind my bedroom door. I do it discreetly like that because, when I was 18, someone cast a spell on me through my fabric protection. And my periods stopped for a long time."*

Beliefs and myths around menstrual blood are the reason why menstruation is managed covertly. The fabric is washed, rinsed and dried in the toilet. It is kept out of sight. Furthermore, some older respondents said that they kept their old fabric protection. They never throw it away due to mystical beliefs.

Graph 4.7

Reasons for not drying sanitary protection in the sun

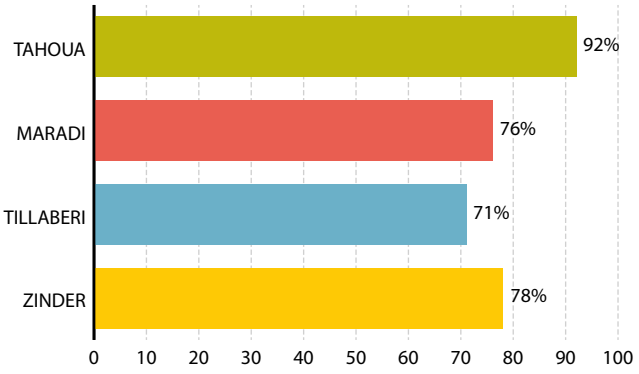


4.1.7 Most women and girls wear underwear during their periods

In answer to *"Do you wear underwear during your periods?"* a majority of girls and women replied that they did, including 92% in Tahoua and 78% in Zinder (Graph 4.8).

Graph 4.8

Wearing underwear during periods

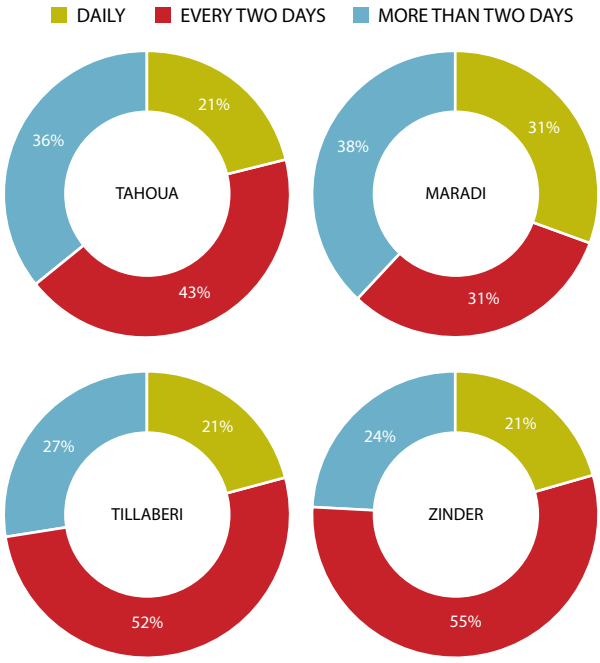


4.1.8 Infrequent changing of underwear

The trend mentioned above, which is beneficial for hygiene, is offset by infrequent changing of underwear during menstruation. On average, only 23% said they changed their underwear every day while 42% changed it every two days. Data also show that 35% go longer than two days without changing their underwear. The detail of the regional variations is shown in Graph 4.9.

Graph 4.9

Frequency of underwear change during periods

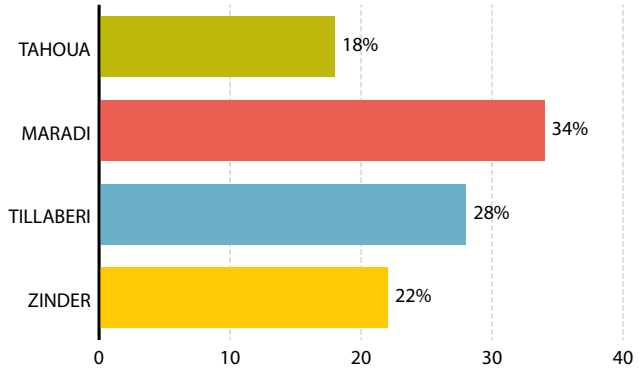


4.1.9 Washing the vulva during menstruation: an unknown practice

Washing the vulva refers here to using water to clean the vulva and remove traces of dried blood. This beneficial practice is unusual. Across all four regions, an average of only 25% of respondents said that they regularly clean themselves in this way during their periods (Graph 4.10).

Graph 4.10

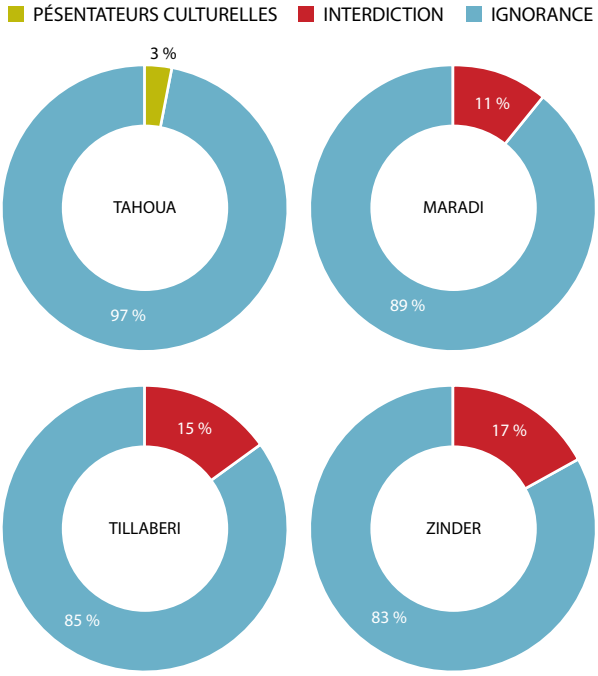
Proper washing of the vulva during menstruation



The reasons for not washing the vulva during menstruation include lack of knowledge (94%), certain prohibitions (4%) and cultural constraints (2%).

Graph 4.11

Reasons for not properly washing the vulva during menstruation

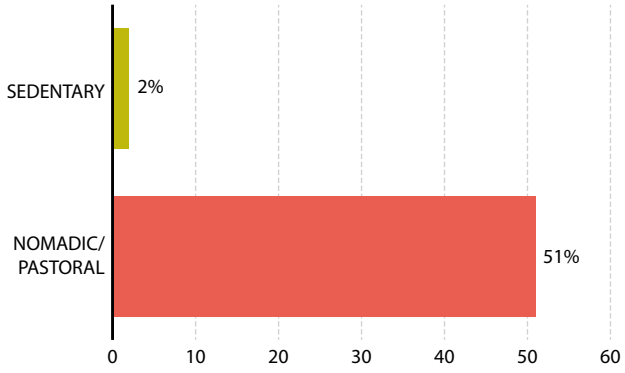


4.2 Profile of women with poor menstrual hygiene practices

A composite indicator, *"MHM practice"*, has been built to highlight practice(s) conducive to good menstrual hygiene. The MHM practice indicator comprises the following components: Type of protection used, washing and drying protection and products used, soak time, washing of hands and products used, quality of water used, frequency of changing of protection, wearing of underwear during menstruation, washing the vulva during menstruation. This indicator shows that poor MHM practice is more prevalent in nomadic women (98%) than in sedentary women (49%) (Graph 4.12).

Graph 4.12

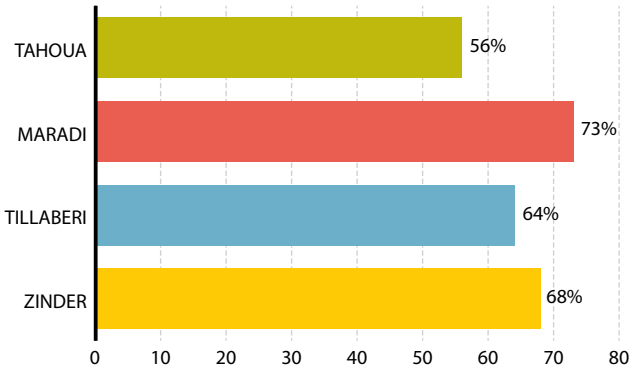
Poor MHM practices by type of residential setting



Based on the regions studied, around 60% adopt poor practices in MHM, with a high proportion among women in Maradi (Graph 4.13).

Graph 4.13

Practice conducive to poor menstrual hygiene



Analysis using the factorial multiple correspondence analysis technique (FMCA) was used to create a profile of women who adopt poor menstrual hygiene practice in Niger (Figure 4.1). Examination of this factorial plot points to this group of women.

This classification includes women whose practices are not conducive to good menstrual hygiene, who are nomadic and from the Maradi region. These Christian or non-religious women live in rural areas, attended school up to the first cycle of secondary at most and have low or average knowledge of MHM. They are single, housewives or work in agriculture and pastoralism.

In broad terms and in light of the qualitative analysis, it seems that women and girls of some localities in Niger have their own special way of managing periods. Their menstrual hygiene management practices include the use of objects that these women have to hand, as they are often unable to afford disposable sanitary protection. One woman from Rougga Idi said, *"We use pieces of sponge and several items of underwear."* The pieces of sponge are used to soak up the menstrual flow. In the absence of pieces of sponge, the second solution is to wear multiple undergarments in the hope, once again, of soaking up the menstrual flow.

Such practices reflect the extreme destitution of women and girls in these communities. But it would not be enough to focus on lack of financial resources to explain or justify these menstrual hygiene management practices – cultural constraints are not far behind. The early marriage of girls, highly valued in these communities, is a key factor in the management of menstrual hygiene. Girls do not have the time to discover their femininity, to learn the rudiments of how to manage their bodies, and they are called upon very early to assume conjugal roles. In such a context, there can be no doubt that it is difficult for them to reconcile conjugal requirements with menstrual management practice, two situations that are completely new to them. As this informant stresses:

> *"Girls only learn all this once they are at home with their husbands and this disturbs them. Most go home to their parents in tears to tell them that they have been torn, while others are so ashamed they do not manage to talk about it. But nowadays, some learn by listening to their sisters-in-laws' conversations without having to question what it is."*[6]

It seems, therefore, that sexual taboos reduce the issue of menstruation to silence. A young girl joins her husband at a stage of sexual immaturity, while the husband himself is incapable of taking the smallest step towards preserving his wife's sexual and menstrual balance.

4.3 Men's attitudes towards and perceptions of menstruation

In the community, men's knowledge, attitudes and perceptions towards menstruation are to a large extent very basic, more so in nomadic than in sedentary populations. Considering the socio-anthropological data collected from men, a thread can be seen throughout of fairly pronounced ignorance of the issue of menstruation. It emerged from some FGDs in Maradi that some men were completely unaware of the modern sanitary pads that are often distributed to their wives at awareness-raising sessions organized by NGOs. In Dakoro, in the Bororo nomad encampments area of Sarki Yama, for example, where the women themselves are less likely to use sanitary pads, we were told that men sometimes *"use sanitary pads for other purposes, such as packing dates and kola nuts."* (Interview with the commune's deputy mayor).

This lack of knowledge is due to the fact that there are few sources of information about menstruation available to men. *"It is through life, earth science and family economics classes at school that boys learn about menstruation,"* said the informant. Teachers reveal, however, that these classes are not actually followed by boys in school.

Therefore beyond the effort to be clean that men "require" of their wives during their periods, empirical observations show that men themselves need to be educated about menstrual hygiene and the use of sanitary protection.

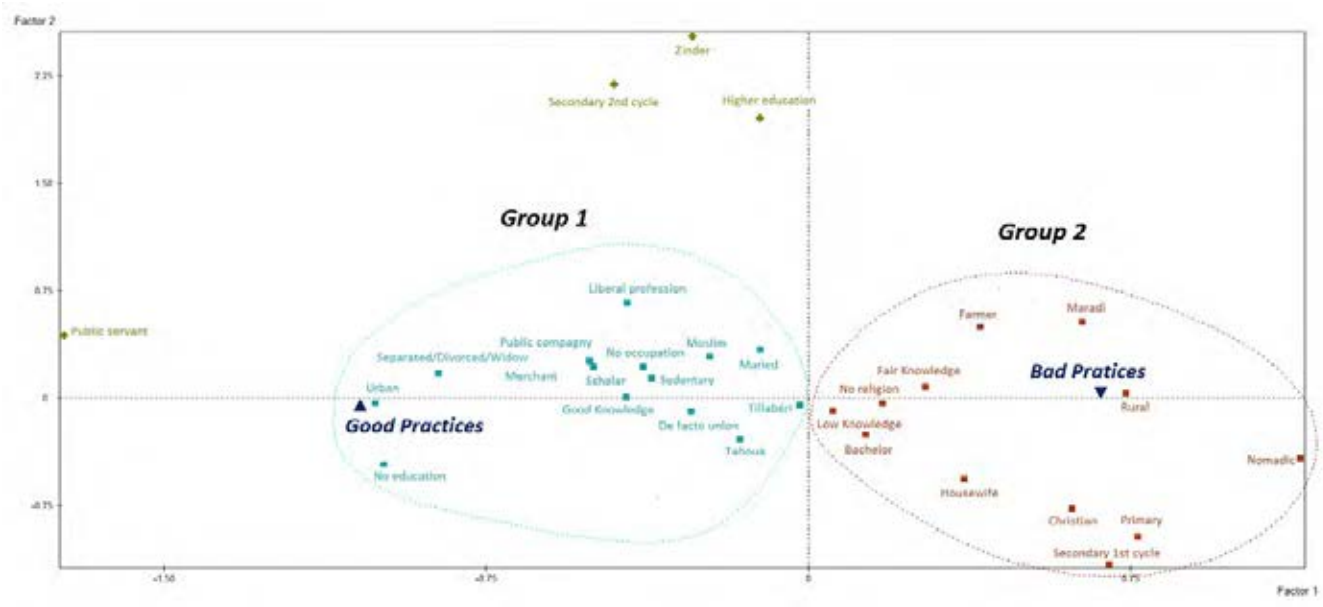
Reading the questions that men and boys pose makes it possible to understand their desire to learn more about menstruation. We might note among these questions: *"Why*

6 Women's FGD in Rougga Marrini, November 2016.

do women have periods?" "What do women have to do to not be unwell during their periods?" etc. Men would like to have this information about menstruation. Especially for those sedentary and town-dwelling men of Tibiri-Maradi and Koleram-Zinder, it is good form for menstruating women to observe proper personal hygiene, particularly since they are placed under certain restrictions. Men know first of all that these "periods of downtime" last several days, during which women have to make a constant effort to keep clean. They are becoming ever more attentive to the changes that affect the women around them.

Figure 4.1

Factorial plot showing the categorization of women according to selected characteristics



CHAPTER 5

SOCIAL AND CULTURAL BARRIERS TO GOOD MANAGEMENT OF MENSTRUAL HYGIENE

The analysis in this chapter covers the beliefs and taboos associated with menstruation. This is important because prejudices lead to harmful consequences for women's and girls' everyday lives which also further hamper their development.

5.1 Widespread persistence of beliefs and taboos around MHM

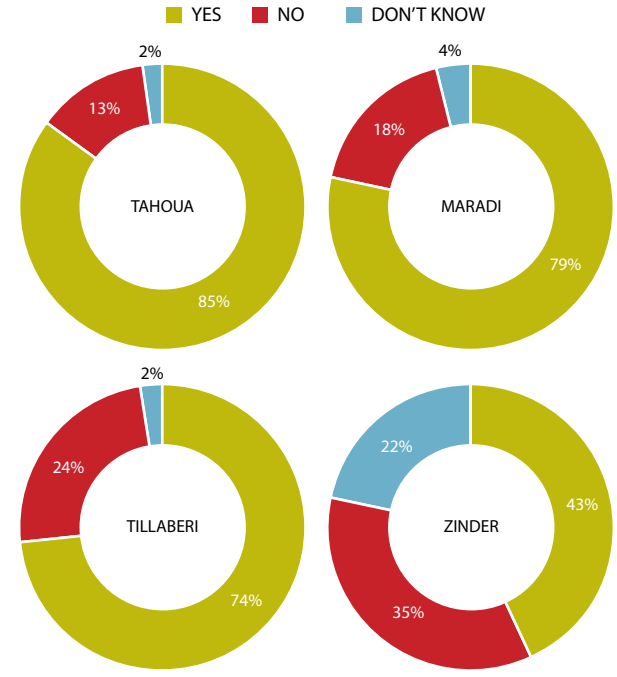
5.1.1 Women more exposed to beliefs and taboos around MHM

Quite high levels of restrictions

Our study shows that many respondents are subject to all sorts of prohibitions during their periods. This was affirmed by 85% in Tahoua, 79% in Maradi, 74% in Tillabéri, and 43% in Zinder.

Graph 5.1

Prohibition of certain practices by religion or community



Social, religious and food restrictions

The restrictions to which the girls and women of Niger are subjected start with the arrival of their first period. As shown in Table 5.1, restrictions cover several areas: social, religious and food.

All or most prohibitions are intended to restrict women and girls' activities during menstruation. They are not allowed to fast, pray or enter holy places (mosques or churches). They often do not participate in religious or cultural ceremonies and are not allowed to be in the company of boys or men. When they are menstruating, women with partners do not share the conjugal bed. They often do not even share the conjugal bedroom and sleep with their mother-in-law. Sexual relations are forbidden during menstruation because menstruating women are considered unclean.

Girls and women are also subjected to food restrictions. Certain drinks and foods are not consumed during menstruation, such as cold water, which is believed to clot the menstrual blood.

Specific recommendations during menstruation

Just as with restrictions, many respondents reported that religion or their communities recommended certain activities (Graph 5.2).

Graph 5.2

Existence of recommendations during periods

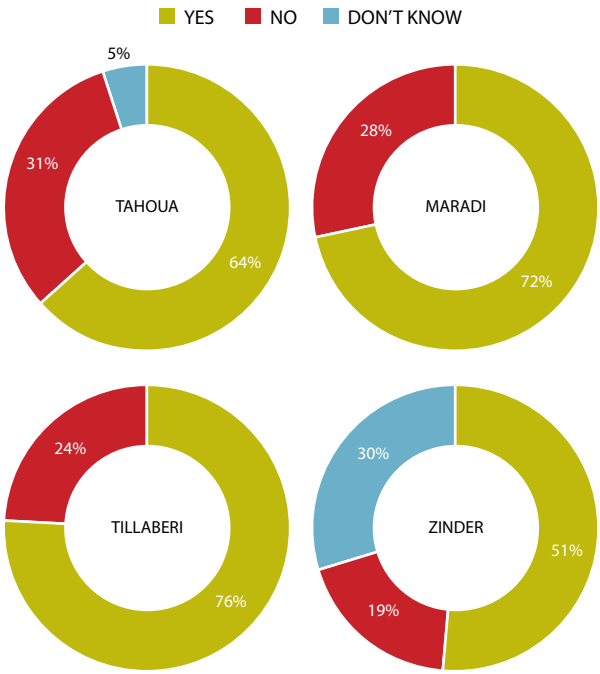


Table 5.1

Activities prohibited by religion or community during menstruation

THINGS PROHIBITED	REGION			
	TAHOUA *Frequency (%)*	**MARADI** *Frequency (%)*	**TILLABÉRI** *Frequency (%)*	**ZINDER** *Frequency (%)*
Do not have sexual relations	86	80	80	88
Do not throw away sanitary protection without having washed the blood out	50	66	66	69
Do not fast	51	42	53	88
Do not walk with boys during menstruation	49	9	9	63
Do not cook certain dishes	27	9	33	44
Do not pray or touch the Koran	38	28	58	50
Do not share the conjugal bed	37	59	55	0
Do not enter holy places	35	67	44	0
Do not accompany fishermen	3	6	3	0
Do not drink cold water	7	4	3	75

Unlike the restrictions, which affected three spheres (social, religious and food), recommendations apply to two spheres: social and food. As Table 5.2 shows, they relate to the management of sanitary protection and the non-consumption of high calorie and acid products (vinegar and lemon).

Social and religious considerations around menstruation

The restrictions and recommendations above appear to be based on beliefs rooted in the community (Table 5.3). Communities think that women's periods are unhealthy, shameful or even dangerous, or perhaps represent an illness or impurity that has to be cleansed in order to remain healthy.

Table 5.2

Recommendations made by religion or the community during menstruation

THINGS RECOMMENDED	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Soak, rinse and dry sanitary protection	94	88	62	68
Give preference to reusable fabric	73	71	62	68
Bury pads after use	50	38	65	21

Table 5.3

Perceptions of menstruation in the community

VIEWS ABOUT MENSTRUATION IN THE COMMUNITY	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Shameful	84	56	72	68
Dirty/unhealthy	66	46	41	81
Impure	56	54	66	51
Dangerous	14	19	21	62
Disease/infection	6	8	6	92

The "reasons" put forward in the community, regardless of the area of study, are social, hygienic and cultural (Table 5.4).

5.1.2 Men's beliefs and taboos around menstruation

A firm stance on talking about women's menstruation, particularly prohibitions and recommendations

Although, a natural biological phenomenon that is intimately linked to women, men in Niger think that the issue is too socially, culturally and religiously important to not get involved. With the exception of Zinder, many men in the regions of the study think they should have a say in women's menstruation (Table 5.5).

One area of interest for men is to remind women of the restrictions they are under during their periods. Graph5.3 shows that the majority of the men in Tahoua (87%), compared with 63% of men in Zinder and 26% of men in Tillabéri support the idea of restrictions for menstruating women.

Graph 5.3

Position of men on the prohibition for religious or community reasons of certain practices by menstruating women

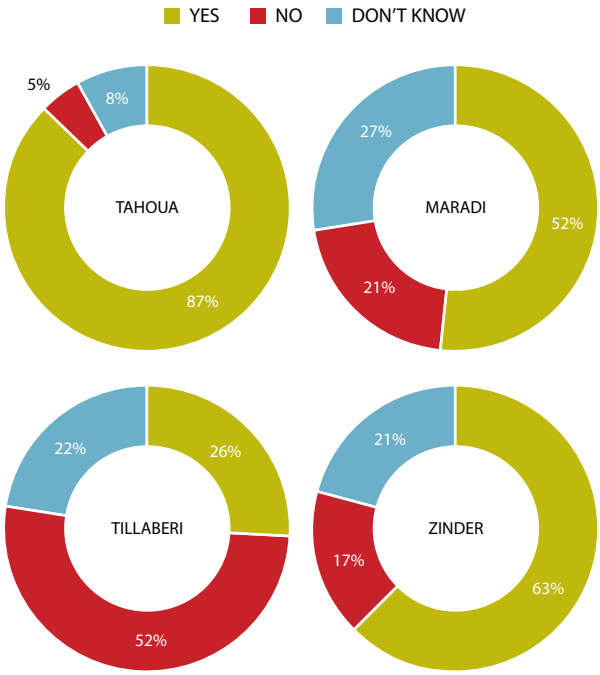


Table 5.4

Underlying reason for perception of periods in the community

REASONS	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Unpleasant smell	47	78	59	78
Bodily waste	21	29	43	46
Illness-inducing excreta	35	28	18	73
Dirty excreta	4	7	7	62

Table 5.5

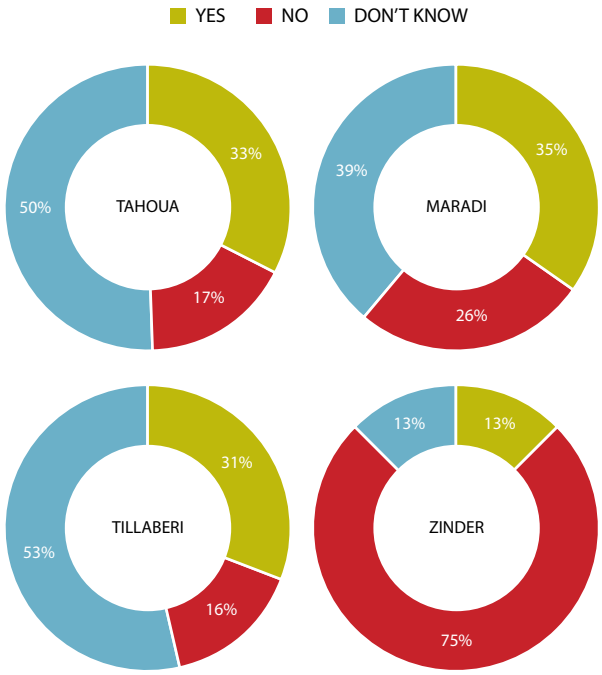
Should women's menstruation also concern men?

PROPORTION OF MEN HAPPY TO SPEAK ABOUT MENSTRUAL HYGIENE MANAGEMENT	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Yes	56	44	64	0
No	44	56	36	100
Total	100	100	100	100

Taking all the study regions together, fewer men support recommendations for menstruating women. Graph5.4 shows that only 35% of men in Maradi support recommendations, 33% in Tahoua, 31% in Tillabéri, and 13% in Zinder..

Graph 5.4

Position of men on the issue of religious or community recommendations for menstruating women



Recommendations for good MHM

Men's recommendations relate to two spheres: the social sphere and the food sphere, but with greater emphasis on the social sphere. As Table 5.6 shows, recommendations concern the management of used sanitary protection and the non-consumption of high calorie or high acid products.

Table 5.6

Men's recommendations for women to manage menstruation

RECOMMENDATIONS FROM MEN FOR MANAGING MENSTRUAL HYGIENE	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Soak, rinse and dry sanitary protection	80	89	11	100
Give preference to reusable fabric	78	97	61	100
Bury pads after use	40	84	61	0
Advise against sanitary pads for some women	34	84	61	0

Social and religious considerations underlying recommendations around menstruation

The restrictions and recommendations mentioned above appear to stem from beliefs around menstruation and men's view that menstruation is shameful and impure (Table 5.7).

The views put forward by men are rooted in the beliefs of different ethnic groups and communities in the region (Table 5.8).

In general, and regardless of study area, numerous prejudices and beliefs surround the phenomenon of women's menstruation (Table 5.9).

Studying beliefs and taboos around menstrual hygiene management in the community in Niger involves exploring social representations around the notion of blood and the different prohibitions or stigmas that affect women and girls because of their periods. To better understand beliefs and taboos around menstruation it is necessary to also study an aspect of sexual initiation in these cultures.

Socio-anthropological observations conducted in some Nigerien localities have made it possible to identify the meaning(s) attached to blood in the culture. When it is from the human body, blood, according to some informants *"represents 'najasa', or dirt"*. Blood, in the collective consciousness, is thought of differently depending on whether it supports living human beings by circulating through their veins or is outside the body, thereby inducing fear. Women's menstrual blood, flowing outside their bodies, can only translate as harm or, to a certain extent, *"misfortune"* or *"curse"*.

Table 5.7

Men's perceptions of menstruation

MEN'S PERCEPTIONS OF MENSTRUATION	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Dirty/unhealthy	5	71	14	100
Dangerous	1	42	29	25
Shameful	23	71	22	100
Impure	20	59	29	67
Disease/infection	2	45	40	71

Table 5.8

Reasons for men's perceptions about menstruation

REASONS FOR MEN'S PERCEPTIONS ABOUT MENSTRUATION	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Unpleasant smell	19	75	36	100
Bodily waste	55	70	40	100
Illness-inducing excreta	17	50	21	83
Dirty excreta	15	65	26	100
Disease/infection	2	45	40	71

Table 5.9

Realities, beliefs and prejudices about periods

REALITIES/BELIEF/PREJUDICE	REGION			
	TAHOUA *Frequency (%)*	**MARADI** *Frequency (%)*	**TILLABÉRI** *Frequency (%)*	**ZINDER** *Frequency (%)*
Increased blood flow when the woman is in a holy place	19	7	11	5
Possibility of using menstrual blood for evil spell	19	17	6	78
Sanitary pads reduce fertility and cause illness	11	11	18	89
Albino and cursed children are the fruit of sexual relations during menstruation	13	15	5	62
Lemon, vinegar and bitter food reduce menstrual blood flow	27	2	16	68
If a menstruating woman touches seed, this will bring a bad harvest	34	9	8	62
If a menstruating woman does the washing, this will dirty the clothes	3	2	13	65
If a menstruating woman braids another woman's hair, that woman will lose her child	3	9	16	54
If a menstruating woman handles canaries they will go unsold	0	0	8	65
If a menstruating woman prepares yoghurt, it will not thicken	0	0	0	59
If a menstruating woman makes wine, it will be unsuitable for drinking	1	14	13	65
The use of fabric is preferable to sanitary pads	25	22	21	46

The point that drew attention in discussions with women is that they have also adopted these widespread *"negative"* ideas about their periods. One informant said about periods

> *"They are something imposed on girls and women when they reach puberty. It is a curse that has been inflicted on women since the time of our ancestors."* [7]

Women have developed a rather negative attitude about periods and do not regard them as a normal bodily function. This makes periods a taboo subject in the community that cannot easily be discussed between members of the same family, or even between groups of male or female friends. For these boys from Kouran Daga, for example, menstrual blood

> *"Is seen as a secret, and that is why there is less talk about this subject between girls and their fathers and between girls and their boyfriends."* [8]

These different perceptions around blood, and especially menstrual blood, are the underpinnings of the prohibitions that primarily affect women in the communities. It should be noted that the communities visited as part of this study in Niger are mostly Muslim. According to this boy from Kouran Daga, in Islamic thinking

> *"A girl who is having her period does not pray, does not fast and does not have sexual relations because periods are dirty."*

As this school principal highlights, the situation is a little more acute among Tuaregs. She said:

> *"Among the Tuaregs, girls are left totally on their own. When they are having their periods, they wear black clothes and keep them on for 4 to 6 days."* [9]

It seems that women or girls having their periods are marginalized in some ways and kept apart from the group. The clothing that they wear at this time is black translating perhaps the fear of unknowingly messing up their clothes and being conspicuous to others.

In nomadic communities, the main activity of the men is livestock breeding. Women are usually responsible for milking the animals for domestic needs. But, as this informant tells us, *"Women having their periods are prohibited from milking the animals."* (Women's FGD, Rougga Yarima). This prohibition from touching cows or the milk obtained from them is closely linked to the presence of menstrual blood.

7 Women's FGD, Rougga Marrini, November 2016.
8 Unmarried boys' FGD, KouranDaga, Novembre 2016
9 Principal of the Birmi Girls' School, November 2016.

5.2 Challenges in MHM

In the daily management of their menstrual hygiene, women and girls face difficulties that may be economic or environmental.

5.2.1 Economic barriers

Nigerien society is increasingly monetarised and almost every social practice has been subjected to this economic requirement. Women do not escape this economic logic in the management of their periods. The communities we visited in Niger rarely present women as wealth producers. These are societies in which women live under the authority of men who are the economic mainstays of the household. But men give scant consideration to women's menstrual hygiene management. A community liaison worker interviewed in the locality of Koleram, Niger, said:

> *"The main barrier to good management is the lack of means to obtain pieces of cotton, because men are reluctant to take this into account and women often do not have money."* [10]

In addition, it is found that even when men are aware of them, they remain *"reluctant"* to support their wives and daughters by financial means when they are menstruating. This reluctance is more the result of pervasive cultural constraints that do not favour women. Other difficulties are environmental.

5.2.2 Environmental and physical barriers

In relation to the environmental and physical barriers, menstrual hygiene management difficulties centre on the type of latrines used by women, the sources of water supply and even the quality of water used.

With regard to the types of toilets used, observations show that households do not have toilets that are sufficiently private. The population is increasing and the sanitation infrastructure in households and even public places no longer meets the needs of male and female users. On the subject of latrines, the women of Rougga Idi complained:

> *"There are no latrines around here. It is impossible to feel at ease in the space reserved for toilets because it is small and enclosed by adobe bricks with no doors and with low walls."* [11].

Indeed, there is no guarantee of privacy when using these toilets to bathe or replace sanitary materials. If the walls are low, offering no privacy, it is easy to understand why good menstrual hygiene is difficult. *"Because of the lack of latrines, they dig a hole to bury the fabric towels they have finished with,"* said one woman from Rouga Marrini. Returning to the economic factor, the mayor of Koleram stated that *"There is*

10 Community liaison worker, Koleram, November 2016.
11 Women's FGD, Rougga Idi, November 2016.

an economic barrier for those who do not have the means to make latrines."

The lack of water is another obstacle. In parts of the Sahel, community access to water is not simple. In the rural Sahel, residents have access to less than 10 litres of water a day for their needs (Watang and Ganota, 2013). In these circumstances, women struggle to obtain water for good personal and menstrual hygiene. While sedentary populations have fewer difficulties, nomadic populations have more. The deputy mayor of the commune of Sarkin Yamma and the hygiene and sanitation manager of Maradi both mentioned this fact. They said:

> *"The lack (...) of water for the nomadic population is the biggest challenge. It is a problem of distance from water points, health centres and means of communication."* [12]

> *"It is mainly the issue of water in some localities, more specifically, nomadic localities. Nomadic people give this water to the animals, rather than using it for personal washing, which is not a priority."* [13]

Listening to these local officials, there is an urgent need to raise awareness among nomadic populations about the use of these limited water resources.

The developments mentioned above show that there are several barriers to good menstrual hygiene management among women and girls in Niger. These barriers mostly arise from beliefs, perceptions and representations about blood in general, and menstrual blood in particular. They are social constructions that are valued by people but are not conducive to supporting women's and girls' menstrual hygiene management. Observations have also shown that these barriers are also economic and environmental.

This study did not examine the impact of menstrual hygiene management on the environment in terms of the handling of used sanitary protection, either by the household or community. Such a study seems essential, for two reasons:

- due to the massive increase in solid and liquid waste from homes and artisan industries in urban and rural areas of Niger, there is a need to determine the proportion (by volume) of waste related to menstruation;
- quantitative data could help further understanding of the options for MHM waste disposal that are influenced by (i) the lack of WASH infrastructure and facilities; and (ii) deeply rooted representations linked to perceptions of menstrual blood as well as to the management of women's privacy.

Given the above, it follows that women face a broad range of difficulties in managing their menstrual hygiene but economic concerns take precedence over environmental concerns. Women inevitably also face health issues linked to menstruation, which will be considered in the next section.

12 Deputy mayor of the commune of Sarkin Yamma, November 2016.

13 Maradi hygiene and sanitation manager, November 2016.

CHAPTER 6

HEALTH PROBLEMS AND HEALTH CARE DURING MENSTRUATION

One point should be clarified here: menstruation is not in itself a *"health problem"*. It is a biological process, a normal function of the female body. It is an empirical point of view that for some women, the arrival of their periods leads to recurrent morbidities that merit attention.

6.1 Health problems dominated by anxiety, fatigue and stress

Problems encountered during menstruation were analysed to discover specific health problems felt to be aggravated by menstruation.

Graph 6.1 shows that most respondents experienced health problems during their periods, with a high proportion in the Zinder region (65%) with all the other regions around the 50% mark.

Graph 6.1

Health problems during menstruation

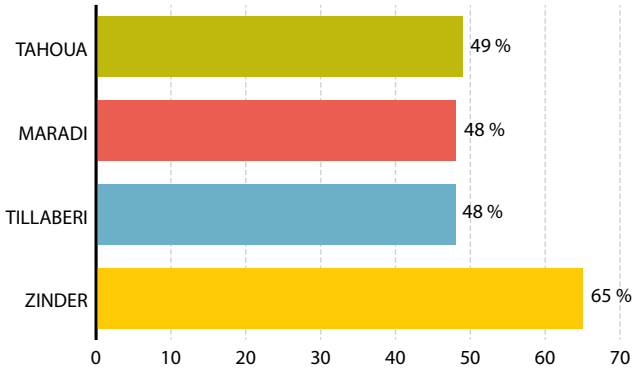


Table 6.1
Health problems when menstruating

USUAL HEALTH PROBLEMS DURING PERIODS	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
General weakness and tiredness	76	87	67	58
Discomfort	58	63	54	51
Bad mood	53	57	53	68
Stress	52	54	45	57
Lack of confidence	45	48	41	59
Anxiety	30	40	32	65
Headache	24	10	36	25
Backache	18	11	5	0
Dizziness, nausea	13	11	7	13
Itching or spots	4	18	12	33
Painful breasts	3	5	5	4

Table 6.2
Illnesses felt or experienced during menstruation

ILLNESSES	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Fever	56	58	53	54
Malaria	28	40	37	65
Cough/cold	25	31	23	73

Table 6.1 shows the most common health issues experienced by women and girls in Niger during menstruation.

Moreover, many said that they are often the subject of *"opportunistic"* diseases when they are having their periods (Table 6.2).

Qualitative data obtained from the various focus group sessions reveal, however, that in the communities visited the health problems faced by women and girls can be mainly summed up as *"low abdominal pain"* and *"excessive bleeding"*. Some respondents also mentioned low grade fevers. The practical management of these problems raises an important issue – that of raising the awareness of women and girls about menstruation. Indeed, the greatest problem around hygiene in general is the population's lack of awareness and ignorance of cleanliness. Various informants argued that this factor, *"ignorance about cleanliness"* is common to everyone, particularly among the nomadic population. It is difficult to conduct awareness raising in nomadic and rural areas due to the difficulty of access and also to the reluctance of nomadic people to embrace new ideas, according to those responsible for sanitation services. The following statements by four informants attest to this situation linked to the lack of awareness about cleanliness issues concerning, for example, how to manage excessive blood flow. When surveyed, women and municipal officers often raise this issue of outreach for the effective management of their health problems while menstruating.

> *"Women need to have their awareness levels raised but they do not know about the communication channels. There is no information about menstruation, not from*

Table 6.3
Types of remedies for health problems due to menstruation

TYPES OF REMEDIES FOR HEALTH PROBLEMS DUE TO MENSTRUATION	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Modern consultation	32	29	29	33
Traditional consultation	50	35	19	54
Modern self-medication	40	38	45	50
Traditional self-medication	44	61	33	67
Nothing/pray	42	39	48	29
Take a hot bath	0	3	0	0
Have a hot drink	26	48	26	46
Go for a walk	2	4	14	0
Rub/massage the abdomen	64	71	55	63
Place a water bottle on the abdomen	4	0	2	0
Lie down on the back	2	0	7	21

parents, let alone anyone else. Mothers are not able to discuss periods with their daughters. Villages do not have health centres."[14]

"There is no communication about menstruation. Girls are not taught this in school; those lucky enough to go to school leave as early as primary." [15]

"The problems women face in managing their menstrual hygiene are a lack of awareness and ignorance." [16]

"Ignorance and shame stop girls from approaching health workers for information about menstrual hygiene, especially given the lack of female health workers." [17]

Listening to these views, it is possible to say that if women and girls had greater awareness and were taught about menstrual cleanliness, some of the problems they face would be resolved in part.

14 Women's FGD, RouggaYarima, November 2016.
15 Women's FGD, Rougga Idi, November 2016.
16 Deputy mayor of the rural commune of SarkinYamma, November 2016.
17 Mayor of Koleram, November 2016.

6.2 Remedies for health problems caused by menstruation

In the event of health problems, women and girls use their own strategies (Table 6.3).

Field observations show two main options favoured by women and girls in the event of health problems during menstruation. The first category of women is those who choose to *"do nothing"*, *"If we get period pain, all we can do is resign ourselves to God"*, was said by women from Koleram during a group discussion.

Alongside this category were those who took medicinal drinks made using traditional medicines. Two women from Tibiri and Rougga Idi share what they do if they get period pains or excessive bleeding: *"If we get pain we take a syrup called 'waaki' and benign water"*; *"If we have heavy bleeding, we use 'gonakier' leaves ('bagaruwa') to stop or slow it."*

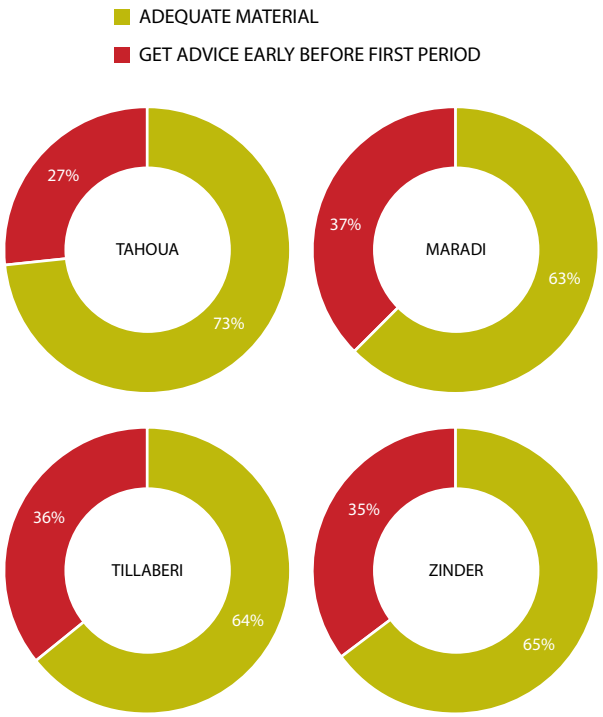
All in all, it seems from these focus group discussions that most of the remedies used are traditional. What this means is that *"home-made medicines"* are used to provide relief for women who have health problems during their periods. Nowhere did they mention medical consultation in a health centre. This could be due to: i) the discomforts associated with menstruation are not so acute as to require a visit to the doctor, or ii) their lack of financial resources to go to a health

centre or, quite simply, iii) the lack of suitable health services at a short distance.

Faced with these various health problems, the girls and women of Niger expressed the needs they have to feel better during their periods as shown in Graph 6.2.

Graph 6.2

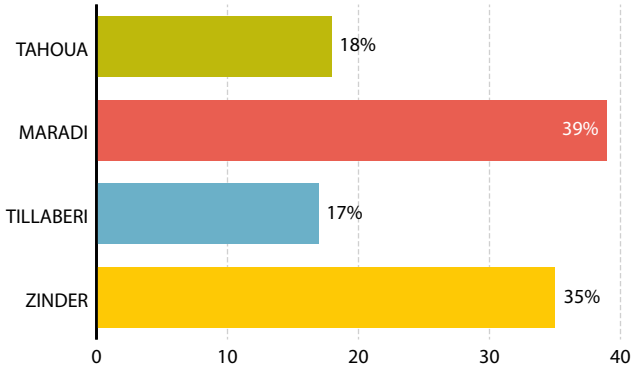
Needs expressed by respondents during their periods



The needs expressed by the girls and women are essentially related to a desire to have appropriate sanitary protection. Some said that they had already received some from humanitarian NGOs (Graph 6.3).

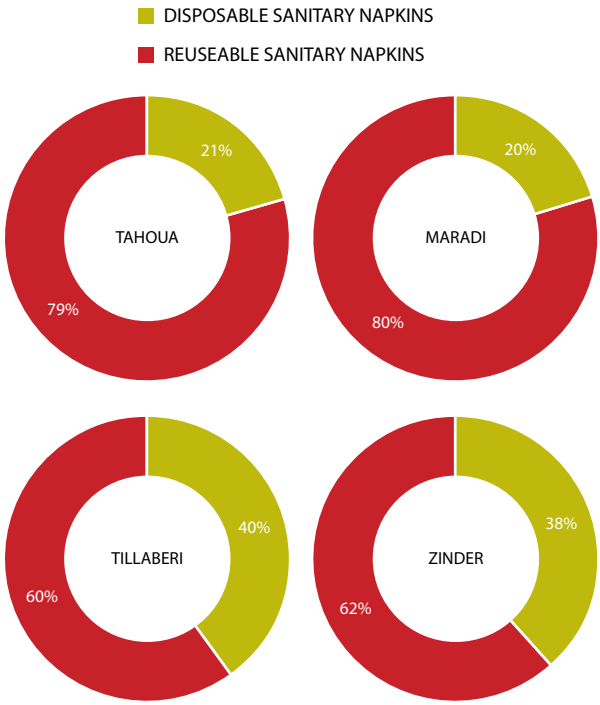
Graph 6.3

Proportion of girls/women who received sanitary protection from NGOs during their periods



Graph 6.4

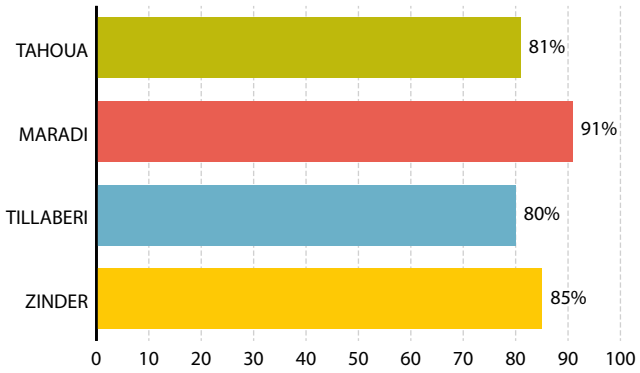
Types of sanitary protection received



In the opinion of these girls and women, the type of sanitary protection that is most often is the washable sanitary towel (Graph 6.4), and the great majority of these women are satisfied with the product (Graph 6.5).

Graph 6.5

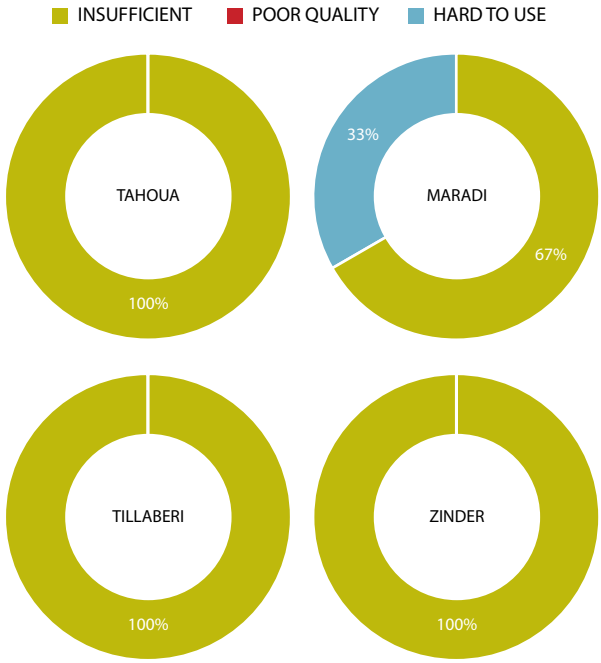
Satisfaction level



The low rate of dissatisfaction (16%) includes girls and women who feel that the sanitary towels received from NGOs are insufficient and call for them to also be provided by public establishments (schools/high schools, markets and workplaces, offices, etc). None of the respondents questioned the quality of the sanitary towels they received (Graph 6.6).

Graph 6.6

Reason for dissatisfaction with towels received



6.3 Perceptions of health problems due to periods

Examining the various remedies presented above, it is understandable that the health problems related to menstruation are not really viewed as urgent in these communities. Furthermore, some ideas about menstruation mean that women and girls favour discretion in the management of their sanitary protection. For example, women do not dare dry their washed reusable protection in the fresh air and sun. Indeed, *"If you dry your used sanitary protection in the open you may catch diseases like cholera,"* said one woman from Zinder. Unfortunately lores such as this are widely accepted.

CHAPTER 7

THE IMPACT OF MENSTRUATION ON WOMEN'S LIVES

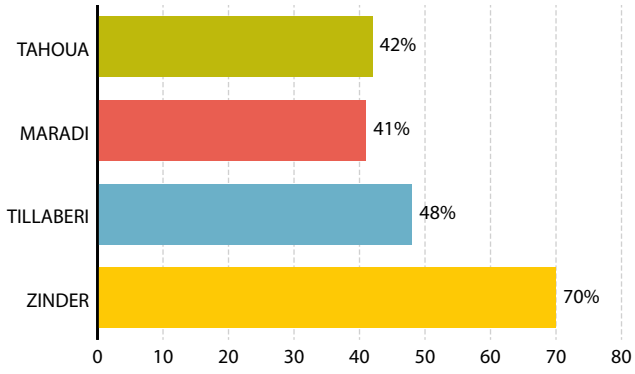
This chapter looks at how poor menstrual hygiene management can be an obstacle to girls' and women's participation in social, cultural, educational and income-generating activities.

7.1 A moderately high level of impact on activities

A relatively high proportion of girls and women said that having their periods was a hindrance. In answer to the question, *"Do you miss out on normal activities during your periods?"* an average of 43% said that they did (with a higher proportion in Zinder (70%) than in Tillabéri (48%) and Maradi (41%). They also said that the start of their periods was detrimental as they were obliged to avoid their normal activities (Graph 7.1).

Graph 7.1

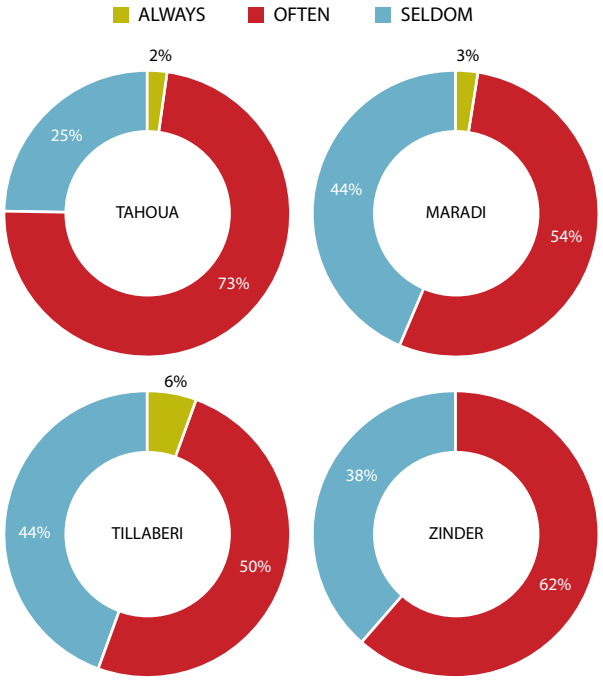
Impact of periods on regular activities



Although Graph 7.2 shows that too often girls and women in Niger miss out on regular activities (school, work in the fields, trade and others), it rarely happens that they completely fail to perform their usual obligations. When this does happen, it is usually only for 2 to 3 days (Graph 7.3).

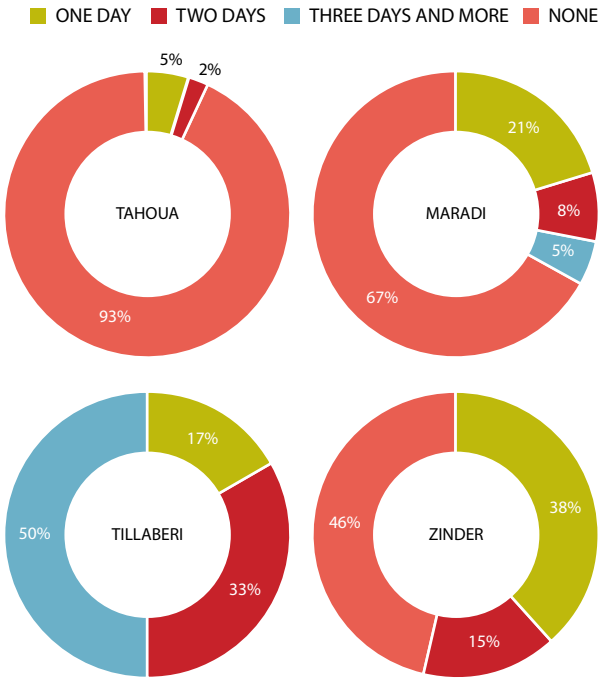
Graph 7.2

Frequency of absence during last period



Graph 7.3

Number of days missed during last period

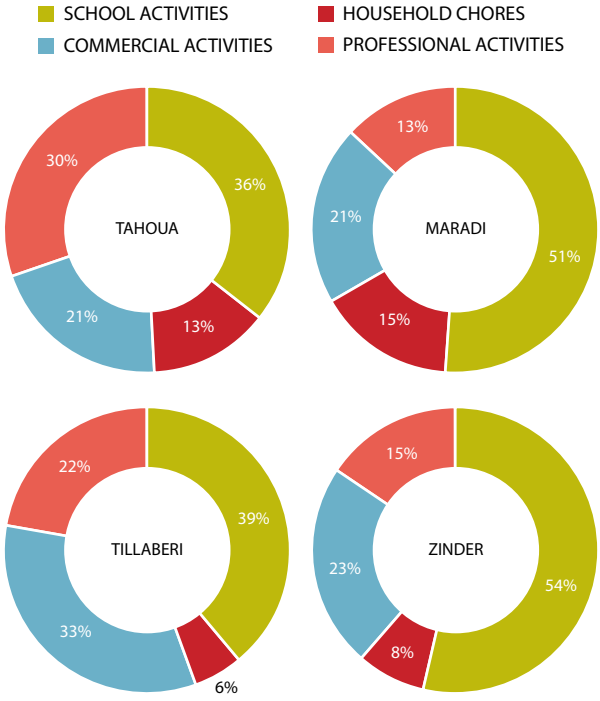


7.2 A range of activities from which girls and women are excluded

Graph 7.4 provides details of the types of activity that women and girl do not attend during their periods. This graph shows that every sector is affected, especially the educational and commercial activities that account for the majority of Nigerien women.

Graph 7.4

Types of activity missed during periods



7.3 Reasons for these absences and attitudes during the period of absence

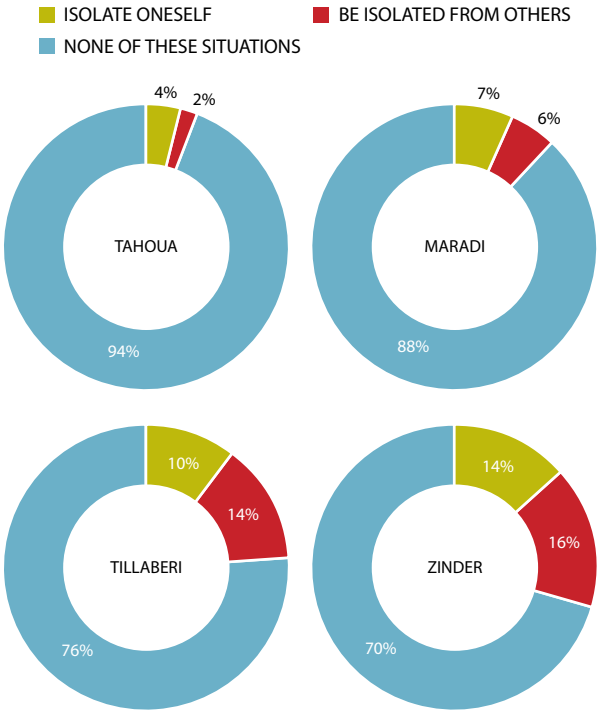
Women and girls in Niger say that they miss their usual socioeconomic activities for three main reasons: period pain, the lack of toilets in the places where they conduct their activities and tradition (Table 7.1).

During the days when they do not take part in regular socioeconomic activities because of their periods, a majority of these women said they did not adopt any particular behaviour other than isolating themselves from others or being isolated by others (Graph 7.5).

Table 7.1
Reasons for absence from activities

REASONS	REGION			
	TAHOUA *Frequency (%)*	MARADI *Frequency (%)*	TILLABÉRI *Frequency (%)*	ZINDER *Frequency (%)*
Pain	75	76	78	77
Lack of toilets in place of activity	21	39	33	38
Tradition	7	9	33	38

Graph 7.5
Withdrawal during menstruation



7.4 Impact of periods on girls' and women's lives

7.4.1 Social impact

From an empirical point of view, women's poor management of menstrual hygiene is likely to have some unpleasant consequences. In the communities visited in Niger, women and girls were seen to have a lack of knowledge of good menstrual hygiene management. Taking just the example of Rougga Idi, it was found that the women there had no idea about the impact of poor menstrual hygiene. Furthermore, they had no knowledge of other methods of sanitary protection. This situation is undoubtedly at the root of social impact, including the deteriorating image of women and girls. In school for example, poor menstrual protection makes girls likely to be exposed to their classmates' ridicule. Poor menstrual hygiene management may prevent women and girls from moving freely in society and from actively participating in social, cultural and educational activities. The psychological impacts are no less significant.

7.4.2 Psychological impact

The occurrence of menstruation in women and girls also causes regular psychological discomfort. In a social context marked by clear male dominance, women, considered as *"social youngsters"* experience multiple pressures. These pressures increase when having to manage their periods which are often thought to make them *"impure"* or *"dirty"*, etc. As these women from Rougga Marrini say, *"Women very often isolate themselves and do not go outside the home."* It clearly appears that the psychological impact experienced by women includes frustration, stress, isolation, stigmatization and rejection.

7.4.3 Economic impact

During their periods, women are often prevented from going about their normal business. In a social context marked by economic insecurity that hits women hardest, some women suffer even more due to their periods generally being a *"dead time"*, from the point of view of economic activities. Women and girls in the communities visited do not work on a full time basis, and it remains clear that periods prevent them from flourishing.

CHAPTER 8

EVALUATION OF THE EXTENT TO WHICH PUBLIC POLICY TAKES ACCOUNT OF MENSTRUAL HYGIENE MANAGEMENT

This chapter is devoted to a review of policies in Niger as they relate to MHM.

8.1 Consideration of MHM in Niger's development goals

It was immediately apparent that aspects related to MHM are not expressly provided in the guidance documents for the country's policies. As menstrual hygiene presents a new and taboo topic in Nigerien society, it appears to be a 'poor topic' for raising interest and even less as a policy subject. Nevertheless, through some operational or strategic documents it is possible to trace texts that establish a relationship with personal hygiene and, consequently, menstrual hygiene.

To ensure proper coordination of the various development programmes and to translate the policy choices of Nigerien leaders into priority action plans, the Ministry of Planning, Land-Use Planning and Community Development was created in order to relaunch the planning function. The relaunch was given form by the preparation of three strategic documents: the Interim Framing Programme for Government Action (Programme intérimaire de cadrage de l'action gouvernementale, PICAG, 2011-2012), the Economic and Social Development Plan, (Plan de développement économique et social, PDES, 2012-2015) and the Strategy for Sustainable Development and Inclusive Growth (Stratégie de développement durable et de croissance inclusive, SDDCI NIGER 2035).

The Interim Framing Programme for Government Action (PICAG 2011-2012) included a diagnostic analysis of the water and sanitation sector. Taking data from different sectoral ministries, it established that there is still poor provision of collective and individual sanitation[18], especially a lack of sanitation infrastructure and poor access to piped water for many Nigeriens, particularly for those living in rural areas. In perspective, it advocates an extension of the Global Decade of Sanitation in Niger, whose actions will be based on an acceleration of the establishment of infrastructure.

18 In rural areas, households produce so-called 'domestic' waste from household activities (cooking, cleaning, etc). As there is virtually no organized system for the removal of household waste in rural areas, households collect it and dump it in the wild. In urban areas and especially in major centres, waste is collected and discharged most often in unregulated dumps or, in rare cases, in bins placed by the municipality that are irregularly emptied for discharge in unregulated dumps. Broadly speaking, between 1998 and 2008, about 8 out of 10 rural homes had no sanitation system of any kind. Even in urban areas, access to sanitation is low. The uncovered latrine is the most common toilet in Niamey (used by one in two households).

Like PICAG, the 2012-2015 Strategic Plan of the Ministry of Population, the Promotion of Women and Protection of Children, whose mandate is to address concerns did not develop a policy that specifically mentions menstrual hygiene. Its strategic goals and expected outcomes are shown below (Table 8.1).

Although complementary to PICAG 2011-2012, the 2012-2015 Economic and Social Development Plan (PDES) developed by the Ministry of Population, the Promotion of Women and Protection of Children, is intended to be more ambitious because issues related to water, hygiene and sanitation in the broadest sense of the term are addressed in great detail. In fact, as an instrument for the operationalization of the Niger Renaissance Programme, intended to be the single reference framework for interventions under the Government's medium-term development agenda, it is aligned with the Sustainable Development Goals (SDGs). For this sector, the PDES is intended to support the strategic direction defined in the Presidential Programme and reflected in the National Programme for the Supply of Drinking Water and Sanitation 2011-2015 (Programme national d'alimentation en eau potable et d'assainissement 2011-2015, (PN-AEPA 2011-2015), adopted in June 2011. The drinking water and sanitation policy over the period of implementation of the PDES was based on three programmes, the WASH component of the first two of which (Table 8.3) proposed that by 2018, children and women, particularly the most vulnerable, would have improved access to drinking water and adequate sanitation infrastructure in schools, health centres and communities, including in emergency situations. In detail, the expected products are:

- **Product 3.1:** Schools, health centres and the most vulnerable communities have increased the number of drinking water and sanitation infrastructure items.
- **Product 3.2:** Children and households adopt behaviours conducive to improving environmentally sustainable hygiene and sanitation conditions, as well as the consumption of water of adequate quality in the home, in schools and in health centres.
- **Product 3.3:** Actors at all levels have the legal framework, coordination mechanisms, an effective monitoring system and strengthened capacities for the development of the water and sanitation sector.
- **Product 3.4:** Vulnerable population groups and those affected by crises, catastrophes and conflicts have improved access to safe water and to hygiene and sanitation.

In short, the basic sanitation programme was aimed at increasing access through i) increasing the number of improved family latrines from 100,000 in 2010 to 293,000 in 2015; ii) the promotion of self-build simple or improved family latrines; iii) the construction of public lavatories and school toilets.

In this initiative, the Ministry intends *"to reduce sociocultural barriers for better and full participation of girls, women and other vulnerable groups in their own personal development and the development of their communities"* (p 21). There are strong reasons to believe that achievement of this objective would involve solving the problems associated with menstrual hygiene management.

Table 8.1

Programmatic pillars of the Ministry of Population, the Promotion of Women and Protection of Children 2012-2015

STRATEGIC GOAL	OBJECTIVES	OUTCOMES
Programmatic strategic goal No. 1: social services	Enhance the availability, accessibility, acceptability and quality of basic social services and specialized services for target groups	Women/girls, children and other vulnerable groups use quality basic/ specialized social services
Programmatic strategic goal No. 2: communication for behaviour change	Reduce sociocultural barriers for better and full participation of girls, women and other vulnerable groups in personal development and the development of their communities	Women/girls, children and other vulnerable groups use quality basic/ specialized social services

Source : Ministry of Population, the Promotion of Women and Protection of Children, 2012 2012-2015 Strategic Plan Niamey, page 29

Moreover, the Community-Led Total Sanitation (CLTS) programme was created in 2010 and this approach has been implemented by Plan International Niger, which remains one of the key non-governmental organizations to use this approach in Niger. The Ministry of Water and Sanitation (MHA, from the French) is responsible for water, sanitation and hygiene (WASH) services in Niger. Nationally, representatives of Plan International Niger coordinate their activities with the MHA and other ministries and international NGOs through the "WASH Cluster" Working Group. The CLTS approach is aimed at bringing about a change in WASH behaviour. This is done through a process of social awareness stimulated by facilitators from within and outside the community. Using the Rural Participatory Evaluation (RPE) methods that are integrated into it enables local communities to analyse their health conditions and become collectively conscious of the terrible impact of open defecation (OD) on public health and their immediate environment. In the end, empowered, the communities build their own latrines.

The findings of a case study of implementation of CLTS in Plan International Niger programme's intervention areas in 2015 revealed that despite the integration of CLTS into the national sanitation policy, district Governments had not yet adopted this approach. Once again, it was found that MHM had not been taken into account in water and sanitation interventions (including CLTS) in Niger.

8.2 Consideration of MHM in United Nations System objectives

In response to the priorities defined in PDES 2012-2015, the United Nations System has, in close collaboration with the Government, civil society and other national actors, developed the 2014-2018 United Nations Development Assistance Framework (UNDAF). The result of a participatory and dynamic process, this framework plan simply sets out the areas of cooperation, including those of social capital and human development. Thus, and in view of the national strategy for access to basic social services, the United Nations System is affirming its participation in building the capacities of Nigerien institutions to enable them to provide quality social services in an increasing and sustainable way, especially in the areas of health, education, access by vulnerable populations to safe water and basic sanitation infrastructure. The document addresses issues of social policy taken as a whole. There are no details on specific issues such as MHM.

In the 2014-2018 Country Programme Action Plan between the Republic of Niger and UNICEF, recent general trends show that nearly two thirds of Nigerien households have access to an improved water source to differing degrees depending on their place of residence, since in urban areas practically every household has access to an improved water source, while in rural areas nearly two out of five households

Table 8.2

PDES programmes with an impact on hygiene and sanitation

PROGRAMMES	OUTCOMES
Supplying the population with drinking water	Rural access to potable water is improved
	Rural access to potable water is improved in 40 new centres
	A system for the management of water works is established and is in operation
	The legal and institutional frameworks for the management of water are adapted and disseminated
Basic sanitation	The population's access to family latrines is increased
	Regional disparities are reduced
	Sludge treatment facilities are enhanced
Integrated water resources management	The level of knowledge, management and protection of water resources is improved
	Hydrological planning schemes are developed

Source : PDES 2012-2015, page 183

face hardship with regard to access to potable water (EDSN-MICS, 2012). (MICS, 2012). There is, however, a low rate of coverage of water points and latrines in health facilities and educational establishments and low rates of hand-washing at critical moments (39%, survey, 2010) contributing to the spread of infectious and parasitic diseases. In response, the Government, working in collaboration with UNICEF, has set up response plans by conducting awareness-raising campaigns with more than 200,000 at risk people and the distribution of water purification kits. It comes through clearly then that stakeholders have taken the trouble to review the situation in different areas (education, health, nutrition, protection of children, etc), including the WASH area. Even if the issue of menstrual hygiene management is not openly and expressly addressed, related issues such as access to water are covered in it.

In conclusion, we see an absence of policies directly related to menstrual hygiene management. Nonetheless, leaders of key sectoral ministries[19] recognized that addressing it would help achieve the Government of Niger and humanitarian organizations' goals related to access to basic services, better health, reduction of poverty and Nigerien women's and girls' empowerment.

19 From 19 to 22 December 2016 a workshop was held in Niamey on the integration of MHM into public policy. Twelve sectoral ministries and other NGOs and development partners were represented. During this workshop we were able to talk with officials from the Ministry of Water and Sanitation, the Ministry of the Environment and Sustainable Development, the Ministry of Public Health, the Ministry for the Promotion of Women and the Ministry of Secondary Education.

CONCLUSION AND RECOMMENDATIONS

This study on menstrual hygiene management in the communities of Niger has revealed various shortcomings, especially in rural areas and, more specifically, among nomadic populations. There are many advantages to dignified and safe management of menstrual hygiene. If better informed, women and girls can fully participate in society and the economy and lead active lives in school, work and leisure. This means that MHM must be clearly articulated in public policies and national strategies with associated budgets and monitoring systems. The capacity to implement such policies is as essential as the services that women and girls can use with total confidence. By listening carefully to different stakeholders on the ground, some recommendations may emerge:

- increase the amount of WASH infrastructure in communities and households (more in rural than urban households), while strengthening the upkeep and maintenance of existing infrastructure;
- intensify interventions for the promotion of good MHM in rural and nomadic environments;
- intensify MHM awareness campaigns for nomadic populations and in the regions of Tahoua and Zinder, where MHM has been shown to be poor;
- conduct awareness campaigns in places where women gather including formal and Koranic schools;
- further raise the awareness of boys who lack information on menstruation and who, consequently, develop stereotypes that reinforce the gender inequalities faced by girls;
- develop the construction of separate latrines in educational establishments and public places, in particular those frequented by economically active women, where most work in the informal sector;
- develop modules on MHM in the secondary and higher curriculums;
- involve men in MHM-related interventions;
- strengthen action research activities to inform political decision-makers and practitioners in the field of MHM;
- strengthen evidence-based advocacy to promote the integration of MHM into public policies and national and local development strategies.

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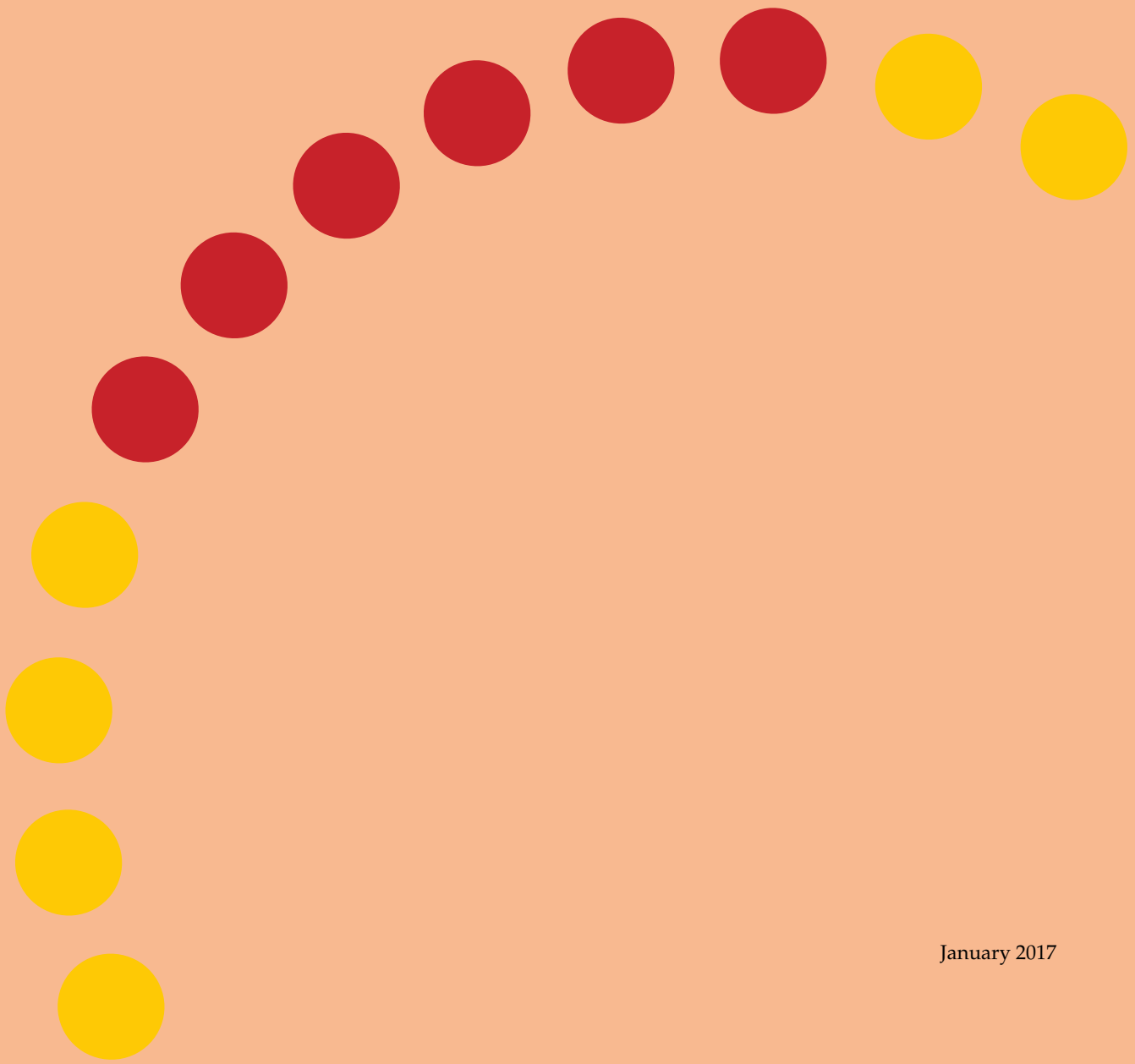
ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AME	Association des Mères Éducatrices, Association of Educating Mothers
CLTS	Community-led Total Sanitation
CPAP	Country Programme Action Plans
CSBC	Communication for Social and Behavioural Change
DDEP	Directeur (direction) Départemental (e) de l'Enseignement Primaire, de la promotion des langues nationales, et de l'éducation civique, Departmental Director (Directorate) of Primary Education, the Promotion of National Languages and Civic Education
DDES	Directeur (direction) Départemental (e) des Enseignements Secondaires, Departmental Director (Directorate) of Secondary Education
DPFS	Direction de la Promotion de la Scolarisation des Filles, Directorate for the Promotion of Girls' Education
DREP	Directeur (direction) Régional (e) de l'Enseignement Primaire, de l'alphabétisation, de la promotion des langues nationales et de l'éducation civique, Regional Director (Directorate) of Primary Education, Literacy, the Promotion of National Languages and Civic Education
ECOWAS	Economic Community of West African States
ECVMA	Enquête sur les Conditions de Vie des Ménages et l'Agriculture, Survey of Living Conditions of Households and Agriculture
EDSN-MICS	Enquête Démographique et de Santé du Niger à Indicateurs Multiples, Niger Multiple Indicator Demographic and Health Survey
ESCR	Economic, Social and Cultural Rights
FE	Family Economy
FGD	Focus Group Discussion
GHS	Gender, Hygiene and Sanitation
GSF	Global Sanitation Fund
HIPC	Heavily Indebted Poor Countries
I3N	Initiative "les Nigériens Nourrissent les Nigériens", "Nigeriens feeding Nigeriens" Initiative
INS	Institut National de la Statistique, National Statistics Institute
MDG	Millennium Development Goals
MEBA	Ministère de l'Education de Base, Ministry of Basic Education (former name of MEP/A/PLN/EC)
MEM/S/RS	Ministère des Enseignements Moyen et Supérieur et de la Recherche Scientifique, Ministry of Middle and Higher Education and Scientific Research
MEN	Ministère de l'Education Nationale, Ministry of National Education (former name of MEP/A/PLN/EC)
MEP/A/PLN/EC	Ministère de l'Enseignement Primaire, de la promotion des langues nationales, et de l'éducation civique, Ministry of Primary Education, the Promotion of National Languages and Civic Education
MES	Ministère des Enseignements Secondaires, Ministry of Secondary Education
MHA	Ministère de l'Hydraulique et de l'Assainissement, Ministry of Water and Sanitation
MHM	Menstrual Hygiene Management
MPATDC	Ministry of Planning, Land-Use Planning and Community Development
MSP	Ministère de la Santé Publique, Ministry of Public Health
OD	Open defecation
PDES	Plan de Développement Economique et Social, Economic and Social Development Plan
PEPAM	Programme d'Eau potable et d'Assainissement du Millénaire (Millennium Drinking Water and Sanitation Programme)
RGPH	Recensement Général de la Population et de l'Habitat, General Survey of Population and Housing
SDDCI	Stratégie de Développement Durable et de Croissance Inclusive, Strategy for Sustainable Development and Inclusive Growth

SDRP	Stratégie de Développement accéléré et de Réduction de la Pauvreté, Strategy for Accelerated Development and Poverty Reduction
SNEEG	Stratégie Nationale pour l'Égalité et l'Équité de Genre, National Strategy for Gender Equity and Equality
SNIS	Système National d'Information Sanitaire, National Health Information System
STI	Sexually Transmitted Infection
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNGEI	United Nations Girls' Education Initiative
UNICEF	United Nations Children's Fund
WAEMU	West African Economic and Monetary Union
WASH	Water, Sanitation and Hygiene
WSSCC	Water Supply and Sanitation Collaborative Council



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