

Using participation to improve menstrual hygiene management in emergencies: IFRC's MHM kit



Alice Robinson with
Alice Obrecht

CASE STUDY



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About the authors

Alice Robinson is a Researcher at Jigsaw Consult

Alice Obrecht is a Research Fellow at ALNAP

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Copyediting by Roo Griffiths

Front and back cover photo: Information, education and communication material for communities and volunteers. Credit: IFRC/Somalia Red Cross



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HIF-ALNAP case studies on successful innovation

This study is one in a series of 15 case studies, undertaken by ALNAP in partnership with ELRHA's Humanitarian Innovation Fund (HIF), exploring the dynamics of successful innovation processes in humanitarian action. They examine what good practice in humanitarian innovation looks like, what approaches and tools organisations have used to innovate in the humanitarian system, what the barriers to innovation are for individual organisations, and how they can be overcome.

About the case studies

Case study subjects are selected from a pool of recipients of grants from the HIF. The HIF awards grants of between £20,000 and £150,000 to support the recognition, invention, development, implementation and diffusion stages of the innovation process. The HIF selects grantees on the basis of a variety of criteria designed to achieve a robust representation of the range of activity in humanitarian innovation.

The case study subjects are chosen to reflect innovation practice in the humanitarian system. They cover information communication technology (ICT) innovations and non-ICT innovations, and they offer a balance between innovations that have reached a diffusion stage and those that have not. They also reflect the wide geographic range of the areas where innovations are being trialled and implemented. (For more information on the methodology and criteria used to select case study subjects, see the forthcoming 'Synthesis report' for the case study series).

About HIF-ALNAP research on successful innovation in humanitarian action

These case studies are part of a broader research partnership between ALNAP and Enhancing Learning and Research for Humanitarian Assistance (ELRHA) that seeks to define and understand what successful innovation looks like in the humanitarian sector. The ultimate aim of this research is to improve humanitarian actors' understanding of how to undertake and support innovative programming in practice. This research partnership builds on ALNAP's long-running work on innovation in the humanitarian system, beginning with its 2009 study, *Innovations in International Humanitarian Action*, and draws on the experience of the HIF grantees, which offer a realistic picture of how innovation actually happens in humanitarian settings.

Innovation is a relatively new area of work in humanitarian action, yet it is one that has seen exponential growth in terms of research, funding and activity at both policy and programming levels. While the knowledge base around innovation in the humanitarian sector is increasing, there remain a number of key questions for humanitarian organisations that may be seeking to initiate or expand their innovation capacity. The HIF-ALNAP research has focused on three of these:

Primary research questions

What does successful humanitarian innovation look like?

What are the practices organisations can adopt to innovate successfully for humanitarian purposes?

Secondary research question

What are the barriers to innovation in the sector and how can they be mitigated?

The case studies will be used to produce a synthesis document that addresses these three questions. The outputs of this research are aimed at humanitarian organisations interested in using innovative practices to improve their performance, as well as organisations outside the humanitarian sector, such as academic institutions or private companies, seeking to engage in innovation in humanitarian action.

1. About this case study

Organisation	International Federation of Red Cross and Red Crescent Societies (IFRC)
Partners	Madagascar Red Cross; Somali Red Crescent; Uganda Red Cross; AFRIPads
Project	Improving Menstrual Hygiene Management in Emergencies

Grant	Start date	Grant period	Total HIF budget	Location
Implementation	1 October 2013	18 months	£125,137	Somalia; Madagascar; Uganda

IFRC is the world's largest volunteer-based humanitarian network.¹ It is a coordinating body, supporting and promoting the work of its 189 member National Societies around the world. Each National Society is formed of volunteers and staff members who provide a range of services to address both immediate and long-term needs. IFRC, National Societies and the International Committee of the Red Cross (ICRC) together constitute the International Red Cross and Red Crescent Movement. This unique structure presents distinct opportunities and challenges for innovation.

This case study explores IFRC's innovation process in developing and testing a comprehensive relief item to meet more effectively and appropriately the menstrual hygiene needs of women and girls in emergencies.

To address the multifaceted nature of menstrual hygiene management (MHM), grantees used a kit-based approach, including appropriate sanitary and hygiene items along with training for staff and information for beneficiaries. They developed two MHM kits – one containing disposable pads (Kit A) and the other reusable pads (Kit B) – with the aim of comparing the two. In addition to sanitary pads, each kit contains a selection of additional items needed to effectively and hygienically manage menstrual flow, such as underwear, soap and a bucket and educational materials.

An initial trial of the kits was developed in Burundi in 2012, supported by the Norwegian, Netherlands and British Red Cross Societies. In 2013, three additional pilots were initiated in Madagascar, Somalia and Uganda with funding from the Humanitarian Innovation Fund (HIF), with the aim of testing the kits in a wider range of locations.

One of the innovative aspects of the project is its focus on generating evidence on appropriate MHM interventions and the use of participatory methods to achieve this. Kit contents were developed through ongoing consultation with the women and girls who would be their users. The kits and

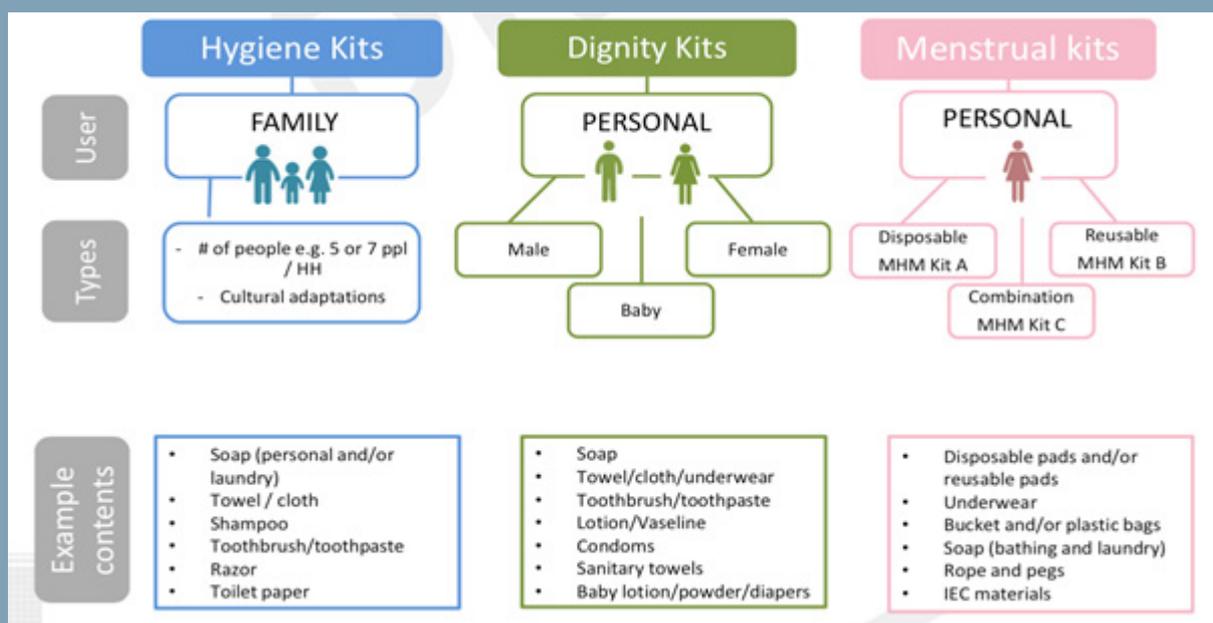
accompanying educational materials have thus evolved over the trials in response to emerging findings from focus group discussions (FGDs) and surveys with beneficiaries in each location. For example, following FGDs in Somalia, a third type of kit (Kit C) containing both reusable and disposable pads was developed to account for seasonal variations in water availability.

Once the trials are completed, detailed specifications for MHM kits will be included in the Red Cross/Red Crescent (RC/RC) Emergency Items Catalogue (EIC), an open-source resource. These will be available to guide humanitarian actors to effectively address MHM needs in new contexts.

A key strength of this innovation process is the effort grantees have made to understand and incorporate the varying needs and preferences of beneficiaries and to seek their feedback on the products provided. Their findings reinforce the need for a multifaceted approach to MHM by humanitarian actors, encompassing not only sanitary pads but also a range of additional products, amendments to infrastructure and information to better meet women and girls' menstrual hygiene needs. However, so far, the extent to which this learning has been shared and translated into changed practice is limited.

This case study is based on a review of project literature and nine interviews with project staff, partner staff, advisors and wider stakeholders across the humanitarian sector over a period of two months in 2015.

Figure 1: IFRC Guidance Note on Hygiene, Dignity and MHM Kits



2. The Problem

MHM refers to a range of interventions that enable women and girls to manage their monthly menstrual flow safely, privately and hygienically.² Women and girls in lower-income settings face significant challenges in managing menstruation.³ These challenges are exacerbated in emergencies.

Disasters and displacement can disrupt usual coping strategies and support structures, including access to sanitary protection materials and proximity to friends and family members who can offer advice. Close, crowded living environments, inadequate financial resources and lack of water pose additional challenges.⁴ Cultural factors also influence how menstruation is managed in an emergency setting. Many cultures have different practices for managing menstruation as well as restrictions on the actions and interactions of menstruating women and girls.⁵ This can prevent discussion and engagement with menstruation, shape or limit coping strategies and enhance vulnerability.

Effective MHM in emergencies therefore requires an interdisciplinary, multifaceted approach, encompassing culturally appropriate sanitary materials, latrines and bathing areas designed with women's safety and menstrual hygiene needs in mind, appropriate means of disposal or care of used sanitary materials, including space for washing and drying reusable pads, and relevant information on managing menstruation.⁶ The context-specific nature of menstrual hygiene means consulting beneficiaries about their practices, preferences and priorities is crucial.

Risks associated with inadequately addressing MHM include a loss of dignity, greater vulnerability to gender-based violence (if women must wait for dark to change pads), risk of irritation and infection and risk of dropout of girls and women from education, employment and other activities.⁷

Until recently, the humanitarian response community has neglected the complex menstrual hygiene needs of women and adolescent girls. When such interventions are used, the approach to MHM has typically been to distribute disposable pads as part of its household hygiene kits. Kits are generally distributed to households, without adjustments to the number of menstruating females.⁸

In addition, there is limited research on MHM in emergencies, beneficiaries' perspectives on their needs in differing contexts and the relief community's response.⁹ This is against the backdrop of a significant absence of accountability to, and dialogue with, women and girls in affected populations.¹⁰ While recent years have seen rapidly growing attention to menstrual hygiene in development settings and, to a lesser extent, in emergencies, no humanitarian agency has developed and field tested a comprehensive relief item specifically for menstrual hygiene management.¹¹

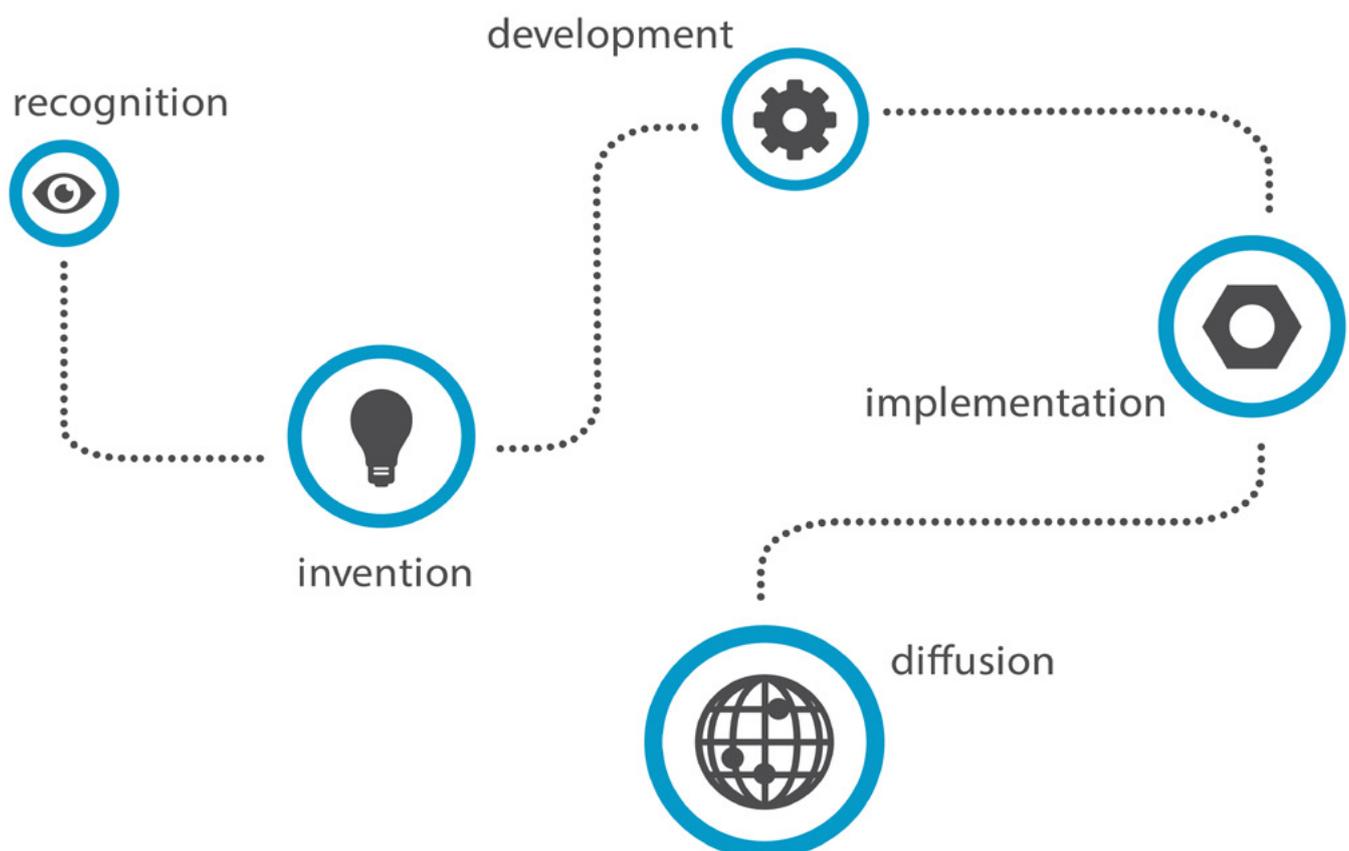
3. The innovation process

The stages through which successful innovations progress are often unpredictable and dynamic in nature, but there are often similarities. It is therefore useful to understand this innovation process when trying to capture why particular innovations succeed or fail.

There are various models to describe the innovation process, but HIF uses a model based on five stages:

- **Recognition** of a specific problem, challenge or opportunity to be seized
- **Invention** of a creative solution or novel idea that addresses a problem or seizes an opportunity
- **Development** of the innovation by creating practical, actionable plans and guidelines
- **Implementation** of the innovation to produce tangible examples of change, testing it to see how it compares with existing solutions
- **Diffusion** of successful innovations – taking them to scale and promoting their wider adoption

These five steps provide a useful archetype for the innovation process and are used in the HIF case study methodology. But they come with the caveat that innovation is complex and non-linear, and that identifying deviations from this model is just as important as (and possibly more so than) confirming the applicability of the model itself. The HIF-ALNAP case studies will seek to map in greater detail the chronology of these stages and how they overlap and interact for each HIF grantee.



3.1 Recognition



Within IFRC, answering the need for a more appropriate and effective response to menstrual hygiene has been a long and gradual process. Evaluations of the IFRC's response to the 2005 earthquake in Pakistan highlighted issues with the cultural appropriateness of its hygiene kits. Complaints were made about the sanitary pads distributed, which were unfamiliar and poorly suited to beneficiaries' needs and practices.¹² Similar messages emerged in evaluations of subsequent responses.¹³

During this time, a broader recognition of MHM issues was slowly growing within IFRC and across the humanitarian sector. The issue was increasingly recognised by National Societies and fed up to headquarters.¹⁴ It also arose at global Water, Sanitation and Hygiene (WASH) cluster meetings¹⁵ and was acknowledged by different departments, including WASH and disaster management.¹⁶ Acceptance of the need to engage with MHM was therefore 'both bottom up and top down [...] a real collaboration'.¹⁷ It was important throughout the innovation process that this came from all levels, as it encouraged buy-in to the idea across IFRC and interest from humanitarian partners.

However, it was also crucial that the idea had a 'champion' at the level of headquarters, which helped propel the idea from recognition to invention. Libertad Gonzalez had worked in the WatSan department at IFRC for a number of years and believed it would take substantive evidence from the field to change IFRC's approach to menstrual hygiene. Libertad's motivation was key,¹⁸ giving momentum to the innovation process in a large organisation that can be slow to change. William Carter, Senior Water and Sanitation Officer for IFRC, recalls that, 'Someone saying this needs to be something that we do, and we need to do it right – that was very critical.'¹⁹ It is indicative of the barriers to change that, despite the messages emerging from evaluations and feedback from beneficiaries, it took a champion within the organisation several years to catalyse this innovation.

This innovation is set within this context of growing engagement with MHM in humanitarian and development settings. Each edition of the Sphere Minimum Standards for Humanitarian Response has included increasingly detailed material relating to menstrual hygiene, with attention to sanitary materials, disposal methods and appropriate infrastructure, plus the need for consultation with local women.²⁰ In 2012, WaterAid published a 'menstrual hygiene matters' toolkit, drawing on the experiences of a wide range of practitioners and researchers, including a chapter on menstrual hygiene in emergencies.²¹ Attention by humanitarian actors is thus increasing, although the scale and efficacy of the response varies significantly.²² William Carter commented, 'I've [worked in WASH] for 15 years and I've never seen a topic go from zero to what we have now with MHM.'²³

3.2 Invention



Libertad Gonzalez attended an emergency environmental health forum in London in 2012, where she learned about a study on MHM in emergencies, commissioned by the UN Children's Fund (UNICEF).²⁴ The objectives of this were to understand how humanitarian emergencies affect normal MHM processes and the needs of women and girls in emergencies, in order to inform UNICEF's approach. Timothy Hayden, a consultant for UNICEF, collected data through FGDs in Somalia, Haiti and the Philippines in 2012. His findings highlighted the need for a multifaceted approach to MHM, including a range of sanitation and hygiene items, gender-sensitive sanitation facilities, access to water in a private location, information on menstrual hygiene and appropriate communication and distribution systems. The study also highlighted the need to strengthen coordination mechanisms between stakeholders and improve consultation and feedback with beneficiaries.²⁵

Gonzalez reached out to UNICEF. UNICEF was open about its learning and shared its research protocols and other tools, which the IFRC team later used as examples to inform the development of its own research protocols. Taking the time to coordinate with other actors at this stage was important; it helped ensure the innovation built on existing research, rather than replicating it.

Another key event in the invention of this innovation was that AFRIPads – a social business in Uganda producing reusable sanitary pads – sent a sample of its pad, unsolicited, to IFRC in Geneva. This arrival inspired confidence in Libertad Gonzalez and the team in Geneva that they would be able to find the items needed for their kits²⁶ and helped them visualise the innovation.²⁷

While the innovation itself had been trialled by other agencies and was not highly novel, the testing of the product and engagement of end users to develop it was new: no other humanitarian agency had tested a comprehensive relief item specifically for MHM.²⁸ Gonzalez decided to initiate an operational research project, through which they could field-test the appropriateness of menstrual hygiene items available in local or regional markets, packed in a kit format ready for deployment.²⁹ The idea was that, following field-testing, an individual menstrual hygiene kit would be incorporated into the RC/RC EIC. Gonzalez wrote a concept note proposing the trials and secured funding from the British, Netherlands and Norwegian Red Cross Societies.

Box 1: The Red Cross/Red Crescent Emergency Items Catalogue

The EIC is an online, open-source catalogue established by IFRC and the ICRC, with support from National Societies.

Its aim is to ‘standardize and harmonise the selection and procurement of relief items during emergency operations’.³⁰ It currently lists over 2,500 standard commodities, providing product specifications, information and assistance for use by National Societies and other humanitarian actors.

The most recent review of the catalogue took place in 2008. The IFRC WatSan team took this opportunity to integrate recommendations for a more culturally sensitive hygiene kit into the catalogue. Information was added to the ‘Hygiene Products’ page, suggesting that hygiene kits – including menstrual hygiene products – be distributed in a second-round distribution, following consultation with the affected population. However, the only menstrual hygiene-related items currently listed in the catalogue are disposable sanitary napkins. The grantees recognised this limited entry did not reflect the diverse elements required to effectively address menstrual hygiene needs.

The pilot projects were therefore intended to help produce detailed, evidence-based specifications for a personal MHM kit that could be included in the RC/RC emergency catalogue.



Photo: Demonstration and training to Red Crescent volunteers in Somalia. Credit: IFRC/Somalia Red Cross

3.3 Development



After funding was secured, Libertad Gonzalez handed the management of the project over to the IFRC's East Africa Regional WatSan Unit, which was to implement a field-test together with the Burundi Red Cross. This reflects the decentralised structure of IFRC. IFRC works with and through National Societies – such as the Burundi Red Cross – but National Societies are independent of IFRC. From the development stage onwards, role of headquarters in this project has primarily been as a 'knowledge-broker': sharing information about the trials between IFRC and National Societies. The day-to-day management of the project was undertaken by IFRC's regional office in Nairobi and by the relevant National Societies. Libertad Gonzalez maintained a supportive role until she left IFRC; at this early stage in 2013, support of the project at the level of headquarters was transferred to IFRC's senior WatSan officer in Geneva.

Objectives, agreements and plans were developed collaboratively between Chelsea Giles-Hansen, the regional WatSan delegate, and the Burundi Red Cross. A camp for Congolese refugees was selected as the location for the trial in early 2013.

IFRC built opportunities for learning into the process from the outset, with a focus on learning from the women and girls themselves.³¹ At the development stage, FGDs and a baseline knowledge, attitude and practices (KAP) survey were conducted by the Burundi Red Cross with support from Giles-Hansen in order to understand existing MHM practices and preferences of women and girls in the camp. IFRC ensured the discussions covered training, information, washing, drying and storage of items, as well as the pads themselves. The contents of the MHM kit were developed on the basis of the findings.³² The kits were thus co-created with significant input from potential end users.

3.4 Implementation



The Burundi Red Cross distributed the kits to 2,000 women and girls. Red Cross volunteers conducted one- and three month-follow-up surveys and further FGDs, gathering feedback from beneficiaries on the performance of the kits and on their impact on hygiene, knowledge and dignity. Key informant interviews (KIIs) were also conducted with camp management officials, the health clinic nurse and women's group leader.

While no outcome targets were set for the trial, results were positive: there were reductions in infections and irritation and respondents reported improvements in confidence and dignity. The reusable kit received higher satisfaction rates than the disposable one. The results were seen as establishing the potential of the MHM kits.³³

The overall recommendation from the Burundi trial was that, given the complex and deeply cultural nature of MHM, further field-tests were needed in different emergency and cultural contexts before specifications could be added to the EIC.³⁴ Vinay Sadavarte, Regional Water and Sanitation

Coordinator in Nairobi, illustrates how these findings influenced their plans, stating, “The Burundi project told us we needed to do more learning, and that’s why we scaled up with funding from the HIF, to do this in three countries with very specific selection criteria.”³⁵ Crucially, the team took the time to capture and document key lessons learnt from the Burundi pilot. They identified potential improvements to the kits, the training and the information, education and communication (IEC) materials and to the distribution and research processes.³⁶ A member of the team in Nairobi travelled to Burundi at the end of the pilot to see what could be improved on in the implementation process itself: ‘His job was to go there, talk to people and see how we could do things better.’³⁷ He also spoke to actors in the Nairobi office, including the logistics team. A learning table was completed, with recommendations for improving procurement, distribution, FGDs and monitoring surveys.³⁸

IFRC placed an application to the HIF in October 2013 in order to conduct additional field-level trials in Madagascar, Somalia and Uganda, locations chosen for their distinct culture and context – rural and peri-urban in Somalia, refugee camp/settlement in Uganda and rural, remote and cyclone-prone in Madagascar.³⁹

The regional office shared lessons learnt in the Burundi pilot with National Societies in Madagascar, Somalia and Uganda. IFRC provided draft FGD guidelines and KAP survey questionnaires to the National Societies, which were then revised and made context-specific by IFRC and National Society staff. Each National Society then conducted baseline FGDs and KAP surveys in August and September 2014 in order to understand menstrual hygiene practices and preferences. The findings of the FGDs and KAP surveys were used to finalise the contents of the kits and the IEC materials in each location. This meant that, although recommendations from the Burundi pilot informed the scale-up, the contents of the kits were primarily based on locally relevant, context-specific information.

For example, in Somalia, initial research revealed the impact of seasonal water scarcity on MHM practices and preferred items and, as a result, an MHM Kit C was developed, containing both reusable and disposable pads.⁴⁰ Female genital mutilation (FGM) is common in this context. FGM restricts menstrual flow, causing menstruation to last for seven or eight days instead of four or five. It also causes pain, swelling and infection.⁴¹ As a result, additional pads must be provided.⁴²

There were significant delays in the implementation of the project, for a number of reasons. It took several months to finalise the project agreement between IFRC and the HIF. In addition, the project lead in IFRC’s regional office in Nairobi left IFRC, and there were delays in the recruitment of a replacement. Management of the project was taken up by other members of the IFRC regional office. With key players in the innovation process leaving the organisation, and those remaining stretched across multiple projects, the project lost some momentum.

MHM kits were developed and procured for all three locations, and were distributed by National Society volunteers in April-May 2015. The one-month post distribution survey was held in June-July 2015 and the three-month survey and FGDs in September 2015.

3.5 Diffusion



National Societies and the team in Nairobi have worked to ensure close communication and collaboration with other humanitarian actors throughout the innovation process. This has generated significant interest in the project at both national⁴³ and regional levels.⁴⁴ Information-sharing and discussion forums on MHM have been initiated in Nairobi, bringing together regional humanitarian WASH actors.⁴⁵

In addition, the WatSan Mission Assistant, an online platform hosted by IFRC, now features a dedicated page for MHM, featuring findings from the Burundi pilot, IEC materials in English, French, Swahili and Kirundi and links to relevant articles.⁴⁶ A training module on MHM has been developed for IFRC national and regional disaster response teams,⁴⁷ which has helped generate interest within National Societies and IFRC.⁴⁸

Some key diffusion-related activities are still outstanding, including the incorporation of MHM kits into the EIC.⁴⁹ It is envisaged that RC/RC Societies and other humanitarian actors will be able to use the specifications in the EIC catalogue, combined with evidence generated through the pilots, to adapt the MHM kits to their own context.⁵⁰ However, there are examples of further application of the MHM kits and the participatory methodology in the East Africa region: as part of the current Rwanda emergency appeal activities, participatory FGDs are being conducted in late 2015/early 2016 in the Mahama refugee camp prior to MHM kit distribution.

4. Was this a successful innovation process?

Inherent in all innovation processes is some degree of failure. This presents a challenge to understanding what contributes to a good innovation process: even successful processes will experience difficult pilots or setbacks in design or diffusion. The HIF-ALNAP research on innovation processes therefore distinguishes between a good innovation – an output of an innovation process that leads to measurable gains in effectiveness, quality and efficiency – and a good innovation process. This research defines a successful innovation process through three criteria:

Table 1: Criteria of success for innovation processes

Increased learning and evidence	There is new knowledge generated or an enhanced evidence base around the problem the innovation is intended to address, or around the performance of the innovation itself.
Improved solution	The innovation offers a measurable, comparative improvement in effectiveness, quality, or efficiency over current approaches to the problem addressed by the innovation.
Adoption	The innovation is taken to scale and used by others to improve humanitarian performance.

Evidence collected for this case study was used by the research team to assess the success of the IFRC MHM innovation process against the above three criteria. Overall, this process was highly successful in increasing evidence and learning and moderately successful in creating an improved solution. As a number of key diffusion activities – such as inclusion in the EIC – are still outstanding, it is too early to assess success in adoption, but current resourcing for diffusion of the kit itself is weak and reliant on National Societies choosing to purchase the kits for their programming. It is also unclear whether there are further plans to diffuse the participatory operational research methods that formed one of the innovative aspects of this project. Specifically, findings were as follows:

Increased learning and evidence

FGDs and KAP surveys at baseline and one and three months after distribution have fostered insights into menstrual hygiene practices and preferences in four diverse contexts, and into the relevance and effectiveness of a range of components of menstrual hygiene kits. This represents an important contribution in a sector in which evidence from the field, particularly on women and girls' views and preferences in different contexts, is lacking.

Findings have reinforced key messages arising from existing research on MHM in emergencies,⁵¹ including, most notably, that MHM is complex and multifaceted, and an appropriate and effective response requires much more than the distribution of sanitary pads – which is the current approach of many agencies. Additional items (such as a bucket, rope and pegs for washing and drying pads), as well as information on managing menstruation, changes to infrastructure to enable safe and private spaces for MHM and consultation with women and girls in each context, are all crucial. Although

this message is not new, IFRC has been the first to conduct operational research with field-tests in a range of locations, thus offering new data on the performance of different materials and insights into the preferences and views of women and girls in emergencies. Findings from the Burundi pilot, along with IEC materials for disposable and reusable pads, are freely available on the WatSan Mission Assistant wiki.⁵² The interagency information-sharing and discussion meetings on MHM in Nairobi, organised by IFRC, have generated interest in the project among regional humanitarian actors and the sharing of activities and learning.

The project has also encouraged learning and discussion around menstrual hygiene within IFRC.⁵³ Pre- and post-tests at training sessions demonstrate improvements in National Society participants' MHM-related knowledge. The Uganda Red Cross has been incorporating MHM into programming in other camps. Vinay Sadavarte says, 'They piloted and designed sanitary pads and latrine facilities and bathing facilities that will have a menstrual hygiene compound included [...] and this was coordinated by a male officer, which I'm proud of!'⁵⁴ Furthermore, national RC/RC staff report evidence gathered through the trials has helped build credibility with government agencies and other stakeholders.⁵⁵



Photo: A joint community sensitization on MHM by Uganda RCS and UNHCR in a refugee camp. Credit: IFRC/Uganda Red Cross

Improved solution

Findings from the Burundi pilot were promising: 88% of beneficiaries said they were very satisfied with Kit B (reusable) and 68% were very satisfied with Kit A (disposable). 99% of respondents said they found the education session provided during distribution useful.⁵⁶ After three months, significant improvements in dignity and confidence were reported, including women not being afraid anymore of standing up in church, going to the market or travelling on buses during their period, adolescent girls feeling able to go to school during their period and reduced costs.⁵⁷

Results from KAP surveys conducted in Madagascar and Somalia demonstrate some improvements from the baseline in relation to knowledge, dignity and hygiene. The number of women reporting feeling uncomfortable or afraid of leakage fell from 59% to 40% after three months. The findings also highlighted that effectively addressing MHM requires provision of appropriate infrastructure, including safe and private spaces for maintaining hygiene and washing and changing pads.

In Somalia, 81.7% of respondents said they were 'very satisfied' with MHM Kit C (combining washable and disposable pads) three months after distribution. There was a decrease in the number of women and girls suffering from irritation or itching, from 19% at the baseline to 0% one month after distribution. There was an increase in preference for washable over disposable pads, from 11% preferring washable pads at the baseline to 73% one month after distribution. This preference fell slightly to 67% three months after distribution. In the three-month follow-up survey, 10% of women and girls said they would not continue to use reusable pads owing to lack of water and soap, the time required to wash and dry the pads and a lack of private places for drying.

Differences in preference for washable or reusable pads between the three age groups were observed in each location. In Uganda, for example, 19% of 12-17 year olds reported a preference for washable pads at the baseline. This fell to 14% three months after distribution. However, among 18-34 year olds, preference for washable pads increased from 15% to 46%; among 35-50 year olds, it increased from 21% to 59%. FGD and KAP survey responses suggest women saw washable pads as a more sustainable, long-term option, whereas adolescent girls found the process of washing and drying the pads more difficult to manage alongside their daily routine.

In each location, FGD participants raised a number of ways the content of the kits could be improved and better tailored to their needs, emphasising the importance of post-distribution follow-up. However, overall, the MHM kits were well received by pilot participants, with positive impacts recorded in relation to health, knowledge and dignity. In addition, National Society staff involved with distribution and monitoring reported the kits were a significant improvement over the status quo approach to MHM issues.

While the trials are generating useful information on end user needs and preferences in specific contexts, the provision of kits – whether inclusive of disposable or reusable pads – is not novel, and the trials have not explored the comparative benefits of distributing individualised kits versus household kits. Therefore, this innovation was determined to be a 'moderate' success with respect to creating an improvement over alternative practices. According to key informants, this innovation is best seen as one contribution among many similar ones by other agencies seeking to develop an evidence base and heightened attention for MHM issues in emergency and humanitarian settings.

Adoption

Recent years have seen an escalation of interest in MHM in humanitarian settings, and a number of actors are now experimenting with new approaches to more effectively meet the menstrual hygiene needs of women and girls in emergencies. This has created an enabling environment for the adoption of MHM kits, although, in this context, the extent to which the MHM kits developed by IFRC appear innovative is somewhat reduced.

It is too early to assess the strength of this as a diffusion strategy, and it remains to be seen whether results from the pilots are effectively communicated within and beyond the RC/RC movement. However, there are a number of factors that may influence adoption and diffusion, including a lack of staff capacity dedicated to the project at the level of headquarters. At present, there are no plans in place for repeat distributions, despite demand from recipients. National Societies and regional staff are now considering ways they could support women and girls to make their own sanitary protection materials or to establish small businesses to more sustainably meet their menstrual hygiene needs.

As a promising sign for wider adoption, MHM kits are now being written into RC/RC emergency response plans and distributed in Sudan, Tanzania and Nepal, and in a second location in Somalia. FGDs have been conducted in each location to determine the contents of the kit. One of the strengths of this innovation process has been the level of engagement with beneficiaries through FGDs and KAP surveys, both in the development of the kits in each location and in post-distribution follow-up. It remains to be seen whether this level of consultation and adaptation will be maintained as the kits are adopted in new locations.

Over the course of the pilots, some information has been shared at a national and regional level through IFRC and National Societies' coordination with other actors. The primary activity intended to enhance adoption – the inclusion of the MHM kits in the EIC – has not yet taken place. Grantees hope including a standard, field-tested description of a personal MHM kit in the EIC will lead National Societies and other humanitarian actors to adopt the kits and adapt them to their local context.

5. What are we learning about innovation?

Drawing on research from the humanitarian sector and beyond, including previous case study material, HIF has identified a range of factors generally held to be fundamental to successful innovation processes. An important part of the case study research lies in testing, through the experience of the HIF grantees, the extent to which these propositions hold true in humanitarian settings.

- **Managing relationships and setting common objectives**

Innovation always involves multiple actors – partners, implementers and end users – all of whom can change over the different stages of an innovation process. Assigning specific time and resources to managing these relationships and ensuring common objectives across the different stakeholders of an innovation will contribute to a successful innovation process.

- **Dividing tasks and responsibilities**

Given the complexity of many innovation processes, a clear division of tasks and responsibilities between individuals and organisational units is important for developing a successful innovation.

- **Resourcing an innovation**

Working in innovation requires flexibility to deal with the unknown, and this is particularly so with an innovation in the humanitarian sector. Budgets and resource plans therefore need to be suitably flexible to accommodate several possible outcomes (e.g. the need for further trials) as well as likely deviations from the original plan.

- **Flexibility of process**

At its heart, managing an innovation process is about creating space for flexibility. Processes featuring flexible timelines, feedback loops for adaptation during the piloting phase and individuals resourced to execute changes in response to emerging results will be more likely to succeed.

- **Assessing and monitoring risk**

Innovation processes in humanitarian action need to have an appropriate relationship to risk. We expect processes will be more likely to produce improved solutions and achieve uptake when they include an assessment of the different risks that might have an impact on the effectiveness of the innovation, as well as a strategy or plan to monitor and adjust development in light of changes in these risks on an ongoing basis.

- **Drawing on existing practice**

Knowledge of existing practice and experiences is expected to contribute to more effective innovations through a better understanding of past attempted solutions, an accurate initial understanding of the problem or opportunity addressed by the innovation and an awareness of potential users and their needs.

Findings for these six propositions are presented in the graphics on the next few pages.

Managing relationships and setting common objectives

How this factor worked in this case study

IFRC adopted a collaborative approach, with National Societies developing and implementing the projects in each country, with support, training and technical expertise provided by the regional office. IFRC allocated a focal person in Nairobi to oversee the project and manage communication with National Societies. Strong relationships between the regional office and the implementing National Societies were fostered through regular communication and visits. Objectives were agreed with National Societies and set out in MOUs at the outset.

Those implementing the project worked closely with other agencies at both national and regional levels. This was largely facilitated through existing relationships and structures.

Challenges

During the early stages of the three scale-up pilot projects, the focal person in Nairobi left the organisation. There were subsequent delays in recruiting a replacement, which, in turn, caused delays to the implementation of the project.

Feedback was gathered from end users through FGDs and KIIs at key stages in the project. However, there are indications that more needed to be done to explain to recipients that the project was only a pilot and to manage expectations about future kit distributions.

How this factor related to the performance of the innovation process

The presence of a focal person for the project in Nairobi who would manage relationships with National Societies helped drive the project forward. The loss of this person delayed implementation of the project.

Regular communication between the regional office and National Societies has helped make the project a collaborative effort in the early stages: interviewees identified close relationships between the national and regional offices as being a key strength of the project.⁵⁸

‘I do a lot of visits to the site, to show you really are involved in the project, and then they will feel like this is a partnership, it’s not just the society that is doing the project.’

George Mugambi, Regional WatSan Officer.

Resourcing an innovation

How this factor worked in this case study

IFRC secured funding for the first pilot from National Societies. Funding received from the HIF enabled IFRC to conduct an additional three pilots. Diffusion to other countries has been facilitated by National Societies securing their own funding and working MHM into their existing emergency response plans.

Challenges

Funding was intended solely for implementation of the pilot projects, which were limited in scope. However, there were hopes in the communities that they would reach more people⁵⁹ or conduct subsequent distributions. The fact that there were limited resources available owing to these being pilot projects could have been better communicated.

Insufficient resources and staff turnover have led to limited staff capacity at both headquarters and in the regional office in Nairobi. As a result, there is no dedicated, full-time focal point for the project in either location, and those involved must balance the MHM project with other, competing, demands.

How this factor related to the performance of the innovation process

The availability of funding enabled IFRC to conduct field-tests in four contexts; delays in securing funds had clear and direct impacts on the timeline of the project. IFRC's success in securing funding was driven by the motivation and enthusiasm of individual staff members, who helped move the project forward.⁶⁰

Questions remain about future resourcing of the innovation, in terms of both staff capacity/availability to move the project forward and disseminate findings, as well as financial resources for future distributions. At present, there is no funding for future distributions in the pilot locations, which has negative implications for wider *adoption* of the kits.

'It's a role that deserves a full-time position [as focal person for the project]. There's so much on [...] stuff moves a lot faster when someone dedicates their time to it. We're hoping that early next year we'll get the resources internally to allow us to move that forward.'

William Carter, Senior Water and Sanitation officer for IFRC.

Dividing tasks and responsibilities

How this factor worked in this case study

Given the complexity of many innovation processes, a clear division of tasks and responsibilities between individuals and organisational units is important for developing a successful innovation. Tasks and responsibilities were divided according to IFRC's existing structures and usual practice. There is very little 'command and control'⁶¹ within IFRC (i.e. National Societies are fairly independent). This meant piloting the innovation depended on buy-in from National Societies.

National Societies had space to develop the field-tests in a way they thought would work in their context, with support and guidance from IFRC. The pilots were implemented by national RC/RC staff and volunteers, who know the local language and context.⁶² The regional office provided resources, feedback and additional information where required.⁶³

Although at a regional level the project sits with the WASH team, the latter has worked closely with the regional disaster response team.

Challenges

The rotation of volunteers in the Burundi pilot meant different volunteers conducted data collection at each stage; this therefore required repeated training, and may have compromised data quality.⁶⁴

How this factor related to the performance of the innovation process

The way responsibilities were divided contributed to the success of the project in a number of ways. Having a focal point in Nairobi to lead the project and manage communication with National Societies helped move the project forward.⁶⁵ Coordination between two departments meant the project benefited from the expertise and insights of both the WASH and the disaster response teams.⁶⁶

Ownership by National Societies has been conducive to the progression of the innovation. There was significant enthusiasm among National Societies about the pilots,⁶⁷ which has enhanced the momentum behind the innovation process. National Societies also built on their existing relationships with other partners in pilot locations (e.g. other humanitarian agencies and governments) to ensure communication and collaboration.⁶⁸

Activities were planned by those with good knowledge of needs on the ground.⁶⁹ This is particularly crucial in an innovation such as this, where the issue has such a strong cultural component.

Assessing and monitoring risk

How this factor worked in this case study

Little formal risk assessment was undertaken for the Burundi pilot, but risks were identified, discussed and managed as they came up through strong communication between team members and between the Nairobi and country offices, and by regular visits.⁷⁰ When the pilots were scaled up in three new locations, assessment of risks and assumptions was undertaken for the application to the HIF.

Challenges

One of the main risks foreseen was turnover of key staff; indeed, early project documents note the importance of retaining key staff throughout the project period.⁷¹ However, this was not sufficiently mitigated for. When the focal point for the project in Nairobi left, there were delays in the recruitment process, leading to delays in implementation of the project.

How this factor related to the performance of the innovation process

IFRC identified lack of community acceptance as a significant risk. This was mitigated for by working closely with National Societies, which have greater sensitivity to culture and context, and through sensitisation and training alongside the project. Consultation with potential beneficiaries in advance of procurement and distribution also helped. These activities enhanced the relevance and cultural specificity of the kits distributed.⁷²

‘In Burundi, because we were piloting it and there wasn’t such a big lead in time, [risk management] was kind of done during the project. There was good communication between me and Vinay, and with the country office, so any issues that came up could be quickly dealt with. Also, having me and Sheila visit regularly helped to keep things on track.’

Chelsea Giles-Hansen, formerly Regional WatSan Delegate.

Flexibility of process

How this factor worked in this case study

This was very much a learning process. IFRC took an experimental approach, testing and refining the kits in a number of different locations. A detailed implementation plan was created at the outset of the project, but this left room for flexibility. Feedback loops between FGDs, KAP surveys and composition of the kits distributed were evident in a number of places, e.g. the decision to include plastic bags in the distribution in Somalia after it was found plastic bags were already widely used and to introduce a kit containing both reusable and washable pads to respond to seasonal changes in water availability.

Challenges

There were significant delays in the procurement of materials in both Somalia and Uganda. This had been anticipated and the timeline was sufficiently flexible to deal with this and other delays.

How this factor related to the performance of the innovation process

The flexibility of the process, in particular the use of strong feedback loops in the design of the intervention, were viewed as supporting the development of an improved solution, as well as enhancing learning and evidence.

‘I had interviews with the women in Madagascar, and they wanted to include a few things in the kit, e.g. most of the women need some undergarments because they felt like they were quite exposed. In Uganda, I noticed on the field visits that they were not using the ropes there. After further investigation I found out that the ropes were short, they usually use the ropes in addition for hanging the pads, to hang the clothes. So we will need longer ropes for that.’

George Mugambi, WatSan Officer.

Drawing on existing practice

How this factor worked in this case study

One of the strongest elements of this innovation was a significant amount of time was taken to understand the problem as the potential end users experienced it, and to develop a solution that met their needs.

Most notably, this came about through the FGDs and KAP surveys conducted in each pilot location. Time was taken to find out about existing practices, needs and preferences. The contents of the kit and the development of country-specific IEC materials were based significantly on this research.

In addition, project leaders had good understanding of existing practices. Key team members had worked in the WASH sector for IFRC for a number of years, and at a regional level they were also able to draw on the experience of colleagues in the disaster response team. They had an in-depth understanding of the problems associated with IFRC's approach to hygiene kits and of the issues arising from a lack of tailoring to culture and context, which informed development of the MHM kits.

Challenges

Those who conducted initial research and explored existing practice left the project. However, their learning had already been captured in key documents and built into the innovation process.

How this factor related to the performance of the innovation process

Project leaders reached out to and learnt from what was initially a small group of people already conducting research in this area. They incorporated existing knowledge into their plans, including work undertaken by Marni Sommer⁷³ and Timothy Hayden for UNICEF⁷⁴

This meant the pilots were able to build on, rather than replicate, existing practice. Both Sommer and Hayden identify the need for a multifaceted approach to MHM; the grantees took this learning and incorporated it into their pilot projects, which led to significant gains in the learning and evidence generated by the innovation.

Additional potential contributing factors

Having a high-level champion

How this worked in Improving MHM in Emergencies

Libertad Gonzalez, at the time Global Hygiene Promotion Advisor at IFRC, helped drive the innovation forward during the early stages by writing the concept note, securing funding and initiating the trial with the Nairobi regional office. William Carter, Senior Water and Sanitation Officer in Geneva, continues to champion the innovation, particularly by sharing information with National Societies.

Challenges

Libertad Gonzalez moved on from her position and, although William Carter continues to support the team, he is limited in the time that he can invest.

How this factor related to the performance of this case study's innovation process

Fostering change in such a large organisation can be a challenge; this project benefited from having advocates at the Geneva level from senior members of the organisation, who championed the innovation and provided some support (such as proof-reading funding proposals) but also gave the regional office and National Societies space to run with the project.

Effective problem identification

How this worked in Improving MHM in Emergencies

Although the idea itself came from Geneva, through Nairobi, to the National Societies, this is addressing a significant problem National Societies were already aware of. They were very enthusiastic about the innovation as they saw that it was addressing a need felt keenly in their areas.

Challenges

Early documentation does not include recognition of the problem among National Societies. That the innovation addresses a widely recognised problem seems to have emerged organically, rather than having been explicitly planned for.

How this factor related to the performance of this case study's innovation process

Buy-in from National Societies has been important in keeping the process moving, particularly given staff turnover. In addition, rapidly growing attention to MHM across the humanitarian sector helped create an enabling environment and contributed to diffusion.



Project leaders had good knowledge of their institutional environment

How this worked in Improving MHM in Emergencies

Project leaders had a deep understanding of the problem but also of the broader institutional environment they would need to influence if they wished to create change. They understood the barriers to innovation within such a large organisation, and that changing mindsets and practice would require incremental shifts, evidence and a champion.

Challenges

Staff turnover limited the extent to which the innovation was ‘championed’, thus causing it to lose some momentum.

How this factor related to the performance of this case study’s innovation process

There is a clear pathway to the adoption of the MHM kit within IFRC, as, once the pilots are completed, it will be incorporated into the EIC. This has been made possible through the pilots, which provide the evidence required to facilitate a change to the catalogue.⁷⁵

6. Emerging lessons for best practice in innovation

- Great ideas come from diverse sources, at all levels (from senior management to affected people), both within and outside the humanitarian sector – reaching out and creating a network of interested individuals and organisations is crucial.
- There remain insufficient channels in humanitarian agencies for generating new innovations and projects based on the feedback and ideas of affected people.
- Having an emergency arise can be a ‘lucky’ opportunity to trial an innovation— however, humanitarian actors do not seem to spend sufficient time on understanding the risks posed to affected people when trialing innovations that involve direct engagement with affected people in a crisis.
- Managers, donors and many others outside the immediate project team have a significant role to play in creating a culture of experimentation, and enabling a flexible process.

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Other case studies from HIF and ALNAP on innovation

Understanding the performance of emergency feeding programmes

Using mobile voice technology to improve the collection of food security data

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Humanitarian Innovation Fund

ELRHA
1 St John's Lane
London EC1M

www.humanitarianinnovation.org

ALNAP

Overseas Development Institute
203 Blackfriars Road
London SE1 8NJ
United Kingdom
Email: alnap@alnap.org

www.alnap.org/innovation