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Improving Women's Opportunities to Succeed in the Workplace: Addressing Workplace Policies in Support of Menstrual Health and Hygiene in Two Kenyan Factories

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Abstract: Women globally experience challenges managing their periods, especially those living in environments that do not support adequate menstrual health and hygiene (MHH). For working women, these challenges may have critical implications for their health, well-being, and economic outcomes (e.g., earnings). As part of a larger initiative that sought to understand the relationship between MHH and women's economic empowerment, a policy analysis was conducted in two workplaces in Kenya to identify policy changes that would better support menstruating employees' MHH needs. Policy analysis findings were synthesized with relevant baseline research findings from the same study to generate policy recommendations for participating companies. Key findings revealed limitations in hiring and induction processes, employee classification, representation and voice, toilet access, sick leave, and supervisor codes of conduct, all of which affected menstruating employees. Recommendations included updating supervisor codes of conduct, increasing women's representation in union committees, and strengthening employee induction processes. Priority areas for policy changes were shared with companies' leadership, alongside technical assistance for implementation. Insight from two private-sector workplaces in Kenya offers guidance on how to identify relevant policy gaps and institutionalize policies and practices that promote adequate workplace MHH in pursuit of women's economic empowerment and improved business outcomes.

Keywords: menstruation; menstrual health and hygiene; menstrual hygiene management; workplace; private sector; women's economic empowerment; policy

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1. Introduction

1.1. Background

Women and girls all over the world experience challenges in managing their periods, especially those who live and work in environments that do not support adequate menstrual health and hygiene (MHH). For working women, these challenges may have critical implications for their health and general well-being, as well as for economic outcomes such as work attendance, performance, and earnings. Even the presence and conditions of toilet infrastructure may serve to attract and/or retain employees who menstruate by increasing employee morale [1]. MHH-related improvements in workplaces may not only improve conditions for menstruating employees but also for the companies that employ them.

MHH is defined by the United States Agency for International Development (USAID) as the ability of women, girls, and transgender and gender non-binary individuals who menstruate to manage their menstrual cycles in a safe, dignified, healthy, and supported manner throughout their lives [2]. Recognizing menstrual health as an emerging issue requiring clear parameters, Hennegan et al. defined menstrual health in 2021 as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in relation to the menstrual cycle" [3] (p. 2). The definition includes

several conditions required for achieving menstrual health for women, girls, and all people who menstruate, including the following: (1) access to accurate menstruation-related information; (2) ability to care for bodies during menstruation, including access to quality and affordable menstrual products and services; (3) access to quality health care for menstruation-related conditions; (4) a supportive environment in which menstruation is free from stigma and psychological stress; and (5) ability for autonomous decision making in participating in "civil, cultural, economic, social, and political" spheres of life without "exclusion, restriction, discrimination, coercion, and/or violence" as related to menstruation [3].

For MHH to be sustained in workplace settings, a systems approach is encouraged. Workplace policies that are sensitive to menstruating employees' needs (that, for example, promote equity, support employee needs, and consider MHH-related investments) may improve their MHH-related experiences at work by regulating the overall workplace culture. In contrast, an unsupportive workplace culture may unconsciously endorse practices and behaviors that place an undue burden on menstruating employees. Institutionalizing workplace policies that support MHH presents a systematic and sustainable approach to tackling menstruation-related challenges at work, advancing menstruating employees' economic potential, and growing business revenue streams.

Whereas the majority of menstruation-related programming and research efforts focus on school- and community-based outcomes, the effects of MHH on adult populations in workplace settings have been largely unaddressed in global efforts and undocumented in the literature [4]. Despite this dearth of research, a 2019 global review of the literature on menstrual hygiene management MHM (Menstrual hygiene management (MHM) is the term used in this publication and refers to a subset of USAID's holistic approach to menstrual health and hygiene (MHH)) and women's economic empowerment noted that women do face significant challenges managing their periods while at work [5]. The need to obtain permission to use toilet facilities while on the job, for example, may present difficulties for women in effectively managing their periods [6]. Additionally, poor MHM conditions (including, but not limited to, low toilet-to-employee ratio, lack of consistent running water, limited toilet paper supply) in the workplace may contribute to worker absenteeism and reduced productivity, among other possible detrimental outcomes for both women and their employers [7–9].

Findings from formative research conducted in Kenya further revealed the relevance of MHH in workplace settings. Many adult working women had limited knowledge about menstruation, generally, and how best to manage their periods at work, specifically. Social norms in the workplace fostered stigma and taboos related to menstruation, preventing menstruating employees from discussing with colleagues the challenges they faced. This silence around menstruation negatively affected women's workplace experiences. Many expressed feeling socially isolated in their menstrual experience, even though nearly all of their women colleagues menstruated monthly. Male-dominated workplaces further contributed to the silence of menstruation and related stigma. Women in these settings concealed menstrual needs to avoid derogatory remarks cast by male colleagues and to not appear as seeking attention. Moreover, access to menstrual products and MHH-friendly infrastructure was limited in the settings under study [10].

Public and private sector policy-specific evidence and learnings from documented literature reveal an association between the policy landscape and investment in MHH initiatives. Specifically, an adverse policy environment tends to limit support for improved MHH in a variety of settings, including private-sector entities [4,5,11]. To address such a limiting policy environment, organizations such as the International Labor Office (ILO), CARE Canada, Nepal's Red Cross Society, TheaCare, Columbia University, the International Rescue Committee (IRC), WaterAid, and Research Triangle International (RTI) have prepared manuals for workplace settings that include, among other content, MHH-sensitive workplace policies and programming guidance [1,5,12–17]. In the absence of globally rec-

ognized standards in workplace MHH, these documents lay the foundation for the general adoption of MHH principles and best practices in workplace settings.

The above-mentioned documents have yet to receive widespread attention from Kenya's private sector; however, the Government of Kenya (GoK) has recently prioritized MHH in its overall policy landscape. Strongly influenced by the internationally recognized Sustainable Development Goals (SDGs), Kenya's Constitution and Vision 2030, and a government-led situation analysis on MHM (The GoK has chosen to use the term MHM for its national policy and relevant nationwide strategies) in Kenya, the GoK released its first MHM Policy in 2020. The MHM Policy and its accompanying MHM Strategy display national-level interest and commitment to the issue of MHM and MHH. The policy focuses on establishing an effective enabling legal and regulatory environment for MHM; countering menstrual stigma, myths, and taboos; ensuring access to menstrual products, services (inducing disposal), and facilities; and establishing an effective monitoring, evaluation, and learning framework for MHM in Kenya [18]. Though the Ministry of Labor was not involved in the policy's development process, the policy makes considerations for institutional water, sanitation, hygiene, and disposal guidelines applicable to workplace settings. Following the release of the policy, the Ministry of Labour was tasked with developing guidelines on workplace MHM nationwide, as well as ensuring the provision of MHM materials and information in workplace settings. Until now, these guidelines have not been formalized. According to GoK stakeholders, workplace-focused policies need to be considered in future editions of the MHM Policy, and further evidence is needed to standardize the nation's approach in areas of MHM and MHH [10].

Gaps in the existing literature and emerging evidence from the above-mentioned few studies warrant the need for additional research and practice around MHH-related policies and workplace settings. Sommer et al. advocate for the rigorous uncovering of social and environmental barriers to managing menstruation at work in order to guide policymakers and the private sector, among others, in improving MHH for working women [4]. Integrated MHH efforts in workplace settings, specifically those that consider a cross-sectoral and systematic approach to MHH in the private sector, may advance women's economic empowerment and business outcomes [5].

1.2. Study Aims

Due to the need for evidence in these areas, including interventions specifically addressing MHH in workplace policies, the USAID Water, Sanitation, and Hygiene Partnerships and Learning for Sustainability (WASHPaLS) project partnered with two companies in Kenya and two companies in Nepal (by invitation of local USAID offices in these two countries) to better understand the relationship between improved MHH in workplace settings and economic outcomes for both women and the companies that employ them. The overall objective of the study was to determine if providing adequate MHH in the workplace contributes to improved business and social outcomes, including women's economic empowerment. Content in this article focuses specifically on the two company partnerships in Kenya, as the country and company contexts in this location contributed to distinct interventions and outcomes from the Nepal study. The overall action research activity also included a cost-benefit analysis to further document the linkages between MHH and economic outcomes.

Drawing on the outcomes documented in the global review of the evidence on workplace MHH and this review's suggested pathway of influence over time [5], the researchers hypothesized that improving MHH in the workplace would benefit both women and businesses. Figure 1 presents this pathway from the evidence review, which served as the conceptual framework for the overall study.

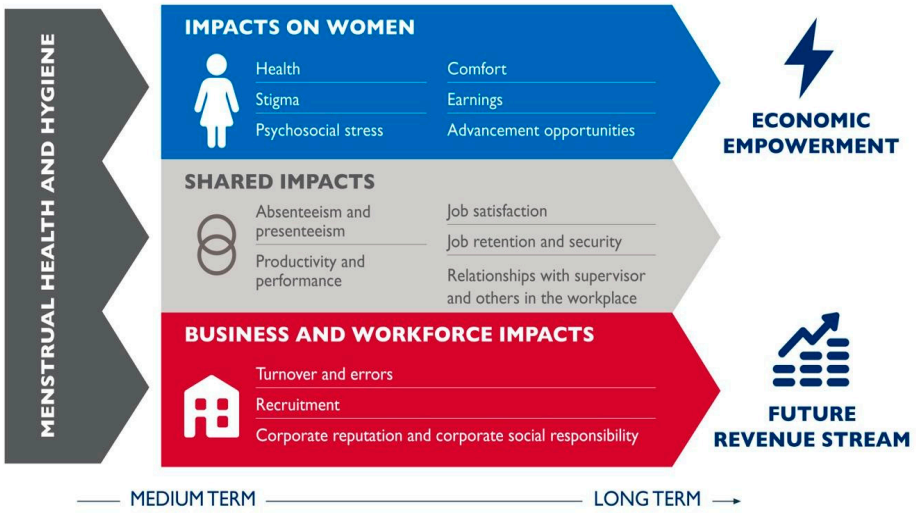


Figure 1. MHH in the Workplace Conceptual Framework.

As part of this overall action research initiative that sought to improve the MHH-enabling environment in two companies, a workplace policy analysis was conducted in both workplaces in Kenya. The focus of this paper is on the policy analysis process, a subset of the overall workplace MHH project. The objective of the policy analysis component of this study was to understand company-specific workplace policies and operational frameworks, as well as to provide technical, policy-specific recommendations to companies wishing to improve MHH in their workplaces.

2. Materials and Methods

2.1. Population and Setting

The project partnered with two private-sector companies based just outside Nairobi, Kenya. Partner companies were recruited based on the following inclusion criteria:

- Medium- or large-sized enterprise (100+ employees) in the formal sector, with multiple places of business/operations and a fixed/permanent workplace;
- Urban or peri-urban location;
- Minimum of 50 female employees per workplace;
- Majority of the female workforce has completed no more than secondary school and is not in professional/managerial positions;
- The workplace has accessible, single-sex toilets with adequate water supply; and
- The workplace does not have existing programs addressing menstrual hygiene management or women's economic empowerment initiatives.

The two companies selected both fit the inclusion criteria and expressed willingness to meet the study's requirements (i.e., access to worksite, workplace policies, select financial records, and employee groups during working hours for research and intervention components of the study). Workplace 1 was a Kenyan-owned garment manufacturer that produced finished products for export. This company employed over 250 staff at the time of the policy analysis, 80% of whom were women. Among managers and supervisors at Workplace 1, 3 men and 1 woman were senior managers, 4 men and 4 women were managers, and 11 men and 6 women were supervisors. Workplace 2 was a Kenyan-owned cloth manufacturer, procuring and selling primarily to the Kenyan market, with an interest to trade internationally in the future. Workplace 2 employed over 700 staff at the time of research, 10% of whom were women. The managing director at this company was a woman, but fewer women were represented in manager and supervisor levels compared to men: at Workplace 2, 7 men and 1 woman were managers, 10 men and 1 woman were assistant managers, and 18 men and 2 women were supervisors.

Workplace interventions were carried out at both workplaces seeking to improve MHH based on guidance from the literature [4,5] and formative research carried out by the project [10]. Intervention elements included products and infrastructure, workplace policies and guidance, and workplace culture. Specifically, the intervention provided menstrual products (i.e., disposable menstrual pads, reusable menstrual pads, menstrual cups, and underwear), supported small-scale infrastructure improvements (e.g., shelves in toilet stalls, hooks behind stall doors, and disposal posters in toilet facilities), recommended large-scale infrastructure upgrades (e.g., water taps in stalls for cleaning, consistent supply of running water, and toilet repairs), conducted policy analyses, facilitated MHH-sensitization sessions, and designed and procured behavior change communication materials to educate and promote positive workplace practices around MHH. This article specifically addresses the workplace policies and guidance element of the intervention, notably the policy analyses in two Kenyan companies.

The policy analysis process began at Workplace 1 in month three of the intervention and in month five at Workplace 2; the policy analysis and supporting technical assistance at each workplace was completed before month nine, or the conclusion of the workplace intervention. The policy analysis process for each workplace incorporated findings from baseline research (efforts conducted prior to the intervention launch) to best contextualize and draw meaning from the content explored in the workplace policies analyzed. Baseline and endline research activities were conducted as part of the overall study to compare changes that occurred as a result of the workplace MHH interventions at both factories. Baseline research that was applied in the policy analysis followed a mixed-methods design (i.e., quantitative surveys, including an infrastructure assessment, and qualitative interviews and focus group discussions) and collected data from women and men employees at both workplaces, as well as supervisors, onsite health providers, union representatives, and senior managers and leaders of the companies.

The research team relied heavily on an external advisory committee (comprised of Kenyan experts working in MHH, private-sector alliances, policy, women's health, media, action research, and behavior change) to guide its work. For the policy analysis documented here, policy and private-sector advisors from the aforementioned list were drawn on for guidance; these advisors were also relied upon for advising the effort's sustainability plans post research.

In addition to a policy analysis, the overall nine-month study employed a behavior change communication (BCC) strategy to positively influence workplace culture, focusing on reducing stigma and the culture of silence around menstruation. BCC elements infused into the intervention included informative posters in the toilet facilities to address issues of disposal of menstrual products and best cleaning practices for MHH-friendly toilets; MHH-sensitization brochures for key populations in the factory, including guards, union representatives, nurses, and senior management/leadership; and engaging digital graphics to facilitate dialogue among menstruating employees on WhatsApp. MHH-specific policy improvements generated from this policy analysis would serve to institutionalize these behavior changes.

2.2. Policy Review Process

The research team conducted a policy analysis at each of the two partner companies following the process illustrated in Figure 2.

First, a set of inclusion criteria were established (see Table 1) for identifying pertinent workplace policies to review.

These criteria considered policies and practices that may have either addressed MHH specifically or had the potential to enhance the experience of menstruating employees in the company. Human resource (HR) managers at both companies were approached with a formal letter by the research team requesting policies that might fit into the criteria set out in Table 1; relevant policies were returned to the research team for review.

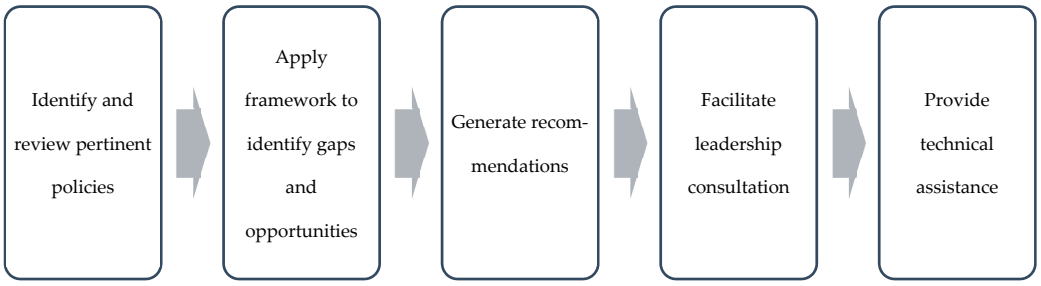


Figure 2. Workplace Policy Analysis Process.

Table 1. Inclusion Criteria for Workplace Policies to Review in the Policy Analysis.

Type of Policy	Details
Leave policies (particularly sick leave)	Noting which employee classifications qualify for leave (and which do not) and whether employees qualify upon hire or after a certain length of employment
Occupational health and safety policy	Detailing workplace approaches to ensure the health and safety of employees
Employee wellness policy	Policies that document ways in which the workplace addresses wellness and well-being for employees (may overlap with Occupational Health and Safety Policy)
Non-discrimination or equal employment opportunity policy	Documentation of how the workplace addresses hiring practices, with specific focus on equal opportunities and non-discrimination
Anti-harassment policy	Documentation of the standard operating procedures for reporting and responding to harassment in the workplace, including details of a company-sponsored, accessible grievance and complaints mechanism
Employee classification information	Documentation about the types of employment contracts (full-time, short-term, etc.) and associated benefits or entitlements
Union or employee associations	Descriptions of these associations, including requirements for membership and serving as representatives, as well as terms of any existing Collective Bargaining Agreements
Expectations of supervisors	Documentation of a supervisor manual, training for supervisors, etc.
Policy with language about periodic breaks	Documentation of toilet breaks and who monitors break time, etc.
Performance management	Description of appraisals, including how performance is measured, how promotions are determined, etc.
New employee induction	Documentation for new employees outlining benefits, breaks allowed, etc., including induction or new hire training provisions by the employer

Upon receiving policies from each company, the research team followed an internally developed analysis framework to identify gaps and opportunities for MHH in the workplace. The framework applied guidance from the USAID Engendering Industries tool on

integrating gender into workplace policies [19], a report that includes "Do's and Don'ts" on how to create an MHH policy in the workplace. The research team generated questions for analysis from the recommended elements in this report, as presented in Table 2, and each policy was examined as a unit of analysis against the question set. This served as the analysis framework for the policy analysis.

Table 2. Questions Inquired of Each Workplace Policy.

Number	Question
1	On what date was the policy instated?
2	Does the policy apply to all employee categories or only some?
3	Does the policy benefit menstruating and non-menstruating employees differently? Is this intentional?
4	Does the policy place undue burden on employees who menstruate? How?
5	What are the potential unintended consequences of this policy, as pertaining to menstruation?
6	How does the policy align with national legislation/policy?
7	Does the policy present an opportunity to promote adequate MHH in the workplace (i.e., recommendations)? How?
8	Based on the analysis of this policy, what are some preliminary recommendations that can be made to promote adequate MHH in the workplace?
9	What clarifications are needed from the HR Manager? List.

Additional questions for the HR managers stemming from the review were identified for a follow-up conversation (see question 9 in Table 2). An interview with the HR manager only took place at Workplace 1; follow-up questions for Workplace 2 were incorporated into the policy consultation meeting with that company's leadership. Where applicable, policies were also reviewed alongside national policies, such as the Labor Relations Act, ensuring alignment with the Kenyan legal framework [20]. Data from the policy analysis were collated with data from baseline research conducted earlier in the intervention period (three and five months prior to the policy analysis, respectively). All data were analyzed qualitatively to generate constructs around the company's potential to enhance the experience of menstruating employees. These constructs served as building blocks for recommendations that would be drafted in the next phase.

The research team followed an iterative and consultative process in generating recommendations, consulting with HR managers and organizational experts, as well as reviewing the existing literature. Company context, including institutional capacity and maturity of established systems, factored into the recommendation development process; the project's intent to improve MHH in the workplace rested largely on the company's ability and willingness to adopt recommendations generated from the analysis.

Recommendations were presented to companies separately by way of a leadership consultation meeting. Individuals present in each of the leadership consultations included the managing director or chief executive officer, factory manager, HR manager, and HR assistant. In this meeting, the research team presented the policy analysis purpose and methodology, key findings of the analysis, with a notable focus on exemplary policies and practices at the time of the analysis, as per the MHH policy analysis framework in Table 2 and recommendations. The consultation concluded with a discussion to address questions, feasibility, and next steps.

Based on outcomes from the leadership consultations, the research team provided follow-on technical assistance to companies, as requested. Technical assistance required a revisitation of the literature for globally transferrable best practice policies and implementation guidance notes to further build out recommended policies and procedures. The national MHM Policy also served as a guide in the recommendations presented to

company leadership, though in the absence of workplace-specific guidance in the current MHM Policy, the research team drew mainly from general MHH recommendations. The research team applied relevant content from the literature to each company's specific policy improvement strategies, customizing policies based on company needs. Technical assistance was offered in full consultation with HR teams at both factories, with routine feedback and course correction to enhance the adoption and sustainability of new policies. Finally, the Do No Harm principle served as a foundational ethos in all technical assistance provided, specifically noting what and how to support in light of the company's capacity to implement recommendations and policies following the action research.

3. Results

This section presents outcomes from the policy analysis process in each workplace, coupled with relevant baseline data; generated recommendations, company feedback, and follow-on technical assistance for advancing MHH-friendly workplace policies are also noted below.

3.1. Workplace 1

Workplace 1 submitted 35 existing policies that fit the inclusion criteria, and the research team reviewed each against the analysis framework questions in Table 2. Where gaps existed in the framework, the team documented questions for a follow-up key informant interview with the HR manager (see Appendix A), which was facilitated after the initial round of policy review. This interview provided the necessary information for the team to complete the framework for analysis.

Workplace 1 demonstrated a number of policy strengths in terms of sensitivity to MHH. The company's policies revealed near-complete compliance with the national labor law, specifically that the company observed requirements in Kenya's Employment Act, Labor Relations Act, and Occupational Health and Safety Act. The company adopted as part of its policy portfolio a Gender Equality and Women's Empowerment Policy, which served as a foundation for the company's desire to support MHH. Workplace 1 supported the election of a worker relations committee, similar to a worker's union, and the company worked to ensure that representation on this committee reflected worker demographics (i.e., 3:1 woman-to-man ratio). While not institutionalized in policies, certain individuals in management provided support to women employees through informal initiatives. One such initiative included encouraging mentorship and facilitating intermittent lunchtime sessions with small groups of women to address their questions; MHH was among these topics of conversation. Workplace 1 also employed a first aid provider to support the basic health needs of employees, and the first aid provider served as a resource to menstruating employees. The company's commitment to workplace wellness through investing in a first aid provider was an overall strength in terms of company systems.

The primary policy gaps for Workplace 1 were categorized into the following themes: (1) lack of company provisions of menstrual products and supplies to employees who menstruate, (2) unheeded supervisor code of conduct, (3) limited access to toilets, (4) insufficient employee induction process, and (5) unpaid sick leave.

The policy framework at Workplace 1 did not explicitly consider the tangible needs of menstruating employees, including access to menstrual products and provision of sufficient break times or rest areas for those menstruating. Though the first aid station was equipped with basic first aid supplies, common painkillers that could help with menstrual pain were not consistently supplied. Menstrual disposal bins were provided in toilet stalls, but the retrieval of menstrual waste occurred twice monthly. International standards for female-friendly toilets [21] encouraged menstrual waste to be collected on a weekly basis to ensure waste bins do not overflow and that menstrual products are routinely removed for disposal. One woman respondent in the baseline research stated, "We'll experience more job satisfaction if we're provided with pads, painkillers, and [if] supervisors understand us and we feel understood and accepted in our condition".

Supervisors' treatment of employees who menstruate did not reflect the company's supervisor code of conduct. Though the policy included useful language, when triangulated with baseline findings, the research team found inconsistencies in this policy's application. Specifically, the policy stipulates that supervisors should "exercise compassion" toward employees who experience personal issues or illness, yet both observational and employee response data revealed that the working environment was harsh to all workers, exacerbating existing stressors felt by menstruating employees. "Sometimes [a menstruating employee] is in pain and she is pushed to meet targets, so she just has to persevere", said one woman. "She will get stressed because she is being scolded by the supervisor". Another woman expressed, "When shouted at by the supervisors on the floor, the blood gushes or comes out like a tap". Supervisor treatment was reportedly consistent between men and women supervisors. The supervisor code of conduct was not implemented as documented, which negatively affected menstruating employees.

Workplace policies at Workplace 1 did not include provisions for toilet facilities and access that would support menstruating employees. In turn, the toilet infrastructure at this workplace was unsatisfactory according to international standards for female-friendly toilets [21]. Only two functioning toilets served over 200 women employees at the time of the analysis, with a ratio of women employees to toilets resting at 103 to 1. The UNICEF/WHO standard of employees to toilets is 25 to 1. Additionally, employees needed to seek guard permission to use the toilet facilities, further creating a barrier for menstruating employees who may feel embarrassed to seek permission multiple times a day, particularly from male guards. Finally, the company restricted access to toilets for one hour in the morning and one hour after lunch to allow for cleaning and drying of toilets, resulting in further restricted access to toilet facilities.

Though Workplace 1 had a number of sound policy documents that were in compliance with national labor laws, the understanding of these policies by the workforce was limited. Employees at Workplace 1 did not know about or comprehend many of the documented policies on file with the company, either because the policies were not effectively implemented (i.e., observed by employees) or communicated to them. For example, women in focus group discussions shared a lack of knowledge about whether or not they were entitled to sick leave; additionally, they did not understand the process of obtaining such leave. The employee induction process, specifically, was relatively brief for incoming employees. In turn, employees did not understand their rights as stipulated in company policies. Low levels of policy awareness limited accountability and reduced the potential for advocacy around existing or future policies, including policies that might have provided for MHH.

Finally, for Workplace 1, leave policies did not accommodate the needs of menstruating employees. Taking sick leave without providing factory management with a doctor's note was often categorized as "a domestic issue" and therefore rendered as unpaid leave. In addition, women reported that it was difficult and often too expensive to receive a doctor's note, leaving menstruating women (particularly those with period-related complications such as endometriosis or polycystic ovary syndrome (PCOS)) with few options but to lose a day's wages when needing to stay home due to menstruation. One woman said, "You just say that you were not feeling well. [The HR manager] may request for a doctor's note or suspend you for two days if you don't produce one. Sometimes you have to go to a health facility and pay 200 KES [approximately 2 USD] to get a doctor's note. Even when you have the doctor's note you will be marked as absent and you will not be paid for the day of work that is missed". Potential implications for frequent, unpaid leave include reduced monthly income and/or reduced advancement potential for these employees.

Based on the policy analysis findings from Workplace 1, the research team provided the following recommendations to the company (i.e., HR manager, HR assistant, and factory manager) in a leadership consultation meeting:

1. Intentionally support menstruating women through the provision of necessary supplies.
    - Provide menstrual products;

- Equip the first aid provider with painkillers at all times;
- Ensure weekly waste pick up to adhere to international hygiene protocols of menstrual waste removal; and
- Provide break time and rest areas.

2. Cultivate a working environment and supervisory approach that is supported and less harsh.
    - Implement the existing Supervisor's Code of Conduct: "Exercise compassion when an employee is unwell, has personal issues, and needs time to resolve these issues";
    - Incorporate MHH-supportive language into the Supervisor's Code of Conduct;
    - Sponsor a supervisor training session about workplace support for employees who menstruate;
    - Incorporate MHH-friendly content into orientation for new supervisors; and
    - Alter supervisor job description to include: "Supervisors are expected to treat employees' health-related concerns with respect".
3. Remove barriers that prevent women from accessing toilets as needed.
    - Increase the number of toilets available to women (25:1 women toilet ratio);
    - Tile toilet floors and walls to reduce drying time after cleaning; and
    - Increase the hours available for women to access toilets.
4. Ensure that new employees fully understand all workplace policies, including their rights and provisions as menstruating employees.
    - Compile HR policies into a single employee handbook, including a signed acknowledgment of understanding by new hires;
    - Prioritize in-person (1:1 or small group) meeting with new hires to thoroughly orient them to all employment policies; and
    - Discuss MHH accommodations clearly with new hires and invite questions (destigmatize the topic).
5. Refrain from penalizing employees who face routine health challenges related to menstruation.
    - Allow paid time off if an employee is unwell due to menstruation;
    - Consider leave without a doctor's note (maximum of 1 day); and
    - Train supervisors to recognize that many employees face menstruation-related complications, encouraging supportive supervision.

The company's management responded positively to these recommendations. With the exception of offering paid leave for menstruation-related days off, the company acknowledged a willingness to enhance existing policies and procedures according to the suggested recommendations. No technical assistance was requested from the research team to support MHH policy changes or implementation. Since the leadership consultation, Workplace 1 has met with supervisors to discuss MHH sensitivity, created an induction policy to document items to be covered in the induction process (including MHH), and created a menstrual hygiene rights policy.

3.2. Workplace 2

Workplace 2 had two existing policies that fit the inclusion criteria detailed in Table 1, and the research team reviewed these against the analysis framework questions in Table 2. The analysis framework proved helpful in analyzing the two policies, especially amidst a general lack of documented systems and institutionalized policies inherent in the company's procedures.

The first submitted policy, the Collective Bargaining Agreement (CBA), entered into by the company and the labor union, included an employee assessment form and provided for an onsite health facility, the provision of refreshments to staff while on duty, transportation allowance for employees, and an additional allowance for employees working the night

shift. The second submitted policy, the Health Policy, aligned with Kenya's Occupational Health and Safety Act of 2007, mandating employers to ensure the safety, health, and welfare of workers. It provided guidance on fire safety, first aid, personal hygiene, personal protective equipment, ventilation, and waste disposal. Workplace 2 enacted certain procedures that specifically supported MHH, including the provision of an onsite nurse, hiring of a woman cleaner for women's toilet facilities, investing in toilet infrastructure upgrades in compliance with international standards [21], and facilitating weekly menstrual waste disposal. The company also allowed employees to take breaks when needed, ensuring full access to toilet facilities.

The primary policy gaps for Workplace 2 were categorized into the following themes: (1) inequitable employee classification, minimal women's representation, and limited voice of women; (2) unpaid sick leave; (3) limited HR policies documented and distributed to employees; (4) inadequate employee induction process; and (5) limited women in management/supervisor roles.

Employees at Workplace 2 were classified as management, permanent staff, or contract staff, with management and permanent staff receiving a fuller range of employee benefits than contract staff. The majority of women employees fell into the contract staff classification, including women who had worked for the factory for more than five years. Contract staff were only granted seven days of sick leave per year (as opposed to 30 days provided to management and 15 days provided to permanent staff) and were not allowed to participate in the trade union. Kenya's Labor Relations Act stipulates that every employee must have the right to join a trade union, and every member has the right to participate in the election of officials/representatives or to vie for a union position [20]. At the time of the policy analysis in Workplace 2, no women were represented in the company's trade union, rendering women voiceless in matters concerning MHH, among other issues facing them as women employees in the company. Additionally, the company lacked an internally generated policy on union or employee association, including requirements for membership or criteria for serving as a representative; company leadership explained that it followed the Labor Relations Act for such matters, which stipulated that all union members must be permanent employees. This disproportionately affected women employees who were, by majority, classified as contract staff.

The leave policy at Workplace 2 limited menstruating employees' ability to take paid time off for menstruation-related complications. According to the CBA, leave policies applied to all employees upon completion of the three-month probation period; however, as noted above, the majority of women were entitled to only seven sick days' paid leave annually as contract employees. Additionally, similar to Workplace 1, the CBA required a doctor's note for employees to be granted paid sick leave, disadvantaging menstruating employees who may not have the ability or resources to visit a health facility for menstrual issues. As such, women reported at baseline that they often took unpaid leave for MHH-related issues.

Workplace 2 had limited HR policies to support employee (as well as employer) rights, affecting menstruating employees in key ways. For example, the company lacked policies addressing equal employment opportunities/non-discrimination, anti-harassment/bullying (including sexual harassment), and processes for grievance and complaint reporting. Though the company leadership adhered to the Employment Act of Kenya, no internally documented policies existed to address such issues. Additionally, Workplace 2 lacked a supervisors' code of conduct or manual stipulating expectations of supervisors, including how the company provided guidance for supervisors' engagement with direct reports. This might have affected employee-supervisor relationships, and, indeed, women employees reported at baseline that supervisors seemed to care more about production than their well-being. Women employees also expressed hesitancy to share MHH-related concerns with supervisors, reporting fear that they would not be believed by supervisors who were the majority men.

Like Workplace 1, Workplace 2 did not employ a robust employee induction process. The process of inducting employees into the company and familiarizing them with company policies was undocumented. Company leadership indicated that all employees underwent role-specific training upon onboarding, though little was shared with new staff by way of review and comprehension of company systems and procedures. Without relevant written policies and a formalized process of sharing these policies, employees were rendered ignorant of and powerless about their rights. As drawn from baseline findings, menstruating employees, specifically, did not consistently receive information about MHH provisions at the factory, including menstrual products provision, onsite nursing services, weekly waste management retrieval, and other potential ways to engage in advancing MHH in the workplace.

Unlike Workplace 1, which was comprised of mostly women, including women in management, Workplace 2 was male dominated, and its management base reflected this demographic. Workplace 2 did not meet the Government of Kenya's 30% gender hiring requirement, specifically the stipulation that any gender must comprise at least 30% of the total workforce [22]. Though the company desired to increase its base of women employees, it employed approximately 10% women and 90% men at the time of the analysis. Due to the male-dominated workforce, women at Workplace 2 reported that they were unlikely to express menstruation-related needs to colleagues, and especially to supervisors who were predominantly men. With women underrepresented in positions of management, in permanent employment classification, and in trade unions, MHH-related needs and concerns in the workplace went undocumented and under-addressed.

As a result of policy analysis findings from Workplace 2, the research team made the following recommendations to the company (i.e., managing director, HR manager, HR assistant, and factory manager) in a leadership consultation meeting:

1. Consider the Labor Relations Act of Kenya, and provide all employees with opportunities for representation.
    - Revisit the rationale behind contract versus permanent employee classification;
    - Consider employees' rights to join a trade union; and
    - Consider employees' right to participate in the election of officials/representatives or to vie for a union position.
2. Consider revising the paid sick leave policy so that its application is equitable across all employee levels.
    - Apply the 30-days-per-year allowance across all employees;
    - Allow paid time off if an employee is unwell due to menstruation;
    - Consider leave without a doctor's note (maximum 1 day); and
    - Recognize that many employees face menstruation-related complications.
3. Adopt additional HR policies.
    - Equal employment opportunity/non-discrimination;
    - Supervisor code of conduct; and
    - Anti-harassment and bullying policy, including reporting mechanism.
4. Ensure that new employees fully understand all workplace policies, including their rights and provisions as menstruating employees.
    - Compile HR policies into a single employee handbook, including a signed acknowledgment of understanding by new hires;
    - Prioritize in-person (1:1 or small group) meeting with new hires to thoroughly orient them to all employment policies; and
    - Discuss MHH accommodations clearly with new hires and invite questions (destigmatize the topic).
5. Promote women in management and supervisory roles to improve supervisor support for menstruating employees and grow women's representation in decision-making channels (also affecting MHH).

- Consider setting targets at the managerial level; and
- Build a strategy around promoting women in leadership positions.

The company's leadership and management responded positively to these recommendations and requested technical assistance from the research team to complete the suggested amendments. Like Workplace 1, Workplace 2 expressed concern about amending the leave policy to either provide additional paid sick leave days or special provisions for MHH; however, the company's restructure of employee classification (i.e., to transfer eligible contract employees, many of whom were women, to permanent employee status), would naturally account for this provision. Since the leadership consultation, employee reclassification has taken place.

At the request of the company's leadership, the research team developed a draft employee handbook, a full suite of employment policies intended to protect both the employer and the employees. Policies included in the handbook addressed equal employment opportunity and non-discrimination, anti-harassment and bullying, and guidance on MHH inclusion, among many other topics. The draft drew upon a template from the Society for Human Resource Management (SHRM) as well as discrete policies from the International Labor Organization (ILO) and Kenyan labor legislation. Technical assistance was provided in full collaboration with the company's HR manager and HR assistant. Once draft policies and procedures were completed, the research team facilitated a follow-up meeting with company leadership and HR teams to discuss policy implementation and sustainability. Specific considerations around grievance and reporting mechanisms were prioritized in this follow-up meeting to ensure the company was prepared to implement the policies consistently, with urgency and impartiality.

4. Discussion

The policy analysis process used to inform policy improvements in two workplaces in Kenya may be applicable to a wide array of audiences. Researchers, implementers, policymakers, and employers in a variety of contexts might benefit from this process. Literature on MHH in similar settings supports the overall policy-related implications of this study, asserting that workplace absenteeism is often linked with menstruation [23–25], poor toilet infrastructure negatively affects working experiences for menstruating employees [23], and menstrual stigma may affect employees' comfort to work while menstruating and overall psychological well-being [23,24]. However, these and other recent publications appeal to MHH researchers for more studies addressing MHH policy and practice, both in the workplace and at large [26,27]. This article adds to the MHH literature base and bridges a gap in existing research around workplace MHH by offering a novel approach to MHH, women's economic empowerment, and private-sector outcomes through enhanced workplace policies. Additionally, the recommendations that were generated from this analysis might serve as a guide for similar private-sector companies that have yet to consider MHH implications on workforce indicators such as productivity, satisfaction, confidence, and growth.

Specific sustainability implications from this study include long-term benefits for the two target companies, replicability models for private-sector adoption, and national-level policy enhancements related to MHH. Workplaces 1 and 2 in this study committed to institutionalizing workplace policy recommendations provided by the research team, demonstrating a commitment to sustaining MHH-sensitive practice in their respective workplaces. Additionally, the research team generated interest and commitment from two Kenyan social enterprises to adopt the policy analysis framework and provide consultation services to others in the private sector in Kenya, similar to those provided to Workplaces 1 and 2. These entities, considered "sustainability partners" by the research team, offer a strategic model of advancing MHH-sensitive workplace policies and practice in the private sector more broadly and leveraging the lessons learned and advances made by Workplaces 1 and 2 who first pioneered this effort to improve MHH in their own companies. Finally, sustainability of MHH-sensitive efforts in the private sector may be embedded

into national policies, commissioning Ministries of Labor and other relevant government stakeholders to ensure that certain standards are met in the nation's private sector. The GoK has expressed interest in incorporating lessons learned from this study's findings, including the policy analysis process and outcomes, to further shape and refine its own MHM Policy and MHM Strategy.

Finally, beyond benefiting menstruating employees in these specific workplace settings, sustaining sound business practices in Workplaces 1 and 2, and influencing the Kenyan private sector through national-level policies, MHH-sensitive workplace policies pave the way for sustainable practice in the private sector in terms of corporate culture and gender equity. MHH-friendly workplace policies have the potential to not only effect change in company systems but also serve to shift corporate culture. When combined with effective BCC strategies, policy changes have the potential to institutionalize gains achieved in areas such as reduced menstrual stigma, increased confidence to speak about menstruation, and increased overall empowerment by menstruating employees. Additionally, highlighting the rights of menstruating employees through workplace policies promotes gender equity by ensuring all employees' efforts (whether man or woman, menstruating employee or non-menstruating employee) are optimized at work. Specifically, those who may be disproportionately disadvantaged due to menstruation will be elevated to a level playing field with their non-menstruating colleagues. These shifts in corporate culture and advances in gender equity, strengthened by MHH-sensitive workplace policies, may demonstrate value and respect to employees and, in turn, generate a return on investment by way of a committed and thriving workforce.

4.1. Limitations of Study

Research limitations may have influenced the outcomes of the policy analysis process documented in this article. While the research team experienced full cooperation from both companies in the policy review process, the information provided may have been influenced by observation bias (or the Hawthorne effect). Specifically, company representatives may have consciously or unconsciously altered information provided, written or verbal, based on an understanding of what information the research team was seeking to understand. Additionally, the policy analysis team was the same team that implemented the workplace MHH intervention at both workplaces, further opening the door to the Hawthorne effect.

4.2. Directions for Future Research

To best understand the efficacy of MHH-sensitive policies, further research is needed in other countries and company contexts. Kenya provided a ripe environment for this study, as evidenced by its recently released MHM Policy, though the national policy landscape in other countries may influence existing workplace policies in the private sector and the potential for advances in MHH. Additionally, Workplaces 1 and 2 were both manufacturing companies with primarily low-educated and low-wage workforces. Further research in other sectors and among a variety of employee demographics would provide insights into how to improve and sustain MHH in the private sector at large.

5. Conclusions

Policy analysis outcomes from two workplaces in Kenya revealed strengths and gaps in the private sector's support for menstruating employees in the workplace. Recognition of policy gaps informed the development of concrete, company-specific recommendations to improve MHH in these workplaces. MHH-informed workplace policy recommendations aligned with the GoK's overall agenda in MHH/MHM, as set out in its 2020 MHM Policy to improve MHM/MHH nationwide. Insight from these two private-sector workplaces in Kenya may inform future policy analyses that promote adequate workplace MHH in pursuit of women's economic empowerment and improved business outcomes.

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Appendix A

Follow up questions for Workplace 1 HR Manager.

1. Policy development
   - How are policies drafted? Who is present/involved in policy development?
   - Who has the authority to make changes?
   - Who is responsible for enforcement/implementation?
   - What is the review process for company policies?
2. Policy application
   - Do policies on disciplinary procedures apply to employees or to those who are not in management only? [Probe for disciplinary procedures for senior employees]
   - Does the policy on pregnancy apply to all categories of employees?
   - Are there other policies that do not apply to all categories of employees?
3. Policy dissemination
   - How are policies communicated to employees?
   - How are supervisors informed/trained on the supervisors' manual and supervisors code of conduct?
4. Policy implementation
   - What measures are in place to actively advance women's leadership as provided in the Gender Equality and Women's Empowerment Policy?
   - How is the piece-rate-compensation policy and overtime policy, which commit to paying workers at government's minimum wage or higher, provides no more than 40 h a week work and to pay workers 1.5 times the regular rate for all hours worked in excess of 45 h in a workweek implemented?
   - Given that senior managers are responsible for handling complaints, how are complaints against senior managers handled?
   - What happens if an employee feels unfairly evaluated?
5. Policy contradictions
   - How is the sick leave policy implemented? [Probe for discrepancies between what exists in policy and the reality of workers having to take unpaid leave for illness]

- How can you explain the contradictions in anti-harassment policy and the reality of the work culture, i.e., harassment as a way to meet targets and lack of compassion as indicated by women during FGDs?

6. Representation
   - How are worker representatives selected? How are employees involved in selection of worker representatives? If they are not involved, why not? [Probe for why management appoints worker representatives]
7. Promoting MHH
   - Are there widespread or recognized company practices and/or guidelines that are not written in policies (less formalized)? [specific to MHH]
   - What recommendations would you make to promote adequate MHH in the workplace?

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