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Periods in a tough period: global health failure to respond to menstruation during war

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SUMMARY BOX

⇒ The burden of menstruation and the unmet needs of menstruating women rise during conflicts.

⇒ Menstruation in conflict-affected settings is overlooked in humanitarian responses, as evident by the lack of research, documentation, interest and access to appropriate products, facilities and education.

⇒ This commentary argues that the poor menstruation management in Gaza epitomises the problem and offers practical recommendations for humanitarian and global health organisations.

⇒ The way forward for global health involves integrating menstruation aid, conducting reliable documentation, enhancing cultural sensitivity and implementing capacity-building programmes.

INTRODUCTION

Menstruation is laden with pains—a recurrent constellation of symptoms that shapes and spans women's reproductive age. Physical pain, fatigue, mood swings and anxiety are among the primary symptoms that characterise the menstrual experience.[1 2] Worse, poor menstrual health and hygiene (MHH) may lead to urinary and reproductive tract infections, infertility and considerable psychosocial impacts on quality of life, education, employment and productivity.[3 4]

The burden of menstruation and the unmet needs of menstruating women increase substantially during acute conflicts. A recent study conducted in Ukraine reported a high prevalence of menstrual cycle disorders (65.8%) among adolescents.[5] Another study conducted in Lebanon revealed that, 6 months after exposure to conflict, menstrual abnormalities were significantly higher in participants who remained in conflict zones than in two other groups of participants who either spent less time in or were unexposed to conflict.[6]

To guide menstrual aid delivery in conflict settings, 11 guidelines have been published by international organisations until 2017 as reported by VanLeeuwen and Torondel.[7] However, menstruation in fragile, conflict-affected and vulnerable settings remains peripheral in global health agendas and sexual and reproductive health discourses. Research and documentation of menstruation in these settings are scarce and often deprioritised amid overriding safety and humanitarian concerns. While menstruation-related reports have increased recently,[7] this increase has been criticised as hardly instructive.[8] Worse still, organisations providing emergency aid abdicate responsibility for gender responsiveness by overlooking the unmet needs of women, especially for MHH. Patel *et al*. reported pooled rates of lack of access to sanitary pads and appropriate disposal of 34% and 54%, respectively.[9]

THE LOCAL

The war in Gaza is an illustrative case study for assessing the role of humanitarian aid in improving MHH in conflict-affected areas. This is because the recent war was peculiar in its sudden onset, high intensity and rapid progression. Adding to the newfound tragedies, people were disenfranchised at the outset, having lived under harsh conditions for years before the war. Approximately 691 300 women and adolescents now face serious challenges in managing menstruation, especially with war-associated stress, increased menstrual abnormalities, and the lack of remedies made available in response to their escalating needs. Of those, nearly over 249 000 are adolescents aged between 10 and 19.[10]

In global health, the discourse around menstruation during adolescence is based on the 'hardware and software' framework, which can also be used to explore the menstrual needs of women across other reproductive age groups.[11] Applying this framework to the case of Gaza exposes a menstruation ordeal.

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Essential needs, such as food and water, have been barely accessible, jeopardising nutrition and limiting water use for washing—both crucial for improved MHH. Similarly, menstrual hygiene products are largely overlooked in non-food item distribution. While UN women estimated that 10 million disposable pads are needed monthly,[12] only 6 182 000 have been distributed by the United Nations Population Fund (UNFPA) in 10 months.[13] Given the severe lack of menstrual hygiene products, women and adolescents use unhealthy alternatives to sanitary pads and resort to norethisterone to suppress or delay menstruation, despite potential adverse effects.[14 15]

In view of the poor emergency response, the contextual menstrual preferences shaped by the cultural and religious practices of Palestinians are likely unconsidered.[16 17] A local study revealed that Palestinian female university students preferred specific menstruation hygiene products and faced social and physical challenges in managing menstruation.[16] Additionally, the constrained physical environment in the overcrowded buildings and tents erected during the war is unfavourable for healthy and dignified menstruation. In Rafah city, an estimated 480 people share a single toilet, for example.[14] The sketchy latrine infrastructure hinders gender segregation and fails to accommodate hygiene and privacy, threatening female dignity and leading to inadequate drying, improper disposal and a high risk of infections.[12]

Atop the hardware problems, the traditional, inadequate education and support that predate the current war might have worsened during wartime. On the one hand, the humanitarian staff, especially males, overseeing and dominating the emergency response lack adequate training in communicating clear, supportive and culturally competent educational messages about menstruation. On the other hand, poor communication about MHH in Palestine makes it even harder to foster a supportive environment. Of note, MHH is challenged by the sociocultural norms of shame and secrecy among Palestinians,[18] making discussions around menstruation an exclusive duty of the female family members and limiting the participation of males and people from outside the family.[19]

The solution to these problems is complex and multifaceted. Stating the obvious, the supply of menstrual hygiene products in aid delivery should be increased to match expected demand. The availability of menstrual hygiene products is a prerequisite for other MHH requirements, including facilities, communication and considerations of privacy and dignity. Once these products are available, the next step is to create the conditions and environments that are conducive to using the products and improving MHH. Without considering the social and psychological needs that shape the sense of the physical space, neither adequate products nor appropriate facilities would suffice, in and of themselves, to respond to the rising menstrual needs. Designing and building acceptable, private and culturally appropriate environments must consider the contextual characteristics and cultural taboos inherent in the structure of the Gazan society. A culturally sensitive response should provide acceptable sanitary kits and washing, drying and disposal methods; and create gender-segregated facilities whereby female dignity is preserved in the presence of men and others. Due to the dearth of previous assessments, these cultural and contextual considerations should be identified by directly consulting with the target population as part of repeated need assessments and postdistribution monitoring surveys. Moreover, humanitarian staff, local informal first responders and the community should engage in manufacturing a menstruation-supportive environment. As men may be the primary receivers of aid in Gaza, addressing male engagement in identifying menstruation needs and communicating educational messages is crucial for an effective emergency response. Male engagement can be improved by addressing knowledge gaps and perceptions about MHH, considering prevailing gender norms and family power dynamics, and channelling communication through influential actors within Gazan society, such as healthcare providers and community and religious leaders.

THE GLOBAL

The failure to integrate MHH into humanitarian responses is part of a broader global scene where MHH is often overlooked in humanitarian settings. This neglect is rooted in the attitudes of both the responders, who do not consider MHH an immediate need, and menstruating women, who do not voice their concerns in the male-dominated response and amid the shame and secrecy surrounding menstruation. Further, the international humanitarian discourse lacks consensus on the best approach on how to implement MHH in conflicts, which can be partly ascribed to the scarcity of reliable data, research and documentation, and monitoring and evaluation (M&E) interventions.[8 20] Consequently, MHH is not adequately addressed in the few published guides, as exemplified by the 2018 and 2019 humanitarian response plans published by the United Nations Office for the Coordination of Humanitarian Affairs (UN-OCHA) that overlooked several MHH aspects.[21] After more than 10 months into the war in Gaza, hardly any reliable data about MHH can be retrieved as has been the case almost everywhere else. Absent reliable research and evaluation, creating technical guidelines on MHH integration into emergency aid becomes difficult, impractical and unsubstantiated. These ingrained setbacks materialise in the makeshift performance of aid organisations in the field of MHH. As one study revealed, the staff supervising and delivering aid in Myanmar and Lebanon were unaware of the guidelines implemented within their organisations.[22] Moreover, the lack of cultural sensitivity is common in menstrual aid delivery. For instance, the International Federation of Red Cross and Red Crescent Societies had

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an experience where inappropriate menstrual hygiene products were withdrawn from an emergency response.[23]

Tellingly, the appalling tragedy of Gaza has exposed the global failure of menstrual aid delivery in conflicts—it has brought this failure to its zenith. The lesson is fourfold: integration, research, cultural sensitivity and capacity building. First, the negative health outcomes of poor MHH in conflict settings justify integrating MHH in immediate packages of emergency aid. The perception of MHH as an inessential, non-life-saving intervention has led to its deprioritisation amid other acute emergency needs. However, MHH can be framed as an issue of acute need that amounts to a life-saving intervention, given that poor MHH can lead to serious complications, including reproductive and urinary tract infections. Importantly, immediate integration should essentially provide an adequate supply of menstrual products, create appropriate spaces and environments, and consider the cultural and contextual factors through community consultation. Second, experiences should be coupled with research, documentation and M&E to help create guidelines that outline a systematic, detailed response, including conducting need assessment, product quantity and setting indicators for M&E. These guidelines should address the multisectoral nature of MHH, aiming to deliver a response adopting an MHH-based approach that avoids the fragmentation of interventions and considers the cultural and educational nuances of menstruation. Furthermore, M&E should move beyond simple indicators to assess the quality and cultural sensitivity of interventions. Implementation research should investigate response effectiveness, perceptions of the target populations and barriers to MHH integration, using implementation outcome variables.[24] Moreover, the cultural context of menstruation in Gaza highlights the need for developing a reference of menstruation-related cultural practices in different contexts across the world, which needs further research to explore the perceptions, taboos and cultural preferences regarding menstruation. Finally, aid organisations should develop capacity-building programmes that enhance communication skills and cultural sensitivity, improving staff interactions with the target population and streamlining communication within the organisation. Amid the atrocities, Gaza is a wealth of opportunities for global health to improve MHH delivery in conflict-affected settings, but, sadly, not for itself.

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