
MENSTRUAL HYGIENE MANAGEMENT AMONG SYRIAN REFUGEE WOMEN IN THE BEKAA

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This research paper explores the different challenges related to menstrual hygiene faced by Syrian refugee women residing in Informal Tented Settlements (ITSs) in the Bekaa valley in Lebanon. The piece first looks at women's distinct lived experiences and practices, focusing on products, safety and health, and delving into the implications of those challenges on paid work and domestic responsibilities and care work. The report then tackles communal perceptions and social stigma, and looks at how those affect women's practices, bodies and lives, with a particular focus on knowledge and informal support systems amongst women. The research finally provides potential solutions and programatic recommendations for integrating menstrual hygiene management in humanitarian responses, particularly targeted at the WASH, protection, education and health sectors.

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ACRONYMS

FGD	Focus Group Discussion
LBP	Lebanese Pounds
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Person
ITS	Informal Tented Settlement
MHM	Menstrual Hygiene Management
NFI	Non-Food Items
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UTI	Urinary Tract Infection
WASH	Water, Sanitation and Hygiene

INTRODUCTION

BACKGROUND

Almost a decade into the Syrian war, the Syrian refugee crisis is at an all-time high, with 6.7 million of the world's refugees originating from Syria (UNHCR, 2020). Lebanon continues to host the highest number of refugees per capita in the world; the most recent estimates put the numbers at 914,648 Syrian refugees in Lebanon registered with UNHCR as of 31 January 2020 (UNHCR, 2020). However, actual numbers are believed to be much higher, at around 1.5 million individuals (Oxfam 2018) dispersed in the governorates of the Bekaa, North Lebanon, Beirut and South Lebanon (UNHCR, 2020). The Bekaa district hosts the highest number of registered Syrian refugees in Lebanon, amounting to 37.8% of the total number (around 344,013) of registered refugees. It is followed by North Lebanon at 26.5%, Beirut at 24.5% and South Lebanon at 11.2% (UNHCR, 2020). Approximately 17% of the refugees live in informal tented settlements (ITSs) and this number is constantly growing (Concern Worldwide, 2018), while the Bekaa alone is home to around 1,934 ITSs (Habib, 2019).

Oxfam has been responding to the humanitarian crisis in Lebanon for the past seven years. This includes implementing WASH, protection and livelihoods interventions in the Bekaa Valley, covering 10 municipalities in 258 informal tented settlements (ITSs) hosting around 11,600 individuals. The WASH intervention consists of services such as water distribution, facilities construction and maintenance, desludging services, and public health and hygiene promotion.

However, high levels of WASH vulnerabilities persist among refugees in an increasingly precarious protection environment. Tensions with host communities increasingly revolve around competition for water resources and the environmental and public health impacts of poor sanitation practices. As international assistance to the refugee crisis in Lebanon has been moving away from direct humanitarian intervention towards more sustainable solutions in recent years, the WASH sector has been severely affected. In March 2018, Oxfam reported that several NGOs and aid agencies providing assistance in the WASH sector in the Bekaa had had to make substantial cuts in their delivery programmes or were expected to do so in the following months (Oxfam 2018). WASH conditions usually tend to be particularly bad in ITSs: the tents are made of water-resistant sheets known as tarp or tarpaulin, which offer little warmth or privacy, and the settlements often have poor hygiene conditions, insufficient water supply and questionable sanitation practices.

During displacement, gendered inequalities and power imbalances are exacerbated and patriarchal social norms are sustained. Women are disproportionately affected when access to WASH is restricted, especially as their distinct needs – such as menstrual hygiene products – are often deprioritized in household spending. Amid the considerable cuts in humanitarian aid related to WASH, it becomes extremely challenging for Syrian refugee women to manage their monthly periods with dignity and privacy.¹

LITERATURE REVIEW

Menstruation is a natural biological process that roughly half of the world's populace experiences during their reproductive years (VanLeeuwen and Torondel, 2018). Management of menstruation remains one of the major concerns when considering the gendered effects of war

and displacement on women's lives. The WHO-UNICEF Joint Monitoring Programme defines good menstrual hygiene management (MHM) as follows:

'Women and adolescent girls are using a clean menstrual management material to absorb or collect menstrual blood, that can be changed in privacy as often as necessary for the duration of a menstrual period, using soap and water for washing the body as required, and having access to safe and convenient facilities to dispose of used menstrual management materials. They understand the basic facts linked to the menstrual cycle and how to manage it with dignity and without discomfort or fear.' (UNICEF 2019: 8).

For refugee women and adolescent girls in their reproductive years, dealing with menstruation carries a huge burden as they attempt to cope with it amid the total loss of privacy and limited access to resources. This impinges on their hygiene and menstrual health; it also has adverse effects on their feelings of safety, privacy and dignity, as well as on their mobility (Concern Worldwide, 2018).

In emergency contexts, women often cannot adequately manage their periods due to lack of available MHM materials and the absence of sufficient MHM supplies. UNICEF's recent 2019 report, 'Guidance on Menstrual Health and Hygiene' (2019), defines menstrual hygiene materials as 'the products used to catch menstrual flow, such as pads, cloths, tampons or cups' (UNICEF 2019: 8) and designates menstrual supplies as 'supportive items needed for MHM, such as body and laundry soap, underwear and pain relief items' (Ibid.).

VanLeeuwen and Torondel (2018) assessed the acceptability of reusable menstrual underwear with built-in pads among refugee women in the Middle East. Their study found that women have a preference for disposable pads, and many expressed acceptance of menstrual underwear as a complimentary or additional product rather than as a replacement for disposable products. Despite this preference, a 2018 report by Oxfam based on a qualitative study around the impact of reduced WASH funding in Syrian refugee camps in the Bekaa revealed that Syrian refugee women do not always use disposable sanitary pads, since these are often unaffordable (Oxfam 2018), and instead resort to reusable cloth pads made from pieces of old fabric (Ibid.). Such materials tend to leak as they do not have adequate capacity to absorb menstrual blood; washing them also usually requires a reasonable amount of water and soap (Parker et al., 2014). This compromises the cleanliness of these menstrual management materials and makes women and girls vulnerable to serious infections (Ibid.).

Another significant challenge that adds to the burden of displaced women and girls during menstruation is the lack of adequate, accessible, safe and private spaces, also referred to as 'menstrual facilities' (UNICEF 2019: 8) to change their menstrual hygiene materials and dispose of their MHM waste. Toilets and latrine facilities are often shared between several households and are usually located away from the tents. Women and girls often only use the bathrooms at night in order to avoid male encounters; this becomes even more problematic for them during their periods, and more often than not exposes them to further risks of violence or assault (Ibid.).

Properly grasping the context – including social norms and perceptions around menstruation – paves the way for more accurate identification of the challenges women face with regard to MHM. We can ensure this by consulting women and adolescent girls about their preferences and the feasibility and practicality of different MHM options, from both hygienic and social viewpoints. This process of engaging in dialogue with the community contextualizes intervention and policy prescriptions and helps humanitarian practitioners to offer better practical solutions to specific and contextualized menstrual needs. For example, a study in camps for internally displaced persons (IDPs) in Pakistan consulted women on building shelters that could enable good menstrual hygiene practices. Women suggested including MHM facilities in the bathing blocks to preserve their privacy, as no one could know that they were using the bathing blocks for MHM purposes (Parker et al., 2014). The organization implemented the shelter-building as

per the recommendations of the community and the bathing blocks proved very successful (Ibid.). A good MHM approach should also keep in mind culturally appropriate menstrual materials as well as socially and environmentally appropriate disposal practices (Sommer, 2012).

Menstruation's direct connection to women's sexuality makes it a taboo topic in many societies, and Syrian refugee communities are no exception. Cultural beliefs, social norms, misconceptions and taboos all exist around menstruation. MHM is often discussed in private and practised in secrecy, given the notions of shame, embarrassment and humiliation associated with it (Schmitt et al., 2017; Sommer et al., 2015; Sommer et al., 2017; VanLeeuwen and Torondel, 2018). Sommer et al. (2015) define this as the 'menstrual etiquette', whereby girls are taught at the onset of menstruation to strictly adhere to a set of practices to discreetly manage their periods and keep them secret from boys and men.

In Lebanon's humanitarian crisis response, MHM has been largely deprioritized in favour of other basic needs, including food and shelter, that are deemed to be life-saving measures (Concern Worldwide, 2018). Exploring the reasons behind this overlooking of MHM more generally in humanitarian responses, Sommer (2012) remarks that the WASH community has been, for the most part, dominated by male practitioners, who inadvertently disregard menstrual needs owing to their lack of personal knowledge and/or experience. She also argues that the taboo nature of the topic among many communities makes it highly unlikely that women and girls will seek support regarding their menstrual needs unless explicitly approached by aid organizations around the matter (Sommer, 2012).

While MHM typically falls within the framework of the WASH sector, many experts have been advocating for a cross-sectoral approach that takes into account the education, protection, shelter, non-food item (NFI) and reproductive health sectors in MHM responses (Sommer et al., 2017). In key informant interviews conducted with humanitarian response staff by Schmitt et al. (2017), findings revealed the many challenges hampering an adequate cross-sectoral MHM response. The interviewed staff spoke of a lack of clarity around which sector should take the lead to coordinate such a response (Ibid.). Although various actors have been involved in MHM responses, there is still no consensus over who bears the ultimate responsibility for addressing MHM needs. This is particularly the case when it comes to hygiene kits, which have been addressed by both the WASH/hygiene promotion and the reproductive health sectors (Sommer, 2012).

There is also a lack of clarity over who should conduct a needs assessment in schools in emergency contexts to ensure that MHM responses are integrated in measures to tackle the water and sanitation needs of girls and female teachers, which probably requires a collaborative intervention among the WASH, education and protection sectors (Ibid.). Recommendations for achieving a more coordinated cross-sectoral MHM response, with minimal overlaps and maximum effectiveness, include the need for revised assessment tools that clearly outline how each sector will target specific MHM components (Ibid.).

More recently, a rising number of NGOs, funding agencies and governments have highlighted the importance of MHM-related humanitarian interventions. While there have been many improvements, there is still no consensus on how best to address such needs with a culturally appropriate and clear MHM response (Ibid.). For a holistic MHM intervention in the Bekaa's ITSs, it remains crucial to understand MHM product appropriateness, acceptable means of disposal, cultural beliefs and practices, and the various challenges that women and girls deal with during menstruation. This will help to identify key components that could be included in a future MHM response within this setting.

OBJECTIVES OF THE STUDY

This study set out to answer the following research questions:

1. What are the lived experiences of Syrian refugee women residing in ITSs in the Bekaa?
2. What are the communal perceptions in relation to menstrual hygiene, and how do these affect women's practices, bodies and lives?
3. What solutions or actions can be taken that most adequately respond to the needs of Syrian refugee women in relation to their menstrual hygiene management?

While this research starts from the understanding that patriarchy as a structure and patriarchal norms as a culture are not peculiar or particular to the context of refugees in the Bekaa, it also aims to highlight how this structure and culture become exacerbated and intensified in the context of their intersection with other forms of inequality and oppression in the refugee camps.

METHODOLOGY

RESEARCH DESIGN

The Bekaa Valley, a governorate in Lebanon hosting the highest number of refugees in the country, was selected as a case study for this research. Using a qualitative and community-based participatory research approach, the study aimed to capture the lived experiences of Syrian refugee women with regards to MHM, as well as to understand the practices they resort to and the MHM solutions that would be most appropriate within this context.

A combination of qualitative methods was adopted for the research. The fieldwork consisted of data collection through focus group discussions (FGDs) and in-depth semi-structured interviews with Syrian refugee women in the Bekaa. All interviews and FGDs were carried out inside the tents following prior agreement with the participating women. When consent was given, FGDs and individual in-depth interviews were tape recorded. Field notes were always taken in parallel, and more thoroughly in cases where the participants refused to be tape recorded. Data collection took place between December 2019 and January 2020 and was carried out by two female researchers. The selected ITSs in which the fieldwork was carried out are all part of the 10 municipalities where Oxfam had previously undertaken WASH interventions: Saide, Bouday, Hourtaala, Houch Barada, Houch Tal Safeyi, Deir el Ahmar, Btedie, Jabaa, Chlifa and Talia. Informed oral consent was sought so as not to alarm the target population by requiring written consent of legal nature. No names were recorded or noted in order to respect anonymity and ensure confidentiality.

SAMPLING

A total of 10 FGDs and 38 interviews were conducted with Syrian refugee women residing in ITSs in the Bekaa Valley in Lebanon. Over 130 female refugees participated in this study. The research followed a mix of cluster sampling (based on ITSs from each municipality) and stratified sampling (based on age, marital status, etc.). The recruitment strategy was made possible through informal conversations between Oxfam's focal persons and the *shaweesh*² in each ITS. The latter served as a gatekeeper and mediator between Oxfam and the female refugee participants, who were identified and approached by the *shaweesh* at the first stage.

The sample distribution included a wide variety of Syrian refugee women and girls of different age groups and marital status. The age range in most FGDs was 15-50 years and they encompassed a wide sample of unmarried and married girls/women. Some FGDs included divorcees or widows. Interview respondents fell into the following age categories: 10 were adolescent girls aged between 12 and 18 years; 7 were aged between 18 and 25 years; 17 were aged between 25 and 40 years; and 4 interviewees were aged 40 or above. Of the 38 interviewees, 15 were unmarried girls or women, while 22 were married and one was a widow. All the married women had children. Despite attempting to reach a bigger number of girls/women with disabilities, the study could only reach one interviewee with a disability, a 15-year-old girl.

CHALLENGES AND LIMITATIONS

Some obstacles and limitations arose during fieldwork. Firstly, the research assignment was originally planned to be implemented between October 2019 and December 2019 but had to be delayed due to the large wave of street protests that swept the country in October 2019 causing road closures and an unstable security situation. This brought about many unintended consequences, as discussed below.

Oxfam had previously agreed with a partner organization to provide childcare during the interviews and focus groups in order to create a calm environment where women and girls could take their time in sharing their thoughts and ideas. However, given the delay in project implementation, coordinating childcare provision proved difficult and no child-friendly space was ensured, which meant children stayed with their mothers during the interviews and focus groups. This often resulted in a noisy and distracting environment, which might have affected participants' engagement.

The delay in the data collection phase, which eventually began in mid-December and continued into January, also meant it took place during harsher weather conditions. Since most targeted ITSs are not surfaced with concrete or gravel, they deteriorate into a mix of mud and sewage during the winter season. For this reason, on harsh winter days when it rains heavily the refugees hardly ever leave their tents, and those refugees who work in the Bekaa's agricultural fields stay at home. This was one of the recurring challenges the research team faced during the data collection. Because of the mud, female refugee participants were unwilling to go out and gather in a tent for the focus groups; they also felt unable to do the research activity on days when their husbands were home. On rainy days, it was also hard to find a tent where women could gather for FGDs without any men being present, as it would have been inconvenient and unethical to ask men to leave the tents. The weather also limited the researchers' mobility and access, as they commuted to the Bekaa Valley on icy and slippery snow-covered roads.

Another challenge was that many mothers were reluctant to allow the field researchers to interview their teenage girls alone; some even refused to allow the interviews be conducted without their presence, reflecting the taboo nature of MHM. For this reason, adolescent girls were sometimes integrated in the focus groups, or in the case of interviews were accompanied by their mothers. As a result, some perceptions might have been missed, owing to the girls' reticence to talk about their experiences or to express their thoughts freely in the presence of their mothers or other older women. The researcher made every effort to make the girls feel comfortable and to prevent older women from dominating the FGDs, to help diminish any possible bias and capture the views of adolescent girls.

LIVED EXPERIENCES AND CURRENT PRACTICES

This section will discuss the challenges that the Syrian refugee women and girls face during their periods, the practices and coping strategies they adopt, and the implications of such practices on their bodies, lives and overall wellbeing. The extent of the challenges faced by women in the ITSs and the gendered nature of hardship was clearly voiced throughout the interviews and FGDs. Having discussed her own experiences, one participant concluded:

‘Sometimes I wish I were a boy.’ FGD participant (40-50 years age range)

Patriarchy as a structure that discriminates against women is clearly not particular to the context of the refugee camps. However, the implications of patriarchal norms can become exacerbated and amplified when they intersect with other hardships and inequalities. The above remark reflects the gendered nature of the challenges and the extra layer of hardship experienced by girls/women compared to boys/men in the ITSs. This is intensified by the problems around MHM, which not only affects women’s lived experiences but also their perceptions of and relationship with their bodies.

In order to better understand women’s lived experiences and practices in the Bekaa ITSs, the following sections will focus on: (1) menstrual product use and preferences; (2) MHM facilities and disposal; (3) heightened accessibility challenges – the case of a 15-year-old girl with disability; (4) menstrual pain and MHM-related health concerns; (5) MHM in the workplace; and (6) MHM and care/domestic work.

MENSTRUAL PRODUCT USE AND PREFERENCES: ACCESSIBILITY AND AFFORDABILITY

In interviews and FGDs, women and girls were often initially reluctant to admit that they resort to using baby nappies (or baby diapers) or cloths to manage their periods, as this was an issue of dignity. When prompted, some would acknowledge using products other than sanitary pads and then the rest would fall in line and start admitting this too. Nearly all interviewees mentioned the problem of affordability. One FGD participant simply put it as follows:

‘Usually we look for the cheapest product, whether it’s a nappy or a pad.’ FGD participant (30-40 years age range)

Once a certain level of trust had been established with the interviewer, most women reported the exclusive use of nappies. This is in line with findings in the literature that report the use of nappies as a menstrual product by Syrian refugee women in Lebanon (Concern Worldwide, 2018) and in Greece (Vanleeuwen and Torondel, 2018). Some participants said they resorted to nappies only when they couldn’t afford to buy sanitary pads, which tend to be more expensive. Others recounted buying sanitary pads for 4,000 Lebanese pounds (LBP) or 2,000 LBP, but said such packs usually contain fewer pads than a pack of nappies. For some women, this meant that they might need more than one pack of sanitary pads per period, depending on their

blood flow and how many days their period lasts. One interviewee said:

'I use nappies because my mum buys them for my siblings anyway.' Interview respondent (18 years old, unmarried)

Most women who mentioned using sanitary pads specifically stated that they usually go for the cheapest product, compromising on quality. For others, even nappies were not within their means. Many women said they have had to resort to using pieces of old cloth or rags – i.e. pieces of fabric that they cut from old clothing – at some point, and some said they regularly resorted to this during menstruation. This also came up in the literature as a common practice among refugee women (Vanleeuwen and Torondel, 2018). According to one respondent:

'I usually use cloths. Pads cost 2,000 LBP but this is very expensive for me. I can't afford it. Even for my kids, I put cloths on them instead of nappies.' (Interview respondent, 19 years old, married)

Washable cloths are usually considered a reusable menstrual hygiene product,³ but in the case of Syrian refugee women in ITSs this was seldom feasible. Washing these cloths requires a reasonable amount of hot water and soap, which according to participants are scarcely available in ITS communities. As one FGD participant said:

'Honestly, most of the time I cannot get it properly cleaned. So I end up throwing it away after one use.' FGD participant (30-40 years age range)

Another challenge is that the reusable menstrual cloths need exposure to sun to dry. This is impossible in the ITSs, due to limited privacy and the taboo around menstruation. As one respondent explained:

'The cloths need sun to dry, but we cannot hang them outside. All the men in the camp would see them and will know that a woman is menstruating, and this is haram [shameful]. So we put them inside the tent to dry. Sometimes we also hang them outside the tent at night when nobody is around.' FGD participant (30-40 years age range)

As a result of such challenges, the majority of women who use cloths as a menstrual material said they just disposed of the used ones. Nonetheless, there were some women who said they would reuse the cloths, although they specifically stated that reused cloths never got cleaned properly. Many women reported the lack of enough soap to wash the MHM product properly, and they also mentioned the problem of lack of privacy and adequate space to dry the washed product. Some said they would wait for the men to leave the camp during the day so they could hang the cloths in the sun, while others hung them inside their tents or under other laundry so that no one sees it.

Such challenges around the practicality of washable cloths are also reported in the literature (Vanleeuwen and Torondel, 2018; Schmitt et al., 2017; Parker et al., 2014). Studies on MHM have also explored the impact of lack of access to safe hygiene facilities with proper locks and the absence of gender-segregated toilets, which also make it particularly difficult for women and girls to clean and dry reusable cloths or underwear (Ibid.).

Two women cited using tissues as a coping strategy given the lack of financial resources to purchase proper menstrual materials. A few women reported using maternity pads, but none mentioned the use of menstrual cups or tampons. In one FGD, women were asked an experimental question around the potential use of cups. First the moderator had to explain how cups are used, since the women had not heard of this type of product before. As soon as they heard the word 'insertable', some shouted out straight away that they would never use this type of MHM material, which suggests that insertable MHM products are not a culturally appropriate option.

Most if not all participants spoke of their preference for using disposable MHM materials rather than reusable ones; the majority said they favoured disposable sanitary pads for reasons of comfort, quality and hygiene, but cost was mentioned as an impediment by almost all interviewees. This preference for disposable sanitary materials over reusable cloths reflects the findings of other studies in the context of Lebanon (Schmitt et al., 2017). A qualitative assessment conducted in Myanmar and Lebanon highlights the constraints and effects that a given environment has on the types of MHM materials used by refugee women and girls (Ibid.). According to the study, women in Lebanon reported a preference for sanitary pads, especially given the absence of privacy, lack of available disposal alternatives, lack of access to water and soap, and the logistical problems of hanging cloths outside in the sun to dry (Ibid.). However, since the purchase of disposable pads was an unsustainable option due to cost, Syrian refugee women had to resort to using reusable cloths as a coping mechanism (Ibid.).

Interviews and FGDs revealed that a number of women preferred to use nappies, given that their absorbent capacity and larger size prevented any leaks in the event of heavy flow. Some said that the type of sanitary pads that they purchase are usually of poor quality and tend to crumble. Many of the women who use them, or nappies said these gave them allergies. Most women did not have any preference for a specific brand for sanitary pads, although a (very) few did mention that the brands 'Always' or 'Private' offer good-quality disposable pads. Cloths were the least-favoured menstrual materials as they are uncomfortable, are the least effective in terms of absorbing blood, and often result in infections. This is in line with findings from numerous studies conducted with women in displacement (Schmitt et al., 2017; Parker et al., 2014; Sommer et al., 2018; Vanleeuwen and Torondel, 2018).

One participant made an interesting observation revealing how women's social lives depend on the quality of the menstrual product they use:

'If I am using bad-quality pads or cloths, I don't leave my tent and I avoid going out. If I am using the good ones, I allow myself to go out or visit the neighbours.' FGD participant (30-40 years old age range, married)

This finding on women and girls' restricted mobility during menstruation has also been reported by Schmitt et al. (2017) in Myanmar. Their study indicates that many interviewed girls would save their sanitary pads for days on which they have to leave the house, since they could not do so if wearing a pad made of cloths (Ibid.). Similarly, VanLeeuwen and Torondel (2018) reported that Syrian refugee women in Greece mentioned their physical whereabouts as a factor affecting their choice of MHM product.

Unaffordability was not the only factor preventing women from buying sanitary pads. While pads are available in nearby pharmacies and markets, women talked about the challenge of purchasing menstrual products if a male was serving at the shop counter. Some women said they would make several trips until there was a woman serving, so they could buy products comfortably. This challenge relates to social norms that stigmatize menstruation and transform the buying of MHM products into a protection concern, with women fearing harassment if the shopkeeper is a man. Some women said that their husbands buy them menstrual products, but this was not an option for everyone. According to one participant:

'I don't have access to pads since I don't go out. Mostly my husband shops for the family, and he doesn't feel comfortable buying pads.' Interview respondent (25 years old, married)

Unmarried girls living with their parents relied on either their mothers or fathers to purchase menstrual products for them. For the most part, women stressed that their choice of menstrual product was their own, and that husbands never interfered with this choice. Nonetheless, as they desperately struggle to make ends meet, women did not consider menstrual products to be

a household priority. According to one participant:

'A bread bundle is worth a thousand pads.' Interview respondent (31 years old, married)

Similarly, many women said that while their husbands do not prevent them from buying menstrual hygiene products, they simply would not ask for the money for them because of the family's financial situation. Economic hardship thus forces women to deprioritize their menstrual hygiene needs and opt for cheaper alternatives – such as using nappies or old pieces of cloths – that are not ideal from a hygiene, comfort or medical perspective.

MHM FACILITIES AND DISPOSAL: PRIVACY, SAFETY AND SOCIAL STIGMA

Dealing with menstruation with dignity requires private and safe hygiene facilities, which are most certainly lacking in ITs in the Bekaa Valley. One of the biggest concerns raised by most interviewed women and girls was the lack of safe and private spaces to change menstrual material. Communal latrines are usually placed outside the tents and are sometimes shared by more than one household. In some cases they are not situated close to the tents; this requires menstruating women to walk all the way to the toilet through the camp carrying menstrual products in their hands, as well as carrying menstrual waste back with them, since most latrines do not include waste bins. Furthermore, many toilets do not have a lock, and there are often many people assigned to use one toilet. This makes it very difficult for women to change their menstrual materials in the communal latrines, given that people would very often come and knock or even push the door and open it. As one refugee woman said during an FGD:

'You don't feel like you are in a bathroom when you use the latrines. It feels like you are in the open air.' FGD participant (20-30 years age range, married)

Another woman also expressed her discomfort at using the communal latrines, saying:

'One toilet flush, and the whole camp hears the noise and they know what you are doing. It's embarrassing!' (Interview respondent, 31 years old, married)

The struggle and anxiety involved in reaching the toilet were expressed by one participant as follows:

'When I have my period and I need to use the external bathroom, I keep observing the place around it. [...] I don't dare pass by my neighbours' tent to use the bathroom, in case they have guests over. Instead, I walk all the other way across camp to reach the bathroom.' Interview respondent (42 years old, married)

Participants mentioned an additional accessibility challenge that arises during the summer. Men tend to gather outside on a daily basis, which makes it even harder for menstruating women to visit the toilets, especially when men gather near the latrines. As mentioned above, in the winter months the wet and muddy conditions create yet another obstacle for women and girls trying to reach the latrines.

For all the above reasons, the majority of interviewed women and girls reported changing their menstrual materials inside their tent, in the absence of a proper menstrual management facility equipped with water, soap and basins. However, even in their own tents many women and girls said they felt unsafe while changing, given that most tent doors cannot be locked.

Women and girls who changed inside the tent or in the communal latrines mentioned that they would always have someone guarding the door for them. For some, their daughters provided

this assistance, while others said their husband would accompany them to the bathroom, especially at night, and guard the door while waiting outside.

Women reminisced about their lives in Syria, frequently recalling better menstrual hygiene practices back home. They all expressed the loss of privacy as the hardest change they have had to endure since their arrival in Lebanon. As one of the interviewed women put it:

'Things were different in Syria. We had our privacy. I had my room, my bathroom. I could lock the bathroom and take all the time I needed to change pads comfortably. Here in the tent, anyone can push the door and enter. I always need to stay alert and I am always rushing when changing a pad.' FGD participant (30-40 years old age range)

While all interviewed women spoke of the loss of privacy and the challenge of accessing latrines safely and without social stigma, another important challenge was also often mentioned: the disposal of menstrual product. Most interviewed women spoke of the difficulty of disposing of the used menstrual product. The majority said they burn them, but many did say they would sometimes throw them away. For those who burn the used pads or cloths, more than half said they would stack put them up in a black plastic bag until it is full and then burn them together. Others said they would burn each one on the spot. A few women mentioned not burning the menstrual materials because the tents in their ITS are so close together; instead, they put them in a black plastic bag, put that into another black plastic bag and throw it in the rubbish lorry.

Such disposal practices were also reported in another study, where women mentioned their preference for putting the MHM materials in dark-coloured bags and later burning or burying them (Schmitt et al., 2017). This study revealed that placing waste bins in latrines was an unpractical solution, since women and girls would not use these to dispose of their used pads (Ibid.). Their chosen methods of disposing of the used materials are indicative of cultural beliefs of shame and humiliation around menstruation, as well as the stigmatization and taboo around menstrual blood. When asked why they opt for burning, one woman answered:

'Why burn them? Because if dogs started messing around the rubbish bags, everybody will know who had her period, and this is haram [shameful].' (FGD participant, 40-50 years old age range).

Although some women mentioned that burning used MHM products was also practised in Syria, others said that they only started to use this disposal method after arriving in Lebanon. When asked if they would use a bin with a fixed lid, that doesn't show its contents, many women welcomed the idea; however, they insisted that they would only use bins if they completely hid the disposed-of product. Thus, providing bins with fixed lids (usually stainless steel) in public toilets could be a possible solution for solid waste management and disposal. It is clear from the findings that the need for 'hiding' one's menstruation and finding ways to make it 'invisible' to the community means that women and girls carry the burden of MHM in silence and with much social and psychological pressure to act as if it didn't exist.

HEIGHTENED ACCESSIBILITY CHALLENGES: THE CASE OF A 15- YEAR-OLD GIRL WITH A DISABILITY

The challenges around access to decent MHM facilities are even more acute for girls and women with disabilities. Our interview with a 15-year-old adolescent with special needs (both physical and mental disabilities) and with her mother (her main caregiver) showed that inaccessibility is a serious obstacle to proper MHM for people with disabilities. While Houch

Barada, the ITS where they live, is equipped with an accessible toilet, the facility had flooded months before and had been out of use ever since. As a result, instead of being carried to the bathroom by her mother, the girl is forced to use the drain for urination and defecation. When she is menstruating, her mother puts her in nappies. Her mother tries to change her nappies three times per day, but considering the lack of disabled-accessible facilities, this is very challenging. As her mother contemplated the situation, she lamented:

'I just wish she would stop getting her period.'

When the mother uttered these words, her daughter just looked at her with sad eyes. The question of dignity is at the heart of providing accessible MHM facilities for women and girls with disabilities, for whom the already complex challenges of MHM are even more acute.

MENSTRUAL PAIN AND MHM-RELATED HEALTH CONCERNS

Most interviewed women referred to menstrual pain as being one of the hardest aspects of their periods. One compared the excruciating pain to that of *'going through labour'*. Another said:

'I would rather stay pregnant than get my period. The pain is so unbearable, and I never know what to do. I just sit on the ground, grab the sheets and press them to my stomach...[and]... just wait for it to be over.' FGD participant (20-25 years age range, married)

Women recounted suffering menstrual cramps, lower back pain, breast pain, thigh pain, stomach aches and abdominal pain, headaches, diarrhoea and nausea. The cold, humid atmosphere in ITSs makes the stomach aches even worse, and pain-relief medication is not always available to or affordable for refugee women. Several (mostly younger) women said they resorted to using medicines inserted via needles or suppositories, which they sometimes obtained from mobile clinics run by the International Committee of the Red Cross (ICRC). Again, such medications are not always accessible or affordable; the women who use them said that cost was never a problem back home in Syria, since *'everything was so cheap and accessible'*.

Some women said they take hot drinks to relieve menstrual pain, such herbal or camomile tea, cumin seed tea, thyme tea or lemon balm. Some said they use hot water bottles to ease menstrual pain, while others mentioned taking medications such as Panadol or Profinal. But for some younger women, economic hardship in addition to the social stigma and feelings of shame around menstruation, meant these options weren't always available:

'Lately, I have become too shy to ask my parents for pain medication. Sometimes it hurts so much at night that I cry myself to sleep, but I don't want to tell them. I feel like I am a burden on them.' Interview respondent (16 years old, unmarried)

Most participants said that menstruation affects their mental health and emotional wellbeing. Many said they would get ill-tempered during their periods, and a lot of women expressed feelings of irritation, anger and annoyance, while others said they lose their appetite.

Findings also revealed women's general sense of discomfort with their bodies during menstruation. However, one participant said she felt happy during her menstrual cycle because the *'dirty blood'* was getting out of her system. Other participants, especially adolescent girls, said menstruation makes them very uncomfortable in their bodies, which is why they prefer to be left unbothered and alone. Some said they don't like seeing or talking to anyone. As expressed by one refugee girl:

'When I get my period, I am always angry, and I get easily irritated, so I try to stay out of everybody's way.' Interview respondent (17 years old, unmarried)

Poor menstrual hygiene conditions in ITSs have resulted in infections for many women and raised some serious health concerns in relation to MHM. One participant said:

'Sometimes I get inflammations after my period, especially when I use bad-quality nappies. They also give me a rash and urine infection.' Interview respondent (25 years old, married)

Many women reported having developed allergies as a result of using old cloths, and sometimes when using nappies. In one FGD, women mentioned that using laundry detergent (specifically referring to the brands 'Persil' and 'Ariel') to wash their reusable cloths often gave them allergies. Most girls and women experienced itching, rash and redness, while many mentioned constipation and Urinary Tract Infection (UTI) symptoms, such as a burning sensation during urination. Women's tendency to reduce the number of visits they make to the toilet during menstruation, given the challenges mentioned above, is a major reason for the development of some medical complications such as constipation or UTIs. In a study by Concern Worldwide (2018) of MHM among Syrian refugee women in Northern Lebanon, the women participants also spoke of inflammation and UTIs as a direct result of using low-quality reusable cloths.

Other MHM problems included menstrual disorders, such as irregular menstrual cycles. The women rarely mentioned consulting a doctor, whether to ask for menstrual pain-relief medication or to treat infections or other health-related MHM problems. Some reported that doctors were neither affordable nor easily accessible, since there aren't any buses or taxis serving their ITS, which means they would need to organize a private lift to reach the hospital or clinic. Some also said they were 'too shy' to visit a doctor, and many said they would go the pharmacist instead. Masterson et al. (2014) conducted a needs assessment study on reproductive health and violence against Syrian refugee women and reported a number of gynaecological problems ranging from menstrual irregularity to pelvic pain, reproductive tract infections and complications during pregnancy and/or delivery.

The fact that infections and inflammations were mentioned in most interviews and FGDs – and that many participants considered these to be normal or natural since they experience them so frequently – raises some serious health and hygiene concerns about the Bekaa's ITSs.

MHM IN THE WORKPLACE

The Bekaa Valley is known as Lebanon's agricultural hub. Given that Syrian refugees residing in the ITSs have few employment options but can provide low-skilled cheap labour, many have joined the agricultural workforce in the Bekaa; indeed, most interviewed female refugees engaged in seasonal agricultural work. However, managing menstruation in this workplace environment carries its own challenges. Since most women and girls work in the tobacco or vegetable fields, they have no access to sanitation facilities during the day. In addition, their workdays tend to be long, and the fields where they work are often located several miles from their ITS; agricultural workers therefore usually commute together and have to wait until the end of the workday to go home. Given the lack of WASH facilities, many women and girls choose to skip work during their periods, thus directly affecting their household income. Others said they couldn't afford a reduced paycheck or feared losing their job if they miss their shifts, and would still go to work despite the lack of facilities. In many cases women who are menstruating are forced to go to work by the *shaweesh*, even when they are experiencing fatigue and pain. According to one adolescent girl:

'We don't dare miss out on a work day! Even if we have our period, the shaweesh forces us to go.' (Interview respondent, 17 years old, unmarried)

In the event of severe menstrual pain and fatigue, many participants said they would skip work at least on the first day of their period to rest. Some said that if they knew that their period would be starting the next day, they would not go to work. Starting their period unexpectedly while at work in the field is challenging for women and girls, given the lack of facilities. Some reported hiding in the field to quickly and secretly put on a MHM product, if they have one with them, and some mentioned wearing their jacket around their hips to avoid bloodstains showing. One interview respondent recalled:

'Once I was working in the field, and it leaked. I got so nervous, but thank God there were nearby toilets, and I went and changed.' Interview respondent (17 years old, unmarried)

In the event of menstrual pain starting when they were at work, some women said they would hide in the field or claim they had a headache to stop working, then wait until the end of the workday to go back to the ITS. Women also spoke of trying to cover up for others so that the 'engineer' or 'manager' doesn't realize that a woman is missing, but this doesn't always work, especially when workers are counted. This raises protection concerns, since in many cases women who start menstruating in the field face abusive comments for hiding or not working and are forced to return to work.

MHM AND CARE/DOMESTIC WORK

It is important also to consider the implications of menstruation on the unpaid labour that women and girls undertake: care and domestic work. As discussed above, traditional gendered roles are sustained and amplified throughout displacement. Both women and girls, regardless of whether they have jobs or go to school, are expected to attend to domestic duties and care responsibilities. This adds yet another burden on female refugees during menstruation, particularly at times of severe menstrual pain. While some women and girls manage to miss one or more work days in the field during their periods, care and household chores are inescapable. This was clearly expressed in many of the interviews and FGDs.

As an ice-breaking exercise, the interviewer would usually start the discussion by asking women and girls about their daily routine. Married women almost unanimously started their answer with: 'In the morning, we prepare breakfast for our kids and husbands.' Unmarried women and girls were also responsible for helping their mothers with household chores. Women rarely said that they could put off their housework until later if they were menstruating. Many said they could not rest because their husbands would be very irritated if they didn't do the housework or prepare the meals. Some women specified that they avoid doing any non-essential housework during their periods, while others said they would avoid lifting heavy things. Nevertheless, the main domestic duties, including cooking and cleaning, could not be postponed. According to one FGD participant:

'My husband sometimes helps me with the housework, but he would get really angry if I didn't cook.' FGD participant (30-40 years age range, married)

One young participant found housework such a burden during her period that when asked about potential solutions that could help her better manage menstruation, she replied:

'Solutions? Not to do housework during my period.' Interview respondent (19 years old, unmarried)

Many women spoke of housework as their 'duty'. When asked why men are not supportive or helpful in these chores, one focus group participant responded:

'Because it is not their duty to help.' FGD participant (40-50 years age range, married)

Another replied:

'They don't cook or clean because they don't know how to!' FGD participant (30-40 years age range, married)

Many women spoke of their reliance on their daughters, sisters, and other female relatives or neighbours for help with housework during menstruation. This solidarity among women is further explored below.

PERCEPTIONS AND ATTITUDES

This section explores communal perceptions and cultural sensitivities around menstruation, as well as knowledge and education around menstrual hygiene. It also examines women's perceptions of their experiences and the coping strategies they have put in place to meet their menstrual hygiene needs.

COMMUNAL PERCEPTIONS AROUND MHM: SHAME, SECRECY AND DIETARY/LIFESTYLE RESTRICTIONS

During one of the focus groups, a girl recounted when she got her first period. As she told her story, it became clear that the older woman next to her was getting uncomfortable, as she kept looking away and blushing. The girl recalled how she had gone to use the bathroom and was shocked to see blood on her underwear. When she uttered the word 'blood', the older woman next to her gently kicked her in the leg and said 'aayb!', which translates as 'shameful!'. The younger girl laughed and went on with her story.

This is a minor but telling example of the intergenerational differences observed during the fieldwork. It also clearly reflects the notions of shame, embarrassment and even disgrace associated with menstruation and menstrual blood. Such social values are deeply embedded in a patriarchal culture that sustains menstruation as a taboo. Whenever perceptions around menstruation were brought up, nearly all participants would describe it as being 'aayb' or 'haram' (which also translates as 'shameful') at some point in the discussion. Some women mentioned that they would not use the latrines during menstruation because it was inappropriate for boys or men to see blood if they use the toilet after them. During one of the FGDs, women elaborated on how they had to 'hide' their menstruation from boys and men and find excuses or stories to cover it up. One woman explained:

'There is a woman in the camp who is hospitalized every month during menstruation, so every month we give a different excuse to the men. Sometimes we tell them she has food poisoning, and other times we say she has a high fever.' FGD participant (30-40 years age range)

This notion of secrecy has major implications for MHM. The taboo around menstruation creates a sense of paranoia among women and girls, who fear that other people might sense they are at 'that time of the month' again. As described above and as confirmed in the literature, feelings of discomfort and fear of menstrual leaks showing on clothing also preclude women and girls from carrying out their daily activities in a normal manner (Parker et al., 2014). Studies in Uganda (Ibid.) and North Lebanon (Concern Worldwide, 2018) have also revealed that some girls stop attending school during their periods and fall behind academically, while other girls/women refrain from going to work, thereby compromising their household income.

In the Bekaa, the stigma around menstrual blood and the fear of staining one's clothes disrupts women's daily activities and causes some to completely put their lives on hold during menstruation. As stated by one participant:

'I don't go out when I get my period. I get the feeling that people can see right through me and everybody can tell that I am menstruating. And they can also smell it.' FGD participant, (20-30 years age range)

One interviewee recalled missing her children's vaccination appointment because she was menstruating and did not want to go out. When she took them to the clinic a few days later she was humiliated and turned away for having missed her appointment, but she was too embarrassed to explain why she had missed it. Her children remain unvaccinated – one of many unfortunate consequences of the challenges refugee women face in managing menstruation. The fact that the implications are as far-reaching as children missing vaccinations or medical appointments raises a serious protection concern. There is an urgent need to take this issue more seriously while also taking into account women's dignity. In fact, many women reported being treated with disrespect by healthcare workers, which actually led some of them to refrain from using the services. One participant said:

'They treat us with disrespect. Last time I was there, the doctor was disgusted by my son's feet and did want to touch him because his shoes were covered with mud from the camp. They think they are cleaner than us!' FGD participant (30-40 years age range, married)

As alluded to above, some women avoided going out during their periods because they were worried about the issue of 'smell'. Many reported that they refrained from using the communal latrines as they feared leaving traces of smell behind, while others expressed their discomfort at changing inside the tents for the same reason. One interview respondent mentioned using perfume to attempt to cover the odour.

As clarified by participants, cultural beliefs that consider women and girls to be 'unclean' or 'impure' at the time of menstruation pose restrictions which touch upon many aspects of a woman's life, including food and dietary restrictions. The majority of participants said that during their periods they do not eat yogurt or lemon and do not drink coffee. Some also mentioned not eating onions, tomatoes and spicy food. Most women said they do not shower for the first days of their period, and more than half said they do not shower at all during menstruation. As articulated by one participant:

'Yogurt gives you stomach ache and showering makes the pain worse. So I don't eat yogurt and I try not to shower.' Interview respondent (35 years old, married)

Another acknowledged:

'I don't shower during my period. I taught this to my daughter as well. I don't let her shower, at least not for the first two to three days.' Interview respondent (30 years old, widowed)

At times, intergenerational differences were observed in the interviews and FGDs. A number of adolescent girls showed a level of resistance to some of these customary practices and refused to abide by them. However, this should not be overstated as the pattern was not very clear. One of the interviewed adolescents confidently stated:

'They tell me I shouldn't shower and they say a lot of things about what to do, but I don't listen to them. I do what I want.' Interview respondent (19 years old, unmarried)

Another girl also expressed her refusal of the 'shower ban', stating:

'I can't not shower because my period lasts around six days, but my mum says I shouldn't shower. [...] She always tells me that the pain is all my fault and that if I had stayed warm

and taken care of myself, I wouldn't have pain on the first day of my period. She always blames me.' Interview respondent (17 years old, unmarried)

Other cultural beliefs about things women should avoid doing during menstruation included: plucking eyebrows or removing any body or pubic hair; brushing hair; touching food, and especially baking bread. Most participants were in agreement that sexual intercourse during menstruation is completely frowned upon. While discussing the effect of menstruation on intimate life and asking whether sexual activities were maintained during menstruation, one FGD participant promptly responded:

'Of course not! It's haram. And it's also disgusting.' FGD participant (30-40 years age range, married)

EDUCATION AND KNOWLEDGE AROUND MHM

The main findings around MHM knowledge revealed that women and girls have little and, more often than not, false information on menstruation and MHM as a result of the culture of shamefulness around it that precludes them from discussing it openly and comfortably. Adolescent girls are not properly taught about menstruation and puberty and are often left with many unanswered questions.

The taboo nature of menstruation results in misinformation and/or lack of information around menstruation and MHM (Schmitt et al., 2017). The study conducted by Concern Worldwide (2018) with Syrian refugee women in North Lebanon revealed that pubescent girls who were about to start or had recently started their periods had received little basic practical information from their mothers on how to manage menstruation. Mothers also pass on cultural norms and practices to their daughters, which sometimes unintentionally perpetuate stigma around menstruation (Sommer et al., 2017).

In the Bekaa, nearly all participants said they typically received information on starting menstruation and MHM from their mothers, while others also mentioned their sisters or aunts; very few referred to friends. In one FGD, participants said that they had previously attended a training session around menstruation organized by Médecins Sans Frontières. For some girls and women, basic information around menstruation had been part of their school curriculum back in Syria. One woman stated:

'At the age of 10, we study puberty for males and females in the science books. It's in the curriculum in Syria.' FGD participant (38 years old, married)

More than half of the girls and women believed that the information provided to them at the onset of menstruation was insufficient or inadequate, and many said they were too shy to ask for further information. Several girls and women had not learnt about menstruation at all, and recalled feeling terrified the first time they had a period. According to one FGD participant:

'When I first got my period, I got so scared I lost my mind. I didn't know what was happening, and I kept thinking that my father was going to kill me.' FGD participant (40-45 years age range)

Several participants said they refrained from telling their mothers when they started menstruating:

'I first got my period when I was in the 8th grade, and my mum did not find out about it for another year or two. I was very shy and when she asked, I always told her that I still

hadn't started my periods. I made sure nobody knew about it. My friend also didn't tell her mother about it for five or six years.' Interview respondent (22 years old, married)

Early child marriage was referred to in all FGDs and interviews. One of the participants said that when she first got her period, her mother told her that she was now a grown woman who was ready for marriage. Many of the adolescent girls who participated in the study, some of whom were as young as 15, were already married with children. One participant said she started her periods at the age of 14 and got married that same year. Another woman revealed that she married her adolescent daughter to young man before the girl had even entered her reproductive years. In an informal conversation with field researchers prior to the beginning of a focus group, two sisters aged 19 and 22 said they were already considered 'spinsters', and often treated as unmarriageable in society, since they were reaching the upper age limit for marriage. This conversation occurred after their brother-in-law jokingly asked the researchers if there were any eligible bachelors who would be willing to marry the two girls.

In addition to the lack of awareness around female menstruation and menstrual health in general, social pressure linked to female reproductive years and the social perceptions and beliefs surrounding menstruation, contribute to its taboo nature. Explanations as to why cultural restrictions exist around menstruation varied among participants and were not clearly defined. Some said showering during menstruation would disrupt the blood flow, while others said it causes stomach pain. A few even mentioned that it would result in infection or inflammation. It seemed clear that adolescent girls did not always understand the thinking behind these practices. During one of the interviews, a young participant said:

'I don't know why I shouldn't shower, but I trust that my mum must have a good reason [for telling me not to].' Interview respondent (16 years old, unmarried)

Another stated:

'My mum says that we shouldn't eat yogurt during our period, but when I ask her why, she just answers that some things are just the way they are. I don't really feel comfortable talking about this with my mum or my sister. [...] Sometimes I get itchy, but my mum says it's normal. Her answer is not convincing, and I'm scared I will get infected.' Interview respondent (17 years old, unmarried)

At one point, this same young woman even asked the field researchers:

'Is it really true that the pain gets worse if I shower during my period?' Interview respondent (17 years old, unmarried)

Lack of information or convincing answers to such questions was a recurring theme throughout the interviews and FGDs. Women and girls alike stated that many of the inherited beliefs are taken for granted and applied without really understanding or knowing why this is the case. In addition, the lack of information was clearly observed in the most basic aspects of menstruation, as some women were not aware of the different types of menstrual products and others did not know how to wear them. In one interview, the respondent revealed that she used nappies because she didn't know how to wear a sanitary pad. In another interview with a 17-year-old girl, she did not even know which type of menstrual product she was using; when asked whether she uses nappies or sanitary pads, she said she didn't know the difference.

In one of the ITSs, a refugee woman said she had been looking forward to the interview as she and her neighbour wanted to ask the field researchers about whether it is medically acceptable to take part in sexual activity during menstruation. She continued:

'Naturally, men want to sustain their sexual activity even when we are menstruating, but we try to avoid it. My husband has another wife, but she's in Syria. My neighbour says

it's okay to have sexual relations during your period, but my mum used to tell me it causes endometrial cancer.' Interview respondent (42 years old, married)

Most interviewees expressed a need for more information, as they had many remaining questions without clear answers. When asked about potential solutions that could help her to manage menstruation, one interviewee said:

'Perhaps you could give us more information?' Interview respondent (30 years old, married)

Another responded:

'For instance, you could give us some advice for what to do when we get our period... something like an awareness session.' FGD participant (30-35 years age range)

A STRONG SUPPORT SYSTEM AMONG WOMEN

Amid poor menstrual hygiene conditions, limited information and resources, and the lack of support from husbands and male relatives, women take comfort from each other. Through the interviews and FGDs, a strong informal support system among women was observed, particularly among female family members. Many mentioned that during menstruation they receive help from their daughters, neighbours, sisters, sisters-in-law or even mothers-in-law. In most cases, women reported that if they were very tired or in pain during the first day of their period, they usually asked their daughters, female relatives or a female neighbour/friend to do the housework and prepare food. Some also reported that their husbands would make them a cup of tea if they were in pain, as an act of kindness and sympathy. However, it is unlikely that men or even boys would take on the housework when women are unable to carry on with daily tasks during menstruation.

Women's support for each other during menstruation was not only manifested through domestic help. As mentioned earlier, female family members would often guard the latrine or tent door to allow women to change menstrual materials in privacy. Some women said that they would borrow pads or nappies from their sisters, cousins or sisters-in-law. As shown above, the strong bond among women was clearly exemplified in one FGD, when the women described how they would cover up for a woman who is hospitalized every month during her period. However, a few women, especially those who don't have family members around, reported not receiving much support from female relatives or friends during menstruation.

Overall, the women's support network helped to compensate for the general lack of support from male figures in the family. Few women reported that their husbands were supportive or understanding during their periods. In FGDs, the women often bonded by complaining in a humorous way about this lack of support. According to one FGD participant:

'Men provide monetary support but no moral support!' FGD participant (40-50 years age range, married)

Moreover, as expressed by most married women in the sample, their husbands were not pleased to hear about their periods, as this would disrupt their sexual activity.

'When he realizes that I am menstruating, he immediately throws me a frowned look. He doesn't like it when I get my period.' FGD participant (30-40 years age range, married)

Another focus group participant added:

'When I get my period, his impatience grows. He stays angry at me from the first day of my period until the last day.' FGD participant (30-40 years age range)

One interviewee said that her husband is sometimes so angry with her when she is menstruating that he chooses to sleep in their neighbour's tent. One focus group participant concluded:

'Men don't have emotions, nor a conscience!' FGD participant (30-40 years age range)

Men's generally unsupportive attitude clearly reflects the taboo nature of menstruation and serves to perpetuate damaging stigmas and social norms.

POTENTIAL SOLUTIONS AND RECOMMENDATIONS

The FGDs and interviews laid bare the daily challenges the women refugees face as they try to navigate their menstrual hygiene needs. Participants were asked to rank and prioritize a set of actions that humanitarian actors could take in order to help them better manage their MHM needs. The following recommendations are based on the lived experiences and stories recalled by Syrian refugee women and girls, and their suggestions on ways to improve MHM in ITSs:

1. WASH actors, including Oxfam and partner organizations, should distribute menstrual hygiene materials (including menstrual pads, soap and cotton underwear, provided in a basin that can be used to wash reusable pads) to women and girls in the form of hygiene kits rather than vouchers.

This would address the fact that MHM products are often deprioritized in household spending. It would also help overcome the problem of social stigma around buying menstrual hygiene products from shops run by men and reduce women's dependency on their husbands to buy menstrual products for them. During the fieldwork, women explicitly reported lycra underwear (which is usually the least expensive) to be uncomfortable and to trigger allergies and infections and asked for cotton underwear.

Women also expressed their preference for disposable pads, but said they wouldn't mind reusable pads if a private space is available for washing and drying them and if enough washing soap is distributed. When asked about the reusable pads that were previously distributed by Oxfam, many women said that they are not thick/absorbent enough, so they usually use them as a supplement or only use them towards the end of their period when their flow is lighter. Women also said that the amount of soap distributed in the Oxfam kit is insufficient for washing the pads properly.

It is important to note that menstrual materials such as tampons or cups are not culturally appropriate in this context; many women were uncomfortable even talking about such products and said that it would be problematic for non-married girls to use them. Provision of menstrual materials needs to be complemented with organized sessions about how the different menstrual products can be hygienically used.

2. WASH actors, including Oxfam and partner organizations, should use a participatory decision-making approach in designing latrines and deciding on their location.

It is crucial to take into account women's voiced concerns and needs prior to proceeding with a WASH or MHM intervention. According to the FGDs and interviews, most women expressed their support for household latrines located inside, or in close proximity to, their tent. It is recommended to set up internal latrines (i.e. inside the tents) at least for the most vulnerable people or for those who face problems accessing MHM facilities that are far from their tents. Latrines close to tents should have proper ventilation to tackle the problem of unpleasant odours. For people with disabilities, internal latrines should be properly equipped to cater for their needs, as well as periodically rehabilitated (e.g. in the event of floods). Where latrines are outside the tents and shared by the community (i.e. not exclusively for the household), most women indicated that gender segregation (separating male and female facilities) would help them better manage their menstrual hygiene.

Women also mentioned the need for larger latrines to enable them to wash and change comfortably. Communal facilities should be equipped with locks so that women can feel safe and comfortable when changing their menstrual products and disposing of waste. It is

necessary to resurface the ITSs with concrete or gravel to make shared latrines more accessible during the winter season. In terms of protection concerns, ITSs need to be well lit at night to make access to latrines safe. If lighting is not possible, women should be equipped with a torch and a whistle for their safety and protection.

MHM programming should also pay attention to solid waste collection by installing waste bins with fixed lids in MHM facilities. Many women said that they would consider using bins (instead of burning and using several dark plastic bags for rubbish disposal) as long as their contents are concealed. Whether the facilities are for household use or communal but gender segregated, bins with fixed lids would solve the problem of disposal of menstrual products, since the main reason for burning or using dark plastic bags is the desire to hide menstrual waste from boys and men. Finally, toilets should be better designed for use by pregnant women, through providing larger latrines and seated toilets instead of squat toilets.

3. Development and humanitarian agencies should create women-only spaces to engage women and girls in the production of MHM products and to support women's livelihoods and informal solidarity networks.

During one of the FGDs, some women mentioned that providing a women-only space/facility with toilets inside would be a better option than locating female toilets outside next to male toilets, as it would be difficult to prevent men from using the women's toilets if they are located outside. Creating a women-only facility could also address many of the challenges mentioned throughout this report, by providing a space for women to: (1) socialize and reinforce informal peer-support networks, and to overcome social isolation during menstruation; (2) use the toilet comfortably and without stigma during menstruation, and solve the problem of waste disposal and management; (3) produce reusable MHM products, and wash and dry them when needed; and (4) take part in activities and awareness sessions on women and girls' issues (as recommended below).

Providing the raw materials for producing reusable MHM products (cloths, cotton and a sewing machine) and a shared space for women to meet and work will enable women to produce their own MHM products, which they can sell at low cost to other women in nearby ITSs to make some income. This is a more sustainable solution than the provision of MHM materials and would also help refugee women to sustain themselves independently. However, this is contingent on providing adequate facilities and creating the necessary space for girls and women to be able to produce MHM products and to manage their own menstrual hygiene in comfort and dignity.

4. Health, WASH and education actors should organize information sessions around menstruation and hygiene for girls and women. This would support mothers in preparing their pubescent daughters for menstruation, especially as the role of schools in such education is not applicable in the context of Syrian refugees living in ITSs in the Bekaa. This recommendation stems from the concerns of more than half of the participants about lacking sufficient knowledge around menstruation, and the fact that so many women approached the researchers with questions regarding MHM and the validity of their cultural beliefs and practices from a medical perspective. It is clear that information sessions are much needed to help demystify MHM practices and to debunk taboos, myths and nonfactual beliefs. Similar sessions could be specifically designed for pregnant women to answer their questions on pregnancy and birth and guide them through the post-delivery process. Such sessions have proved successful in the past, as many women spoke about having changed their behaviour (e.g. regarding showering or wearing lycra underwear) after attending awareness sessions with other organizations.

5. Health, WASH and education actors need to set up youth programmes that provide structured psychosocial support in the form of awareness-raising sessions on menstrual hygiene management for adolescent girls. This idea draws upon the interviews and

discussions in FGDs about women and girls' past experience in Syria, when they were taught about menstruation as part of their school curriculum. Such sessions would also introduce adolescents to puberty and attempt to break the silence and overcome the taboo around menstruation. They would focus on encouraging girls to prioritize their needs and comfort in an attempt to counter the de-prioritisation of MHM. The psychosocial support provided during the sessions will also address girls' relationship with their bodies and help them to adapt to the new experience of menstruation.

6. Health, WASH and education actors should also organize awareness sessions for boys and men, if additional budget is available. While the priority for MHM is to address girls' and women's needs, awareness sessions for boys and men can be helpful in trying to address the underlying patriarchal structure and culture that complicates women and girls' ability to manage their menstruation comfortably. Such sessions can also help to break the taboo around menstruation. However, despite their usefulness in creating a space for reflection and debate, given the limited ability of awareness sessions in themselves to change established patriarchal structures, it is advisable to only implement such awareness sessions if a separate budget is available for male-related programmes.

7. Health actors should ensure rotational visits of midwives or gynaecologists to the ITs. When asked to share their opinions and ideas about an MHM intervention that could better support their needs, most participants spoke of financial restrictions and accessibility issues that prevent them from receiving much-needed medical attention. Some were in dire need of menstrual pain relief medication, others were concerned with menstrual health complications such as infections or menstrual irregularities, while pregnant women needed prenatal care or basic check-ups. Providing rotational visits of doctors or midwives to the ITs would cater for women and girls' needs and help to answer their questions.

8. Oxfam and livelihoods actors need to tailor cash for work programmes to take into account women's needs. Oxfam's current cash for work programming enables numerous women in the Bekaa to earn an income and become more independent. However, when designing cash for work programmes it is important to take into account the many MHM obstacles in the workplace that were raised by the women refugees – especially those who work in the agricultural sector. Measures that can be taken to cater for women's needs in the workplace include: providing latrines (especially in agricultural fields) where women work, offering flexibility in work schedules (e.g. allowing women to take a day off if needed during their periods), providing decent work conditions and providing childcare to enable women to go to work.

9. Organizations implementing WASH must address the issue of a male-dominated sector and de-prioritisation of women's distinct needs, including MHM, in humanitarian interventions. Based on the literature and on some preliminary observations from the field, it is crucial to adopt an integrated approach that links all sectors of humanitarian interventions within a holistic framework that does not deprioritize women's distinct needs. To do so, it is important to have the input and involvement of women community workers and humanitarian actors, and to always adopt a consultative approach with the community. It is advisable that Hygiene Promoters in the WASH programmes are women, and it is important to train them on women's specific needs and possible challenges before they start working in the field. While MHM typically falls under the framework of the WASH sector, many experts have been advocating for a cross-sectoral approach to MHM that takes into account the education, protection, shelter, non-food items and reproductive health sectors in MHM responses. Recommendations for a more coordinated cross-sectoral MHM response, with minimal overlaps and maximum effectiveness, include the need for a holistic and integrated approach to revise assessment tools and to clearly outline how each sector will target specific MHM components.

10. Oxfam and partner organizations' staff must be trained on psychosocial support (PSS) and protection, gender and inclusion (PGI). Preparing staff and fieldworkers to be attuned to women's specific needs and challenges is crucial for the success of any

humanitarian intervention that adopts a holistic approach. Throughout our fieldwork, it was clear that many staff members would benefit from training sessions that can further develop their capacities and skills in working in the ITS context. Such trainings are also vital given that issues of dignity and respect were often raised by the women as one of the main problems in their dealings with some humanitarian workers, e.g. in the medical clinics. By training staff in the different sectors and by making sure that partners have also completed PSS and PGI trainings, the development and implementation of any programme will have indirect positive implications for MHM by ensuring that women are treated with respect and that their needs are not overlooked.

11. Oxfam and partner organizations' staff must be trained on safe programming and community-based participatory approaches. It is crucial for staff and fieldworkers to receive solid training and understanding on how to implement community-based participatory approaches and how to evaluate the projects and programmes being implemented. Our fieldwork highlighted a misunderstanding of participatory programming and a lack of follow-up after the initial participatory planning approach. A holistic safe programming approach can help to ensure better planning and delivery of programmes, and better outcomes that directly and most effectively address the needs of refugee communities.

12. Oxfam and partner organizations' staff should ensure continued monitoring field trips through a participatory community approach that seeks to strengthen effective coordination between humanitarian actors and the people they support, as well as to positively engage communities in every aspect of the intervention. The field research revealed a lack of coordination, given the poor MHM conditions as a result of communal latrines that did not cater for women's menstrual hygiene needs. For a successful MHM response activity, it thus remains crucial to consult women and girls at all stages of MHM (or WASH) programming through a needs-assessment that would identify, clarify and enable understanding of their practices and preferences.

ANNEX 1: CONSENT FORM

Oral Consent Form

Oxfam/Menstrual Hygiene Management Project

Hello my name is _____ and I am _____ doing research for Oxfam.

We are here today to have a discussion about a topic that might be sensitive but that is very important to our lives as girls/women. We want to talk about menstrual hygiene management: how do you manage your period, what are the main challenges, how has the management of your menstrual hygiene changed for you since displacement, etc.

We are aware that this topic might be difficult to talk about initially, but we hope that this room will provide a safe space where there is no need to feel shy or embarrassed. All our stories and experiences are valuable and important. It is important to note that there are no right or wrong answers.

The information that you will share will help us all better understand the needs of girls and women in order to collectively come up with some recommendations. It is therefore important to give information that is as accurate as possible. The participatory approach of this research means that everyone in this room is considered a researcher. We will all reflect on the topic together to highlight the most important lived experiences and to come up with recommendations for Oxfam. This, of course, is not a promise that Oxfam will be providing any services in that area or any preferential treatment to the participants in this research.

Please note that your participation in this discussion is fully voluntary. You can decide, without any repercussions on your relationship with Oxfam, not to take part in this study. Similarly, if you agree to participate you are free to leave at any time or to abstain from answering any questions you do not want to answer.

If you decide to participate, everything that you will say will remain confidential and anonymous. Your names or any indicator that might reveal who you are will not be used or published in the study. All the recorded material and the collected data will be destroyed as soon as the research is over.

If you grant us permission, we would like to tape record what you say so that we do not miss anything. We are going to take notes too. I'm going to put the recorder here. If at any time you feel uncomfortable, tell me and I will press this button and the recorder will be off.

I'd like to stress once more that your participation is fully voluntary and has no repercussions on your relationship with Oxfam.

Do you agree on the above and wish to participate? If yes, do you have any questions for me before we start?

Date: _____

Location: _____

Time of the FGD/Interview: _____

Age of the participants: _____

Number of the participants: _____

ANNEX 2: INTERVIEW GUIDE FOR THE FOCUS GROUP/IN- DEPTH INTERVIEWS

OXFAM/MENSTRUAL HYGIENE MANAGEMENT PROJECT

TOPICS:

Make sure to focus on the below topics and to **collect quotes** regarding each topic if possible, to reflect the initial findings:

1. Lived experiences
2. Perceptions
3. Potential solutions/actions

SAMPLE:

Before starting the Focus Group Discussion, make sure the sample includes:

- Adolescent girls/young women attending and not attending school
- Women working in formal and informal work settings (age from 12-50 years old or menopause)
- Unemployed women
- Mothers (women with children)
- Single women (unmarried, divorced or widowed)
- Women with physical disabilities (if possible)

INTERVIEW METHODS:

Focus Groups Discussions (FGDs):

- 60-90 mins
- 8 to 10 participants in each focus group session

ICE-BREAKING EXERCISE (15-20 MINS):

1. Welcome and introduction of the researchers.
2. Explaining the research, reading the consent form and making sure there is consent to participate. Also agree on the principles of working together (safe space, respect each other's opinions, etc.).
3. Ask participants to introduce themselves and whether they know or are related to each other.
4. Thank the participants for coming to discuss menstrual hygiene management (MHM), noting that this is a critical but neglected issue that affects the wellbeing, dignity and productive lives of girls and women around the world.

INTERVIEW GUIDE (60-75 MIN):

This guide serves as a reference for the field researcher. You do not need to follow it word-by-word. Prompts are used to remind you of possible aspects that should be covered under the bigger question. You should use the prompts in case the discussion following the main question doesn't tackle those sub-questions.

Lived experiences (25 mins):

- a. Could you describe a typical day at the ITS? What are your main responsibilities and the main tasks you carry out?

Prompts:

- What are your main household chores? (Will vary with age groups.)
- Was it the same when you were in Syria? Have things changed since you arrived in Lebanon? If yes, how? Give examples.
- How would you describe your daily socializing activities? (Visiting or being visited by family, friends or neighbours, going to school, going out, etc.)

- b. Do you feel that these tasks and responsibilities are affected by your menstruation? If yes, how? Give examples.

Prompts:

- How do you cope with household chores when you have your period?
- Do you change/adjust any of your usual routine/tasks/responsibilities during menstruation? If yes, can you describe how and explain why?
- Was it the same when you were in Syria?

- c. Could you tell us in general how you manage your menstrual health in the ITS you live in?

Prompts:

MHM products:

- What type of MHM products do you use?
- Have you always used this product? (Compared to when they were in Syria or when they first arrived in Lebanon.) If no, ask why change happened (personal reasons, funding, communal reasons, etc.). If yes, ask if it was easy to find the same product.

- Where do you buy it from?
- How much does it cost? Is it affordable?
- Who decides on how much is to be spent on MHM products in the households? How are such decisions made? Are you satisfied with the decision-making process? (Especially if more than one female in the household: mother /daughters etc.)
- Is the quality of the product adequate? How does it compare to the product used in Syria, if different?
- If the product is reusable (in case mentioned), how do you wash it (water, soap, quality, etc.)? Are there any challenges you'd like to mention here (water shortage, etc.)?

Facilities: access and safety:

- Where do you change the menstrual hygiene product? (Important to know how many use the same facility/shared latrines and if it is used by both sexes or if it is strictly for females.)
- Do you feel safe while using the facilities mentioned? If no, why?
- Do you feel comfortable? If no, why?
- Do you have the privacy needed in disposing of the product or in washing the underwear or reused pads? If no, what are the main challenges? What are the main coping mechanisms? Was it the same in Syria?
- Do you have enough access to water in the facilities used? How much water is generally needed during your menstruation? How it is used? Is it easily accessed?

Disposal:

- If the product is not reusable, where do you dispose of it (school, home, etc.)?
- Are there any challenges you want to mention regarding disposal?
- Are there any important coping mechanisms worth mentioning in relation to disposal?
- How does the disposal of your menstruation product compare to when you were in Syria? If there is any change, can you explain it?

Medication and health issues:

- Do you have any health issues related to the product used? If yes, what and how do you treat it?
- How do you cope with menstrual pain, if any?
- Is pain medication available when needed? Is it affordable?
- Did you use any menstrual pain medication when in Syria? How does it compare to the situation now?
- Does your menstruation affect your daily toilet-use routine? If yes, does this affect your general health (gastro, constipation, etc.)? How do you cope with it?

d. For teenagers: when you got your period for the first time, how did you cope with it?

Prompts:

- Where did you get information about how to deal with your period?
- What type of information did you get?

- Did you feel that it was sufficient?
 - Do you think the information you received was helpful/useful and accurate?
 - Did you feel that it was easy or comfortable discussing the issue?
 - What were the main challenges you faced?
- e. For mothers/pregnancy: could you tell us about your experience dealing with post-delivery bleeding and how you coped with it in the ITS?

Prompts:

- Are there any challenges specific to post-pregnancy bleeding that you'd like to mention?
 - Are there any coping mechanisms that you'd like to share?
 - How does it compare to previous experiences with post-delivery bleeding when you were in Syria (if applicable)?
- f. Are there specific challenges that girls and women with disabilities face with their menstrual hygiene?

Prompt:

- Accessibility issues

Participatory wrapping-up: Together with the participants, recap the main ideas discussed in this section and ask them if they want to add anything or clarify/modify anything based on the group discussion.

Attitudes, beliefs and social norms relating to menstruation (20 mins):

- a. In a lot of places around the globe, there are some beliefs or cultural norms and taboos surrounding menstrual hygiene. Can you describe the cultural norms and communal perceptions that exist in your community around this topic?

Prompts:

- What are some communal perceptions around menstruation, menstrual hygiene and menstrual blood? Give examples.
 - Do you talk about your menstruation and menstrual hygiene or is it taboo? Who do you feel comfortable talking to about your menstrual hygiene (other women? Older women, etc.)?
 - Do you feel support from male members of your family/community during your menstruation? If yes, how?
 - Do you feel support from female members of your family/community during your menstruation? If yes, how?
 - Is there a change in perceptions around menstruation compared to when you were in Syria? Explain more.
- b. Based on your experience, do you think menstruation limits your (girls'/women's) access to services, activities or tasks? If yes, can you tell us more? (What are these activities? Cooking, school, work, etc.). Has it always been like this (compared to when they were in Syria)?

Prompts:

- Do girls go out or attend school during their menstruation?
 - Are you able to work during your menstruation?
 - Do you shower during your menstruation?
 - Do girls 'play' or carry out physical activities during their menstruation?
 - Does your menstruation affect your intimate life with your partner?
- c. Do you feel that your menstruation affects your wellbeing and feeling of (dis-)comfort? If yes, how do you deal with it? Has it always been like this?

Participatory wrapping-up: Together with the participants, recap the main ideas discussed in this section and ask them if they want to add anything or clarify/modify anything based on the group discussion.

Potential solutions/actions (20 mins):

1. Participatory community-based approach: based on the previous discussion, would you agree that the following are the main coping mechanisms that could work in terms of managing your menstrual hygiene (list based on analysis of previous discussion)?
2. Would you want to add any other potential solutions/actions that you think we have not tackled?
3. Are there any MHM tools or strategies that have been tried and did not work? Is there anything that you know you definitely don't want?
4. What kind of external support is needed? What do you think international and local organizations and agencies can provide in order to respond to the menstrual hygiene management challenges we have raised in this discussion?
5. Is there anything that you'd like to add or that you feel we have not tackled enough?

Don't forget to thank the participant for their time and valuable participation.

It is important for recommendations to be presented as ranked and prioritized by women from the communities engaged in the research, possibly through community-based participatory exercises.

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NOTES

¹ This information can be found in unpublished monitoring and evaluation reports as well as preliminary assessments conducted by Oxfam in Lebanon.

² As defined by Habib (2019), the *shaweesh* is '[a] member of the Syrian refugee population who is well-connected to the community and who acts as a foreman/middleman [...]' (Habib 2019: 10).

³ As part of a pilot project, Oxfam distributed reusable pads in January 2020. The preliminary feedback received during a FGD in February 2020 highlighted the issue of insufficiency of soap, the use of the distributed reusable pads as a secondary option (rather than as a primary MHM product), and the problems related to drying the pads.

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