SOCIO-CULTURAL CONTEXT OF MENSTRUATION: LIVED EXPERIENCES OF FIRST-GENERATION PUNJABI IMMIGRANT WOMEN FROM INDIA LIVING IN GREATER TORONTO AREA

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ABSTRACT

Menstruation may appear as nothing more than a natural, physiological process experienced by menstruators every month, but its meaning is derived from a particular cultural, historical and social context. This research project focused on uncovering and exploring the complex cultural and racial dynamics of menstruation by positioning this biological process of menstruation in a broader socio-cultural context. This study critiques the medicalization of menstruation that ignores the cultural and racial narrative of menstruation, which directly and indirectly impacts the agency of menstruators to openly discuss and access menstrual health care. The research utilizes the theoretical framework of intersectionality and postcolonial feminism to analyze how mutually constitutive categories of difference, such as gender, culture, and race, shape individual lives, health, social practices, and cultural ideologies around menstruation. The research consisted of semi-structured interviews with ten first-generation Punjabi immigrant women menstruators aged 21 to 30, who migrated from Punjab, India, to Toronto in the last decade. The findings of this study are analyzed using reflective thematic analysis grounded in feminist standpoint theory to center the lived experiences of menstruators. The thesis reframes menstruation as a structural and policy issue rather than a mere individual concern, embedded in broader power structures. Findings suggest that migration reshapes access to menstrual period healthcare systems and infrastructure, informed by gendered and racialized norms of productivity and endurance across borders.

DEDICATION

I dedicate this thesis to my mother, Balwinder Kaur, who fought for my education and always inspired me. I would also like to dedicate this thesis to all the women in my life who supported me, guided me, and continue to inspire me. These women, including my grandmothers, cousins, aunts, friends, mentors, teachers, and colleagues, held my hand throughout this journey and continue to do so. Last but not least, all the participants in this research are the reason I am writing this and able to do this project in the first place. You all not only supported my research but also taught me a lot and inspired me to face life and be a better person.

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CHAPTER 1- INTRODUCTION

Menstruation is a biological process as old as humanity and a symbolic marker of sexuality, health, fertility, and age (Bobel et al., 2020). Menstruation may appear as nothing more than a natural, physiological process experienced by menstruators every month; however, meaning is derived from a particular cultural, historical, and social context. Menstruation is generally viewed as a mark of womanhood across cultures and therefore acts as a socio-cultural signal of gender/sex identity (Frank, 2020). Menstrual taboos and restrictions across different cultures have been shown to increase poor health outcomes, gender inequality, isolation, marginalization and nutritional deficiencies. Therefore, it is crucial to discuss menstruation openly and develop strategies to enhance the lives and overall well-being of menstruators, aiming to build a more inclusive society.

In this study, I examine the socio-cultural narrative of menstruation. Most studies on this topic "have been through a medical lens alone, leaving aside possible differences in views of menstruation" (Lahiri-Dutt, 2015, p. 1159). In this study, I critique the medicalization of menstruation that ignores its cultural narrative, which directly and indirectly impacts the agency of menstruators to discuss and access menstrual health care openly. This study specifically focuses on the narratives of the migrant women, as very few focus on their menstrual experiences and their impact on the conflicting cultural ideals of reproductive health (Hawkey et al., 2017; Ussher et al., 2017). This research project engages with narratives of ten first-generation Punjabi immigrant women (henceforth, FGPIW) aged between 21 and 40 years who migrated from Punjab, India, to Toronto, Ontario, Canada in the last 10 years.

1.1 Research Questions

The guiding research questions that this project seeks to answer are: How does exposure to different gender norms in Canada influence FGPIW's perceptions of menstruation? What are the implications of these perceptions and experiences for the broader sexual and reproductive health of menstruators? What lessons can be drawn from FGPIW's adaptive strategies to improve menstrual health education and accessibility for immigrant communities in Canada?

I utilize an intersectionality and postcolonial feminist framework to understand the pre-migration and post-migration experiences of FGPIW. Intersectionality enables a nuanced understanding of categories of difference, such as gender, culture, and migration, which shape individual lives, health, social practices, and cultural ideologies surrounding menstruation (Yuval-Davis, 2006). The postcolonial feminist framework examines menstruation among the Indian diasporic community in Canada from the women's perspective, focusing on their reproductive rights and agency shaped by transnational mobility and racialized hierarchies.

1.2 Scope

This study will fill an existing gap in the field of menstruation research by placing this biological event in a broader socio-cultural context to understand how meanings, practices, and challenges around menstruation are negotiated across borders. Additionally, this study will focus on the commonalities and contrasts of the cultural narratives of FGPIW by using an interdisciplinary lens that incorporates Gender, Feminist and Women's Studies, Sociology, and Health Studies, thereby providing an original contribution to the literature. This study contributes to the originality of research by examining the experiences and negotiations of first-generation immigrants regarding the narrative around menstruation, specifically those who migrated to

Canada from India. The fact that this study explores how the term "menstruators" is gendered in the mainstream gender and health debates makes it unique in its field. The findings will not only address the scholarly gaps but are also anticipated to inform policies around immigration, healthcare, and social programs to support the FGPIW's reproductive health and overall quality of life. Further, the research provided a platform for the participants of this research to share their perspectives on menstruation, which may also increase the readers' understanding of how menstrual practices evolve in diasporic settings.

1.3 Limitations

While this research provides important insight into the experiences of ten FGPIW based in GTA (Toronto), this small sample size does not attempt to generalize the experiences of all immigrant women in Canada. The study focuses on Punjabi-speaking participants, which may exclude experiences from diverse linguistic backgrounds in Punjab, such as Hindi. The research includes the narratives of cisgender women but does not encompass the menstrual experiences of non-binary menstruators and non-menstruators. The theoretical framework of intersectionality is utilized in this research, but is also limited to the categories of gender, race, immigration, and health due to the scope and scale of the master's thesis. The exclusion of other important dimensions, including but not limited to religion, caste, and class, remains vital for future research. The study focuses on women aged 21-40 years old who have migrated from India within the last ten years (i.e. after 2014) to capture immigration experiences shaped by recent policies, programs and social contexts. However, this focus excludes earlier migrants whose experiences may differ, narrowing the understanding of immigrant menstrual norms over time.

1.4 Personal Observations

Growing up, whenever I asked myself, my friends or any girl or woman I met, "What do you dislike most about being a girl?" the answer was almost always the same – *periods*. Menstruation was unanimously labelled as discomforting, an inconvenience and a burden. The utopia my friends and I created was a period-free life where we would not have to make or cancel plans according to our menstrual cycle. We could go anywhere, wear anything, or do anything freely without thinking about periods. All this made me question the socio-cultural experiences of menstruation rather than just its biological nature. Was it just the physical discomfort, or was it the way society perceived menstruation and made it feel like an unwelcome part of life? Is it just in my city, or do geographical locations also affect the experiences surrounding menstruation? All these questions would appear with the first drop of blood every month.

After I moved to Canada in 2018, a layer of complexity of migration and race was added to my questions. While working in a Canadian grocery store's pharmacy aisle where sanitary products are sold, I encountered various men purchasing these items. This was a rare sight for me, as I came from a background where women primarily bought sanitary products and were handed over by shopkeepers in a black, non-transparent bag to conceal the contents. One day at work, a man approached me and asked in Punjabi which pads he should buy for his daughter. After speaking with him, I realized he was also a first-generation immigrant from India like me. This experience made me question the role of migration in changing attitude towards menstruation. Is there something we could learn from migration to change the outlook towards menstruation to make it more positive for menstruators like me? With this hope and many questions in my mind, I began this research project.

1.5 Organization of thesis

The thesis chapters are organized into five chapters that build upon each other to provide a comprehensive understanding of this research.

Chapter One introduces the focus of the study and begins by situating menstruation within a socio-cultural context shaped by migration, gender and cultural norms. The chapter outlines the key research questions and provides an overview of the conceptual terms used throughout the thesis. It further explains the scope of the study as well as the limitations that need to be taken into account for future research on menstruation.

Chapter two critically examines the existing scholarship on menstruation in both the Indian and Canadian contexts. It explores how menstruation has been theorized through various theoretical frameworks and how the intersectionality of overlapping factors, such as gender, migration, race, class, and religion, contributes to a broader understanding of the gendered bodily experiences of menstruation. Literature on immigrants in Canada is also reviewed to explore how different immigration policies and access to resources contribute to the shaping and negotiation of menstrual norms among immigrants.

Chapter three outlines the qualitative research methods used in this study. It includes the theoretical framework of intersectionality and postcolonial feminism that supported my investigation and helped me analyze the lived experiences of FGPIW. It also provides an overview of the methodological framework for comparative analysis, enabling an understanding of the similarities and differences in the conceptualizations of menstruation among FGPIW. It details the research design, participant selection criteria, recruitment strategies, and data collection methods. The chapter also addresses ethical considerations and reflects on the researcher's positionality.

Chapter four presents and analyzes the main themes that emerged from the data collected through semi-structured interviews. It examines how intersections of gender, race, immigration, and health shape and transform FGPIW's menstrual practices and perceptions in Canada. The emerging themes are analyzed using reflexive thematic analysis informed by feminist standpoint theory to center the voices of FGPIW in the broader policy, public health, and conversations about menstruation.

Chapter Five summarizes the final findings of the research and provides policy recommendations, research initiatives, and more inclusive health policies to address the barriers faced by racialized communities, advocating for culturally sensitive healthcare awareness.

1.6 Conceptual key terms:

In this following section, I present a few interlinked key terms that form the conceptual vocabulary I use throughout the thesis.

A. Menstruation

Menstruation is a biological process entails the shedding of lining of the uterus when an egg is not fertilized. Marked by bleeding from the vagina, it may appear as nothing more than a natural, physiological process experienced by menstruators every month; however, its meaning is derived from a particular cultural, historical, and social context (Hawkey et al., 2017; Uskul, 2004; Wood, 2020). Menarche is the first menstruation bleeding, which occurs at varying ages across countries. In India, the age of menarche ranges from 9 to 18 with an average of 12 years (Sharma et al., 2008; UNICEF, 2016). In addition to that, I have used the term menstruator to recognize the complexities around gender identities as women are not the only ones who menstruate (Bobel, 2020). Menstruation is not only an early sign of puberty and a mark of womanhood, as it signals

pregnancy and childbirth, but it has also been inscribed as a weakness of the female body as an uncontrollable fluid of the body (Grosz, 1994) :

> Menstruation, associated as it is with blood, with injury and the wound, with a mess that does not dry invisibly, that leaks, uncontrollable, not in sleep, in dreams, but whenever it occurs, indicates the beginning of an out-of-control status that she was led to believe ends with childhood. The idea of soiling oneself, of dirt, of the very dirt produced by the body itself, staining the subject, is a "normal" condition of infancy, but in the case of the maturing woman it is a mark or stain of her future status, the impulsion into a future of a past that she thought she had left behind. This necessarily arks womanhood, whatever else it may mean for particular women, as outside itself, outside its time (the time of a self-contained adulthood) and place (the place definitively within its own skin, as a self-identical being), and thus a paradoxical entity, on the very border between infancy and adulthood, nature and culture, subject and objects, rational being and irrational animal (Grosz, 1994, p. 205).

In this study, I have used the term menstruator to recognize the complexities around gender identities as women are not the only ones who menstruate (Bobel, 2020). This study adopts a broader approach to menstruation, aiming to understand how it intersects with the everyday lives of migrant women.

B. Period Poverty

The limited or inadequate access to menstrual products or menstrual health education as a result of financial constraints as well as lack of socio-economic support available to menstruators due to negative socio-cultural stigmas associated with menstruation.

C. Immigrants

As defined by Statistics Canada, Immigrants are people who are, or who have ever been, landed immigrants or permanent residents (Statistics Canada, 2016). For the purpose of this study, I have decided to use the term first-generation immigrant as people who are born in a foreign country and moved to another country. The main categories of immigration in Canada include economic class, family class, and refugee status (Government of Canada, 2016). In this research, I have focused on first-generation immigrants who were born in India and moved to Canada since 2014 through economic-class and family-class immigration pathways.

D. Punjabi Immigrants in Canada

According to the 2021 Census, 23% of the population were foreign–born immigrants and the top places of birth among immigrants living in Canada were India, the Philippines and China (Statistics Canada, 2021). The Punjabi people originate from residents of the state of Punjab in North India. In this context, I am referring to people born in Punjab, India and who speak the Punjabi language. According to the 2021 census, Punjabi is the second most spoken non-official language among immigrants, marking the growing presence of the Punjabi immigrant community in Canada (Statistics Canada, 2021).

CHAPTER 2 - LITERATURE REVIEW

Despite a growing interest in menstruation within academic and activist circles as a biological process and as a site of social and cultural regulation, literature on immigrant women's menstruation experiences is limited. Scholars in feminist, sociological, medical, and legal fields have highlighted how menstruation is not just a biological and universal experience but also a social and political one. Existing studies explore various themes, including menarche, menstrual stigma, cultural taboos, the pathologization of premenstrual syndrome, and the socio-cultural context of menstruation across different settings. However, much of the work remains focused on Western-centric and biomedical narratives of menstruation, often reflecting how migration, intersectional identities, and indigenous knowledge influence menstruation (Ussher, 2005; King, 2020; Ussher & Prez, 2020). This literature review highlights significant contributions by various scholars while emphasizing the importance of considering the diverse experiences of racialized immigrant women, especially in Canada. To provide a comprehensive understanding, the review is organized into five sections:

1) Menstruation as a social and physiological experience, including menarche and premenstrual syndrome

2) Menstruation in the Indian cultural context

3) Menstruation in the Canadian context

4) Menstrual experiences of immigrant women.

Together, these sections highlight existing literature in these fields and identify gaps that this research aims to address.

2.1 Menstruation and Its Social Construction

The meaning of menstruation, a normal biological occurrence, is influenced by certain cultural, social, and historical contexts. Scholarship has revealed that many cultures celebrate girls' menarche to mark the transition from girlhood to womanhood, like the Hindu ceremony Ritushuddhi, which takes place in South India (Ganguly & Satpati, 2012; Nagarajan, 2017; Guérin et al., 2019). But in West, menarche has historically been considered a "private event that is treated as a hygiene crisis", a framing that continues to influence the contemporary attitude towards menstruation (Stubbs, 2008; Marvan & Alcala-Herrera, 2020). The literature highlights that "popular discourse often portrays menstruation as something dirty and disgusting, and a bodily function to be silenced and concealed" (Brantelid et al., 2014, p. 606; Mason et al., 2017, p.174).

To problematize the dominant popular discourse, second-wave feminists in the 1970s began to question male-centric medical views on women's bodies, including how menstruation is perceived (Gerhard, 2001; Becknuss, 2022). Feminist theorists like Dawn Macdonald (1970) and Judith Ramsay (1975) argue that menstruation limits women and instead encourages women to explore their individuality by investing in themselves and putting reproduction and menstruation in the background. Conversely, researchers like Bullough and Voght (1973) highlight that traditional medical and scientific beliefs are not based on facts but are myths created by male medical authorities. They conducted research to debunk the myth that during menstruation "brain work destroys feminine capabilities" and encouraged women to rest to "preserve women's bodies" (Clark, 1873; Bullough & Voght, 1973, p. 71). Second-wave feminist thinkers advocated for the

use of contraception not only as a tool for birth control but also to suppress menstruation, which allowed women to control their bodies and enjoy sexuality (Smith-Rosenberg & Rosenberg, 1973; Freidenfelds, 2009; Baldy, 2018). Menstrual health activists of the 1970s challenged the traditional male-authored research and perspectives on women and their bodies, advocating for better menstrual management to liberate women from menstrual discomfort. As an example, feminist writer Landsberg (1974) paved the way for new menstrual products like tampons and more comfortable, less noticeable pads to manage menstruation and relieve the discomfort associated with it (Becknuss, 2022, p. 96). Women's health advocates played a significant role in challenging the traditional views of menstruation and its management.

Some feminist scholars argue that menstruation is experienced and perceived within a broader sociocultural context (Koesko, 1983; Johnston-Robeldo & Stubbs, 2012; Sitar, 2018; Mondragon & Txertudi, 2019). A critique emerges in Randi Daimon Koesko's work that the medicalization of research in the 19th century on the menstrual cycle is characterized by "biases such as sexism and biological determinism" (Koesko, 1983, p. 1). In the 1980s Koesko critiques the biomedical perspective on menstruation and advocates for a feminist perspective, offering critical analysis and committing to more self-aware alternative methods of research, including insiders' perspectives that prioritize equal client-practitioner relationships (Koesko, 1983). Second-wave feminist scholars advocated for women's active participation in the workforce and the choice to explore life beyond reproduction.

The scholarly understanding of menstruation has evolved significantly over time, shifting away from purely biomedical perspectives to encompass socio-cultural contexts. One of the earliest works (Golub, 1983) focuses not only on the physiological aspects of menarche but also

on psychological aspects, discussing hormonal changes, genetic factors and environmental factors. The author suggests that menarche "can have an organizing effect for the adolescent girls by clarifying the perception of her genitals as a landmark of feminine identification" (Golub, 1983, p. 26). However, even though the author argues for the need for social and emotional support to overcome a negative attitude towards menstruation, the burden falls solely on mothers to make this possible. It also fails to recognize the socio-cultural aspects that contribute to the stigmatization of menarche.

The literature on menstrual stigma, taboos, shame, and period poverty is key to understanding menstrual experiences in any context (Hasson, 2016; Sitar, 2018; Dutt & McCarthy, 2020; Ussher et al., 2020). Scholars demonstrate how stigma, popular culture, and orthodox traditions shape women's embodied experiences of menstruation. For instance, in the book Menstruation Matters, Crawford and Waldman (2022) explore the role of menstrual activism and legal reforms in schools, workplaces, prisons and tax policies to address period poverty in the U.S and around the globe. In order to achieve gender and menstrual equity, "law and society must account for biological functions such as menstruation" so as not to limit menstruators' ability to participate in society (Crawford & Waldman, 2022, p. 33).

The need for a feminist perspective in menstrual research began to emerge in the 1970s and 1980s as part of second-wave feminist inventions to develop a broader understanding of menstruation from an insider's (i.e., menstruator) experiential views instead of merely relying on scientific data. Johnston-Robeldo & Stubbs (2012) argue that "women negotiate the meaning of menstruation in their lives, shaping their health, sexuality and identities, and this negotiation is affected by their unique social locations (e.g. religious affiliations, sexual orientation, ability

status)" (p. 2). A key example of this is Hasson's (2016) article "Not A "Real" Period" which critiques the definition of menstruation as a "natural" bodily process and the need to question the distinction between bleeding with menstrual suppression technologies (e.g., hormonal birth control pills, IUDs) referred to as "pill periods" and without them as "natural" (Hassan, 2016). The author emphasizes the importance of redefining menstruation by "recognizing menstruation as multiple and taking seriously the material differences in bleeding" (Hassan, 2016, p 976). This work is groundbreaking in feminist menstruation scholarship as it brings on the biological aspect of bleeding to question the stabilized definitions of menstruation.

This impact of intersectional feminist perspectives is demonstrated by Mondragon & Txertudi (2019), who conducted a study with 250 young Spanish people to understand the impact of gender and ideological factors on perceptions of menstruation. The author argues that "contemporary feminist perspective is uniquely positioned to foster an empowered understanding of menstruation" (Mondragon & Txertudi, 2019, p. 367). The study found that the traditional and non-feminist groups hold very negative, stigmatized, and medicalized notions of periods and regard menstruation as a huge crisis. Conversely, the feminist and progressive groups offer a more nuanced view of menstruation and generally show more positive acceptance.

The complexity is inherent because menstruation and its experience are not the same for everyone, but it is rather complex as it "unites the personal and the political and the physiological and the socio-cultural (Winkler, 2020, p. 9). Literature on menstruation highlights that the reproductive body has the power to provoke a reaction of disgust; menstrual blood becomes a stigmatizing stain (Johnston-Robledo & Chrisler, 2013; Roberts, 2020). The tension between medical and feminist views emerges when scholars examine the embodiment of premenstrual

changes that "position reproductive body as site of disease, epitome of "monstrous feminine" and "sign of madness" (Ussher, 2006; Ussher & Prez, 2020, p. 215). While biomedical and psychological views categorize these experiences as a syndrome or disorder, feminist perspectives see these changes as normal and stemming from negative cultural beliefs about menstruation (Chrisler, 2004; Ussher, 2006; Ussher & Prez, 2020).

This pathologization of menstruation leads to internalized views of menstruation as abnormal, and something that needs to be restrained, controlled, and corrected. Sally King's work echoes the previous scholarship on the pathologization of Premenstrual Syndrome (PMS), influenced by a "sexist historical assumption referred to as the myth of the irrational female" (King, 2020, p. 287). This ongoing prioritizing of psychological symptoms over physical to understand PMS positions women to a reduced capacity for reason and stigmatizes an entire gender (Ussher, 2005, 2011; King, 2020). These notions are also culturally rooted and influence how premenstrual symptoms are perceived, so there is a need for improved research and healthcare technologies to support menstruators without pathologizing menstruation.

Literature also highlights that menstruation is often defined as a universal female experience tied to reproductive function, thereby reinforcing "menstrual normativity" (Guillo-Arakistain, 2020). Furthermore, this generalization of menstruation as a "universal physiological process with little mention of the sociocultural processes that influence it and thus an ethnocentric view" (Guillo-Arakistain, 2020, p. 872). This body of work emphasizes the need to resist these rigid definitions by centering the lived experiences of people from diverse cultures, religions, and geographical territories. This also prompts a discussion about the importance of studying

menstruation in various cultural and political contexts to challenge heteronormative and ethnocentric ideologies that view menstruation as a mere biological process.

2.2 Menstruation in the Indian Context

India has a vast and complex culture, comprising diverse languages, religions, and rituals, which makes it challenging to study and define. In terms of menstruation, India also has various traditions and cultural practices that differ in urban and rural areas, as well as the religious sentiments of the people. Multiple scholars have contributed to the literature on menstruation in the Indian context; however, for the purpose of this study, the focus is on studies related to menstruation within its socio-cultural context, which will be discussed.

Within Hinduism, two contradictory beliefs exist: one regards menstruating bodies as "polluting as all bodily excretions are ritually impure," and the second tantric view is that a menstruating body "embodies infinite creative power and immense energy." (Chawla, 2002; Bhartiya, 2013; Garg & Anand, 2015; Manorama & Desai, 2020, p. 511). Religion and culture-embedded taboos have occupied every space in menstruators' lives – at home, at work and places of worship. Menorama and Desai (2020) argue that menstruation, being an intricate part of women's health and reproductive life, is "largely shamed and silenced in India" (p. 511). Another example of religious tradition is the customary celebration of menstruation at the Kamakhya temple in the northeast Indian state of Assam. In which the goddess Kamakhya is believed to menstruate for three days each year, and the temple remains closed during this time, as the site is considered impure during this period (Deka, 2020, p. 152). On the fourth day, the temple reopens with a grand ceremony celebrating fertility and creation (Deka, 2020; Times of India, 2025). This religious ceremony is mainly performed and followed by Assamese Hindus, which symbolizes

casteism but also serves as a means of social regulation of women's sexuality by linking biology to purity and pollution (Deka, 2020). At home, menstruators are prohibited from performing religious rituals, entering the kitchen and touching certain foods, especially pickles. The taboos are so widespread that a sanitary pads advertisement started a campaign in 2015 called 'Touch the pickle' to draw attention to menstrual taboos (Sukumar, 2020). As Manorama and Desai (2020) critically observe:

> The state, rather than confronting this complex web of beliefs and practices centred on menstruation, chooses to endorse it. Most recently, the state support for the continued exclusion of women of menstruating age from the Sabarimala temple is the most egregious instance of the state's role in the perpetuation of menstrual stigma. (p. 512)

These menstruation segregation practices are even worse for Dalit women, as they face discrimination not only from religious customs but also from caste-based hierarchies that render them untouchable not only as Dalits but also as menstruating women. (Sukumar, 2020). The burden on women for maintaining purity during menstruation not only excludes women from private and public spaces but also reinforces patriarchy in society.

McCarthy & Lahiri-Dutt (2021), critically examines the knowledge production of menstruation in India that "positions bodies, cultural practices as deficient" through five contexts: colonial medical theories, Hindu reform movements, early 20th-century Ayurvedic practices, contemporary menstrual hygiene management initiatives, and slum-dwelling women and girls" (p. 193). The authors highlights that colonial theorists linked early menarche in Indian women to "racial differences" and concluded that:

> It is some consolation to learn … that the more intelligent Hindus of the present day hesitate not to pronounce these early unions [child marriages] as the monster evils of their country..... So interwoven is the custom with the social habits and most inveterate prejudices of the Hindus, that we can only look for change for the better by slow degrees, and as the fruit of prudent, benevolent exertion on the part of their European masters. (Roberton, 1851, p. 131)

Ishita Pande (2010) argues that Hindu reformists also "embraced the same language of medicine focusing on the women as victim and agent of degeneration" (p. 157). In contrast to these discourses, early 20th-century Ayurvedic practitioners, such as Yashoda Devi, promoted indigenous knowledge through books and clinics focused on menstruation, emphasizing women's lived experiences and menstrual pain (Gupta, 2005; McCarthy & Lahiri-Dutt, 2021).

Scholars also emphasize that India's health policies and programs like Swachh Bharat Abhiyan (Clean India mission) launched in 2014 and Menstrual Hygiene Management (2011) focus on menstrual hygiene but overlook the cultural significance of menstruation and its impact on women's overall well-being (Deka, 2020; Bobel, 2019; Manorama & Desai, 2020). Due to the government of India's focus on menstrual hygiene through the implementation of such programs, it undermines the sociocultural aspect of menstruation and also portrays it as a country lacking in hygiene, resources, and infrastructure. These health programs are often based on "zombie statistics that reflect Western stereotypes of third world girls and the politics of rescue" (Bobel, 2019, p. 132; McCarthy & Lahiri-Dutt, 2021). This portrayal reinforces a narrative of Indian women as ignorant and neglects their strategies and knowledge of their own bodies. While systematically underestimated and neglected, "women's knowledge collectively and individually contributes to the production of different ways of knowing" (McCarthy & Lahiri-Dutt, 2021, p. 201). Lahiri-

Dutt (2014) provides a grounded feminist critique of medicalized MHM initiatives driven by global development agencies and donors as:

> I argue that by framing menstruation as an ailment of the body in need of 'sanitizing' and remedying, those who do not use the mainstream hygiene practices are seen as deficient and lacking. I argue that the MHM initiatives serve two economic functions: they facilitate the access by multinational corporations to a new and emerging market and present the relentless work by the female body as the norm. A feminist critique cannot ignore these economic implications that hide behind the ideas of cleanliness and 'proper' management practices. To substantiate my argument, I present alternative views, knowledge, experiences and practices related to menstruation. (p. 1159)

In the context of India, development agencies played a significant role in reinforcing menstruation as a site of lack, silence, and stigma that positions Western ways of knowing and doing menstruation as superior to the rest. Scholars critique the menstrual hygiene management program approach, which focuses on disposable, single-use products without considering environmental impact, and inclusive products for diverse needs (e.g., individuals with disabilities) (Lahiri-Dutt, 2014; McLaren & Padhee, 2021). The imposition of Western ideas and products without regard for the local context and cultural practices strips menstruators of their agency to decide for themselves.

This calls for a shift in the approach to menstruation from focusing on hygiene and infrastructure to a more comprehensive sexual and reproductive health rights perspective. The role of grassroots organizations like Goonj, Ecofemme, Barefoot College, and Jatan Sansthan, based in India, is crucial in providing community education to challenge the stigma around menstruation and focus on culturally appropriate menstrual products (McLaren & Padhee, 2021). Menstrual

stigma and taboos vary regionally; therefore, the more effective approach is to involve community members directly in challenging them rather than relying solely on international agencies (McLaren & Padhee, 2021).

The literature reiterates the importance of challenging this complex web of sociocultural and political factors leading to the stigmatization of menstruation. Some scholars advocate for the framework of menstrual justice, which aims to adopt a holistic approach to women's health by integrating psychosocial and physical health to address the systemic discrimination and human rights violations of menstruators (Rishyasyringa, 2000; Manorama & Desai, 2020). Scholars argue for a feminist approach that can take into account local practices, religious ceremonies, and stigmas regarding menstruation under the feminist lens, exposing both patriarchal and hegemonic discourses (Lahiri-Dutt, 2015; Deka, 2020). In order to challenge the menstrual stigmas and to promote the overall well-being of the menstruators, a community-driven approach to raise awareness is the way forward. As McLaren & Padhee argue:

> The education and awareness that the local community-based programs provide recognize that menstrual health is intimately connected to social and cultural contexts, and it involves challenging gender discrimination when it limits girls and women's access to education, work, and public presence. Taboos need to be addressed and challenged, and this can only happen by taking a multi-generational approach involving girls and women of all ages – as well as men and boys – in conversations and training about menstrual and reproductive health. An important aspect of this education is to create inclusive educational tools which provide accurate information in the most engaging and interactive way, thus promoting critical discussions. Because these conversations require trust and openness, they should be led by community health workers and local teachers. (p. 147)

This highlights the need for a more holistic, intersectional and culturally sensitive research that moves beyond hygienic-centric medicalized framing of menstruation and its experiences in the Indian context.

2.3 Menstruation in the Canadian Context

While Canada, being a part of the global north, is often framed as progressive in the global discourse, menstrual experiences remain deeply embedded within the intersections of race, migration, class, and settler colonial structures. In most countries, including Canada until 2015, menstrual products were subject to sales tax and were classified as non-essential items (Scala, 2023). According to a survey of 1000 women aged 18 and above by Plan International Canada in 2023, more than half (52 percent) of women always feel the need to hide their periods in public and private spaces. The survey further highlights that the majority of menstruators find menstrual products to be expensive and unaffordable, resulting in financial strains (Pan International Canada, 2023). This depicts that menstruation is stigmatized, and policies fall short when it comes to addressing period poverty in Canada. Indigenous peoples, people living with disabilities, racialized people, and immigrants are more likely to face period poverty.

The survey conducted by Women and Gender Equality Canada (WAGE) in 2023 provides a measure of awareness of menstrual equity and period poverty among Canadians. The report's findings suggest that there are notable gender gaps in both comfort and knowledge, as only 59 percent of men feel comfortable discussing menstruation compared to 87 percent of women (WAGE, 2023). Furthermore, the survey reveals misconceptions about menstruation, as almost half of Canadians link periods with physical weakness and a lack of control over emotions (WAGE,

2023). These findings are consistent with the widely held perception of menstruation as a disease that makes menstruators, especially women, weaker and emotionally irrational compared to men.

Research highlights the importance of collective action in advancing menstrual equity and reproductive health rights to disrupt menstrual stigma (Leaks, 2011; Kuhlmann et al., 2016). Literature highlights that sex education often neglects teaching non-menstruating individuals about menstrual equity, making it a foreign concept for many (Plan International Canada, 2018; Khan & Ovesi, 2020). Scholars argue that traditional health education and medicalized understanding of menstruation offer "deeply disembodied and overly anatomical, mechanistic understandings of menstruation rather than on the lived experiences of menstruation" (Clark & Southerton, 2024, p. 364). As a result, young people in Canada actively use digital platforms as sources of knowledge and tools to normalize their experiences by comparing them to those of a wider range of internet users (Clark & Southerton, 2024). This also challenges the conventional ways of knowing, doing and negotiating menstruation. Nicola Hill (2023), speaking before the Standing Committee on the Status of Women, emphasized that during the COVID pandemic, the level of menstrual education declined as schools were adjusting to the new reality of online learning.

Research focusing on menstrual suppression through oral contraceptives in Canada shows that women's perceptions are shaped by negative cultural constructions of menstruation as unpleasant, dirty, gross, and messy. (Repta & Clarke, 2011). Menstrual suppression can be seen as a way of controlling the female body to produce 'ideal' femininity by conforming to the sociological association of menstruation with impurity and disgust. As Howson Repta & Clarke argue:

> Controlling one's menstrual cycle, by suppressing or by taking regular oral contraceptives, produces a self-disciplined body that more closely resembles a male body. It is thus important to note that women are encouraged to take responsibility for their bodies more so than men, and in different ways, and that this is a function of patriarchal society. (p.104)

Existing literature highlights that menstrual equity requires addressing stigmas, structural barriers, and the diverse physical and emotional needs of all menstruators. In June 2023, the Standing Committee on the Status of Women (FEWO) released a report on menstrual equity in Canada to address the barriers menstruators face in accessing menstrual products, hygiene and education regarding menstrual health. The FEWO (2023) made recommendations as follows for the Government of Canada to achieve menstrual equity:

- facilitating access to different types of menstrual products (both disposable and reusable) in a variety of settings, including in the workplace;
- educating Canadians on menstrual health;
- supporting women-led small- and medium-sized businesses and other groups that seek to provide increased access to menstrual products; and
- investing in menstrual health research.

While policy advancements and advocacy represent progress in menstrual equity, a gap remains in addressing the lived realities of diverse menstruators. This review highlights the need for further research on the experiences of marginalized communities, including Indigenous peoples, immigrants, racialized individuals, and non-binary menstruators. The recommendations

provided by FEWO are a good start towards achieving menstrual equity, as menstruators and their needs are diverse and require a multifaceted approach.

2.4 Menstruation and Immigrant Menstruators in Canada

Canada is one of the most ethnically diverse countries in the world. According to the 2021 census, 23 percent of the population were foreign-born immigrants, and Indians are the largest visible minority group since 2016 (Statistics Canada, 2021). Due to differing cultural values in societies, immigrants have varied cultural and religious perspectives on health, gender, sexuality, and menstruation. These differences can lead to difficulties "when people are exposed to or socialized in both cultures" (Zaidi et al., 2016; Meherali et al., 2021, p. 329). Menstruation, being a shared experience among menstruators, is not managed and perceived in the same way as access to products, taxation policies, health services, and public spaces differ from one country to another.

Much of the literature indicates that immigrants, particularly women, encounter substantial obstacles in accessing health services due to the complex interplay of individual, institutional, and social factors (Crawford et al., 2021). Neglecting these challenges can have consequences for immigrants' health and well-being, as well as their access to healthcare services. Immigrants also have limited support networks to guide them regarding access to available services (Liban, 2007). Research shows that migrant women often face challenges navigating health services due to language barriers, which make it hard to understand health information and services. (Crawford et al., 2021). To improve the well-being of migrant women, "concerted efforts are needed to address upstream societal and institutional factors that influence knowledge, attitudes, and behaviours such as access to health services and gender equity" (Crawford et al., 2021, p. 11).

Across cultures, menstruation can be a transitional point for women "to start produce themselves as women in compliance with, and in resistance to, contemporary messages about gender" (Schooler et al., 2005; Marvan et al., 2006; Lee, 2009, p.615). As scholars highlight that:

> Fear of discrimination, stigma, shame and the lack of information, the lack of knowledge on how to navigate a complex health care system, and the underreporting of the use of sexual health services because of the conservative views on sexual behaviour in some Asian cultures are major barriers to immigrant South Asian immigrant adolescents' access to and utilization of Sexual health and reproductive services. (Meherali et al., 2021, p. 335)

Although much is written about the reproductive health of women, less is known about racialized immigrant women and their specific needs. Choudhary (1998) argues that existing Western health programs are "dysfunctional for people from non-Western values, leading to newcomers remaining invisible health care consumers" (p. 269). Findings suggest that Indian women rely on traditional ayurvedic remedies for their health issues, which makes it difficult to adapt to Western health care practices (Choudhary, 1998). Similar to the other, South Asian immigrant women face a double burden in terms of paid work and unpaid work at home in the form of cooking, care of children and family, which has implications on their overall health. Adjusting to life as an immigrant in another country also presents its own challenges, including social isolation, language barriers, the stress of adaptation, accessing health information, and managing a workload.

Findings from Ussher et al.'s (2017) qualitative study on the sexual embodiment experiences of migrant women reveal that the discourse of shame, silence, and secrecy impacts

sexual health knowledge, agency, and access to services. Research further highlights that women not only reproduce these discourses but also resist them as:

> Many women adopted a human rights-based sexual health discourse in order to resist traditional cultural and religious constructions of sexual embodiment, allowing them to communicate or gain knowledge about sexuality and develop sexual agency, or to allow their daughters to do so. Women negotiated a discourse of menstrual shame through acknowledging the cultural positioning of menstrual blood as abject, at the same time as contravening practices of secrecy and silence in order to educate their daughters, or to critically reflect upon their own menarche experience. Those with little menarche support themselves were those who intended to provide their daughters with menstrual education. (Ussher et al., 2017, p. 1916)

A study on migrant women's experiences with sexual and reproductive health in Australia and Canada shows women possess inadequate knowledge of these topics due to socio-cultural taboos against discussing them (Metusela et al., 2017). These barriers lead to traumatic menarche and menstrual experiences, which further reinforce negative psycho-sexual well-being and overall quality of life among migrant women. Similar research focusing on experiences of menarche and menstruation among refugee and migrant women in Australia and Canada highlights the pervasive "cycle of shame" surrounding menstruation and its implications on migrant women's health (Hawkey et al., 2017). The cross-cultural studies on menstruation highlight the similarities in the experiences of menstruation across cultures, "such as lack of menarche preparation and difficulty managing menstruation from a hygiene perspective" (Hawkey et al., 2017, p. 1474). The research findings highlight that:

> As a result of menstrual shame and stigma, many women across cultural groups experience menarche with a complete absence of knowledge about their bodies, and

> within patriarchal societies, particularly those who follow strict religious doctrine, women might be more likely to consider menstruation as shameful and polluting, resulting in negative attitudes toward the corporeality of their bodies. This research has demonstrated that some migrant and refugee women arrive in host countries with little or no knowledge of menarche and menstruation, highlighting the importance of appropriate menstrual education as a part of sexual and reproductive health education, for young girls and for mothers to transmit to their daughters. (Hawkey et al., 2017, p. 1487)

The stigmatization of menstruation and the feelings of shame and embarrassment linked to menstrual blood cause migrant women to hesitate to disclose menstrual health issues to healthcare providers. (Hawkey et al., 2017, Metusela et al., 2017). To address these barriers, a more holistic approach is needed by "embedding sexual and reproductive health education in culturally acceptable programs in consultation with community and religious leaders to gain community support on women's health issues" (Metusela et al., 2017, p. 842). A multifaceted approach is required to address these complex and intricate factors by involving culturally informed and accessible health care services for immigrants because "migrant histories and intergenerational dynamics play a significant role in shaping belief and access to resources" (Thakur, 2023, p. 131).

Understanding these complex negotiations is essential for shaping policies and programs that enhance access to sexual health services for migrant women in a culturally safe environment. Incorporating the diverse cross-cultural constructions and experiences of menstruation is crucial for providing culturally sensitive, comprehensive menstrual education. Therefore, the menstrual experiences of migrant women require not only culturally sensitive menstrual awareness but also research that is informed by the complexity of both their home and host countries.

2.5 Gaps in the Literature

While there is room for further exploration of immigrant racialized menstruators' experiences, the literature that does exist highlights the diverse experiences of menstruation across cultures are filled with complexities. Even though studies address the social construct of menstruation broadly, few examine the barriers experienced by indigenous peoples, racialized minorities, immigrants, disabled individuals and non-binary menstruators. The intersectional analysis of menstruation is lacking in the literature to analyze how race, disability and migration status impact the well-being of menstruators. Specific studies on menstruation in the Canadian context remain sparse, with limited research on the experiences of Indigenous peoples and migrant communities. Despite extensive documentation of menstrual rituals and beliefs in the Hindu religion, there is minimal research on other religions like Sikhism, Islam, or Christianity in the Indian context. Similarly, when it comes to caste-specific narratives of menstruation, the literature fails to address the marginalization of other castes, specifically Dalits and their menstrual embodied experiences. The literature critiques the medicalization of menstruation and Western healthcare practices, but research on alternative menstrual practices like Ayurveda, Chinese medicine, or Indigenous practices is very limited. The literature highlights that understanding menstrual experiences at the intersections of race, gender, religion, caste, class, and migration status is very complex, requiring critical approaches that enable a more nuanced exploration of these intersections. To build on the existing literature, this research adopts a combination of critical theories, such as intersectionality and qualitative methodologies, to uncover findings.

CHAPTER 3: THEORETICAL FRAMEWORK AND METHODOLOGIES

This chapter covers the theoretical framework, and the methodological tools employed to facilitate the research findings. It begins by explaining the theoretical framework of intersectionality and postcolonial feminism. Then it explains why I chose a qualitative analysis approach to collect, code, and analyze data from semi-structured interviews. I also explain the interdisciplinary approach of this research, combining three different disciplines to produce a more nuanced study of the lived experiences of menstruating immigrant women. Finally, I discuss my positionality as a researcher and ethical considerations around representing the marginalized voices of my respondents in this research.

3.1 Theoretical framework

Through my research, I aimed to understand the lived experiences of FGPIW in Canada regarding menstruation and how the socio-cultural aspects of menstruation change with migration. To unpack these complex and multifaceted questions, I employed the theoretical frameworks of intersectionality and postcolonial feminism.

A. Intersectionality

Kimberlé Crenshaw coined the term ‘intersectionality’ in 1989 to conceptualize the junction at which race, and gender interacted to oppress Black women. By analyzing certain legal cases, she illustrates the ways in which exclusively considering sexism or racism failed to help liberate women who experienced both. There are specific ways in which these two categories interact that the court fails to recognize (Crenshaw, Kimberle, 1991). Intersectionality is widely adopted and used by scholars, activists, and policymakers to understand and analyze the complex interplay of various social and political factors that shape individual experiences and power

structures (Collins & Bilge, 2016; Hobbs & Rice, 2018). It is used as an analytic tool across disciplines to acknowledge the multifaceted and complex nature of human experiences, allowing for a more nuanced understanding of social problems. Intersectionality is not only confined to the West as scholars and activists in the Global South have used this analytic tool without naming it as such (Collins & Bilge, 2016). The work of Indian activist Savitribai Phulle suggests the same as noted by Sharma (2015):

> Here's why you should know more about her. She got intersectionality. Savitribai along with her husband Jyotirao, was a staunch advocate of anti-caste ideology and women's rights. Phule's vision of social equality included fighting against the subjugation of women, and they also stood for Adivasis and Muslims. She organized a barbers' strike against shaving the heads of Hindu widows, fought for widow remarriage and in 1853, started a shelter for pregnant widows. She also cared for those affected by famine and plague and died in 1897 after contracting plague from her patients. – (Sharma, 2015, as cited in Collins & Bilge, 2016, p. 3)

Many scholars continue to employ the theory of intersectionality in research, which makes for compelling findings. Despite its widespread use, scholars have also critiqued intersectionality as a framework that tokenizes women of colour within academia by marking them as symbols of difference and diversity and by essentializing identity boundaries (Yuval-Davis, 2006; Mohanty, 2013; Falcon & Nash, 2015). Bowleg (2008) examines the challenges posed in conducting qualitative and quantitative research using intersectionality as a research framework. She highlights the limitations faced by various disciplines, such as psychology and health studies, in conducting intersectionality research due to the "prevailing view of social identities as being uni-dimensional and independent, rather than intersecting" (Bowleg, 2008, p. 313). In her work,

Bowleg addresses the methodological challenges of developing research questions, analyzing and interpreting intersectional data. Indian feminists have also debated the hegemony of Western-evolved concepts like intersectionality and its application in the Indian context (Gopal, 2015; M.E John, 2015; Menon, 2015).

At the same time other scholars maintain that intersectionality is constantly evolving and is still a valuable resource for understanding and "tackling social analysis" (Rice et al., 2019, p. 411). These critiques offer researchers an ethical guide to the deployment of intersectionality to empower marginalized voices. Scholars also argue that researchers "must resist opportunistic uses of intersectionality in favour of developing ethical, politically grounded approaches to truly collaborative research and counter-hegemonic knowledge production" (Bilge, 2013, p. 407; Rice et al., 2019). To avoid undermining the objectives, intersectionality researchers should employ self-reflexivity to disrupt power relations and understand how privilege operates (Bilge, 2013; Lewis, 2013). Intersectionality's adaptability makes it a suitable guiding framework to conduct qualitative research and for meaningful intersectional work, diverse and marginalized perspectives should be centred.

This framework allowed me to analyze how mutually constitutive categories of difference, such as gender, culture, migration and class, shape individual lives, health, social practices, and cultural ideologies around menstruation (Davis, 2006). Intersectionality in the context of migrant's lives, including "gender, age, ethnicity, sexuality, geography, education and literacy, socioeconomic status, and work conditions, can shape health outcomes by influencing access to health care and experiences of health, wellbeing, illness and death" (Yuval-Davis, 2006, p.3). Intersectionality as an analytic tool examines the interrelated social structures that produce and

reshape the knowledge of menstruators surrounding menstrual health care accessibility. As there are multiple intersections at "micro, mezzo, and macro levels, but it is neither necessary nor ideal to address in detail every dimension at every level" (Rice et al., 2019, p. 416). Therefore, for this research, intersections of gender, race, culture, migration, and health are used to move beyond the single axis of menstruation as a biological phenomenon and instead to reveal how multiple systems of power are understood, experienced, and negotiated across different contexts. The framework informed by intersectionality is particularly important for identifying inequalities and diversity within menstruators as a group, and for ensuring that changes to health policies or laws address the full range of needs. By using intersectionality, the lived experiences of racialized immigrant women are centred instead of relying on a generalized understanding of menstruation. Without taking intersectionality into account, it would be challenging to uncover the hidden inequalities that racialized migrant menstruators face in the host countries.

B. Postcolonial Feminism

In addition to intersectionality, I also drew from postcolonial feminism to critically understand immigrant women's menstrual health and its intersections with other forms of social differences. Postcolonial theory can be defined as an "interdisciplinary theory that shares a common political and social concern about the legacy of colonialism, and how this continues to shape people's lives and life opportunities" (Young, 2001; Browne et al., 2007, p. 125). This theory is grounded in the foundational works of scholars like Edward Said (1978), Chandra Talpade Mohanty (1984), Homi Bhabha (1994), Stuart Hall (1995, 1996), and Gyatri Spivak (1994). The main emphasis of postcolonial theory is to centre the voices of the marginalized and diverse, which have been excluded from the mainstream. Scholars argue that the post in postcolonial does not

mean that “colonialism is finished business” (Smith, 1999, p. 98), but “rather that new, evolving configurations of power relations are emerging” (Hall, 1996; Browne et al.,2008, p. 125). Postcolonial theory is focused on disrupting the structural inequalities that have been caused by “histories of colonization and ongoing neocolonial practices” (Anderson, 2004; Browne et al., 2008, p.126).

There are a few important tenets of the postcolonial feminist perspective that characterize and guide the research and its process. First, the positionality and reflexivity of the researcher are key to acknowledging the limits of objectivism (Gandhi, 1998; Deutsch, 2004). As researchers, being an instrument in the analysis and interpretation of the research plays an integral part in knowledge production. Second, the postcolonial feminist perspective helps to theorize how “gender, class, race and historical position intersect to shape the lives of individuals, communities and populations” (Anderson, 2000, 2004; Browne et al., 2007, p. 124). Lastly, a postcolonial feminist perspective centres the lived experiences of women at the centre of the analysis (Anderson, 2002; Collins, 2000; O’Mahony & Donnelly, 2010). This theoretical framework not only brings the marginalized experiences into the mainstream but also focuses on better strategies to improve their lives.

To understand the healthcare experiences of immigrant women, the need for a framework that goes beyond individual experiences is essential. This framework acknowledges that menstrual health experiences of immigrant women must be addressed within the social, political, historical, and cultural context of their lives. Postcolonial feminist theory examines how the socially constructed categories of race intersect with gender, culture, and class to understand menstrual health and menstrual health care practices of immigrants. Through this critical framework,

researchers shift their gaze from menstruators responsible for their own health to examining how health care institutions and policies affect immigrants' menstrual health. Postcolonial feminism brings "questions about the structured subordination of racialized groups and how this may influence and contribute to immigrant women's health care issues" (O'Mahony & Donnelly, 2010, p. 443). The prevalent racism, sexism, and class inequalities impact how immigrant women experience menstruation and how their menstrual health needs are understood and addressed by health care providers and society.

3.2 Research Methods

I conducted in-depth semi-structured interviews (SSIs) and open-ended questions to gather the data for qualitative research. SSIs are "conducted conversationally with one respondent at a time", and this interview method is a "blend of closed and open-ended questions, often accompanied by follow-up why or how questions" (Adams,2015, p. 493). The SSI approach is vital for my research project because this investigation is very present-day, and there is limited quantitative data available regarding this topic. SSIs are organized beforehand on a specific topic that allows researchers to limit their questions to a particular topic. The open-ended questions allow the respondents to explain their thoughts. At the same time, the possibility of probing freely gives researchers the opportunity to explore unexpected or unclear aspects of respondents' views. It often leads to valuable discussion for further qualitative analysis. Moreover, it is hard to analyze the respondent's emotions and their ideas about a particular subject without asking the right and open-ended questions.

I conducted interviews with ten FGPIW menstruators who identified themselves as women, aged 18 -35 years, who migrated from Punjab, India, to Toronto, Ontario, Canada in the last ten

years. These interviews took place between March 2024 and June 2024, seeking to learn about the lived experiences of immigrant menstruators in Canada. During this time, I attended community events in the Greater Toronto Area and also joined organizations working towards menstrual equity in Canada. These community networks of friends that I have developed have helped me to recruit respondents using snowball sampling technique. All of my respondents are first-generation immigrants who arrived in Canada within the last year under the category of temporary residents as international students in post-secondary diploma programs in Designated Learning Institutes in the Greater Toronto Area (GTA). Although at the time of the interview they held varied statuses, including study permit, work permit and permanent residency in Canada.

My call for respondents in the Greater Toronto Area was initially aimed at menstruators and non-menstruators who arrived in Canada as temporary residents within the last 10 years. However, due to a lack of response from non-menstruators, I decided to restructure my interview sample and focus on menstruators only. The length of time since landing in Canada ranged from 1 to 10 years, providing insight into both recent and established immigration experiences in Canada. This also highlights the differences in healthcare accessibility between temporary and permanent residents. Further, I stated in my call for respondents that the interviews can take place in three languages – English, Hindi and Punjabi, and this led to a largely Punjabi-speaking sample. If the interviews are only conducted in English, respondents often struggle to express their thoughts due to their English being a second or third language. With the given options, respondents choose to share the information in their native language, Hindi and Punjabi.

With respondents, I first requested a phone conversation to share information about myself and the research project, including a brief overview of my interview questions. After receiving

approval from the participants, we scheduled an interview according to their availability and the location of their choice. Each respondent received an informed consent form and an interview questionnaire before the interview, and they were asked for permission to proceed with the interview. The questionnaire and the interview guide were drafted beforehand and framed with consideration of the sensitivity and appropriateness of the respondents. Most importantly, the topics and questions were prepared in simple language, and technical terms were avoided. The questionnaire had closed-ended survey-like questions for obtaining general information from the respondents. The interview guide has general topics with open-ended questions rather than a long hierarchical list of questions.

Each interview session lasted about 40 to 60 minutes, including the time to fill out the questionnaire. Consent was obtained prior to scheduling the interviews to audio-record the responses of the respondents, and I used my mobile phone to record the interviews. I stored the recordings on my phone's internal memory and then transferred them to a password-protected external hard drive. I gave the respondents the option to choose when they wanted to be recorded by handing them my phone. Respondents played, paused, and stopped the recording as per their choice. This practice also helped me build trust with them and served as a reminder of their ownership of their narrative. I asked participants to select their own pseudonyms for this interview project. I intended to maintain anonymity, but also to be reminded not to make decisions on their behalf and to be aware of their agency.

A. Data Analysis

For the purpose of my research, I adopted feminist research praxis with a commitment to taking an intersectional, postcolonial feminist and feminist standpoint lens to understand the

menstrual experiences of FGPIW. Standpoint refers to the understanding of how people's interpretations develop based on their experiences of being socially situated within specific categories and intersections of race, gender, class, sexuality, citizenship, ability, and so forth (Bischoping and Gaszo, 2021, p. 3; Sprague and Zimmerman, 1993; Weedon, 1999; Intemann, 2010). Feminists from the late 1970s called for a knowledge grounded in the social and material realities of women through their lived experiences (Hekman, 1997). Feminist philosophers Nancy Hartsock (1983/2003), Sandra Harding (1986) and Dorothy Smith (1987) are the three earliest standpoint theorists, who argued that knowledge grounded in the standpoint of women is necessary to challenge the patriarchal institutions and ideology. Since the late 1970s, feminist standpoint theory has evolved into a framework that focuses on situated knowledges within multiple systems of oppression. This epistemological development marks the importance of bringing intersectionality into the feminist standpoint framework to offer insights into the structure of power, knowledge and social inequality.

As Patricia Hill Collins articulates, feminist standpoint theory is "an interpretative framework dedicated to explicating how knowledge remains central to managing and changing unjust systems of power" (Collins, 1997, p. 375). As Dorothy Smith[1] argues, "women's standpoint as a method commits us to beginning in the local historical actualities of one's experiences" (Smith, 1997, p. 129). Drawing from Smith, I approach first-generation Indian immigrant menstruators as central to the study, recognizing their agency and the worthiness of their experiences in the production of scholarly knowledge.

[1] Dorothy Smith (1987) in fact called her framework "standpoint of women" to differentiate her particular way of analysing institutional relations of power as different from other feminist standpoint theorists.

Using a feminist standpoint as my guiding methodology, I utilize reflexive thematic analysis (Braun & Clarke, 2006, 2019, 2021, 2022) as a data analysis method for "identifying, analyzing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79). Reflexivity of the researcher is the core of this approach, as knowledge generation is situated and subjective and should be understood as a resource for conducting data analysis (Braun & Clarke, 2022). The reflexivity approach of this method aligns with the intersectionality, postcolonial feminism and feminist standpoint framework of my research. Braun & Clarke (2006) provide a six-phase analysis process:

1. Familiarizing yourself with data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

Using these steps, I began by transcribing the verbal data from interviews into written form. Before that, I translated my interviews conducted in Hindi and Punjabi into English. I manually coded the data by reading and re-reading the transcriptions. In this, I used latent themes that "identity or examine the underlying ideas, assumptions and conceptualizations and ideologies that are shaping the content of data" (Braun & Clarke, 2022, p. 85). In the next step, the codes generated are combined to form an overarching theme of the research, illustrating how these different codes relate to the central theme. In the concluding steps, the themes are reviewed for coherence and combined with the participants' narratives to make an argument related to the research question.

During this entire process, I kept a journal of my role, my assumptions, and how my positionality as a researcher and a member of the community impacts my research outcomes. Taking a break in between interviews and in the process of writing really helped me to question my assumptions. Reflexive thematic analysis is a flexible and creative approach that creates space for combining different theoretical approaches and recognizes that the researcher is an integral part of the research. It also acknowledges that the researcher is not always accessible or beneficial to the research.

3.3 Positionality and Reflexivity

The question of positionality and reflexivity is central to my research topic, methods, theoretical framework and my experience of conducting research. Being a menstruating first-generation Punjabi immigrant from India, currently residing in Toronto and using the same immigration pathways of education as my research participants, I share a similar social situation with them and would be considered an "insider" to the community. The shared positionality with my research participants helped me establish rapport with them. Using Hindi and Punjabi during interviews also helped both me and the participants express ourselves with ease. But at the same time, my position as a researcher, graduate student, permanent resident, and upper-caste background grants me a privileged standpoint that I must recognize and critically interrogate. I adopted several reflective strategies to remain critical and aware of my privilege, like reflexive journaling to examine how my assumptions and my internal and external roles influence my research and shape my relationships with research participants. I also invited participants to choose their own pseudonyms to remind myself that I cannot decide on their behalf. The interviews are not mechanical processes in my research; instead, I approach them as care work that fosters trust,

active listening, and involves sharing my own vulnerabilities. I did not refrain from sharing my own experiences of menstruation, as I cannot ask my participants to share their intimate experiences by holding my own vulnerabilities. This practice really helped in creating a safe space for participants to share their lived realities as menstruators and racialized immigrants.

During analysis, I re-read transcripts repeatedly to ensure that emerging themes represent the voices of participants instead of my own assumptions. The lived experiences of my participants are central to my approach, but I also recognize that it is not entirely possible to detach my perspective from analyzing and interpreting the data. With the help of reflexive strategies, I was able to include myself without overemphasizing my role in the research process. I also shared the analysis and interpretation of their narratives as I documented them in this project to ensure that their story was shared as they wanted it to be. I also acknowledge that consent is an ongoing process, not a one-time procedural requirement. Participants were informed that they can refuse to answer any questions or withdraw from the study at any time.

The reason for conducting this research is that menstruation is an intimate and integral part of my life, as I experience very painful periods and my day-to-day plans revolve around this biological process, yet I have never embraced this embodied experience. These experiences became even more complicated with migration, as a 14-hour flight added the challenge of being women of colour. My difficulty in navigating health care in Canada, being a temporary resident, made me wonder how other temporary residents navigate this. After being disappointed with the underrepresentation of first-generation immigrants in menstruation research or research in general, I undertook this research to include our lived experiences and to demonstrate that our experiences are worthy of being included in scholarly work.

3.4 Ethics

The process of ethics also contributed towards a reflexive and care-informed research practice, as the process allowed me to revisit my research practices, address my assumptions and come up with strategies to protect the safety and security of participants and their narratives. I have also completed the TCPS 2 core certificate on research ethics to train myself with the knowledge and skills necessary to conduct interviews. As part of the ethics process, I created a detailed consent form (Appendix C) that clearly outlined the purpose of the study, the right to refuse, the voluntary nature of participation, and the scope of the project, helping participants make informed decisions about their involvement. The ethics protocol also required me to provide participants with a list of community and mental health resources in case of any harm or emotional discomfort caused while sharing sensitive experiences related to menstruation stigma or migration. This step was important for uploading feminist ethics of care, ensuring that participants had access to support beyond the research context.

3.5 Interdisciplinary lens

In Interdisciplinary research, researchers from two or more disciplines work jointly on a particular problem and collaborate in the design of research strategies and in the analysis of outcomes. Interdisciplinary research is “a cooperative effort by a team of investigators, each expert in the use of different methods and concepts, who have joined in an organized program to attack a challenging problem” (Pellmar & Eisenberg, 2000, p. x). This interdisciplinary research is grounded in three disciplinary lenses: Gender, Feminist & Women’s Studies, Sociology, and Health Studies. These three lenses complemented each other to understand how sexism, racism and migration affect menstrual experiences and shaped the way I conceptualized, analyzed, and interpreted menstruation as a socio-cultural and embodied phenomenon.

From Gender, Feminist & Women's Studies and Sociology, I adopted a feminist lens of postcolonial feminism and a feminist standpoint that situates menstruation within broader structures of power, gender and embodiment. Scholar Datta (2008) argues that gender is crucial to recognize how "intimately the materialities of bodies and bodily performances are connected to masculine or feminine marking of places in narratives and discourses" (p.202). This perspective also highlights that menstruation is not merely a biological phenomenon but acts as a site of cultural control in a patriarchal context. This lens allows me to centre the voices of participants and analyze how race, immigration, and culture intersect with gender in shaping menstrual experiences.

Sociology complements this study by examining broader social institutions and structures, such as migration, religion, myths, and taboos, that influence menstrual practices and the lived experiences of menstruators. Sociological analysis of menstruation focuses on the idea that menstruation is a socially and culturally constructed phenomenon shaped by systems of power, class hierarchies, and gendered socialization. (Hawkey et al., 2017). The discipline also aids in understanding the need to highlight strategies required to address "structural barriers while being cognizant of conflicting cultural expectations within pre- and post-migration contexts of immigrants" (Meherali et al., 2022, p. 8). It also provides tools to analyze how immigrant women resist these norms through their everyday practices and community support.

Health studies enable us to challenge the medicalized views of menstruation and advocate for a more integrated approach that considers the physical, mental, and social health aspects of menstruation. This health studies perspective highlights crucial dimensions of menstruation, such as physical symptoms, access to healthcare, sanitation, period poverty, health policy implications,

and mental health outcomes. This lens further complicates the binary of “private” and “public,” as menstrual health and well-being are often considered private matters, yet, in the absence of access to healthcare, sanitation infrastructure, and awareness, they become public. (McCarthy & Lahiri-Dutt, 2020, p.15). This discipline directs attention to how the lived experiences of menstruation among immigrant women in Canada get complicated by temporary immigration status, financial precarity, and limited access to culturally sensitive healthcare.

Combining all three disciplines provides a more comprehensive and nuanced understanding of menstruation and allows connecting the bodily experience of menstruation with larger social, political, and economic structures that are essential for creating culturally informed interventions and advocacy programs, as well as health care policies aimed at reducing menstrual inequities among immigrant communities.

CHAPTER 4: FINDINGS AND DISCUSSION

This chapter focuses on the findings of the study from the reflexive thematic analysis of the interview data, grounded in feminist standpoint methodology. Drawing on in-depth semi-structured interviews with first-generation immigrant women from India living in Canada, this chapter explores how they understand, experience, and manage menstruation across transnational familial, social, and institutional settings. Guided by an international framework, postcolonial feminist theory, and feminist standpoint epistemology, the analysis foregrounds FGPIW's lived experiences as situated, embodied, and socially produced forms of knowledge.

Using reflexive thematic analysis, five main themes are generated from the coding, capturing recurring patterns in how participants learned about menstruation, navigated menstrual stigma and hygiene, encountered healthcare systems, and managed menstruation as migrant and working women. These themes capture key patterns across the data and are discussed in relation to broader social, cultural, and institutional processes. These excerpts serve as entry points for examining how menstruation is shaped by intersections of gender, race, migration, and healthcare access. My own positionality as a first-generation migrant woman in Canada from India informed both data interpretation and theme development, not as a source of biases to be eliminated but as an analytic resource that contributes to the understanding of silences, shared assumptions, and culturally specific meanings within the interviews.

4.1 Socio-Demographics of Participants

The chapter begins with a demographic overview of the participants to contextualize the findings within their specific migration trajectories, access to healthcare, and employment

conditions. The basic demographic information (appendix A) collected via questionnaire during the interviews included key variables such as age, residency status, healthcare, and employment-related information. In accordance with the ethical research practices, participant anonymity was ensured through the thesis using pseudonyms, and identifying information like specific locations of residence and workplace has been excluded to protect participants' privacy.

Table 4.1 Demographics of Participants

Pseudonyms	Age	Gender	Place of Origin	Place of Residence
Simran	35	Woman	Punjab, India	Greater Toronto Area
Maheer	28	Woman	Punjab, India	GTA
Naira	28	Woman	Punjab, India	GTA
Neetu	29	Woman	Punjab, India	GTA
Anu	24	Woman	Punjab, India	GTA
Dharam Kaur	25	Woman	Punjab, India	GTA
Aashi	28	Woman	Punjab, India	GTA
Amrita	30	Woman	Punjab, India	GTA
Osheen	22	Woman	Punjab, India	GTA
Nimmo	28	Woman	Punjab, India	GTA

The table 4.1 provides basic socio-demographics of participants who took part in the study. The study includes ten first-generation immigrant women, all from Punjab, India, residing in the Greater Toronto Area in Ontario, Canada. All participants identified as women and were between the ages of 24 and 35 at the time of the interview. This information is crucial to situate the findings

within the intersections of age, gender, race and migration, which shape the participants' experiences of migration.

Table 4.2 Migration and Residency Status in Canada

Pseudonyms	Duration of Stay in Canada (in years)	Residency Status	Migration Pathway
Simran	3	Permanent Resident	International Student
Maheer	2	Permanent Resident	International Student
Naira	9	Permanent Resident	International Student
Neetu	6	Permanent Resident	International Student
Anu	5	Work Permit holder	International Student
Dharma Kaur	3	Work Permit holder	International Student
Aashi	2	Work Permit holder	International Student
Amrita	3	Work Permit holder	International Student
Osheen	2	Work Permit Holder	International Student
Nimmo	7	Work Permit Holder	International Student

The table 4.2 above provides information regarding participants' residency status in Canada and the migration pathways they chose to come to Canada. Participants varied in terms of length of residence in Canada, ranging from two to nine years. All the participants held different residency statuses in Canada, including four participants as permanent residents and the remaining six candidates as non-permanent residents currently on work permits. All the participants came to Canada as economic migrants through the education stream as international students in designated

learning institutions in Canada. These distinctions are analytically significant as immigration status and migration pathways determine access to employment opportunities and healthcare, which directly impacts menstrual health outcomes.

Table 4.3 Employment and Healthcare Access in Canada

Pseudonym	Healthcare Access	Paid work weekly (in hours)	Paid/unpaid sick days
Simran	Public	10	Unpaid
Maheer	Public	10	paid
Naira	Public	40	unpaid
Neetu	Public	40	Paid
Anu	None	40	Paid
Dharam Kaur	Private	40	Unpaid
Aashi	Public	40	Unpaid
Amrita	None	48	Unpaid
Osheen	Public	40	Unpaid
Nimmo	None	40	Unpaid

Table 4.3 depicts the employment and healthcare access in Canada for the participants. Most participants are engaged in paid work, with weekly hours ranging from part-time ten hours to full-time forty to forty-eight hours. Healthcare access varies; those who are permanent residents have public healthcare access, but non-residents rely on private insurance, and two of the

participants have no healthcare insurance or public access. There are also two participants who, despite being temporary residents, have public health access as they work full-time jobs, which grant them access to the provisional coverage policy. In terms of paid and unpaid sick days, the majority of the participants have unpaid sick days, and three have paid sick days. These structural conditions provide important context for understanding how menstruation intersects with productivity expectations and the uneven healthcare support available to participants to manage menstrual pain and related health needs.

Table 4.4 Menstrual Pain Medication and Products Use

Pseudonym	Menstrual Products used in India	Menstrual Product use in Canada	Menstrual Pain Medication
Simran	Sanitary Pads	Menstrual Cup	None
Maheer	Sanitary Pads	Sanitary Pads	Yes (Prescription)
Naira	Sanitary Pads	Sanitary Pads	Yes (Over the Counter)
Neetu	Sanitary Pads	Sanitary Pads	Yes (OTC)
Anu	Sanitary Pads	Sanitary Pads	Yes (OTC)
Dharam Kaur	Sanitary Pads	Sanitary Pads	None
Aashi	Sanitary Pads	Sanitary Pads	None
Amrita	Sanitary Pads	Tampons	None
Osheen	Sanitary Pads	Tampons	None
Nimmo	Sanitary pads	Sanitary pads/Tampons	Yes (OTC)

Table 4.4 presents participants' use of menstrual products pre- and post-migration, as well as their reported use of medication for menstrual pain. All participants reported using sanitary pads in India, reflecting widespread availability of pads. Following migration to Canada, most participants continued using sanitary pads, while two switched to alternative products like menstrual cups and tampons. This table also highlights variation in the menstrual pain management strategies of participants, with some relying on over-the-counter and prescription medicines, and others reporting no medication use due to lack of public healthcare access and myths around using medicine, as discussed in the themes below. This table provided crucial context for understanding how menstrual practices are negotiated across borders and how decisions around pain management and menstrual materials are shaped by individual and social beliefs, and also according to work demands, as discussed in greater depth in the thematic analysis that follows.

A. Reflexive Thematic Analysis

This research utilizes the reflexive thematic analysis (Braun & Clarke, 2006, 2019, 2021, 2022) to analyze qualitative interview data. It is a flexible, theoretically informed approach for identifying, analyzing and interpreting recurrent themes across datasets, emphasizing the active role of the researcher as a central resource in this process rather than biases. Through this analytical process, five overarching themes emerge that capture the complexity of FGPIW's lived menstrual experiences. These five themes are: (1) menstruation as gendered and embodied experience, (2) silence, stigma and regulation of menstrual bodies, (3) menstruation across borders: menstrual hygiene, infrastructure, and everyday menstrual management, (4) pain, productivity and medicalization of menstruation, (5) reframing menstruation as a structural and policy issue. Each

theme is supported by subthemes, providing focused analytical depth while centring the participants' narratives.

4.2 Theme 1: Menstruation as Gendered and Embodied Experience

This theme illuminates menstruation as a gendered bodily experience, where social meanings intersect to construct it as an inherently women's experience marked by discomfort and disruption of everyday life. The participants' narratives reveal that menstruation-related experiences are not merely biological but are especially constructed and normalized through gendered expectations around women's pain endurance and vulnerability. This theme comprises three subthemes as discussed below:

A. Menstruation Defined Through Discomfort and Pain

All the participants overwhelmingly defined menstruation through association with physical and emotional distress. The participants used words like inconvenient, blood, low energy, pain and problem to define their menstruation experiences. One participant said

> When I think about periods, I still get disgusted by the thought of blood and get stressed about them. I wish women didn't have to go through them. I do not like being a woman just because of periods; I wish men also experienced the same. This is so unfair. (Dharam Kaur)

Other participants also associated periods with the discomfort that menstruation brings to their everyday lives. One participant mentioned, "Other than pain, it is a beautiful thing as you become a mother because of periods" (Amreet). Menstrual pain and discomfort are defining features of menstruation for all the participants. Some participants mentioned that they plan and cancel their daily activities depending on their menstrual cycle. Aashi mentioned:

> All my friends planned to go to the water park, and I got my period. So, I had no other option but to cancel. It is not only about the water activities; it's also hard to enjoy when you are in pain.

Most of the participants mentioned that they avoid going to the beach when they are on their period, as going in the water feels uncomfortable. Another participant also shared a similar cancellation in plans due to menstruation as "I had to attend a wedding, and it was a very close family member's wedding. I postponed my period by taking a pill to delay it" (Amrita). While cancelling plans is a part of managing menstruation, especially in public spaces, sometimes they are also due to religious norms and restrictions that regulate menstruating bodies. As one participant stated:

> Once, my family planned to visit the famous Sikh temple, the Golden Temple. It was far from my city, so we booked train tickets and planned the whole trip, including hotel bookings and other arrangements. When we were leaving for the train station, I got my period. I was all ready and packed to leave, but because I experienced very painful periods and was very young, I always found it hard to manage due to heavy bleeding. I had to cancel because of the pain, and I felt bad about going to a religious place while on my period. Everyone in my family also agreed that I should stay at home. It was heartbreaking. (Nimmo)

Other participants mentioned their reasons for change as 'discomfort and low energy during periods' (Neetu and Dharam Kaur). One participant shared her experience of cancelling plans as:

> I do not cancel my plans if I really have to go. But if I have the option, I do cancel, but if I had pain-free periods and there was access to clean washrooms everywhere, I would never have to postpone anything. (Maheer)

These responses show that menstruation requires constant planning and adjustment in participants' daily lives. Physical pain, fatigue, and discomfort intersect with social and religious norms,

compelling participants to change or cancel plans, withdraw from public and religious spaces, and adjust their daily routines according to their menstrual cycle.

B. Gendered Transmission of Menstrual Knowledge

This subtheme includes accounts of how menstrual knowledge is transmitted along gendered lines. Most participants learned about menstruation from their mothers, sisters, and/or female teachers. As one participant shared:

> I came to know about periods from my mom. It is not common to talk about these things. I was aware of periods when I first got my period, but we never really discussed it openly, and it's not common to talk about private things. (Naira)

All the participants described menstruation as inherently associated with womanhood, positioning women, especially mothers and sisters, as their primary source of menstrual knowledge. Participants also reported feeling uncomfortable discussing menstruation with non-menstruators, mainly men. As Neetu shared, “I don’t mind talking to men about my periods. The problem is that men get uncomfortable. They make it weird, especially brown men”. Along the same lines, another participant mentioned that:

> Even if I have to talk to men about periods, I prefer to talk to young men rather than old men. Young people are understanding, but the older generation still hesitates to talk about periods. (Amrita)

These narratives show that menstrual information is transmitted through gendered familial networks, where female family members play a central role in informing participants about menstruation and guiding their understanding of it. All the participants also mentioned that their mothers bought pads for them in India, as they felt uncomfortable asking their fathers or brothers to buy pads for them. One participant mentioned:

> My mother used to buy pads for me all the time in India. One time, when my mother was not home, I had to ask my father to get the pads, and I felt ashamed while asking him. I still remember that feeling of hesitation. (Maheer)

This reliance on women as knowledge bearers reinforces the perception of menstruation as a private, feminized experience, limiting open discussion beyond these intimate circles and reproducing norms of gendered menstrual care.

4.3 Theme 2: Silence, Stigma and the Regulation of Menstruating Bodies

This theme explores how silence and stigma surrounding menstruation function as a mechanism through which menstruating bodies are socially regulated. Participants' narratives reveal that menstruation is not only governed through individual beliefs but is deeply embedded in cultural, religious, and gender norms that restrict how, where and with whom menstruation can be discussed or made visible. The subthemes are discussed below:

A. Menarche and Regulation of Menstruation through Taboos and Silence

From menarche onward, participants mentioned learning that menstruation was not a topic for open discussion (see theme 1). Stigma around menstruation was more evident in participants' everyday practices of concealment, like the experience of buying menstrual products, concealing stains on clothing, and hiding the pain. Rather than being framed as a normalized bodily function, menstruation is introduced discreetly, requiring secrecy and gendered containment. For all participants, mothers and sisters are the primary sources of information about menstruation and communication in enclosed settings. As one participant recalls her introduction to periods:

> I remember when my mother first told me about it. She took me into a room, closed the doors, and showed me a pad, whispering the entire conversation. She didn’t explain it in great detail, just telling me that one day I would see blood in my

> underwear, not to panic, and to come directly to her. I laughed at how she was whispering and didn't take it seriously. But I did understand that it was a taboo topic and needed to be discussed privately. (Dharam Kaur)

While the participant found the whispering manner humorous at the time, she later recognized the taboo nature of this conversation. This narrative illustrates the silence not merely as an absence of information but as an embodied lesson in secrecy, teaching girls who and with whom menstruation can be discussed and how. Another similar account of another participant highlights the gendered nature of menstrual knowledge:

> One of my friends got her period in the classroom, and I told my mother that a girl had started bleeding in class. Then my mother said it was not an injury but that she had her period. She said she would tell me about periods when the time comes. Then I got my period, and my mother noticed the stains and told me I had gotten my period. Some of my friends told me that they talk to their fathers about periods, and I was shocked. I never talked about this with my father or my brother. I mean, I can talk to my brother if needed about periods, but I never did; it's weird. (Osheen)

This response underscores how silence is reinforced through gendered boundaries within households and in society, where menstruation is considered a woman's issue and cross-gender discussion is not normalized but rather discouraged. Institutional settings further reproduce this regulation through segregation and exclusion of boys from menstruation discussion, as the participant shares below:

> We were introduced to periods in a school workshop. Our teachers asked all the girls to go to a different room, and the boys were not allowed to attend that workshop. The workshop was held by a well-known sanitary pad company, which showed us a film about menstruation. When we came back, all the boys were

> laughing and saying they knew where we had gone. It was really embarrassing because they were laughing at us. (Simran)

This experience emphasizes that silence is not neutral but actively (re)produced through institutional practices that both stigmatize and conceal menstruation. Beyond formal instruction, cultural beliefs and myths further sustain silence. As one participant shared:

> I don't know whether it's true or not, but there is a saying that if you talk about periods often, then you get your period. So, I don't talk about periods a lot. (Naira)

Such beliefs function as an informal regulatory mechanism, discouraging open conversation and framing menstruation as something that should not be thought of and talked about frequently. These narratives demonstrate how silence is internalized and reproduced, becoming a self-surveillance practice. These practices not only influence early menstrual experiences but also impact menstruators' attitudes towards menstruation in later life.

B. Stigma, Myths and Concealment in Everyday Menstrual Practices

Participants' accounts demonstrate that menstrual stigma is not only articulated through silence but is actively reproduced in everyday practices of concealment and behavioural regulation. These practices operate across familial, educational, religious, caste and media contexts, shaping how menstruation is managed, hidden and made socially legible. Although some participants described having a fairly supportive family system, concealment is still considered a normal part of routine menstrual management. Amrita's experience reflects both support and regulation within the family. She noted:

> I had a very positive introduction to periods because both my parents are very educated. My father really supported me during my periods, and he always cared for me. My mother used to buy pads for me, but then I started buying them myself.

> My mother used to write it on a piece of paper and tell me to hand it over to the shopkeeper, and then the shopkeeper would give me the pads. When I was approaching the end of high school, I got angry about this whole writing on the paper act, so I just started asking the shopkeeper myself. (Amrita)

This narrative illustrates how stigma is transmitted through seemingly mundane routines, even in a progressive household. Educational institutions, which are supposed to be a space where these stigmas are challenged, also sometimes reinforce the need to manage menstruation discreetly. As one participant mentioned:

> We used to wear white uniforms to school, and a lot of times, girls would get period stains on them. It must be very embarrassing and thank God it never happened to me. But a lot of my friends used to carry a white chalk or marker with them in case they got stains, so they could hide them with it. I also remember some carrying an extra pair of pants with them in case of stains. (Simran)

These strategies used by young menstruators indicate how stigma is anticipated and managed collectively, embedding menstrual concealment into girls' bodily discipline and mobility. This shows how menstruators constantly engage in self-surveillance of their menstruating bodies to prevent menstrual visibility and social discomfort that comes with this visibility. Cultural myths, rituals and restrictions also play a significant role in regulating menstrual behaviour. Participants referred to widely circulating beliefs surrounding purity, religious participation and bodily practices. A few of the participants shared such myths and beliefs as:

> I know there are restrictions that you should not go to the temple or a sacred place, not pray, and avoid sexual relationships. There are no scientific facts, but people still follow them. I also heard about not taking a shower when you are on your period. (Anu)

> There are a lot of myths, and most are practised by upper-caste people, especially Brahmins. For example, you cannot be part of a pooja (prayer ceremony). I have also heard that certain foods, like desi ghee, can delay your menarche (Maheer).
>
> I know that elderly people say that women should not enter the kitchen during their period as their touch can make the food go bad, and also that you should not wash your hair during your period. (Aashi)

These narratives demonstrate how menstrual stigma is sustained through intersecting systems of religion, caste, and gender, positioning menstruation as contaminating and in need of regulation. Language itself emerged as a key site of concealment. As one participant mentioned:

> Whenever we talked about periods in school, we never used the word "periods" but had code words so we could talk about it without anyone knowing exactly what we were talking about. I think it was not just us. I have noticed my mother, sisters, and cousins all had different code words. We used to call it "those days", and we also used funny words like "leakage" or "puncture". (Nimmo)

This statement described how menstruation was rarely named directly, and the use of derogatory terms like "leakage" or "puncture" signals the objectification of menstruation as a mechanical system rather than as a bodily function. This illustrates the normalization of such terms across generations, which actively obscure menstruation and reinforce its unspeakability. Participants also reflected on the contradictory role of popular media and the state in the stigmatization of menstruation. As Amrita mentioned.

> I feel like Indian government is okay with advertising so much about sanitary pads on TV, but at the same time, they want girls to be quiet about it. If any girl talks about periods openly, they consider her open-minded and too modern and argue that some things should be concealed. (Amrita)

This reveals how visibility is selectively permitted while embodied discussion of menstruation remains socially policed. This contradiction underscores how stigma operates not through the absence of representations in media but through controlled and depoliticized forms of visibility.

All the participants mentioned the stigmatization of menstruation in popular media, especially in movies, memes on social media that make fun of women, such as “PMSing angry woman”. One participant mentioned “yes, I have heard it a lot of times that men disgust their partners when they are on their period and they make fun of their experience” (Neetu). Another participant also shared “there are a lot of memes that these YouTube creators make about mood swings, and one of my colleagues also said to me that you look sad so you must be PMSing” (Maheer).

Although one participant shared a different approach towards these jokes, “I know that a lot of jokes and memes are on mood swings when we are on our periods, but I think they are right about it. I do feel irritated and frustrated, and my mood is really emotional, so whatever fun they make is actually based on facts” (Osheen). These narratives highlight how stigma can be both resisted and internalized, shaping how women understand, interpret, and justify their embodied experiences of menstrual discomfort. Importantly, such narratives also serve to discipline women’s behaviour in public and professional spaces, discouraging expressions of pain or vulnerability for fear of being dismissed as hormonally irrational. Taken together, these accounts demonstrate how menstrual stigma is reproduced through everyday practices that regulate not only visibility and speech but also emotional expressions and bodily mobility of menstruators.

4.4 Theme 3: Menstruation Across Borders: Menstrual Hygiene, Infrastructure and Everyday Menstrual Management

This theme examines how menstruation is managed across borders, explicitly focusing on India and Canada in this paper. Drawing on participants' cross-border experiences, the theme highlights how women from India negotiate menstrual hygiene, public infrastructure, and social norms in Canada.

A. Continuity and Change in Menstrual Management Post-Migration

Participants' accounts demonstrate that purchasing menstrual products emerges as a key site where shifts in autonomy, visibility, and comfort are negotiated after migration. Several participants mentioned that menstrual product production in India was mediated through female family members and governed through discomfort and concealment. As one of the participants shared:

> My mom bought the pads for me in India, and if I had to get them, it was very uncomfortable for me to ask the shopkeeper for a pad. But here, you don't have the option of having your mom buy it for you. So, you have to pick it for yourself. (Naira, Participant)

This reflects the gendered nature of the act of purchasing menstrual products and the discomfort associated with the experience that impacts attitudes towards managing menstruation, even post-migration. For other participants as well, the act of purchasing menstrual products in India was inseparable from stigma and concealment. As mentioned below:

> It's a taboo topic in India, so the buying experience was also very embarrassing. It was always whispered about, and the shopkeeper used to wrap the product in a newspaper so that no one could see it. I still have that image, which makes me feel

> weird about the whole process of getting menstrual products. But here in Canada, everything is open, and you can get your pads. (Dharam Kaur)

The participant here emphasizes that the memory of concealment continues to shape her feelings about menstrual product-buying experiences. This suggests that despite the change in spatial context, embodied memories of stigma continue to shape menstrual experiences post-migration. Amrita also shares a similar experience, as she states:

> My father used to buy the products for us, but then he moved abroad, and we were all women in the house. So, whenever we used to buy the pads, they would wrap them in a black bag, and it wasn't only one shop. Anywhere we went, the black bag continued. In the back of my mind, I used to think it was natural, so why hide the pads? But here in Canada, everything is in front of you in every store, and you can just grab it. It was refreshing to see it in the open, really. (Amrit)

The persistent use of black bag signals towards the normalization of concealment of menstruation acts as a powerful symbol of how stigma is materially enacted in everyday life. By wrapping menstrual products in a black bag, the shopkeepers participate in maintaining social norms that frame menstruation as something that needs to be hidden from public view. In contrast, the experience of openness in terms of menstrual products in retail spaces in Canada provides participants with a more positive experience. Another participant also shared a similar view:

> Managing periods is much easier and more convenient in Canada than back home. In India, even buying pads is a task, but here everyone knows about it and talks about it. I never feel embarrassed here to talk about periods. When people visit stores to buy sanitary products, they can choose what they want. So, if you want a cup, a thin pad, or a thick pad, they're all in front of you, and you can choose. (Neetu)

In contrast to the experience of concealment in India, participants described purchasing menstrual products in Canada as marked by visibility, accessibility, and choice. This open display of products in retail spaces in Canada allows menstruators to browse and select items without the mediation of a shopkeeper or family members. The wide variety of products also allowed participants to engage in more active decision-making rather than relying on standardized, limited choices of products. At the same time, participants also problematized the assumption that the post-migration context necessarily offers superior menstrual management. As one participant mentioned:

> In India, they used to wrap the pads in a black bag. Here, it's open. But the quality and variety of products are much better in India. In Canada, the pads are very bad and plasticky, but in India, you can get pads at affordable prices, and there are even products for pain, like roll-ons and cotton pads. I still get my pads shipped from India. (Aashi)

Participants' accounts indicate assumptions that the global north offers superior menstrual conditions. While Canadian contexts were associated with openness and more choice, concerns regarding product quality, affordability, and suitability emerged. This shows the transnational strategies of participants, who source menstrual products from India based on a comparative evaluation of cost, comfort, and bodily preferences.

B. Menstrual hygiene and public infrastructure

Participants' accounts illustrate that menstrual hygiene management is not solely an individual matter but is shaped by the governance of public infrastructure, including washroom accessibility, design, menstrual-friendly facilities, and privacy. Moving across borders requires not only adaptation to new social norms but also engagement with different material conditions that

shape how menstruation is managed in public. Several participants described Indian public washrooms as largely inaccessible for menstruation. As one participant shared:

> Indian public washrooms are so bad, unless you are going to an expensive place like a five-star hotel or a mall. I don't use public washrooms in India, and here as well I am scared of infections, so I avoid them in Canada too. (Dharam Kaur)

This account highlights the fear of infection and lack of trust in public infrastructure, which shape menstrual practices across both contexts. Participants' continued avoidance of public washrooms underscores infrastructural inadequacies across national contexts and how they lead to restricted mobility for menstruators. Disposal management emerged as another critical factor shaping menstrual hygiene, as one of the participants mentioned:

> Public washrooms are all dirty and unclean. They may be better in Canada, where there is a proper disposal system for pads in washrooms. They have disposal facilities in India, but not everywhere. (Anu)

Another participant also shared her views along the same lines: "In India, there are no provisions for menstrual products, but in Canada, there are separate disposal bins for that" (Neetu, participant). These accounts demonstrate how the presence or absence of disposal management directly affects menstruation management in public spaces. As another participant also shared her experiences along the same lines:

> We used to live in a city in India, but whenever we visited our ancestral village, managing periods became very hard. Older people in villages still don't feel comfortable talking about periods, and there are no disposal bins in villages for pads. So, managing periods became very challenging, but here in Canada, there are disposal bins for pads in every washroom, so it's much easier. (Osheen)

Geographic differences within India further shape menstrual hygiene experiences. Across both India and Canada, participants described adopting individual strategies to manage infrastructural shortcomings. As one participant summarized, “Public washrooms are dirty in both countries, so I always carry toilet paper and wet wipes” (Amrita). This statement depicts how the responsibility of menstrual management is shifted onto menstruators, requiring constant adaptation and preparedness in public spaces. A few participants challenged the common perception that Canadian public washrooms and public infrastructure are inherently better than those in India. As one participant mentioned:

> I think the image of India is that it’s very dirty, and I don’t agree with that. The washrooms in Canada are much worse, and there are no bidets here. I never experienced urinary tract infections in India, but I did within six months in Canada. (Maheer)

This narrative disrupts the simplistic global North–global South dichotomy by foregrounding bold experiences as measures of menstrual hygiene and safety. Rather than equating development with cleanliness, Maheer’s account highlights how infrastructural design, such as the absence of water-based cleaning systems, can negatively affect women’s reproductive health. Another participant mentioned, “The washrooms are not clean anywhere, but in India, the jet spray in the washrooms makes using cups much easier” (Naira, participant). This reflects how infrastructural features, such as washroom design, intersect with menstrual technologies, shaping which products are usable in different settings. Access to water-based cleaning systems emerged as a significant consideration for those using reusable menstrual products like cups. Another participant also expressed similar dissatisfaction with Canadian menstrual infrastructure:

> I don’t prefer to use public washrooms, and I don’t like the washrooms in Canada, as I had bad experiences in terms of cleanliness in Canada. India has better washrooms, and they are much cleaner than here. (Aashi)

Taken together, these accounts illustrate that public washrooms and larger public infrastructure are inadequate across both contexts and that migration does not guarantee improved menstrual hygiene conditions. Participants' narratives are grounded in embodied experience as menstruators in both contexts rather than in abstract notions of development.

4.5 Theme 4: Pain, Productivity and Medicalization of Menstruation

This theme examines how menstruation is experienced, interpreted, and managed within regimes of productivity, migration, and healthcare. This theme explores how menstruating bodies are expected to remain productive and untroubled by managing menstrual pain privately rather than providing accommodations. There are two subthemes as discussed below:

A. Navigating Menstruation as a Racialized Migrant Working Woman

This subtheme examines how participants navigate menstruation within the context of paid work and immigration precarity. It focuses on how labour expectations, temporary migration status, and fear of joblessness shape decisions about disclosing menstrual health issues, managing pain, and taking sick leave. Participants’ accounts below highlight how work routines constrain menstrual management, particularly in physically demanding and time-regulated labour sectors. As a participant shared:

> It is stressful and very hard to manage periods at work. You are relaxed at home, but at work, you cannot take a break, especially since I work in the food sector, which is very fast-paced. I only get one lunch break, so changing pads or relaxing in between is not an option. It is just constant standing. (Neetu)

This narrative situates menstrual pain within the low-wage, labour-intensive workplace, where breaks are limited and bodily needs are subordinated to productivity demands. Menstruation here is structurally unaccommodated, reinforcing how workplace regimes render menstruators invisible. Another participant also shared a similar narrative, as she mentions:

> All you can do is take pain medication to manage the pain, but even then, it isn't easy to manage work. I always keep products like pads and pain pills handy in case I get my period. I have always had issues with my menstrual cycles because I have polycystic ovarian syndrome [henceforth, PCOS]. My periods are mostly delayed, and when I get them, it's very painful with a heavy flow of blood. Even though I need to see a doctor for these issues, I can't call in sick to work that often. If you discuss these problems at work, you are seen as unreliable as an employee, so I have given up on that. (Amrita)

This narrative illustrates how menstrual pain becomes medicalized and self-managed in the absence of support from employers and an inaccessible health care system. It also shows that the responsibility for managing menstrual health concerns falls on the individual, with work performance demands leading to hiding menstruation and tolerating pain. Another participant also talked about her precarious life as a migrant worker in Canada:

> It is very difficult to even ask for a sick day, as the manager asks so many questions and makes you feel bad for taking one. I used to save my sick days every month just for periods, as I always had very painful periods. If there are female colleagues and a female boss, it’s easy to share, but around men at work, it gets very uncomfortable. As a temporary immigrant, if you call in sick every month, even for one day, you are scared that they might fire you or be a hindrance in your path to permanent residency. To be a good employee, I tolerate a lot of pain and discomfort at work. I don’t have the luxury to take some rest. (Anu)

This narrative shows how immigration status compels women to internalize pain as part of migration success and employability. Osheen's narrative below further complicates this migration precarity within economic vulnerability which intersect with menstrual health-related decisions:

> I know a lot of women have very bad periods, but you have to just manage them. I get unpaid sick days, so if I call in sick every month, I lose money. I need work experience for my residency application, so you just tolerate everything. Even when I used to study, losing even a day's pay was a big deal due to high tuition costs. (Osheen)

Here, menstruation is framed as something to be endured rather than addressed, reflecting the financial precarity of migrant women's disciplined bodies into silence and compliance. Participants also connected their menstrual pain management to other structural gaps in labour policy, highlighting the absence of institutional provisions for menstrual pain. She mentions:

> There are more women in the labour force in Canada than in India, but there are no provisions for paid leave, especially during periods. As a result, we face a double burden: first, paid work, and then chores at home. It's time for Canada to introduce paid menstrual leave for all women employees. (Amrita)

This narrative reframes menstruation as a policy issue and a failure to recognize the double burden on women of paid as well as unpaid work. Some narratives also bring healthcare exclusion into focus, illustrating how medicalization is often inaccessible for most temporary migrant women. As one participant shared:

> I am on a work permit and have been in Canada for almost four years now. I don't have a health card and have never had one. I have PCOS, so even if I need medication or to see a doctor, I cannot do that. Visiting a doctor costs a lot of money and takes time, too. I am not going to spend hundreds of dollars just for them to put

> me on birth control pills. No one takes periods that seriously, and a lot of my friends have had bad experiences here, as doctors ignore period problems. (Dharam Kaur)

These narratives show that menstrual pain is not merely endured but actively governed through workplace expectations, immigration precarity, and unequal access to healthcare. Participants' accounts also reflect broader systems in which menstruation is rendered invisible in order to maintain productivity, particularly in low-waged, feminized and racialized sectors of work. As a result of a lack of support in these work regimes, menstruators monitor their bodies, plan pain management in advance, and limit disclosure to avoid being perceived as unreliable workers.

B. Normalization of Menstrual Pain and Marginalization of Lived Experiences

This subtheme explores how menstrual pain is routinely normalized, minimized or rendered invisible in clinical and social settings, resulting in marginalization of women's embodied experience of painful menstrual cycles. Nearly half of the participants reported using over-the-counter pain medication, while the remaining participants did not use any form of pain relief, reinforcing the notion that menstrual pain must simply be endured (see Table 4.4). As one participant explained:

> I get very painful periods, and there is a misconception that taking pain medication during periods leads to disruptions in your blood flow. I still feel scared to take any medication due to this misconception and just tolerate pain. (Dharam Kaur)

This illustrates how social norms and beliefs circulate within families and communities, discouraging menstruators from using any pain-relief medication. Fear of disrupting the menstrual cycle reflects anxieties about menstruation that frame intervention as risky, while endurance is framed as normative femininity. Participants also described encounters with healthcare systems

where their lived experiences were dismissed or reframed through biomedical logics that failed to account for structural and hormonal complexities.

> I have PCOS and very irregular cycles. At one point, I didn't get my period for six months. I started gaining weight despite not eating much. I visited the doctor here in Canada, and she told me to come back if I didn't get my period for at least 9 months. She showed me a bunch of exercise videos. She kept pointing out my weight and said it was because I was obese. But my weight gain was actually due to my PCOS. I decided to give up on the medical system that day. (Amrita)

Here, the medical authorities, rather than investigating the root cause of irregular menstrual cycle, shift the responsibility onto the individual for managing their menstruation, leading to distrust in healthcare. Similar patterns emerge in other accounts of early medical encounters, where pain was normalized through comparison, discipline and female endurance of pain. As the participant reflects on her experience:

> I used to have very heavy and painful periods, especially in the first two to three years when I started having periods. It was so painful and so much bleeding that I had to call sick in school every time, and my clothes used to be full of period stains despite wearing pads. My parents took me to a very famous gynecologist. She told my mother that you care for your daughter too much, and that she told me you know girls who play sports never stop because of periods. She told my mother to make me do more physical activity during periods and not take my pain so seriously. I felt very embarrassed and kept tolerating the pain. After a few months, when I had my regular blood work test, I was very anemic and had a lot of other deficiencies, which were probably making things worse, but that doctor never cared to do any tests and didn't take my pain seriously. (Nimmo)

This demonstrates how pain is framed as weakness or as made-up, particularly when expressed by young girls. The dismissal of symptoms not only leads to missed diagnoses but also reinforces shame, silence, and menstrual suffering. At the same time, participants' narratives also depict the normalization of pain as being reproduced in families where endurance is modelled as strength. A participant mentioned:

> I never experienced painful or difficult periods, but I know a lot of women do. My mother sometimes gets very painful periods, but she never shows. So, I think people sometimes make a big deal out of it. If someone gets painful periods, it doesn't mean you have to give everything up and pause your life. I think some people do this because they want to just rest and take off from work. My mother never stopped working even when she was in pain, so I also don't take pain very seriously. (Osheen)

Osheen's account reflects the intergenerational perception of what constitutes "acceptable" menstrual discomfort. This perspective frames the woman's unacknowledged pain as a benchmark of menstrual experience, further marginalizing those who require rest, care, or medical attention. Participants also expressed frustration with standard diagnoses and pharmaceutical solutions for their menstrual health concerns. As the participant expressed:

> I have irregular periods, and every time I go to a doctor, the first thing they say is PCOS/PCOD. I mean, one can have irregular periods for other reasons as well. They don't dig deep when it comes to periods. A lot of the time, doctors blame everything on my weight and tell me to control it. They don't think it might be connected to my irregular periods. In any scenario, doctors prescribe birth control pills. (Naira)

Participant described how irregular menstruation is frequently reduced to PCOS or weight management rather than a menstruator's specific symptom inquiry. Such framing not only

reproduces bodily insecurities among women but also shifts responsibility onto menstruators' lifestyles, operating as a moralized explanation that limits meaningful engagement with menstrual health concerns. Finally, participants highlighted gendered power dynamics within health care settings, as participants noted:

> I do understand that doctors are doctors. I don't mind seeing a doctor if I have any menstrual health issues, but I don't think I will be comfortable discussing this with a male doctor. How will I explain something they have never experienced? (Anu)

Collectively, these narratives demonstrate that the normalization of menstrual pain is structurally produced through cultural beliefs, biomedical logics, and gendered expectations of pain tolerance. Menstrual pain becomes simultaneously invisible and ubiquitous, acknowledged as normal yet insufficiently serious for medical attention. This subtheme thus foregrounds how embodied experiences of menstrual pain are marginalized, reinforcing inequalities in access to care.

4.6 Theme 5: Reframing Menstruation as a Structural and Policy Issue

Rather than positing menstruation as a private or personal concern, this theme conceptualizes it as a structural issue shaped by gaps in policy, education, institutional accountability and medical interventions. This theme foregrounds participants' call for systemic change, situating menstruation within broader structures of health equity, public infrastructure and policy contexts to shape how menstruation is understood, governed and addressed.

A. Menstrual Awareness as a Collective Responsibility

This subtheme explores how participants articulate menstrual awareness as a shared social responsibility rather than an individual burden borne by menstruators. In this study, participants emphasized the role of families, schools, media, policy, healthcare systems, and other cultural and

social beliefs in shaping menstrual knowledge and studies. Several participants mentioned a lack of accessible, intergenerational education on menstruation, as one participant noted:

> In India, awareness is very important to make it easier for all of us to accept our bodies. There should be more informative programs on TV focusing on menstrual health, especially for young children, and to educate older people about the importance of talking about these sexual health topics. (Simran)

This account calls for public education and mass media to create menstrual awareness in India, specifically for all age groups and non-menstruators as well. Participants also drew attention to the contribution of healthcare systems in sustaining and perpetuating stigma through moral judgment and narrow interpretation of menstrual health concerns, as a participant mentioned:

> There are so many judgments in medical systems. At times, they connect missing periods with pregnancy or lifestyle. These judgements increase stress, and stress makes periods worse. It's easier for everyone to talk about abortions and pregnancy, but not about periods. (Maheer)

This illustrates how discussing menstruation is marginalized even within reproductive health issues despite its centrality to the overall health of menstruators. This also reveals judgment-laden assumptions prevalent in medical fields about menstrual health concerns, particularly the tendency to associate irregular periods with their weight and lifestyle choices. These assumptions, experienced as dismissive of participants' lived experiences, added to menstrual anxieties and have consequences for psychological and sexual well-being (Johnston-Robledo & Chrisler, 2011). Challenging the framing of menstruation as merely pathological, one participant shared:

> It should be taught at an early stage to both men and women that periods are natural and there is nothing to hide. Periods are not a disease, and many women perceive

> them as one. With awareness, we can address the taboos associated with menstruation. (Aashi)

This narrative emphasizes early education to inform menstruators as well as non-menstruators about this natural biological function of menstruation to address the stigmatization of this topic. It also highlights how the medicalization of menstruation often leads to menstruation being internalized as an illness rather than a bodily process. Participants also expressed frustration with the limited scope of menstrual health research, as one participant articulated this:

> Menstrual health is not really taken seriously. No one really cares to know why periods are irregular or how to cure them. It's high time for more research on periods, other than just prescribing birth control for every period issue. (Dharam Kaur)

This narrative draws attention to gaps in research related to menstruation and its associated health concerns, as well as the failure of medical systems to prioritize women's reproductive health concerns. At the same time, participants acknowledge the role of familial support to address menstrual stigma and silence. One participant shared:

> I had a very positive introduction to periods thanks to my family. Outside my home, when you buy pads or see what's happening around you, that's how I felt, ashamed at times, to carry a pad in public. But now I don't give a shit about what people think. Why should we hide something that's so natural? I can carry a pad and walk around a neighbourhood full of people with confidence, and that's because people around me never talked about periods in a weird way. It's very important, in my view, how you introduce periods to a child. I am so glad my brother also understands this, and I can talk to him about it. All thanks to my parents. (Amrita)

This shows how early normalization of menstruation through family support can help build confidence and challenge the concealment of menstruation in public spaces. It also reveals that

with familial socialization, one can counteract dominant norms of concealment and surveillance of menstruating bodies. The reference to the participants' brother highlights the importance of inclusive education within families, which can problematize the gendered isolation of menstruation knowledge. Another participant also shared something similar:

> Boys and men should be educated about periods and the difficulties women face because of them. Only then can they understand what we go through instead of laughing at us and making us feel weird. I wish they could experience what it feels like just once. (Simran)

This narrative shows the lack of men's engagement with menstrual awareness, contributing to the ongoing marginalization of women's reproductive health concerns. The gendered gap in menstrual knowledge contributes to persistent stigma and ridicule, positioning menstruation as a "women's issue" that perpetuates not only ignorance but also structural inequalities across all settings, such as schools, workplaces, and healthcare.

B. Access, Affordability and Public Infrastructure

This subtheme examines how broader structural factors, such as socio-economic and political factors, policy, and public infrastructure across national contexts, impact access to menstrual products, healthcare, and menstrual infrastructure. Participants' narratives highlight gaps in public provision, ranging from accessible, affordable menstrual products to sanitation infrastructure, revealing the marginalization of menstrual care. A participant's narrative below challenges the normalization of high prices for menstrual products as:

> Prices for menstrual products are so high in Canada. This is not a luxury we splurge on. Especially in Canada, it can afford to provide products at a lower cost. India has

> a large population and limited resources, so that is understandable, but Canada has no excuse for such high costs. (Dharam Kaur)

This account challenges the dominant assumption that developed and wealthier nations offer better menstrual support by contrasting Canada and India. This highlights that better economic conditions do not translate into equitable access and reframes the responsibility for affordability onto the state. Another participant underscored the importance of open display of menstrual products in retail and public spaces:

> Pads should be available in every washroom, regardless of the country. Buying menstrual products should be normalized in India and should not feel like smuggling an illicit product. If products are displayed in front of you, then you can make a choice whether you want a pad, a cup or a reusable pad. (Anu)

The comparison to illicit goods signals towards the concealment of menstruation as a form of regulation that restricts the menstrual decision-making of menstruators. This narrative situates choice as structural rather than individual, and how product concealment reinforces stigma. Some participants emphasized the importance of basic facilities for disposal systems in menstrual management:

> There is a need to work on public washrooms in both countries, but most importantly in India. Disposable bins and pad dispensers should be made available in every public washroom. (Aashi)

This account highlights the importance of urban planning, sanitation, and gendered access to public spaces in menstrual management. Participants further extended the discussion of infrastructure and the absence of menstrual leave:

> There should be menstrual paid leave everywhere, no matter where you work and how much you earn. It can help, especially for those who experience difficulties during periods. (Neetu)

This statement situates menstrual leave within debates over labour rights and workplace policies, challenging productivity norms that demand uninterrupted work. By positioning premenstrual leave as universal, this narrative resists that menstrual accommodation and care are essential rather than special treatment. Another participant challenged the inaccessible healthcare system in Canada:

> Canada is definitely much better when it comes to access to products and openness in discussing periods. But Canada has terrible healthcare. First of all, it takes a lot of time, and it's so expensive for people like us who don't have health cards. It's so expensive that I still rely on Indian doctors for my menstrual health concerns, as I have PCOS. I get my medications from there. (Amrita)

This challenges the dominant narrative of healthcare superiority in the global north by highlighting how immigration status influences access to healthcare facilities. Participants' dependence on transnational medical care demonstrates how exclusion from public healthcare systems compels immigrants to find alternatives for managing menstrual health. Another participant described the uneven distribution of affordability and quality of menstrual products:

> The quality of products is really poor, and prices are too high in Canada. If you want better products, they are only available in some high-end stores. Most stores carry cheap plastic products. Cotton-based pads are so expensive and hard to find. There are no other alternatives, either, other than those generic pain meds like Advil or Tylenol. There are no pain pills specifically for menstrual pain, and no other pain management products like oils, herbs, etc., even if they exist, because no one knows about them. (Nimmo)

This narrative highlights the unequal access to menstrual products based on financial means, which leads to inequality in menstrual management. The absence of specific pain management options for menstrual pain further underscores the narrow scope of menstrual care. Finally, participants framed menstruation as a tool used by corporations to generate more profit:

> People should be more vocal about periods so that no one needs to hide their pain. Companies are making money from periods through products, pain medications, and birth control pills, but there should be alternatives to these. Girls and women are still suffering during periods, and companies are profiting from our suffering. (Naira)

By focusing on alternatives, participants challenge the profit-driven solutions and highlight the importance of non-commercial responses to menstrual health. These narratives demonstrate that access, affordability, and public infrastructure are central to menstrual care. Instead of placing the responsibility on individuals to manage menstruation, participants called for accountability from the state, healthcare systems, employers, and corporations.

4.7 Discussion

This study demonstrates that menstruation is not experienced merely as a biological process but as a deeply socially organized and structurally embedded phenomenon shaped by gendered norms, labour conditions, healthcare access, migration, and capitalist regimes. Participants' narratives highlight the intersection of social categories of gender, race, culture, migration, and health, resulting in "crossroads of multiple oppressions" that influence the construction and experiences of menstruation among migrant women (Marecek, 2019, p. 178; Hawkey et al., 2016). The findings of this study align with the intersectionality framework that

emphasizes how menstrual health experiences are produced through overlapping systems of power rather than single, isolated categories (Yuval-Davis, 2006; Collins, 2016; Hawkey et al., 2016).

FGPIW's accounts of menarche and early menstruation experiences underscore how menstruation is personally (re)produced through silence, misinformation and gendered transmission of knowledge. The findings are consistent with the existing literature, which indicates that menstrual knowledge is overwhelmingly transmitted through female kin, particularly mothers and sisters (Erchull et al., 2002; Berger, 2011; White, 2012; Hawkey et al., 2016). As White (2012) argues, mothers are the most important source of information on menstruation, but their own negative attitudes and lack of information framed by societal norms and practices reinforce menstrual taboos. Consistent with prior research, participants' accounts revealed that a lack of knowledge about menstruation led girls to initially interpret menarche as a serious illness (Barkar et al., 2000; Lahiri-Dutt, 2015). As findings indicate, the association of menstruation with discomfort and pain aligns with the scholarship which argues that menstruation is framed as an inherently disruptive, painful, uncomfortable and burdensome condition (Golub, 1983; Chrisler, 2011; McMahon et al., 2011; Sommer & Sahin, 2013). As Golub (1983) notes, early socialization leads menstruating women to expect menstruation to involve discomfort, emotional instability, and interruption to everyday life. This normalization of menstrual pain and discomfort limits the possibility of menstrual care, accommodation, and policy intervention and renders menstrual discomfort a natural part of being a woman.

In parallel with the other studies, participants' narratives reveal that the responsibility of communicating about menstruation and providing support to young menstruating women often falls on female family members, and men remain free from this responsibility (Gupta & Gupta,

2001; Narayan et al., 2001; Lahiri-Dutt & Robinson, 2008). This makes menstruation a gendered and private matter and discussing it with fathers and male peers remain an uncomfortable experience, as a few participants mentioned. Along the same lines, Erchull et al. (2002) also noted in their research that menstrual education materials available in schools and the media reinforce these taboos instead of dismantling them. Some studies also found culturally specific restrictions on the consumption of certain foods during menstruation, consistent with FGPIW's narratives in this study (Chang et al., 2009; Sommer et al., 2015). Stigmatization not only produces silence on this topic but also results in menstruation being discussed in derogatory terms, as participants also mentioned (Costos et al., 2002; Sveen, 2016). In parallel with the literature, participants' narratives also reveal that menstrual blood and menstruating women are considered ritually impure in some Indian cultures, leading to the stigmatization of menstruation and the exclusion of women from religious and public spaces (Narayan et al., 2001; Singh, 2006; Kavitha & Jayalaxmi, 2019; Thakur et al., 2014). Studies also highlight that stigma and silence give rise to period poverty, which functions as a barrier to the accessibility and affordability of menstrual care (Golub, 1983; Ussher, 2006; Bobel, 2010).

As Kissling (2002) describes, stigma is transmitted through advertisements, educational material, silence, taboos, and cultural artifacts, all of which are evident in participants' accounts. In parallel with the findings, some previous studies also highlight that mothers' attitudes towards menstruation have a direct influence on their daughters' experiences of menstruation, especially the self-surveillance surrounding menstruation (Sommer, 2010; Johnston-Robledo & Chrisler, 2011). This self-surveillance through clothing, constant checking for stains during periods, and their everyday acts of concealment shape participants' relationship with their bodies over time.

Findings also suggest that such self-surveillance is not only individual but also structural, reinforcing feelings of shame and inferiority among menstruators towards their bodies (Guterman, 2008; Crawford et al., 2014; Hawkey et al., 2017). The findings align with the scholarship, arguing that since parents influence their children's early attitudes toward menstruation, they should be equipped with adequate menstrual information to ensure effective communication (Akers et al., 2011; Meherali et al., 2021).

The findings of the study align with the scholarship arguing the need to study menstruation in the broader context of experiences of women rather than just pathologizing menstruation through a medical lens (Uskul, 2004; Chrisler, 2014; Lahiri-Dutt, 2014; McCarthy & Lahiri-Dutt, 2020; Bobel, 2010). Bobel (2019) argues that the focus on menstruation from a hygiene perspective actively ignores the social and moral aspects linked to menstruation. Similarly, Lahiri-Dutt (2017) argues that "by portraying menstrual blood as a mark of illness, health care practices also imply that women's agency needs to be controlled" (p. 1162). The author further argues that corporations benefit from the medicalization of menstruation and making it a mere sanitation issue, as menstrual products are a huge market (Lahiri-Dutt, 2017). Participants critique the absence of menstrual leave, reflecting broader capitalist logics that devalue reproductive and embodied labour while extracting maximum productivity from racialized bodies (Fraser, 2016; Lahiri-Dutt,2017; Hawkey et al., 2017). FGPIW's accounts highlight that labour precarity among migrant women intensifies this situation, as low-wage, precarious employment marginalizes bodily needs and focuses solely on productivity (Rahim & Mukherjee, 1984; Hawkey et al., 2017). Because menstruation is deemed a private and gendered matter, it lacks political and policy relevance, resulting in the commodification of menstruation (Allwood, 2018; Scala, 2020, 2022).

There are very few studies focusing on the experiences of menstruation among migrant women despite migration being the determinant of health, especially in Western countries (Davis et al., 2009; Zimmerman et al., 2011). Scholars argue that social and cultural factors influence migrant women's menstrual care and overall well-being (Kissling, 2012; Dean et al., 2017; Ussher et al., 2017). While menstruation in the Western context is portrayed as a "hygiene crisis" that needs to be concealed and managed (Johnston-Robledo, 2002; Kissling, 2002), it is simultaneously associated with taboos, rituals, and impurity in non-Western contexts (Garg et al., 2001; Sommer et al., 2015). Literature on menstruation among migrants and refugee women argues that the studies are mostly done within a white Western context and there is a need to study cross-cultural experiences of migrant women residing in the West (Uskul, 2004; Metsula et al., 2017; Hawkey et al., 2017; Hennegan et al., 2019). Participants' accounts described increased openness and product visibility in Canada, but these were accompanied by other constraints related to affordability, healthcare access, and labour precarity. Consistent with postcolonial feminist critique, the findings challenge the simplistic narrative that portrays Western countries as inherently developed and non-Western contexts as oppressive and underdeveloped (Mohanty, 1984; Grewal & Kaplan, 1994). Scholars also argue that researchers and health care providers should be aware of the religious and cultural constraints that impact migrant women's agency (Ussher et al., 2017; Heard et al., 2019).

Participants' call for awareness, education, and reform aligns with Hardings (1987) and Collins (1991), who argue that women, especially those rendered invisible or marginalized, possess epistemic insights precisely because of their lived experiences and social location. This research, drawing on feminist standpoint theory, recognizes that knowledge is situated and that

migrant women are knowers capable of producing knowledge through their critical insights. By centring the voices of migrant women, this research contributes to feminist scholarship that calls for examining menstruation beyond a hygiene and medicalized lens and within broader social, political, and economic structures (Bobel, 2010; Chrisler, 2014; Lahiri-Dutt, 2017). By documenting everyday strategies of concealment, negotiation, and refusal, this research also argues that migrant women exercise agency to resist the structural barriers to menstrual care and bodily autonomy.

CHAPTER 5: CONCLUSION

This final chapter highlights the analysis of first-generation migrant women's menstrual experiences and reflects on the broader research, policy and practical implications. Drawing on the reflexive thematic analysis of participants' narratives, this study situates the findings within postcolonial and intersectional frameworks, focusing on menstruation at the intersections of migration, gender, culture, race, and health. This chapter is organized into three parts. First, the chapter summarizes the research and its contribution and relevance to scholarship on menstruation, migration, and race and gender, highlighting the importance of centering migrant women's voices towards menstrual justice and overall well-being. Second, it outlines recommendations for policy, healthcare, and education, grounded in FGPIW's narratives and informed by the structural barriers that shape menstrual experiences. Finally, it critically reflects on the strengths and limitations of this study and recommendations for future research within the feminist commitment to reflexivity and situated knowledge.

The study demonstrates that menstruation is not merely a biological function experienced by menstruators but rather political, as its deeply gendered and socially regulated experience is complicated by broader power structures. By centering the lived experiences of FGPIWs, findings reveal how menstrual stigma, discomfort, pain, silence and productivity expectations are embedded within broader systems of gender norms, migration and racialized inequalities. Findings also draw attention towards the normalization of menstrual pain, which makes the suffering of menstruators, especially women, invisible within the social context. These figures are particularly

relevant because they shift attention from individual strategies to the structural barriers that affect menstrual management.

The relevance of this study lies in its focus on menstruation as a site of ongoing gendered regulation through silence and stigma. Silence and stigma are not neutral but active mechanisms that restrict knowledge, agency, access to healthcare, and the disciplining of bodies. Furthermore, the transnational context of this study adds another layer of complexity to the structures that sustain menstrual inequality. As findings blur the distinction between "traditional" and "modernity" by challenging the assumption that crossing borders from the Global South to the Global North automatically means better menstrual management. The transnational dimension of this research highlights that migration reshapes the menstrual experience through access to products, healthcare, and infrastructure, but gendered and neoliberal expansions of endurance and productivity persist across borders.

The research contributes to the fields of gender studies, health studies, and sociology by extending the feminist analysis of menstruation, embodiment, and regulation, not as a private concern but as a structural issue complicated by intersecting systems of power. Drawing on intersectionality and postcolonial feminism, the study situates menstrual experiences within the colonial discourses, racialization, gendered norms and global inequality. By centring the lived experiences of FGPIWs, the study contributes to the feminist scholarship on health, labour, and migration and reflects how menstruation is a site where agency, embodiment, and power intersect. Ultimately, the findings call for institutional reform in healthcare and policies that recognize menstruation as integral to the overall well-being of menstruators, equity, and social justice.

This study offers several recommendations that move beyond individual-based solutions and emphasize structural change, emphasizing that menstruation is a social, political, and economic issue rather than merely a private issue. The findings demonstrate that menstruation is managed within the context of labour demands, productivity pressures, and inadequate workplace conditions, particularly for migrants working in low-wage and precarious employment. Participants emphasized paid menstrual leave for all menstruators, which would challenge the capitalist logic that prioritizes uninterrupted labour by ignoring workers' well-being and disproportionately impacting racialized migrant women. FGPIW's experiences also highlighted the gaps in menstrual healthcare, including barriers related to cost, immigration status, over-reliance on birth control pills, dismissal of menstrual discomfort and pain, and weight-related medical bias. These experiences reflect the medicalization of menstruation while overlooking social, cultural, racial and structural determinants of health. The findings also revealed that stigma, silence and concealment continue to shape the attitude of menstruators towards menstruation and their bodies through gendered transmission of menstrual knowledge, which reinforces that menstruation and its management are women's only matter. Educational Interventions are necessary to challenge cultural taboos, normalize conversations about menstruation with non-menstruators, and redistribute the responsibility for menstruation management beyond menstruators. Accordingly, this study recommends:

- The introduction of paid menstrual leave across all sectors for menstruators, especially in sectors that have a high proportion of racialized and migrant menstruators.

- Recognition of menstruation in occupational health and safety frameworks to provide provisions for access to restrooms, flexible breaks and availability of menstrual products at the workplace.
- Healthcare systems must address language barriers, cultural sensitivities, and structural barriers that affect racialized migrant women's access to health care. Culturally responsive menstrual care for migrant women is critical for those navigating unfamiliar medical systems.
- Expanding public healthcare coverage for temporary migrant workers, including access to gynecological care and menstrual pain management.
- Comprehensive gender-inclusive menstrual education that challenges menstruation stigma and normalizes diverse menstrual experiences should be taught at early stages to everyone, including non-menstruators.
- Community organizations working with migrant populations should be supported to provide accessible menstrual education that addresses stigma, cultural taboos, healthcare navigation, and support open conversations at home and in public.

To the best of my knowledge, this study is the first to focus on the lived experiences of FGPIW living in Canada on menstruation. By centring FGPIW, this research addresses a significant gap in menstruation scholarship that has largely focused on White Western contexts (Uskul, 2004; Hawkey et al., 2017). The qualitative, in-depth interviews, using feminist standpoint theory and reflexive thematic analysis, provided a nuanced understanding of how FGPIW experience menstruation at home, at work, in healthcare settings, and in transnational spaces. Additionally, the researcher's reflective positionality as FGPIW contributed to building trust with participants

and the ability to facilitate interviews in participants' first language, allowing for more open conversations.

The study focuses on the experiences of cisgender women; future research could focus on the experiences of trans and non-binary menstruators. While the study captures the experiences of Punjabi migrant women from India, it does not represent the diversity of migrant women from other regions or different immigration pathways. A prospective future project could analyze different regions of India and different immigration pathways and their impact on menstrual experiences. This study included intersectional analysis of gender, culture, migration, race and health, but there are other crucial categories that have a huge impact on the social construction of menstruation, like religion, sexuality, caste and class. However, the broad nature of this topic does give rise to multiple research directions, which I hope will be pursued in future research projects. Further, as my participant sample comprised predominantly of a majority of a single linguistic group (Punjabi), a single region (Punjab), and a single immigration pathway (international students), the experiences are not representative of all Punjabi women or migrant women. Future research could engage with more diverse menstrual experiences by including participants from different linguistic, caste, religious, or regional backgrounds.

The aim of this project is to center the lived experiences of FGPIW related to menstruation, with particular attention to structures of power, inequality and socially regulated aspects of everyday life. In parallel, this research also focused on how FGPIW's menstruation experiences are shaped by the intersections of race, gender, migration, culture, and healthcare access. The thesis findings argue that while menstrual pain is recognized as an inevitable part of menstruation in mainstream discourses, it limits recognition of discomfort as a ground for accommodation and

rest. This naturalization of menstrual discomfort disciplines menstruating bodies into invisible suffering, prioritizing productivity and output, and reinforcing the marginalization of menstruators' lived experiences. This study emphasizes that FGPIW are active agents and knowers, with various strategies to navigate their menstrual health in host and home societies. FGPIW reinterpret gendered and cultural norms surrounding menstruation, advocating for more accessible and inclusive healthcare for migrant menstruators.

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Appendix A

Basic Demographic Questionnaire

1. Name: _____
2. Age: _
3. Gender: _____
4. Place of Birth: _____
5. City of Residence: __
6. Duration of your stay in Canada: ___
7. Residency Status: ___
8. Accessibility to healthcare: (Public/Private/None)
9. Do you take any over-the-counter or prescribed medication for menstruation?

   Probe: If yes, Over-the counter_____Or Prescription_____
10. During the week, how much time do you spend doing paid work?

    Probe: Paid/Unpaid sick days per year: ____

Appendix B

Interview Guide

- What comes to your mind when you hear the word menstruation and menstruator?

Probe: What terms do you use/heard for menstruation?

- Can you tell me about your menarche (first period) experience?

Probe: What were your Primary source of information?

- According to you, what type of menstrual products are commonly used in India and Canada?

Probe: How accessible are they?

- Can you tell me your experience of buying sanitary products in India and Canada?
- Do you feel comfortable in talking about menstruation with non-menstruators?

Probe: Can you share any experiences of comfort and/or discomfort talking to them?

- Have you experienced any change in the level of openness of discussion regarding menstruation in Canada?
- Have you heard of any myths, restrictions, or rituals associated with menstruation in India?

Probe: Any similar or different cultural practices or rituals related to menstruation in Canada?

- Can you tell me about any restrictions and/or rituals followed during menstruation in your family during menstruation? how do you feel about that?
- How do you manage menstruation at home and workplace?

- Can you share your views on accessibility of public restrooms in India and Canada?
- Can you share some stories where you had to cancel or postpone your plans due to menstruation?
- What do you feel when you hear jokes on social media, movies or in real life that make fun of menstruation like “PMSing angry women”, “that time of the month” etc?
- How comfortable are you in talking to health care providers regarding menstrual health issues?
- Can you tell me about your views on accessibility of menstrual health care in India and Canada?
- What changes would you like to see in India and Canada regarding improving menstruation narrative?

Appendix C

Informed Consent Form

Date: March,2024

Study Name: Socio-Cultural Context of Menstruation: A Comparative Study of First-Generation Punjabi Immigrants from India Living in GTA(Toronto).

Researchers: Navneet Kaur, M.A. Candidate, Interdisciplinary Studies, York University Contact Information: nav96@yorku.ca

Graduate supervisor: Dr. Merle Jacobs e-mail merlej@yorku.ca

Purpose of the Research:

The purpose of this research is to explore and understand the socio-cultural context of menstruation among first-generation Punjabi immigrants living in GTA(Toronto), with the aim of challenging myths, taboos, and silence surrounding menstruation. By examining their experiences and perspectives, the research seeks to promote social awareness to contribute to a more inclusive, informed understanding of menstrual health among immigrant communities.

The anticipated forms of output resulting from this research will include a thesis and may also include presentations and written papers. Ethical guidelines and participant confidentiality will be handled with utmost care. The written papers and presentations identifying information will be thoroughly anonymized, de-identified, coded or pseudonymized.

What You Will Be Asked to Do in the Research:

You will be asked to fill out a questionnaire at the outset or conclusion of the interview date. The qualitative interview will be conducted in-person. The estimated time will be 5 to 7 minutes for

the questionnaire and 50 to 60 minutes for the interviews. Each participant will be assigned a unique code or pseudonym, ensuring confidentiality. Each participant will receive a $10 gift card from Tim Hortons.

Risks and Discomforts:

Potential risks to participants in this research include emotional discomfort during interviews and triggering experiences due to the social stigma attached to menstruation. To mitigate these risks, informed consent will be obtained, confidentiality measures will be implemented, and participants will have the option to withdraw anytime. Also, participants will be provided contact information for resources available for mental health support and menstrual health awareness in GTA, such as Toronto Distress Centre local crisis helpline (416- 408- HELP), Sexual Health helpline (416-533-8538).

Benefits of the Research and Benefits to You:

The research aims to better understand the socio-cultural context of menstruation among first-generation immigrants and promotes social awareness through challenging myths and taboos surrounding menstruation. Participants will benefit from increased representation of first-generation immigrants in academia by shedding light on their discourse of menstruation and the need to address the silence around sexual health issues among immigrants in Canada.

Voluntary Participation and Withdrawal:

Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer, to stop participating, or to refuse to answer questions will not influence the nature of your relationship with York University either now, or in the future.

In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality:

Unless you choose otherwise, all information you supply during the research will be held in confidence, and unless you specifically indicate your consent, your name will not appear in any report or publication of the research. The principal investigator will keep a link that identifies you to your coded information, but this link will be kept secure and available only to the principal investigator and/or selected members of the research team. Any information that can identify you will remain confidential. The data will be collected by using audio recording. Your data will be safely stored in a locked facility, and only research staff/research team members will have access to this information. The recorded data will be destroyed by December 10, 2024. Confidentiality will be provided to the fullest extent possible by law.

Recordings(audio) from the data collection will be saved in a password protected file to research team members' local computer, not the cloud-based service.

Please note that it is the expectation that participants agree not to make any unauthorized recordings of the content of a meeting/data collection session.

Questions About the Research?

If you have questions about the research in general or about your role in the study, please feel free to contact me (Navneet Kaur) via e-mail nav94@yorku.ca , and/or my supervisor Dr. Merle Jacobs e-mail merlej@yorku.ca. You may also contact the Graduate Program in Interdisciplinary Studies at pffern@yorku.ca.

This research has received ethics review and approval by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Director, Research Ethics in the Office of Research Ethics, 3rd Floor, Kaneff Tower, York University (e-mail ore@yorku.ca).

Legal Rights and Signatures:

I_____consent to participate in Socio-Cultural Context of Menstruation conducted by Navneet Kaur. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature_____ Date_____

Participant

Signature_____ Date_____

Principal Investigator

Additional Consent

Audio recording

I consent to the audio-recording of my interview(s).

- Y
- N

Consent to use of quotes

I consent to the use of quotations in any final reports/ publications of the research?

- Y
- N

Appendix D

Ethics Approval Form

YORK
UNIVERSITÉ
UNIVERSITY

Certificate #: **STU 2024-007**

Approval Period: 02/06/24-02/06/25

OFFICE OF RESEARCH ETHICS (ORE)
Kaneff Tower

4700 Keele St. Toronto ON
Canada M3J 1P3 Tel 416 736 5914 www.research.yorku.ca

ETHICS APPROVAL

To: **Navneet Kaur**
Graduate Student of Interdisciplinary Studies
nav94@yorku.ca

From: Alison M. Collins-Mrakas, Director, Research Ethics
(on behalf of You-ta Chuang, Chair, Human Participants Review Committee)

Date: Tuesday, February 6, 2024

Title: **Socio-Cultural Context of Menstruation: A Comparative Study of First-Generation Punjabi Immigrants from India Living in GTA(Toronto)**

Risk Level: ☒ Minimal Risk ☐ More than Minimal Risk

Level of Review: ☒ Delegated Review ☐ Full Committee Review

I am writing to inform you that this research project, **"Socio-Cultural Context of Menstruation: A Comparative Study of First-Generation Punjabi Immigrants from India Living in GTA(Toronto)"** has received ethics review and approval by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.

Note that approval is granted for one year. Ongoing research – research that extends beyond one year – must be renewed prior to the expiry date.

Any changes to the approved protocol must be reviewed and approved through the amendment process by submission of an amendment application to the HPRC prior to its implementation.

Any adverse or unanticipated events in the research should be reported to the Office of Research ethics (ore@yorku.ca) as soon as possible.

For further information on researcher responsibilities as it pertains to this approved research ethics protocol, please refer to the attached document, **"RESEARCH ETHICS: PROCEDURES to ENSURE ONGOING COMPLIANCE"**.

Should you have any questions, please feel free to contact me at acollins@yorku.ca.

Yours sincerely,

Alison M. Collins-Mrakas M.Sc., LLM

Director, Office of Research Ethics

RESEARCH ETHICS: PROCEDURES to ENSURE ONGOING COMPLIANCE

Upon receipt of an ethics approval certificate, researchers are reminded that they are required to ensure that the following measures are undertaken so as to ensure on-going compliance with Senate and TCPS ethics guidelines:

1. **RENEWALS:** Research Ethics Approval certificates are subject to annual renewal. **Failure to renew an ethics approval certificate or (to notify ORE that no further research involving human participants will be undertaken) will result in the closure of the protocol.** No further research activities may be undertaken until such time as a new protocol has been reviewed and approved. **Further, it may result in suspension of research cost fund and access to research funds may be suspended/withheld**;

2. **AMENDMENTS:** Amendments must be reviewed and approved **PRIOR** to undertaking/making the proposed amendments to an approved ethics protocol;

3. **END OF PROJECT:** ORE must be notified when a project is complete;

4. **ADVERSE EVENTS:** Adverse events must be reported to ORE as soon as possible;

5. **POST APPROVAL MONITORING:**
   a. More than minimal risk research may be subject to post approval monitoring as per TCPS guidelines;
   b. A spot sample of minimal risk research may similarly be subject to Post Approval Monitoring as per TCPS guidelines.

FORMS: As per the above, the following forms relating to on-going research ethics compliance are available on the Research website:

a. Renewal
b. Amendment
c. End of Project
d. Adverse Event