Tracing Stigma Beyond Borders: Menstrual Health Amongst Second-Generation Bangladeshi Women in the UK

Sarah Rashid

London School of Economics

Abstract

This study explores how menstrual health stigmas from Bangladesh have persisted or transformed among second-generation Bangladeshi women in the UK. The literature review is structured using Dahlgren and Whitehead's (1991) model of the social determinants of health. Drawing on twelve semi-structured interviews and analysed through reflexive thematic analysis, the study identifies four core themes: silence, education, intergenerational transmission, and adaptation. Findings reveal that menstrual stigma is not static; while cultural expectations around modesty and silence endure, participants demonstrate agency by challenging, modifying, or integrating traditions. Berry's Acculturation Model (1997) provides a theoretical lens for interpreting how participants navigate between inherited norms and contemporary British values. Many engage in bicultural practices, using institutional education to reinterpret familial beliefs, while others resist stigma through open communication or product choices. This study highlights the need for culturally responsive menstrual health education and policy, arguing that menstrual equity requires attention not only to material access but also to cultural meaning and generational change.

Key words: Menstrual Health; Stigma and 'Shame'; Berry's Acculturation Model; Social Determinants of Health; Intergenerational Transmission; Bicultural Identity; Cultural Negotiation; Health Inequalities

Table of Contents

1. Introduction

Rooted in the British colonial era, Bangladeshi migration to the United Kingdom (UK) intensified in the 1970s due to economic hardship, the Bangladesh Liberation War, and political upheaval (Mahmud, 2023; Alexander and Lidher, 2024). According to the Office for National Statistics Census 2021, approximately 644,881 people of Bangladeshi descent are living in England and Wales. Bangladeshi migrants have established close-knit communities in the UK grounded in cultural traditions, Islamic values, and strong family ties (Alexander and Lidher, 2024). Today, second-generation Bangladeshi women—defined as those born and raised in the UK to Bangladeshi-born parents (European Commission, n.d.)—occupy a unique sociocultural space in which they are exposed to both cultures. Within this bicultural context, menstrual health becomes a site of cultural negotiation, shaped by inherited expectations, public policy, and shifting generational perspectives.

Menstruation affects half the global population yet remains shrouded in silence and stigma across many cultures (McCammon et al., 2020). Defined as the 'negative perception of menstruation and those who menstruate, characterising the menstruating body as abnormal and abject' (Olsen et al., 2022, p. 2), menstrual stigma contributes to discrimination, reinforces gender inequality, and limits women's full participation in social, educational, and economic life (Barrington et al., 2021). Beyond social consequences, stigma also poses public health risks, contributing to poor menstrual hygiene management (Kumar et al., 2017) and associated physical, emotional, and psychological harms (Miller et al., 2023). As most girls learn about menstruation from female relatives or peers, stigma is often reproduced informally across generations (Muralidharan, 2019). It is thus both a consequence and a cause of inadequate menstrual health education and care, highlighting its significance as a public health issue (Babbar et al., 2022).

Despite a growing body of research focused on menstrual health in low- and middle-income countries and increasing attention to period poverty and stigma in the UK, little is known about how menstrual stigma evolves across generations in migrant communities. Specifically, the menstrual experiences of second-generation Bangladeshi women in the UK remain under-explored. This is a notable gap, given the social and cultural pressures these

women may experience from both their cultural background and their surrounding society. Migration does not necessarily erase stigma; instead, stigma may persist, transform, or be reinterpreted in new ways as women navigate life in a different cultural and institutional context (Bhugra and Becker, 2005).

The central question guiding this study is: Have menstrual health stigmas from Bangladesh persisted or transformed among second-generation Bangladeshi women in the UK? The question recognises that stigma is not static (Farrimond, 2021). Rather, it is a dynamic process shaped by acculturation, family narratives, institutional learning, and personal agency. Understanding this process is crucial for improving menstrual health outcomes among ethnic minority women in the UK, and also for informing inclusive public health strategies that move beyond "one-size-fits-all" approaches (Kriznik et al., 2018).

Two conceptual frameworks underpin this study. First, Dahlgren and Whitehead's (1991) model of the social determinants of health is used to structure the literature review. Menstrual health is a public health issue (Babbar et al., 2022), meaning this model allowed for an exploration of how menstrual stigma operates at multiple levels—from individual behaviours to cultural norms and policy environments. Second, Berry's Acculturation Model (1997) provides a theoretical lens to interpret how second-generation women negotiate inherited beliefs with contemporary British norms. Berry's (1997) framework supports analysis of cultural identity and change, particularly intergenerational dynamics within migrant communities.

This study proceeds as follows: The literature review considers existing research on menstrual stigma in both Bangladesh and the UK, highlighting gaps this research addresses. The methodology outlines the research design, including the qualitative approach, participant recruitment, and ethical considerations. The findings present four core themes developed through reflexive thematic analysis of interviews with twelve second-generation Bangladeshi women in the UK. The discussion interprets these findings through Berry's Acculturation Model to explore the persistence, transformation, or rejection of menstrual stigma. The conclusion summarises key insights, reflects on implications for public health policy, and suggests directions for future research.

2. Literature Review

Despite increasing global attention to menstrual health, there remains a notable gap in the literature concerning how menstrual stigma evolves across generations in diasporic communities. Specifically, little research exists on the menstrual experiences of second-generation Bangladeshi women living in the UK, an absence this study addresses. This matters because stigma surrounding menstruation can limit access to education, healthcare, and social participation (House, Mahon and Cavill, 2012). Understanding how stigma is transmitted, adapted, or challenged across generations is essential for inclusive policy and health promotion.

Given the complexity of menstrual stigma, this review adopts Dahlgren and Whitehead's (1991) model of the social determinants of health to structure the analysis. The model maps health outcomes across multiple, interacting levels—from individual behaviours to broader policy environments—helping to trace how stigma is embedded in social structures. However, as Wilderink et al. (2022) note, these layers are often interdependent rather than discrete. This review therefore foregrounds their intersections while drawing on research from both Bangladesh and the UK to contextualise the environments in which first- and second-generation women were raised.

In the absence of direct literature on first-generation Bangladeshi women's menstrual experiences, recent studies from Bangladesh are cautiously used to infer the cultural norms likely shaping their perspectives. Public health attention to menstrual hygiene in Bangladesh has only emerged recently, with menstrual health indicators included in national surveys since 2014 (Bangladesh Bureau of Statistics, 2020). While contemporary data cannot fully capture past experiences or the effects of migration, they offer a useful reference point for understanding the cultural frameworks that may influence intergenerational transmission of stigma.

2.1 Individual Lifestyle Factors

In Bangladesh, recent data show that over a third of women rely on cloths for menstrual management, with cloths being the primary choice for 91% of low-income women due to

their negligible cost (WaterAid Bangladesh, 2024). However, this practice is not solely a result of financial constraints—cultural beliefs and stigma also play a significant role. For example, many women hide cloths while drying them to ensure they are not seen (Castra and Czura, 2024), and some bury used cloths due to the fear that evil spirits may be 'attracted to the blood' (Seymour, 2008, p.1). These practices reflect how menstrual management behaviours, often framed as individual choices, are shaped by wider cultural and social pressures. Apparent personal preferences are often shaped by hardship, stigma, and norms. Although these findings reflect current practices, they provide valuable insight into the enduring cultural norms and stigmas that likely shaped the menstrual experiences of first-generation Bangladeshi women. This offers a contextual baseline through which participants' accounts of their mothers can be better understood.

In contrast, second-generation Bangladeshi women and girls in the UK generally have access to a broader range of menstrual products, including pads, tampons, and menstrual cups—products of which around 4.3 billion are used annually in the UK (AHPMA, n.d.). Yet access alone does not guarantee equity in menstrual health outcomes. Financial barriers continue to affect low-income groups, of which Bangladeshi households in the UK fall into, with over half reported as living in poverty (Joseph Rowntree Foundation, 2025). ActionAid UK finds that many individuals are forced to adopt unsafe menstrual practices due to cost; this includes behaviours such as using products for longer than recommended, reusing disposable pads, or substituting sanitary products with tissue or clothing (Pycroft, 2023). While these practices may reflect a similar kind of resourcefulness to that seen in Bangladesh, they occur in a very different structural context.

Second-generation women, therefore, find themselves at a complex intersection. Despite being situated in a high-resource country, their menstrual experiences may still be shaped by both economic hardship and inherited cultural attitudes. In these cases, stigma may shift from supernatural fears to more secular concerns about shame, privacy, and financial vulnerability, which raises important questions that this study seeks to address.

2.2 Social and Community Networks

In Bangladesh, menstrual knowledge is primarily transmitted between women, reinforcing the notion that menstruation is a "women's matter" (Mostafa, 2019). However, this system of female-to-female knowledge transmission often takes place in a context of silence and misinformation. Bosch, Hutter, and van Ginneken's (2008) study found that 64% of adolescent girls experienced menarche in fear, largely due to a lack of prior understanding about menstruation. Crucially, their research also revealed that mothers themselves were often uninformed, indicating that inadequate reproductive knowledge is perpetuated across generations. This gap in understanding is not just a reflection of individual neglect but part of a broader culture of secrecy, where even pharmacies discreetly wrap sanitary pads in newspaper (Mostafa, 2019). Additionally, cultural and religious taboos impose dietary restrictions, limit social activities (Chowdhuri, 2008), and perpetuate beliefs that menstrual blood can bring misfortune (Seymour, 2008). Taken together, these findings illustrate how menstrual stigma in Bangladesh is not only culturally embedded but actively maintained through social norms and intergenerational practices. For first-generation women, these dynamics likely shaped their early menstrual experiences—and may continue to influence the knowledge, attitudes, and expectations they pass on to their daughters in the UK.

In the UK, second-generation Bangladeshi women encounter distinct sociocultural dynamics, shaped by both mainstream British norms and inherited cultural expectations. While open communication about menstruation with female peers is increasingly common (Tingle and Vora, 2018), nearly 80% of adolescent girls with concerning menstrual symptoms still avoid seeking medical advice due to embarrassment (Lancet, 2018). These broader UK trends indicate that menstrual stigma persists even within a relatively open public health environment. For second-generation women, such stigma may be further compounded by culturally specific taboos inherited from their families, creating a layered experience of shame or silence. However, this intersection remains underexplored in existing research. For example, while many women in the UK report reduced participation in sports, exercise, and social activities during menstruation (Pycroft, 2023), few studies examine how cultural expectations around modesty or propriety within ethnic minority communities may reinforce or intensify these behaviours. By situating second-generation

experiences within both national and cultural contexts, this study aims to explore how menstrual stigma is uniquely negotiated at the intersection of public discourse and private tradition.

Thus, for second-generation Bangladeshi women, the potential for open communication with peers in the UK may be tempered by an internalised expectation of silence shaped by intergenerational norms. This study aims to explore this interplay more closely, investigating whether inherited norms interact with contemporary UK influences to shape second-generation women's menstrual experiences.

2.3 Living and Working Conditions

In Bangladesh, inadequate facilities and resources have long contributed to high rates of school absenteeism among girls during menstruation (Alam et al., 2017). WaterAid (2022) highlights how water scarcity and poor sanitation infrastructure continue to exacerbate these challenges. While a lack of adequate school toilets is often cited as a key barrier, Alam et al. (2017) found that subjective discomfort (reported by 99% of girls) and misconceptions about menstruation (64%) were stronger predictors of absence than infrastructural issues alone. This suggests that psychosocial factors, such as internalised stigma, shame, and restrictive family environments, play a critical role in shaping school attendance during menstruation. These challenges are embedded in broader structural conditions. Historical data further illustrate the severity of infrastructural limitations: for example, coverage of sanitary latrines in Bangladesh rose from just 1% in 1981 to 33% by 1992 (Quazi and Pramanik, 2004). Such conditions offer insight into the resource-scarce environments that many first-generation Bangladeshi women may have grown up in. These contextual insights help frame how structural and cultural factors have shaped menstrual hygiene management, offering a backdrop through which intergenerational attitudes and practices can be better understood.

In the UK, second-generation Bangladeshi women may encounter a different set of challenges, but existing research often fails to capture their specific experiences. Brown et al. (2022) highlight inconsistencies in menstrual education, with over a third of teachers

reporting that their school either did not provide menstrual cycle education or they were unsure if it was included in the curriculum. Furthermore, Pycroft (2023) discusses discomfort with school uniforms as a barrier to menstrual confidence, as well as fears of bullying. However, it remains unclear how these barriers may disproportionately impact ethnic minority students, particularly those from communities where menstruation remains taboo. Cultural sensitivities, language barriers, and lack of representation in education materials may all contribute to unequal experiences of menstrual education (Raleigh, 2025). These intersecting challenges suggest that universal policy interventions may not adequately address the needs of all students, especially those navigating both structural and cultural barriers.

In this context, second-generation Bangladeshi women may well have access to improved infrastructure and policy support, yet still face challenges rooted in cultural expectations and personal discomfort. The literature does not yet provide a comprehensive analysis of how structural and cultural dimensions intersect, highlighting an important gap this study seeks to explore.

2.4 Broader Socioeconomic, Cultural, and Environmental Conditions

In Bangladesh, patriarchal norms limit women's decision-making power within households (WaterAid, 2020), affecting their access to healthcare and resources related to menstrual health. These dynamics are reinforced by male-dominated household structures, where 87.4% of households are headed by men (Bangladesh Bureau of Statistics, 2023), often leaving women with little autonomy over spending on personal health products. Such constraints are further compounded by broader structural inequalities, including low levels of menstrual health education and deeply embedded gender roles, which cast menstruation as impure or shameful (McHugh, 2020). Menstrual health management in Bangladesh typically fails to engage male family members, thereby reinforcing the notion that menstruation is a private, women-only concern (Murshid et al., 2023). These intersecting barriers likely had a profound impact on first-generation Bangladeshi women, restricting not only their access to resources but also their capacity to challenge menstrual stigma within their homes and communities.

In the UK, significant policy strides have been made. For example, England's voluntary Period Product Scheme (Department for Education, 2025) provides free menstrual products to state-maintained schools, while Scotland has abolished the tampon tax and introduced free product provision under the Period Products Act (2021). However, period poverty remains a persistent issue (Pycroft, 2023). This economic reality disproportionately affects low-income families, including second-generation Bangladeshi women (Raleigh, 2025). Furthermore, while UK-based policies are designed to promote equity and break period taboos, they often lack comprehensive equality impact assessments that meaningfully account for cultural, religious, and ethnic differences in menstruation-related experiences. Although the Department for Education (2022) acknowledges that some groups may face additional stigma or restrictions based on religion or ethnicity, it also notes limited disaggregated data and highlights the need for further research to understand how different groups are affected in practice. For Bangladeshi women, the stigma may not relate solely to menstruation itself but also to broader cultural expectations around modesty and gender roles. Without acknowledging these nuances, interventions aiming to normalise menstrual health may be less effective for diasporic communities.

Second-generation Bangladeshi women may face a disconnect between UK policies promoting menstrual equity and the enduring influence of cultural and socioeconomic factors. This study aims to explore how menstrual stigma is reshaped within diasporic contexts, challenging assumptions of a universal experience.

2.5 Navigating Two Worlds

Second-generation Bangladeshi women in the UK navigate the intersection of two cultural approaches to menstrual health. While benefiting from improved access to products and supportive policies, they simultaneously contend with inherited cultural beliefs, economic challenges, and persistent stigmas. This unique position enables blending of both cultures but presents challenges in reconciling differing expectations. Research confirms similar patterns of cultural navigation in other health domains among similar populations. Ahmed et al. (2022) document how second-generation Bangladeshis and Pakistanis modify their asthma self-management based on familial versus peer contexts, while Akhter et al. (2021)

demonstrate how acculturation status significantly impacts obesity-related health risks among UK Bangladeshis. Hybrid contexts necessitate examining how such populations manage differing cultural expectations. Therefore, to understand the processes through which second-generation Bangladeshi women in the UK reconcile heritage and host cultures, this study considers Berry's Acculturation Model (1997) as a theoretical lens to shape the discussion.

3. Theoretical Framework

3.1 Berry's Acculturation Model

Acculturation refers to the processes and outcomes, both cultural and psychological, that result from sustained intercultural contact (Berry, 1997). Berry (1997) highlights four acculturation strategies: assimilation, where individuals abandon their cultural identity to integrate into the dominant society; separation, where individuals maintain their original culture while avoiding interaction with the larger society; integration, where individuals balance cultural maintenance with active participation in the wider community; and marginalisation, where individuals lose connection to both their heritage culture and the dominant society, often due to exclusion or discrimination. These strategies offer a useful framework for interpreting how individuals navigate cultural identity, making them particularly relevant for analysing participants' lived experiences.

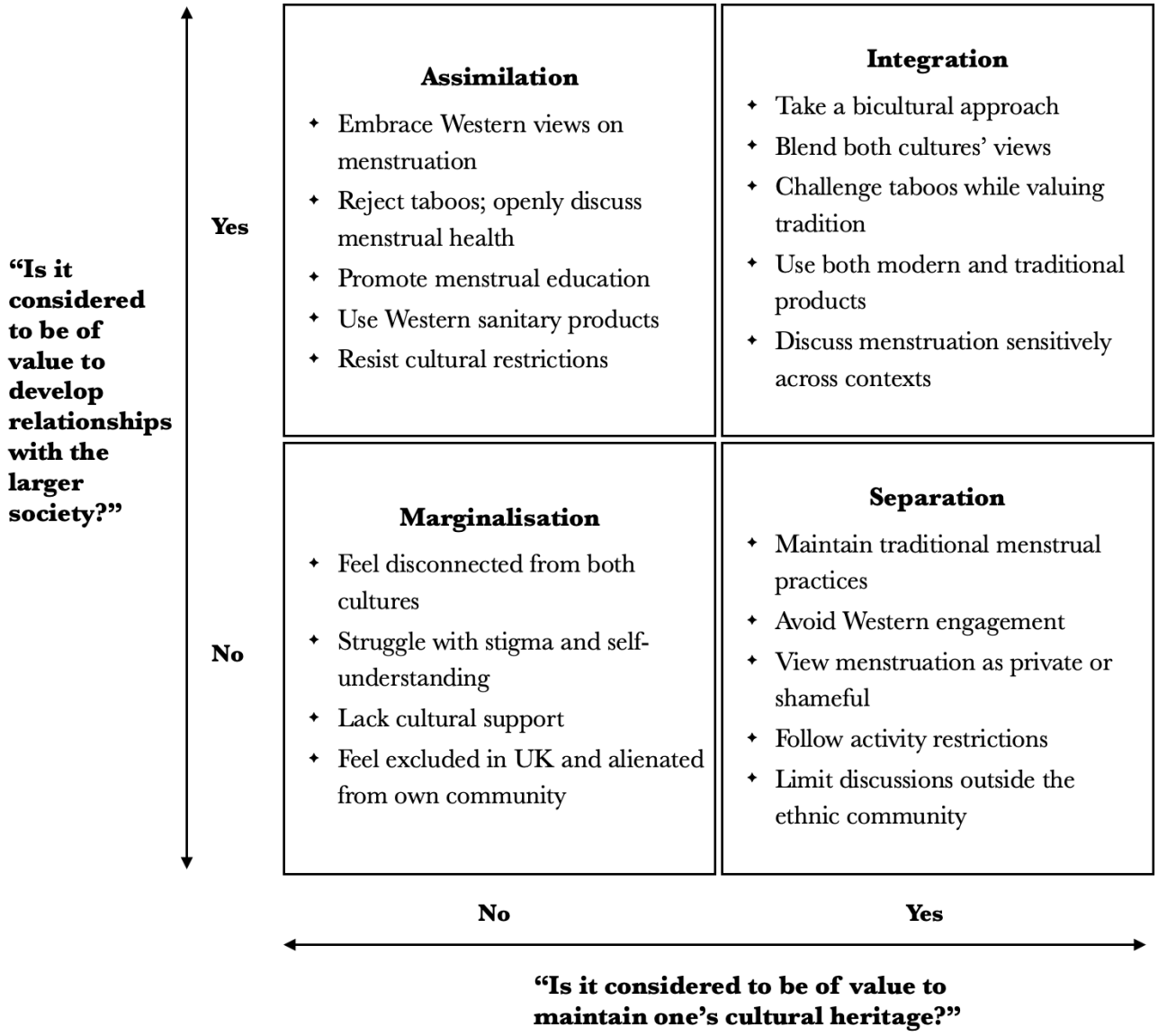
Although scholars, such as Sam and Oppedal (2003), have raised concerns regarding the model's applicability to second-generation individuals, it remains valuable for this study. While originally designed for first-generation migrants, its core premise—how individuals navigate between cultural influences—still applies to second-generation experiences. Research has shown the model provides a conceptual foundation to examine how cultural beliefs are retained, reinterpreted, or rejected across multiple generations (See Berry and Sabatier, 2010; Berry and Hou, 2017; Schwarz and Pfammatter, 2024). To account for this as a limitation, this study applies Berry's model as a flexible analytical tool rather than a rigid categorisation system, exploring acculturation as fluid and multidimensional. In doing so, it acknowledges that second-generation women's experiences of menstrual health stigma are shaped not only by their cultural heritage but also by the broader social, political, and familial environments in which they are embedded.

3.2 Berry's Acculturation Model and Menstrual Health Stigma

Each of Berry's four acculturation strategies can be seen in the ways individuals engage with or challenge menstrual stigma. Extending Berry's Acculturation Model (1997), Figure

1 illustrates how second-generation Bangladeshi women in the UK may navigate menstrual health behaviours, mapping them onto the four acculturation strategies.

Figure 1



Extension of Berry's Acculturation Model (1997) with Menstrual Health Behaviours

4. Methodology

4.1 Research Design

This study adopts a qualitative research design to explore how menstrual stigma is experienced and negotiated by second-generation Bangladeshi women in the UK. Given the topic's sensitive and culturally embedded nature, a qualitative approach enables in-depth exploration of lived experiences, intergenerational dynamics, and subjective meanings (Weiss, 1995). Since menstrual stigma is often shaped by silence, shame, and interpersonal relationships (Johnston-Robledo & Chrisler, 2011), these nuances are difficult to capture through quantitative methods. The design also aligns with feminist research principles that prioritise marginalised voices and value experiential knowledge (McHugh, 2020). As with many small-scale qualitative studies, the sample size was limited. Whilst the aim was not statistical generalisability, it is acknowledged that the perspectives captured represent a specific age group and cultural background; this may not reflect the full diversity of second-generation Bangladeshi women in the UK. Instead, this design was chosen specifically to explore the depth and complexity of individual experiences (Bryman, 2012).

4.2 Participants and Recruitment

Participants were selected through purposive sampling; this is a form of non-probability sampling in which individuals are chosen strategically based on their ability to provide relevant and meaningful insights, typically due to specific life experience or cultural knowledge (Clark, Foster & Sloan, 2021). This approach was particularly appropriate given this study's focus on second-generation Bangladeshi women in the UK, whose lived experiences are central to addressing the research question. Participants met the following criteria: second-generation Bangladeshi women (i.e., children of first-generation migrants who moved from Bangladesh to the UK), were aged 18–25, currently residing in the UK, and felt comfortable discussing their menstrual experiences (See Appendix 8.1: Participant Characteristics for further details). It is important to note that the sample may be subject to self-selection bias—the idea that participants who partake in the research may 'differ substantially' from those who do not (DeShea and Toothaker, 2015, p.12). Those who felt more comfortable or motivated to speak about menstruation may have been more likely to

participate. However, this was partly mitigated by recruitment strategies that included outreach through community groups and snowball sampling, helping to diversify the range of participants and encourage engagement from individuals who might not otherwise volunteer.

4.3 Data Collection

Initial information and consent forms were sent to individuals who expressed interest in participating in the study. These forms included questions regarding age, primary language spoken at home, and self-described and self-rated cultural identity (See Appendix 8.2: Information and Consent Form for further details). These items were selected from the Suinn-Lew (1987) Asian Self-Identity Acculturation Scale (SL-ASIA). Consistent with prior research (Ahmed et al., 2022), only a small number of scale items were used to identify the degree of cultural orientation among participants. Full use of the scale was avoided based on concerns around its length and cultural relevance, especially given that acculturation categorisation in this study serves an interpretive, not diagnostic, function.

Following this, data for this study were collected through semi-structured interviews. These are especially appropriate for this study as they offer rich insight into both personal narratives and broader social dynamics (Brinkmann, 2020). Semi-structured interviews allowed for consistency using guiding questions while also enabling participants to raise topics that may not have been anticipated—an approach particularly suited to exploratory, experience-based research (Braun & Clarke, 2013). Such flexibility is essential for a topic as personal and potentially sensitive as menstruation, particularly in culturally specific contexts where stigma may manifest in unexpected ways. I considered the questions carefully, given my positionality as a researcher with lived experience of menstrual stigma. While this offered valuable cultural insight and empathy, it also carried the risk of influencing how I interpreted participants' responses. To minimise this, I used neutral, open-ended questions that did not assume the presence of stigma, allowing participants to define their own experiences on their terms. Throughout the analysis, I engaged in reflexive practice to remain aware of how my assumptions might shape the interpretation of data.

Twelve online interviews were conducted in total via Microsoft Teams. While virtual interviews have traditionally received 'limited attention in the qualitative literature', their popularity has increased since the COVID-19 pandemic (Keen et al., 2022, p.1). In this study, virtual interviews enabled greater accessibility, which made it more feasible to engage with participants who might otherwise have been unreachable for in-person conversations. It also allowed for automatic transcriptions of the 60–75-minute interviews, requiring minimal manual correction. This significantly streamlined the familiarisation and coding process, allowing for a smoother transition from data collection to analysis.

4.4 Data Analysis

With consent, virtual interviews were audio-recorded, automatically transcribed verbatim, and analysed. Interview data were analysed using reflexive thematic analysis (Braun & Clarke, 2013), a method well-suited to exploring patterns of meaning within qualitative data. Braun and Clarke (2006) outline six phases of reflexive thematic analysis: familiarisation, coding, theme development, theme review, theme definition, and report production. This approach provided the flexibility to identify both anticipated and emergent themes relating to menstrual stigma, cultural transmission, and intergenerational dynamics. Analysis involved close engagement with the data through transcription review and repeated reading, followed by systematic coding. These initial codes were developed into broader themes that captured recurring patterns across participants' narratives.

Berry's Acculturation Model (1997) was used as a theoretical lens to guide the later stages of interpretation. While themes were developed inductively from the data, the model offered a structured framework to explore how participants navigated inherited cultural beliefs alongside UK societal norms. Initially, the study aimed to categorise participants into acculturation quadrants. However, during analysis, it became evident that participants' experiences were more fluid and context-dependent than fixed classifications would suggest. Therefore, rather than categorising individuals, the analysis mapped thematic behaviours and practices across Berry's quadrants, reflecting the dynamic ways participants negotiated cultural expectations in different relational and institutional contexts.

4.5 Ethical Considerations

This study received ethical approval through a Departmental Review at the London School of Economics. Participants were provided with an information sheet outlining the core principles of the study, and informed consent was obtained before the interview process. To build rapport and foster a comfortable environment, each interview began with an informal conversation. Participants were reminded of their right to skip any question, withdraw or end the interview at any time. Careful attention was paid to tone, language, and non-verbal cues to ensure sensitivity and respect throughout. Participants were assured of their anonymity and informed that they would be assigned pseudonyms (See Appendix 8.1: Participant Characteristics). Audio recordings and transcripts were securely stored on encrypted devices with password protection.

5. Results

Using reflexive thematic analysis (Braun & Clarke, 2013), four central themes were developed from the semi-structured interviews with participants. The results highlighted both anticipated and emergent patterns relating to silence, education, intergenerational transmission and adaptation.

5.1 "That Thing"—Menstruation as a Silent Subject

Across the interviews, all twelve participants described growing up in environments where menstruation was not openly discussed. This silence was often both gendered and culturally shaped. Over half of the participants explained that they had learnt menstruation should not be discussed in front of men, while all participants framed menstruation as something to be managed privately, often in ways that implied embarrassment or shame.

One of the most consistent manifestations of this discomfort was the use of euphemistic or coded language. Amina shared that her mum '*never really used the word "period", [she] would just say it in a vague way, like "that time" or something like that.*' Similarly, Ayesha recalled, '*Mum wouldn't even call it a period in front of me, just in case my brothers or dad heard. She instead referred to it as "hota"—which directly translates to "that thing".*' The conscious efforts to avoid saying "period" aloud, particularly in front of men, positioned menstruation as not just private, but inappropriate for mixed-gender contexts.

Khadija noted that her mother 'wouldn't call them periods; she would just ask me "Nomaz nai ni?" (So, you're not praying then?)'. As Halima explained, 'At fora (after-school Islamic classes), we were told not to pray or fast during your period, not to touch the Quran'. This highlights how the broader silence around menstruation was reinforced not only through language, but also through religious expectation.

This culture of secrecy extended beyond speech into everyday practices. Participants described routine efforts to hide their menstrual products, especially in shared family spaces. Zara recalled, '*My mum would give me old newspapers so I could wrap my pads up properly before putting them in the bin. I think she did it because we all shared one bathroom, and my dad might have seen*

the pads'. Such behaviours reinforced gendered boundaries designed to hide any evidence of menstruation in front of male relatives.

Maya shared, '*My mum bought me pads when I first started my period, and she put them into my cupboard but hid them under loads of towels'*. Concealment was further expressed by Salma and Ayesha, who both stated they would "hide" their menstrual products up their sleeves before going into the bathroom. Salma continued to say how it was frustrating that she could not '*keep any products in the shared bathroom'*.

5.2 'School Taught Me First'—Incomplete Knowledge

All participants credited schools, particularly PSHE (Personal, Social, and Health Education), RSE (Relationships and Sex Education) and Biology classes, as their primary source of menstrual education. While family members often provided some form of practical support, many participants recalled little to no explanation of menstruation before menarche. School-based lessons on menstruation were described as a vital source of information.

Most participants had their first encounter with menstruation at school. All of them were able to remember their first formal lessons, recounting how '*the class was split into boys and girls'(Zara)*. These lessons covered both biological facts and practical guidance. Ayesha recalled how '*the teacher had loads of different cups filled with red food colouring. She showed us how much blood was normal to lose'*. Maya was '*shown different types of products, like pads and tampons. I remember them demonstrating how to open them'*. This form of institutional knowledge was frequently viewed as more reliable and normalising than what participants encountered at home.

This was in direct contrast to home-based messages, which were more ambiguous or shaped by silence. There was often delayed or limited information offered at home. Salma, who began menstruating unexpectedly on a school trip, shared: '*When I told my mum I had been bleeding, she handed me a children's encyclopaedia, opened the page on menstruation, and left the room. That*

was it.' Sabina also reflected: '*School told me it was normal. At home, no one said it wasn't normal—but no one really talked about it either.'*

Some participants also highlighted a clash with religious or cultural messages heard at home or during Islamic studies. Halima explained how notions she was taught during Islamic classes, such as not participating in prayer, fasting or touching the Quran, were *'a little confusing'* because *'school never spoke about any kind of restrictions in that sense'*. To make sense of these conflicting messages, many participants turned to peers or online platforms for clarification and support. Participants highlighted that friends were often the ones who explained symptoms, comforted them through painful cycles, or normalised menstruation as a shared experience. As Salma highlighted, *'I remember having to google them [tampons] and the associated issues with toxic shock syndrome.'*

5.3 Mothers, Aunts, and the 'Bad Blood'—Intergenerational Shifts

Participants frequently reflected on the stories and attitudes of their mothers, aunts, and grandmothers, often contrasting these with their own experiences of menstruation. These reflections highlighted both the endurance of certain beliefs and a slow but perceptible shift in openness and understanding.

Many participants expressed shock or empathy when learning how older women in their families had managed their periods. Salma was surprised to hear how women in Bangladesh *'would use cloths'*. Maya shared a similar experience, stating how her mother, who spent most of her adolescence in Bangladesh, '*used to use cloth, wash it by hand, and hide it in the bathroom... She told me it was always something to be embarrassed about.'* Sabina shared an account from her grandmother's youth in Bangladesh: '*She didn't know what was happening to her. No one told her'*. Such stories illustrated how deeply rooted menstrual stigma was in earlier generations, often linked to a complete lack of education or open dialogue. For example, Ayesha shared: '*My mum said her mum taught her that periods were just "bad blood" leaving the body.'*

Despite this, several participants noted that their mothers had become more open over time, often influenced by their daughters' confidence in discussing menstruation. Khadija

described this evolving dynamic: '*At first, my mum was kind of awkward, but now she'll ask me if I've got enough pads or if I need painkillers. She's more practical about it now, which I appreciate.'* Ayesha, whose mum thought menstruation was "bad blood", went on to say: '*My mum doesn't fully believe that anymore. I have tried to teach her more about menstruation. I would sit with her and explain some of the biological processes with one of my textbooks.'* While often subtle, these shifts signalled a growing openness in how knowledge was shared and how stigma was being gently challenged within families. The intergenerational relationship was slowly being reshaped through new forms of dialogue and mutual learning.

5.4 Adopting, Challenging and Modifying Traditions

While participants inherited a range of cultural expectations around menstruation, many described selectively adopting and actively modifying or rejecting these practices to suit their own needs. Rather than simply replicating their mothers' or grandmothers' approaches, participants demonstrated agency in adapting traditional practices, balancing respect for cultural values with practical and personal autonomy.

Adopting

Some participants adopted traditional practices, such as avoiding tampons, based on guidance they received from their mothers or older female relatives. These decisions were often shaped by inherited fears or misunderstandings rather than personal choice. Ayesha described how her mother warned her against them: '*She would say tampons were "weird sticks" … she thought they would hurt or make periods worse. I never used them because of that fear.'* Salma similarly recalled being discouraged from using tampons and instead sticking to pads: '*I think the fear around tampons was definitely passed down. I never even tried them.'* These fears meant participants were selectively adopting these practices.

Modifying

Some participants adopted hybrid approaches, combining traditional practices with modern menstrual products. Amina, who experienced heavy periods, shared that her mother encouraged using cloth layered under a pad—a practice she linked to menstrual management in Bangladesh: '*My mum would say women use cloths over there, so she gave me one to*

use under my pad to help with managing the bleeding.' This demonstrates how some participants were using a mix of approaches they had been exposed to in their hybrid cultural context.

Challenging

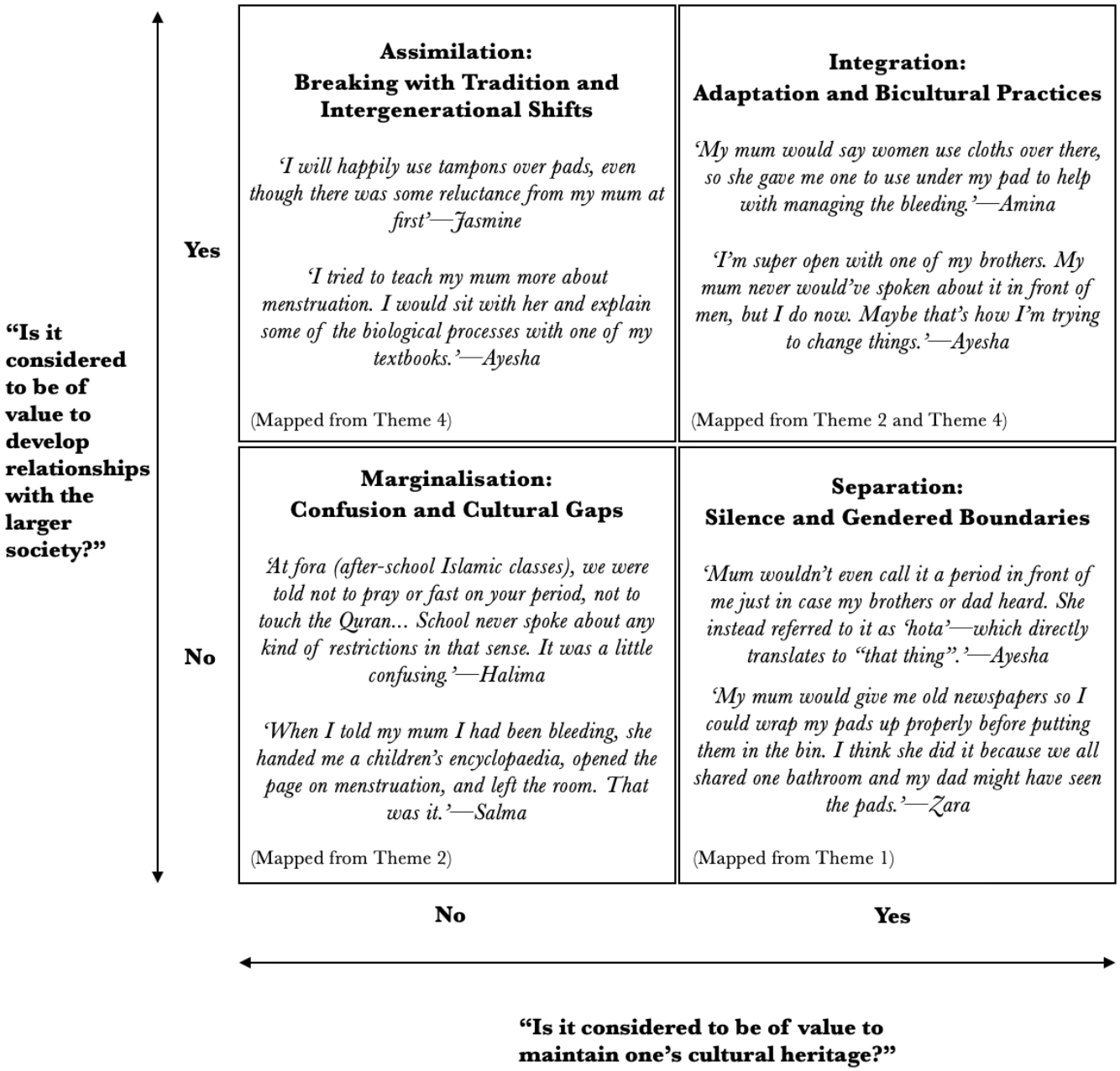
While some of these practices were retained for practical reasons, others were deliberately discarded. Jasmine, for instance, stated: *'I will happily use tampons over pads, even though there was some reluctance from my mum at first'*. Participants also described shifting communication patterns as part of this adaptation. While many grew up in households where menstruation was kept private, some made deliberate efforts to be more open, especially with siblings. Ayesha shared, '*I'm super open with one of my brothers. My mum never would've spoken about it in front of men, but I do now. Maybe that's how I'm trying to change things.'* Despite these changes, most still maintained a level of discretion around older relatives or in community spaces, indicating that change was often partial and context dependent. As Zara put it, '*I wouldn't talk about periods in front of my dad or uncles. I've changed some things, but I still feel weird breaking those boundaries.'*

Collectively, these findings reveal that second-generation Bangladeshi women in the UK do not passively inherit menstrual stigma but instead engage with it through a dynamic process of negotiation. While silence, discomfort, and inherited restrictions remain present, participants demonstrated agency in how they adapted, challenged, or reinterpreted traditional expectations. These interwoven themes highlight the importance of context (cultural, educational, and intergenerational) in shaping menstrual health experiences.

6. Discussion

Building on the thematic findings presented, this discussion interprets those themes more deeply in relation to Berry's (1997) Acculturation Model and the wider literature on cultural transmission and menstrual health (See Figure 2).

Figure 2



Mapped themes extending Berry's Acculturation Model (1997)

6.1 Separation: Silence and Gendered Boundaries

Participants' narratives revealed how deeply ingrained cultural expectations around modesty and discretion shaped their early experiences of menstruation. For many, the topic was treated with silence or euphemism, particularly within the home. These behaviours reflect what Berry (1997) terms a separation strategy, where heritage cultural values are maintained while interaction with host culture norms is limited or resisted.

This separation was especially visible in the gendered boundaries participants described. Multiple participants spoke about how their mothers avoided saying "period" or "mashi" (Bangla) in front of male relatives, with some drawing on religious cues rather than naming menstruation explicitly. Participants also recounted behavioural norms that reinforced this silence: wrapping up sanitary pads in newspaper or hiding products up their sleeves. These behaviours reflect a culturally ingrained habit of silence, particularly regarding gender roles and bodily functions. Within Berry's model, these narratives exemplify separation, as participants maintained traditional cultural norms without integrating the more open, normalised British discourses around menstrual health.

Participants did not uniformly accept these norms. Many expressed discomfort or frustration with this inherited silence, acknowledging it as something they had internalised but now wished to unlearn. Still, within their households and extended families, the legacy of separation remained strong, guiding how menstruation was spoken about, managed, and passed down. These behaviours demonstrate the persistence of menstrual health stigma, highlighting how such norms can endure even when second-generation women are raised within the UK. While this strategy may preserve cultural continuity, Berry and Sabatier (2010) note that separation is often linked to lower psychological well-being and community adjustment, indicating the need for culturally sensitive interventions that encourage open dialogue without undermining heritage values.

6.2 Marginalisation: Confusion and Cultural Gaps

Many participants highlighted moments where they felt unsupported, uncertain, or caught between conflicting knowledge systems. These experiences reflect Berry's (1997) concept of

marginalisation, which occurs when individuals feel disconnected from both their heritage culture and the host society, often resulting in confusion, exclusion, or unmet needs.

Participants frequently encountered incomplete or conflicting guidance on menstruation. In these situations, neither school nor home provided the full picture. Institutional education often offered factual clarity but lacked cultural and emotional relevance—an issue reflected more broadly in research highlighting inconsistencies in menstrual education provision across UK schools (Brown et al., 2022). Meanwhile, family environments offered care but not always communication, mirroring findings from Bangladesh where silence and misinformation around menstruation are common within intergenerational knowledge transmission (Bosch, Hutter, and van Ginneken, 2008). As a result, participants were often left to navigate these gaps alone, turning to peers, social media, or Google to piece together their understanding—behaviours that underline a lack of coherent support across both cultural spheres.

These examples of marginalisation were not dominant across all narratives, but they were significant. They appeared most acutely during transitional moments—such as menarche, religious education, or early conversations (or silences) at home—where existing support structures failed to meet emotional or cultural needs. Participants did not describe themselves as alienated from both cultures entirely, but they felt temporarily suspended, uncertain of which knowledge system to trust. According to Berry and Sabatier (2010), marginalisation is associated with the poorest outcomes in terms of adjustment and well-being, underlining the importance of comprehensive, culturally inclusive education that bridges both institutional and familial gaps.

6.3 Integration: Adaptation and Bicultural Practices

Although silence and separation characterised many participants' early experiences at home, their accounts also revealed moments of integration, where cultural knowledge from home and institutional learning from school were combined and negotiated. This reflects what Berry (1997) defines as integration, where individuals maintain aspects of their heritage culture while also engaging meaningfully with the host culture.

Participants frequently credited school as their primary source of menstrual education. These lessons offered scientific explanations and demonstrations that were absent at home, aligning with broader research that highlights the role of school-based menstrual education in the UK (Plan International, 2018). Institutional experiences helped participants make sense of menstruation in ways that contrasted with the more cautious or coded approaches they encountered in their families. However, rather than simply discarding family knowledge, many participants engaged in selective adaptation. For example, some combined mothers' advice with their own needs, such as using a cloth under a pad during heavy periods—an approach rooted in a mother's experience in Bangladesh but adapted to a UK context.

Similarly, although several participants described being open about menstruation with certain family members (such as sisters or brothers), they would still maintain silence around elders or male relatives. These decisions were not contradictory but reflective of a situational balancing between inherited norms and contemporary values. In some cases, participants also had to reconcile school-based biological explanations with religious teachings. Confusion was noted between Islamic studies, where menstruation involved religious restrictions, and school lessons, which presented it as purely physiological. Rather than choosing one over the other, many participants developed their understanding, drawing from both systems to form a personalised, hybrid approach to menstruation.

These accounts illustrate integration not as a fixed state but as a dynamic, context-specific strategy. Participants maintained cultural ties through retained practices while simultaneously engaging with institutional and digital sources to expand their knowledge and agency. This ability to navigate across cultural domains demonstrates how second-generation Bangladeshi women are creating hybrid frameworks that honour their heritage while also asserting their autonomy. As Berry and Sabatier (2010) argue, integration is associated with the most positive outcomes in psychological well-being and social adjustment, supporting the view that bicultural approaches may offer the most empowering path for navigating menstrual stigma.

6.4 Assimilation: Breaking with Tradition

While many participants sought to adapt inherited practices, some moments in the data revealed a clearer rejection of cultural expectations. These instances align with Berry's (1997) notion of assimilation, where individuals adopt the norms and behaviours of the host culture while discarding elements of their heritage culture, either temporarily or more definitively.

Product use, especially the embrace of tampons, was a clear example of this shift. This move represented more than a change in product choice—it symbolised a challenge to myths around virginity (Berg and Coutts, 2023), discomfort, and bodily control that were embedded in the cultural advice participants had received growing up. By prioritising personal comfort and autonomy, participants asserted menstrual decisions based on individual knowledge rather than inherited rules.

A similar dynamic appeared in how participants redefined communication boundaries. Some participants explicitly spoke with their brothers about menstruation behaviours that contrast with traditional patterns of gendered silence documented both in Bangladesh and the UK. While others retained discretion around older male relatives, some shifts signalled a significant departure from traditional gendered modesty expectations. In these moments, participants reoriented themselves toward cultural norms of the UK, where menstrual health is increasingly framed through openness, body literacy, and self-advocacy.

Importantly, these behaviours were not described with a sense of cultural betrayal or rupture. Rather, participants framed them as personal growth or necessary change. The rejection of specific taboos did not equate to wholesale cultural rejection—instead, it often coexisted with continued respect for other aspects of their identity. This nuance resonates with critiques of assumptions about cultural "assimilation" as total loss, highlighting instead the agency with which second-generation individuals navigate heritage and host culture norms. Nevertheless, Berry and Sabatier (2010) observe that individuals who orient exclusively toward one culture, as in assimilation, often report outcomes less positive than those engaged with both. These findings suggest that while assimilation may offer

empowerment, bicultural support structures may better sustain long-term well-being and social belonging.

6.5 Implications for Policy and Practice

While policy initiatives in the UK have improved material access to menstrual products, the findings of this study suggest that such policies may fall short for second-generation British-Bangladeshi women. As highlighted, stigma is often transmitted through silence, euphemism, and gendered boundaries—dimensions that are not addressed through access alone. Echoing critiques by ActionAid (2023) and WaterAid (2020), this research highlights the need for menstrual health interventions that are not only materially resourced but also culturally responsive. Schools should thoughtfully integrate menstrual education that reflects the lived experiences of ethnic minority communities, supports intergenerational conversations, and challenges persistent myths in safe, inclusive ways. Without recognising how stigma operates across cultural, familial, and institutional levels, policies risk reinforcing inequities rather than dismantling them. Future strategies must address both access and meaning to achieve true menstrual equity.

6.6 Limitations and Directions for Future Research

While this study offers insights into how second-generation Bangladeshi women in the UK experience and negotiate menstrual stigma, several limitations must be acknowledged. The research focused exclusively on second-generation participants and did not include the perspectives of first-generation women, which limits the ability to draw direct comparisons or fully capture intergenerational dynamics. Future studies could include both generations to better understand how stigma is transmitted or transformed over time.

The study also explored a specific cultural group, and while this focus allows for depth and nuance, it limits the transferability of findings to other ethnic or religious communities. Comparative research across South Asian diasporas could reveal whether similar patterns emerge or whether cultural specificity plays a larger role in shaping menstrual experiences.

Additionally, while participants came from varying backgrounds, future research should more explicitly examine how intersecting identities (Crenshaw, 1989)—such as class, disability, or religious practice—further shape menstrual health experiences and access to care. Including these dimensions could help build a multi-dimensional understanding of how menstrual stigma operates within and across communities.

7. Conclusion

This study set out to explore whether menstrual health stigmas from Bangladesh have persisted or transformed among second-generation Bangladeshi women in the UK. Embedded in the complexities of bicultural identity, findings revealed that menstrual stigma is not static, but rather a dynamic, negotiated process shaped by the interplay of intergenerational beliefs, institutional learning, and individual agency.

By situating menstrual stigma within both public health and sociocultural frameworks, this study contributes to the literature by recognising menstruation as more than a private or individual issue. It reinforces the view that menstrual stigma must be understood as a structural and relational problem that operates across personal, familial, and policy levels. Drawing on the Dahlgren and Whitehead (1991) model, the study examined how stigma is shaped by broader socioeconomic and environmental conditions. Berry's (1997) Acculturation Model helped interpret the strategies second-generation women employ in navigating their menstrual experiences between inherited traditions and contemporary British norms.

Through twelve semi-structured interviews and reflexive thematic analysis, four core themes emerged: silence, education, intergenerational transmission, and adaptation. Participants described growing up with gendered expectations of discretion and coded language—practices that echoed the experiences of their mothers and grandmothers. Yet many also revealed moments of resistance and transformation. School-based education, peer support, and increased digital access played key roles in reshaping menstrual knowledge, while some participants actively challenged taboos by openly discussing menstruation with male relatives or adopting menstrual products previously discouraged in their families. Others retained certain cultural practices but reinterpreted them within a new context, highlighting the nuanced, non-binary nature of acculturation.

These findings demonstrate that while elements of menstrual stigma have persisted across generations, particularly those tied to silence and modesty, many second-generation women are transforming these narratives. Their experiences do not neatly align with fixed cultural

categories. Instead, they reflect an ongoing process of hybrid identity formation, in which women blend, negotiate, or resist cultural expectations depending on their relational and institutional environments.

Importantly, this study also challenges assumptions embedded in UK menstrual health policies. While recent interventions, such as free menstrual product schemes, are vital, they risk overlooking the cultural and emotional dimensions of stigma that persist within ethnic minority communities. Without acknowledging how stigma is transmitted across generations and shaped by cultural norms, such policies may fail to reach those most affected. This dissertation argues that true menstrual equity must involve both material provision and culturally responsive education that validates diverse experiences.

Ultimately, this study foregrounds the agency of second-generation Bangladeshi women as they navigate inherited stigma, redefine norms, and advocate for more inclusive understandings of menstrual health. Their voices reveal that menstrual stigma is not simply passed down; it is questioned, reimagined, and, in many cases, transformed.

By exploring how stigma is negotiated within diasporic contexts, this research offers a unique contribution to the literature on menstrual health, culture, and migration. It highlights the limitations of one-size-fits-all policy approaches and emphasises the importance of embedding cultural sensitivity and equality into menstrual health interventions. These findings hold relevance not only for Bangladeshi communities in the UK, but for other minoritised groups navigating similar tensions between tradition and modernity, providing a foundation for more inclusive, responsive policy and future research.

8. Appendix

8.1 Participant Characteristics

Pseudonym	Age	SL-Asia Scale (Adapted)		
		Primary Language(s) Spoken at Home	**Self-Described Cultural Identity**	**Self-Rated Cultural Identity**
Mariam	19	English and Bengali mix	British-Bangladeshi	Bicultural
Ayesha	21	Sylheti	British-Bangladeshi	Bicultural
Sabina	22	Sylheti	British-Bangladeshi	More British than Bangladeshi
Salma	25	English and Sylheti mix	British-Bangladeshi	Bicultural
Fatima	18	English	British-Bangladeshi	More British than Bangladeshi
Khadija	21	English and Sylheti mix	British-Bangladeshi	Bicultural
Amina	25	Sylheti	British-Bangladeshi	Bicultural
Halima	25	Sylheti	British-Bangladeshi	Bicultural
Zara	23	Sylheti	British-Bangladeshi	Bicultural
Jasmine	19	English and Sylheti mix	British-Bangladeshi	More British than Bangladeshi
Maya	21	Sylheti	British-Bangladeshi	Bicultural
Fahmida	21	Sylheti	British-Bangladeshi	Bicultural

8.2 Information and Consent Form

Thank you for your consideration in participating in this study. Your contribution is greatly appreciated.

What is the study about?

This study explores the experiences of second-generation Bengali women growing up in the UK, with a focus on culture & tradition, and perspectives on topics such as menstruation & health. I aim to understand how attitudes toward these topics may have changed across generations and how they have shaped personal experiences.

What will your involvement be?

Your participation is central to this study, and I truly value your insights and experiences. You will be invited to take part in a one-on-one interview lasting 30-45 minutes, where you can share your thoughts and experiences in a safe and confidential space. The conversation will explore topics related to growing up in a Bengali household, including cultural traditions and personal perspectives on menstruation. You are free to share as much or as little as you feel comfortable with, and you can skip any questions or stop the interview at any time.

Do you have to take part?

Participation is **voluntary**. There are no negative consequences for you if you decide not to take part in this study. If you decide to take part but then later on you change your mind, you can let me know by *20th April 2025*—you will not have to give any explanation why. It is also absolutely fine if you feel that you do not want to answer any specific questions – you can just tell me, and we will move on.

What will your information be used for?

The information collected during the interview will be used for an undergraduate dissertation project and may be used in future academic endeavours.

Will your information be anonymous?

Your participation will be **entirely anonymous**. Your name and personal details will not be included in any reports or publications resulting from the study. Your privacy is of utmost importance.

If you still wish to partake in the interview, please complete the consent form below, stating your name and that you agree to the statements included. If you have any questions or require further clarification, please do not hesitate to contact:

s.rashid3@lse.ac.uk

Consent Form

Your name:

Please read these statements. If you agree with them, put an X in the boxes below:	
I have read this message and had the opportunity to ask questions.	☐
I agree to participate in the interview	☐
I understand that my responses will be kept confidential and anonymous, and that my personal information will be kept securely and destroyed at the end of the study	☐
I consent to my interview being audio-recorded	Yes ☐ No ☐

Please put an X in the boxes below based on which you align most with:	
I consider myself: Bangladeshi British British Bangladeshi	 ☐ ☐ ☐
How would you rate yourself? Very Bangladeshi More Bangladeshi than British Bicultural More British than Bangladeshi Very British	 ☐ ☐ ☐ ☐ ☐
Primary Language(s) Spoken at Home English Bengali (Any dialect) Please specify the dialect English and Bengali (Any dialect) mix Please specify the dialect	 ☐ ☐ ☐

Date:

Student Name: Sarah Rashid
Student Email Address: s.rashid3@lse.ac.uk

9. References

Acts of the Scottish Parliament (2021) Period Products (Free Provision) (Scotland) Act 2021, 1.

Ahmed, S. et al. (2022) 'Generational perspective on asthma self-management in the Bangladeshi and Pakistani community in the United Kingdom: A qualitative study', Health Expectations, 25(5), pp. 2534–2547.

AHPMA (no date) Menstruation Facts And Figures, Absorbent Hygiene Product Manufacturers Association (AHPMA).

Akhter, N. et al. (2021) 'Risk factors for non-communicable diseases related to obesity among first- and second-generation Bangladeshi migrants living in north-east or south-east England', International Journal of Obesity, 45(7), pp. 1588–1598.

Alam, M.-U. et al. (2017) 'Menstrual hygiene management among Bangladeshi adolescent schoolgirls and risk factors affecting school absence: results from a cross-sectional survey', BMJ Open, 7(7), p. e015508.

Alexander, C. and Lidher, S. (2024) 'British Bangladeshis', in Oxford Research Encyclopedia of Asian History. Oxford University Press.

Babbar, K. et al. (2022) 'Menstrual health is a public health and human rights issue', The Lancet Public Health, 7(1), pp. e10–e11.

Bangladesh Bureau of Statistics (2020) National hygiene survey 2018. Dhaka: Demography and Health Wing, Bangladesh Bureau of Statistics, Statistics and Informatics Division, Ministry of Planning.

Bangladesh Bureau of Statistics (2023) 'Household Income and Expenditure Survey HIES 2022'. Bangladesh Bureau of Statistics (BBS)-Statistics and Informatics Division (SID).

Barrington, D.J. et al. (2021) 'Experiences of menstruation in high-income countries: A systematic review, qualitative evidence synthesis and comparison to low- and middle-income countries', PLOS ONE. Edited by W. Mavhu, 16(7), p. e0255001.

Berg, D.H. and Coutts, L.B. (1993) 'Virginity and tampons: The beginner myth as a case of alteration', Health Care for Women International, 14(1), pp. 27–38.

Berry, J.W. (1997) 'Immigration, Acculturation, and Adaptation', Applied Psychology, 46(1), pp. 5–34.

Berry, J.W. and Hou, F. (2017) 'Acculturation, discrimination and wellbeing among second generation of immigrants in Canada', International Journal of Intercultural Relations, 61, pp. 29–39.

Berry, J.W. and Sabatier, C. (2010) 'Acculturation, discrimination, and adaptation among second generation immigrant youth in Montreal and Paris', International Journal of Intercultural Relations, 34(3), pp. 191–207.

Bhugra, D. and Becker, M.A. (2005) 'Migration, cultural bereavement and cultural identity', World psychiatry: Official Journal of the World Psychiatric Association (WPA), 4(1), pp. 18–24.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', Qualitative Research in Psychology, 3(2), pp. 77–101.

Braun, V. and Clarke, V. (2013) Successful qualitative research: a practical guide for beginners. Los Angeles: SAGE.

Brinkmann, S. (2020) 'Unstructured and Semistructured Interviewing', in P. Leavy (ed.) The Oxford Handbook of Qualitative Research. 2nd edn. Oxford University Press, pp. 424–456.

Bryman, A. (2012) Social research methods. 4. ed. Oxford: Oxford Univ. Press.

Castro, S. and Czura, K. (2025) 'Cultural taboos and misinformation about menstrual health management in rural Bangladesh', World Development, 188, p. 106871.

Cavill, S., House, S. and Mahon, T. (2012) Menstrual hygiene matters: A resource for improving menstrual hygiene around the world. WaterAid, p. 347.

Chowdhuri, S. (2008) Menstrual Problems of Women in Bangladesh. James P. Grant School of Public Health BRAC University.

Clark, T. et al. (2021) Bryman's social research methods. Sixth edition. Oxford: Oxford University Press.

Crenshaw, K. (1989) 'Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics', University of Chicago Legal Forum, 1989(1).

Dahlgren, G. and Whitehead, M. (2021) 'The Dahlgren-Whitehead model of health determinants: 30 years on and still chasing rainbows', Public Health, 199, pp. 20–24.

Department for Education (2022) 'Equalities Impact Assessment for the scheme to provide access to period products in education organisations in England'. GOV.UK.

Department for Education (2025) Period product scheme for schools and colleges, GOV.UK.

DeShea, L. (2015) Introductory Statistics for the Health Sciences. 1st ed. Bosa Roca: CRC Press LLC.

European Commision (no date) second-generation migrant.

Farrimond, H. (2023) 'Stigma Mutation: Tracking Lineage, Variation and Strength in Emerging COVID-19 Stigma', Sociological Research Online, 28(1), pp. 171–188.

Johnston-Robledo, I. and Chrisler, J.C. (2013) 'The Menstrual Mark: Menstruation as Social Stigma', Sex Roles, 68(1–2), pp. 9–18.

Joseph Rowntree Foundation (2025) UK Poverty 2025. Joseph Rowntree Foundation, p. 177.

Keen, S., Lomeli-Rodriguez, M. and Joffe, H. (2022) 'From Challenge to Opportunity: Virtual Qualitative Research During COVID-19 and Beyond', International Journal of Qualitative Methods, 21, p. 16094069221105075.

Kriznik, N.M. et al. (2018) 'Moving beyond individual choice in policies to reduce health inequalities: the integration of dynamic with individual explanations', Journal of Public Health, 40(4), pp. 764–775.

Kumar, G., Prasuna, J. and Seth, G. (2017) 'Assessment of menstrual hygiene among reproductive age women in South-west Delhi', Journal of Family Medicine and Primary Care, 6(4), p. 730.

Mahmud, H. (2023) 'International Migration in Bangladesh: A Political Economic Overview', in IMISCOE Research Series. Cham: Springer International Publishing, pp. 49–65.

McCammon, E. et al. (2020) 'Exploring young women's menstruation-related challenges in Uttar Pradesh, India, using the socio-ecological framework', Sexual and Reproductive Health Matters, 28(1), p. 1749342.

McHugh, M.C. (2020) 'Menstrual Shame: Exploring the Role of "Menstrual Moaning"', in C. Bobel et al. (eds) The Palgrave Handbook of Critical Menstruation Studies. Singapore: Springer Singapore, pp. 409–422.

Miller, T.A. et al. (2024) 'Understanding period poverty and stigma: Highlighting the need for improved public health initiatives and provider awareness', Journal of the American Pharmacists Association, 64(1), pp. 218–221.

Mostafa, I. (2019) The Real Period Stain: Menstrual Stigma and Its Pressures in South Asia. Augustana College.

Muralidharan, A. (2019) 'Constrained Choices? Menstrual Health and Hygiene Needs Among Adolescents in Mumbai Slums', Indian Journal of Gender Studies, 26(1–2), pp. 12–39.

Murshid, M.E. et al. (2023) 'Effects of the Involvement of Male Counterparts in the Menstrual Hygiene Management of Women and Adolescent Girls With Disabilities in Selected Sub-districts of Bangladesh: Protocol for a Quasi-experimental Study', Cureus, 15(10), p. e47704.

Office for National Statistics (ONS) (2022) Ethnic group, England and Wales: Census 2021.

Olson, M.M. et al. (2022) 'The persistent power of stigma: A critical review of policy initiatives to break the menstrual silence and advance menstrual literacy', PLOS Global Public Health. Edited by A. Kapilashrami, 2(7), p. e0000070.

Pycroft, H. (2023) 'Cost of living: UK period poverty has risen from 12% to 21% in a year', ActionAid.

Quazi, A. and Pramanik, A. (2004) 'The sanitation movement in Bangladesh and the role of private sector'. IRC.

Raleigh, V. (2025) 'The health of women from ethnic minority groups in England', The King's Fund.

Sam, D.L. and Oppedal, B. (2003) 'Acculturation as a Developmental Pathway', Online Readings in Psychology and Culture, 8(1).

Schwarz, B. and Pfammatter, P. (2024) 'The Association of Acculturation and Well-Being: Second-Generation Immigrants in Switzerland', Journal of Happiness Studies, 25(6), p. 77.

Seymour, K. (2008) 'Bangladesh Tackling menstrual hygiene taboos'. UNICEF.

Suinn, R.M., Ahuna, C. and Khoo, G. (1992) 'The Suinn-Lew Asian Self-Identity Acculturation Scale: Concurrent and Factorial Validation', Educational and Psychological Measurement, 52(4), pp. 1041–1046.

The Lancet Child & Adolescent Health (2018) 'Normalising menstruation, empowering girls', The Lancet Child & Adolescent Health, 2(6), p. 379.

Tingle, C. and Vora, S. (2018) Break the Barriers: Girls' Experiences Of Menstruation in the UK. Plan International.

WaterAid (2020) 'Menstrual health and hygiene Challenges associated with the COVID-119 pandemic in Bangladesh'. WaterAid.

WaterAid (2022) Bangladesh - Facts and Statistics, WaterAid.

WaterAid Bangladesh (2024) 'Health starts with hygiene Comparative analysis of feasibility and accessibility of MHM products in low-Income communities of Bangladesh'. WaterAid.

Weiss, R.S. (1995) Learning from strangers: the art and method of qualitative interview studies. First Free Press paperback ed. New York: Free Press.

Wilderink, L. et al. (2022) 'A Theoretical Perspective on Why Socioeconomic Health Inequalities Are Persistent: Building the Case for an Effective Approach', International Journal of Environmental Research and Public Health, 19(14), p. 8384.