Periods in a Pandemic: How the Covid-19 pandemic influenced UK experiences of providing and accessing menstrual health support

Gemma Williams

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School of Life & Health Sciences, Birmingham City University

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Abstract

The Covid-19 pandemic exacerbated existing gendered health inequalities, including menstrual inequality. With the onset of the pandemic, UK non-profit menstrual health support organisations experienced an increase in demand.

Using critical and feminist theories, this study seeks to understand the influence that the pandemic had on menstrual health experiences within the UK by examining the experiences of those providing and accessing menstrual health support. A mixed methods design was applied encompassing 2 phases. Phase 1 explored the perspectives of those providing menstrual health support, utilising interviews with 17 organisations and survey responses from a further 17. Phase 2 focused on the experiences of those needing menstrual health support, employing surveys (n-240) and semi-structured interviews (n-4).

Using reflexive thematic analysis, phase 1 analysis demonstrates how menstrual health support services overcame pandemic-related barriers to continue service provision during lockdown, related to products, education and healthcare. Barriers included disease-prevention measures which exacerbated existing inequalities around gender, poverty and health, and menstrual stigma. Inconsistencies in government policy and an increase in pandemic-related financial insecurity further compounded the challenges that service providers experienced.

Phase 2 combines reflexive thematic analysis and descriptive statistics to provide insight to menstrual cycle experiences during the pandemic, with participants seeking to understand their menstrual cycle changes and how best to manage menstruation. Disease-prevention measures affecting the accessibility of products and healthcare, combined with menstrual stigma and changes to the menstrual cycle during lockdown, influenced menstrual management and help-seeking decisions during lockdown.

This study addresses gaps in pandemic-related menstrual health research which has focused on menstrual hygiene management and menstrual cycle changes attributed to Covid-19 from the perspective of those who menstruate. This study is the first to combine the experiences of those who menstruate with those who provide menstrual health services to examine the wider social, political and psychological factors that influenced menstrual health experiences during the pandemic. The analysis illustrates how existing pre-pandemic inequalities, including poverty, gender and menstrual stigma, intersect with pandemic-related factors further increasing menstrual inequality within the UK. To achieve menstrual equity, the UK must ensure that menstrual health support is included within future disaster responses in addition to wider financial, health and education-related policies.

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List of Abbreviations

CFP	Critical Feminist Psychology
CHP	Critical Health Psychology
DfE	Department for Education
ESRC	Economic & Social Research Council
FCP	Feminist Community Psychology
MHE	Menstrual Health Education
PAG	Project Advisory Group
PIP	Periods in a Pandemic
PPE	Personal Protective Equipment
RSHE	Relationship & Sexual Health Education
UK	United Kingdom
UKRI	UK Research & Innovation
UNICEF	United Nations International Children's Emergency Fund
USA	United States of America

1 Chapter 1: Introduction

1.1 Research overview

In 2019, the first cases of coronavirus were detected in China, spreading globally and leading to the classification of 'pandemic' by the World Health Organisation in March, 2020 (World Health Organisation., n.d.-a). The coronavirus pandemic, also referred to as the 'Covid-19 pandemic', lasted for several years and involved many measures designed to reduce the spread of the disease. Globally, countries set up taskforces to respond to the challenges posed by the pandemic and reduce the spread of the virus.

Research shows various ways as to how the Covid-19 pandemic exacerbated existing health and gender inequalities (CARE & United Nations., 2020; Carli, 2020; Dang & Viet Nguyen, 2021; de Paz et al., 2020; Delanerolle et al., 2023; European Institute for Gender Equality, 2020a; Menta, 2021; Weiss-Wolf, 2020). For example, evidence demonstrates that women and girls were more likely to experience gender-based violence, poverty, poorer education access and barriers to sexual and reproductive health during the pandemic (European Institute for Gender Equality, 2020a; Plan International UK., 2020; UN Women., 2022; United Nations, 2020). During the pandemic, a number of organisations dedicated to gender equality campaigned for women and girls to be more visible within global pandemic responses, highlighting the plethora of ways that their needs were ignored in Covid-related policy and strategy (European Institute for Gender Equality, 2020b; Fawcett Society, 2020; Irise International, 2020).

With an increase in gender inequality attributed to the pandemic, an increase in experiences of period poverty were also reported. Period poverty typically refers to financial difficulties associated with accessing menstrual products (Jaafar et al., 2023) and forms part of wider menstrual inequality, which is a gendered health inequality (Sommer & Mason, 2021; Weiss-Wolf, 2017). Services that work to support those experiencing period poverty reported an increase in demand for menstrual products during Covid-19 lockdowns attributed to the rise in financial insecurity attributed to pandemic job losses and the closure of places that would normally provide free products (Babbar et al., 2023; BBC News England, 2020; Edlin, 2020; Moss, 2020; Murphy et al., 2024; Schmitt et al., 2023; Sommer et al., 2022). As such, the increase in period poverty, globally, during the pandemic called for a policy response to address menstrual health inequality. Guidance on providing menstrual health support during the Covid-19 pandemic was limited, with available information mainly focusing upon menstrual hygiene management and sanitation practices within the Global South (Farrington, 2020; Poague et al., 2022; UNICEF, 2020).

In addition to the lack of menstrual health representation within global Covid-19 responses, there remains to be little in-depth research regarding the impact of Covid-19 upon menstrual health support. Most of the available research focuses on the impact that the virus or vaccinations have upon the menstrual cycle, demonstrating changes to menstrual cycle regularity and menstrual symptoms such as heavy bleeding and pain (Al-Furaydi et al., 2023; Al-Mehaisen L et al., 2022; Chourasia et al., 2022; Dabbousi et al., 2023; Darney et al., 2023; Kumar et al., 2023; Lessans et al., 2023; Martínez-Zamora et al., 2023; Matar et al., 2023; Medina-Perucha et al., 2022; Mohr-Sasson et al., 2023; Qazi et al., 2023; Taşkaldiran et al., 2022; Tripathy et al., 2022). Research into other aspects of menstrual health during the pandemic centres on period poverty and menstrual hygiene management, predominantly within the Global South. Less research is available on wider areas such as menstrual health education and menstrual health care which are important factors to address within menstrual health (Hennegan et al., 2021).

Much of what is known about United Kingdom's (UK) menstrual health experiences during the pandemic was detailed within the news media (BBC News England, 2020; BBC News Wales, 2020b; Edlin, 2020; Moss, 2020; Williams, 2021). Early in the pandemic, Plan International UK reported on the impact of lockdown upon schoolgirls across the UK, highlighting an increase in period poverty during this time (Plan International UK, 2020). There is currently only one other study that has focused upon menstrual health within Great Britain during the pandemic, which focuses on the experiences of menstrual activists (Tomlinson, 2023). Furthermore, the UK's Covid-19 taskforce did not address menstrual health support within any response plans and has since been criticised for failing to address gendered factors within its Covid response (Devlin, 2023; UN Women., 2022).

1.2 Research aims and objectives

This study therefore aims to critically examine a gendered health inequality, menstrual health, within the context of a global pandemic that exacerbated existing gender and health inequalities. By re-analysing pre-existing data on the experiences of menstrual health service providers and those who needed menstrual health support during the pandemic, the study further aims to address the gaps in knowledge and inform menstrual health policy and practice within the UK. The study investigates the experiences of those who menstruate in addition to those who provide menstrual health support, examining wider aspects of menstrual health to identify what factors and intersecting inequalities influenced experiences during the pandemic. To address the aims of the study, the research therefore examines the following research questions:

1. *How did the pandemic influence menstrual health support during lockdowns within the UK?*
2. *What were the experiences of menstrual health service providers during Covid-19 lockdowns and how did they deal with any challenges to providing support during these times?*
3. *What were the needs of women, girls and people who menstruate during the pandemic, in relation to their menstrual health?*
4. *What were the experiences of those needing to access menstrual health support during the pandemic and what factors influenced their decisions in seeking such support?*

The study builds on the initial findings of the ESRC/UKRI funded 'Periods in a Pandemic' (PIP) project, which addressed the urgent need to capture knowledge and inform practice during the pandemic, as per the funding specifications. The project examined how menstrual health service providers were adapting to challenges posed by the Covid-19 pandemic in real time, examining how they worked to meet the needs of those experiencing period poverty to identify gaps in provision and best practice. The project findings therefore aimed to inform practice, shape policy and assist in the development of strategies within the ongoing crisis, to ensure women and girls' voices were centralised and to address menstrual inequalities. The project findings provide an overview of key areas of menstrual health support impacted by the pandemic, however, due to funding and time limitations the findings do not provide in-depth analysis or insights into how existing, underlying structures and inequalities intersect with specific pandemic-related factors (such as disease prevention measures) to influence menstrual health support. This study therefore aims to examine these factors by applying critical, feminist frameworks to the re-analysis.

While the PIP project comprised of a team of research academics, the project was led by the researcher (as Principal Investigator) who created the concept of the project, and it's aims and objectives. The researcher was also responsible for the research design, methodology and data analysis throughout the project. This thesis builds upon the researcher's work under the PIP project with permission to use the data for such purposes having been obtained from the research team and the funding body.

1.3 Study design

The PIP project used mixed methods to examine the pandemic's impact on period poverty within the UK, across two phases of data-gathering over 12 months (August 2020 to August 2021). Phase 1 focused upon the experiences of those providing menstrual health support services, comprising of semi-structured interviews (n=17) and online survey responses (n=17). Phase 2 centred the experiences of those needing menstrual health support during lockdown, using online survey responses (n=240) and semi-structured interviews (n=4).

Due to the conditions of the funding, findings were expected to be disseminated rapidly throughout the project to inform the ever-changing pandemic landscape with key up-to-date knowledge. This meant that a rapid analysis was undertaken to be able to quickly share information. The key findings highlighted challenges experienced by service providers and those needing menstrual health support, and opportunities that the pandemic presented to adapt service provision and raise awareness of period poverty (Williams et al., 2022). The implications of the initial findings were discussed within the context of wider political and economic contexts, although the data analysis did not specifically examine intersections with existing inequalities such as gender and health. Furthermore, the initial findings were reported as separate phases and were not brought together to examine any shared themes within these contexts.

Using the data gathered during the PIP project, this current study therefore applies reflexive thematic analysis and descriptive statistics to the data to provide a more in-depth analysis and discussion of what influenced menstrual health support during the pandemic through a critical, feminist lens. By applying Critical Health Psychology and critical feminist theoretical frameworks to data analysis, this thesis examines how existing health and gender inequalities influenced menstrual health experiences during the pandemic.

1.4 Thesis structure

The thesis is divided into 7 chapters. To provide context and background to the thesis, chapter 2 provides an overview of key topics imperative to understanding the aims of this research, including definitions, measures to address menstrual inequality within the UK, and the UK's response to the Covid-19 pandemic. Chapter 3 then presents the available literature on menstrual health and the Covid-19 pandemic to further examine academic research and 'grey' literature, discussing the contributions, gaps and limitations of the available literature to provide context to the research questions and aims of the study. Chapter 3 also discusses how the application of feminist, Critical Health Psychology frameworks to the study contributes to understanding UK menstrual health experiences during the pandemic, to address the study's aims and objectives.

Chapter 4 further describes the research frameworks applied to the study to address the aims and research questions, explaining how they informed the methodologies used to gather and analyse the data. The chapter describes the research design and main ethical considerations, providing an overview of the two-phase approach to data gathering applied to the PIP project. Finally, the chapter provides an overview of the data analysis applied to each phase of data gathering to meet the aims and objectives of this study.

Chapter 5 provides a more in-depth description of phase 1, presenting the analysis of the experiences of menstrual health service providers during the pandemic. The chapter comprises of details of the research questions pertinent to the phase and the mixed methods approach used during the PIP project, including participants, recruitment, data gathering and data analysis. It addresses the main ethical considerations of phase 1 of the study and provides a reflexive account of the research process. The analysis of the data for this current study is then presented and discussed, situating the key themes within menstrual health and other related research. *N.B. some of the data from phase 1 of the study has been written up and published as an article within the Journal of Poverty and Social Justice (Craddock et al., 2025) (Appendix P).*

Chapter 6 provides an account of phase 2 of the study, detailing the same aspects of the research process as those in chapter 5 and presenting the re-analysis of the experiences of those needing menstrual health support during lockdowns. The themes of the analysis are discussed within the context of menstrual health and other related research.

The re-analysis of both phases is discussed within chapter 7, which situates the overall findings within existing research to compare and discuss the implications of the study. The chapter provides an evaluation of the study, identifying key strengths and limitations, with discussion of how the study can contribute to menstrual health policy and practice within the UK. The researcher provides a further reflexive account of the study and their position within research, building on those provided within chapters 4, 5 and 6. Finally, the implications of the thesis are discussed outlining its contributions to feminist, Critical Health Psychology and recommendations for policy, practice and future research considerations.

Please note, throughout the thesis the terms ‘women’ and ‘girls’ are used to reflect how gender is reported within the literature cited and the study’s data. The researcher recognises that not all who menstruate identify as ‘women’, so the phrase ‘people who menstruate’ is therefore also used where gender was not reported.

2 Chapter 2: Context & background

This chapter provides background and context to key topics imperative to understanding the aims of this research. The chapter provides an explanation of definitions used throughout the thesis, including menstrual health, period poverty, menstrual inequality and Covid-19. The chapter further provides an overview of relevant policies aimed to address menstrual inequality within the UK, to provide context to the research questions and aims of the study. The chapter also provides insight into the gendered inequalities amplified by the Covid-19 pandemic, including gaps in policy and government responses that contributed to such inequality. Again, there is a focus upon UK responses to further contextualise the research aims and strengthen the rationale for the study. Finally, the chapter highlights examples of how menstrual health was neglected within pandemic responses, further increasing menstrual inequality, to reiterate why the study is prudent.

The information provided within this chapter aims to provide background and contextual details to further develop the rationale for the thesis. The following literature review chapter (chapter 3) provides relevant research evidence to further enrich this understanding, providing the basis for why the research study is necessary.

2.1 Menstrual health

This section provides an overview of the physiology of menstruation and the definition of ‘menstrual health’ which is applied throughout the thesis. It also includes definitions of ‘menstrual management’, ‘period poverty’, ‘menstrual inequality’ and ‘menstrual stigma’, which are included within the thesis.

Menstruation is the monthly shedding of uterine lining via menstrual bleeding which flows from the uterus, through the cervix and out of the body from the vagina (Itriyeva, 2022; Silberstein & Merriam, 2000). It is also referred to as ‘menstrual cycle’, ‘menses’, ‘menstrual period’ or ‘period’. Menstruation occurs due to the release of hormones via the pituitary gland and ovaries at various stages of the menstrual cycle, when the body realises that the fertilisation of an egg has not occurred and the thickened uterine lining is no longer needed (Silberstein & Merriam, 2000). There are four stages in the menstrual cycle: menses (menstruation), follicular, ovulation and luteal (Silberstein & Merriam, 2000).

The average menstrual cycle is 28 days, although a ‘normal’ menstrual cycle can vary from 21-35 days (Itriyeva, 2022). The normal length of menstruation (menstrual bleeding) also varies from 3-7 days (Itriyeva, 2022). Menstruation typically starts at the age of 12, ending after menopause on average around the age of 51 (Itriyeva, 2022). Menstruation is a normal physiological process that (cisgender) women, girls and those assigned female at birth will experience (Itriyeva, 2022; Silberstein & Merriam, 2000). Although menstruation is a shared physiological process for many, menstrual symptoms can vary significantly between individuals (Itriyeva, 2022). Symptoms can vary in severity including conditions such as dysmenorrhea (period pain), menorrhagia (heavy menstrual bleeding), hypomenorrhea (extremely light menstrual bleeding), amenorrhoea (when periods stop), oligomenorrhea (infrequent menstruation), metrorrhagia (bleeding in-between menstruation), pre-menstrual syndrome and pre-menstrual dysphoric disorder (Chandler, 2024). Menstrual symptoms can also be impacted by menstrual health related conditions, such as endometriosis, Polycystic Ovary Syndrome, fibroids and adenomyosis (Chandler, 2024).

In addition to the physical variations in menstrual symptoms that many experience, Chrisler (2017) states that this normal physiological process affects, and is affected by, women’s behaviour. Although those who menstruate share the same physiology of menstruation, their menstrual experiences are therefore shaped by things that influence behaviour – beliefs and attitudes which are learned within an individual’s sociocultural environment (Chrisler, 2017). The impact of wider sociocultural factors upon menstruation experiences is mirrored within Hennegan et al.’s (2021) definition of ‘menstrual health’ as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in relation to the menstrual cycle.” (Hennegan et al., 2021, p.1) . This definition therefore includes mental and social wellbeing as well as physical health, acknowledging the broader factors that impact upon menstrual health. These factors include access to menstrual health education and health care, supportive sanitation and hygiene facilities and affordable, effective menstrual products. These should all be available within an environment that promotes freedom from menstrual stigma and psychological distress. This then allows people the ability to make informed choices about their bodies and to participate in all aspects of life (Hennegan et al., 2021).

Hennegan et al.’s (2021) definition of menstrual health moves away from those previously used within research and practice, which have focussed more on menstrual hygiene practice such as access to products and sanitation facilities (Roaf & de Albuquerque, 2020). The use of the term ‘menstrual hygiene’ within menstrual-related policy and guidance has recently been replaced with this definition of menstrual health, reframing menstruation as a health issue that encompasses physical, psychological and societal dimensions that need to be addressed to ensure menstrual equity (World Health Organisation, 2022). This definition provides a more holistic understanding, situating menstrual health within wider areas of sociocultural context that must be addressed. Hennegan et al.'s (2021) definition therefore produces a framework to tackle menstrual inequality, whilst acknowledging that many of the factors attributed to achieving menstrual equity are intrinsically linked to tackling gender, financial, educational, disability and health inequalities. It is therefore this definition of menstrual health that is used throughout this thesis.

2.1.1 Menstrual management

Within the context of menstrual health, 'menstrual management' encompasses the different ways that those who menstruate manage the physical symptoms associated with menstruation, such as menstrual blood flow and menstrual pain (Bobel, 2019b; Thomson et al., 2019). Although there is no agreed definition, menstrual management typically includes choices around preferred menstrual products, access to sanitation facilities, pain management, medication to help with associated symptoms (e.g. bleeding, pain, regularity), diet, exercise and other strategies to relieve symptoms (Bobel, 2019b; Thomson et al., 2019). This is a broader description of how the physical symptoms of menstruation are managed in comparison to 'menstrual hygiene' practices/management, which focus on hygiene and sanitation and ignores wider factors associated with menstruation and menstrual health experiences (Bobel, 2019b). This thesis therefore uses the term 'menstrual management' unless the term 'menstrual hygiene' has been used within the cited research.

2.1.2 Menstrual stigma

Hennegan et al.'s (2021) definition of menstrual health acknowledges the importance of addressing menstrual stigma to improve menstrual equity. The definition specifies that those who menstruate should "experience a positive and respectful environment in relation to the menstrual cycle, *free from stigma* and psychological distress, including the resources and support they need to confidently care for their bodies and make informed decisions about self-care throughout their menstrual cycle" (Hennegan et al., 2021, p.1).

Menstruation is often viewed as disgusting and something that should be hidden, with menstrual euphemisms and myths further perpetuating this notion (Johnston-Robledo & Chrisler, 2020; McHugh, 2020). The secrecy around menstruation forms part of what Laws (1990) refers to as 'menstrual etiquette'. Menstrual etiquette includes concealment of menstrual blood and any evidence of menstruation (such as menstrual products) and not discussing menstruation in public (also referred to as 'menstrual concealment') (Laws, 1990; Seear, 2009). Such etiquette is taught across society in numerous ways, from being passed down by mothers or other family members, the advertisement of menstrual products, how menstruation is taught (or not taught) within school settings, and how those who menstruate are allowed to practice religion or interact within their communities (Chrisler, 2017; Hawkey et al., 2020; Winkler et al., 2024). The advertisement of menstrual products further reinforces this ideation, promoting menstrual concealment and the use of stigmatising language (Tomlinson, 2025). Menstrual stigma is therefore considered part of gender inequality within society, as a method of social control of women and those who menstruate, leading them to monitor their bodies constantly to ensure menstrual etiquette is maintained (Tomlinson, 2025).

2.1.3 Summary

Menstruation is a normal physiological process that (cisgender) women, girls and those assigned female at birth will experience, although menstrual symptoms can vary significantly between people. Furthermore, menstruation experiences are also influenced by wider psychological and sociocultural factors, including menstrual stigma and structural inequalities. This thesis therefore adopts Hennegan et al.'s (2021) definition of menstrual health which acknowledges the importance of addressing physical, psychological and societal factors that can influence menstrual health experiences to achieve menstrual equity.

2.2 Period poverty, menstrual inequality and menstrual equity

'Period poverty' is often used to describe financial difficulties in accessing period products (Jaafar et al., 2023). However, the term also encompasses poverty and inequality in relation to wider menstrual health, such as poor education, poor health care and menstrual stigma (Plan International UK, 2018). This wider term mirrors Hennegan et al.'s (2021) definition of menstrual health, acknowledging the intersections with societal and structural inequalities within menstrual inequality. The terms 'menstrual inequality' and 'menstrual equity' are often used as an alternative to period poverty, to better reflect the scale of factors that can impact upon menstrual health and the gendered nature of such inequality (Goldblatt & Steele, 2019; Rome & Tyson, 2024; Sommer & Mason, 2021; Weiss-Wolf, 2017). Menstrual equity (Sommer & Mason, 2021; Weiss-Wolf, 2017) further describes the measures that should be undertaken to address menstrual inequality, positioning menstrual health as a human rights and public health issue that must be addressed structurally within society, as per Hennegan et al.'s (2021) definition.

The World Bank (Pyecroft, 2022) estimates around 500 million women and girls globally lack access to the facilities they need to manage menstruation. Period poverty within the UK is estimated to affect 1 in 4 menstruators, with marginalised and minoritised groups being less likely to be able to afford menstrual products (InKind Direct. et al., 2024; Irise International., 2025b). Research indicates generational poverty and barriers to accessing menstrual health support, with 1 in 5 menstruators who had gone without menstrual products during adulthood having also gone without menstrual products during their childhood (InKind Direct. et al., 2024).

Across the globe, initiatives have been introduced in efforts to address period poverty. Many of these focus upon improving the accessibility of affordable or free menstrual products, including the promotion and provision of reusable products such as pads and menstrual cups (Paula et al., 2025; Roaf & de Albuquerque, 2020). Efforts to improve sanitation and hygiene facilities, most notably in the Global South, have also been introduced along with menstrual health education provision (Roaf & de Albuquerque, 2020). Much of the provision of services to tackle period poverty comes from grassroots, non-profit organisations, with some geographical areas introducing policies and laws to enshrine the provision of free menstrual products (Dave et al., 2022; Mann & Byrne, 2023).

Within the UK, measures to address period poverty and menstrual inequality are varied but predominantly focus on the provision of menstrual products. In 2019, the UK government pledged to end period poverty by 2030 (Mourdant, 2019). The strategy for this pledge included a Period Poverty Taskforce (Open Access Government, 2019b), which aimed to tackle menstrual stigma, improve menstrual health education and widen the accessibility of menstrual products. £250,000 was allocated to the taskforce to develop a sustainable solution to period poverty within the UK (Open Access Government., 2019). The outcomes of the taskforce's first meeting on 23rd July 2019 were published (Government Office for Equalities, 2019), however the taskforce ceased during the Covid-19 pandemic and little information has been forthcoming as to its achievements to date. In light of the limited progress made by the taskforce, in 2020, a Period Equality All-Parliamentary Party Group was established to ensure free period products are accessible in educational settings and other public venues. As of 2025, this is 'defunct' according to Parallel Parliament's webpage (Parallel Parliament, 2025).

In January 2021, the 5% VAT 'tampon tax' was abolished from 'women's sanitary products' recognising menstrual products are essential, and not luxury, items (HM Treasury, 2021). In 2024, campaign efforts to get reusable options included were rewarded as the government extended the tax exemption to reusable period pants (Alao, 2024). However, research shows that the abolition of the tampon tax has not contributed to a reduction in period poverty (Wood, 2023), with an analysis of Office of National Statistics data by Tax Policy Associates showing that at least 80% of the saving was retained by retailers (Neidle, 2022).

The UK has introduced various measures to provide access to free menstrual products across the country. In England, the Department for Education (DfE) introduced the 'Period Product Scheme' from 2020 to address access to products in schools and colleges, however, the full impact and efficacy of the scheme remain unknown. The scheme is available for all state-maintained schools and further education establishments (Department for Education., 2025). Currently, universities and other learning settings are exempt from applying to the DfE scheme (Department for Education, 2025). Access to free menstrual products is also mandatory within custodial/institutional settings (Home Office. & Hurd, 2019) and NHS hospitals (NHS England., 2019). The provision of free menstrual products within local authority areas is not consistent within England, as there is no central government funding or policy in relation to this. However, some areas have introduced free product schemes within their publicly accessible spaces, including Bristol City Council's 'Period Friendly Places' (Period Friendly Places., 2020), Stoke-On-Trent City Council (Baba Baboon., 2019) and Surrey City Council (BBC News Surrey, 2021). These initiatives are all collaborations with local non-profit organisations, who provide access to products and information.

Other parts of the UK have introduced more consistent policies to provide access to free menstrual products. In Scotland, free menstrual products have been provided in schools, colleges and universities since 2018. In 2020, the 'Period Products Free Provision Bill' (The Scottish Parliament, 2021) was passed, with The Act being implemented from 2023. Local authorities have the legal duty to provide products, with each deciding how to ensure such products are easily accessible. Northern Ireland have also passed the 'Period Products (Free Provision) Act to provide free menstrual products in public service buildings (Northern Ireland Assembly., 2022). Wales have yet to enshrine free provision of menstrual products within law, however, since 2018, the Welsh Government has pledged monies towards tackling period poverty across Wales (Welsh Government., 2023). Initially the funding was provided to local authorities, with further monies being made available to widen provision within schools, further education establishments, communities in need and hospital patients (Welsh Government., 2025).

The provision of menstrual health education (MHE) within the UK remains inconsistent. England is currently the only part of the UK which has mandatory MHE within Relationships, Health and Sex Education (RHSE) curriculum in primary and secondary schools (Department for Education, 2025b). Current DfE RSHE guidelines refer to menstrual health under the 'Developing Bodies' section of secondary school guidance, stating that pupils should learn about "menstrual and gynaecological health, including: what is an average period; period problems such as premenstrual syndrome; heavy menstrual bleeding; endometriosis; and polycystic ovary syndrome (PCOS)." (Department for Education, 2025a, p.31). For primary school pupils, the guidance states that pupils should learn about the menstrual cycle, including physical and emotional changes, and acknowledges that children should be taught about menstruation from an early age as young as eight can start menstruation (Department for Education, 2025a). The guidance does not provide any recommendation as to the age-appropriateness of the content within primary of secondary schools, or recommend what age pupils should be taught about menstruation, leaving these decisions for the educational establishment (Department for Education, 2025a). Furthermore, the guidance provides no further information or instruction on how to implement the delivery of MHE, nor provides any suggested resources for MHE other than reference to the Period Products Scheme (Department for Education, 2025a). There is no DfE RSHE teacher training provision dedicated solely to MHE delivery (Department for Education, 2025a). To date, the allocation of RSHE funding to MHE activities is unknown, and no evaluation of the impact and efficacy of introduced MHE has been undertaken.

The accessibility and quality of menstrual health care across the UK is also varied, with women's health strategies across the country beginning to recognise the importance of improving related services. In 2024, the Welsh Government launched its 10-year 'Women's Health Plan', which included menstrual health as a key priority, aiming to create specialist women's health hubs to help diagnose menstrual health conditions. The plan also aims to increase research into such conditions and improve menstrual health educational materials (Welsh Government., 2024). England have also prioritised 'menstrual health and gynaecological issues' within the Department of Health and Social Care's 'Women's Health Strategy for England' (Department of Health and Social Care, 2022). Building on the strategy priorities, the Women and Equalities Committee produced a report based on the outcomes of the inquiry on reproductive health conditions, which made several recommendations to address menstrual health inequality. These included the provision of free menstrual products, improvements in menstrual health education for young people and adults, and improvements in training for medical professionals (Women & Equalities Committee, 2024). Since the Women's Health Strategy for England was launched, a change in government leadership has occurred, with the current government launching its ‘10 Year Health Plan for England: fit for the future’ (Department of Health and Social Care., 2025). The plan does not reference menstrual health, nor reference any of the recommendations within the Women and Equalities report. It is not clear if this plan supersedes or replaces the Women’s Health Strategy.

Uncertainties around progress with regards to women’s health strategies are also apparent across other parts of the UK. In 2021, Scottish Parliament launched its ‘Women’s Health Plan 2021-2024’, which included ‘menstrual health and endometriosis’ as a key priority focussing on improving menstrual health education and endometriosis care pathways (Scottish Government., 2021). However, there are no updates available on progress to date. Similarly, in Northern Ireland, the outcome of the public listening exercise to inform the development of the ‘Women’s Health Action Plan’ (Department of Health., 2024) have not been released to date.

2.2.1 Summary

Period poverty forms part of menstrual inequality, which has historically focused upon financial barriers to accessing menstrual products. Initiatives designed to tackle menstrual inequality have been introduced globally, with the majority centred on the provision of free menstrual products and improvements to sanitary facilities. Within the UK, efforts to tackle menstrual inequality have typically focussed on the provision of free menstrual products. UK policy remains inconsistent across the country, with menstrual health education and health care provision falling short of government commitment.

2.3 Covid-19 pandemic

This section provides a definition of Covid-19 virus, outlining the UK response to disease-prevention and lockdown measures for the duration of the pandemic. It also provides insight into the gender implications of global Covid-19 responses, highlighting gaps that contributed to an increase in gender inequality and further exacerbated menstrual inequality during the pandemic.

According to the World Health Organisation, the Covid-19 pandemic is a “global outbreak of coronavirus – an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).” (World

Health Organisation, n.d.-a, p.1). Symptoms can include: fever or chills, cough, shortness of breath or difficulty breathing, sore throat, congestion or runny nose, new loss of taste or smell, fatigue, muscle or body aches, headache, nausea or vomiting and diarrhoea (Centre for Disease Control., 2025).

In December 2019, the first cases of coronavirus were detected in China. The virus rapidly spread globally, leading WHO to characterise the outbreak as a 'pandemic' on 11th March 2020 (World Health Organisation., n.d.-a, n.d.-b). The announcement prompted governments globally to act, introducing laws and restrictions designed to prevent the spread of the virus. The first vaccination for Covid-19, outside of clinical trials, was administered in the UK in December 2020 (GOV.UK., 2021). The pandemic is estimated to have caused 18.2 million deaths, globally, during 2020-2021 (Wang et al., 2022). This includes deaths caused directly by Covid-19 virus and deaths that may have been prevented under 'normal' circumstances (for example, people who did not receive adequate treatment or had surgeries delayed while medical services were prioritising Covid-19 cases).

In March 2020, the UK Prime Minister announced the first 'lockdown' in the UK, to prevent the spread of Covid-19 (Institute for Government., 2022). The lockdown involved the temporary closure of all but essential services, including educational, community, religious and business establishments. Measures to prevent the spread of the virus restricted face-to-face contact, with people being urged to 'stay at home' unless travel was essential (e.g. purchasing food or a medical emergency). Travel outside of local areas was also prohibited, as were gatherings of groups of people (GOV.UK., 2020). The restrictions introduced to reduce the spread of infection impacted people's daily routines, strained public and other essential services, and exacerbated vulnerabilities within certain groups, such as homeless people, elderly people and disabled people (British Medical Association, 2024; Stevens et al., 2021).

During lockdowns across the UK, changes in education and health care provision were introduced as part of disease-prevention measures. Within educational establishments, schools, colleges and universities closed and moved the provision of teaching onto remote online platforms. Priority was given to the teaching of 'mandatory' topics, such as mathematics and English, with suggestions that schools should cease 'specialist' subjects (such as relationships and sex education) to ease pressure (Santry, 2022). Within health provision settings, services prioritised responding to the pandemic with many services being diverted to support Covid-19 cases (British Medical Association., 2024). This included disruption to secondary care provision, with elective procedures, diagnostic tests and routine outpatient services being cancelled. Within primary care, general practice surgeries ceased face-to-face appointments and moved to telephone/video consultancy, whilst also picking up some of the care responsibilities attributed to the disruption of secondary care (British Medical Association., 2024). The UK government eased restrictions and enforced additional lockdowns several times from 2020-2021, with the final end to restrictions being July 2021 (UK Parliament., 2021).

2.3.1 Gendered implications of the pandemic

A number of sources have provided evidence of the gendered implications of the pandemic, with women and girls being more likely to experience gender-based violence, poverty, poorer education access and barriers to sexual and reproductive health during the pandemic (European Institute for Gender Equality, 2020b; Plan International UK., 2020; UN Women., 2022; United Nations, 2020). Furthermore, UN Women reported that only 24% of global taskforce members were women, with only 18% of taskforces being led by women, which influenced the number of gender-sensitive measures introduced within pandemic responses. Their report also provides insight into the pivotal role that women's rights organisations played within pandemic responses, and their continued efforts to have women's representation included, with taskforces that had greater representation of women being more likely to engage with such organisations (UN Women., 2022). Similar findings were reported by other sources, highlighting how government responses did not factor in gender (or other inequalities, such as race and disability) in Covid-19 taskforces and policy decisions (European Institute for Gender Equality, 2020b; Gharib, 2020; Plan International UK., 2020; Trian, 2021).

Within the UK, key gender equality organisations called for more gender inclusion in government Covid-19 responses, producing policy guidance and recommendations to ensure rights of women and girls (Fawcett Society, 2020; Ingham, 2020; Plan International UK., 2020). For example, the Fawcett Society (2020) highlighted how the UK's prioritisation of the economy over childcare and social care infrastructure in their plans to ease lockdown restrictions negatively impacted women's financial security by hindering their ability to return to work. Helen McNamara, the UK's second most senior official during the height of the pandemic, further critiqued the UK's Covid-19 response, stating it was impaired because of the lack of representation of women in key decision-making forums including the taskforce (Devlin, 2023). An analysis of Covid-19 measures introduced by global taskforces outlines the 14 gender-sensitive measures that the UK introduced in its Covid response strategies, with much of these centred on gendered violence (UN Women, 2022). However, women's economic security was neglected within its response (UN Women, 2022), despite calls to address this issue (Fawcett Society, 2020).

The gendered implications of worsening financial poverty during the pandemic have been discussed by several sources (CARE & United Nations., 2020; Carli, 2020; de Paz et al., 2020; Menta, 2021), highlighting that women were more likely to experience financial insecurity. One study found that women were 24% more likely than men to lose their job permanently during the pandemic (Dang & Viet Nguyen, 2021), while others demonstrated how the increase in the gendered 'burden of care' during the pandemic meant that women had to take on additional unpaid care and household responsibilities during lockdowns (Carli, 2020; de Paz et al., 2020; Dinella et al., 2023; European Institute for Gender Equality, 2020a; Power, 2020; UN Women., 2022).

The gender differences in frontline services were also flagged as a neglected area in terms of Covid-19 responses and policy. Women make up the majority of health service employees globally, with such workforce being more likely to be at the forefront of health responses to the pandemic (European Institute for Gender Equality, 2020b; UNICEF, 2020). Despite this, the provision of 'one size fits all' personal protective equipment (PPE) for frontline health workers was criticised for being based upon male bodies and therefore too big to be effective, or safe, for women to use (European Institute for Gender Equality, 2020b; Weiss-Wolf, 2020).

Weiss-Wolf (2020) further highlights how PPE provision failed to recognise the importance of including menstrual products for frontline workers who menstruate, many of whom were working extra-long shift patterns with limited bathroom breaks. The lack of inclusion of menstrual health and hygiene provision within responses to Covid-19 was criticised by a number of activists and organisations as an indicator of how gender inequality was exacerbated during the pandemic (Ajari et al., 2020; Crawford & Waldman, 2021; Farrington, 2020; Irise International, 2020; Jahan, 2020; Rodriguez, 2020; Water Supply and Sanitation Collaborative Council, 2020). In response to the neglect of menstrual health within such responses, UNICEF (2020) produced a policy document outlining all areas that must be considered to ensure menstrual equity during the pandemic, which stressed that menstrual products must be considered as 'essential' items. The guidance also references the importance of ensuring adequate sanitation and hygiene facilities for all, providing crucial menstrual health education and information even when physical premises are closed, and ensuring that access to sexual and reproductive health services remains a priority. However, it is not known how many countries implemented any of the recommendations within the guidance and the limited research available on menstrual health experiences during the pandemic indicates that menstrual inequality continued to increase during this time (Babbar et al., 2023; Garg et al., 2020; Holst et al., 2023; Murphy et al., 2024; Patel et al., 2022; Schmitt et al., 2023; Sommer et al., 2022; Wood et al., 2022).

Although evidence demonstrates an increase in period poverty and menstrual inequality during the pandemic, much of the research undertaken on menstruation experiences centred on how Covid-19 virus and vaccinations impacted the menstrual cycle (Al-Furaydi et al., 2023; Al-Mehaisen L et al., 2022; Chourasia et al., 2022; Dabbousi et al., 2023; Darney et al., 2023; Kumar et al., 2023; Lessans et al., 2023; Martínez-Zamora et al., 2023; Matar et al., 2023; Medina-Perucha et al., 2022; Mohr-Sasson et al., 2023; Qazi et al., 2023; Taşkaldiran et al., 2022; Tripathy et al., 2022). Despite the amount of research which demonstrates how the virus and vaccinations can negatively affect menstruation and the menstrual cycle, the recognition of this in patient information regarding both is limited. The inclusion of ‘heavy menstrual bleeding’ under ‘Possible Side Effects’, ‘not known’ frequency, were added to Covid-19 vaccination Patient Information Leaflets in UK for Pfizer-BioNTech in late 2021 (Medicine and Healthcare products Regulatory Agency., 2024) and Spikevax (formerly Moderna) in late 2022 (Medicine and Healthcare products Regulatory Agency., 2023). To date, the inclusion of menstrual cycle changes is not included in other Covid-19 vaccinations including (not exhaustive): AstraZeneca, Janssen, Sinopharm, Convidicea, Novavax, Covaxin and VLA2002. Reference to menstrual cycle changes linked to the virus have not, to date, been included within medical definitions of Covid-19 and associated symptoms, despite numerous anecdotal and evidence-based reports. The lack of transparency over how Covid-19 (virus and vaccinations) can impact the menstrual cycle and associated symptoms is indicative of wider neglect of menstrual health within pandemic responses, as discussed previously.

2.3.2 Summary

The Covid-19 pandemic led to governments across the world introducing disease-prevention measures to stop the spread of the disease. This led to the closure of many establishments and services, and the introduction of travel restrictions, which caused disruption to education, community and health services. Research shows that government responses to Covid-19 rarely included considerations around gender or other inequalities, despite evidence of an increase in gender inequality attributed to pandemic-related factors such as financial insecurity. Menstrual health considerations were often neglected, with menstrual products not being considered as essential items within pandemic responses. Furthermore, a lack of transparency around the impact of the virus and vaccinations upon the menstrual cycle demonstrates a neglect of menstrual health within pandemic responses, contributing to an increase in menstrual inequality during this time.

Within the UK, efforts to address menstrual inequality are varied across the devolved nations with much of what exists centring on the provision of free menstrual products. Education, healthcare and wider issues such as menstrual stigma have received less attention, to date. Organisations that champion gender equality and menstrual equity called for the UK government to include menstrual health within their responses to the Covid-19 pandemic, however, the government's response has been criticised for failing to address gender inequalities, particularly regarding financial insecurity. Furthermore, menstrual health was not addressed within such responses.

3 Chapter 3: Literature review

3.1 Introduction

This chapter provides an overview of the available literature on menstrual health and the Covid-19 pandemic, discussing key topics imperative to understand the aims of the thesis. Building on the context provided within the previous chapter, this chapter brings together academic research and 'grey'[1] literature to discuss the contributions, gaps and limitations of the available literature. Grey literature is included within this literature review to reflect that much of the evidence available on menstrual health and period poverty experiences comes from grassroots, non-profit organisations that are working with affected communities.

The chapter begins with a comparison of health psychology models to explain how feminist Critical Health Psychology can contribute to an understanding of menstrual health experiences during the pandemic, using Hennegan et al.'s (2021) definition of menstrual health. As discussed in the previous chapter, this definition provides a framework to examine physical, psychological and sociocultural factors that can influence experiences of menstruation.

The chapter then focuses on key aspects of menstrual health to strengthen the rationale for the thesis. The chapter therefore discusses evidence regarding period poverty, menstrual product accessibility, menstrual health education and knowledge, and menstrual health care. The chapter also discusses evidence regarding wider sociocultural factors, such as menstrual stigma, which can influence menstrual health experiences. Finally, to provide further context to the research study and the study aims, the chapter provides evidence of how humanitarian crises, such as the Covid-19 pandemic, affect different aspects of menstrual health.

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[1] 'Grey literature': information produced on all levels of government, academia, business and industry in electronic and print formats not controlled by commercial publishing i.e. where publishing is not the primary activity of the producing body: https://libguides.exeter.ac.uk/c.php?g=670055&p=4756572

3.2 Health Psychology and Critical Health Psychology: applying a critical, feminist framework to menstrual health experiences during the pandemic

Mainstream health psychology seeks to understand the role of psychological processes within the context of health and illness experiences, including causes of health and illness, how health and illness progress and the consequences of health and illness (Albery & Munafo, 2008; Ogden, 2019). The study of health psychology focuses on health promotion and maintenance, diagnosis and aetiology of health and illness, treatment and prevention of illness and the development of healthcare services and related policies (Albery & Munafo, 2008; Ogden, 2019). This model of health psychology has been critiqued for being too narrow in terms of its application, favouring established theories, hypotheses and quantitative methods to determine the psychological determinants of health behaviours (Crossley, 2000; Lyons et al., 2006). By applying a scientific, objective approach to health psychology, the discipline generalises and categorises behaviour to be able to predict, control and manage health and illness, placing an emphasis on the individual's responsibility to maintain health (Lyons et al., 2006). A criticism of the scientific approach is its failure to capture wider factors that have not previously been considered, such as values, meaning and human morality that shape our health-related experiences and behaviours (Crossley, 2000; Ogden, 2019). Furthermore, mainstream health psychology fails to critically evaluate individual behaviour within broader sociocultural contexts which contribute towards our health and illness experiences (Lyons et al., 2006). It is important to explore this to better understand how our 'meaning-systems' (experiences, beliefs and knowledge) vary between social and cultural worlds and are interpreted by the individual, as opposed to generalising experiences and assuming one 'truth' across all individuals (Crossley, 2000; Lyons et al., 2006).

Critical Health Psychology (CHP) is therefore favoured as an alternative to mainstream health psychology as it allows us to examine these broader contexts to better understand health and illness experiences and behaviours (Crossley, 2000). CHP considers health-related knowledge and associated health behaviours to be rooted within historical and sociocultural contexts, drawing upon different disciplines, epistemologies, theories and methods to critically examine health and illness experiences (Locke & Carral, 2025). Where mainstream health psychology favours objectivity and generalisation of health behaviours to establish causality and create models of behaviour, CHP centres subjectivity, meaning and reflexivity (Locke & Carral, 2025; Ogden, 2019). CHP further acknowledges how power structures and relationships also contribute to how we experience and interpret health and illness, providing a framework to address issues around inequality, diversity and social justice and a means to create social change (Chamberlain & Murray, 2009).

CHP therefore favours qualitative approaches to gain a richer understanding of our meaning systems and how they shape and influence our health and illness experiences (Lyons et al., 2006). The primary use of qualitative methodologies within CHP further addresses critiques of mainstream health psychology research design and practice which is historically based on positivist and quantitative approaches. Such approaches have been critiqued for failing to acknowledge the active (subjective) role of the researcher within knowledge generation, including ethical issues around power and representation within research practice (Chamberlain & Murray, 2009; Lyons et al., 2006; Ogden, 2019). CHP therefore provides a further means to attend to issues of ethics and power dynamics, recognising structural inequalities and biases that apply to research design and practice (Ussher & Walkerdine, 2001). Using qualitative methods and reflexivity are therefore pivotal in facilitating and managing the researcher-participant relationship, aiming to address such ethical issues by utilising varied methodologies including community-based, participatory and arts-based methods (Chamberlain & Murray, 2009; Murray, 2012; Ussher & Walkerdine, 2001). The use of such methods also aims to address some of the criticisms of more traditional qualitative methods, such as interviews, where participants were still considered to be 'passive' subjects within research and had little agency in contributing to social change within their communities (Chamberlain & Murray, 2009).

Within the context of gender and health, CHP provides insight into how gender roles and stereotypes affect the health, healthcare and health behaviours of men and women (Chrisler & Gorman, 2016; Lyons et al., 2006). Gender stereotypes have been found to influence patient-doctor communication, diagnosis outcomes and treatment decisions (Chrisler et al., 2016; Dixon-Woods et al., 2001; Doyal, 2001; Hwang & Danoff-Burg, 2010; Lyons et al., 2006; Travis et al., 2009). For example, research suggests that most physicians believe that women do not want to talk about sexual health concerns with male medical professionals. As such, sexual health conversations within these circumstances are often only discussed within the context of reproductive health concerns (Dixon-Woods et al., 2001; Travis et al., 2009). This may also reflect gender roles and expectations within patriarchal societies whereby women are positioned as mothers and caregivers, with a duty to procreate (Ellemers, 2018), meaning that male medical professionals are likely to assume that women are more concerned about reproductive rather than sexual health (Young et al., 2016). Gender expectations have also been found to influence how chronic illnesses are experienced, with women experiencing a double-burden of managing their illness in addition to tasks traditionally expected of women, such as housework and childcare. This double-burden causes additional emotional and physical stress, meaning that women are more likely to report a lower quality of living than men living with the same illness (Danoff-Burg & Revenson, 2000).

CHP also provides insights into how health and illnesses specific to gender are experienced, such those associated with cisgender women, transgender men and non-binary people assigned female at birth. Many of these are associated with reproductive and sexual health, including (but are not exhaustive to) menopause, ovarian cancer, menstrual health-related conditions (such as endometriosis, uterine fibroids, Polycystic Ovary Syndrome) and menstruation. For example, Ussher and Perz (2019) state that women's lives must be explored within the context of normal physiological functions, such as menstruation and menopause, to better understand how such experiences are interpreted and understood. This is echoed by Chrisler (2017) who argues that such insights are crucial in recognising that although menstruation is a shared physiological function within women, the way that menstruation is experienced and therefore the impact of menstruation upon a person's health, wellbeing and quality of life will vary significantly depending upon sociocultural and political factors (such as race, socioeconomic status, disability).

This study is therefore situated within the discipline of Critical Health Psychology as it seeks to understand how the Covid-19 pandemic influenced menstrual health support and experiences of menstruation. The study therefore critically examines a gendered health inequality, menstrual health, within the context of a global disaster that has been found to exacerbate existing inequalities around health and gender (as discussed within chapter 2). The study further aims to understand how pandemic-related factors intersect with existing menstrual health, gender and health inequalities within the UK, by examining the experiences of those providing and seeking menstrual health support during lockdowns. To address the study aims, it is therefore crucial to consider all aspects of menstrual health to be able to understand the factors that influence such experiences, including physical, psychological, sociocultural and structural ones (such as existing inequalities). Within the context of the study's aims and objectives, CHP therefore provides a useful framework to examine the research questions, particularly when moving away from the traditional biomedical definition of menstrual health that solely focuses on the menstrual cycle as shared physiological experience amongst those who menstruate (Chrisler, 2017). CHP recognises the relationship between sociocultural and psychological factors within health and illness experiences and behaviours, whilst acknowledging structural and societal power dynamics and structural inequalities within health experiences.

Furthermore, the principles of CHP are aligned with feminist approaches to health psychology, which seek to examine the political context of women's experiences and the meaning they attribute to them (Chrisler &

Gorman, 2016). Feminist applications of health psychology also focus on the principles of equity and inclusiveness which mirror the shared principles of CHP that aim to address inequality, diversity and social justice (Martin, 2003; Travis et al., 1991). These principles again provide a useful framework for examining menstrual health experiences during the pandemic to better understand what factors contribute to such experiences and further exacerbate menstrual health inequalities. Furthermore, the feminist principles of inclusiveness, equity and representation are crucial to examining such inequalities, recognising that the health needs of historically minoritised and underprivileged groups are often underrepresented within menstrual health research (Perro et al., 2022; Travis et al., 1991; Weckesser, Randhawa, et al., 2019).

This study therefore embodies CHP and feminist principles by using Hennegan et al.'s (2021) menstrual health definition, recognising how physical aspects of the menstrual cycle and menstrual hygiene management influence experiences of menstruation in addition to the wider impact of social, political and psychological factors such as menstrual stigma, shame and gender inequality. Moving away from focussing on physical aspects of menstruation and menstrual management further addresses criticisms of mainstream health psychology research that examines women's health. Feminist scholars have critiqued such research for its focus on reproductive health and fertility (Chrisler & Gorman, 2016). Scholars argue that this focus reinforces biomedical narratives that women's bodies are 'abnormal' as they are different to male bodies, with male bodies being the accepted norm within society and across the medical field (Chrisler & Gorman, 2016). This abnormality of women's bodies therefore means that they are considered to be inferior to male bodies (e.g. weak) and therefore need to be medically managed (Chrisler & Gorman, 2016; Ford et al., 2025; Ussher & Perz, 2019). By applying Hennegan et al.'s (2021) definition within a feminist CHP framework, we can begin to examine how factors outside of physiology influence menstrual health and recognise the sociocultural and political context of health experiences. These are important areas to examine when addressing menstrual health inequalities which are recognised within the context of wider inequalities, particularly gender inequality. Menstrual health and period poverty are also often positioned within critical feminist research and activism, which further develops an understanding of how inequalities such as gender, health, race, disability intersect to increase menstrual inequalities (Goldblatt & Steele, 2019; Rome & Tyson, 2024; Weiss-Wolf, 2017). This is important within the context of the pandemic, as the pandemic was found to increase existing gender inequalities and exacerbate period poverty, both within the UK and globally (see chapter 2 for further details).

Applying Hennegan et al.'s (2021) menstrual health definition within a feminist, CHP framework therefore allows us to examine menstrual health inequality during the pandemic through a critical lens, identifying factors linked to structural imbalances and inequalities within society. This thesis applies critical feminist and CHP frameworks to address menstrual inequality within the UK by understanding how the pandemic impacted UK menstrual health experiences. The study therefore examines menstrual product accessibility, menstrual health education and knowledge, access to menstrual health care and wider sociocultural issues such as menstrual stigma and gender inequality. As such, this chapter will discuss the available literature related to these areas, to compliment the definition of menstrual health applied to the thesis and research study aims (see chapter 2 for further details).

3.3 Period poverty: menstrual hygiene and access to menstrual products

Period poverty has historically been discussed within the context of the Global South, focussing on menstrual hygiene provision and sanitation access (Roaf & de Albuquerque, 2020). Research demonstrates how those within the Global South struggle to access affordable, effective menstrual products and the facilities to be able to maintain hygiene in a safe and sanitary environment, with much of the research centred on the experiences of young girls (Delanerolle et al., 2023; Garg et al., 2022; Ha & Alam, 2022; Paula et al., 2025; Rossouw & Ross, 2021; Soeiro et al., 2021). Access to clean, private, safe spaces for menstrual hygiene management was linked to financial status within numerous countries, with those living in less wealthy households being less likely to have access to such spaces (Roussouw & Ross, 2021). The impact of financial difficulties on the ability to purchase menstrual products was found in Garg et al.'s (2022) study of menstrual hygiene in adolescent girls in India. The study found that 27% of girls had trouble purchasing menstrual pads despite having access to free products within schools, with 62% attributing such difficulties to financial constraints. The study also highlights the impact of menstrual stigma when purchasing menstrual products, with 47% of adolescents experiencing menstrual shame when buying pads, thus demonstrating multiple factors that influence the accessibility of menstrual products. Financial difficulties and menstrual shame were also found to influence adolescent girls' menstrual hygiene practices within Bangladesh (Ha & Alam, 2022).

The impact of poor menstrual hygiene, including inadequate access to menstrual products, has been demonstrated in several ways. For example, inadequate and infrequent changing of menstrual products from not being able to afford disposable products, or not having access to safe, private wash facilities to keep oneself clean (or wash reusable products), has been found to increase the risk of urinary and reproductive tract infections (Sumpter & Torondel, 2013). Several studies have also demonstrated the link between poor school attendance and not having access to appropriate, effective menstrual products (Elledge et al., 2018; Sommer et al., 2013). Poor school attendance in such circumstances also forms part of the associated stigma and shame related to concerns over poor menstrual hygiene and visible menstruation, with pupils choosing to miss school to avoid such anxieties (Elledge et al., 2018; Ha & Alam, 2022). These examples illustrate the various ways that inadequate access to menstrual products and hygiene facilities can impact women, girls and people who menstruate's overall health, wellbeing and ability to participate in all spheres of life. However, much of the research examining period poverty and menstrual hygiene experiences within the Global South quantifies such experiences to provide insight into the frequency of period poverty, examining the effectiveness of menstrual product schemes through predominantly quantitative measures. While this data is crucial to understanding the scale of the issue and establishing how many people are impacted, it misses other factors that contribute to people's menstrual health experiences that may be identified through more qualitative methods. These would create a greater understanding of how wider sociocultural and psychological determinants shape such experiences, mirroring Hennegan et al.'s (2021) framework for addressing menstrual health inequalities.

In the global North, period poverty research has predominantly focused on financial difficulties associated with accessing menstrual products, with the sanitation and hygiene implications associated with menstrual hygiene management being less researched. Types of evidence are more varied than research within the Global South in terms of participant experiences, including adults, young people and marginalised groups (Barrington et al., 2021). Research methods are also more varied, including mixed methods and qualitative studies as preferred ways to understand menstrual experiences, addressing some of the gaps in our understanding of wider factors that contribute to period poverty.

Within the UK, studies examining the experiences of low-income women in the north of England show the intersections of financial poverty, menstrual stigma and psychological anxiety and stress (Boyers et al., 2022; Briggs, 2021). For example, Boyers et al. (2022) found that women discussed prioritising food, heating and lighting over menstrual management, meaning many women improvised with makeshift menstrual products or wore products for longer than recommended by health professionals and product manufacturers. Furthermore, most women reported being unaware of organisations that may be able to assist them by providing free menstrual products. Some resorted to borrowing products and shoplifting to access them, which was described as embarrassing and shameful. Women described menstruation as a 'burden', causing not only physical pain and distress but emotional symptoms, such as anxiety, stress and low mood. Similar accounts of menstruation experiences were reported by Briggs et al. (2013), with women who could not afford menstrual products discussing embarrassment at their situation which caused further distress and anxiety associated with menstrual shame and the need to conceal menstruation. Another UK study further demonstrates how period poverty impacts educational experiences, with a study of higher education students establishing a link between menstrual product affordability and attendance at university classes (Stephenson, 2025). The study found that almost half (47%) of students that had struggled to afford menstrual products within the past 12 months had stayed at home and missed classes. However, the study does not examine the impact that this has upon academic performance within higher education.

Similar findings have been reported in period poverty experiences within the USA (Miller et al., 2024; Sebert Kuhlmann et al., 2019; Trant et al., 2022), Canada (Lukindo et al., 2022) and Spain (Gallo, 2024; Marí-Klose et al., 2023). Barriers attributed to financial insecurity and accessing menstrual products were reported by Miller et al. (2024) in their study of low-income women who accessed a Free Clinic in USA for their healthcare needs. Women in Missouri, USA, with low income who had struggled to afford menstrual products were also found to be more likely to use makeshift products (Sebert Kuhlmann et al., 2019). Evidence of menstrual product insecurity has also been found within adolescent girls in USA, although it is not clear if this is linked to financial insecurity or other barriers (Trant et al., 2022). In Canada, period poverty in adolescent girls was linked to financial insecurity, with participants reporting that a lack of affordability of menstrual products caused them to miss school and not engage with social activities (Lukindo et al., 2022). In Spain, studies have similarly found that financial insecurity is linked to experiences of period poverty (Gallo, 2024; Marí-Klose et al., 2023), with findings further indicating that those who experienced period poverty were also more likely to experience poor mental health (Marí-Klose et al., 2023).

Period poverty research within the global North has also looked at the experiences of marginalised groups, including homeless women in UK (Vora, 2020) and USA (Boden et al., 2023; Sommer et al., 2020). For example, Vora (2020) describes the experiences of homeless women living in Bristol, UK, with women using makeshift products when they could not access products within shelters or other public spaces, while others resorted to shoplifting to get products. The study also describes challenges around privacy and hygiene while being reliant on public toilets and shared shelter facilities. These findings are echoed in both Boden et al. (2023) and Sommer et al.'s (2020) studies of homeless women's menstruation experiences within USA, illustrating the importance of providing menstrual products in accessible places and safe, private spaces to manage menstruation.

As discussed, several studies examine wider factors within the context of menstrual hygiene management and product accessibility, acknowledging intersections between menstrual stigma and how period poverty affects the ability to participate in all aspects of life. However, most of the menstrual health and period poverty research discussed within this section has focused on determinants and psychological consequences of menstrual hygiene management and product accessibility. This approach mirrors typical biomedical models of health-related determinants, which centre the individual as being responsible and culpable for their health behaviours (Rohleder & Flowers, 2018). This is also a criticism of period poverty and menstrual inequality initiatives that focus on menstrual hygiene management via menstrual product-based solutions which imply that the problem lies with the individual menstruator (Bobel, 2019a). Although it is important for those who menstruate to have control over decisions as to how they manage their menstruation, Bobel (2019) critiques such solutions as further reinforcing menstrual stigma via concealment practices, perpetuating notions that periods are dirty and should be hidden. Instead, Bobel (2019) argues that efforts to address menstrual inequality must be reframed to focus on tackling menstrual stigma and improving access to menstrual health education, in addition to providing menstrual products.

Research on menstrual hygiene management and period poverty, in terms of product accessibility, does not typically include the experiences of those providing services to address menstrual inequality within these circumstances. This is an important area to include within research, as many schemes designed to improve menstrual product accessibility and menstrual hygiene are delivered by state-funded departments or third sector organisations that may experience limitations around funding and resources that impact their work (Bach-Mortensen et al., 2018; Cairns et al., 2005; Pettman et al., 2013). One exception to this is Boyers et al.'s (2022) study of experiences of period poverty within a highly deprived area of Northwest England, UK. This study also includes interviews with staff from supported accommodation services (n=3) and food banks (n=2). Staff described being reliant on donations to be able to provide access to free menstrual products for service users, which limited the range of products they could provide, indicating funding and resource barriers. Boyers et al.'s (2022) study therefore demonstrates the importance of including service provider experiences within period poverty and menstrual health research as it is difficult to establish what barriers further contribute to the menstrual experiences of those who struggle to access menstrual products when they are excluded. Thus, echoing Bobel’s (2019) argument that the problem of menstrual inequality should not sit with the affected individual.

3.4 Menstrual health education and knowledge

Studies have shown how other factors associated with period poverty, such as poor menstrual health education, affect those who menstruate (Belay et al., 2020; Betsu et al., 2024; Blake et al., 2017; InKind Direct. et al., 2024; Irise International., 2025b; Montgomery et al., 2012; Plan International UK, 2018). Much of the focus of menstrual health education research has been on adolescents’ experiences of education within school settings, from the side of those receiving the education, within the Global South. Little research exists from the perspective of those providing menstrual health education, in terms of possible barriers to service provision.

Studies show that menstrual health education and knowledge of adolescents in the Global South is poor (Chandra-Mouli & Patel, 2020; Coast et al., 2019). Several studies within the Global South have examined the effectiveness of combining menstrual product provision with menstrual health education, addressing some of Bobel’s (2019) criticisms of menstrual product schemes by including other factors associated with wider menstrual health. Studies indicate that improving access to menstrual products and sanitation facilities within schools, when paired with menstrual health education, improve school attendance for young menstruators in the Global South (Belay et al., 2020; Betsu et al., 2024; Montgomery et al., 2012). For example, in Ghana, efforts to combine menstrual product provision with menstrual health education were found to significantly increase school attendance (Montgomery et al., 2012). Similar findings were reported in Belay et al.’s (2020) study of girls’ school attendance in northern Ethiopia. Furthermore, Blake et al.’s (2017) study demonstrates how menstrual health education can address menstrual stigma, evidencing the importance of using an integrated approach towards addressing menstrual inequality. The study assesses the effectiveness of the distribution of a book about puberty within schools in rural districts of Oromia, Ethiopia, with results showing access to the book had significantly increased girls menstruation knowledge and improved attitudes towards menstruation.

In the global North, research includes both adults and young peoples’ experiences of menstrual health education, with much of the research being conducted within the UK. As with research in the Global South, menstrual health education and knowledge has been found to be poor. For example, Irise International’s (2025) UK survey of adults finding less than 1% of those surveyed could answer more than 9/10 questions about menstruation correctly. Another UK-based survey found that 34% of those who had received some menstrual health education within school felt confident in identifying things that would cause them to be concerned about their period and only 15% had been taught about menstrual health conditions like endometriosis (InKind Direct. et al., 2024). Research on young people's menstrual health education within UK reveals similar evidence. For example, Randhawa et al. (2021) found a lack of awareness around what a 'typical' period or menstrual is within adolescent girls surveyed, with 27% of adolescent girls surveyed being unsure as to whether their menstrual cycle was 'typical' and 30% reported not knowing whether their periods were 'regular'. Plan International UK (2018) also found that young people felt unprepared for menstruation, even if they had received some form of menstrual health education within school. The research further describes how young people thought such education was too focused on biology and did not provide enough information about the experience of menstruation, including how it feels to menstruate and what to expect. Similar findings were reported by Stephenson (2025) in their survey of females within Higher Education in UK, with most students stating they had received 'very poor' or 'poor' menstrual health education. Thus, poor menstrual health education for girls and young people who menstruate can lead to feelings of embarrassment and anxiety associated with menstruation, further perpetuating menstrual stigma (Betsu et al., 2023). Consequently, one of the most significant factors that shapes women's understanding and interpretation of the 'normality' their menstruation experience is often the poor and inaccurate information they received about menstruation during school education (Wood et al., 2007).

With menstrual health education being poor in terms of content and provision, alternative sources of information are often turned to in order to fill gaps and alleviate concerns. For example, young people reportedly learn more about menstrual health from social media as opposed to within school (Plan International UK, 2018; Stephenson, 2025). For many who menstruate, their main source of information about menstruation comes from a family member, typically the mother, around the age of menarche (first period) (Betsu et al., 2023; Finlay et al., 2000). However, these alternative sources of information may further perpetuate menstrual myths and menstrual stigma (Armour et al., 2019; Suttor et al., 2024). For example, menstrual pain is typically normalised within society, with many who experience significant menstrual pain reporting that their mothers told them it was a normal part of being a woman (Seear, 2009). However, significant and severe menstrual pain (dysmenorrhea) may be indicative of associated menstrual-related conditions such as endometriosis and uterine fibroids (Chandler, 2024). Similar concerns over the use of the internet or social media as alternative forms of menstrual health education have also been raised, with sources being found to further perpetuate harmful narratives about menstrual health that contribute to menstrual stigma (Suttor et al., 2024; Tomlinson, 2025).

The implications of poor menstrual health education and inadequate sources of menstrual health information have been discussed within the context of endometriosis diagnosis in young girls, with significant delays in obtaining a diagnosis being further influenced by a lack of awareness of endometriosis and what is considered to be ‘normal’ menstruation (Randhawa, 2023). Endometriosis is a chronic, systemic disease that can cause debilitating menstrual pain and severe bleeding in addition to other symptoms that are not specific to menstruation. Diagnosis times were also found to be impacted by frequent dismissals by health professionals, indicating poor knowledge of menstrual health conditions (such as endometriosis) and gendered health inequalities where women and girls’ pain is normalised (Randhawa, 2023).

While it is important to examine menstrual health education experiences from the perspective of those receiving education, it is also necessary to look at the experiences of those providing such education. As with gaps in menstrual product focused research, without knowing what affects the provision of this type of service, we are limited in our understanding of wider sociocultural and political factors that may influence menstrual health education and knowledge. This is typically missing from menstrual health education research, although there is some evidence to suggest that teaching taboo subjects (such as menstruation) comes with additional challenges (Chrisler, 2013).

3.5 Menstrual health care and menstrual health-related conditions

Research into gendered health inequalities provides evidence of how menstruation and menstrual health-related conditions have been regarded within the medical community (Chen et al., 2018; Culley et al., 2013; Denny et al., 2011; Dusenbery, 2018; Ghant et al., 2016; Grogan et al., 2018; Laws, 1990; Seear, 2009; Sengoba et al., 2017; Söderman et al., 2019; Tomlinson et al., 2017; Young et al., 2018). With the development of Gynaecology practice in the mid-1800s, women’s physiological functions, such as menstruation, became medicalised and pathologized as disease (Ford et al., 2025) and attributed to being an unpleasant and undesirable aspect of ‘femininity’. Menstruation was thought to be a physical illness, which caused emotional instability and disability, and therefore something that needed to be controlled (Ford et al., 2025; Ussher, 1996). Within this context, menstruation was used as a basis for why women were better suited to roles of mother, caregiver or homemaker underpinning gender inequality across many societies (Strange, 2000).

The history of medical misogyny regarding menstrual health, within the context of wider women's health, is vastly documented. Medical misogyny refers to gender bias within medicine, whereby women's health concerns are largely dismissed or ignored (Philbin et al., 2024; Ussher, 1996). From accounts of ancient Greek theories of hysteria being attributed to the 'wandering womb' by Hippocrates and Plato (Faraone, 2011), to Galen and Celsus in ancient Rome, St. Thomas Aquina's statement that "the woman is a failed man" and the religious persecution of 'hysterical women' in the Middle Ages (Tasca et al., 2012). Such theories influenced much of the treatment for women's health up to the mid-1900s (Baloh, 2021), with women being thought of as 'naturally hysterical' and any associated symptoms therefore considered as 'normal' (Dusenbery, 2018).

Such attitudes continue to be reported within patient accounts of seeking medical advice and treatment for menstrual-related symptoms. Much of these accounts stem from research on experiences of endometriosis. Research demonstrates how medical professionals discourse around endometriosis patients still endorses notions of 'hysteria', particularly in patients deemed to be 'difficult' (Young et al., 2018). These were typically patients who had not found treatment helpful, or who had a different opinion of their disease to their clinician (Young et al., 2018). Research also demonstrates how endometriosis patients' accounts of their symptoms continue to be minimised by medical professionals, with accounts of menstrual pain and heavy bleeding being dismissed as 'normal' or 'in their head' (Culley et al., 2013; Denny et al., 2011; Grogan et al., 2018; Lemaire, 2004; Manderson et al., 2008; Plotkin, 2004; Randhawa et al., 2021; Requadt et al., 2024; Seear, 2009; Stanek et al., 2023). Such dismissal influences the diagnosis and treatment of endometriosis, with the average diagnosis time being 8 years 10 months within UK (Endometriosis UK, 2024). The dismissal and minimisation of menstrual pain and heavy bleeding is also reported in research on other menstrual-related conditions including uterine fibroids (Ghant et al., 2016; Katon et al., 2023; Sengoba et al., 2017; VanNoy et al., 2021), Polycystic Ovary Syndrome (Tomlinson et al., 2017) and dysmenorrhea (Chen et al., 2018; Ní Chéileachair et al., 2022; Söderman et al., 2019).

In her book, 'Issues of Blood', Laws (1990) discusses medical professionals views of menstruation and menstrual pain, noting the intersections between sexism, medical misogyny and racism in perceptions of who experiences pain and how severe the pain is. Menstrual pain is viewed in many ways including being psychosomatic, something that 'primitive' women do not experience, and something that only lazy, sedentary women experience. These harmful narratives therefore influence how seriously male medical professionals, most notably gynaecologists, view reported menstrual pain.

Similar evidence of sexism within medicine has been found in wider pain management practices, with women being less likely to be prescribed pain relief than men reporting the same symptoms within emergency care (Guzikevits et al., 2024). Within the UK, a 2024 report from the Women and Equalities Committee outlined the ongoing impact that medical misogyny has within the provision of women's health care, providing evidence of the continued dismissal of menstrual health concerns (Women & Equalities Committee, 2024). The intersections between sexism and racism in women's reproductive and sexual health experiences is also vastly documented (Abrahams et al., 2022; Birthrights, 2022; Cory et al., 2025; Howell, 2023; Perro et al., 2022; Rosenthal & Lobel, 2020). For example, Birthrights (2022) found that two thirds of respondents felt that their race, ethnicity or religion negatively impacted on their maternity care. Respondents reported racist stereotyping, microaggressions and race-based assumptions about risk levels during their birthing experiences. Racial and ethnicity differences have also been found within experiences of uterine fibroid care (Sengoba et al., 2017), with Black women being disproportionately affected by uterine fibroids and more likely to experience delays in diagnosis and worse clinical outcomes compared to white women (Katon et al., 2023). This is important to note within the context of menstrual health, as symptoms of uterine fibroids typically present as menstruation-related including heavy menstrual bleeding and increased menstrual pain. When examining the menstrual health experiences of UK Black women, Abrahams et al.'s (2022) study found that 92% of Black British women surveyed experienced barriers when accessing or receiving menstrual-reproductive healthcare. Barriers were attributed to lack of education or information, feeling dismissed by doctors and having a negative experience when seeking health support. Furthermore, a high proportion of respondents experienced heavy menstrual bleeding and significant menstrual and/or chronic pelvic pain.

Menstrual health care inequalities have also been highlighted in relation to disabled people, where menstrual suppression and sterilisation is favoured over menstrual management (Goldblatt & Steele, 2019; Wilbur et al., 2019). Disabled menstruators are also more likely to face barriers in accessing menstrual health education and health care, with carers also receiving inadequate training, information and support to be able to meet the menstrual needs of those they care for (Wilbur et al., 2019). The needs of transgender people who menstruate have also been neglected within healthcare settings, causing distress and gender dysphoria (Frank, 2020; Frank & Dellaria, 2020). For example, using menstruation as a 'marker' for measuring health (e.g. 'when was your last period?') or using menstruation as a reason to dismiss patient symptoms, have both been reported as increasing gender dysphoria (Frank, 2020; Frank & Dellaria, 2020).

3.6 Menstrual stigma

Menstruation is highly stigmatised within society, leading to negative physical and emotional implications for women and people who menstruate (Johnston-Robledo & Chrisler, 2020). Menstrual stigma, and the fear of being seen as menstruating, therefore leads those who menstruate to engage in self-policing behaviours to hide this (Wood, 2020). These behaviours allude to menstrual concealment and menstrual etiquette practices (Laws, 1990) including hiding menstrual products, wearing loose and/or dark clothing and skipping activities, such as swimming and other sports. Furthermore, some may choose to suppress their menstrual cycles and menstruation via the use of medication to avoid the perceived negative consequences of being seen as menstruating (Johnston-Robledo et al., 2003).

Ussher (2008) argues that the internalisation of menstrual stigma can negatively impact experiences of typical pre-menstrual symptoms, with self-policing practices and continued self-surveillance to conceal menstruation leading to self-blame and distress if symptoms are not well 'managed' (Ussher, 2008). Within such contexts, the pre-menstrual body does not conform to societal expectations of the 'feminine ideal', particularly within Western societies that perpetuate idealised notions of how women's bodies and behaviour should be (such as 'being thin' and 'in control') (Ussher & Perz, 2019). This internalisation of menstrual stigma, combined with societal expectations around femininity, is referred to as 'self-objectification' (Ussher & Perz, 2019). Self-objectification, self-policing and self-surveillance within the context of menstrual health are contributing factors that influence and shape how those who menstruate seek help for menstrual health concerns, with women seeking to 'control' symptoms and behaviours that fall outside of what is typically expected of them.

A key example of this relates to experiences of pre-menstrual changes and associated mood disorders, such as pre-menstrual syndrome (PMS). Disorders such as PMS can cause symptoms such as anxiety, irritability, anger, depression, a feeling of 'loss of control' and mood swings, often in conjunction with physical symptoms such as bloating, breast tenderness and headaches, that can occur up to 2 weeks before menstruation starts (Rapkin & Lewis, 2013). Although such changes are extremely common, there is variation reported across cultures in terms of severity and associated impact of such symptoms upon quality of life (Ussher & Perz, 2019). Within Western society, menstruation is constructed as a highly medicalised 'condition', leading those who menstruate to seek medical support for any symptoms that are viewed as undesirable or inconvenient, even if such symptoms are typical or common (Barnack-Tavlaris, 2015; Ford et al., 2025; McHugh & Chrisler, 2015). Thus the medicalisation of menstruation further creates a need to self-monitor and conceal menstruation, perpetuating menstrual stigma (Barnack-Tavlaris, 2015; Ford et al., 2025; McHugh & Chrisler, 2015). Indeed, cultures that view menstruation as ‘natural’, as opposed to Western ideals that menstruation (and associated symptoms) should be controlled and managed as a medical condition, have been found to report less pre-menstrual distress and less negative pre-menstrual moods than those within Western societies (Ussher & Perz, 2019). Thus echoing Chrisler’s (2017) position that menstrual experiences must be considered and understood within the context of women’s behaviour and what influences and shapes such behaviour, looking at broader sociocultural and structural factors as per Hennegan et al.’s (2021) definition of menstrual health.

3.6.1 Menstrual stigma and menstrual health support

Menstrual stigma has been found to negatively impact how menstrual health support is accessed, contributing to menstrual inequality across the globe. Studies demonstrate that menstrual stigma influences menstrual product accessibility. For example, Lukindo et al.’s (2022) Canadian study highlights how adolescents were embarrassed to ask for menstrual products, even when they were provided for free. Ha and Alam (2022) further reported that adolescent girls in Bangladesh also experienced barriers to accessing menstrual products attributed to menstrual stigma, with girls reporting feeling embarrassed to buy menstrual products. This embarrassment was made worse within the presence of other men within the premises, with some reporting they were too shy to ask a male shopkeeper for products.

Menstrual stigma, when combined with financial poverty, further creates additional stigma for those who experience period poverty. The effects of the dual stigma of poverty and menstruation lead to additional stress and anxiety for those who experience it (Briggs, 2021). Vora (2020) similarly describes the impact of the dual stigma of menstruation and poverty within the experiences of homeless menstruators in UK. The negative emotional consequences are further exacerbated by the additional stigma associated with being homeless, with women reporting feelings of shame, embarrassment and guilt (Vora, 2020).

Menstrual stigma has also been found to influence how menstruation is discussed within healthcare settings, with Seear (2009) arguing that ‘menstrual etiquette’ is a factor in why some women delay seeking help for their endometriosis symptoms, such as heavy bleeding and pain. Such symptoms were minimised and viewed as ‘normal’ by both women and healthcare providers, with women reporting feeling ‘embarrassed’ and ‘ashamed’ of the problematic symptoms they were experiencing (Seear, 2009). The role of menstrual stigma within help-seeking behaviours of endometriosis patients is also discussed by Kocas et al. (2023) who draw upon several studies to demonstrate the impact that stigma has upon those with endometriosis. Kocas et al. (2023) surmise that menstrual stigma, when combined with additional stigmas around chronic pain and infertility that many endometriosis patients experience, causes further mental distress for such patients.

Research also demonstrates that menstrual stigma impacts help-seeking health behaviours that are not related to endometriosis. For example, the normalisation of menstrual pain forms part of overarching menstrual stigma and shame that is perpetuated across different cultures, with those experiencing such pain being taught not to discuss it (Johnston-Robledo & Chrisler, 2020; Winkler et al., 2024). Åkerman et al.’s (2024) study on young people’s experiences of menstruation in Sweden further found that public stigma contributed to shame and worries around menstruating and also affected help-seeking behaviours (Åkerman et al., 2024). Recent research on the impact of menstrual stigma within the UK also discovered that 24% of adults surveyed do not feel comfortable talking to a doctor about menstrual health concerns (Irise International., 2025b). Similar findings were reported in another UK-based survey, which found that 37% of respondents were confident they could go to their GP with concerns about their menstrual health and be taken seriously (InKind Direct. et al., 2024), further demonstrating the intersections between medical misogyny and menstrual stigma discussed previously.

In addition to impacting the experiences of period poverty and menstrual health care, menstrual stigma has also been found to negatively impact the ability to participate in other spheres of life. For example, Plan International UK ‘s (2018) survey of young people within the UK found that menstrual stigma negatively influenced young menstruator’s body image and self-esteem. Furthermore, anxieties over visible menstrual blood during school negatively impacted their ability to concentrate within school lessons and limited their involvement in sports activities (Plan International UK, 2018). Menstrual stigma has also been found to have a negative impact upon the task performance of women within the workplace (Zaman & Mohiuddin, 2023).

3.7 Menstrual health within humanitarian crises

There is an increasing body of work that examines the impact of humanitarian crises upon sexual and reproductive health, including menstrual health. A humanitarian crisis is typically defined as “an event or series of events that represents a critical threat to the health, safety, security or wellbeing of a community or other large group of people, usually over a wide area” (Concern Worldwide, 2022, p.1). Much of the available research on menstrual health within such circumstances has focused on menstrual hygiene management and sanitation, with research on wider aspects of menstrual health, such as education, healthcare and menstrual stigma, being limited.

3.7.1 Period poverty

Within humanitarian crises, period poverty has been found to increase (Patel et al., 2022). During such crises, the availability and accessibility of menstrual products are negatively impacted, with safe, private spaces to change products and maintain cleanliness also becoming more difficult to access (Patel et al., 2022; Soeiro et al., 2021; Sommer et al., 2016). For example, Soeiro et al.'s (2021) study of Venezuelan adolescents and young migrants living in the northwestern Brazilian border further highlights how menstrual hygiene management needs within displaced communities are neglected. Their study found 46% of participants who menstruated had not received any menstrual products, 61% were not able to wash their hands whenever they wanted, and 76% did not feel safe to use the toilets.

The Covid-19 pandemic is recognised as a humanitarian crisis (Connell, 2020; United Nations., n.d.). Menstrual health research on the Covid-19 pandemic has predominantly focused on the impact of the virus/vaccinations upon the menstrual cycle. There are limited studies on period poverty and product accessibility, with wider aspects of menstrual health, such as education, healthcare provision and stigma receiving little attention. With the onset of the pandemic in 2020, much of the information around the impact of the pandemic on menstrual health and period poverty was reported within the media. For example, within the UK several articles cited period poverty non-profit organisations, such as Bloody Good Period and Freedom4Girls, who reported an increase in demand for menstrual products with the closure of places that would normally provide free products and the rise in financial insecurity attributed to pandemic job losses (BBC News England, 2020; Edlin, 2020; Moss, 2020). A report from Plan International UK released in 2020 examined the impact of pandemic lockdowns on the experiences of girls and young women, finding that 11% of those surveyed could not afford menstrual products. Of those struggling to afford products, 54% had used toilet roll, 11% used socks, 8% used other fabric and 6% had used newspaper/paper for makeshift menstrual products. The survey also found that of those that could afford products, 22% had struggled to access them during lockdown, with 64% stating they could not find them in shops (Plan International UK, 2020).

Globally, studies examining the effect of the pandemic on financial insecurity upon period poverty have found similar evidence, with more people struggling to afford menstrual products and resorting to using makeshift products during lockdowns as a result (Babbar et al., 2023; Garg et al., 2020; Holst et al., 2023; Murphy et al., 2024; Patel et al., 2022; Schmitt et al., 2023; Sommer et al., 2022; Wood et al., 2022). Studies also found that people were using the same menstrual product (e.g. a pad or tampon) for longer than recommended as they could not afford to purchase menstrual products (Murphy et al., 2024; Schmitt et al., 2023; Sommer et al., 2022). This was attributed to a reduction in income from pandemic-related job losses in several studies (Murphy et al., 2024; Schmitt et al., 2023; Sommer et al., 2022). Furthermore, Wood et al.'s (2022) research on young adolescents' and girls' experiences of menstruation during Covid-19 also found that the increase in pandemic-related financial insecurity that affected product accessibility was further exacerbated by the closure of buildings that would usually provide access to free menstrual products, such as schools. Changes in infrastructure due to Covid disease prevention measures, such as travel restrictions and building closures, were found to negatively impact the accessibility and availability of menstrual products in several studies (Babbar et al., 2023; DeMark et al., 2024; Murphy et al., 2024; Patel et al., 2022; Plan International UK, 2020). The failure to recognise menstrual products as essential items during lockdown was an additional factor that complicated the availability and accessibility of menstrual products during this time, with Babbar et al. (2023) finding that areas within India that were subject to the most stringent lockdown restrictions also reported the biggest decline in menstrual product distribution, further contributing to menstrual inequality (Babbar et al., 2023).

Although few research studies have examined the impact of the pandemic on those who *provide* menstrual products for those experiencing period poverty, several Covid-19 related seminars and media pieces at the beginning of the pandemic highlighted the barriers that period poverty initiatives were facing globally (Edlin, 2020; Rodriguez, 2020). Difficulties were attributed to social distancing and lockdown measures (e.g. lack of product availability due to stockpiling and closure of support services) as well as the emerging gender disparities in terms of wider Covid-related issues that have been discussed in the previous chapter (chapter 2). For example, Dana Marlowe, founder of 'I Support the Girls', discussed how school closures during lockdown had led to an increase in calls from young girls needing access to period products within USA (Rodriguez, 2020). Gaby Edlin, Founder of Bloody Good Period (England, UK), explained how they had received requests from frontline health workers who did not have the time or money to be able to buy menstrual products during lockdown, and whose workplace did not provide access to products (Edlin, 2020). Of the limited studies that do include accounts from menstrual health service providers, Tomlinson's (2023) study on British menstrual activist experiences highlights similar barriers associated with providing support during the pandemic. For activists who primarily focused on providing menstrual products to those in need, social distancing provided further challenges to engaging with affected communities, particularly if communities were not already aware of services (pre-pandemic). However, the pandemic also provided opportunities for activists to work with different organisations to provide menstrual products, such as food banks, while other community and local services remained closed.

Building on these initial accounts of period poverty experiences within the pandemic, several studies further examined wider menstruation experiences during the pandemic. For example, the menstrual experiences of frontline staff during the pandemic were included within global studies (Hazar et al., 2022; Kondapalli et al., 2022). Kondapalli et al.'s (2022) global survey of female health workers who wore PPE kit found that the symptoms most aggravated during menstruation while wearing PPE were rashes, itching, sweating and dehydration, with psychological symptoms like irritability and depression also being experienced. Hazar et al.'s (2022) survey of female nurses in Turkey also found that rates of depression and anxiety were higher in those who experienced irregular menstrual cycles during the pandemic.

These findings are in contrast to other studies that examined menstrual experiences during the pandemic, who found that those who could work from home found menstrual management easier during this time (DeMark et al., 2024; Holst et al., 2023). Within these studies, participants were less likely to be frontline workers and therefore did not experience the same complications related to PPE equipment or longer shift patterns in terms of menstrual management as those previously discussed (Hazar et al., 2022; Kondapalli et al., 2022). For those who could work from home, menstrual management was found to be easier particularly for those who experienced menstrual pain, as they were more comfortable (DeMark et al., 2024; Holst et al., 2023). Holst et al. (2023) also reported that participants found menstrual management easier as they were spending less time in public during lockdowns and could change their menstrual product more frequently than they would usually be able to when at work.

3.7.2 Menstrual health education and knowledge

Little is known about the impact of humanitarian crises on the accessibility and provision of menstrual health education. While menstrual health knowledge in women and girls displaced as a result of such crises has been found to be poor (Ivanova et al., 2019; Metusela et al., 2017), it is not clear as to whether this is because of displacement or poor education prior to being displaced. Furthermore, poor menstrual knowledge is not uncommon amongst women, girls and people who menstruate, as demonstrated previously within this chapter.

With the onset of the Covid-19 pandemic many educational establishments, such as schools, were forced to close. Within some countries, educational content was moved to digital, online settings. The consequences of shifting to digital provision within the context of menstrual health education were examined by several studies (Lindberg et al., 2020; Plan International, 2020; Sex Education Forum, 2022; Tomlinson, 2023). For example, Sex Education Forum (2022) found Relationship and Sex Education provision remained inconsistent across England during the pandemic, with 24% of young people surveyed reporting they did not learn about menstrual health at all during the pandemic. Similar findings were also reported by Plan International UK in their 2020 survey of global menstrual health providers, which highlighted how school closures negatively impacted the provision of menstrual health education particularly in areas where access to digital learning resources was limited (Plan International, 2020). Tomlinson (2023) also found that limits around access to digital technology during the pandemic was a barrier to accessing menstrual health education in educational and community settings, especially for those who are in already disadvantaged by factors such as race, disability or class.

3.7.3 Menstrual health care

Access to sexual and reproductive health is significantly reduced during humanitarian crises (Patel et al., 2022; Warren et al., 2015). Crisis responses within the Global South have mainly focussed on education and awareness campaigns to prevent disease such as HIV/AIDs and address other related factors such as gender-based violence, though little is known about the effectiveness of these strategies (Patel et al., 2022; Warren et al., 2015). In terms of gender-specific health concerns within humanitarian crises, gender-based violence and maternity care have been key priorities, while menstrual health care remains low priority despite an increase in awareness of the importance of addressing menstrual health within such circumstances (Sommer et al., 2016; UNICEF, 2020).

Of the few studies that have looked at menstrual hygiene management within humanitarian crises (Patel et al., 2022; Sommer et al., 2016), menstrual health care was not included. Wider studies on displaced women and girls experiences of accessing sexual and reproductive care demonstrates the uptake of such services remains low, with stigma and shame being key barriers (Ivanova et al., 2019; Metusela et al., 2017). For example, Metusela et al.’s (2017) study specifically mentions menstrual stigma as a barrier to accessing health-related support in migrant and refugee women within Australia and Canada.

Regarding the Covid-19 pandemic, few studies directly examined the impact of the pandemic on the provision and accessibility of menstrual health care, including both primary and secondary medical healthcare. However, studies examining the accessibility of wider reproductive and sexual health care during the pandemic found that access to such services was greatly reduced (Bosó Pérez et al., 2023; Lindberg et al., 2020; VandeVusse et al., 2022). Barriers to accessing care included self-limiting behaviours, such as not wanting to catch Covid or to burden already pressurised health services (Bosó Pérez et al., 2023), changes to how appointments could be accessed or booked (Bosó Pérez et al., 2023; Lindberg et al., 2020), not having privacy in the home for telemedicine appointments (Lindberg et al., 2020) and not having access to the necessary technology to access appointments (VandeVusse et al., 2022).

Of the limited studies that focused on menstruation experiences specifically during the pandemic, similar barriers to receiving healthcare during lockdown were reported (DeMark et al., 2024; Holst et al., 2023). DeMark et al.'s (2024) study of menstruation experiences in Italy during the pandemic found that participants had experienced challenges when accessing healthcare, although it is not clear how many participants had needed specific menstrual health support. Holst et al.'s (2023) study of menstrual experiences within Spain during the pandemic similarly reported challenges in accessing healthcare. However, Holst et al.'s (2023) study specifically asked about menstrual health care, with participants experiencing barriers to care due to changes in how health services could be accessed. Participants also reported dismissal of menstrual health concerns related to Covid-19 when seeking healthcare during the pandemic.

3.7.4 Menstrual cycle changes and Covid-19 virus/vaccinations

Within the context of disease prevention and management, including humanitarian crises such as epidemics and pandemics, there is limited research into the impact that vaccinations or viruses can have upon the menstrual cycle and menstruation-associated symptoms. However, there is evidence to suggest that the influenza vaccination can impact menstrual cycle regularity (Boniface et al., 2025), with further evidence suggesting that HIV and Ebola can similarly impact the menstrual cycle (Drogy et al., 2025; Harlow et al., 2000).

Despite the lack of research on menstrual cycle changes across a range of vaccinations and viruses, there is a wealth of research on the impact of the Covid-19 vaccinations and virus upon menstrual cycle changes. It is unclear as to why Covid-19 warranted more research than other forms of virus and vaccination, however, the media covered several stories of reported menstrual cycle changes as a result of both during the pandemic which may have prompted more interest (Schuster-Bruce, 2021; Sky News, 2021; Wilson, 2022).

Evidence suggests that both Covid-19 vaccination and virus can affect the severity of bleeding (heavier or lighter), regularity of menstruation, menstrual pain severity and mood-related symptoms (Al-Furaydi et al., 2023; Al-Mehaisen L et al., 2022; Chourasia et al., 2022; Dabbousi et al., 2023; Darney et al., 2023; Kumar et al., 2023; Lessans et al., 2023; Martínez-Zamora et al., 2023; Matar et al., 2023; Medina-Perucha et al., 2022; Mohr-Sasson et al., 2023; Qazi et al., 2023; Taşkaldiran et al., 2022; Tripathy et al., 2022). In addition to the direct effects of the Covid-19 virus and vaccination upon menstruation, several studies have also examined the impact that other pandemic-related factors may have had on the menstrual cycle during the pandemic, such as stress. Studies found that higher reported stress and anxiety during the pandemic was linked with menstrual cycle changes, including changes in regularity, heavier bleeding and increased spotting in-between periods (Anto-Ocrah et al., 2023; Aolymat et al., 2023; Bruinvels et al., 2021; Demir et al., 2021; Garg et al., 2022; Phelan et al., 2021; Takmaz et al., 2021). These studies demonstrate the various ways that the pandemic impacted the menstrual cycle and associated symptoms, adding further weight to the need to address menstrual health within pandemic responses.

3.7.5 Menstrual stigma

Within humanitarian crises, the impact of menstrual stigma has been discussed in several ways (Garg et al., 2020; Tellier et al., 2020), although the number of studies that include reference to menstrual stigma is limited. For example, Tellier et al. (2020) describe the impact of such stigma upon Ugandan refugee communities, with women feeling shame and embarrassment over washing and drying menstrual products in public and expressing worries over visible menstrual blood. This study is not specific to the Covid-19 pandemic, instead discussing the menstruation experiences of displaced communities. However, Garg et al.'s (2020) study describes how pandemic-related financial insecurity within India created additional barriers for college students who could not afford to buy menstrual products and had to use makeshift products, contributing to menstrual stigma. Students reported experiencing shame, insecurity and anxiety within such circumstances (Garg et al., 2020).

3.8 Research rationale

The literature review has discussed the gaps in menstrual health knowledge, specifically regarding the Covid-19 pandemic. Much of the available research has focused on the impact that the virus or vaccinations have upon the menstrual cycle, while research into other aspects of menstrual health during the pandemic have examined period poverty and menstrual hygiene management, predominantly within the Global South. Other factors included within Hennegan et al.'s (2021) definition of menstrual health, such as education, healthcare and menstrual stigma have been neglected within pandemic-related menstrual health research.

Furthermore, the research that is available on pandemic menstrual health experiences has focused on the experiences of those who menstruate, with those from who provide menstrual health support missing from the evidence. This lack of representation means we are not fully aware of all potential factors that can impact menstrual health support and menstruation experiences. This is especially important within the context of the pandemic as additional restrictions could have been imposed to stop the spread of infection that could affect service provision and availability, as well as previously discussed issues that may have affected funding and resource capacity.

This study therefore aims to critically examine menstrual health, which is gendered health inequality, within the context of the Covid-19 pandemic. To address the gaps in knowledge and address the menstrual health inequalities discussed within this chapter, this study aims to examine the experiences of those who menstruate in addition to those who provide menstrual health support by looking at wider aspects of menstrual health to identify what factors influenced experiences during the pandemic. CHP and feminist frameworks are therefore ideally suited to the study to critically analyse such factors and further identify inequalities exacerbated or created by the pandemic, adhering to their shared principles of addressing inequalities and promoting social justice.

3.9 Chapter summary

The chapter began by providing a rationale for why Critical Health Psychology and feminist approaches offer a suitable framework to examine menstrual health experiences during the pandemic. It explained how applying Hennegan et al.'s (2021) definition of menstrual health to the thesis further compliments this approach, as it allows us to critically examine factors outside of physiological menstruation that also contribute to menstruation experiences and menstrual inequality.

The chapter discusses limitations within current menstrual health research, which has predominantly focused on adolescent experiences of menstrual hygiene management within the Global south and patient experiences of accessing healthcare for menstrual-related health conditions such as endometriosis. There are therefore gaps in knowledge around wider factors that influence menstrual health as per Hennegan et al.'s (2021) definition, such as education, knowledge and the impact of menstrual stigma. Furthermore, the experiences of menstrual health service providers are often not included within menstrual health research, meaning it is unclear as to how factors that impact the provision of menstrual health support intersect, influence and contribute to the experiences of those who need menstrual health support and our understanding of them.

The chapter further focuses on menstrual health during humanitarian crises, highlighting gaps in research specifically related to menstrual health experiences during the pandemic. Where such research has been undertaken, studies are mainly quantitative, focussing on physiological changes experienced because of the Covid-19 vaccination or virus, or the impact of disease prevention measures on menstrual hygiene management practices within the Global South. As with wider menstrual health research, little research is available on additional factors that influence menstrual health experiences (such as education, healthcare and stigma) and much of the available research excludes the experiences of those providing menstrual health support.

The gaps identified within pandemic-related menstrual health research mean that we are not fully aware of all potential factors that can impact menstrual health support and menstruation experiences. This is especially important within the context of the pandemic as additional restrictions could have been imposed to stop the spread of infection that could affect service provision and availability, as well as issues that may have affected funding and resource capacity. To address the gaps in Covid-19 related menstrual health research and broaden our understanding of menstrual inequality during the pandemic, this thesis therefore applies a feminist, Critical Health Psychology framework to examine menstrual health experiences from the perspective of both service providers and those who needed menstrual health support during the pandemic. The following chapter further outlines this approach and the methods used to address the aims of the research study.

4 Chapter 4: Research design & methodology

4.1 Introduction

The previous chapter provided an overview of the available literature on menstrual health and the Covid-19 pandemic, discussing key topics imperative to understand the aims of the thesis within the context of Hennegan et al.’s (2021) menstrual health definition and framework for menstrual equity. The chapter also provided a rationale for how feminist Critical Health Psychology can contribute to an understanding of UK menstrual health experiences during the pandemic to address the aims of the study.

This chapter provides details of how data was gathered for the Periods in a Pandemic (PIP) project and re-analysed for the current study, providing justification for the various methodological aspects of the research. The chapter also discusses the impact of the Covid-19 pandemic upon the PIP project design and the ethical considerations of conducting research during this time. The chapter further explains the ontological and epistemological position of the research and why critical, feminist frameworks were chosen to address the research study aims. It explores how these frameworks were useful in addressing the ethical issues of undertaking research during a pandemic and provides an overview of the ethical approval process for the research. The role and contribution of the Project Advisory Group is discussed within this context, highlighting how the inclusion of key community representatives shaped the Periods in a Pandemic project research design and dissemination of findings.

The chapter describes the methodological approaches used to gather data for the Periods in a Pandemic project and explains how the data from the project was re-analysed to address the current study’s aims. It describes how critical realism was applied to the data analysis to examine underlying structure and mechanism that influenced menstrual health experiences during the pandemic. The chapter further provides an overview of the reflexive thematic analysis process applied to the qualitative data and how the quantitative data was analysed. A reflexive account of the researcher’s positionality within the research process, including the analysis, is provided.

4.2 Study aims & research questions

The current study re-examines data collected during the Periods in a Pandemic (PIP) project to examine the impact of the pandemic upon menstrual health experiences within the UK via the following research questions:

1. *How did the pandemic influence menstrual health support during lockdowns within the UK?*
2. *What were the experiences of menstrual health service providers during Covid-19 lockdowns and how did they deal with any challenges to providing support during these times?*
3. *What were the needs of women, girls and people who menstruate during the pandemic, in relation to their menstrual health?*
4. *What were the experiences of those needing to access menstrual health support during the pandemic and what factors influenced their decisions in seeking such support?*

The key research aims research questions for the current study reflect those of the PIP project (Williams et al., 2022). However, the current study aims to address gaps identified during the analysis of the PIP project, specifically to examine underlying, intersecting inequalities that influenced menstrual health support during the pandemic. By applying critical realism to the data re-analysis, the thesis aims to highlight how existing, underlying structures further intersect with specific pandemic-related factors to influence and shape menstrual health experiences during the pandemic, mirroring the core principles of Critical Health Psychology and critical, feminist research (Chamberlain & Murray, 2009; Cosgrove & McHugh, 2000; Lykes & Crosby, 2013). This chapter therefore provides an overview of the critical, feminist methodologies applied to the PIP project research design and data gathering, and a deeper explanation of how critical frameworks were applied to the re-analysis of the PIP data to examine and address the current thesis aims and research questions.

4.3 Research frameworks and methodology

The current study is positioned within critical realism, recognising that our understanding of the world is constructed from our own perspectives and experiences of what we observe, in addition to underlying structures and mechanisms that we cannot see (Albert et al., 2020; Fletcher, 2017; Galazka & O'Mahoney, 2021; Lawani, 2020). Critical realism assumes the existence of multi-layered realities, shaped by three levels: empirical, actual and real (Fletcher, 2017; Lawani, 2020). The first layer, the 'empirical', describes events as we experience (or 'observe') them, including our ideas, decisions and behaviours/actions. The second layer is then the 'actual' event that occurred, which exists independently of whether we have experienced the event. The final, third layer is then the ‘real’, which are the underlying, unobservable structures and mechanisms that cause the events that are then experienced at the empirical level (Fletcher, 2017; Lawani, 2020).

Critical realism is therefore useful to uncover deeper, structural factors to better understand our experiences of the world and our interpretation of reality. Furthermore, this epistemological framework provides a useful basis to understand these factors as a means to recommend suggestions to address social issues and tackle inequalities (Fletcher, 2017). Within the context of this study, critical realism informs a methodological framework to examine not only how the pandemic shaped menstrual health experiences but how other hidden structural inequalities influenced participant’s perceived realities at that particular time, with a view to recommend policy and practice recommendations to address menstrual health inequalities.

The PIP project utilised a mixed methods design, which is ideally suited within critical realism to examine the impact of the pandemic upon menstrual health experiences within the UK. Using both qualitative and quantitative methods provide in-depth, complimentary means to analyse and discuss data to answer the research questions posed, allowing for a richer understanding of underlying structures and unobservable causalities (Doyle et al., 2009; Fletcher, 2017; Lawani, 2020). Furthermore, mixed methods are increasingly used within health research, allowing researcher to use multiple methods to better understand complex issues (Doyle et al., 2009). The PIP project therefore applies Critical Health Psychology (CHP), Critical Feminist Research (CFR) and Feminist Community Psychology (FCP) methodologies to address its aims. This current study then applies critical realism to the analysis of the pre-existing data obtained from semi-structured interviews and online survey responses as part of the PIP project to understand menstrual health experiences during the pandemic.

Within critical frameworks such as CHP and CFR, qualitative research is often favoured (Ussher, 1999). Qualitative research aims to discover and explore new social contexts and perspectives, using strategies to obtain knowledge and develop theories (Uwe, 2014). Qualitative methods provide ways to overcome the power imbalance that exists between the researcher and the participant by facilitating openness, trust, care, and engagement, promoting solidarity amongst women and empowerment to promote social change (Lafrance & Wigginton, 2019). These are also important considerations within CHP and CFR methodologies, ensuring that research practice is reflexive, representative and intersectional, with a view to mobilize research for social change (Lafrance & Wigginton, 2019). The PIP project utilised semi-structured interviews and open-ended questions within an online survey to gather qualitative data, allowing participants to share insights into what factors influenced their menstrual health experiences during the pandemic without being constrained by pre-conceived ideas about what was important during the time.

Semi-structured interviews therefore provided an opportunity for participants to share their experiences freely, while covering the key topics needed to address the research questions (Brinkmann, 2020). This method allowed the researcher to facilitate trust and care with participants, addressing potential power imbalances via open dialogue (Lafrance & Wigginton, 2019). These were important for the researcher to address not only from an ethical perspective but in recognising the wider inequalities that influence menstrual health experiences such as gender, health, disability and ethnicity, reflecting the principles of feminist, critical research practice.

Online surveys that include open-ended questions are recognised as being an effective method to gain an in-depth understanding of the topic while being able to access more participants than typical qualitative interviews allow for (Braun et al., 2021). The use of such surveys are increasing in use within menstrual and reproductive health research for these reasons (Grogan et al., 2018; Sirohi et al., 2023). This method was therefore used within the PIP project to collect further data, widening the opportunity for participation and increasing the diversity of experiences represented in the data. Also, considering the restrictions within the UK around social distancing and travel during the pandemic, and ethical considerations around data collection at this time (discussed in chapters 4 and 5), the use of online data gathering was chosen as a suitable alternative for those who did not want to be interviewed. Furthermore, the use of online surveys within health research during the pandemic increased because of these reasons, facilitating research during constrained times (Hlatshwako et al., 2021).

The use of quantitative descriptive data, such as percentages, provides insight into how different factors affect communities and identifies any trends that warrant further investigation to better understand causality (Fletcher, 2017; Marshall & Jonker, 2010). Within the context of the PIP project, quantitative data was gathered for phase 2 of the project via fixed questions within the online survey to examine any trends in shared menstrual health experiences (e.g. how many people experienced financial difficulties accessing menstrual products). The quantitative data was therefore not used to generalise data or to identify correlations. Instead, the fixed questions within the online survey provided the means to quantify shared experiences, providing insight into trends that occurred in relation to menstrual health during the pandemic whilst recognising that individual experiences are influenced by other unobservable causalities.

This current study therefore re-examines the qualitative and quantitative data generated during the Periods in a Pandemic project to address the aims of the study. Using quantitative descriptive statistics to further support the qualitative data provides a richer account of how the pandemic shaped menstrual health experiences and deeper explores the underlying hidden structural mechanisms that also influenced such experiences. A more detailed description of the data analysis methods applied to the data follows in section 4.7.

4.4 Establishment of the Project Advisory Group

Critical and feminist methodologies, such as those applied to the PIP project, have been criticised for being idealistic in their aspirations of addressing social change and offering no practical realistic solutions to create change (Martin, 2003). To address these criticisms, the PIP project applied the Feminist Community Psychology principles of participatory or 'community' research, ensuring that the research focused on the needs and priorities of all involved in the research, addressing problems identified by the communities involved to provide solution-focussed actions (Lykes & Crosby, 2013). The project therefore involved affected communities within the research process, design and dissemination of the project, including them decisions around how they wanted their experiences to be heard and who they wanted to hear them (Cosgrove & McHugh, 2000).

In line with FCP principles, the decision to set up a Project Advisory Group (PAG) to act as advisors throughout the duration of the project was born from initial discussions and questions over the ethics of conducting research *about* the pandemic *during* the pandemic. Furthermore, to meet the funder requirements around the rapid sharing of information during the pandemic the group's links to the menstrual health sector and wider involvement in addressing gender inequality meant they were ideally positioned to advise on how best to share information in a meaningful, impactful way that could facilitate change. The Project Advisory Group were therefore crucial in shaping the PIP project's research aims and the key research questions, ensuring that the research benefited affected communities with a view to influence and create social change to address menstrual health inequalities within the UK. These are core principles of FCP and CHP which aim to reflect the needs of communities and address existing inequalities via research practice and outcomes (Chamberlain & Murray, 2009; Cosgrove & McHugh, 2000; Lykes & Crosby, 2013).

The PAG were also pivotal in the decision to include quantitative methods and descriptive statistics within the PIP project design, analysis and dissemination, informing the researcher that these are often used by service providers within the menstrual health sector to demonstrate the need for and uptake of services as part of organisational accountability and funding requirements. It was therefore important to capture evidence in this way, so service providers could reference the information in ways meaningful to their own practices, mirroring the principles of FCP. This further enabled the affected communities involved in the project to ensure that their voices were heard in the ways that they had chosen (Cosgrove & McHugh, 2000; Lafrance & Wigginton, 2019; Lykes & Crosby, 2013).

The PAG's purpose was to ensure that data gathering continued to be mindful of the changing landscape of the pandemic and address the project aims, and to assist with the dissemination of the analysis to affect social change and tackle inequalities exacerbated by the pandemic, reflecting crucial elements within the critical, feminist frameworks applied to the project. The group comprised representatives from key UK-based strategic NGOs committed to gender equality, which pledged to make women and girls more visible within the pandemic: Fawcett Society (West Midlands), Periods Matter, Irise International and Plan International UK. Periods Matter, Irise International and Plan International UK also conduct work to address menstrual health inequalities within the UK and were ideally placed to provide insights into this area. The group were consulted at key stages during data gathering to provide advice on the research design, topic areas and questions to be asked during data gathering and recruitment strategies. The panel also helped to share key messages from the analysis across their networks as part of the ongoing dissemination funder requirements, to share information that might help address the needs of those experiencing period poverty or problems with their menstrual health during the pandemic. The PAG were therefore an instrumental part of the research following the principles of the critical, feminist methodologies applied to the study, providing a way to ensure that relevant communities were included and represented in all aspects of the research and that project findings were shared to help affect social change during the pandemic.

This was especially pertinent to be able to conduct the study within a critical framework and to ensure that the analysis was useful to address the increasing inequalities exacerbated by the pandemic. The ongoing dissemination throughout the project further strengthens the collaborative, feminist approach adopted by ensuring that key messages from the analysis and identified best practice were shared with those on the frontline of tackling menstrual health inequalities within the UK and globally. This was of high importance given the lack of specific guidance and policy regarding menstrual health support within the Covid-19 pandemic, and the increase in demand that services were experiencing.

Although the PAG disbanded after the PIP project ended, the insights and expertise that the PAG provided throughout the project shaped the research aims and questions for the current re-analysis of the PIP data for the purposes of the thesis. The research aims and key research questions for the current study reflect those of the PIP project, recognising gaps in PIP project analysis which did not examine underlying, intersecting inequalities that influenced menstrual health support during the pandemic in any depth. Indeed the re-analysis aims to specifically examine gaps in the PIP project's findings, through a critical realist lens, to identify wider, unseen factors that impacted menstrual health experiences during the pandemic. This approach to re-analysis further compliments principles of Critical Health Psychology and the critical, feminist methodologies applied to the PIP project, highlighting how existing inequalities (such as gendered health and menstrual health inequalities) influence and impact the experiences of those providing and seeking menstrual health support.

4.5 Dissemination strategy

In recognition of the lack of evidence and guidance relating to menstrual health support within a pandemic, and to meet the funder requirements around rapid sharing of information, the Periods in a Pandemic project included ongoing dissemination of the analysis to those providing frontline support and services to those impacted by period poverty or who experienced problems accessing menstrual health support. This helped to share best practice and facilitate discussions between services that could provide support or resources as needed. By providing timely updates to those directly working to support people experiencing period poverty or problems accessing menstrual health support, the project aimed to facilitate social change by sharing best practice and a forum for people within the sector to connect and forge links to access resources, in line with FCP principles (Cosgrove & McHugh, 2000; Lykes & Crosby, 2013).

Regular dissemination was adopted throughout the project in recognition of the lack of evidence and guidance specifically related to menstrual health support within the UK during a pandemic and in acknowledgment of the exacerbation of existing inequalities related to Covid-19, particularly around gender and the visibility of women and girls within government responses. Sharing the analysis across a variety of channels was a key element in keeping with the frameworks adopted for the project, in recognition of the need for social change and the development of solution-focussed actions to address identified problems (Cosgrove & McHugh, 2000; Lykes & Crosby, 2013).

Dissemination methods were varied to ensure greater accessibility and that relevant Covid-19 restrictions were adhered to. Most of the dissemination took place via online means, via social media or remote access/online events, which suited the needs of those who the information was aimed at – mainly those working within the menstrual health/menstrual activism sector in some capacity or that had a specific political or strategic interest in the subject. Using social media to disseminate information is extremely common within the menstrual activist space, for example, and a considerable number of services had moved to using online platforms during lockdown (such as Zoom or MS Teams) to keep in contact with service users. Social media allowed the information to reach many communities and services and for the information to be shared further via reposting. Information about the study was shared via Facebook and Twitter (X) predominantly. Utilising social media for this study helped to develop the researcher's links and profile within the menstrual health community, which assisted with the development of the study to ensure the research aims were being addressed.

During phase 1 data gathering, participants were asked if they were happy to be contacted about the research in the future, so those who had given their permission to be contacted were sent updates via email. Those that were sent emails were also given the option to ask to be removed from the 'mailing list' at any time. Emails were sent via the 'Bcc' function to maintain anonymity and to avoid spamming/reply all responses. Sharing information via email was useful, as people could share this easily with those that would find the details helpful and forward the information, as necessary.

The PAG were also key in helping to share information at different points throughout the project. The group met bi-monthly to ensure that the research aims were addressed and to keep informed of any challenges or issues that the researcher needed their input on. Any key messages from the analysis were shared within these meetings and the minutes/recordings of the meetings were shared to keep a record of any agreed actions and to keep those that could not attend updated. The PAG were able to further share such messages across their own organisations and relevant networks/contacts, including those involved in local and national policy and strategy.

The final method of dissemination were the online seminar events that happened after each stage of initial data analysis had been completed. These events not only included the researcher's analysis but invited speakers from within the menstrual health activist and advocacy sector to share their own insights and experiences of continuing to support those that needed help with their menstrual health during the pandemic. Events were free and open to the public as well as those within relevant sectors and were advertised via social media, the researcher's networks, the PAG and those that had been invited to present who also shared the details via their own social media/networks. Two events were held over the duration of the project, one focused on phase 1 and one on phase 2 analysis. The events consisted of several 20-minute presentations, with time for audience question and answers and a final 20-minute panel discussion on key messages to take forward. Copies of presentation slides and recordings were then shared via email to those that had signed up to the event and posted to a YouTube channel for anyone to view.

Using a variety of ways to disseminate the analysis allowed the information to be accessed by a wider audience, contributing to discussions happening across the menstrual health advocacy and activist sector across the UK and globally. Although the impact of this is difficult to ascertain, the engagement via social media and online dissemination events further enriched the research design and dissemination plan, reflecting the key principles of the frameworks adopted by the researcher to address the project aims. For example, organisations and attendees shared reports, articles and news media reports within social media posts and event chat functions that the researcher then referred to as part of determining topic areas for interviews and survey questions.

4.6 Applying a phased data gathering approach

To further facilitate participant engagement and ensure that the project aims and research questions were addressed within the context of the emerging pandemic, data gathering for the PIP project was planned across a 12-month period taking place over two phases (August 2020 to August 2021). During this time, the UK went through several lockdowns and phases of relaxation in Covid-19 restrictions, regarding face-to-face contact and travel, with most of this period involving significant social distancing. To be able to meet the necessary Covid-19 restrictions and gather data, flexibility was crucial as situations and plans could change within a noticeably short space of time. It was therefore decided that a 2-stage data gathering plan would be the most practical approach to data gathering within the pandemic as it allowed greater flexibility and acknowledged the frequency of Covid-19 restriction changes.

In agreement with the PAG, it was decided that Phase 1 would focus on the experiences of those providing menstrual health support and Phase 2 would focus on the experiences of those needing support with their menstrual health. Furthermore, the analysis of Phase 1 would help to inform Phase 2 in terms of key topics to address, participant recruitment and data gathering methods, in recognition of the emerging pandemic situation and changes within the UK to minimise the spread of Covid-19. A more detailed description of each phase of the project is provided in chapters 5 (Phase 1) and 6 (Phase 2).

4.7 Data gathering

The PIP project used mixed methods to examine the impact of the pandemic upon menstrual health experiences within the UK. Both phases use semi-structured interviews and online surveys (open and fixed questions) to gather data to answer the research questions. A more detailed description of data gathering for each phase of the project can be found in chapters 5 (Phase 1) and 6 (Phase 2).

Adopting a phased approach to data gathering and analysis allowed the researcher to meet the needs of those being recruited to the project, whilst adapting to the unpredictable nature of the social distancing and Covid-19 restrictions imposed upon various parts of the UK and adhering to government and BCU guidance/policies. By using the lessons learned from phase 1 to inform how phase 2 was undertaken and if any new research questions should subsequently be addressed, this allowed the researcher to ensure that the research was reflecting the emerging pandemic situation within the UK, mirroring the challenges reported by those providing menstrual health support.

4.7.1 Phase 1 data gathering: service providers

Phase 1 involved telephone or online semi-structured interviews with ‘experts’ from menstrual health service providers across the UK. The term ‘menstrual health service provider’ has been applied throughout the thesis to capture the range of services that are offered by those provide menstrual health support. These include organisations that provide specific support for menstrual health, such as period poverty initiatives, and those who provide access to menstrual health support as part of a broader service, such as food banks, schools and community centres who provide menstrual products. The term ‘menstrual health service provider’ therefore recognises that there are many ways to support menstrual health, as per Hennegan et al.’s (2021) definition, and as such moves away from previously used language within the menstrual advocacy sector that has focused on menstrual hygiene and period poverty.

Participants were recruited via the researcher's existing networks, social media advertisements and snowballing (Sadler et al., 2010). This stage of data gathering happened during the first major lockdown period within the UK, when it was not possible to travel to other parts of the country and where face-to-face contact with those outside of your 'bubble' was prohibited (Roberts, 2021). Telephone and online data gathering methods worked well within these circumstances, however as the increase in demand for menstrual health support and period products continued across the UK it became more difficult to recruit people to be interviewed. The decision to introduce an online survey to be circulated to service providers was therefore made as a quicker alternative for service providers to enable their participation. Survey respondents were also offered the opportunity to be interviewed if they chose to. The proposal to add the survey was checked with the PAG and with some of the service providers that had already been interviewed to ensure that it was a realistic and accessible way to obtain further data.

4.7.2 Phase 2 data gathering: those needing menstrual health support

For phase 2 of data gathering, the decision to use an online survey as the main source of data gathering was made considering ongoing social distancing and travel restrictions across the UK and feedback obtained from service providers during phase 1. The survey included open ended and fixed questions to capture both qualitative data and quantitative, descriptive statistics, providing an overview of shared occurrences and a more in-depth description of menstrual health experiences during the pandemic. Creating an online survey that services could send out to service users (and paper copy alternative for those without sufficient internet or phone access), with the option of being contacted for a follow-up telephone interview, was deemed to be the most suitable way to engage with service users. Several service providers stated they had experienced issues around online/telephone engagement due to digital poverty and lack of privacy that many of their service users had been struggling with. Moving semi-structured interviews and/or focus groups to telephone or online interviews was therefore not an accessible option for many service users.

Using an online survey, with the option of a follow-up interview, therefore addressed some of these barriers by offering privacy and the ability to complete the survey at their own pace either via smartphone, internet or via paper. Instead of using the allocated funding to purchase recording equipment and pay for travel/expenses, the monies were set aside for printing and postage costs if any services wanted to send out paper copy questionnaires and self-addressed envelopes to those who did not have access to the online survey. As with phase 1, the PAG were consulted on how best to accommodate the changing pandemic situation to ensure that the way data was gathered minimised the burden on participants and that participation remained accessible. They were also consulted on the best way to share the online survey, with social media also being identified to gather data.

The use of the online survey as the main source of data for phase 2 was not what was originally proposed. As this stage of data gathering was to take place after Phase 1 and the most stringent lockdown periods, it was hoped that UK Covid-19 restrictions would have been relaxed enough to be able to conduct face-to-face data gathering as the pandemic became better controlled. Phase 2 of data gathering was originally planned to be undertaken in conjunction with service providers (who had taken part in phase 1). Providers would recruit participants and assist with data gathering in accordance with the ethos of FCP and collaborative research principles. A proportion of funding to be able to support services with this had been allocated to be able to provide funds for recording equipment, participant incentives and any travel/other expenses incurred. The researcher had proposed to work with services to develop their skills to assist with data gathering (e.g., online surveys, interviews, focus groups), ensuring quality whilst gathering data and adherence to BCU's data protection and storage requirements. The original plan was to obtain data from 15-30 service users, across the UK, depending upon data gathering methods to be used. Data gathering was mainly to be face-to-face, as services would be routinely working with service users within their settings.

The original data gathering plan for phase 2 had to be significantly altered due to the ongoing pandemic situation within the UK and variations between England, Wales, Scotland, and Northern Ireland in terms of social distancing and travel restrictions (Shearing & Lee, 2021). A benefit of gathering data in phases meant the researcher was able to speak to services and the PAG about phase 2 of the study to seek their advice on whether it would be possible within their current working practices. As a result of service provider feedback, the researcher used a mixed methods online survey (comprised of fixed and open questions) and semi-structured telephone interviews to gather data for this phase (see chapter 6 for further details).

4.8 Analysis for each phase of data gathering

For both phases, semi-structured interviews conducted by telephone were recorded using audio recorder. Online interviews were conducted using MS Teams and recorded within the MS Teams platform. Audio and video recordings were sent to an external transcription company which has been approved via BCU procurement processes. Recordings were transcribed verbatim and returned via the company's secure portal, within a fifteen working day timescale.

For the current study, transcripts from both phases were thematically analysed (Bickman & Rog, 2008) using NVivo12 software. For the online survey data analysis in both phases, the responses were saved within the Online Surveyv1 software and exported into Microsoft Excel spreadsheets for thematic analysis of open-ended questions within NVivo12. The analysis of the qualitative data was undertaken according to each individual phase to examine the data in accordance with the relevant research questions. For phase 2, descriptive statistics were produced within Online Survey software for fixed questions to illustrate response frequencies as percentages. These provided an overview of shared experiences of those needing to access support for their menstrual health, for example, how many people needed to speak to a GP about their menstrual health during lockdown/s.

Reflexive thematic analysis (RTA) was applied to the qualitative data for each phase. This allowed the researcher to determine the outcome and focus of the work without being bound to a specific theoretical framework (Campbell et al., 2021), whilst still being able to use a critical lens. Furthermore, RTA is ideally suited to critical analytical approaches that work towards addressing social inequalities and improving social justice, which are key values within the critical, feminist frameworks applied to this study (Lawless & Chen, 2019). RTA was therefore applied to both semi-structured interviews and open-ended survey responses with the data from both sources being combined to identify and craft the final themes. The decision to combine data for the re-analysis, as opposed to conducting separate analysis for both types of qualitative data, is centred around the research questions and the overall aim of critically examining how the Covid-19 pandemic influenced menstrual health support in the UK. In order to better understand what factors contributed to menstrual health experiences during this time, in recognition of the wider socio-economic factors that can influence menstrual health (Hennegan et al., 2021) and the increase in inequalities exacerbated by the pandemic (CARE & United Nations., 2020; Carli, 2020; Dang & Viet Nguyen, 2021; de Paz et al., 2020; Delanerolle et al., 2023; European Institute for Gender Equality, 2020a; Menta, 2021; Weiss-Wolf, 2020), combining the data provides a richer and more diverse bank of experiences to draw from. Thus, providing sufficient information power to meet the aims of the study (Braun & Clarke, 2021). Combining the data for re-analysis further allows for a more comprehensive and holistic insight into the myriad of intersecting inequalities and pandemic-related factors that influence menstrual health support during the pandemic, in keeping with Critical Health Psychology principles of addressing existing inequalities to promote social change (Chamberlain & Murray, 2009; Murray, 2015). Furthermore, both data gathering methods include similar questions and topic areas to address the research questions for each phase, but use different modes to gather responses from participants to meet the ethical and practical implications of gathering data during the pandemic (see section 4.10 for further details of the ethical implications related to data collection). They are therefore not designed to be able to compare data between the different methods, but compliment each other in their shared aims and research questions to provide a more in-depth understanding of underlying structures and causalities via RTA and the application of critical realism to the re-analysis (Doyle et al., 2009; Fletcher, 2017; Lawani, 2020).

Applying critical realism to the reflexive thematic analysis aims to provide a rich account of menstrual health experiences and does not attempt to make the data fit into existing theories. The primary goal of critical realism is to explain events via causal structures, examining the effects such structures can have upon our multi-layered 'reality' (Fletcher, 2017). The RTA was therefore guided, not constrained, by the relevant research questions for each phase of the study to construct the final themes described in chapters 5 (Phase 1) and 6 (Phase 2) and provide a description of reality via the experiences of participants during a specific event (i.e. the pandemic).

Using Braun & Clarke's 6-step approach to RTA (Braun & Clarke, 2006, 2019), an inductive approach was used to generate themes directly from the pre-existing data without being constrained by the questions asked of the participants. Interview transcripts and qualitative survey responses were therefore analysed together to craft themes for each phase to address the research questions for each phase and the overarching study aims. This allowed for a more in-depth analysis of the experiences of those providing and accessing menstrual health support during the pandemic, providing insight into how the pandemic and other factors influenced such experiences.

Firstly, the researcher re-familiarised themself with the qualitative data obtained from the semi-structured interviews and open-ended survey questions. This was especially important to do as the transcription of the interview data had been completed by an external agency. However, as this current study is a re-analysis of the data gathered from the Periods in a Pandemic project, which the researcher led, the researcher had previously examined the data from the project and was therefore already familiar with it. The researcher then generated the initial codes based upon keywords and phrases that were pertinent to the research questions, conducting line-by-line analysis of both interview transcripts and open-ended survey responses to identify relevant data which was then combined to generate the initial codes . Ideally a keyword or phrase will occur multiple times across a data set, however, a higher prevalence of the word or phrase does not necessarily mean that it is of higher importance. The keyness was therefore useful to consider, as it offered the opportunity to assess the importance of the keywords and phrases within the context of the research questions to examine the pandemic's influence on menstrual health experiences in the UK (Braun & Clarke, 2006; Campbell et al., 2021). It was also important to consider the context of the keywords and phrases within initial code development and how the examples described by participants contributed to addressing the research questions. For example, the phrase 'period poverty' was used by most service providers within phase 1, indicating high prevalence and importance. However, the phrase was not discussed within the same context across the data for phase 1, with some using the phrase to describe an increase in awareness of menstrual inequality during the pandemic and others using it to describe the aims of their work or how period poverty is linked to financial poverty. When used within the context of financial insecurity, the phrase 'period poverty' therefore then developed into the initial code of 'financial insecurity/period poverty' (see Appendix N for further examples and mapping of themes for phase 1).

Keywords and phrases were then grouped and organised to form initial codes, reflecting the context of how they were described within the data to provide a more robust description and reflection of the relationships between the data. These codes were then grouped to craft meaningful themes which provided more in-depth areas of understanding, encompassing wider elements around inequalities, relationships, and dependencies to develop a richer picture of the data, addressing both keyness and prevalence. For example, all service providers in Phase 1 discussed experiencing an increase in service demand during lockdown (prevalence), but not all mentioned the opportunities this provided to raise awareness of period poverty. However, being able to raise awareness of period poverty was seen as a positive outcome of the pandemic's impact and was therefore important in its 'keyness', forming the sub-theme *'Positive progress and new* *opportunities'* within the final theme "*It's kind of forced everyone to re-look at the way that we do things."*: overcoming barriers to continue menstrual health service provision during lockdown (see Appendices N and O for examples of RTA mapping).

Another crucial element of reflexive thematic analysis is deciding whether themes will be descriptive (semantic) or interpretive (latent). Descriptive themes summarise what was explicitly said whereas interpretive themes offer underlying ideas, assumptions, or conceptualisations of the data. The analysis of the data for this study uses both descriptive and latent themes to both summarise and further interpret experiences of menstrual health support during the pandemic. While Braun and Clarke (2006) typically favour using either descriptive or interpretive themes consistently, within critical realism frameworks using both allows for the examination of data that describe experiences of events (descriptive themes) and the underlying causality of the events being described (interpretive themes) (Fryer, 2022). Furthermore, using latent, interpretive themes in addition to descriptive themes provided a way to critically examine and interpret data in line with the critical frameworks applied to this study. For example, to address the following research question: "*What were the experiences of those needing to access menstrual health support during the pandemic and what factors influenced their decisions in seeking such support?"* the latent theme of *"During a pandemic, my concerns about my periods seemed frivolous": seeking menstrual health support during the pandemic'* (chapter 6.8.4) further captured experiences of accessing menstrual health care but these were interpreted within narratives of menstrual stigma, demonstrating how society's attitudes towards menstruation impact on health seeking behaviours (Seear, 2009). Once initial themes were established, they were reviewed to ensure that data was correctly coded, minimised duplication and assessed relationships between themes. As with code generation, the keyness of a theme was considered during the final theme generation, to assess the extent to which it addresses the research question (Braun & Clarke, 2006; Campbell et al., 2021). The researcher therefore discussed the development of the initial codes and sub-themes into final themes with their supervisory team, to ensure that final themes addressed the research questions and accurately reflected participant voice to ensure the validity and trustworthiness of the analysis (Braun & Clarke, 2023; Braun & Clarke, 2024). Once the review was complete, the final theme names were established to ensure the keyness and relationship/s between each theme were clear, drawing analytic conclusions across themes to address the research questions. Further details regarding the final themes for each phase of the study can be found in chapters 5 and 6, with examples of the analysis process provided in appendices N and O.

During the reflexive thematic analysis undertaken for the current study, owing to the principles of Critical Health Psychology and critical feminist research applied to the research that centre participant voice, intersectionality and addressing structural inequalities, the researcher consciously decided to highlight experiences of historically minoritised groups and the voices of those missing within menstrual health research. These include reference to the experiences of chronically ill and disabled people and South Asian communities. Although the diversity of experiences described by participants may not have been a key theme within the analysis, in terms of prevalence, these experiences were crucial to include as they demonstrate the different ways that inequality presents itself within the context of menstrual health support and the pandemic. Thus, the inclusion and representation of a diverse range of experiences within the analysis was integral to addressing the study's aims.

4.9 Researcher positionality and reflexivity

It is important to discuss researcher positionality and reflexivity within the context of the overall study, and each phase of the PIP project. Reflexivity and positionality are important aspects for the researcher to explore, particularly when examining inequalities and ensuring that the research addresses the needs of the community involved (Lawless & Chen, 2019). Reflexivity is pivotal to feminist, critical research (Martin, 2003) and to reflexive thematic analysis (Braun et al., 2022) and acknowledging any potential for influencing the study design and/or analysis is therefore crucial. For these purposes, I will write in the first person in my role as 'researcher'. I am a well-educated, 'middle-class', white cisgender woman who is presently employed by an academic institution. I also menstruate and have had problems in accessing healthcare to support my own menstrual health. These factors influence and shape how data is gathered, interpreted and analysed, consciously and unconsciously, and are important to acknowledge.

My employment history is largely research and evaluation focused, within both public and academic sectors, and I am familiar with working with third sector and non-profit organisations because of my career background. My more recent academic work has focused on period poverty and menstrual health and I have an established relationship with many of the organisations and service providers involved within this phase of the research. I would position myself as an 'insider researcher' for these reasons (Dinçer, 2019). I am aware that this could lead to 'over familiarity' between myself (as researcher) and the interview participant that could influence the questions asked and lead to assumptions being made about responses given (Hockey, 1993). This could also have led to some organisations and services feeling 'obliged' to take part in the research, impacting their ability to provide informed voluntary consent.

Being an ‘insider’ within this context can, however, help with establishing rapport with participants and encouraging them to share the research with other organisations to aid with recruitment and therefore widen the reach of the research (Saidin, 2016). As I was conducting research during a pandemic while services were experiencing large increases in demand for their support, I feel that my ‘insider’ status and the trust that I had already established with many of the organisations and services made them feel more comfortable with taking part and that their input was valued, as opposed to feeling like a waste of their time (which was often very limited). Furthermore, my ‘insider’ status was helpful in addressing the ethical considerations posed by conducting research during an emerging pandemic situation. The establishment of the PAG helped to expand my awareness as an insider researcher as I was able to involve those working more directly with services and service users in the research design, analysis and dissemination.

The menstrual health research and advocacy sector is predominantly a space for white, middle-class, cisgender women (Weckesser, Randhawa, et al., 2019) of which I am one. This is reflected within the sector also in terms of how experiences are represented, who is visible and whose voices are centred when talking about menstrual health and period poverty. I am aware that my positionality influenced the research questions asked, who they were asked of and how they were asked. Again, the PAG was helpful in addressing this as it allowed for a greater representation of service providers to approach to take part in the research, in terms of geography and service users. The services that took part within this phase of the study were also invaluable in helping to shape the research methods to improve the accessibility of taking part and in encouraging others to participate, further widening the representation of participants.

My positionality will have also influenced my analysis of the data gathered, with my own experiences and my knowledge about menstrual health and period poverty within the UK shaping what I considered to be important to include within the analysis. Furthermore, my positionality influenced my interpretations and assumptions regarding the meaning of data and participants descriptions of their experiences. My own interpretations may therefore not match what the participant experienced, meaning that I have applied my own ideas and decisions to create a different version of reality. For example, some service providers described providing ‘discreet’ packaging for menstrual products as part of promoting dignity for those who menstruate. However, I have interpreted this within my understanding of menstrual stigma and ‘menstrual concealment’, which reinforce secrecy and shame around menstruation, and therefore do not view this as a way to promote dignity. I have therefore examined this practice through a critical lens, as opposed to the positive way it was described by participants.

4.10 Conducting research during the Covid-19 pandemic: ethical considerations

When conceptualising the research questions, it was important to consider the ethical dilemma posed by conducting research about the impact of a pandemic *during* the pandemic in question. It was therefore important to consider the Covid-19 pandemic within the context of humanitarian crises and ‘disaster research’ (Mezinska et al., 2016), while assessing the ethical implications of conducting research within a global disaster. A ‘disaster’ is defined as “phenomena caused by environmental events or armed conflicts that lead to fatalities, injuries, stress, physical damage and economic breakdown of great significance” (Mezinska et al., 2016, p.1). The inclusion of contagious infections or viruses within the category of ‘disaster’ is widely accepted, as these are often ‘by-products’ of natural events or armed conflicts that have had significant impact (Suk et al., 2020). Although the Covid-19 pandemic did not occur because of these types of events, the global scale and significant societal impact mirror those within Mezinska et al.’s (2016) definition. Indeed, the Covid-19 pandemic is recognised to be a humanitarian crisis (Concern Worldwide, 2022; United Nations., n.d.), being referred to as a social disaster in addition to a medical one (Connell, 2020). As such, the pandemic is acknowledged under the remit of disaster research.

Disaster research seeks to describe the challenges and the impact of the disaster/s in question, with a key outcome of identifying lessons learned in readiness for similar events occurring in the future. Disaster research has historically focused on why and/or how disasters have occurred, but an increase in understanding the impact upon the human population in terms of psychological and psychosocial well-being continues to grow (Ferreira et al., 2015). It was therefore imperative that the ethical considerations of disaster research were incorporated into the research methodology and design of the Periods in a Pandemic project, and that the potential social and medical implications for both participants and the researcher were addressed to minimise risk of harm.

To do this, several ethical guidelines and recommendations were consulted, specific to conducting research within the Covid-19 pandemic. Ethical issues pertinent to this study included minimising the risk of infection amongst participants and the researcher (World Health Organisation, 2020), whether the research could be undertaken post-pandemic to address the aims of the study (cost versus benefits) (Buckle, 2021;

Vindrola-Padros et al., 2020), minimising participant 'burden' and the risk of psychological harm to those involved (Buckle, 2021; Shuja et al., 2020) and how data could be gathered and disseminated within the parameters of any local or national/international guidance or laws (World Health Organisation, 2020).

Throughout the duration of the PIP project data collection, the researcher adhered to UK government Covid-19 laws and restrictions around social distancing and travel, in addition to institutional guidance around data gathering during this time. Face-to-face data gathering was not permitted during the study, and travel was also prohibited, which impacted the methods used to gather data and how analysis were distributed. These factors helped minimise the risk of spreading Covid-19 to the researcher and participants.

In keeping with the feminist research frameworks applied to the PIP project, it was particularly important to consider how the extra burden of taking part in a research study might impact on service providers. Most of the period poverty and (non-medical) menstrual health support within the UK is provided by women-led third sector organisations, many of whom are run by volunteers. During the pandemic, these services were further stretched and experienced an increase in demand for their support while trying to adapt their own service provision to mitigate any Covid-19 related restrictions imposed by the UK government. The researcher consulted with several non-profit organisations within the UK that deliver support to those experiencing period poverty about concerns over participation burden and appropriateness of the timing of the research. The researcher has conducted research within the area of period poverty and menstrual health for several years and has an extensive network of contacts they were able to consult. Those consulted were keen for the research to be undertaken as they felt it would be helpful to have the impact of the pandemic documented and 'evidenced,' that could be cited in future funding applications, or if seeking additional resources. These benefits outweighed the potential costs of undertaking research during the pandemic, strengthening the case for conducting the study during the pandemic as opposed to retrospectively.

Furthermore, organisations were keen to be involved in the research design and to work collaboratively to ensure that the communities they supported were included and represented, owing to the principles of CHP, CFR and FCP outlined earlier in this chapter. Involving organisations in all aspects of the research helped to ensure that data gathering was done in a way that minimised participation burden, reduced risk of harm and increased their ability to take part and share their experiences. For example, being able to conduct interviews via telephone or video call allowed for flexibility in location and time of day, while adhering to social distancing and travel restrictions during lockdowns.

Collaborative research design also improved the accessibility of participating in the PIP project for those that needed support with their menstrual health during the pandemic, many of whom were engaged with the services involved with the design of the project, again minimising participant burden and the potential for psychological harm. For example, using an online survey allowed respondents to save and return to the survey enabling them to complete it at times and places most convenient to them. Indeed, Lykes and Crosby (2013) state that the processes and outcomes involved in undertaking collaborative, participatory feminist research should "benefit those most in need, and should "do no harm" to participants and researchers" (Lykes & Crosby, 2013 p.1) as one of the key principles of FCP. This is also cited within the British Psychological Association's (2021) Code of Human Research Ethics.

4.10.1 Ethical approvals for each phase of data gathering

The study received full ethical approval from Birmingham City University's Health, Education and Life Sciences Faculty Academic Ethics Committee. Ethical approval (see appendices A, B and C) for data gathering was obtained in two stages as per the data gathering plan and in recognition of the emerging pandemic situation and changes in social distancing requirements. An amendment to Phase 1 ethical approval was further obtained to include online survey data gathering, as this method had not originally been selected for the study. Further discussion of the ethical implications for each phase of the study can be found in chapters 5 and 6.

4.11 Chapter summary

The chapter described how the Covid-19 pandemic influenced the methodologies, ethical considerations and data gathering for the Periods in a Pandemic project. Applying critical, feminist, community methodologies to undertake the project collaboratively allowed the researcher to continue to meet the ethical issues related to conducting research during the pandemic discussed within the chapter, minimising risks to both participants and the researcher whilst reflecting the principles of the critical, feminist frameworks applied to the project. These methodological frameworks also helped to broaden the researcher's awareness and understanding of key areas to include within the project, expanding on their own experiences of being an 'insider' researcher. The chapter further described the crucial role that the Project Advisory Group had in shaping how the project was designed and how the findings were disseminated, reflecting the principles of Feminist Community Psychology (Lykes & Crosby, 2013). The main ethical considerations related to conducting research during a pandemic were also discussed within the chapter providing details of how the researcher minimised potential risks.

The chapter described the mixed methods used by the PIP project to gather qualitative and quantitative data. The chapter further described how the current study applied critical realism to re-analyse the data generated from the project to better understand the underlying structures and mechanisms that influenced menstrual health experiences during the pandemic. The data analysis methods for the study were then described, providing details of the reflexive thematic analysis undertaken to examine the quantitative data gathered from semi-structured interviews and open-ended online survey responses. The methods applied to analyse the quantitative data gathered from the fixed questions within the online survey were also described, explaining how the reflexive thematic analysis is further complimented by descriptive statistics to provide additional context and insights into shared experiences and trends in data. In keeping with the critical, feminist frameworks applied to the PIP project and the current study, a reflexive account of the researcher's positionality within the context of the project design, data gathering and data analysis was also provided within the chapter.

The following chapter provides a more detailed account of how data was gathered during the phase 1 of the PIP project. It further describes the re-analysis of the data for the purposes of this current study, focusing on the experiences of those providing menstrual health support during the pandemic. It then presents the reflexive thematic analysis undertaken, discussing the implications in relation to the study aims.

5 Chapter 5: Phase 1: how the pandemic impacted the provision of menstrual health support

5.1 Introduction

The previous chapter outlined the epistemological and ontological frameworks adopted for this study and the methodologies used to address the research aims. The chapter provided an overview of the phased approach used to gather and analyse data, providing justification for the methodologies used and addressing the ethical considerations of conducting research during the pandemic.

This chapter provides a more in-depth description of the research methods utilised during phase 1 of the Periods in a Pandemic (PIP) project and presents the reflexive thematic analysis undertaken to address the aims of the current study. Phase 1 focused on how UK menstrual health service providers were managing Covid-specific challenges and continuing to meet the needs of those they support, particularly during lockdowns and social distancing restrictions.

The chapter outlines the research questions relevant to this phase of the current study and goes on to describe the research design that the PIP project used to gather data for phase 1, including recruitment and data gathering methods. The main ethical considerations for this phase are discussed, and a reflexive account of the research process is included. Finally, the re-analysis of the qualitative data and the themes generated from the reflexive thematic analysis are presented and discussed within the context of menstrual health and other related research to address the aims of the current study.

5.2 Research questions and aims

Phase 1 of the PIP project focussed on menstrual health support and provision during the pandemic, from March 2020-March 2021. It examined how the pandemic shaped and influenced menstrual health support within the UK, from the perspective of those providing services. Within this context, ‘menstrual health’ and ‘period poverty’ are used interchangeably as many services recognise the similarity and use both terms to describe their work. Both reference menstrual products, menstrual health education and healthcare, and menstrual stigma and shame as factors to be addressed to tackle menstrual inequality.

To address the current study's aim of investigating menstrual health experiences to identify what factors influenced them during the pandemic, the key research questions for this phase are therefore:

1. *What were the experiences of menstrual health service providers during Covid-19 lockdowns and how did they deal with any challenges to providing support during these times?*
2. *What were the needs of women, girls and people who menstruate, during the pandemic, in relation to their menstrual health?*
3. *How did the pandemic influence the provision of menstrual health support during lockdowns within the UK?*

5.3 Methods

5.3.1 Eligibility criteria

Participants were eligible to take part in the PIP project if they worked for a service that provided any of the following: access to period products, menstrual health education and/or menstrual health support within the UK. These included organisations or establishments that provided these as part of another service (e.g. food banks, secondary schools), as well as specialised provision (e.g. period poverty charity).

5.3.2 Recruitment

5.3.2.1 Semi-structured interviews

Participants were recruited using social media posts (via X and Facebook) and snowballing techniques (Ellard-Gray et al., 2015; Naderifar et al., 2017) using the menstrual health and equity sector networks of the researcher and the Project Advisory Group (PAG). This allowed for a wider reach across the UK, with information being cascaded between relevant organisations and their own subsequent networks that the researcher may not have been in contact with. The menstrual activism and advocacy sector utilises social media as a means of sharing information about their services and to campaign for raising awareness/charitable donations and other forms of support they may need. Sharing the recruitment advertisement via social media was therefore an appropriate, effective method for recruiting participants to the study and allowed organisations to further share the information via resharing posts.

The social media recruitment advertisement included details of how to find out more about the study and what participation entailed, providing the researcher's email (see Appendix D for example). For those that contacted the researcher to find out more about the study, a copy of the Participant Information Sheet (Appendix E) and consent form (Appendix F) was sent to them with a request to send the researcher some possible dates and times for interview. They were also asked to confirm if they preferred telephone or video interview (via MS Teams). If the researcher had not received a response within 5 working days, a reminder email was sent with a further 5 working days granted for a response to be received. If the researcher had still not received a response within this time, the respondent was not contacted again.

A recruitment advertisement was also sent out via email to the researcher's own contacts within the menstrual health sector and other relevant networks (see Appendix D for example). These included the PAG and the 'Menstrual Activist' network which comprised of a range of UK and internationally based organisations and academics working within the sector. The researcher also asked if the advertisement could be shared further if those contacted were happy to do so. The email contained a copy of the Information Sheet and consent form and asked interested respondents to contact the researcher to arrange a suitable date and time for interview, along with any preference as to telephone or video (MS Teams) interview. As with the social media recruitment strategy, if the researcher had not received a response within 5 working days, a reminder email was sent with a further 5 working days granted for a response to be received.

5.3.2.2 Online survey

An online survey was introduced part-way through phase 1 data gathering in response to the increase in demand for relevant services because of the pandemic, and in recognition that service providers therefore had less time available to take part in interviews. The online survey was shared via the same recruitment strategies outlined above for semi-structured interviews, with a link to the survey being included in social media posts (Appendix D) and emails. The survey link included participant information and consent questions, with an option to be contacted for a follow-up interview later. Where survey respondents had stated they were interested in taking part in a follow-up interview the researcher then contacted them via the email address provided, following the same approach described previously.

5.3.3 Data gathering

The justifications for using a mixed methods approach to data gathering for this study have been explained within chapter 4. To avoid repetition, they will not be discussed within this chapter.

5.3.3.1 Semi-structured interviews

A semi-structured interview (SSI) guide (Appendix G) was constructed by the researcher. The topic guide was produced using insight from initial discussions with organisations providing support for those experiencing period poverty within the UK while the researcher was considering the ethical implications of researching the impact of the pandemic during the pandemic (see chapter 4 for further discussion). News media coverage of the increase of period poverty during the first lockdown within the UK in 2020 was also used as this provided additional insights into key issues (BBC News England, 2020; Edlin, 2020). The topic guide was shared with the PAG for feedback prior to data gathering, to ensure that all relevant areas were included. Topics included how Covid-19 impacted service provision, what measures were introduced to manage any changes and how service user needs have changed during lockdown. For example, interviewees were asked 'What did 'normal' provision/services look like before Covid-19 lockdown?', 'Can you tell me how Covid-19 lockdown, from March until September, affected your service provision?' and 'What sorts of things did service users tell you about how Covid lockdown was affecting them?'.

Finalised questions were structured chronologically to reflect pre-pandemic services, provision during the first lockdown period of March – September 2020, what services currently provided was at the time of interview and what future service provision may be. Open-ended questions then asked for more detail around service provision, service user needs and any challenges. The researcher used the first few questions around service provision and their geographical location as ice breakers to establish rapport (Adams, 2015). This was especially helpful with participants that had not taken part in research before, or that were not familiar with talking about their service's work and their role. The topic guide was set up to reflect the chronology of the pandemic, however the questions were unstructured to allow a more natural conversation (Brinkmann, 2020; Trier-Bieniek, 2012). Questions asked were open-ended, to allow the participant to be able to speak freely and provide as much detail as they wished (Trier-Bieniek, 2012). The researcher used prompts to encourage participants to share their experiences and to guide them to provide useful information if the participant had not provided it themselves, unprompted. For example, if the participant had not explained about who their key service users were when they had been asked about the services they provide, the researcher asked them to explain who they usually supported. At the beginning of the interview, the researcher checked again if the participant had any questions and were happy to continue, as per the consent form they had signed. If the participant had not yet returned the consent form prior to interview, the researcher obtained verbal consent by reading through the consent form and asking the participant to confirm each question (Flory & Emanuel, 2004). A copy of the completed consent form was sent to the participant after the interview had been completed, for their reference.

Interviews were audio-recorded or recorded via MS Teams if they were video interviews. Recordings were sent to an external company for verbatim transcription and copies of completed transcriptions were then sent to the participant to check if any amendments/changes needed to be made, or if there were any parts of the interview that they did not want to be included in publications. The external transcription service used was approved under Birmingham City University's procurement and due diligence processes. Participants were given a deadline to respond to the researcher with any amendments. They were also informed that a non-response to the deadline was assumed to equate to them being happy with the transcription and for its use as per the consent process. The researcher kept a record of when participants were sent their transcripts and whether they had responded by the deadline given, along with whether they any amendments had been made to the original transcript copy, to ensure that the correct versions were included within the data analysis. This data was linked-anonymous, as each participant had been allocated a unique reference number that was attributed to their anonymised transcripts.

5.3.3.2 Online survey

To further facilitate data gathering an online survey was also distributed. Survey questions followed the semi-structured interview topic guide and included open and fixed questions (Appendix H). Fixed questions were used to ascertain service provider details including geographical location and what sort of menstrual health/period poverty support they provided (e.g. period products only, menstrual health education only). The survey was created using Online Survey v2 and open for completion for a period of four weeks. Optional questions were included for services to indicate whether they would be interested in taking part in a follow-up interview phase 2 of the research. Those interested were asked to provide a suitable email address where further information could be sent. This information was kept separate to the survey responses.

Participants were also given the option to be entered into a prize draw to win £50 Amazon voucher for their service. This incentive was offered to encourage participation and to acknowledge that services were stretched and under-resourced at the time. Those interested were asked to provide a suitable email address where further information could be sent to. This information was kept separate to the survey responses and deleted once the prize draw had been completed.

5.3.4 Ethical considerations

The main considerations for this phase of data gathering centred on informed consent procedures, confidentiality/anonymity of participants data, equality, diversity and inclusion (EDI) issues and minimising the risks associated with Covid-19 infection. The ethical implications of conducting research during the pandemic have already been discussed in chapter 4. The researcher adhered to British Psychological Society (BPS) guidelines (British Psychological Society., 2021) in addition to relevant organisational guidance specific to Covid-19 research (World Health Organisation, 2020).

To minimise any risk of Covid-19 infection, and to ensure that social distancing/travel restrictions were adhered to, interviews were conducted via telephone or MS Teams video and the survey was administered online (Hensen et al., 2021). For semi-structured interviews, participants were given the option to choose which they preferred. To ensure informed consent was obtained from participants, an information sheet (Appendix E) and consent form (Appendix F) were sent to SSI participants prior to interview as per British Psychological Society (2021) ethical guidance. The information sheet provided details of what the study aims were, the inclusion criteria for taking part, what participation involved (i.e. SSI taking around 30 minutes), ethical rights, any potential risks/benefits to taking part, how data would be recorded and stored, who had access to data and what data would be used for (e.g. reports, publications, presentations). Details around who to contact about data protection concerns, a complaint, or if they chose to withdraw from the study, were also provided. As the researcher had previously established professional relationships with some of the services recruited to the study, it was important to highlight the voluntary nature of the research and that participants could choose to opt out/withdraw from the research at any time prior to data analysis, minimising the risk of participants feeling obliged to take part and addressing potential power imbalances between the researcher and participant.

As interviews were with service providers who are experts within their respective areas, the researcher gave participants the option for their service's name to be attributed to any quotes used within any outputs. Participants were able to confirm this on the consent form, or to confirm that they wanted their responses to remain anonymous. While anonymity is the norm in qualitative research when quoting participants, with expert interviews, professional participants and their organisations often prefer to be named in studies in recognition of their expertise and their contribution (Van Audenhove & Donders, 2019). All participants were also given the option to have final approval of their interview transcripts to ensure they were happy and comfortable with the presentation of their expertise viewpoint. Any personal, identifiable data retained was stored in accordance with BCU's Data Protection Policy[2] which states that personal data is: processed fairly, lawfully and in a transparent manner; used only for limited, specified stated purposes and not used or disclosed in any way incompatible with

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[2] Birmingham City University Data Protection Policy: https://www.bcu.ac.uk/about-us/corporate-information/policies-and-procedures

those purposes; adequate, relevant and limited to what is necessary; accurate and, where necessary, up-to-date; not kept for longer than necessary; and, kept safe and secure. For SSI participants that had not returned a completed consent form prior to interview, the researcher obtained verbal consent by reading through the consent form and asking for confirmation of each point (Flory & Emanuel, 2004). The researcher then signed this, and a copy of the completed consent form was then sent to the participant for their records. If the participant did not consent to audio or videorecording, the researcher would take notes during the interview instead.

For the online survey, participant information was provided on the first page of the survey prior to the questionnaire (Appendix H), covering the same points as per the SSI information sheet. Survey-specific details made clear that consent to use survey data within the study would be assumed via submission of the survey, unless stated otherwise, and that it would not be possible to withdraw a submitted survey response as the data was anonymous. Participants were asked to confirm that they were happy for their anonymised responses to be used within any publications, reports or presentations before completing the questionnaire. Participants were also asked if they would be interested in a follow-up interview, assisting with phase 2 or being entered into the voucher prize draw. Anyone who stated yes was asked to provide an email address for further contact and were informed that their contact details would be kept separate from their survey responses to ensure anonymity.

It is not usual practice to offer an incentive to participate in research when utilising expert interviews, in recognition that representatives are often expected to discuss their work and practice within their professional capacity (Bogner et al., 2009; von Soest, 2023). Phase 1 semi-structured interview participants were therefore not offered any token of thanks for their contribution to the research. However, with the introduction of the online survey part-way through data gathering for phase 1, survey respondents were given the option to enter their organisation into a prize draw to win a £50 voucher. This incentive was offered following feedback from the Project Advisory Group who raised concerns over the capacity of services to engage in research, as menstrual health service providers continued to experience an increase in demand for services during lockdown. Offering a prize draw was therefore suggested as an appropriate way to encourage participation in the research whilst also acknowledging that services were stretched and under-resourced at the time.

5.3.4.1 Equality, Diversity and Inclusion considerations

All participant documentation and materials used gender inclusive language around menstrual health in recognition that not all who menstruate are women and girls. Using phrases such as ‘women, girls and people who menstruate’ or ‘those who menstruate’ are inclusive of transgender, non-binary and gender diverse people who menstruate. Such inclusive language is best practice within menstrual health and period poverty advocacy sectors (Weckesser, Randhawa, et al., 2019).

As some participants may not have had English as their first language, or may have had learning difficulties (Cameron & Murphy, 2007), the option of using verbal consent at the beginning of the interview process allowed for more 'lay friendly' conversation to occur to aid understanding, clarify queries or alleviate any concerns as needed (Flory & Emanuel, 2004). Funds were also available for translation of participant documentation, and/or any interpreter services that may be needed during data gathering, however, no participants requested interpreter services at any stage of phase 1 data gathering.

In addition to minimising Covid-19 infection risks by reducing the need for travel and face-to-face contact, telephone and online (video) interviews may have been beneficial for those with physical disabilities, as participants could to utilise spaces and equipment to aid their participation (e.g. assisted technology, headsets, speakerphone etc).

5.3.4.2 Ethical approval

Phase 1 ethical approval was obtained via BCU’s Health, Education and Life Sciences Faculty Ethics Committee, under reference number: Williams /7567 /R(A) /2020 /Jul /HELS FAEC (Appendix A). A subsequent amendment for inclusion of the online survey element of data gathering was submitted and approved by the same committee, under reference number: Williams /#7567 /sub1 /Am /2020 /Nov /HELS FAEC (Appendix B).

5.4 Data analysis methodology

Semi-structured interviews (SSIs) were audio/video-recorded and sent to an approved external service for transcription. Interviews lasted between 20-60 minutes. Interviews were transcribed verbatim and sent back to the researcher, who anonymised the transcripts prior to sending them to the interview participant for final approval before inclusion in analysis. Transcripts were given an identifying code which was linked to an Excel spreadsheet that contained details of the service provider’s names and whether consent to include the service name in against any quotes used in publications, reports or presentations had been obtained. Participant’s individual names were not included. Anonymised transcripts were stored in the researcher's secure BCU OneDrive account, which only they can access. Online Survey data was exported into an Excel spreadsheet for analysis and stored in the researcher's BCU OneDrive account, as with the interview transcripts.

To complete the reflexive thematic analysis for the current study, SSI and qualitative online survey data were combined for analysis within NVivo12. The justification for using reflexive thematic analysis (RTA) for the study has been explained within chapter 4, with a more detailed description of how data was analysed. To avoid repetition, this has not been discussed within this chapter. The analysis of phase 1 data does not include any quantitative data, as fixed survey questions were only used to ascertain demographic details related to service provision (e.g. geographical location). The final RTA produced five key themes, with related sub-themes, which are summarised in Table 1 below. Themes and sub-themes are both descriptive and latent, producing an analysis of the data that describe the experiences of service providers during the pandemic (descriptive themes) and the underlying causality of the events being described (interpretive themes) to provide a more in-depth picture of the complexities of menstrual health support and how menstrual health was impacted by the pandemic. A more detailed example of the RTA process for this phase of the study can be found in Appendix N.

Theme	Sub-theme
"*Overnight we lost all of our locations*": the pandemic's effect on the accessibility and provision of menstrual products	• The need for more menstrual products • Recognising menstrual products as essential • The increase in 'period poverty' and financial hardship • Reduction in volunteer support
"…we can't talk about these sorts of issues at home via a telephone appointment, it just does not work for us.": providing menstrual health education and support during the pandemic	
"*It's kind of forced everyone to re-look at the way that we do things."*: overcoming barriers to continue menstrual health service provision during lockdown	• Responding to change to meet service user needs • Positive progress and new opportunities
"We've had to fight so hard…": uncertainties and inconsistencies in menstrual health policies during the pandemic	

"If someone has worked up the courage to go to a foodbank, it should just then be really easy to get her period products": menstrual stigma and shame during the pandemic	

TABLE 1: PHASE 1 REFLEXIVE THEMATIC ANALYSIS THEMES AND SUB-THEMES

5.5 Researcher reflexivity

Reflecting and reflexivity are key elements to both feminist, critical research (Martin, 2003) and to reflexive thematic analysis (Braun et al., 2022). This section therefore provides a reflexive account of the research design for this phase of the research. As such, I will write in the first person in my role as 'researcher'. As previously discussed within chapter 4's 'Researcher Positionality' section, I am a well-educated, 'middle-class', white cisgender woman employed by an academic institution. Furthermore, I position myself as an 'insider researcher' as I have been conducting research within the period poverty and menstrual health sector for several years. I also menstruate, and my experiences will affect my own interpretation of what I feel is important to focus on within this research.

During the pandemic, I fell into the Clinically Extremely Vulnerable category in terms of risks to my own health, and experienced numerous difficulties accessing healthcare services for new and ongoing issues. This influenced my decisions around the Periods in a Pandemic project design and implementation, in addition to factors that I felt were important to focus on during the re-analysis for the current study (e.g. accessing menstrual health care). These influences will have shaped my decisions around the research questions posed, how participants were recruited and how data was gathered and how I interpreted and analysed the data gathered. Using a collaborative research design was therefore a useful method for providing additional insights that broadened my understanding and awareness of how menstrual health was being impacted by the pandemic. This approach further helped me to understand what the affected communities felt were important to highlight within the analysis and dissemination of information that I may not have considered within my own awareness and experiences during the pandemic. A collaborative approach also helped to widen the recruitment strategy and implement new data gathering methods improving the reach and accessibility of the research.

5.6 Data analysis

5.6.1 Demographics

Representatives from 17 UK based menstrual health service providers were interviewed, and a further 17 UK based menstrual health service providers completed the online survey, equalling representation from 34 services across England, Scotland and Wales (Table 2). Services provided specific menstrual health support or provided access to products and/or support as part of their wider remit (e.g. food banks, community drop-in centres, educational establishments). Services worked with diverse communities, including those living in financial poverty, young people and school pupils, asylum seekers and refugees, South Asian communities, displaced and homeless people, Traveller communities and disabled, chronically ill people.

As per the agreed informal consent process, organisation names have been used with quotes where service providers granted permission for them to be included (e.g. Organisation Name – SSI to clarify the quote is from a semi-structured interview). Online survey responses were anonymous, so service provider names are not attributed to any quotes derived from survey data and are referred to as "Online Survey Response #number".

	Provision of specific menstrual health support	Provision of products and/or menstrual health support as part of wider remit
England	15	7
Northern Ireland	0	0
Scotland	2	0
Wales	1	6
Missing responses	3	3
Total*	18	13

TABLE 2: PHASE 1 DEMOGRAPHIC DETAILS

5.6.2 "*Overnight we lost all of our locations*": the pandemic's effect on the accessibility and provision of menstrual products

This theme describes service provider experiences of providing menstrual products to those who needed them during the pandemic, examining the diverse ways that the provision and accessibility of menstrual products was impacted during the pandemic. The sub-themes encompass descriptions of how service providers experienced an increase in need for menstrual products during lockdown which further exacerbated existing period poverty across the UK. Themes further describe the pandemic-related barriers that service providers experienced, which were further compounded by existing structural inequalities.

5.6.2.1 The need for more menstrual products

In the following quote, Bloody Good Period (BGP) discussed how they noticed a significant increase in demand for menstrual products over several months during the first lockdown in 2020: *"I think it was in the autumn we had a look at the figures, and we saw that there was six times the amount that we'd given out previously, in previous months. So, a huge, huge increase."* This significant increase in demand for menstrual health products was not unique to BGP with all services that that provided menstrual products to service users experiencing an increase in requests for products during lockdowns. Reasons for why an increase in demand had been experienced by services were numerous, attributed not only to the closure of public spaces/establishments where people may usually access free products, such as schools, community centres, food banks and libraries, but also to difficulties in finding products within shops and supermarkets. Free Periods Angus describe the impact that these types of closures had upon their ability to provide access to free menstrual products across their area of Scotland: *"…overnight we lost all of our locations. So, we went from 150 down to eight…".* Milford Haven School further describes the impact that the closure of educational establishments had upon those that rely on the free products available within school in Wales:

> …the demand just went crazy. All the girls that we were worried about, and we expected to come out of the woodwork, did. Their mums were asking us for packs...usually they'd go and find a food bank but they couldn't get there because of COVID (Milford Haven School, Wales - SSI)

Here we see the different ways in how measures to control the spread of Covid-19, via government law, impacted the accessibility of products that are provided by local authorities within Wales and Scotland. Both are areas where menstrual products are provided for free within certain settings: Wales within educational establishments, Scotland within local authority properties (e.g. schools, libraries). For Milford Haven School (Wales), changes in how parents could access products for their children, for example via shops, led to an increase in requests for products via the provision of free products within schools. For Free Periods Angus, in Scotland, the closure of public buildings where local authorities provided free products meant that their ability to deliver their usual service was significantly reduced.

Issues around stockpiling of menstrual products and other items during lockdown (such as toilet paper) were experienced by several service providers who discussed the impact of stockpiling behaviour upon their ability to purchase and provide menstrual products: *"…everyone was bulk buying products because they were panicking. So, that has an impact in terms of purchasing, which was a bit bizarre" (AD TRAC 16-24 - SSI).* This quote references problems that the scarcity in menstrual products within retail outlets posed for many services during the pandemic as a result of stockpiling behaviours. The introduction of restrictions on products to curb stockpiling was also discussed as a barrier to providing support for service providers as they could not buy bulk amounts of menstrual products in one purchase. This then impacted their ability to restock products and to distribute larger amounts to places that had requested their support.

Limitations on menstrual product purchases were also discussed by service providers in relation to buying products for personal use. Such limitations created additional barriers for those who experienced heavy menstrual bleeding and therefore needed to buy large numbers of products to manage their menstruation: *"But actually when you have a chronic illness that affects reproductive and menstrual wellbeing, you're not stockpiling, that's normal" (Cysters - SSI).* This quote from Cysters, who support those within the chronic health community, demonstrates how a 'one size fits all' approach to addressing stockpiling behaviours excludes certain groups that have a legitimate need for requiring more menstrual products than typically expected. The approach to negate the stockpiling of essential items introduced during the pandemic was widely criticised by the disabled and chronic health community for failing to consider how this blanket approach would negatively impact those with specific health issues. In addition to the points raised by Cysters within the above quote, other disability advocacy groups criticised policies on toilet roll purchasing restrictions for failing to consider the needs of those with gastro-intestinal conditions, such as inflammatory bowel disease (Gladwell, 2020; Mikocka-Walus et al., 2022). Thus demonstrating how intersecting inequalities, such as disability and health inequalities, were not initially considered within the UK's response to Covid-19 (Gupta et al., 2021). The perceived stockpiling of menstrual products described by Cysters was also reported to cause tensions within online chronic health communities as some viewed the bulk purchasing of menstrual products for personal use as 'selfish'. This behaviour was especially viewed as problematic when others within the community had experienced problems finding products because of purchasing restrictions and shops running out of affordable items.

5.6.2.2 Recognising menstrual products as essential items

Several service providers talked about how menstrual products were not viewed as essential items and something that people would need access to as part of wider service provision, which added to the increase in demand for products. For example, food banks sometimes did not include menstrual products within food packages as they “*have not understood that menstrual products are also a basic necessity” (Online Survey response #4).* Notions of what was ‘essential’ had also not been communicated properly across some parts of the UK, creating further barriers to purchasing products. In this example, a representative from AD TRAC 16-24 describes how they could not purchase bulk menstrual products: “*Because, when we were purchasing everything, someone somewhere in Wales said that tampons weren’t essential.”.* This confusion over whether to class menstrual products as essential, which could be purchased under Covid-19 restrictions (such as toilet paper, basic food and hygiene items), as opposed to being ‘non-essential’, stemmed from the differences in how Covid-19 restrictions were implemented across different parts of the UK. Although all shops across the country were instructed to close unless they provided essential goods and services, in Wales, shops that were eligible to remain open still had to cordon off areas of the premises that stocked non-essential goods (BBC News Wales, 2020b). This then caused issues for some of the service providers located within Wales, who needed to purchase menstrual products, when such products were sectioned off as non-essential within shops.

Furthermore, some service providers had been informed that ‘care’ packages for those that were Clinically Extremely Vulnerable and shielding (provided by the local authority) were often missing menstrual products, again failing to recognise the essential nature of such products. In this example, Periods Matter talk about how they were contacted because a local authority had not thought to include products within their care packages, and their household included several people who would need them:

> …they’ve got two teenage daughters and they also had to isolate too so they were very, very reliant upon food, the food delivery by the local authority and they reached out to us because they were really struggling because they had three menstruating women in the house and they couldn’t get out the house and they weren’t being given products (Periods Matter - SSI)

These examples not only highlight how failing to recognise menstrual products as essential can impact the accessibility of them within retail premises, like supermarkets. They demonstrate how other intersecting inequalities, such as chronic health and disabilities, are often forgotten about within policy responses regarding disease prevention and humanitarian crises, such as pandemics. Such responses often think that ‘equality’ means giving everyone the same access, when what is actually needed is an equitable approach that considers individual’s needs and that can be applied flexibly (Jesus et al., 2021). This mirrors previously described accounts around stockpiling behaviour and supermarket restrictions raised by Cysters, where the implications of these actions are talked about in relation to the needs of those who experience heavy menstrual bleeding.

Confusion around the essential nature of menstrual products, and the failure of places like food banks and local authorities to acknowledge the inclusion of menstrual products as necessary for the communities they support, support arguments that menstrual health is not viewed as a priority within society (Babbar et al., 2022). Within the context of the pandemic, many menstrual advocacy and humanitarian organisations that prioritise gender equality highlighted that menstrual products must be included as ‘essential’ within Covid-19 responses, in recognition of the barriers that those needing menstrual health support were experiencing and the increase in period poverty that was reported globally (Irise International, 2020; UNICEF, 2020; Water Supply and Sanitation Collaborative Council, 2020). Such failings therefore further contribute to why menstrual health service providers experienced such a significant increase in requests for menstrual products during the pandemic, further exacerbating menstrual inequality in the UK.

The inaccessibility and lack of availability of products within the workplace, particularly for frontline workers within healthcare settings, was discussed by several service providers. Again, the failure to recognise the essential nature of menstrual products was at the root of this, as products were not routinely provided within workplaces such as hospitals. In the following example, we see how this oversight is further compounded by other issues around the accessibility of menstrual products during the pandemic:

> At the beginning of the lockdown we got quite a lot of messages from NHS workers who found they were not able to find products in the supermarket and then obviously if you go to just the corner shop that’s way more expensive…Nurses who were not able to get out of the hospital for however long and then all the shops are closed as well (Bloody Good Period - SSI)

This oversight in terms of workplace provision is indicative of wider gender inequality within society, with those involved in gender equality activism consistently highlighting how the pandemic worsened existing inequalities (Fisher & Ryan, 2021). Within the context of the pandemic, women made up over 70% of frontline health care workers globally, including nursing staff (de Paz et al., 2020; European Institute for Gender Equality, 2020b). Failing to provide essential items within the workplace, such as menstrual products, created additional stresses for staff who menstruate who could not access products when needed or who needed to use additional protective equipment to prevent disease spreading (Gender and Public Health Emergencies., 2024; Kondapalli et al., 2022). As with previous accounts of confusion around whether to class menstrual products as essential, and failings to acknowledge menstrual products as necessary items within community and local authority outreach provision during the pandemic, inconsistencies in workplace provision of menstrual products further illustrates how menstrual health is not considered to be important within society, despite half of the population experiencing the normal physiological function of menstruation (Babbar et al., 2022; Sommer & Mason, 2021; Weiss-Wolf, 2017).

5.6.2.3 The increase in "period poverty" and financial hardship

In this quote from Period Positive, the links between period poverty, austerity and pandemic-related are discussed: *"Like, period poverty is clearly linked to austerity. And it's clearly linked to the financial crisis that's come about through COVID."* These thoughts were echoed by many service providers, who discussed how the increase in need for their services was linked to the financial insecurity created by the pandemic. Service providers discussed the emergence of new groups of people that had started to request products as result of pandemic-related financial insecurity: *"we are being made aware of households where maybe people have been put on furlough or lost their jobs due to COVID and how they're having to prioritise obviously feeding their kids…" (Periods Matter - SSI).*

The increase in financial poverty linked to the pandemic was highlighted as something that was at the root of period poverty, and that needed to be acknowledged and addressed, particularly by the UK government. The recognition of some elements of poverty in terms of government policy, but not others, was seen as hypocritical:

> [But] it's actually more about poverty, isn't it, just more generally than just period poverty or food poverty… it just makes me feel slightly uncomfortable when they [UK government] claim that they're doing these amazing things and actually there's other areas of poverty that are not being addressed at all (Brook - SSI)

In this example, Brook discuss the changes in the provision of free school meals during the pandemic driven by a high-profile celebrity campaign and how food poverty, and period poverty, are part of the same underlying issue that is not acknowledged in policy: financial poverty.

5.6.2.4 Reduction in volunteer support

For services reliant upon volunteer support, the pandemic affected the availability of such support as some volunteers had to shield (due to being Clinically Extremely Vulnerable) or isolate due to Covid infection/exposure, and some experienced changes in their work and/or care responsibilities. Access to volunteer support was greatly reduced, with the issues also applying to the availability of such support:

> Many of our volunteers are in 'vulnerable' categories and so have had to shield and not come for their volunteering times. The number of people allowed in the building due to social distancing has dramatically reduced so there are less hands to sort, bag, store and distribute resources (Online Survey response #8)

The reduction of volunteer support not only impacted on the ability to pack and distribute products, but also upon the wellbeing of those that managed the service who were left with little support to meet the increase in demand. Service providers described being left to manage such operations of their own under such circumstances, as illustrated in the following online survey response: "…*majority of operations has fallen down to one person." (Online Survey response #4)*. To be able to continue to meet the increase in demands, whilst having reduced volunteer capacity, some service providers becoming *"heavily reliant"* on those outside of their service for their help in distributing products. In this example, a representative from Cysters describe how they are further limited by the reduction in volunteer support to distribute products as they do not drive: *"I'm heavily reliant on my volunteers here because I don't drive, and my partner's been doing lots of driving around Birmingham to drop products off to different food banks.".* Having to rely on partners or family members to help in the absence of service's usual volunteer bank was discussed by several people, to be able to continue to meet the needs of the community. Some service providers discussed the stress they had experienced under these circumstances. A representative from PKAVS Tampon Taxi describes her experiences of trying to manage service provision during the pandemic and how she has been running the Tampon Taxi service in addition to her full-time job, stating *"I have to say it's not been easy".* The difficulties around running a voluntary service in addition to full-time work where also discussed by a representative from Real Period Project, who was working on the frontline of the pandemic in their capacity as a healthcare worker:

> …from a personal level, I am a nurse and, I am a community nurse, and our workload, it didn't increase at the time, although it did subsequently but, you know, all the stresses and pressures of what COVID was going to mean for our service, you know, I was just exhausted outside of my work… (The Real Period Project - SSI)

These examples illustrate existing gender inequality related to 'burden of care', whereby women are expected to take on much of the unpaid, voluntary work associated with caring for others. Most of the services that took part in this phase of the study are run by women, with most staff and volunteer support also provided by women. Furthermore, women made up most of the workforce within frontline support services during the pandemic, again demonstrating gender inequality. Indeed, research suggests that this burden of care increased because of the pandemic, further exacerbating existing gender inequality (Carli, 2020; Dinella et al., 2023; Power, 2020).

5.6.2.5 Summary

Demand for menstrual health products was reported to have risen significantly during lockdowns, attributed to an increase in financial poverty, changes in how those needing free menstrual products could access them and restrictions on purchasing menstrual products. Service providers reliant on volunteer support experienced difficulties in continuing service delivery, as many volunteers had to shield/self-isolate or reduce their time due to changes in workload or carer responsibilities during lockdown.

5.6.3 *"…we can't talk about these sorts of issues at home via a telephone appointment, it just does not work for us."*: providing menstrual health education and support during the pandemic

This theme describes service provider experiences of providing menstrual health education and support during the pandemic, focusing on the change in practice from face-to-face to remote, online provision. The theme provides insight into the challenges that service providers experienced in providing menstrual health-related content within the context of remote support, and the impact that this had upon the communities they supported during the pandemic.

For those menstrual health service providers that included menstrual health education within their remit, social distancing, travel restrictions and building closures meant that their usual in-person service had to stop during lockdown. Many described moving such provision onto online platforms, such as social media and remote access video calls (such as Zoom or MS Teams), to be able to continue menstrual health education within schools and community settings. However, many encountered barriers to providing such sessions, meaning that the effectiveness and accessibility of menstrual health education was negatively impacted during lockdown. Service providers described how those needing menstrual health education within the community often did not have access to the private, safe spaces they needed to be able to talk about menstruation within an online setting:

> …when you're talking about anything, but like, especially sensitive topics, such as sexual and reproductive health, you need to create at least a safer space, right? And we did quite well

> in that, by going into existing asylum seeker and refugee drop-in service centres. But online, it's a completely different kettle of fish, right? (Bloody Good Period – SSI)

This quote from a representative from Bloody Good Period alludes to some of the challenges associated with providing menstrual health education within an online environment, particularly in how to create a safe space when talking about issues that are deemed to be 'sensitive'. She goes on to explain:

> Because if you don't feel safe in your home, which a lot of people don't, then, you know, you're not going to be able to talk about things … you're not going to be able to vocalise that, even if the people in the room, or the people in the house can't hear the content, 'cause you've got your earphones in. (Bloody Good Period – SSI)

Being able to have such conversations in-person was therefore preferred by services that provided menstrual health education or support sessions as it helped to facilitate an open, reassuring space. The "nuances" around body language that get missed within online environments were also described as being important when discussing potentially sensitive subjects, as a way to further foster a safe environment and encourage participation and engagement when discussing 'taboo' issues like menstrual health . Furthermore, face-to-face sessions provided informal peer support for those attending them and opportunities to further discuss topics. For service users who would usually attend in-person sessions that provided an opportunity to continue to talk with their peers, moving to remote access often meant that opportunities for peer support were reduced. The following quote from Cysters further describes the implications of this in terms of service user wellbeing:

> …when you've talked about something that's so traumatic to you and relative to you, then suddenly to be on your own is quite difficult, whereas when we were doing it in person when we would finish a session people would sort of either mingle around afterwards and have a chat with each other (Cysters - SSI)

The quote suggests that there are additional needs to consider for vulnerable people accessing remote sessions, especially if discussions in sessions could cause stress or upset for service users. For service providers like Cysters, additional pastoral support was therefore made available for online sessions as people struggled to connect in more remote, less socially connected environment. The additional support provided was also viewed as an extra responsibility for those people delivering online sessions, as opposed to being able to share the responsibility with others during in-person sessions via peer support.

In addition to barriers around creating safe spaces within an online context, many services providers described 'digital poverty'[3] barriers that those they supported experienced, which made it more difficult for service users to access online educational content during the pandemic. An increase in awareness of digital poverty and exclusion was highlighted during the pandemic, particularly with the closure of educational establishments and the shift to providing education via remote, online sessions (Holmes & Burgess, 2022). The impact of digital poverty, and subsequent increase during the pandemic attributed to financial insecurity, was raised as a concern for many menstrual health service providers. Service providers expressed concerns over people subsequently being "missed" and therefore not able to access the menstrual health support they needed. Service providers explained how some service users could not access the technology needed to be able to attend online sessions (e.g. Smartphone access, laptops, Wi-Fi) due to financial constraints. Service users also sometimes lacked the digital skills needed to navigate online platforms. However, efforts to improve access to digital equipment for those who needed it were introduced by some organisations that service providers worked with, as discussed in the following quote:

> …loads of women's groups were starting to do that [run sessions online], and they were incredible really, of like galvanising efforts around digital inclusion and trying to get the women that they work with online, making sure they have access to Wi-Fi and devices and things like this, and kind of taking them through Zoom, taking us all through Zoom, 'cause no one knew what we were doing there. (Bloody Good Period - SSI)

This quote not only describes how other organisations were addressing digital access and inclusion for service users, but how those providing services also struggled with the shift to using online delivery. In the example above, a representative from Bloody Good Period talks about how they also needed support in using remote access software to run sessions online, as *"no one knew"* what they were doing.

Digital poverty during the pandemic was also flagged as a barrier to accessing healthcare during lockdown, as many appointments moved to telephone or video calls with healthcare professionals (Zhai, 2020). This not only included issues around access to digital technology, but the lack of privacy and space to be able to have telephone or video consultations was also reported as a 'digital barrier' to accessing healthcare during the pandemic (Bosó Pérez et al., 2023). The implications of moving face-to-face medical appointments to telephone

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[3] 'Digital poverty' definition: "the inability, for a wide variety of reasons, to interact fully with the digital world" https://www.bcs.org/articles-opinion-and-research/digital-poverty-and-digital-capital/

or video calls was discussed by a number of service providers, within the context of menstrual health support. Service providers described similar challenges to accessing remote healthcare as those associated with delivering menstrual health education online, particularly around having access to safe, private spaces to discuss menstrual health concerns. For example, a representative from Cysters talks about the importance of having access to private spaces to be able to have a telephone appointment with a GP, and how living with extended family can mean this sort of privacy is not easily afforded particularly for South Asian families: *"…we can't talk about these sorts of issues at home via a telephone appointment, it just does not work for us.".* The representative from Cysters goes on to explain how this was something that had not been taken into consideration by GPs when they had moved provision to solely telephone or online appointments during lockdowns, when surgeries were not open for in-person appointments:

> The first time I said it none of the GPs in that room had a clue. And this is the problem when you're not there to advocate for yourself or your community you get left out and a decision gets made for you and this is what the pandemic is highlighting. (Cysters - SSI)

In this example, Cysters had raised concerns over this as part of their advocacy work, stressing the importance of including those impacted *by* decisions within decisions that can affect them. Again, we see how intersections between other existing inequalities, such as race and disability, have not been considered within pandemic responses (Gupta et al., 2021; Khazanchi et al., 2020). Indeed, disparities in how digital telemedicine is accessed with regards to disability, race, socioeconomic status, age and e-literacy, have been found to further exacerbate health inequalities (Yao et al., 2022). The implications of the closure of GP practices and changes in how healthcare could be accessed during lockdown were further discussed within the context of menstrual health concerns during the pandemic. For example, Period Positive experienced an increase in the number of menstrual health-related queries they had received, with their representative stating: *"a lot of people are contacting us because their menstrual health is a concern, and they don't know what to do because their doctors is closed… Some people have asked about whether COVID is affected by periods and vice versa."* This quote illustrates how barriers to accessing menstrual health care, coupled with poor menstrual health education and knowledge within society, seemingly increased anxiety and distress within those who menstruate during the pandemic. The quote further illustrates the importance of being able to provide menstrual health education within educational and community settings during the pandemic, to help address gaps in menstrual health care created by digital barriers and the closure of healthcare services. However, as this theme demonstrates, menstrual health services experienced multiple barriers to providing such educational support within a predominantly online environment during lockdowns, meaning that some communities may have been doubly impacted by changes in how menstrual health education and healthcare could be accessed. Thus, further increasing menstrual inequality within such communities during the pandemic.

5.6.3.1 Summary

Changes in how menstrual health support was provided during lockdown reportedly led to an increase in requests for menstrual health information for some services, particularly if people could not access their usual GP service due to closure of surgeries. Changes in how menstrual health education and support was delivered during lockdowns created barriers in access for some service users. Moving to online, remote service provision meant that some struggled to access education and support due to digital poverty and a lack of safe, private spaces to be able to have conversations about ‘sensitive’ subjects such as menstruation.

5.6.4 *“It’s kind of forced everyone to re-look at the way that we do things.”*: overcoming barriers to continue menstrual health provision during lockdown

This theme describes service provider experiences of their continued efforts to provide menstrual health support services within the context of pandemic lockdowns. Sub-themes describe how services adapted pre-pandemic provision to continue to meet the needs of the communities they supported during lockdown, further illustrating progress and new opportunities created by the pandemic.

5.6.4.1 Responding to change to meet service user needs

For services that provide menstrual products to other service providers for distribution, several factors impacted their experiences of obtaining and distributing products. These have been described previously within section 5.6.2 and included: social distancing, building closures and travel restrictions. To be able to meet the increase in demand for products experienced during the pandemic, services therefore described how they had adapted their service provision to address Covid-related disease prevention measures and the closure of premises:

> We had an increase in demand from food banks and different organisations, but then we also had to change our way in which we could deliver those products to them because obviously different offices were shut, our offices were shut (Periods Matter - SSI)

In response to the changes that impacted their usual service provision, services developed and implemented new and different ways of collecting and distributing products whilst at reduced capacity. For example, services that usually relied upon donations of products had to change to monetary donations to be able to purchase products directly as many donation stations had closed or there had been a reduction in products donated.

Service providers also introduced ‘referral systems’ where partner organisations or relevant staff could refer people to services that provide products to access them. Some offered doorstep delivery or postage of products directly to people’s home addresses. Several service providers introduced ‘take what you need’ boxes or lockers that people could access while still adhering to social distancing requirements:

> When it was announced that the schools were going to close we actually arranged like a pick and mix: we had a big set of plastic drawers full of every colour of tampon you can think of and all these pads, and put it in an area of the building that people could come in and out without coming into contact with anyone (PKAVS Tampon Taxi - SSI)

> So, we created a take what you need locker. So, we also had this huge locker full of products … we thought why don’t we make it possible for people to just come by and pick up what they need and also just sort of have a look around and be able to see other stuff. (Bloody Good Period - SSI)

Changes in communication were needed to keep people updated as to where products were available and how they could access them, while usual locations were closed or if supermarkets/shops were running low on stock. Several service providers described the usefulness of social media in helping to raise awareness of how people could access menstrual products:

> Through our Facebook page, Free Period Angus, we've been able to engage with a lot of people and if we have experienced an issue people have just contacted us through that and we've just got in touch with them instantly (Free Periods Angus - SSI)

> Facebook groups have been so, so helpful for this and I’m probably going to send a message out a bit later trying to say to people do you know anybody, where can we be sending them to and getting people to share that because that’s really important for us right now to make sure it gets to the right person. (Cysters - SSI)

These quotes both highlight how social media not only provided a way to share helpful information more widely, but how services were then better able to respond to queries via messages and provide information in a timely way that better served their communities. However, as described in the previous theme (section 5.6.3), digital poverty created additional barriers for some communities, particularly those who experienced financial insecurity. As such, service providers expressed concerns that they were missing those that did not have access to WiFi, smartphones, internet access, laptops and other digital devices that would provide a means to find out information via social media. This demonstrates the importance of being able to provide information in numerous accessible ways to best engage with and support affected communities, however, service providers seemed pleased that they were still able to engage with some members of the communities they work with given the limitations of lockdown.

Service providers described how lockdown had provided an opportunity to promote reusable products as an alternative option to disposable ones, especially within the context of menstrual product supply issues (such as stockpiling and supermarket shortages). Reusable menstrual products include menstrual cups, period pants and washable menstrual pads, which not only address environmental concerns over disposable plastic use, but also long-term financial concerns (Johnson et al., 2025; van Eijk et al., 2021). However, many reusable options require a large upfront cost to purchasing them, with additional anxieties over whether the products are suitable and ‘user-friendly’, which is not practical or reassuring for some (Johnson et al., 2025; van Eijk et al., 2021). Service providers that work within schools discussed the role of reusable menstrual products to help alleviate anxiety around the availability of products during lockdown, particularly for those experiencing financial insecurity. The ability to be able to provide such products for free also would have alleviated concerns over the upfront costs associated with reusable products, which can be a barrier for those on lower incomes (Ramsay et al., 2023), allowing pupils to try out products without experiencing financial loss. In this example, a representative from Milford Haven School talks through the *“genuine relief”* that they saw during the pandemic when they distributed reusable products to pupils during lockdown:

> But as soon as you give people reusable items it’s almost like you’re giving them, like, a longer term solution and relieving them of that monthly stress of, you know, if we are still in lockdown next month and I cannot get to the food bank because of COVID or if I cannot get to Tesco’s for whatever reason, you know, because of COVID related circumstances, I found that once we’d given people the reusable items, that was where you saw the genuine relief of, oh, well, that’s great because I can wash this item and sanitise it and I can reuse it next month if I need to (Milford Haven School - SSI)

A representative from Conwy Council also described some of the feedback they have received around reusable products from parents: *“…saying how delighted she was and how lovely the product was and that for the first time in a long time her daughter had come home feeling happy and reassured”.* The descriptive words included within both of these quotes, such as “relief”, “happy” and “reassured”, provide insights into how useful reusable products can be for those who experience menstrual product insecurity. Where free menstrual products were usually provided within primary and secondary schools, an increase in the promotion of reusable products during lockdown and a subsequent increase in requests for such products was therefore seen as a positive aspect of the pandemic. Reusable products not only alleviated financial concerns for pupils and parents, but anxieties over menstrual product insecurities related to school closures and stock issues within shops.

Opportunities to raise further awareness of reusable products during lockdowns were also viewed as positive, particularly for environmental reasons. Online resources to support the use of products and online pad-making workshops were also introduced to compliment the provision of reusable products, and to raise awareness of reusable options:

> Towards the beginning of the first lockdown, we ran like a mini campaign called Quarantine Period which was trying to harness the fact that people were at home and potentially examining some of the things that were previously just normal behaviours to them, to raise awareness of the fact that there are other period options (City to Sea- SSI)

Service providers that worked within schools also described creating digital content for pupils to compliment the provision of free products provided during lockdowns. This included information on product options and other aspects such as menstrual hygiene, self-care and how to relieve period pain via exercise. This addresses one of the criticisms of free menstrual product schemes that only provide menstrual products and do not provide any additional efforts to improve menstrual health education or tackle menstrual stigma (Bobel, 2019a). By introducing menstrual health education to compliment the provision of free products within schools, this approach provides a more holistic approach to menstrual health and tackling menstrual inequalities (Bobel, 2019a; Hennegan et al., 2021; Weckesser et al, 2019). The following example from a representative from Milford Haven School illustrates the importance of combining product provision with menstrual health education for pupils:

> …what we've, kind of, said to the girls is you cannot make an educated decision if you are not educated. So you are not in a position, any of you, to choose what is best for your body and what is right for your body if you don't even know the options available to you. (Milford Haven School - SSI)

The quote further illustrates how menstrual health education and knowledge is crucial to body autonomy and being able to make the right decisions and choices about your own body. Thus, further demonstrating the importance of combining menstrual products with menstrual health education as an effective way to address menstrual inequality.

For those services that provide menstrual health education training for school staff, moving to online provision of such training also worked well during lockdown. Being able to move training online provided greater flexibility in terms of time and geographical location for those attending:

> It ended up actually working better online because it meant people could tune into the trainings from anywhere, they didn't only have one local training that they could join, they had an option of like five upcoming trainings online. So, it was much easier for people to join, much more flexible with being able to join from home and having more sessions to choose from. (City to Sea - SSI)

This not only proved beneficial for the school staff attending sessions, but for those delivering the online sessions. For City to Sea, this improvement in accessibility meant they were able to train more staff than they would in-person as they could offer more choice. Being flexible in terms of time and location were also beneficial to those delivering the training as travel time did not need to be factored into delivery.

5.6.4.2 Positive progress and new opportunities

Service providers that had changed the ways they provided their support because of Covid restrictions viewed the need to adapt services as generally positive, with many saying they were going to continue to offer their services in the adapted ways once they could resume their 'normal' provision: *"I think COVID has done a lot of things and I think it's kind of forced everyone to re-look at the way that we do things." (AD TRAC 16-24 - SSI).* Others described how the pandemic helped to move along progress: *"…if it wasn't for lockdown I think this would've all happened far more gradually over a longer period of time. I don't think there would've been a sense of urgency." (Milford Haven School - SSI)*. Being 'forced' to adapt and make services more accessible was seen as beneficial to the communities they supported, with Covid being a catalyst to making improvements to services.

The increase in awareness of period poverty during lockdown was also seen as a positive of the pandemic. This was beneficial for those who experienced period poverty, or needed menstrual health support, as described within the following online quote: "*Our beneficiary numbers have grown as more refugees and asylum seekers hear about our services. Due to the range of products provided, we are more able to cater to individual needs" (Online Survey response #5).* An increase in awareness of period poverty within this context is interpreted as better supporting the needs of communities that may not have been aware of services available prior to the pandemic. The increase in period poverty awareness was also viewed as positive for service providers, with services being able to draw on media interest in the subject during lockdown to access further support. A representative from Period Positive summarises the benefits for service providers in the following quote: *"I think it's worth saying that organisations that focus on product donation have been able to use the messages of COVID to amplify the need and get more products." (Period Positive - SSI).*

5.6.4.3 Summary

Those providing access to free products had to adapt their service provision to be able to support their service users within the constraints of Covid-19 disease control measures, such as social distancing and building closures. Despite challenges, new ways to reach service users were introduced successfully, including the promotion of reusable menstrual products. Reusable products were particularly helpful for those attending school as they helped to reduce anxiety around not being able to access products easily during Covid-related school closures. Online MHE sessions for teaching staff were also successfully introduced, offering flexibility and improved accessibility for those delivering and attending them. Services viewed the increase in awareness of period poverty during the pandemic as positive, with Covid-19 being a catalyst for improvements to service delivery for some.

5.6.5 *"We've had to fight so hard…":* uncertainties and inconsistencies in menstrual health policies during the pandemic

This theme describes service provider experiences of providing menstrual health support during the pandemic within the wider context of menstrual health policy and strategy across the UK. These include various policies introduced by the UK government to tackle menstrual inequality such as providing access to free menstrual products and the provision of mandatory menstrual health education within schools (see chapter 2.2 for further details).

Services expressed concerns that pre-pandemic progress around menstrual health recognition, and addressing period poverty, would be sidelined by the pandemic. For example, a representative from AD TRAC 16-24 described how period poverty had *"gained momentum"* before the pandemic, in terms of wider acknowledgement and support, further stating they hoped that discussions around tackling period poverty *"continues to be on everyone's lips in the next five [years]".* A representative from The Real Period Project expressed their worries around period poverty progress being impacted by the pandemic, especially as they have had to "*fight so hard to get that [period poverty] even vaguely recognised in good times".* They go on to describe how the pandemic had created a need to address *"more pressing"* issues that communities were experiencing:

> …people's health and wellbeing and…and financial security and housing security; like the basic bottom of Maslow's triangle of need, hierarchy of need, you know, those things feel so important just now… raising it [period poverty] as an important enough issue to pay attention to will also be hard because there's so many other competing demands. (The Real Period Project - SSI).

Several service providers raised similar concerns that the pre-pandemic progress that had been made to address menstrual health inequalities was going to stop, or even go backwards, as menstrual health was not viewed as important as other issues within the context if the pandemic. These were further compounded by fears that the government would blame the pandemic for why measures introduced to address menstrual inequality pre-pandemic had not been successful, as described by a representative from Period Positive within the following quote: *"I don't want the government in a year's time to blame COVID on the scheme not working…".* This quote is specifically discussing the introduction of free menstrual products within schools in England, which was implemented just prior to the pandemic in January 2020 but had received poor take-up within schools across the country (Department for Education., 2023). The representative from Period Positive goes on to explain why they felt the implementation of the scheme had been poorly received within schools, explaining that *"The scheme didn't work because they [Department for Education] did it wrong. Because they didn't ask the right questions of the right people. And the people they did ask questions of may have had a different agenda." (Period Positive - SSI).*

Frustrations around a perceived lack of commitment to addressing menstrual inequality with the onset of the pandemic were also described by several service providers regarding the Government Office for Equalities 'Period Poverty Taskforce' (see chapter 2.2 for further details). Providers discussed the lack of communication and transparency on the future of the taskforce, with a representative from Brook stating that the taskforce had been *"kind of disbanded"* during the pandemic. The taskforce was further discussed within the context of uncertainties around the future funding available address menstrual equity: "*it [taskforce] was pitifully funded in the first place, but, at least it was something." (The Real Period Project – SSI).*

The link between financial poverty, period poverty and the increase in the need for more menstrual health support during the pandemic was also talked about within the context of funding for service provision.

Despite the increase in demand during the pandemic, the funding available for services that provide menstrual health support and access to free menstrual products, had not increased to reflect this:

> It [the pandemic] has pushed more people into period poverty and so there is just more of a burden on services than ever before, but funding has not reflected this increase (Online Survey response #17)

Service provider representatives discussed the uncertainties over how much funding would remain available given the additional spend attributed to Covid-19 measures and the shift in government priorities, despite pledges by the government to 'end period poverty by 2030' (Mourdant, 2019). Although local authorities within Scotland and Wales received government funding to provide access to free menstrual products within various locations (such as schools), an apprehension over how the pandemic might impact their future funding was still prevalent as illustrated by the following quotes:

> We did have our allocation confirmed this year, but then with COVID it was reduced by half, because of WG [Welsh Government] having to spend money elsewhere, which is understandable, so we're hoping, when and if things improve next year, that the full allocation will be resumed. (Merthyr Tydfil County Borough Council - SSI)

> In a lot of other areas in Scotland it is the local authority who have taken on the delivering of products and such, so taking on the logistics of that on their behalf. I think there is some acknowledgment that we will have a role in whatever comes next. But I do think there will be an element of fighting our corner, as always in the third sector, to get the recognition and resources that we would need to keep doing that. (PKAVS Tampon Taxi - SSI)

In late 2021, Scottish government made the free provision of menstrual products in public buildings a legal requirement (The Scottish Parliament, 2021). This was viewed as positive and referenced by many of the service providers that took part in the study as a significant achievement, particularly during the pandemic. However, for those already involved in the delivery of free menstrual products within Scotland this also caused anxiety over how the newly imposed law might impact existing service provision, as a representative from PKAVS Taxi stated:

> We have some big conversations to have, but in terms of the period products free provision bill that's now been passed in Scotland, we have some conversations coming up with our

> local authority about what that's going to look like in our own local area (PKAVS Tampon Taxi - SSI)

For service providers in England that worked with schools to provide menstrual health education (MHE), several expressed concerns that MHE continued to be deprioritised during the pandemic. Despite MHE becoming mandatory September 2020, service providers were concerned that MHE "*seems to have been put on a backburner." (Periods Matter - SSI).* Several talked about their fears that mandatory MHE implementation would continue to be 'pushed back' during the pandemic:

> Relationships, sex, education and health education is now mandatory in schools. But the government have pushed that back, although it's mandatory, they've kind of pushed it back to the summer to kind of make schools comply, I suppose. (Brook - SSI)

> I think menstrual health education, because it's meant to be mandatory now as well, isn't it?... But we're all worried that it's just going to keep getting pushed back and pushed back. (City to Sea - SSI)

The deprioritisation of menstrual health education within schools was felt to have existed pre-pandemic, but worries about further setbacks due to the pandemic were also expressed with the need for menstrual products and education being 'amplified' as a result:

> …the main thing I'm gathering is that everything is just amplified. There is a desire to find out more about periods, which is amplified. There's a desire to find out about reusables, which is amplified. There is a lack of access to products whether that's through financial reasons or fear factor or lack of access to people they can talk to reasons. And that's bigger. (Period Positive - SSI)

The concerns expressed by service providers around lack of funding, inconsistencies and uncertainties around menstrual health policy and the deprioritisation of menstrual health during the pandemic are indicative of the historical neglect and ignorance of menstrual and wider women's health across society. Despite applying to roughly half of the world's population, menstrual health remains vastly neglected within global priorities (Babbar et al., 2022; Jalali, 2023; Women & Equalities Committee, 2024), owing to calls to address menstrual health inequality as a human rights issue (Babbar et al., 2022; United Nations General Assembly, 2024). More broadly, women's health research remains vastly underfunded, despite women being more likely to be misdiagnosed and to experience delays in accessing treatment (Chang & Johnson, 2025; Young, 2024). Funding for research into conditions that predominantly effect (cisgender) women, such as endometriosis, uterine fibroids and Polycystic Ovary Syndrome, is further limited despite their prevalence and the associated negative impact upon quality of life for those living with the condition/s (Chang & Johnson, 2025). For example, despite the prevalence of uterine fibroids within women in United States of America, no new medical drug treatments have been approved for use in over 15 years (Young, 2024). The chronic underfunding of women's health research is therefore mirrored in the neglect of women's health within healthcare policy and practice, further demonstrating that women's health overall is viewed as 'less important' than men's health within society (Young, 2024).

Despite the concerns raised by numerous service providers around the uncertainties and shift in priorities related to menstrual health policy during the pandemic, the shift in priorities and focus to the pandemic was seen as a positive for some historically minoritised communities:

> What COVID has done for us which has been quite useful is highlighted the health inequalities with people of colour, with people from LGBTQ backgrounds, and I think that has been…it's finding everything we've been chatting about for the last five years, and someone's actually turned round and said actually that's true. (Cysters - SSI)

In the above quote from a representative from Cysters, they are not specifically discussing menstrual health but wider health inequalities that have not received attention. However, for service providers that worked with historically minoritised communities (such as Cysters), it was 'validating' that society was beginning to recognise and shine a light on such existing inequalities as a result of the pandemic.

5.6.5.1 Summary

The pandemic was thought to have negatively impacted pre-pandemic progress made regarding menstrual health support, most notably regarding the provision of free menstrual products and MHE. Services providers expressed concerns over potential setbacks and uncertainty over future funding which would impact their ability to provide services. Inconsistency in UK policy regarding menstrual health and a failure to acknowledge the wider context of poverty in addressing period poverty were seen as ongoing issues, exacerbated by the pandemic.

5.6.6 *“If someone has worked up the courage to go to a foodbank, it should just then be really easy to get her period products”*: menstrual stigma and shame during the pandemic

This theme interprets service provider experiences during the pandemic within the context of menstrual stigma and shame, examining their influence on how menstrual health support was provided and accessed during lockdown. Many service providers discussed the role menstrual stigma and shame played in provision of menstrual health support. ‘Menstrual stigma’ and ‘menstrual shame’ both encapsulate the notion of menstruation as something that needs to be concealed and hidden, with menstrual blood and menstruating bodies being seen as ‘impure’ and indeed ‘monstrous’ by society (Laws, 1990; Tomlinson, 2025; Wood, 2020). Such stigma is perpetuated across society, from the advertisement of menstrual products (‘discreet’ packaging, ‘scented’ products, ‘leaking’ etc) through to poor menstrual health education and the minimisation of menstrual pain and heavy bleeding (Seear, 2009; Winkler et al., 2024).

Menstrual health service providers described different ways that menstrual stigma presented and impacted their work. For some service providers, the stigma around menstruation created barriers for their organisation as well as for those that needed the support, further demonstrating the entrenchment of menstrual stigma within society. For example, in the following example a representative from In Touch Foundation discusses how the ‘awkwardness’ that exists around menstruation can put people off donating to their collections:

> I think as well one of the challenges around what I wanted to highlight about period poverty is that I think what we’re finding is that people are happy to donate things like food products or anything like that. *But asking for people for donations or even broaching the topic about period poverty of hygiene packs, there’s that little bit of awkwardness, I can’t describe it any other way*… people are less willing to donate for that kind of cause in a way potentially to not think about it or it’s not important, or it’s not going to apply the issue around stigma. (In Touch Foundation - SSI)

In this quote, the representative from In Touch Foundation goes on to speculate how people do not want to think about menstruation or periods, or do not view them as important, because of stigma attached to menstrual health and period poverty. Menstrual shame was also raised by a representative from The Real Period Project as a barrier the organisation experiences when trying to broach the subject with people that might need help because of financial poverty. However, in this example, the participant acknowledges that their own internalised menstrual shame might also influence how they discuss the nature of their menstrual health support service:

> I have felt myself often thinking how can I bring up the subject of menstrual education; people are worrying about getting food on the table, like it's just not…it feels like…and that *feels to me linked to menstrual shame. Like it's, you know, people don't want to hear about it. It's a bit yucky* and…you know, all of that (The Real Period Project - SSI)

Both examples illustrate how menstrual stigma creates additional barriers in raising awareness of menstrual inequalities, influencing how menstrual health service providers carry out their work. Within the context of the pandemic, menstrual stigma seemed to coincide with concerns over the prioritisation of other aspects of basic needs (such as buying food) with menstrual health seemingly viewed as 'lesser' or not as important as other aspects of inequality that had also increased during the pandemic. The example from The Real Period Project further demonstrates how stigma, such as menstrual stigma and poverty, often intersect within menstrual health support to create a 'dual stigma' that creates additional challenges for both service providers and those needing menstrual health support, especially if such support is related to financial insecurity.

The dual stigma of menstrual stigma and poverty was discussed by several service providers, particularly regarding menstrual products. A representative from Periods Matter explained how the stigma attached to poverty means some people struggle to ask for help and are using makeshift products because *"it's something people don't want to admit to very easily." (Periods Matter - SSI).* A representative from Milford Haven School also talked about the reluctance they have experienced when they have promoted free reusable product packs within the school, which they attributed to the 'embarrassment' of financial poverty:

> We basically said, look, you know, we've got these packs, they're really high-quality items, we, kind of, promoted them, we said, you know, just come and get them. But people wouldn't come and then we realised it was because of the embarrassment of if you go and collect the packs, it's basically you saying, isn't it, like, I'm not in a position to fund my period. (Milford Haven School - SSI)

A representative from Bloody Good Period further discussed how recognising menstrual products as 'essential' would help to remove the 'double effort' of asking for menstrual products when accessing foodbanks, for example:

> …if someone has worked up the courage to go to a foodbank, it should just then be really easy to get her period products. Like that's where they should be. It shouldn't be an ask for someone to have to do that double effort. They should just be with all the other essentials (Bloody Good Period - SSI)

The removal of such barriers for those needing menstrual products was further described within the context of menstrual stigma and shame through the lens of menstrual concealment. Tensions between service provider approaches to providing free menstrual products demonstrate how menstrual concealment practices, such as providing discreet packaging, remain part of solutions to tackle menstrual inequality. For some menstrual health service providers, the ability to provide menstrual products in a 'discreet' manner was seen as part of promoting 'dignity' and 'respect' around menstruation and periods as a way to help combat menstrual stigma. Concealment was therefore seen as a positive way to help improve the accessibility of support within certain circumstances, removing barriers around embarrassment and shame:

> …we put like the brown paper sandwich bags so that if it was a single father and he needed products for somebody in the household could put them in the wee brown bag, so it just looked like he had their lunch, you know, to *remove the stigma*… (Free Periods Angus - SSI)

> And then the food banks then wanted to be discreet, well just wanted to be respectful really, just, you know, made arrangements to…well parcel them up and then just leave them but they knew if there were students coming to collect. So, it was all done with *respect and dignity*. (Conwy Council - SSI)

> We have little business cards, which are my favourite ones, because they're easy to give to someone and for them to have. And it's keeping that *dignity aspect*; you're not handing them a big flyer with free period products emblazoned on the front. (PKAVS Tampon Taxi - SSI)

These quotes are an interesting contrast compared to how other services talked about menstrual concealment and it's role in perpetuating menstrual stigma, as opposed to helping to address it via schemes that promote 'dignity' via discretion. For example, 'hiding' products in different ways was viewed as poor practice, placing additional barriers and burdens on those who need them. The embarrassment and shame associated with having to ask someone for a menstrual product was described as a key as a barrier in terms of accessing menstrual products, particularly within schools:

> …if they lock those products in a cupboard and it means that some poor girl or young person who menstruates has then got to go and knock on someone's door and ask for a pad and they get given one pad at a time or one tampon at a time, it's just not good enough. (Brook - SSI)

This echoes similar criticisms of 'well-meaning' schemes that were introduced during lockdown to address menstrual inequality, particularly in relation to menstrual product and financial insecurity, via coded sayings or having to ask for help (Ford et al., 2025). For example, UK supermarket chain Morrisons introduced its 'Package for Sandy' campaign during lockdown (Morrisons, 2021). The scheme requires those who need free menstrual products to attend the customer service desk and ask for a 'package for Sandy'. The employee will then give a 'discreet' package of menstrual products for the person with 'no questions asked' (Morrisons, 2021). Although the intentions behind the scheme are good, having to ask someone for products as opposed to having them freely available within spaces such as toilets, still creates an additional barrier for the person who needs products to have to go and ask for them, particularly within the context of dual stigma. Having to go and ask someone for menstrual products is indicative of the extra burden and 'double effort' placed upon menstruators when products are not easily accessible in a variety of locations, situating the solution to menstrual inequality with the individual as opposed to something that needs to be addressed within society (Bobel, 2019a).

Menstrual stigma was further described by service providers within the context of having a safe, private space to be able to talk about menstruation. Menstruation is often framed as a taboo subject that requires privacy to be able to talk about it, forming part of the secrecy and shame associated with menstrual stigma (Chrisler, 2013; Johnston-Robledo & Chrisler, 2020). Service providers described how this form of menstrual stigma, and the secrecy attached to talking about menstruation as a 'taboo' subject, applied to people who needed to speak to medical professionals via phone or video appointments and to those attending online educational sessions on menstrual health. Service provider representatives discussed how the shift to holding educational sessions online, remote access created barriers when talking about menstruation:

> It's also easier to explain something taboo if you're physically there to be a reassuring and open presence. If you're just doing it over Zoom there's another barrier there, there's like an othering that doesn't need to take place. (Period Positive - SSI)

A representative from Period Positive further described how being able to have 'natural' conversations in-person was particularly important to further counteract stigma within school settings, stating: *"you also are* *missing access to the conversations and the lessons and the dialogues that people could also be having about periods which make access smoother." (Period Positive - SSI).* Being able to have conversations and interactions with people about menstrual health, in both online and in-person environments, therefore provides a range of ways to tackle menstrual stigma. Although online environments and the use of telemedicine during the pandemic can be seen to perpetuate menstrual stigma, treating menstruation as a 'taboo' subject that requires privacy, it is still important to be able to provide safe spaces for people to feel comfortable to engage within discussions around menstrual health. This argument also applies to the use of 'discreet' packaging for menstrual products described previously, as it is important to be able to provide products in ways that are accessible for everyone. Although these practices reinforce menstrual concealment and menstrual stigma, to be able to address menstrual inequality we must prioritise the needs of those who menstruate and create opportunities for everyone to feel included and able to access support in their preferred way (Weckesser et al., 2019). This ethos also applies to how menstrual products, and wider menstrual health issues, are discussed within public to further ensure that everyone who menstruates feels included and represented (Weckesser et al., 2019).

Some service providers described the different ways that the pandemic provided opportunities to address the gendered language typically associated with menstruation. For example, the gendered language associated with menstrual products was tied in with such discussions around recognition of products as essential items during lockdown. Within the following example, the use of gendered language when advertising menstrual products within retail outlets was critiqued due to its use of 'outdated' language:

> I saw somebody putting something on Twitter today for Morrisons, like shouldn't we stop calling it feminine hygiene now, because, you know above the aisles they've got the signs?... In Morrisons they still call it feminine hygiene. And it was like, yeah, we need that kind of whole system change for this stuff. (Free Periods Angus - SSI)

Such stigmatising language was also discussed in relation to gender inclusion and gender neutrality when discussing menstrual health and products:

> …it's sort of been there since the beginning of our campaigning but it feels more polarised this year, is peoples' opinions on the language that we use around periods, particularly in relation to talking about people with periods instead of women and girls… it's hard to pinpoint it's the pandemic or wider goings on…(City to Sea - SSI)

For City to Sea, such discussion was felt to be polarising within the context of the pandemic and 'wider goings on' around transgender rights and 'gender critical' ideologies. Within the menstrual equity sector, the use of gender inclusive and gender-neutral language is part of addressing menstrual stigma, with many services adopting such language to be more inclusive of everyone who menstruates. Thus further demonstrating the importance of accessibility, inclusion and representation when addressing menstrual inequalities.

5.6.6.1 Summary

Although stigma and shame were not specific to the pandemic, many service providers discussed them as being ongoing barriers to service provision. The combined, intersectional stigma of menstruation and poverty were thought to impact how those needing support could access things like menstrual products, with wider stigma around language and how menstruation is talked about further compounding this. However, the pandemic did provide some opportunities to discuss and address menstrual stigma within wider society, particularly around the essential nature of menstrual products and the use of gendered language designed to perpetuate menstrual concealment (e.g. 'feminine hygiene').

5.7 Discussion

The re-analysis data addresses the research questions and aims relevant to this phase of the study (section 5.2) providing insight into menstrual health support provider experiences during lockdown, what influenced their experiences and how services managed any challenges to continue to meet the needs of those they supported during the pandemic. The analysis demonstrates how it is important to recognise the pandemic's impact within wider contexts when examining how it shaped menstrual health support provision within the UK. Although many of the challenges experienced by service providers were related to measures introduced to prevent the spread of Covid-19, existing menstrual stigma and gender inequality further influenced and exacerbated them, causing barriers for service providers as well as service users. The analysis shows how services were able to adapt in response to Covid-related challenges and continue to provide menstrual health support to meet the needs of their service users, thus addressing the first research question (RQ1). Improving engagement with communities, although adding to the increase in demand for support related to the pandemic, was something that service providers viewed as positive. Although the pandemic was seen to exacerbate existing menstrual health inequalities within the UK, services interpreted the increase in awareness in period poverty during the pandemic as more people knowing how to seek support for their menstrual health, most notably around menstrual products.

Arguably the increase in the need for menstrual health support contributed to an increase in menstrual inequality, as more people sought already over-stretched and under-resourced services filling a gap within menstrual health support. The analysis demonstrates how volunteer-led services at the frontline of the pandemic, led by women to support women and people who menstruate, suffered additional stress as their staffing resource dwindled during lockdown. However, it is important to reflect on how the reported increase in the need for menstrual health support during the pandemic also *addressed* menstrual inequality as more were able to have their menstrual support needs met by accessing these services.

This juxtaposition around menstrual inequality is further compounded within the context of UK policy and funding for menstrual health, with the uncertainty around central government funding and policy regarding menstrual health being key concerns discussed by service providers across the UK. Fears that pre-pandemic progress around menstrual equality had halted or been set back during the pandemic time were expressed by many, along with concerns that the pandemic would be 'blamed' for perceived failings in the implementation of policies (e.g. the provision of free period products within schools in England). However, progress regarding menstrual equity *was* seen during the pandemic with the passing of Scotland's Period Products (Free Provision) Act in 2021 (The Scottish Parliament, 2021), indicating that it is possible to enact change to address menstrual inequality even during challenging times.

Service providers felt that the potential for government to shift blame to the pandemic ignored the underlying issues that needed to be addressed that had been *exacerbated,* not caused, by the pandemic. This is discussed in numerous ways throughout the analysis, with multiple inequalities and identities (including race, disability and gender) intersecting with existing menstrual stigma, creating barriers to menstrual health support. These existed pre-pandemic, with Covid-specific factors such as non-essential workplace closures, social distancing and purchasing restrictions, causing extra challenges for those providing such support during lockdown. Findings therefore address research questions one (RQ1) and three (RQ3), providing insight into menstrual health support provider experiences during the pandemic, how the pandemic influenced and shaped such experiences and how any challenges to service provision were overcome.

The increase in such 'intersectional stigma' during the pandemic was discussed in several ways throughout the research analysis. 'Intersectional stigma' refers to multiple stigmatised identities within a person or group, building on Crenshaw's work on 'intersectionality'(Crenshaw, 2013) and the sociology of 'stigma' (Tyler & Slater, 2018), whereby systems and structures of oppression also 'combine and overlap' (Logie et al., 2022). The analysis of this phase demonstrates how identities such as gender, race, disability and socioeconomic status further intersect with menstrual stigma, influencing how menstrual health support was provided and accessed during the pandemic. For example, the intersectional stigma of menstruation and poverty was talked about as a barrier to accessing menstrual health support, recognising that not only is it difficult to talk about periods because of menstrual stigma and shame, but it can also be difficult to talk about money and needing financial support as this is also stigmatised within society (Inglis et al., 2019; Sutton et al., 2014). The intersection of disability and menstrual stigma was discussed within the context of menstrual product access, with those who needed to purchase larger amounts of products due to heavy menstrual bleeding suffering because of purchasing restrictions on such items. These examples further demonstrate the importance of having an intersectional approach to addressing menstrual inequality, to ensure that the needs of all menstruators are met (Hennegan et al., 2021; Weckesser et al., 2019). Furthermore, the analysis of such examples provides insights into what the needs of those who menstruate were during lockdown and how those needs were met by service providers during the pandemic, addressing research question 2 (RQ2).

5.8 Conclusion

The provision of menstrual health support within the UK is illustrative of how existing inequalities were exacerbated because of the pandemic and the UK's response to Covid-19, providing insight into how such factors influenced the provision of menstrual health support during lockdown. While menstrual health remained low priority in terms of the governments' Covid-19 response, those providing menstrual health support experienced high increase in demand for their services to fill the gaps created, and further exacerbated, by the pandemic. Although this increased menstrual inequality across the UK, service providers viewed the increase in the need for their services as positive as more people became aware of what menstrual health support was available to them during this time.

The following chapter (Chapter 6) turns to Phase 2 of the study, outlining the methods employed to capture the experiences of those who needed menstrual health support during the pandemic. It then presents the analysis of the reflexive thematic analysis undertaken, discussing the implications in relation to the study aims.

6 Chapter 6: Phase 2: how the pandemic impacted those needing menstrual health support

6.1 Introduction

The previous chapter provided detailed description of the research methods utilised during phase 1 of the Periods in a Pandemic project and presented the reflexive thematic analysis undertaken to address the aims of the current study. This chapter provides a more in-depth description of the research methods utilised during phase 2 of the Periods in a Pandemic project, focusing on service user experiences, and presents the analysis undertaken to address the aims of the current study.

The chapter outlines the research questions relevant to this phase of the current study and goes on to describe the research design that the PIP project used to gather data for phase 2, including recruitment and data gathering methods. The main ethical considerations for this phase are discussed, and a reflexive account of the research process is included. Finally, the re-analysis of both qualitative and quantitative data is presented and discussed, combining the reflexive thematic analysis with descriptive statistics to provide a richer account of how the pandemic shaped menstrual health experiences.

NB. 'Menstrual health support' within this phase refers to: access to menstrual products, information about menstrual health and needing additional support with any menstrual health concerns (such a professional medical advice).

6.2 Research questions and aims

Phase 2 data gathering took place during July – December 2021. However, participants were asked about their menstrual health experiences from the beginning of the Covid-19 restrictions within the UK (March 2020) to the date of participation, which included several lockdown periods during this time. Building on phase 1 of the study, phase 2 sought to explore menstrual health support needs and the impact of the pandemic from the perspective of those needing menstrual health support (e.g. service users). Additionally, it also examined whether any menstrual cycle or menstruation changes had been experienced during lockdown, and whether such changes had led to any difference in menstrual management practices.

The key research questions for this phase were therefore:

1. *What menstrual health support do women, girls and people who menstruate need during the pandemic?*
2. *What are the experiences of women, girls and people who menstruate who need menstrual health support, during the pandemic (including any changes to their menstrual cycle)?*
3. *How did the pandemic influence the accessibility of menstrual health support for those needing such support during lockdowns within the UK?*

6.3 Methods

6.3.1 Eligibility criteria

Participants were eligible to take part in phase 2 if they were over 16 years of age, currently resided within the UK and had needed support with their menstrual health/periods during the pandemic. This was specified in the recruitment materials.

6.3.2 Recruitment

6.3.2.1 Online survey

Participants were recruited via social media, using an advertisement that included the link to the survey (see Appendix I). The survey was shared via Twitter (X) and Facebook, with the option for re-sharing (public posts). Social media provided the opportunity for the survey advertisement to be shared. During the pandemic, this was a useful strategy to share the survey due to social distancing restrictions and the increase in the use of social media to share information during this time (Aggarwal et al., 2022).

The survey link was also shared with phase 1 service providers that had stated they would be happy to be involved in helping to recruit for phase 2, with a request to share with their service users. Services were informed that paper copies of the survey could be sent to them with stamped addressed envelopes, for any service users who did not have access to the internet and/or preferred this option. They were also informed that participant information was available in different languages, upon request. However, no requests for paper copies of surveys or for translated participant information were received.

6.3.2.2 Semi-structured interviews

Where survey respondents had stated they were interested in taking part in a follow-up interview, the researcher then contacted them via the email address provided and sent a copy of the Participant Information sheet (Appendix K) and consent form (Appendix L) for semi-structured interviews. If the researcher had not received a response to the initial email within 5 working days, a reminder email was sent with a further 5 working days granted for a response to be received. If the researcher had still not received a response within this time, they were not contacted again. An advert was also placed on social media platforms for interested participants to contact the researcher if they wanted to find out more or take part in an interview (Appendix I).

6.4 Data gathering

The justification for using a mixed methods approach to data gathering for this study have been explained within chapter 4. To avoid repetition, they will not be discussed within this chapter.

6.4.1 Online survey

The online survey questions were developed following the analysis of phase 1 data for the Periods in a Pandemic project, to identify the key priorities and factors that were impacting access to menstrual health support during the pandemic and any emerging or new areas that warranted further examination (Appendix J). These included access to menstrual products, menstrual health knowledge and education, and menstrual healthcare experiences. As with phase 1, news media coverage of the impact of the pandemic on menstrual health and period poverty was also drawn upon, as this provided additional insights into key current issues to include, such as the impact of Covid on the menstrual cycle (BBC News Health, 2021; Thomas, 2022). The draft questions were shared and agreed with the Project Advisory Group (PAG) for feedback, to ensure that all relevant areas were included. The survey was piloted before it was launched with the researchers' colleagues and several university students, to check the functionality of the survey and the accessibility of the layout and language used. Questions sought to compare individuals' pre-pandemic experiences with their current pandemic experiences and covered the following areas: accessing period products, needing help/support for periods, periods during Covid/lockdown and accessing future support during the pandemic.

The survey included closed and open-ended questions, with closed questions acting as prompts for each section to provide a clear, comprehensive structure for respondents. All closed questions were provided with an 'other' option, where respondents could provide details of anything that was not included in the options available. Open-ended questions were also provided to find out about factors influencing closed question responses, and what people's experiences were in more depth. Providing open-ended questions in this way and including the use of 'other' as a category, allowed participants to populate questions with their own responses and include details of experiences they deemed to be important to share, using their own language, (Ball, 2019).

Participants were also asked optional demographic information, including questions on age, gender, ethnicity, preferred language, disability, employment status, relationship status, if they had any children/dependents and geographical location. These questions were based on the latest (2021) UK Census survey (UK Data Service, n.d.) to allow for comparisons against relevant census data, if requested by service providers or other organisations that were interested in the data obtained during the Periods in a Pandemic project.

Respondents were also given the option to receive a £10 Amazon voucher as a ‘thank you’ for taking part. Those interested were asked to provide a suitable email address where further information could be sent to, which was kept separate to the survey responses. Vouchers were available until the funding for participant vouchers for survey responses had been exhausted (n=200 responses), however, more responses were received than originally planned for. The funding accounted for payment for up to 200 responses. At the point that this was then exceeded, the recruitment information and the survey details were amended to inform people that the vouchers were no longer available (n=40 responses). The survey was created using Online Survey v2 and open for completion for a period of eight weeks.

6.4.2 Semi-structured interviews

A semi-structured interview (SSI) guide (Appendix M) was produced, following the topic areas included within the online survey as agreed with the PAG. If the participant had not yet returned the consent form prior to interview, the researcher obtained verbal consent by reading through the consent form and asking the participant to confirm each question (Flory & Emanuel, 2004). A copy of the completed consent form was sent to the participant after the interview had been completed, for their reference. Participants were offered a £10 ‘thank you’ voucher for their interview.

At the beginning of the interview, the researcher checked again if the participant had any questions and were happy to continue. This was especially important given the potential sensitivity of the questions and the possibility of participants becoming upset or distressed when talking about their experiences (Pascoe Leahy, 2021). The researcher therefore reiterated that the participant did not need to answer any question they were not comfortable with and could stop the interview at any time. This did not occur during any of the semi-structured interviews. To build rapport and trust between the researcher and interviewer, the researcher allowed for a more informal and natural conversation to occur (Mealer & Jones Rn, 2014) when going through the semi-structured questions. The researcher also reciprocated with information about their own experiences during the pandemic and seeking menstrual health support, where appropriate, to provide reassurance and facilitate engagement (Drabble et al., 2015).

As with phase 1 interviews, the researcher used prompts to encourage participants to share their experiences. Given the potentially sensitive nature of the questions asked, the researcher made sure that they used active listening techniques to pick up on any verbal cues or sounds of distress or upset, as they could not see the interviewee to pick up on non-verbal cues (Drabble et al., 2015). If such cues were picked up on, the researcher checked if the participant was okay and if they wanted to carry on with the interview stating that it was fine to pause or to stop altogether. This occurred during one interview when the participant sounded upset while discussing their experiences of seeking help for heavy menstrual bleeding during the pandemic. The researcher paused the interview to make sure the participant was happy to continue or if they wanted to have a break or stop altogether, however, the participant stated they were happy to carry on. Interviews were audio-recorded with recordings sent to the same external transcription service used during Phase 1 for verbatim transcription.

6.5 Ethical considerations

As with phase 1, the main considerations for phase 2 of data gathering centred on informed consent procedures, confidentiality/anonymity of participants data, equality, diversity and inclusion (EDI) issues and minimising the risks associated with Covid-19 infection. The ethical implications of conducting research during the pandemic have already been discussed in chapter 4. For semi-structured interview participants, an additional risk of potential distress or upset while talking about their experiences during the pandemic or about their menstrual health, was also important to address.

Risks of Covid-19 infection were minimised as no face-to-face data gathering was planned during this phase. The main form of data gathering was an online survey, with semi-structured follow-up interviews undertaken via telephone. To ensure informed consent for the online survey was obtained, participant information was provided on the first page of the survey, prior to the questionnaire (Appendix J). The information provided details of the study aims, inclusion criteria for taking part, what taking part involved (i.e. questionnaire with tick box and open questions to write as much as participants wanted), any potential risks/benefits to taking part and any incentives involved (e.g. £10 voucher upon submission of completed survey), how survey responses would be stored and who would have access to them. Details of who to contact with any complaints or questions about the research were also provided. The information was written in lay-friendly language, as the survey was aimed at members of the public.

The information made clear that consent to use survey data within the study would be assumed via submission of the survey, unless stated otherwise, and that it would not be possible to withdraw a submitted survey response as the data was anonymous. Participants were asked to confirm that they were happy for their anonymised responses to be used within any publications, reports or presentations before completing the questionnaire, by ticking ‘yes’ or ‘no’.

For those interested in taking part in a follow-up interview, the researcher sent a copy of the information sheet (Appendix K) and consent form (Appendix L) via the email address provided via the survey response. This provided details of what the study aims were, the inclusion criteria for taking part, what taking part involved (i.e. SSI taking around 30 minutes), right to withdraw from the study, any potential risks/benefits to taking part and any incentives to taking part, how data would be recorded and stored, who had access to data and what data would be used for (e.g. reports, publications, presentations). Details around who to contact about data protection concerns, a complaint, or if they chose to withdraw from the study, were also provided.

For SSI participants that had not returned a completed consent form prior to interview, the researcher obtained verbal consent by reading through the consent form and asking for confirmation of each point (Flory & Emanuel, 2004). The researcher then signed this, and a copy of the completed consent form was then sent to the participant for their records. If the participant did not consent to audio recording, the researcher would take notes during the interview instead, however, this did not occur during any interviews. Interview participants received a £10 ‘thank you’ voucher for taking part, which was available even if they chose to withdraw from the research at any stage (during or post interview).

To minimise the potential for distress or upset during SSIs when talking about potentially sensitive subjects (Pascoe Leahy, 2021) like the pandemic or menstruation, the researcher ensured that reassurances were provided within the information sheet. These included informing participants they could skip questions they were not comfortable with or stop the interview at any point without negative consequences. This was also reiterated at the start of the interview, before asking questions. If someone sounded distressed or became upset during the interview, the researcher checked if the participant was okay to continue or if they wanted to have a break or stop the interview (Drabble et al., 2015; Mealer & Jones Rn, 2014).

To ensure privacy and confidentiality during interviews, the researcher ensured that they were in a private office space to undertake telephone interviews and asked participants if they were happy to be interviewed in the location they were at when they received the phone call (e.g. home). By agreeing to a suitable interview date based on the participant's availability, and checking if it was still appropriate to undertake the interview before starting, this minimised risks for the participant in terms of confidentiality and privacy (Mealer & Jones Rn, 2014).

Participants in both the online survey and semi-structured interviews were offered a £10 voucher as a thank you for taking part in the study, available upon completed survey submission and interview completion. This was felt to be appropriate by the Project Advisory Group given the nature of the research and that some participants may be struggling financially during the pandemic, especially with regards to purchasing menstrual products (Groth, 2010). However, for those completing the online survey, funds for vouchers ran out part-way through the data gathering period as the researcher only had a budget for 200 responses. At this point, the project team and PAG were consulted to decide whether to keep the survey open for the full amount of time allotted to data collection. It was agreed that the survey would be kept open for the originally planned amount of time, as the survey also acted as a way to recruit participants to semi-structured interviews for phase 2. The survey details and recruitment materials were therefore amended to clarify that the £10 voucher was no longer available, but a question was included to ask participants if they would like to receive a voucher in the future if further funding became available as the researcher explored possible alternative funding sources to be able to continue with the provision of survey vouchers. Unfortunately, no additional funding became available which meant that 40 survey respondents did not receive a thank you voucher for taking part in the study. Interview participants were not impacted by this as separate monies had been made available for interview vouchers.

6.5.1 Equality, Diversity and Inclusion considerations

All participant documentation and materials used gender inclusive language around menstrual health in recognition that not all who menstruate are cisgender women and girls. Using phrases such as 'women, girls and people who menstruate' or 'those who menstruate' are inclusive of transgender, non-binary and gender diverse individuals. Such inclusive language is best practice within menstrual health and period poverty advocacy sectors (Weckesser, Randhawa, et al., 2019). Lay-friendly language was also used within all documentation, as this phase of research was aimed at members of the public whose knowledge around menstruation may vary significantly and who may not be familiar with research and what it involves.

As some participants may not have had English as their first language, may have had learning difficulties (Cameron & Murphy, 2007), or may not have had access to computers/smartphone technology to complete an online survey, several options were made available to increase the accessibility of the survey and interviews. The survey was available in paper format for those who preferred this option or could not access a laptop/smartphone to complete it, with stamped address return envelopes to minimise costs of returning the survey. The researcher did not receive any requests for paper copies of the survey. For interviews, the option of using verbal consent at the beginning of the interview process allowed for more 'lay friendly' conversation to occur to aid understanding, clarify queries or alleviate any concerns as needed (Flory & Emanuel, 2004). Participant documentation was translated into 5 different languages, available upon request: Welsh, Punjabi, Urdu, Bengali and Gujarati. Funds were also available for any interpreter services that may be needed during data gathering. The researcher did not receive any translation requests for participant documentation or any requests for interpreter services.

In addition to minimising Covid-19 infection risks by reducing the need for travel and face-to-face contact, online surveys and telephone interviews may have been beneficial for disabled participants, as they could utilise spaces and equipment to aid their participation (e.g. assisted technology, headsets, speakerphone etc).

6.5.2 Ethical approval

Phase 2 ethical approval was obtained via BCU's Health, Education and Life Sciences Faculty Ethics Committee, under reference number: Williams /#8034 /sub2 /R(B) /2021 /Jan /HELS FAEC (Appendix C).

6.6 Data analysis methodology

Online Survey data was exported into an Excel spreadsheet for analysis and stored in the researcher's BCU OneDrive account. The researcher also utilised the analysis tools available within Online Survey to produce descriptive statistics showing percentage responses to closed-ended questions. Semi-structured interviews were audio recorded and sent to an approved external service for verbatim transcription. Anonymised transcripts were stored in the researcher's secure BCU OneDrive account, which only they can access. Interviews lasted between 20-60 minutes, with three lasting 20-30 minutes and one being an hour in duration.

Open-ended online survey data and SSI data were combined for analysis within NVivo12. Reflexive thematic analysis was applied to the qualitative data to produce themes and sub-themes. Descriptive statistics, shown as percentages, were then used to demonstrate the frequency of shared experiences, not to provide any correlations. The justifications for using reflexive thematic analysis and descriptive statistics for this phase of the study has been explained within chapter 4, with a more detailed description of how data was analysed. To avoid repetition, this has not been discussed within this chapter. The final reflexive thematic analysis produced three overall themes and related sub-themes, summarised in Table 3 below. Themes and sub-themes are both descriptive and latent (interpretive), producing an analysis of the data that describe the experiences of those needing menstrual health support during lockdowns (descriptive themes) and the underlying causes behind the events being described (interpretive themes). When combined with the descriptive statistics, the analysis provides richer insights into what factors shaped menstrual health experiences during the pandemic and how the pandemic shaped menstrual health needs. A more detailed example of the RTA process for this phase of the study can be found in Appendix O.

Theme	Sub-theme
"Maybe it's the stress that causes me to have irregular periods": trying to understand menstruation during the pandemic	
"During a pandemic, my concerns about my periods seemed frivolous": seeking menstrual health support during the pandemic	• Difficulties getting healthcare – are periods important during a pandemic? • Problems getting (menstrual) products
"I've got enough to last about 6 months now": managing menstruation during lockdown	

TABLE 3: PHASE 2 REFLEXIVE THEMATIC ANALYSIS THEMES AND SUB-THEMES

6.7 Researcher reflexivity

As discussed in chapter 4, reflecting and reflexivity are vital parts to undertaking feminist, critical research (Martin, 2003) and reflexive thematic analysis (Braun et al., 2022). As with prior discussions on reflexivity (chapters 4 and 5), this section will be written in the first person.

As this phase of the research focused on people's experiences of accessing menstrual health support during the pandemic, it was important to acknowledge that I would have been eligible to take part in this stage of the study due to my own menstrual health needs during lockdown. I was, therefore, aware that my own experiences would shape some of the questions posed and how I approached the semi-structured interviews, possibly limiting the scope of what was asked. As with phase 1, using a collaborative approach towards recruitment and data gathering via the Project Advisory Group involvement was helpful in making sure that all potential areas for inclusion were covered within the survey and subsequent interviews. Furthermore, as the interim analysis from phase 1 of the Periods in a Pandemic project was also used to shape the focus of phase 2, this informed and shaped the design of the online survey and interview questions.

Furthermore, my own experiences during lockdown and my own health-seeking experiences will have influenced how I conducted the reflexive thematic analysis, and what aspects I considered to be important to focus on. As mentioned in chapter 5, during the pandemic, I was classed as Clinically Extremely Vulnerable and experienced difficulties accessing healthcare services for new and ongoing issues. These experiences not only influenced decisions around the research design and implementation but also issues that I felt were important to focus on during the analysis (e.g. accessing menstrual health care, dismissal and minimisation of health concerns) based on my own lived experiences.

My own experiences were helpful to draw upon when conducting the interviews as they provided a way to build rapport and trust, showing sympathy and empathy with those who had needed to access support for their menstrual health during lockdowns. For example, where participants that had struggled to access medical support during the pandemic for their menstrual health needs, I was able to empathise by echoing that I had also experienced similar problems. However, I was not prepared for how some of the experiences people talked about would impact me, personally, and had not included this in my ethics application as a potential researcher risk. My insider researcher position and familiarity with the topic of menstruation had led me to think such risk would be low to non-existent. However, some of the accounts I heard were highly emotive for myself, although the participants did not seem to voice any distress or upset and were fine to carry on with the interview. One interview made me feel upset and angry over how the participant had been treated by the healthcare service, her experiences echoing some of the gaslighting and dismissal I have also experienced. I contacted one of my supervisors to talk about how this affected me and to plan for any potential future occurrences, including debriefing after interviews and keeping a reflexive journal to record thoughts and feelings.

6.8 Data analysis

The justification for using reflexive thematic analysis and descriptive statistics for the study analysis has been explained within chapter 4, with a more detailed description of how data was analysed. To avoid repetition, this has not been discussed within this chapter.

6.8.1 Demographics

6.8.1.1 Online survey demographics

240 online survey responses were submitted from July – December 2021. Most survey respondents identified as 'white' (71%) female/women (89%), aged 21-30 (48%), residing in England (74%). Over 70% were employed, either full (55%) or part (27%) time. 58% stated they had children/dependents, with 40% being married (highest percentage). Only 2 respondents stated they considered themselves to be disabled (hearing impaired and Post-Traumatic Stress Disorder). Most respondents used English as their preferred language, with only 2 respondents stating they preferred to use a different language. However, neither of these participants contacted the researcher to ask for translated versions of any participant documentation, or the survey questions.

Several responses were missing or counted as 'nonsense' responses for each demographic question (e.g. putting a number or a series of random letters). These have been included in the below tables (Tables 4-11). These responses have not been excluded from data analysis, as it is difficult to ascertain whether they are false and other questions had been completed as expected (e.g. coherent answer given). Furthermore, fixed demographic questions which provided pre-categorised responses (Tables 4,10 and 11) elicited a better response rate compared to open-ended demographic questions, indicating that convenience may have influenced how participants completed the optional demographic questions (O'Cathain & Thomas, 2004). For survey responses to be submitted and included within the data set, they had to have actively clicked on 'submit' at the end of the survey. Those who had not clicked 'submit' at the end therefore did not get included.

Age	Response numbers	Response percentage
16-20	19	8%
21-30	115	48%
31-40	94	40%
41-50	10	4%
51-60	0	0
Over 60	0	0
Missing	2	0.8%

TABLE 4: AGE (FIXED SURVEY RESPONSE)

Gender	Response numbers	Response percentage
Female	205	86%
Male	8	3%
Woman	5	2%
Cisgender woman	3	1%
Non-binary	1	0.4%
Missing/nonsense	18	7.5%

TABLE 5: GENDER (FREE TEXT RESPONSE)

Ethnicity	Response numbers	Response percentage
Black	5	2%
British	4	2%
Caucasian	33	14%
England/English	22	9%
Indian	2	0.8%
Irish	1	0.4%
Japanese	1	0.4%
Jewish	1	0.4%
Polish	1	0.4%
Mixed	2	0.8%
White	112	47%
White British	19	8%
White Scottish	6	3%
Missing/nonsense	31	13%

TABLE 6: ETHNICITY (FREE TEXT RESPONSE)

Disability	Response number	Response percentage
No disability/not applicable	19	8%
Hearing impaired	1	0.4%
PTSD	1	0.4%
Missing/nonsense	219	91%

TABLE 7: DISABILITY (FREE TEXT RESPONSE)

Relationship status	Response number	Response percentage
Living with partner	33	14%
Married	96	40%
Common law	1	0.4%
Engaged	1	0.4%
In relationship/love	19	8%
Precarious	1	0.4%
Separated	2	0.8%
Single	58	24%
Missing/nonsense	29	12%

TABLE 8: RELATIONSHIP STATUS (FREE TEXT RESPONSE)

Children/dependents	Response number	Response percentage
Yes	137	58%
No	101	43%
Missing/nonsense	2	0.8%

TABLE 9:CHILDREN OR DEPENDENTS (FIXED RESPONSE)

Preferred language	Response number	Response percentage
English	220	92%
Hindu	1	0.4%
Polish	1	0.4%
Missing/nonsense	18	7.5%

TABLE 10:PREFERRED LANGUAGE(FREE TEXT RESPONSE)

UK country of residence	Response number	Response percentage
England	117	74%
Northern Ireland	19	8%
Scotland	39	17%
Wales	5	2%
Missing	0	0

TABLE 11:UK COUNTRY OF RESIDENCE (FIXED RESPONSE)

Employment status	Response number	Response percentage
Employed full time	128	55%
Employed part time	62	27%
Furloughed	4	2%
Full time student	31	13%
Part time student	6	3%
Caregiver	1	0.4%
Stay at home parent	1	0.4%
Volunteer	4	2%
Not currently employed	8	4%
Other	1	0.4%
Missing	0	0

TABLE 12: EMPLOYMENT STATUS (FIXED RESPONSE, COULD CHOOSE MORE THAN ONE OPTION)

6.8.1.2 *Semi-structured interview demographics*

For semi-structured interviews, four telephone interviews were undertaken. All respondents identified as 'white' women, aged 31-40, with no disabilities. 3 resided in England, one in Scotland. 3 were married, one divorced and 3 had children/dependents. All were employed and used English as their preferred language.

For context, 40% (n=96) of survey respondents stated they would be interested in taking part in a follow-up interview. An advertisement for interview participants was also placed on social media (Appendix I). However, only 4 interviews were arranged despite efforts to contact everyone who had expressed an interest. The implications of this are discussed further within chapter 7, section 7.5.2.

6.8.2 Reflexive thematic analysis & descriptive statistics

Please note, survey participants are labelled as “SRnumber”. Semi-structured interview participants are labelled as “SInumber”. Descriptive statistics are presented as percentages, to illustrate the frequency of survey responses. Percentages have been rounded up to the higher whole number for those .5 or over (e.g. 79.6% reported as 80%) and down to the lower number for those less than .5 (e.g. 55.4% reported as 55%).

6.8.3 *“Maybe it's the stress that causes me to have irregular periods”*: trying to understand menstruation during the pandemic

This theme interprets survey and interview participant experiences as they tried to understand any menstrual cycle changes they encountered during the pandemic and examines the varied factors thought to contribute to such changes, such as stress and the Covid virus/vaccination. Many participants felt that there was not enough awareness or understanding of how the menstrual cycle and menstruation can impact women and those who menstruate. Within the context of the pandemic, many stated that their periods had changed during lockdown but the believed reasons for such changes varied.

When asked if they had experienced any changes to their period or menstrual cycle during lockdown, 80% of survey respondents stated they had. Participants noted changes to their periods during the pandemic, with changes to blood loss (becoming heavier), changes in regularity and predictability and changes in pain experienced being commonly reported: *“My periods over lockdown became more painful, and I seemed to bleed more and for longer periods of time” (SR110).* For one participant, their periods had become “*so bad since the pandemic I've had to be referred to the hospital” (SR222)*. The survey respondent, however, did not provide more information on why their periods had led to their hospital referral.

When survey respondents were asked if they knew what had caused any menstrual cycle or associated menstrual symptom changes, ‘stress’ was the most common response reported (58%), followed by having the Covid-19 virus (26%) and receiving the Covid vaccination (23%). 11% of respondents stated they did not know what had caused the changes. The responses to these fixed answer questions could be interpreted as showing a level of certainty in knowing what was causing cycle changes during lockdown. However, responses to open-ended questions regarding cycle changes demonstrate the diverse ways that uncertainty was described by participants, with explanations for what may be causing changes to menstruation varying. In addition to factors such as stress and having the virus/vaccination, respondents mentioned pandemic-related factors including lifestyle changes (e.g. being more sedentary, poorer sleep) and problems relating to accessing hormonal contraception during lockdown as possible issues that impacted their menstruation during lockdown. For example, one participant (SR235) stated that they were experiencing changes to their periods during the pandemic as they needed their contraceptive implant replacing, but minor surgeries were not "*being allowed*" at their GP surgery due to disease-prevention measures. Several respondents also described how they were unsure as to whether they were experiencing perimenopause symptoms, expressing uncertainties about whether that was responsible for some of the changes they were experiencing during lockdown. Although some participants seemed to be confident that their menstrual cycle changes were caused by specific reasons, such as having had Covid-19 or experiencing problems with their hormonal contraception, many participants remained unsure. The uncertainty described was often linked to wanting more 'awareness' or 'information' about the menstrual health concerns or changes that they had experienced during lockdown. The need for better knowledge and awareness of menstrual health is indicative of wider issues within society related to the quality and effectiveness of menstrual health education and the prevalence of menstrual stigma (Barrington et al., 2021; Chandra-Mouli & Patel, 2020; Coast et al., 2019; InKind Direct et al., 2024; Irise International., 2025b).

Further evidence of how menstrual health and associated symptoms are understood and interpreted, particularly within the context of poor menstrual health knowledge, are present within participant accounts of trying to make sense of menstrual changes they experienced during the pandemic. Changes to regularity, bleeding and pain were discussed in relation to the potential impact that stress was thought to have upon periods were mentioned numerous times across open-ended responses, mirroring the high number of respondents who stated that stress had caused changes to their periods or menstrual cycle during lockdown (58% of responses): *"Clearly lockdown has caused stress because they [periods] have been much heavier" (SR127).* More awareness and recognition of the impact that pandemic-related stress can have upon menstrual health was something that some participants expressed, with SI2 stating that she wished there was more recognition of the relationship between them during the pandemic: *"stress and anxiety, that can have a massive impact on your cycle and of course, being in a global pandemic has been incredibly stressful." (SI2).* Throughout survey responses, the lack of knowledge and understanding of menstruation within society particularly for those who menstruate, and how things like stress can impact menstruation, were often talked about in conjunction with each other. Again, this was typically within the context of needing more 'awareness' or 'information' about the impact that stress can have upon menstruation: *"More info about how stress is related to cycle fluctuation and how cycles change as you age would be hugely beneficial!" (SR215).* For others, a lack of knowledge about menstruation and what can affect the menstrual cycle meant that they were not sure if stress was causing the menstrual cycle changes they were experiencing during the pandemic: "*Maybe it's the stress that causes me to have irregular periods" (SR207).* Participants recognised not only their own uncertainties and limited understanding, but also how the lack of awareness of menstrual health in wider society further contributed to their understanding of menstruation during the pandemic (e.g. *"maybe it's the stress…", "more info about how stress is related to cycle fluctuation…"*). Thus demonstrating the importance of menstrual health education and knowledge in shaping lay understandings of menstrual health and menstruation experiences during the pandemic. Indeed, Wood et al. (2007) argues that one of the most significant factors that shapes women's understanding and interpretation of the 'normality' of their menstrual patterns is the limited and typically inaccurate information they received about menstruation within school (Wood et al., 2007).

The uncertainties and anxieties described by a number of survey respondents as to what was causing menstrual cycle changes reflect wider issues within society related to menstrual health knowledge and education. Globally, menstrual health education (MHE) remains poor, negatively impacting the knowledge and understanding of those who menstruate in addition to that of others involved with MHE and menstrual health care (Barrington et al., 2021; Chandra-Mouli & Patel, 2020; Coast et al., 2019; InKind Direct et al., 2024; Irise International., 2025b). While formal MHE within schools has been found to focus on the physiology of menstruation as opposed to the experience of menstruating, many young women and girls still feel 'unprepared' for menstruation when they leave school and are still unaware of what is 'typical' or 'normal' (Barrington et al., 2021; Randhawa et al., 2021). This is echoed in participant accounts of 'wondering' whether menstrual cycle changes they experienced were caused by specific factors during lockdown, providing insight into how the effects of poor menstrual health education and knowledge continue throughout the lifetime of those who menstruate (InKind Direct et al., 2024).

Similar uncertainties around menstrual cycle variations applied to participant accounts of changes that were thought to be linked to side effects that Covid-19 virus or Covid-19 vaccinations had upon their periods, with changes in bleeding and cycle regularity being the most reported symptoms. For some women, the change was significant with their periods starting again after years of not experiencing them, stopping altogether or being extremely delayed, with SR126 describing that she thought her period would "*would never come back*" after she tested positive for Covid-19 and her period was delayed by 64 days. Others reported changes in their periods but were not sure if it was Covid-related, as seen here in SR240's experience: *"My periods have just* *stopped suddenly. Last one in April. Could be menopause but I've had no other symptoms. 1st covid jab in March, 2nd in June. Wondering now if there's a link?".* Her last question, "*wondering now if there's a link?*", is indicative of the recurring theme throughout this section around participants trying to understand what could be causing the changes to their menstrual cycle, particularly when the information that is needed to alleviate concerns is difficult to access or inaccurate. In this case, the query is linked to the pandemic, with the uncertainty relating not only to the impact of the Covid-19 virus but uncertainty around how Covid vaccinations could affect menstruation as there was very little information available at the time as to side effects. This was mentioned several times in survey responses, coinciding with a time during the pandemic when reports about how the virus and vaccination could impact periods had started to emerge. Participants wanted to know about "*the effects COVID or the vaccine has on periods*" (SR16) and wanted "*warnings the vaccinations might affect cycles*" (SR226). One participant (SR126) explained that the lack of information about these issues led them to search the internet for answers, only to find "*so many terrible rumours*" leading to them becoming "*very worried*" about their symptoms. This is particularly important to note within the context of the current study, where survey respondents reported an increase in using online sources to answer questions about their periods during lockdown compared to pre-pandemic times. Participant SR126's experience of seeking answers via the internet echoes concerns raised in relation to seeking alternative sources of information to fill gaps in menstrual health education and knowledge, where misinformation and inaccuracies have been found to fuel menstrual stigma and harmful narratives (Armour et al., 2021; Randhawa, 2023; Suttor et al., 2024). Again, we see how a lack of knowledge and understanding of menstruation across society intersects with the pandemic, causing uncertainty and anxiety for those who menstruate.

6.8.3.1 Summary

Participants experienced various changes to their menstrual cycles and menstruation symptoms during lockdown, with many expressing uncertainties over why such changes were happening. For some, changes around menstrual bleeding and regularity were a source of concern, particularly around the unknown impact of Covid-19 virus and vaccination side-effects. The uncertainty and anxiety reported around why changes to the menstrual cycle may have occurred during lockdown arises in a context of wider lack of knowledge and awareness of menstrual health within society (Coast et al., 2019; Moon et al., 2020; Randhawa et al., 2021). This not only relates to those who menstruate, but to wider menstrual stigma around discussing periods, and the importance of menstrual health education which has historically been poor and undervalued. The lack of transparency and accessible information about the effects of the Covid-19 virus, and vaccination side effects, provide an example of how these factors intersect leading to confusion and anxiety.

6.8.4 *"During a pandemic, my concerns about my periods seemed frivolous":* seeking menstrual health support during the pandemic

This theme encompasses the types of menstrual health support that participants needed during the pandemic, including help in accessing period products, advice or information about periods and symptoms (e.g. what is 'normal' or common) and medical or healthcare support.

6.8.4.1 Difficulties getting healthcare: are periods important during a pandemic?

75% of respondents stated they had needed support or advice about their menstrual health during lockdown, with 48% seeking such support from their friends, 40% from their family and 37% seeking support online. 20% of those reporting that they needed support or advice, sought such support from a medical professional. Prior to the pandemic, respondents reported that were more likely to seek support from their friends (52%), medical professionals (48%), family (41%) or online (31%). This shows a possible decline in seeking medical support and a slight increase in seeking support via the internet during the pandemic. Such changes in sources of support may be attributed to changes in how medical support could be accessed with many GP services and specialist consultants switching to telephone or online service provision during lockdowns.

For those that had tried to seek medical assistance via their doctor or GP surgery because of concerns over changes to their menstrual health during the pandemic, many encountered barriers to accessing appointments due to changes in how surgeries operated during lockdowns:

> I was hoping to start using the pill so that my periods would not be as painful in hope it wouldn't have as negative effect on my mental health however was unable to get through to my doctor despite phoning several times and changing GP practices (SR14)

These difficulties were echoed by several participants, who reported that telephone queues or phone lines were not working. Some experienced long waiting times for an appointment. When asked if she would try to access medical support for her menstrual concerns in any further lockdowns, SI3 describes how her problems in accessing health screening services so far during lockdown would influence her decisions to seek menstrual health support during the pandemic: *"I think I've been trying to book a smear for about four months. So, no, I don't really have much confidence in trying to get appointments for these issues, to be honest." (SI3).* Others struggled with the option of telephone appointments. For example, SR242 stated she "*didn't have the privacy*" to speak to a doctor via phone. This was echoed by SR214, who explained they did not want a phone appointment as: *"Sometimes it's uncomfortable talking to someone on the phone with other people in the* *room." (SR214).* For those that had extended family or were responsible for the majority of childcare, the option of trying to speak to a doctor via the telephone was something that was not possible, as discussed by interviewee SI3:

> I wouldn't want to phone the GP. And do you know why? Because I felt like they wanted to do it over the phone and I've got a five-year-old and also, it's not always convenient. There's maybe other people around. It's different, you don't get that privacy over the phone as you would if you were a one-to-one in the room.

These types of barriers to being able to access healthcare appointments via telephone, such as lack of privacy and childcare responsibilities, provide insight into experiences of gendered burden of care during the pandemic. Within the context of the current study, the majority of survey respondents reported being married or living with a partner, with 58% of respondents having children or dependents. This potentially indicates that the majority of those who participated in the survey could have experienced similar barriers to accessing menstrual health care during the pandemic if they had needed an appointment. The findings echo other pandemic-related research that demonstrates how women bore the brunt of childcare and other care responsibilities during lockdowns, however, the ramifications of this were not discussed within the context of accessing healthcare (Carli, 2020; Dinella et al., 2023; Power, 2020).

Furthermore, some participants felt that they should not be contacting or bothering doctors' surgeries about their menstrual health, because it was not thought to be appropriate or as important as dealing with the pandemic. One participant referred to their concerns as being "*frivolous*" during a pandemic (SR238). Another explained how they "*felt like it wasn't a big enough problem in the scheme of things*" (SR3). This demonstrates how respondents minimised the seriousness of menstruation, even when they needed help with their periods. Such minimising reflects the attitudes held by wider society whereby menstrual pain and other troublesome symptoms are normalised and not taken seriously (Barrington et al., 2021; Chen et al., 2018; Ní Chéileachair et al., 2022):

> Asides from tests for anaemia (which I thought was related/exacerbated around my period), I've been reluctant to contact health services about concerns during the pandemic. My GPs have an automated response saying they are only available for urgent reasons, and it never feels that urgent to me when I think of other people and the overall pressure on services. At the same time, I think it's important that patients continue to get health care support and

> aren't deterred; signposting who and how to contact a HCP would make this easier and might reassure me (and other patients) that this is still important. (SR206)

Here we see SR206 grapple with their own feelings around whether she should seek help for her periods via their GP during the pandemic, while also acknowledging that people should not feel like they cannot access normal healthcare support during the pandemic as it was "*still important*".

For those who did not want to talk to a medical professional about their menstrual health concerns, the lack of awareness and understanding about periods was a factor that impacted the type of help they wanted. One participant explained how it is "*terrifying*" that seeking doctors' advice is the "*answer for everything*" (SR236) even when symptoms are common, linking this back to needing more discussion and awareness over menstruation and how it varies in terms of blood loss and regularity. The medicalisation of the normal physiological aspects of menstruation, within this context, seemingly adds to anxiety and frustration over poor menstrual health knowledge and support within society. By considering typical menstrual symptoms, such as irregularity and pre-menstrual changes, as medical disorders that need to be managed via medical solutions (such as taking medication), menstruation is thus viewed as something that must be harmful and therefore controlled (Barnack-Tavlaris, 2015; McHugh & Chrisler, 2015). However, if these sorts of symptoms are not causing distress or negatively interrupting a menstruating person's life, there is an argument that such symptoms do not require medical management (Ford et al., 2025). Indeed, the medicalisation of typical aspects of menstruation that do not interfere with daily life forms part of the menstrual stigma and shame within society, perpetuating the need for menstrual concealment and secrecy that can have a negative impact upon a person's psychological and physical wellbeing (Barnack-Tavlaris, 2015).

Such participant concerns over the medicalisation of menstruation within phase 2 are in contrast to how other participants explained feelings of being dismissed by doctors when they had sought support for their periods, with accounts of being told their worrying or troublesome symptoms were "*minor problem[s]*" (SR148) or "*nothing to worry about*" (SR214). This demonstrates the 'double-edged sword' that Ford et al. (2025) refer to within their paper, where the medicalisation of menstruation is necessary in some cases to relieve symptoms that interfere with quality of life. However, in the circumstances described by participants who wanted medical support for menstrual-related symptoms they were worried about, the dismissal of their concerns by medical professionals created barriers to accessing such support. The following quotes from different survey respondents provide further accounts of feeling dismissed by medical professionals when they sought menstrual health support:

> I felt like my issue [irregularity] was sort of dismissed and not of massive concern, which to be fair it wasn't. But it still didn't make me feel any more confident (SR214)

> They [doctors] didn't see this [heavier bleeding and irregularity] as a genuine issue and said it could wait (SR133)

Both accounts are describing their experiences of speaking to a medical professional about their menstrual concerns during the pandemic, with phrases such as "*not of massive concern*" and not seeing heavy menstrual bleeding and irregularity as a *"genuine issue"* echoing existing research on the dismissal of menstrual health related concerns within healthcare, most notably regarding endometriosis (Culley et al., 2013; Denny et al., 2011; Grogan et al., 2018; Lemaire, 2004; Manderson et al., 2008; Plotkin, 2004; Randhawa et al., 2021; Requadt et al., 2024; Seear, 2009; Stanek et al., 2023). Wanting menstruation to be taken more seriously was also mentioned within the context of wider society: *"I can't think of anything specific to the pandemic but in general I wish people took period pain and the effects of blood loss more seriously." (SR3).* However, SR3 explained this was not specific to the pandemic, linking back to wider attitudes around menstruation seen throughout the analysis and previous research around menstrual stigma (Barrington et al., 2021) and attitudes towards menstrual pain (Chen et al., 2018).

6.8.4.2 Problems getting (menstrual) products

For some, the pandemic had meant they had struggled to get menstrual products, with 85% of survey respondents stating they had experienced problems accessing period products since lockdown. This is potential increase, as 60% of respondents reported that they had also had problems accessing period products prior to the pandemic. One participant (SR146) stated how "*tough*" it was to get products because people were "*panic buying*". The most common reason as to why survey respondents had struggled to access menstrual products during lockdown was cited as not being able to go to the shops to buy products (45%), with respondents describing the impact that shielding and health anxieties had upon their ability to access products. For SR4, shielding meant that she had to "*plan in advance*" so she always had access to products. SR133 stated that not only had she been impacted by having to self-isolate during lockdown, but she had experienced anxiety related to the pandemic and "*couldn't leave the house*" to buy period products. For those with supportive partners, they described how they had become "*reliant*" on them to go and buy period products for them, providing detailed descriptions of the items needed and what the packaging would look like:

> Access to products which I would normally buy from the shop has also been affected and so I've been reliant on my partner to get them for me, and he's not always been able to find what I've described (packaging has changed, lots more products in the supermarket than there were before) (SR206)

Of those that had experienced difficulties accessing menstrual products during lockdown, 40% got help from their family, 37% made their own 'makeshift items' (e.g. using toilet roll or old clothes), 37% got help from their friends, 23% contacted a charity for help and 20% got products from a food bank. Although some participants had used makeshift products during lockdown where they had experienced difficulties accessing products, this was not something that was described within the data. Some participants did, however, describe trying reusable menstrual products as a solution to menstrual product accessibility concerns:

> I haven't had any difficulties accessing products and I've been investigating the more, sort of, environmentally friendly products and solutions as well. Like, the period pants and stuff that you can, kind of, re-use and stuff like that (SI3)

Three out of the four interview participants similarly described how lockdowns provided an opportunity for them to try out reusable products for the first time. However, this was not prompted by problems accessing menstrual products during lockdown, but by environmental concerns and having the space to be able to do more 'research' into alternative products.

Other participants struggled to access menstrual products because the places they would normally get them from were closed. For example, SR14 describes how she was "*no longer able to go into college*" to access free period products and how she then "*struggled to afford my preferred products*" during lockdown. This was also an issue for SR12, a student residing in Scotland, where free menstrual products are available within public buildings, including her college:

> Through the Scottish Govts ambition to end period poverty they provide free period products in schools, colleges & universities and so when my college closed I struggled to get access to the products I would usually use and had to opt for cheaper alternatives of pads/ tampons which were less comfortable and often leaked (SR12)

Not being able to afford products because of changes in employment or financial security during the pandemic was described within survey responses, with 30% of respondents saying they were not able to afford period products during lockdown. SR205 describes how she had to leave her job during the pandemic because of childcare issues, on top of her partner having lost his job a year before and was now “*unable to afford products*”. Others had been furloughed and that had impacted their access to menstrual products, financially. Although the survey did not ask for details of estimated household income, the majority of survey respondents were employed in full-time or part-time work. However, research on the gendered implications of the pandemic indicates an increase in financial insecurity for the majority of women, despite employment status, with women being more likely to earn less (United Nations, 2020). Thus, being employed may not provide sufficient monies to be able to cover the costs of essential items such as menstrual products. Indeed within the UK, the cost of living crisis exacerbated by the pandemic added to financial insecurities of those who are employed and further increased period poverty (Williams, 2022a).

6.8.4.3 Summary

Many participants experienced problems accessing the menstrual health support they needed during lockdown, most notably around accessing health care and menstrual products. For those that needed medical support or advice related to their menstrual health, they reported needing support due to concerns over changes to their menstrual cycle/periods during lockdown. For those that had tried to seek medical advice, problems with how GP services could be accessed were common. However, some participants did not seek medical advice during lockdown as they did not view their menstrual health concerns as being ‘important’ enough during a global pandemic. This was further echoed by respondent reports of some healthcare professionals dismissing their concerns or not taking them ‘seriously’.

Participants also experienced problems in obtaining menstrual products during lockdown, mainly because of not being able to attend places they would usually get their preferred products. For some, this was because the location was closed during lockdown, for others it was because they had to shield or self-isolate during this time. Participants also described how ‘panic buying’ of products impacted their ability to find what they needed. Some also struggled to afford menstrual products, as their financial situation had been impacted by the pandemic (e.g. job losses or furlough), while others viewed the opportunity to try reusable products for the first time as positive.

6.8.5 *"I've got enough to last about 6 months now"*: managing menstruation during lockdown

This theme entails the diverse ways that participants managed menstruation during lockdown and reasons why any changes were made to pre-pandemic menstrual management practices. The theme further interprets participant experiences of menstrual management within the context of menstrual stigma and how menstrual etiquette practices, such as concealment of menstruation, influenced menstrual management decisions.

Participants were asked questions about various aspects of menstrual management and whether the pandemic had changed the way they managed their periods, including changes to period products used or pain management strategies. 61% of survey respondents stated they had changed the way they managed their periods because of changes to their menstrual cycle and/or menstrual-related symptoms during lockdown. In addition to menstrual product changes to menstrual management, some respondents reported needing to change how they managed period pain during lockdown by switching their pain medication or taking more of it. One person mentions having to switch from paracetamol to codeine to better manage the pain, due to the changes they had experienced during lockdown: *"Periods now around 35-day cycle, instead of 27/28 and also a lot heavier, have needed to take codeine." (SR3).* Others described needing to *"take lots of pain killers" (SR227)* and using pain killers *"more frequently" (SR128*) because of an increase in menstrual pain during lockdown.

Being 'prepared' for menstruation during lockdown was a common theme throughout the data, influencing menstrual product decisions and menstrual management. Many participants described purchasing several months' worth of products in advance and "*stockpiling*" products as a way to alleviate anxieties over not being 'prepared' during lockdown, as illustrated by these quotes:

> I've got enough to last about 6 months now (SR228)
>
> I'd also stockpile menstrual products so I have a supply for longer, vs doing it month by month (SR206)

Preparation was particularly important when asked about future lockdowns and what steps they would take if they needed support with their menstrual health during this time. For example, SR231 stated she would ensure she would "*always have tampons in stock*". It was also important for those who had experienced changes to their menstrual cycle during lockdown, most notably if their cycles had become more irregular or heavier. For example, one NHS worker (SR218) described how she had not "*been caught out for years*" but had to ask a friend for a tampon as she was "*unprepared*" due to changes in her menstrual cycle during lockdown. Feeling the need to be ‘prepared’ for menstruation during lockdown is indicative of menstrual stigma and menstrual concealment, alleviating anxieties over visible menstruation and adhering to ‘menstrual etiquette’ principles (Johnston-Robledo & Chrisler, 2020; Laws, 1990; Wood, 2020). These principles include hiding menstrual products, choosing products that are ‘better’ at hiding menstruation (such as internal products, like tampons) and not disclosing menstruation within public (Laws, 1990). For some, the fear of being unprepared during lockdowns had therefore prompted a change in the types of products they used to alleviate concerns over being ‘caught out’ and leaking in public, even during social distancing and a shift to working from home for non-essential services. Several participants described switching to re-usable period products, such as period pants or menstrual cups, as a result of such anxieties. For example, SR215 experienced changes in the regularity of her periods during lockdown so she “*bought period underwear so I could wear more protection in case of leakage or spotting*”, again demonstrating how concerns over visible menstrual bleeding, and menstrual etiquette, influenced their menstrual management choices during lockdown. Another person (SR236) changed to reusable options as they could not find affordable brands in the supermarket during lockdown and did not want to rely on ‘cheap’ products that are more prone to leaks. Several participants described the benefits of being able to try out reusable products, like menstrual cups, while being at home for the majority of time as it allowed them to test products without fear of leaking or needing to wash their cup in public. This is a common concern in relation to reusable products, where the possibility of menstrual blood being seen in public (such as shared, public bathrooms) acts as a deterrent to trying options such as menstrual cups (Johnson et al., 2025). This concern and anxiety associated with visible menstrual blood therefore influences menstrual management choices, forming part of menstrual concealment and menstrual etiquette practices (Johnson et al., 2025; Johnston-Robledo & Chrisler, 2020; Laws, 1990). However, during the pandemic, being able to test out reusable products without the fear of showing menstrual blood in public influenced decisions around trying out such products, although it is not clear as to whether the use of reusable products like menstrual cups continued once lockdowns were lifted.

For participants that already used reusable products prior to the pandemic, the ability to work from home and use their own toilet to empty and clean their menstrual cup was therefore a positive, alleviating worries over having to clean their cup in public spaces:

> The pandemic has made me realise how awful it was sharing dirty work toilets with loads of other, having to dash out of physical meetings to change my cup and how nice it is to be able to lie down when I have cramps and manage my work around my body, rather than trying to force it the other way around. (SR236)

In this example, SR236 reported several benefits to working from home during the pandemic while she is menstruating. These included improved hygiene as well as being better able to manager her menstrual cramps and "work around" her body, alluding to feeling more comfortable when menstruating in private. This is echoed by SR215 who wrote that she felt "*more able to do my job on days when I feel a bit rubbish*" when she worked from home. This could be interpreted in terms of menstrual etiquette practices that are expected within public settings where menstruation should be concealed from others, with the burden of having to maintain this behaviour being lessened when working from home, leading to greater comfort during menstruation. Being better able to manage heavy menstrual bleeding while working from home was also mentioned by SI1, who has Polycystic Ovary Syndrome, within the context of comfort. She describes how being the only woman in an all-male team made her more conscious of needing to go to the toilet frequently to manage her heavy bleeding, whilst attending the office (pre-pandemic): *"I was aware that perhaps me getting up to go to the toilet every 40 minutes was starting to attract attention. So, working from home has been quite good for that" (SI1).* Again, within this example we see how being able to shirk some of the usual menstrual concealment and menstrual etiquette practices that are typically applied within public settings, such as hiding menstruation from colleagues to not 'attract attention', lessens anxiety and promotes comfort. Within the circumstances described within these participant's accounts of working from home, being able to manage menstruation in a more private setting (such as at home) therefore provides a more comfortable experience during work. The following quote from interview participant, SI4, further illustrates the perceived benefits of being more 'comfortable' managing menstruation during lockdown, as the need to monitor and check for visible menstruation was less of a concern during times when people were less likely to out in public and more 'socially restricted'. This influenced decisions around the types of menstrual products that she had been using, which was echoed by friends she had spoken to about menstrual products and periods during lockdown:

> …it was partly because of lockdown, and because we weren't going anywhere, we were talking about different products that we use…would maybe wear tampons more often, if we were going out and about, and sort of quite busy at work and so on. Whereas, at home we could wear pads a bit more, and feel a bit more comfortable doing that, I suppose…But I think that is pandemic related, because it's reflecting on being more comfortable wearing pads versus tampons. Just because of being socially restricted, and physically at home so much more.

Although working from home was beneficial for some in terms of menstrual management, particularly in relation to comfort, others discussed feelings of discomfort linked to changes in menstrual hygiene practices. For example, some participants described how their hygiene habits had changed as they were not changing their products as frequently as they would if they were attending their usual place of work. For SI4, this seemed to be linked to her perceived social etiquette around hygiene and being more *"conscious*" of it while she was at work, stating that she felt her change in cleanliness during lockdown was "*a little bit gross*" as she was not changing her pads as frequently compared to how often she would change tampons when she was out in public. This is interesting to note when being able to switch from internal menstrual products (such as tampons) was described as being more 'comfortable', however, menstrual etiquette practices and self-surveillance of visible menstruation still remained present within more private settings during lockdown. Thus demonstrating how menstrual stigma and the fear of being seen as menstruating influences those who menstruate to continue to engage in self-policing behaviours to conceal menstruation, even in private (Wood, 2020). Furthermore, this type of behaviour management provides insight into how the self-objectification and menstrual etiquette practices shape menstrual health-related choices during lockdown, particularly in relation to menstrual product use (Johnston-Robledo & Chrisler, 2020; Laws, 1990; Ussher & Perz, 2019).

6.8.5.1 Summary

Participants described several ways they had changed their menstrual management during lockdown. Some changes were introduced to better manage a change in symptoms they had experienced (e.g. heavy bleeding, irregularity, more pain), whereas others were imposed as part of Covid-19 regulations (e.g. working from home). The changes to menstrual management described during lockdown, particularly around product use, are interesting as they demonstrate the prevalence of menstrual stigma and shame even in circumstances where social interactions are limited – as with lockdowns and social distancing restrictions during the pandemic. Participants still wanted to conceal their periods and wanted to be 'prepared', even though they acknowledged that they do not have to do this in the same way. If they had been less stringent with their menstrual hygiene during lockdown because of limited social interaction, they still felt shame around menstruating and leaking menstrual blood. Although working from home seemed to lessen anxieties around visible menstruation and made some women feel more comfortable in terms of pain management, concerns over menstrual etiquette (Johnston-Robledo & Chrisler, 2020; Laws, 1990; Seear, 2009) still prevailed.

6.9 Discussion

The analysis of phase 2 demonstrates several ways that the pandemic affected menstrual health during lockdown, for those who menstruate, addressing the research questions and aims related to this phase of the study (section 6.2). Findings provide insight into the menstrual health experiences of those who needed menstrual health support during lockdowns, highlighting numerous factors that influenced and shaped menstrual health needs and the ability to access menstrual health support during the pandemic. As with phase 1 analysis, many of the barriers to menstrual health support were related to Covid-19 disease prevention, such as closure of services and lack of available stock. However, phase 2 analysis further examines the experiences of those who menstruate during lockdown, providing us with a greater understanding and awareness of how wider, existing inequalities around poor menstrual health education and menstrual stigma intersect with Covid-19 specific factors.

The analysis illustrates how the existing poor awareness and understanding of menstruation across society contributed to menstrual-related concerns and anxieties attributed to pandemic stress and the effects of the Covid-19 virus and vaccinations. For participants, the lack of knowledge and transparency around what can impact the menstrual cycle, and what is ‘normal’, was compounded by unknown factors related to the emerging pandemic and the impact of the virus. The stress of the pandemic for example, being a frequent issue discussed by participants in terms of being a possible factor related to menstrual health changes experienced during lockdown. The findings provide insight into how existing inequalities around menstrual health education and knowledge further contribute to menstrual health-related anxieties exacerbated by Covid-19 uncertainties and poor communication around vaccine and virus side effects. Thus addressing research questions one and two, which focus on menstrual health experiences and menstrual health support needs during lockdown (RQ1 & RQ2).

The findings further address the research questions for this phase of the study by demonstrating how menstrual cycle changes during lockdown influenced menstrual management decisions and help-seeking behaviours (RQ1, RQ2, RQ3). The most commonly cited menstrual cycle changes during lockdown were an increase in irregularity, heavier bleeding and an increase in menstrual pain. For some participants these changes promoted an increase in the need to be ‘prepared’ for menstruation, which focused on having enough suitable products for menstrual blood and stopping visible leaks. Menstrual concealment practices were still prioritised despite social contact being more limited during lockdowns, and many people working from home instead of shared spaces. This continued practice in menstrual secrecy is indicative of menstrual stigma and shame within wider society (Johnston-Robledo & Chrisler, 2020; Laws, 1990; Wood, 2020). Challenges around menstrual management were further influenced by specific pandemic-related factors, such as disease-prevention measures, shielding and financial insecurity, which impacted the accessibility of menstrual products. Such challenges were further compounded by existing gender and health inequalities, which added to existing barriers to accessing menstrual health support.

Although some participants sought medical advice for the changes they had experienced during lockdown, misinformation about menstrual health and the virus/vaccinations (Wong et al., 2022) caused additional anxieties. The shift in how accessible medical appointments became being a further barrier to obtaining accurate information and support for any menstrual health concerns related to the pandemic. Experiences of medical gaslighting and minimisation of menstrual concerns were also raised, adding to feelings that people should not be bothering healthcare professionals with menstrual health issues during a pandemic as it is not 'important'. As with menstrual management changes, feelings that menstrual health is not important are part of wider menstrual stigma and menstrual etiquette perpetuated within society (Barnack & Chrisler, 2007; Johnston-Robledo & Chrisler, 2020). These accounts provide insight into how existing inequalities intersected and influenced menstrual health support decisions and the accessibility of menstrual health care during lockdowns, to further address the research questions (RQ1,RQ2 & RQ3).

6.10 Conclusion

Existing menstrual stigma combined with Covid-19 disease management created additional barriers to accessing menstrual health support for those who needed it, during lockdowns in the UK. The analysis demonstrates how the pandemic exacerbated existing inequalities within society, rooted in menstrual stigma and the practice of menstrual etiquette. Through the accounts of those who menstruate during the pandemic, stigma and related menstrual concealment practices permeate. These are evident in accounts of not seeking medical support because menstrual health seems less important within a pandemic, or because it will not be taken 'seriously', through to accounts of feeling 'gross' because they are not changing their products as often as they would normally (due to social distancing), to feeling like they need to prepare for menstruation well in advance and avoid 'leaking' menstrual blood. These factors, combined with Covid-19 restrictions, influenced the needs of those who menstruate and how menstrual health support was accessed during the pandemic. The next chapter combines the analysis of both phases of the study to discuss the overall implications of the thesis.

7 Chapter 7: Discussion

Chapters 5 and 6 provided findings from each phase of the study, describing the themes generated and discussing the analysis within the context of key relevant menstrual health, pandemic-related and wider health inequalities research. This chapter will summarise the overall study findings, drawing together analysis of the two phases to illustrate how they address the research questions and study aims. It will compare and situate findings within existing pandemic-related menstrual health research and research on wider related factors, including gender inequality and menstrual stigma. The strengths and limitations of the research study will be discussed, examining the study's contribution to research and reflecting upon the researcher's role in generating new knowledge. Finally, the chapter will discuss the implications of thesis findings, including for policy and practice and future research considerations.

7.1 Introduction

By applying Critical Health Psychology and critical feminist theoretical frameworks to data re-analysis, the thesis aimed to examine how existing health and gender inequalities influenced menstrual health experiences during the pandemic. This study therefore aimed to examine how the Covid-19 pandemic impacted menstrual health experiences within the UK, from the perspective of those who *provide* menstrual health support and those who *need* menstrual health support, to address the following research questions:

1. *What were the experiences of menstrual health service providers in the UK during Covid-19 lockdowns and how did they deal with any challenges to providing support during these times?*
2. *What were the needs of women, girls and people who menstruate, during the pandemic, in relation to their menstrual health?*
3. *What were the experiences of those needing to access menstrual health support during the pandemic and what factors influenced their decisions in seeking such support?*
4. *How did the pandemic influence the provision of menstrual health support during lockdowns within the UK?*

This chapter therefore examines the overall findings of the study in addressing the research questions, situating the findings within existing pandemic-related, and wider, menstrual health research to discuss the implications of the thesis. The chapter further outlines thesis contributions to the field of Critical Health Psychology, before discussing the study's strengths and limitations, and a final reflexive account of the overall thesis. Finally, the chapter provides key recommendations for policy, practice and research.

7.2 Summary and overview of analysis

The overall findings of this study provide insights into the experiences of those providing and accessing menstrual health support during the pandemic in the UK to address the research study aims and questions (section 4.2). Thesis findings demonstrate how existing structural inequalities, such as gender inequality and menstrual stigma, intersect with specific pandemic-related factors to influence menstrual health support during lockdowns. Findings therefore contribute to our understanding of how menstrual health service providers and those needing menstrual health support sought to overcome barriers and challenges to menstrual health support during lockdown. For example, phase 1 findings demonstrate how menstrual health service providers encountered and overcame various barriers to continue provision during lockdown to meet the menstrual health needs of those requiring support, providing evidence to address the overall study research questions.

Phase 2 findings illustrate changes in the menstrual health needs of women and people who menstruate during Covid-19 lockdowns within the UK and what factors influenced how they sought any menstrual health support needed during this time, addressing research questions 2, 3 and 4. Finally, thesis findings provide evidence of how existing pre-pandemic inequalities intersect with the pandemic, exacerbating menstrual inequality within the UK. Thus, further addressing the research questions and aims of the study to demonstrate the thesis's contribution to Critical Health Psychology and our knowledge and understanding of menstrual health.

The overall analysis demonstrates how an increase in the need for menstrual health support during the pandemic was linked to disease-prevention measures, such as building closures and changes in access to medical support. This impacted both those providing and needing, affecting support including menstrual product availability and accessibility, education and knowledge around menstrual health, and menstrual health care. For example, the shift to telephone or online appointments for GP services created barriers for some women who needed to speak to a medical professional about their menstrual health. A lack of privacy at home and digital poverty were both reported as barriers to attending virtual appointments. Others experienced difficulties getting through to GP surgery to book an appointment as the phone lines were busy or were told waiting times for appointments were high.

Furthermore, women and people who menstruate experienced menstrual cycle changes related to pandemic-related stress, as well as from contracting Covid-19 virus or having vaccinations. Uncertainties around the causes of such changes contributed to a need for more knowledge and support around the menstrual cycle. Menstrual cycle-related changes also meant that some modified the way they managed menstruation during the pandemic in response to such things as increased irregularity and/or heavier bleeding. This included stockpiling menstrual products or switching to reusable options to alleviate anxieties around needing to be ‘prepared’. For those who needed medical support for their menstrual health, a range of factors influenced their help-seeking behaviours, including pandemic-related challenges in accessing doctor’s appointments and menstrual stigma.

For those providing menstrual health support during lockdown, challenges included delivering menstrual products to those who needed them, obtaining stock and working with a reduced volunteer capacity. Services that provide menstrual health education within communities experienced barriers in moving from face-to-face support to remote online provision, while those that provided education within schools felt that menstrual health had been ‘deprioritised’. These challenges were further compounded by inconsistent UK central government policy and commitment to addressing menstrual inequality, which existed pre-pandemic, and a worsening of menstrual inequality during the pandemic exacerbated by financial insecurity. However, many service providers adapted their provision to meet the increase in demand they experienced and viewed the pandemic as an opportunity to expand the reach of their services and the support they offered.

Thesis findings illustrate how existing pre-pandemic inequalities, such as poverty, gender and menstrual stigma, intersect with pandemic-related factors to create additional barriers to menstrual health support during lockdown. These factors influenced how menstrual health support was accessed and provided during lockdowns in numerous ways. For example, women needing to access medical support because of menstrual health concerns felt that they should not be contacting such services during a pandemic as they did not view their menstrual health concerns ‘as important’ as Covid-19. This minimisation of menstrual health concerns, particularly the dismissal of menstrual pain (Seear, 2009), is part of the menstrual stigma and shame that exists within society (Johnston-Robledo & Chrisler, 2020; Winkler et al., 2024) which exacerbates health inequalities. Thesis findings therefore contribute to Critical Health Psychology, providing insight into how existing structural inequalities influence and shape menstrual health experiences and the accessibility of menstrual health support during the pandemic. Findings further demonstrate how such inequalities intersect with specific pandemic factors, such as disease prevention measures, to exacerbate menstrual health inequalities within the UK.

7.3 Situating the analysis within existing research

7.3.1 Menstrual product access and the increase in 'period poverty'

This study found that an increase in financial poverty due to Covid-19-related income loss had increased period poverty, with service providers citing this a reason for the increase in requests for menstrual products during lockdowns. Globally, studies have shown that the increase in financial poverty caused by the pandemic also increased period poverty, with more people struggling to afford period products and resorting to using makeshift products (Babbar et al., 2023; Holst et al., 2023; Murphy et al., 2024; Patel et al., 2022; Schmitt et al., 2023; Wood et al., 2022). In this study, the use of makeshift products was not something many participants in either phases reported, even when products were not easily accessed or could not be afforded. Instead, participants in both phases talked about switching to reusable products to help alleviate anxieties around accessing menstrual products. Bulk buying of products was also talked about as a 'solution' to such anxiety. This contrasts with other studies globally (Babbar et al., 2023; Holst et al., 2023; Murphy et al., 2024; Patel et al., 2022; Schmitt et al., 2023; Wood et al., 2022), where the use of makeshift products was often cited as an alternative to disposable or other reusable products during the pandemic, particularly when linked to financial insecurities. For example, within the UK, Plan International UK's survey of adolescent girls' experiences during the first lockdown in May 2020 found that 11% of surveyed schoolgirls used makeshift products as they could not afford menstrual products (Plan International UK, 2020). Furthermore, Wood et al.'s (2022) research on Kenyan young adolescents' and girls' experiences of menstruation during Covid-19 highlights again that pandemic-related loss of income impacted families' abilities to afford menstrual products. This was further compounded by the closure of buildings that would usually provide access to free menstrual products, such as schools (Wood et al., 2022), which was also a finding of this current study.

Difficulties experienced in accessing menstrual products during the pandemic, due to product availability, travel restrictions and building closures were identified within this study as barriers to providing and accessing menstrual products. For example, service providers within areas that had established policies to provide free products (such as Scotland and Wales) discussed factors that pupils and families experienced during school closures when they would usually be able to obtain products in schools or other public buildings. Several other studies further highlighted the difficulties that women experienced in accessing menstrual products during the pandemic, due to product availability, travel restrictions and building closures (DeMark et al., 2024; Murphy et al., 2024). Problems accessing menstrual products were reported within countries that have the infrastructure to provide access to free products (Babbar et al., 2023; Patel et al., 2022; Plan International, 2020), as was found in this current study (e.g. Scotland). For example, Babbar et al.'s (2023) study mapped locations across India where menstrual products for adolescent girls are provided via the Ministry of Health and Family Welfare's Menstrual Hygiene Scheme against areas with the Covid-19 restrictions in place and noted that a decline in menstrual pad distribution was linked to more severe pandemic restrictions. These disruptions were attributed to a delay in adding menstrual products to the government's list of essential items and further delays in the production and distribution of menstrual products and subsequent supply chain problems.

Within this current study, many service providers reported difficulties attributed to confusion over whether menstrual products were classed as 'essential' in retail outlets that had placed restrictions on the purchasing of essential and non-essential items. These restrictions were introduced to curb hoarding and stockpiling of goods and to minimise the spread of the virus via supermarkets and other retail outlets. Difficulties in accessing period products were reported within this study, attributed to services or community groups not classifying menstrual products as essential items that people would need access to if they were seeking support from food banks, community centres or local authorities. Service providers further reported the problems they had encountered when trying to purchase products from supermarkets or online shops. They also relayed accounts from those they support who had struggled to find affordable products during shortages.

These accounts are echoed within several studies on menstruation experiences during the pandemic. For example, Tomlinson's (2023) UK-based research further highlights how institutions such as food banks ignored the needs of menstruating women and people during the pandemic, according to the reports of menstrual activists. Within Italy, menstrual products were not classed as essential and restrictions on the number of products that could be purchased in one transaction were therefore imposed (DeMark et al., 2024). Furthermore, one participant within DeMark et al.'s (2024) study described how the strict travel restrictions within Italy meant they needed a certificate to travel to supermarkets or pharmacies; thus, they required approval from authorities to go out to purchase menstrual products. Similar experiences are reported in Holst et al.'s (2023) study of menstruation experiences within Spain, with queries over the classification of 'essential items' during the pandemic and why menstrual products were not included as such.

Within the current study, inconsistencies in workplace provision, particularly for frontline health care workers, was reported by service providers as a further 'failure' to recognise that menstrual products are essential. Service providers described how they received more requests from NHS organisations and healthcare workers for menstrual products as they were not readily available for staff on shift. Staff were also struggling to find menstrual products within supermarkets after their shifts had ended. Other studies report similar accounts from frontline staff during the pandemic (Hazar et al., 2022; Kondapalli et al., 2022; Tomlinson, 2023). Indeed, the inclusion of menstrual product provision for frontline health care workers during pandemics is also a key recommendation within UNICEF’s guidance (UNICEF, 2020). The failure to include menstrual health and hygiene provision within emergency and disaster responses is something that activists continuously highlighted during the Covid-19 pandemic (Ajari et al., 2020; Crawford & Waldman, 2021; Farrington, 2020; Irise International, 2020; Jahan, 2020; Rodriguez, 2020; Water Supply and Sanitation Collaborative Council, 2020). As a result, UNICEF (2020) produced a comprehensive and extensive policy document outlining all areas that must be considered to ensure menstrual equity during crises such as the pandemic (UNICEF, 2020). Within the policy document, UNICEF stress the importance of recognising that menstrual products are considered ‘essential items’ to remove barriers around manufacturing, supply and distribution during pandemics (UNICEF, 2020).

The current study also found the pandemic provided opportunities to raise awareness of period poverty. The increase in demand for menstrual health support was viewed by service providers as not only due to the negative aspects of the pandemic such as financial poverty, but because more people were now aware of the issue and where they could seek help. This finding is echoed in Tomlinson’s (2023) study on UK online menstrual activism during the pandemic, with the increase in awareness of period poverty being celebrated and recognised as a potential reason for an increase in donations that some experienced.

7.3.2 Menstrual cycle changes and menstrual management

The current study provides insight into some of the menstrual cycle changes that women experienced during the pandemic, and the reasons why women felt that they occurred. Variations in reported menstrual symptoms, such as bleeding, regularity and pain, were thought to be linked to pandemic-related stress and Covid-19 virus/vaccinations. The changes reported by participants mirror much of the existing research focused on the impact the virus and/or vaccinations had on the menstrual cycle. This substantial body of work provides evidence of changes in relation to cycle regularity, bleeding severity, pain intensity and pre-menstrual symptoms including anxiety and depression (Al-Furaydi et al., 2023; Al-Mehaisen L et al., 2022; Chourasia et al., 2022; Dabbousi et al., 2023; Darney et al., 2023; Kumar et al., 2023; Lessans et al., 2023; Martínez-Zamora et al., 2023; Matar et al., 2023; Medina-Perucha et al., 2022; Mohr-Sasson et al., 2023; Qazi et al., 2023; Taşkaldiran et al., 2022; Tripathy et al., 2022).

Several studies directly examined the impact that other factors have had on the menstrual cycle during the pandemic, such as stress, which was an issue that many women within this current study talked about as impacting their periods (Payne et al., 2023; Sualeh et al., 2022; Sun et al., 2023). Other studies found a link between pandemic-related stress and menstrual cycle changes, with such changes being associated with higher stress (Anto-Ocrah et al., 2023; Aolymat et al., 2023; Bruinvels et al., 2021; Demir et al., 2021; Garg et al., 2022; Phelan et al., 2021; Takmaz et al., 2021). However, many of these studies are quantitative and offer little insight into how women managed any differences they experienced or if they sought medical advice or support because of these experiences.

Accounts of how menstrual management was adapted during the pandemic are provided in this current study with women describing variations in products used, frequency of changing them, pain management and encounters with healthcare professionals during lockdown as ways to manage and understand the differences they experienced. Women expressed a desire to understand and know more about the potential impact that the Covid-19 virus and its vaccinations, as well as pandemic-related stress, could have upon their menstrual cycle. A small number of qualitative studies include reference to menstrual management during the pandemic, although these did not focus on how people managed any menstrual cycle changes they experienced during lockdowns (Holst et al., 2023; Schmitt et al., 2023). Studies within Spain and the USA evidence women seeking to be ‘prepared’ for menstruation and changes around menstrual hygiene, particularly if they were home more often (e.g. working from home). Within Spain, participants talked about how menstrual management was ‘easier’ as they are spending less time out in public and able to change their products more often than they usually would at work and mentioned buying more products than usual to be ‘prepared’ in case of shortages (Holst et al., 2023). In contrast, within USA, to accommodate for challenges around the affordability of menstrual products participants reported staying at home to avoid visible leaks associated with having to use cheaper or makeshift products, or wearing darker and baggier clothes to conceal menstruation (Schmitt et al., 2023).

Menstrual concealment during Covid lockdowns was discussed by participants in the current study, with women reporting how they remained concerned over menstrual leaks even though they were less likely to be out in public. Some participants switched to using reusable products. Others resorted to bulk buying or ‘stockpiling’ products, so they were prepared for menstruation and reduce the risk of leaking. Participants also changed their usual menstrual hygiene practices as they were at home and unable to take as many toilet breaks as they usually would if they were at their usual workplace, leading them to change their products less frequently. This contrasts with participants' accounts within Holst et al.'s (2023) study, where they felt better able to change their products more frequently when working from home. This study also highlighted some of the benefits associated within being at home more often, especially when working, as participants could better manage their pain and other associated menstruation-related symptoms. These benefits were also talked about within Holst et al.'s (2023) study, with DeMark et al. (2024) finding that participants expressed feeling more comfortable during menstruation as they were at home.

7.3.3 Accessing wider menstrual health support: knowledge, education and healthcare

The current study found that menstrual health education within the UK had been 'deprioritised' because of school closures and pressures to address poor performance in core subjects attributed to changes in how education was delivered during the pandemic. Although menstrual health education became mandatory within England in 2020, as part of wider Relationships and Sex Education (RSE) provision, many service providers that worked within schools discussed how they were not aware of how this had been implemented. This has been highlighted in several other studies around wider RSE provision across the UK during the pandemic, with Horan et al.'s (2025) study providing evidence that RSE was not viewed as important as other subjects, despite being a mandatory. Furthermore, a 2021 survey found RSE provision remained inconsistent across England with approximately a quarter of young people (24%) reporting they did not learn about menstrual health at all during the pandemic (Sex Education Forum, 2022). Similar findings have also been reported in USA, with Lindberg et al. (2020) highlighting that sex education within the country was not likely to have been included in the shift to online learning during the pandemic.

Within Holst et al.'s (2023) study of menstruation experiences in Spain during the pandemic concerns over the potential negative consequences of the cessation of health education programmes, such as menstrual health education, were discussed by participants. Challenges around the provision and accessibility of menstrual health education for school-aged children were also discussed in Plan International's (2020) global survey of menstrual health providers. The survey highlighted the negative impact that the closure of schools for disease-prevention measures had on adolescent girls' menstrual health education, especially in locations where pupils had limited or no access to online resources, with access to such education being greatly reduced (Plan International, 2020). This current study similarly found that digital poverty was a barrier to providing menstrual health education within educational and community settings, as with Plan International (2020) and Tomlinson's (2023) research findings. Not only did digital poverty mean that some were not able to access online education, but relying on online technology to deliver ‘sensitive’ and ‘taboo’ subjects, such as menstruation, created additional barriers around fostering a safe space for people to talk about their concerns and experiences. This was also discussed as a barrier to providing RSE sessions by participants within Horan’s (2025) research, with teaching staff raising concerns around safeguarding and privacy when discussing sensitive subjects to pupils who are within a home environment. Tomlinson’s (2023) study also provides accounts of such concerns when delivering menstrual health education in online environments.

Issues around the lack of privacy and safe spaces to discuss menstrual health were also emphasised in this current study with regards to accessing menstrual health care, and the shift in how medical healthcare was provided during lockdowns in the UK. Participants discussed how the shift to providing medical appointments via telephone or video calls created problems for those living with extended families or that had childcare responsibilities, making access to private spaces more difficult. This was further compounded by problems booking appointments, with changes in how GP services could be accessed and many struggling to get through on busy phone lines. Participants mentioned that they also then faced longer waiting times to get an appointment during the pandemic. Similar barriers to accessing healthcare have been found in other studies examining the accessibility of reproductive and sexual health care during the pandemic (Bosó Pérez et al., 2023; Lindberg et al., 2020; VandeVusse et al., 2022). Studies in Italy and Spain on menstruation experiences during the pandemic reported an increase in barriers to receiving healthcare because it became more difficult to go to the doctor (DeMark et al., 2024; Holst et al., 2023). Holst’s (2023) research goes on to further explore people’s experiences, highlighting how medical professionals were perceived to dismiss concerns over how Covid-19 could impact reproductive and gynaecological health, including menstruation. Junkins et al. (2024) found similar concerns amongst women that were interviewed about their experiences of menstruation during the pandemic. Participants expressed wanting to have more inclusion of women in Covid-19 vaccination studies, in recognition of the different side effects they may experience.

The dismissal and minimisation of menstrual health concerns during the pandemic was a key finding of the current study, with women reporting how they themselves had not sought out medical advice or support over their concerns as they did not feel they were ‘important’ enough during a pandemic. Women also talked about how they wanted more information about the impact that the virus, vaccination and pandemic-related stress could have upon the menstrual cycle. The dismissal and minimisation of menstrual-related concerns and anxiety, coupled with poor menstrual health education and knowledge, is widely documented within research though not pandemic-specific. Several studies have provided evidence of menstrual stigma around healthcare access (Barrington et al., 2021; Chen et al., 2018; Ní Chéileachair et al., 2022; Seear, 2009), whereby menstrual pain and heavy bleeding are dismissed as 'normal' and are 'taboo' to discuss. This was also a key finding of the Women & Equalities Committee (2024) inquiry into women's reproductive health conditions within the UK, which stresses that 'pervasive stigma' around gynaecological health is a key factor in why there is poor awareness of menstrual and reproductive health conditions in England.

7.3.4 Menstrual stigma

The influence of menstrual stigma upon help-seeking behaviours was explored within phase 2 of this study. Participants described feeling hesitant to contact their GP with their menstrual health concerns because they feared they would not be taken seriously. Several participants described past experiences of being dismissed when they have tried to seek medical help for their menstrual health, which then influenced their help-seeking behaviour. The impact of such concerns is further discussed within the Women & Equalities Committee (2024) report, which highlighted the importance of tackling menstrual stigma and medical misogyny. It stressed the negative impact that such attitudes cause in terms of seeking healthcare, causing a barrier to discussing associated medical concerns leading to the worsening of symptoms and progression of related diseases. These findings are echoed within other studies (Holland et al., 2020; Åkerman et al., 2024). For example, Holland et al. (2020) found that internalised menstrual stigma was a significant barrier when accessing sexual health care for young women. Greater occurrence of internalised menstrual stigma was associated with greater discomfort when speaking to health professionals and a greater reluctance to attend preventative health screening, such as cervical smears.

The current study also provides accounts from women who did not feel like there was not enough known about menstrual health and what can impact it, such as stress and Covid-19. This lack of knowledge and understanding caused anxiety for some participants, further compounded by poor understanding of what is 'normal' in terms of menstruation and menstrual pain. Participants expressed frustration that the answer provided by peers or social media is to seek medical advice in the absence of this information. Within this study, examples of how women were seeking alternative sources of information to try and understand changes to their menstrual cycle during the pandemic were discussed. Women sought menstrual health information via the internet to make sense of the differences they experienced, as an alternative to seeking medical advice. This caused further anxiety for some participants as the information they found was based in rumours and not based on evidence. Others found it frustrating that the only advice they found while searching suggested they should seek medical advice, providing insight into the medicalisation of menstruation and the perpetuation of narratives of needing to ‘control’ menstruation as part of menstrual etiquette (Barnack-Tavlaris, 2015; McHugh & Chrisler, 2015).

The use of alternative sources of information to try and fill the gap in poor menstrual health education has been discovered within other studies as well (InKind Direct. et al., 2024; Irise International., 2025b; Ussher, 1989). Ussher (1989) further described how the secrecy around discussing menstruation leads women and girls to seek education from alternative sources, such as magazines, which reinforce stigma and myths around menstruation. More recent research indicates that women and girls are more likely to seek information about menstruation via the internet or social media (InKind Direct. et al., 2024; Irise International., 2025b), which has been raised by menstrual activists as concerning given the inaccuracy of available information (Tomlinson, 2025). Furthermore, information obtained via the internet and social media can also perpetuate negative stereotypes and myths around menstruation that can be harmful (Tomlinson, 2025).

A lack of menstrual health knowledge and understanding is part of wider menstrual stigma, with uncertainties around what is ‘typical’ or ‘normal’ menstruation being part of sexism within healthcare, as discussed in the previous section, but also part of the secrecy and shame around discussing menstruation publicly (InKind Direct. et al., 2024; Irise International., 2025b; Tomlinson, 2025). This forms part of what Laws (1990) refers to as ‘menstrual etiquette’ where, within patriarchal society, women must not draw attention to menstruation, especially in front of men. This current study also describes numerous accounts of menstrual stigma in relation to talking about menstruation in public, again demonstrating menstrual etiquette. These include service providers questioning when to bring up the subject of menstrual health support as it can be seen as ‘awkward’ and ‘yukky’. Within the analysis, when talking about barriers to providing menstrual health support in online or other remote environments (such as phone appointments with GPs or menstrual health education sessions) the need for some to be able to have private conversations or private spaces to talk about menstrual health was mentioned several times within the context of menstruation being a ‘taboo’ subject. However, it is important to stress that menstrual stigma may not be the sole reason attributed to why people would want access to a private space to discuss their menstrual health as there may be safeguarding issues that apply to the situation, including sexual and other forms of domestic abuse (Heskin et al., 2022).

Menstrual stigma further presented itself within the current study findings through accounts of 'menstrual concealment', which includes hiding menstrual blood and menstrual pain (Johnston-Robledo & Chrisler, 2020; Wood, 2020). Such concealment is a key element of menstrual etiquette (Laws, 1990; Seear, 2009). Within phase 1 data findings, several service providers talked about how important it is to provide 'discreet' packaging for menstrual products when they give them to people who need them to avoid embarrassment. Although the intentions for this were to ensure 'dignity', hiding menstrual products further (unintentionally) perpetuates menstrual concealment practices and menstrual stigma (Bobel, 2019a; Johnston-Robledo & Chrisler, 2020; Laws, 1990; Tomlinson, 2025). Hiding menstrual products within schools (e.g. locking them in cupboards), for example, creates a barrier to accessing them not only because they are not easy to find but because someone may not feel able to ask for products because of menstrual stigma and embarrassment (Irise International, 2023). Within England, Morrisons supermarket adopted a 'Package for Sandy' scheme during the pandemic, where people could ask for 'Sandy' and receive free menstrual products (Morrisons, 2021). Again, the intentions behind this scheme are to help people access products, but the secrecy and use of code words continues to reinforce the notion that menstruation should be hidden (Johnston-Robledo & Chrisler, 2020; Laws, 1990).

Menstrual concealment practices were also discussed within Phase 2 findings, with women remaining concerned about visible leaking and hygiene even when they are not engaging in public or social activities. Participants mentioned a need to be prepared for their periods, and anxiety around being 'unprepared', which was attributed to problems in finding products and changes to their menstrual cycles during lockdown making periods more unpredictable for some. These concerns came from women who were frontline workers and from those who were able to work from home. It is interesting to hear that even those who were not attending workplaces, or leaving their houses often, were still concerned about things like visible leaking. Such practices imply menstrual shame, secrecy and self-surveillance, even in private spaces. For those who described a change in their menstrual hygiene practices by not changing their products as often as they usually would because they were not leaving the house as often, this behaviour was still construed as 'gross'. Such constructions of menstrual hygiene practices are indicative of menstrual stigma and shame within wider society (Chrisler, 2011; Johnston-Robledo & Chrisler, 2020; Laws, 1990; Wood, 2020).

7.4 Recognising inequalities and intersections

Applying Critical Health Psychology and critical feminist frameworks to this study allows for a richer interpretation of how existing structural and societal inequalities intersect and contribute to the experiences of those providing and accessing menstrual health support during lockdowns. Applying these frameworks further demonstrates disparities in menstrual health service provision that were further amplified during the pandemic and how such disparities impacted menstrual health experiences during lockdowns in the UK. For example, the increase in demand for menstrual health support during the pandemic contributed to an increase in menstrual inequality as more people sought already over-stretched and under-resourced services.

The overall analysis of the current study reflects wider research around inequalities and intersections, both pre-pandemic and pandemic related (CARE & United Nations., 2020; Carli, 2020; Dang & Viet Nguyen, 2021; de Paz et al., 2020; Delanerolle et al., 2023; European Institute for Gender Equality, 2020a; Menta, 2021; Weiss-Wolf, 2020). Looking at shared themes across the two phases of data gathering, the overall thesis findings provide insight into how existing inequalities, such as menstrual stigma, gender, health and poverty, continued to influence menstrual health support experiences during the pandemic. Furthermore, the intersection of pandemic-specific factors with existing inequalities was found to exacerbate menstrual inequality within the UK. With academics calling for the pandemic to be looked at through a ‘gendered’ or ‘intersectional’ lens (Laster Pirtle & Wright, 2021; Lokot & Avakyan, 2020; Ryan & El Ayadi, 2020; Smith et al., 2021; Trian, 2021), applying CHP and critical feminist frameworks to the study therefore helps to highlight and explore how menstrual health experiences during the pandemic are shaped by intersecting power and social inequalities (Chamberlain & Murray, 2009; Lafrance & Wigginton, 2019; Lykes & Crosby, 2013; Martin, 2003).

The following sections represent shared themes across the 2 phases of data analysis, highlighting common factors that influenced the menstrual health support experiences of those providing and needing such support during lockdowns. These shared themes reflect how menstrual health experiences were interpreted and understood by affected communities, within the context of existing inequalities, to create additional barriers to menstrual health support during the pandemic. Thus demonstrating how thesis findings apply beyond the pandemic and their contribution to wider menstrual health research, policy and practice.

7.4.1 Menstrual products: essential or not?

Theis findings highlight how the pandemic created barriers to product accessibility in areas that provided free products, with the closure of buildings and travel restrictions imposed. The analysis also provides insight into how the confusion as to whether such products should be classed as ‘essential’ in UK government guidelines on Covid-19 disease prevention further contributed to barriers in accessing menstrual products.

Furthermore, the analysis describes a more general failure to recognise products as essential within frontline services, such as food banks, local authorities and health-based workplaces. These factors influenced both the provision and accessibility of menstrual products during UK lockdowns, as described in both phases of the analysis (Chapters 5 & 6).

The continued failure to recognise menstrual products as essential for those who menstruate, and inconsistencies in government policy as to whether access to menstrual products should be enshrined in law, are indicative of existing gender inequality within society (Hennegan et al., 2021; Sommer & Mason, 2021; Weiss-Wolf, 2017). Using a critical lens for the study analysis further demonstrates how this oversight contributes to the perpetuation of menstrual and gender inequalities within society, increasing barriers around accessing this type of menstrual health support. Failing to acknowledge that menstrual products are essential for those who menstruate, to be able to fully participate within society, therefore means that women, girls and people who menstruate are at a disadvantage (Hennegan et al., 2021; UNICEF, 2020).

Although present day is deemed to be ‘post-pandemic’, planning for events like the pandemic that can disrupt the provision of essential menstrual products must be included within response strategies and planning to minimise disruption (see section 7.8 for further discussion). This not only applies to free product schemes provided by government bodies, but to the accessibility of menstrual products within retail outlets and other community-based locations (such as food banks) in recognition that such items are essential. Supply and distribution of products during the pandemic was negatively impacted because of failure to acknowledge this, as found in this study and several others (Babbar et al., 2023; DeMark et al., 2024; Patel et al., 2022; Plan International UK, 2020; Tomlinson, 2023).

Despite the abolishment of the ‘tampon tax’ within the UK in 2021 (HM Treasury, 2021), in recognition that disposable menstrual products should not be taxed as ‘luxury’ items as they are essential for those who menstruate, UK policy around the provision of free menstrual products remains inconsistent. Within the four UK nations, Scotland and Northern Ireland have the more comprehensive approaches to providing free menstrual products, as such provision is now enshrined in law (Northern Ireland Assembly., 2022; The Scottish Parliament, 2021). This means all local authority buildings must provide free menstrual products. Wales has adopted a similar approach, though not currently a law (Welsh Government., 2023). England currently only provides access to free menstrual products within primary and secondary schools and colleges (Adams, 2020) and for hospital patients (NHS England., 2019). In 2022, the UK Police and Criminal Evidence Act (1984) was amended to state that detainees must be offered free menstrual products (Home Office, 2022).

Except for the provision for hospital patients within England, much of these were implemented during or after the pandemic. Little evaluation has been undertaken as to how successfully such initiatives have been implemented, with much of what is available being undertaken to inform the introduction of mandatory provision and not to evaluate current practice (Ducie, 2023; Scottish Government., 2023; The Executive Office., 2023). The exception to this is the management information undertaken to monitor the Period Products Scheme within England, which provides numerical data on the take-up of free menstrual product provision within schools and colleges (Department for Education., 2023), though it does not provide any insight into how the scheme has been accessed within such establishments. It is therefore not clear as to how successful the provision of free menstrual products across the UK has been implemented and if those who require such products are able to access them when needed. The pandemic has not been included within such evaluations as something that may have impacted free product schemes across the UK. This would be useful to include in future research on menstrual health product schemes, as a measure of how such disruption contributed to any barriers in service provision (see section 7.8 for further discussion).

As stated previously, recognising menstrual products as essential items is highlighted within UNICEF's guidance on menstrual health and hygiene management during the pandemic (UNICEF, 2020), ensuring menstrual equity for women, girls and people who menstruate. This has also been highlighted as necessary in addressing wider gender inequality, particularly within disaster situations such as the pandemic (de Paz et al., 2020; Weiss-Wolf, 2020). Beyond the pandemic, having access to menstrual products is a crucial factor to address within Hennegan et al.'s (2021) definition of menstrual health to achieve menstrual equity and therefore tackle wider gender inequality (Babbar et al., 2022). However, as outlined in chapter 2, UK approaches to address this element of menstrual health inequality remains inconsistent despite recommendations that endorse the provision of free menstrual products within public spaces (Women & Equalities Committee, 2024). Although thesis findings provide insight into how such inconsistencies impacted the provision and accessibility of menstrual products during UK lockdowns, findings can also be applied beyond the pandemic as the existing, underlying barriers that contributed to pandemic experiences still exist within the UK to date.

7.4.2 Period poverty and financial poverty

Applying critical analysis to the study data provides a further example of how existing gender inequality influenced the accessibility of menstrual health support during the pandemic within the UK. Findings demonstrate how an increase in pandemic-related financial poverty attributed to job losses and furlough not only exacerbated existing period poverty for some but caused new groups of people to experience financial barriers to accessing menstrual products during lockdowns. Research in other countries on pandemic-era menstrual product access supports these findings (Murphy et al., 2024; Schmitt et al., 2023; Sommer et al., 2022; Wood et al., 2022). Period poverty existed pre-pandemic, with evidence of the impact of financial poverty in relation to menstrual management (Barrington et al., 2021; Briggs, 2021; Delanerolle et al., 2023; Medina, 2020; Poague et al., 2022; Vora, 2020). The pandemic worsened existing poverty and caused a 'new wave' of period poverty for those that experienced pandemic-related financial insecurity (Moss, 2020; Thomas, 2022).

A number of Covid-19 studies examined the gendered implications of worsening financial poverty during the pandemic, with findings highlighting how the pandemic worsened financial security for women and girls (CARE & United Nations., 2020; Carli, 2020; de Paz et al., 2020; Menta, 2021). For example, Dang & Viet Nguyen's (2021) study of the impact of Covid-19 on gender gaps in economic outcomes, which draws on data from 6 countries (China, South Korea, Japan, Italy, UK & USA), found that women were 24% more likely than men to lose their job permanently during the pandemic. Although such studies do not examine the impact of such financial losses in relation to menstrual product affordability, it is not unreasonable to apply this logic more widely considering the existing research that has examined this issue and the analysis of this study. Globally, period poverty related to financial insecurity continues to increase (Pyecroft, 2023; UN Women., 2025). Although the pandemic contributed to this increase, the existing systemic issues described above that contribute to period poverty remain. Thesis findings therefore contribute to this body of knowledge, providing further insight into how such inequalities influence the accessibility of menstrual products.

The current study also describes the dual stigma between menstruation and financial poverty, recognising the intersection between the two as being important particularly when people need to access menstrual products from non-profit or community groups that support those experiencing financial hardship. Embarrassment and shame attributed to both financial poverty and menstruation made it harder for some to seek out support, further compounded when places such as food banks did not then include menstrual products as essential items. This then created a 'double effort' for those who needed such items, exacerbating barriers in seeking this type of menstrual health support. This dual stigma has not been reported in any other pandemic-related research. Many studies, however, document the impact that financial poverty stigma and menstrual stigma have upon help-seeking behaviours (Chrisler, 2011; Inglis et al., 2019; Johnston-Robledo & Chrisler, 2020; Seear, 2009; Sutton et al., 2014; Wilbur et al., 2019), further demonstrating the intersections between poverty, stigma and menstrual health.

7.4.3 Gendered ‘burden of care’

Applying critical feminist frameworks (Lafrance & Wigginton, 2019) to the analysis provides insight into how existing gender inequalities were further exacerbated by the pandemic, contributing to barriers and challenges that menstrual health services experienced. The experiences of those providing menstrual health support within this study provide an example of the gendered ‘burden of care’ during the pandemic, with most interview participants in Phase 1 identifying as women and most of the services they represented being led by and staffed by predominantly women. These services filled an important gap in menstrual health support during the pandemic, recognising their work as being part of the frontline services available to continue to meet the needs of the communities they worked with.

Organisations that examined the equality implications of the pandemic have stressed the gender differences in terms of frontline services, with women making up the majority of such services globally (European Institute for Gender Equality, 2020b; UNICEF, 2020). For example, UNICEF’s (2020) report states that women make up 70% of the global health force, being more likely to be frontline workers such as nurses, midwives and community health workers. However, despite this, many global responses to the pandemic failed to achieve gender equity in decision making forums, such as Covid-19 taskforces, meaning the needs of women on the frontline of the pandemic were neglected (de Paz et al., 2020; European Institute for Gender Equality, 2020b; Gharib, 2020; Plan International UK., 2020; Trian, 2021; UN Women., 2022; Weiss-Wolf, 2020).

The current study also described the increase in stress that women providing menstrual health support during the pandemic experienced. This was partly attributed to a reduction in the availability of staff and volunteers, mostly women, some of whom had to take on additional care responsibilities during the pandemic such as home-schooling and childcare. Several studies discuss similar points around the increase in a gendered ‘burden of care’ during the pandemic with women taking on additional care and household responsibilities during lockdowns (Carli, 2020; Dang & Viet Nguyen, 2021; de Paz et al., 2020; Dinella et al., 2023; European

Institute for Gender Equality, 2020a; Power, 2020). This increase in gendered burden of care was also evident within phase 2 accounts of seeking menstrual health care support during lockdowns, influencing help-seeking behaviours. For some women that had childcare or other family responsibilities, they described how they would be less likely to seek medical advice for their menstrual health concerns during lockdown as they lacked the 'private' spaces needed to attend telephone or online medical appointments due to their care responsibilities. This was similarly described by service providers in Phase 1 analysis, particularly in relation to the South Asian community. Although participants did not necessarily discuss this within the context of having less support from partners or family during lockdown, it is not unreasonable to interpret such experiences within the context of the increase in gendered care responsibilities during the pandemic as reported by other research.

7.4.4 Gender & health inequalities: dismissal and delays

The current study's analysis has highlighted examples of gendered health inequalities around menstrual health support, pertaining to crucial aspects of Critical Health Psychology and critical feminist frameworks (Chamberlain & Murray, 2009; Lafrance & Wigginton, 2019; Lykes & Crosby, 2013). Such examples include the analysis from this study where women felt they could not approach healthcare professionals during the pandemic with their menstrual health concerns as such concerns were not thought to be 'important enough' or dismissed by healthcare professionals. It is important to acknowledge the history of women's health, and menstrual health provision, when situating this study's outcomes within health and gender inequality research.

The history of sexism, gender bias and medical misogyny regarding women's health is widely documented, going back to ancient Greek theories of hysteria and the 'wandering womb', with such theories pervading much of the treatment for women's health up to the mid-1900s. Women were deemed to be naturally 'hysterical' and therefore any symptoms they experienced that could be attributed to such hysteria were considered 'normal' (Dusenbery, 2018). Evidence of gender bias and sexism within medicine has been found in pain management practices (Guzikevits et al., 2024) and gynaecology services (Laws, 1990; Miani et al., 2024). Numerous studies highlight the intersection between gender bias and racism in terms of women's reproductive and sexual health experiences (Abrahams et al., 2022; Cory et al., 2025; Howell, 2023; Rosenthal & Lobel, 2020).

The most prevalent research on the impact of gender bias in help-seeking and treatment of health conditions relates to experiences of accessing endometriosis care. Globally, studies highlight the delays that patients experience in receiving diagnosis and the dismissal of symptoms such as menstrual pain and heavy bleeding (Culley et al., 2013; Denny et al., 2011; Grogan et al., 2018; Lemaire, 2004; Manderson et al., 2008; Plotkin, 2004; Randhawa et al., 2021; Seear, 2009). Similar experiences are reported with other menstrual-related health conditions such as dysmenorrhea (Chen et al., 2018; Ní Chéileachair et al., 2022; Söderman et al., 2019), uterine fibroids (Ghant et al., 2016; VanNoy et al., 2021) and Polycystic Ovary Syndrome (Tomlinson et al., 2017).

These studies all include findings on the delays experienced in obtaining a diagnosis or treatment for their health condition. This was also referred to within the current study as a barrier to receiving menstrual healthcare, with challenges in obtaining appointments and an increase in waiting times for appointments being discussed by participants. Within the UK, the pandemic was found to have increased the waiting times for gynaecology appointments by 60% (Burns, 2022). More recent figures on waiting times and delays to accessing care were reported by the Royal College of Obstetricians and Gynaecologists, who found that waiting list delays had continued to increase (Royal College of Obstetricians and Gynaecologists, 2024). The report acknowledges the reasons attributed to why gynaecology care within the UK is at 'crisis' levels, including the historical lack of prioritisation of women's health care (Royal College of Obstetricians and Gynaecologists, 2024). Thesis findings therefore add weight to this body of research, further demonstrating how the deprioritisation of menstrual health continues to impact the overall health and wellbeing of those who menstruate.

Thesis findings also highlight the impact of poor menstrual health education and knowledge upon people's understanding of menstruation and their menstrual health experiences. While menstrual health education (MHE) remains poor throughout the life course of many who menstruate, as educational establishments do not provide adequate MHE, those who menstruate often turn to alternative sources of information to seek answers and better understand their menstruation experiences (Armour et al., 2019; Suttor et al., 2024; Tomlinson, 2025; Wood et al., 2007). This was evident within the current study, with participants describing a need for more awareness and information about menstruation during lockdown to help make sense of menstrual cycle changes they were experiencing. Furthermore, with the increase in barriers to accessing medical appointments for menstrual health care during the pandemic, an increase in the use of social media and the internet to seek support and knowledge to help alleviate menstrual concerns was reported by many participants in phase 2. The increase in reliance upon alternative sources of menstrual health information to address gaps in knowledge and understanding of menstruation raises concerns over the accuracy of such information and its usefulness in alleviating menstrual health concerns. Social media in particular has been critiqued for often perpetuating harmful narratives and myths about menstruation which further increase menstrual health anxieties (Armour et al., 2019; Suttor et al., 2024; Tomlinson, 2025; Wood et al., 2007). Furthermore, an increase in the use of the internet and social media to provide menstrual health education mirrors changes within overall healthcare provision which continues to move into a more digital platform via use of apps and telemedicine (Haslett, 2025; NHS England, 2026). Although these can provide a useful method to engage with patients, as noted within the current study, a reliance upon digital technology to share information and provide educational context is not an effective tool for everyone (Haslett, 2025; Tomlinson, 2023). As such, many historically minoritised and vulnerable groups may miss out on valuable health information and healthcare support, adding to existing menstrual and wider health inequalities (Cysters & Endometriosis UK, 2026).

7.4.5 Menstrual stigma

Thesis findings provide numerous examples of how existing menstrual stigma influenced the experiences of both those providing menstrual health support and those needing menstrual health support during lockdown. Applying critical analysis to the data for both phases provides insight into how different forms of menstrual stigma intersect with other inequalities and specific pandemic-related factors to further exacerbate menstrual inequality during the pandemic. For example, menstrual etiquette practices such as secrecy and the minimisation of menstrual health concerns influenced how menstrual health education and health care were provided and accessed. This is evident is accounts that describe the need for safe, private spaces to discuss menstruation as a sensitive and 'taboo' subject and in phase 2 participant descriptions of feeling like their menstrual health concerns were not important within the context of the pandemic. This type of secrecy and shame around discussing menstruation has been found to shape help-seeking behaviours, particularly when menstrual health concerns are also dismissed by medical professionals (Laws, 1990; Seear, 2009).

Evidence of menstrual concealment practices were also prevalent within study findings across both phases of analysis, influencing menstrual management choices and service provision solutions to supplying menstrual products during lockdown. For those who experienced issues accessing menstrual products, or menstrual cycle changes that increased symptoms such as irregularity or heavy menstrual bleeding, a need to be better prepared for menstruation caused anxiety for many participants. This appeared to be linked to worries over visible menstrual bleeding, even for those who were not as socially active during lockdown (e.g. worked from home) and were therefore less likely to be 'seen' as menstruating. Thus demonstrating how menstrual concealment and menstrual etiquette practices influenced menstrual management behaviour during the pandemic. Fir those providing menstrual health products as part of their service provision during lockdown, examples of 'discreet' packaging and methods to disseminate products were described by several service providers within phase 1 analysis. Although this was viewed as a positive way to engage with certain communities as it helped to promote 'dignity' for those who menstruate, this type of secrecy and concealment of menstrual products further perpetuates menstrual stigma. However, as menstrual stigma, shame and embarrassment about menstruation remain highly influential upon menstrual health experiences, being able to provide 'discreet' products can be a useful option to include within efforts to address menstrual inequality, recognising the importance of diversity within menstrual health choices (Ford et al., 2025; Hennegan et al., 2021; Weckesser, Randhawa, et al., 2019; Weckesser, Williams, et al., 2019). This also applies to menstrual health education and health care provision, where it is important to tackle menstrual stigma but also to acknowledge diversity and personal preference in how such support is accessed and provided, as demonstrated within the analysis, to better engage with and support affected communities (Hennegan et al., 2021; Weckesser, Randhawa, et al., 2019; Weckesser, Williams, et al., 2019).

7.4.6 Acknowledging wider health inequalities

The current study's analysis has demonstrated several examples of intersecting inequalities thus far which were discovered, including gender, poverty and stigma. Situating the analysis within Critical Health Psychology and critical feminist frameworks provides further insight into how wider health inequalities influenced menstrual health experiences during the pandemic. Using a critical lens, the experiences of both service providers and those needing menstrual health support show the ways that inequalities around chronic health, disability and race intersect with pandemic and non-pandemic inequalities to exacerbate barriers to menstrual health support.

Within phase 1 of this study, services that provide menstrual health support for those within the chronic health and disabled communities discussed some of the difficulties that service users encountered when trying to purchase menstrual products during lockdown. These occurred when supermarkets and other retail outlets had placed restrictions on the number of items that could be purchased per transaction, with menstrual products being included under such restrictions. For those who experienced heavy menstrual bleeding, the number of products required per transaction was more than what was permitted at the time. One service provider reported tensions within the chronic health community they supported, with people accusing those needing to buy more products than permitted of ‘stockpiling’ or ‘hoarding’ products. The analysis of phase 1 also discovered that the menstrual health needs of those classed as ‘Clinically Extremely Vulnerable’, who were instructed to shield and not leave their homes during lockdown to minimise the threat of infection, were not included in local policy decisions. Service providers reported that they had been contacted by people who needed menstrual products as they had not been routinely provided within the ‘essential care packages’ that local authorities delivered.

These accounts demonstrate the ways in which inequalities within the chronic health and disability communities intersect with gender inequality during the pandemic. Not only have global governments been criticised for failing to acknowledge gender within their pandemic responses (de Paz et al., 2020; European Institute for Gender Equality, 2020b; Gharib, 2020; Plan International UK., 2020; Trian, 2021; UN Women., 2022; Weiss-Wolf, 2020), but they have been criticised for ignoring the needs of the chronic health and disabled communities (Lasseter et al., 2022; The Health Foundation, 2021). For example the needs of these communities were not initially considered with regards to mandatory face-mask wearing (Department of Health and Social Care., 2022) and the closure of public toilets (BBC News Wales, 2020a) or with decisions regarding the stockpiling of toilet paper (Gladwell, 2020). Furthermore, failing to include menstrual products within care packages again illustrates the continued neglect of menstrual health within the context of existing gender inequality, as discussed in section 7.4.1. This is particularly important for those who experience heavy menstrual bleeding as a symptom of their chronic health condition, adding further weight to recommendations to make menstrual products free for those who experience dysmenorrhea (Women & Equalities Committee, 2024).

The current study also provides insight into how racial inequalities intersected with gender inequality during the pandemic. When discussing barriers to accessing menstrual health care, the analysis highlights the experiences of the South Asian community who struggled to attend telephone or online medical appointments as they were less likely to have access to a safe, private space to discuss their menstrual health concerns. This was attributed to being more likely to live within extended family households or to having greater care duties, with Yong & Germain’s (2022) study reporting similar barriers for women of colour when accessing health care during the pandemic. Research into the experiences of women of colour during the pandemic provides evidence that the pandemic exacerbated existing gendered structural racism (Laster Pirtle & Wright, 2021), exacerbating barriers for those seeking healthcare support. These included language and communication problems attributed to the rapid provision of information about the virus, and being more likely to experience digital poverty making it more difficult to attend remote or online appointments (Yong & Germain, 2022). Furthermore, women of colour were more likely to experience difficulties in accessing remote healthcare because of caring duties and family settings (Yong & Germain, 2022). These types of barriers are especially important to highlight with the continuation of the use of telemedicine post-pandemic, and the shift within the National Health Service in the UK to using app-based systems to access health care such as GP services (Haslett, 2025; NHS England., 2026). Furthermore, although recent women's health strategies across the UK acknowledge racial inequalities within healthcare, efforts to meaningfully address such inequalities remain poor and lack solid commitment (Cysters & Endometriosis UK, 2026).

7.5 Contribution to Critical Health Psychology

Critical Health Psychology (CHP) considers health-related knowledge and associated health behaviours to be rooted within historical and sociocultural contexts, acknowledging the influence of power structures and relationships upon how we experience and interpret health and illness. Thus, CHP provides a framework to address issues around inequality, diversity and social justice (Chamberlain & Murray, 2009; Locke & Carral, 2025). The thesis is therefore situated within the discipline of Critical Health Psychology (CHP), critically examining a gendered health inequality, menstrual health, within the context of a global disaster that has been found to exacerbate existing inequalities around health and gender. Owing to principles of CHP (Chamberlain & Murray, 2009; Locke & Carral, 2025; Murray, 2015; Ussher & Walkerdine, 2001), thesis findings further add to our understanding of how specific pandemic-related factors intersect with existing menstrual health, gender and health inequalities within the UK, through the accounts and experiences of those providing and seeking menstrual health support during lockdowns.

Furthermore, by applying Hennegan et al.'s (2019) definition of menstrual health to the study, thesis findings provide insight into how such influences contribute to broad range of factors that are pivotal to menstrual health experiences, such as physical, psychological and sociocultural causes and existing, structural inequalities. Moving away from a more traditional, biomedical definition of menstrual health, which has solely focused on the physiology of menstruation, therefore acknowledges the wider existing inequalities that influence menstrual health experiences and how menstrual health support is accessed, pertaining to the key aims of CHP which recognises the relationship between sociocultural and psychological factors within health and illness experiences and behaviours (Chamberlain & Murray, 2009; Chrisler, 2017; Lyons et al., 2006; Ussher & Perz, 2019). CHP further acknowledges the influence of structural and societal power dynamics and inequalities within health experiences, reflecting the sociocultural and structural inequalities that are recognised within Hennegan et al.'s (2019) definition of menstrual health and its application throughout the thesis (Chamberlain & Murray, 2009; Murray, 2015; Ussher & Walkerdine, 2001).

Thesis findings provide a deeper interpretation and understanding of how intersecting factors impacted menstrual health inequalities during the pandemic, which is the study's main contribution to CHP. These factors have been described throughout the discussion, demonstrating how gender inequality, gendered health inequalities, menstrual stigma and wider health inequalities (such as race and disability) combined with specific pandemic-related issues to influence menstrual health support experiences during lockdown. Thesis findings also apply to wider menstrual health research, beyond the pandemic, demonstrating how existing menstrual inequality and associated underlying structures (such as gender inequality) further influenced menstrual health experiences. These factors continue to impact menstrual health support provision and accessibility, and menstrual health experiences, with menstrual inequality prevailing globally. For example, within the UK, period poverty related to financial insecurity is estimated to effect 2.8 million people (Pyecroft, 2023). This figure is indicative of several intersecting factors: the continuing cost of living crisis, inconsistent government policy and funding to tackle menstrual inequalities and underlying gendered inequalities related to health and socio-economic status (Mehrara, n.d.; Pyecroft, 2023; Williams, 2022a). Furthermore, menstrual health education and access to menstrual health care within the UK remain poor despite efforts to introduce mandatory MHE within schools (in England) and several women's health strategies that prioritise menstrual health and gynaecology support within their recommendations. Thesis findings therefore highlight the importance of tackling the underlying structures that impact menstrual health support in order to improve menstrual equity, in addition to ensuring that any future disease-prevention measures or similar disaster responses effectively address menstrual health support. Thus echoing they key factors within Hennegan et al.'s (2021) menstrual health definition that enable women, girls and those who menstruate to participate in all spheres of life, free from menstrual stigma and shame, and mirroring core CHP principles of tackling inequality to improve social justice (Chamberlain & Murray, 2009; Murray, 2015; Ussher & Walkerdine, 2001).

7.6 Evaluation of the research study

7.6.1 Strengths

This study is one of a few that looks at experiences of providing and accessing menstrual health support during the pandemic, addressing gaps in available knowledge and understanding of how the pandemic influenced menstrual health experiences. Much of the existing Covid-19 and menstrual health related research focuses on the impact of either the Covid-19 virus or vaccination upon the menstrual cycle, or the availability of menstrual products and menstrual hygiene practices during the pandemic. While this study includes aspects of these from a qualitative perspective, they are not the sole focus of the research. Expanding this research study to include wider elements of menstrual health including access to products, healthcare and education, and whether Covid-19 virus/vaccination impacts the menstrual cycle, therefore provides a more holistic and in-depth examination of how the pandemic impacted the menstrual health needs of women and people who menstruate. This also includes whether the pandemic influenced how they sought help for any menstrual health needs during lockdown and how those providing menstrual health support adapted to any pandemic-related challenges they experienced, addressing the aims and research questions of the study.

A further strength of the study relates to the diversity of experiences represented in Phase 1 of the study, which focused on service provider experiences. Services that participated within this phase provided representation from a various types of menstrual health support provision, who supported a diverse range of communities. Services worked within rural and city locations, educational establishments and local authorities. Services also varied in terms of the type of support they provided, including non-profit services that solely provide period poverty support and those who provide support as part of a wider remit (e.g. food banks). Those accessing their services were also diverse, including those living in financial poverty, young people and school pupils, asylum seekers and refugees, South Asian communities, displaced and homeless people, Traveller communities and disabled, chronically ill people. This is a key strength of the study as it gives insights into how several diverse groups were affected during the pandemic in terms of their menstrual health needs.

Furthermore, this study provides insights into the provision of menstrual health support from the perspective of service providers within the UK. There is currently only one other study within the UK that examines this perspective, however it focuses on ‘menstrual activism’ and does not include the experiences of those providing menstrual health support that do not identify as ‘menstrual activism’, such as food banks and schools (Tomlinson, 2023). Moreover, this current study combines the experiences of service providers with those who needed menstrual health support during the pandemic, to compare experiences within the UK. This is a unique contribution of this study and often a perspective that is missing within menstrual health research. By failing to capture the experiences of those who provide menstrual health support within research, we are often not fully aware of the range of potential factors that can impact menstrual health support and menstruation experiences. This is especially important to consider within the context of the pandemic, as additional restrictions introduced to stop the spread of infection were found to impact service provision and availability as well as overall funding and resource capacity for menstrual health support. Furthermore, as the experiences of menstrual health service providers are often not included within menstrual health research, it is unclear as to how factors that impact the provision of menstrual health support intersect, influence and contribute to the experiences of those who need menstrual health support. This study therefore addresses these gaps in understanding and awareness by combining the experiences of service providers with those who needed menstrual health support to provide insight into the shared, intersecting factors that shaped menstrual health support accessibility and provision during the pandemic within the UK. For example, thesis findings illustrate how pandemic-specific factors, such as disease-prevention measures and financial insecurity, intersect with existing underlying structures such as gender inequality and menstrual stigma, to influence the menstrual health support experiences of both groups.

Thus, the use of critical frameworks to identify how structural inequalities within society contribute to the experiences of those providing and needing menstrual health support during the pandemic is a further strength of the study. Whilst it is not uncommon to utilise critical theories when undertaking gender and health inequality research, or menstrual inequality research, using them in combination to examine such experiences during the pandemic allows for a deeper interpretation and understanding of how intersecting factors impacted menstrual health inequalities during the pandemic.

7.6.2 Limitations

The main limitations to the study are methodological, which in turn effect the representation and diversity of the data and experiences captured. Phase 1 did not include any representatives from Northern Ireland, so responses are representative of Great Britain (England, Scotland and Wales) and not the UK, despite attempts to recruit more broadly. However, phase 2 does include survey responses from those who reside in Northern Ireland, so experiences across the whole of the UK are represented within the current study. Despite including responses from a wider geographical area, phase 2 of the study (which focused on the experiences of those who needed menstrual health support during lockdown), was not as diverse or representative of the UK in comparison to Phase 1 in terms of wider demographics such as ethnicity and disability. This may be attributed to the recruitment strategy and the use of online data gathering, which relied on social media and subsequent snowballing to recruit respondents. It also relied on participants having access to the necessary digital technology to be able to see and respond to the online survey (Keat et al., 2023) and digital poverty was identified within the study as a barrier that those also experiencing period poverty could encounter. Although paper versions of the survey were available upon request for those who experienced problems accessing the survey online, interested participants would still have needed to see the recruitment information via an online source in the first instance.

As research methods were constrained during the pandemic this impacted the methods used to collect data, which may have further affected engagement with recruitment and data collection during phase 2. For example, face-to-face data gathering was halted due to disease prevention measures and changes to university ethics guidelines. This meant that the researcher's original plan for data gathering for phase 2 had to be altered, moving from face-to-face interviews and focus groups to online, remote data gathering methods. Furthermore, the plans for working more collaboratively with services that provided menstrual health support during the pandemic (e.g. service providers that took part in phase 1) to recruit participants during community-based events had to be stopped as services were still not able to engage in-person during lockdowns. Moving to online, remote recruitment and data gathering may therefore have affected participation in the PIP project, particularly for those groups who are less likely to engage with online platforms (Shakir, n.d.).

Phase 2 of the PIP project only recruited 4 participants for semi-structured interviews, which is a further limitation. It is difficult to understand why there was such a high attrition rate between expression of interest in being interviewed and the final interview numbers, as 40% (96) of survey respondents indicated they would be interested in a follow-up interview and were subsequently contacted to arrange the interview. The interviews were also advertised separately via social media to help boost interest and engagement following the low response to survey follow-ups. However, research fatigue may have been a significant factor that influenced potential participant recruitment to interviews. Research fatigue refers to the psychological and emotional exhaustion that accompanies participation or engagement with research (Ashley, 2021). Such fatigue is more likely to occur in historically minoritized groups or smaller specific populations when they become 'over-researched' to address research gaps (Ashley, 2021). For example, the researcher is aware that other UK-based menstrual health research projects also experienced problems in recruiting participants for interviews and focus groups during the pandemic (T.A.P Project & Freedom4Girls, 2022). These research projects, including the Periods in a Pandemic project, may have been targeting the same groups of people which then created research fatigue within such groups. The pandemic may also have impacted research fatigue as many pandemic-specific research studies were being undertaken at the time (Patel et al., 2020). Another factor which may have impacted participation in interviews was the timing of when data gathering occurred. Much of the attempts to contact interested participants and recruit to phase 2 interviews happened during the school summer holidays in the UK, when those with families have additional childcare responsibilities. As the PIP project would have mainly been recruiting cisgender women to the study much of the additional childcare responsibilities may have fallen to the women within the family, especially during the pandemic (see chapter 2.3.1 for further discussion). This could have affected their access to private spaces and time afforded to participating, therefore limiting such women's opportunities to take part in an interview.

Using an online survey as the main data gathering method for phase 2 was therefore convenient within the pandemic situation as it addresses some of these issues (e.g. privacy, time, convenience, Covid-restrictions). However, online surveys are at risk of being compromised by false entries and the increase in use of 'bots' to provide data (Keat et al., 2023; Ménard et al., 2025; Singh & Sagar, 2021). Within the data gathered for phase 2, it was difficult to ascertain if any responses were falsified or had been generated via a bot. With hindsight and having more experience in administering online surveys since the PIP project was undertaken, the researcher would have designed the survey with more stringent checks to reduce the likelihood of these occurring. For example, including trick questions that prompted for a specific answer to test attention (e.g. asking them to select a specific answer from the available options) may have helped to deter false responses (Ménard et al., 2025).

With the current study, as it was not possible to check for false responses, all responses for phase 2 were included within the analysis as only surveys that had been actively submitted were part of the data. Those who had not clicked 'submit' at the end did not get included. The optional open-ended demographic responses for the phase 2 survey did include some missing responses and some 'nonsense' ones (e.g. putting lots of letters or numbers), however, responses to other questions had been properly completed so it was not possible to conclude if these were false responses. In contrast, the response rate for fixed questions such as age, geographical location and employment status received very few missing answers. This could indicate that convenience may have influenced how participants completed the optional demographic questions (O'Cathain & Thomas, 2004), with it being easier to skip or not properly complete open-ended questions compared to fixed questions. As demographic data was not included in the overall analysis of phase 2, this had minimal impact upon the descriptive statistics used within the analysis. However, missing demographic data on certain categories means it is not possible to know how representative the survey data is in terms of ethnicity, disability, relationship status and preferred language.

The £10 voucher incentive for completed survey submissions in phase 2 may have also influenced the response rate and quality of responses received. Despite the funding for vouchers running out partway through the online survey submission timeline (after 200 responses submitted), and participant documentation being amended to inform potential participants of this, the survey still received 40 responses that did not receive any vouchers. There appears to be little difference in the quality of the survey submissions between those that did and did not receive financial incentives. This echoes other research that has compared the quality of online survey submissions for those that have been offered monetary incentives and those that did not receive them, which shows little difference in the quality of the responses and data provided (Singer & Ye, 2013).

The available demographic data suggests that phase 2 participants were predominantly white women, aged 21-30 years. The experiences of historically minoritised groups are therefore lacking within the data analysis. This is also a critique of menstrual health research within the UK (Perro et al., 2022), which is often centred on white women's experiences, and is something that future research must consider (see section 7.8 for further discussion). Furthermore, most participants in Phase 2 resided in England, which does not currently provide free period products within local authorities as standard. Scotland, Wales and Northern Ireland, however, do have such provision and this may have influenced the experiences of those needing menstrual health support during the pandemic. As such, potential participants may not have viewed this study as something that was relevant to them. It would have been useful to be able to look at whether such policies helped those needing support, and how easy it was to access the free products within the different geographical areas during lockdown, from the perspective of those needing the support as opposed to providing it. This would be a useful comparison for future research to consider (see section 7.8 for further discussion).

7.7 Dissemination and research impact

In line with the underlying principles of Critical Health Psychology, Critical Feminist Research and Feminist Community Psychology, the PIP project has contributed towards recognising and addressing intersectional health inequalities (Chamberlain & Murray, 2009; Cosgrove & McHugh, 2000; Lafrance & Wigginton, 2019; Lykes & Crosby, 2013; Martin, 2003). The contributions of the project findings to menstrual health knowledge and practice are encouraging, demonstrating how the project has produced meaningful research impact, informing policy and practice to address menstrual inequality within England. Furthermore, they demonstrate the numerous pathways to impact that this thesis can more widely contribute to by building on the findings and impact of the PIP project.

The dissemination strategy for the Periods in a Pandemic project was described in chapter 4, outlining how the findings were shared throughout the duration of the project. The strategy allowed for different approaches to sharing knowledge during the developing pandemic situation, helping to share best practice and identify the needs of affected communities. Sharing the in this manner, for these purposes, adheres to the principles of the critical frameworks applied to the project, addressing social change and inequalities exacerbated by the pandemic to create solution-focussed actions that address barriers in menstrual health service provision and accessibility (Cosgrove & McHugh, 2000; Lykes & Crosby, 2013).

Using different ways to disseminate the analysis and share best practice allowed knowledge to be shared more widely across different sectors, contributing to menstrual health and period poverty discussions happening across the UK and globally. In addition to the dissemination strategy outlined, the researcher published an interim report (Williams et al., 2022) and several articles in reputed, global online media outlets to highlight key messages from the PIP project and share knowledge during the pandemic (Williams, 2021, 2022a, 2022b). Although it the impact of such engagement in still relatively unknown, the research was used to inform the ‘Period Literacy Toolkit for the Homeless Sector’ (Raisbeck, 2025). The toolkit provides information and guidance on how to support homeless people who menstruate, tackling the dual stigma around menstruation and homelessness with the aim of improving menstrual health (Raisbeck, 2025). Furthermore, the interim report has been cited as evidence within the Women and Equalities Committee inquiry into women’s reproductive health conditions, informing the recommendation that the UK government considers legislating for the free provision of menstrual products within England (Women & Equalities Committee, 2024). The PIP project findings have also contributed to discussions to inform the Department for Education roundtable forums on the provision of free menstrual products within schools (Department for Education., 2025) and campaigns to improve access to menstrual health knowledge, education and support within the UK (Essity., 2025; Irise International., 2025a).

Although these are examples of how the Periods in a Pandemic interim project findings have contributed to shaping menstrual equity policy and guidance across the UK, they demonstrate further ways that this thesis can contribute to address menstrual inequality within the UK. The thesis findings will therefore be shared within relevant forums, events, communications and evidence inquiries to share knowledge more widely, outside of academia, where it can practically inform policy and strategy.

7.8 Reflexivity and positionality

As with previous sections addressing reflexivity (see chapters 4,5 and 6), I will refer to myself in the first person as opposed to 'the researcher'. I have embedded reflexivity into this thesis, reflecting upon my positionality and how my own experiences and identity influence each stage of the study. Within the critical frameworks adopted for this study, acknowledging these factors and how they have shaped the research design and analysis are crucial when examining inequalities, addressing power imbalances and ensuring that the research addresses the needs of the community involved (Cosgrove & McHugh, 2000; Lafrance & Wigginton, 2019; Lawless & Chen, 2019; Lykes & Crosby, 2013; Martin, 2003). Reflexivity and positionality are also important to acknowledge within reflexive thematic analysis, recognising that the researcher cannot be objective within the generation of themes and is an active participant in crafting and interpreting the meaning of the data gathered (Braun & Clarke, 2023).

I have addressed my positionality previously and how these aspects influenced my decision-making during the research design of the Periods in a Pandemic project and the re-analysis of the data for the current study (chapters 4,5 and 6). Some of these aspects also afford me privilege that is important to acknowledge particularly when adopting a critical lens to examine gender and health inequalities, and other aspects of inequality, relevant to this study. For example, I am a well-educated, 'middle-class', white cisgender woman who is presently employed by an academic institution. I am also known within the UK menstrual health activism and advocacy sector, having worked with numerous non-profit organisations and period poverty initiatives over several years. Furthermore, I feel that my position as an 'insider researcher' (Dinçer, 2019) within the menstrual health sector helped to shape the initial concept of the PIP project, when I was questioning whether to do a study on this specific area (menstrual health access) during the pandemic. By speaking to several service providers at this stage, I was able to discuss my ethical concerns on placing additional burdens on already over-stretched frontline services by asking them to take part in a research study, to see if the service providers would find the study useful to them. This also ensured that community priorities were included from the very beginning of the study, helping to shape the study as a whole and throughout its duration.

In previous chapters (4,5 & 6), while reflecting on my position within the research study, I have disclosed my own health vulnerabilities during the pandemic in addition to being someone who currently menstruates. These factors influenced and shaped many aspects of the PIP project and the current study, including how data was gathered, interpreted and analysed. They also influenced what I thought was important to highlight and focus upon during the analysis, particularly within phase 2 which focused on the experiences of those needing menstrual health support during lockdown.

As with phase 1 and the initial conception of the PIP project, using a collaborative research design was a useful method for providing additional insights that broadened my understanding and awareness of how menstrual health was being impacted by the pandemic. This approach allowed me to develop my understanding of what the affected communities felt were important to highlight within the analysis and dissemination of information, outside of my own experiences. The PAG was crucial in this development, along with the regular dissemination events that I presented the ongoing research analysis at. The events generated discussion around menstrual health support across the UK, and internationally, by those within the sector and from other sectors that I was not already engaged in. These discussions helped me to re-interpret data gathered within phase 2 through a more diverse, critical lens by expanding my awareness of what the menstrual health sector was experiencing throughout the pandemic (as opposed to being constrained to phase 1, which focused on service provider experiences during a specific time).

My own experiences around menstruation, health and the pandemic were helpful to draw upon when conducting interviews in phase 2, as they provided a way to build rapport and trust, showing sympathy and empathy with those who had needed menstrual health support during the pandemic. However, I did find this challenging, as discussed in chapter 6, as I was not prepared for how some of the experiences people talked about would impact me, personally. Furthermore, my own health complications during the pandemic added to my distress on occasion. In these circumstances, I found the support of my supervisory team to be important, using supervision to reflect upon and discuss ways to minimise further distress if it should occur.

My positionality will have also influenced the re-analysis of the data for the current study. My own experiences and my knowledge about menstrual health and period poverty within the UK shaped what I considered to be important to include within the analysis and my interpretation of the meaning of the data. My own interpretations may therefore not be the same as what the participant experienced which is important to acknowledge.

7.9 Implications for policy, practice and future research

7.9.1 Policy & practice recommendations

This study provided evidence relevant to the following policy areas: menstrual health and period poverty, health, gender equality, financial poverty and austerity and disaster/disease outbreak prevention. The key recommendations from this study, therefore, centre on the accessibility of menstrual products, the provision of lifetime menstrual health education and knowledge, addressing menstrual health barriers, and ensuring consistent menstrual equity policies across the UK including the provision of menstrual health support in UK disaster and disease prevention planning. The recommendations help to address wider existing intersecting inequalities around menstrual stigma, gender and health inequalities and poverty-related inequality. ***Please note, recommendations from the thesis are italicised in bold.***

7.9.1.1 Improving the accessibility of menstrual products

This study provides accounts of difficulties in accessing menstrual products during the pandemic in the UK. Although some of the challenges relate to disease-prevention measures during the pandemic (such as building closures), many of the challenges faced by those needing products and providing access to products were rooted in wider issues around gender inequality and menstrual stigma. Menstrual products are not considered to be essential or necessary items as toilet roll, and soap are. Within the UK, despite changes around the ‘tampon tax’ and a wider awareness of period poverty, there remains inconsistency in the provision and accessibility of such products.

The importance of recognising the necessity of menstrual products is a key component of addressing wider gender inequality, in addition to menstrual inequality. This is reflected in numerous humanitarian organisation responses to addressing such inequalities, both specific to the pandemic and more generally. These include UNICEF (2020), World Health Organization (2022) and the United Nations (2024). As such, it is also vital that menstrual products are easily accessible for those who need them and that scheme that provide access to free menstrual products also provide a choice of product to ensure body autonomy.

It is therefore recommended that menstrual products are recognised as essential products and are treated in the same manner as other necessary items such as toilet paper and soap. Products should be freely provided within public and shared spaces, including workplaces, schools, community centres, hospitals and other medical facilities, custodial institutions, facilities for displaced individuals and public toilets. It is also recommended that government guidance in the event of another pandemic or similar emergency or disaster situation make it clear that menstrual products are 'essential' products.

7.9.1.2 Providing lifetime menstrual health education

This study provides examples of how poor menstrual health knowledge and poor menstrual health education leads to anxiety over changes to the menstrual cycle, which can lead to increase in stress and menstrual shame. During the pandemic, the provision of menstrual health education in educational and community settings experienced challenges related to moving education sessions online or had to cease provision of such sessions. It was also reported that there was not enough information available about how stress and Covid-19 could affect the menstrual cycle, causing further worry for some who experienced changes to their menstrual cycle during the pandemic, which is echoed in Junkins et al.'s (2024) study.

Poor menstrual health knowledge and education are recognised as barriers for women, girls and people who menstruate (InKind Direct. et al., 2024; Irise International., 2025b; Plan International UK, 2018; Randhawa et al., 2021; Tomlinson, 2025). Without knowing what is 'typical' or 'normal' in terms of menstruation, menstrual cycle and menstrual-related symptoms, there are delays in seeking medical advice for anything that is atypical. Furthermore, without accurate and accessible information, people seek out support and information from other sources that may perpetuate menstrual stigma and shame (InKind Direct. et al., 2024; Irise International., 2025b; Tomlinson, 2025). This not only applies to school-aged children and young people, but to adults who have received poor menstrual health education. As with menstrual product provision, humanitarian organisations acknowledge that menstrual health education is a vital component when addressing wider gender inequality (UNICEF, 2020; United Nations General Assembly, 2024; World Health Organisation, 2022). Menstrual health education was also highlighted within the UK Government Women and Equalities report (2024) on

Women's Reproductive Health Conditions as a key issue to address, to ensure that women and girls have access to accurate 'lifetime' information from pre-puberty to post-menopause.

It is therefore recommended that menstrual health education is considered 'mandatory' teaching within RSE provision in primary and secondary schools across the UK, covering all aspects of menstruation. This should include the menopause and what sorts of factors can affect menstrual cycle regularity and menstrual-related symptoms, including changes to menstrual bleeding, menstrual pain and pre-menstrual symptoms. Furthermore, the same information must be provided for adults in an accessible, inclusive way with a range of options (such as online and in-person).

7.9.1.3 Addressing menstrual health barriers

This study provides examples of how menstrual stigma, medical gaslighting and poor health systems act as barriers to accessing and receiving appropriate menstrual health care and support. Again, this finding was mirrored in other research studies, both pandemic (DeMark et al., 2024; Holst et al., 2023) and non-pandemic related (Barrington et al., 2021; Chen et al., 2018; Holland et al., 2020; Ní Chéileachair et al., 2022; Seear, 2009; Åkerman et al., 2024). Addressing such barriers are widely acknowledged as part of tackling wider gender and health inequalities (Department of Health and Social Care, 2022; Department of Health., 2024; Scottish Government., 2021; UNICEF, 2020; United Nations General Assembly, 2024; Welsh Government., 2024; Women & Equalities Committee, 2024; World Health Organisation, 2022). In addition to the humanitarian organisations already mentioned within this section of the discussion, several key health-related organisations stress the importance of addressing barriers to menstrual health care. Within the UK, organisations including the Royal College for Obstetricians and Gynaecologists (2024) , Royal College of Nursing (2024) and Endometriosis UK (2024) have all called for urgent action to address the increasing waiting times associated with menstrual health-related conditions and for improvements to be made to the accessibility of information and education to improve help-seeking behaviour and facilitate earlier diagnosis.

It is therefore recommended that menstrual health is viewed as an important part of overall health and wellbeing for those who menstruate. It is also recommended that those within healthcare settings therefore receive accurate regular training on menstrual health-related symptoms, menstrual health

conditions and menopause. This includes GPs, nurses, specialists and other associated healthcare professionals.

7.9.1.4 Ensuring consistent menstrual equity policies across the UK

This study demonstrates how inconsistency in menstrual equity policies across the UK caused uncertainty and anxiety for those involved in providing menstrual health support during the pandemic. This was especially pertinent for local authorities and non-profit service providers, most notably within England where government-funded menstrual product provision only applies within specific settings.

Prior to the pandemic, the UK government had committed to ‘end period poverty by 2030’ and allocated a set budget towards this target (Mourdant, 2019). The ‘Period Poverty Taskforce’ was set up to begin work on tackling menstrual inequality across the UK (Government Office for Equalities, 2019). Pockets of progress had occurred with Scotland and Wales providing access to free menstrual products within local authority areas (Welsh Government, 2020; Zipp et al., 2018), and the introduction of free products within educational settings in England (Adams, 2020) being the most significant. During the pandemic, the taskforce ceased to exist and despite campaigns from grassroots organisations such as Bloody Good Period to find out what was happening with regards to the government’s plans to end period poverty, little information was forthcoming (Bloody Good Period, 2023). Some progress has been made in recognition that menstrual health should be addressed as a key priority within UK health strategies, although there is varied development of recommendations and the implementation of such across the country (Department of Health and Social Care, 2022; Department of Health., 2024; Scottish Government., 2021; Welsh Government., 2024; Women & Equalities Committee, 2024).

It is therefore recommended that the UK government commits to addressing the points raised within national health strategies and menstrual health-related inquiries, which aim to improve access to free menstrual products, menstrual health education and menstrual health care (Department of Health and Social Care, 2022; Department of Health., 2024; Scottish Government., 2021; Welsh Government., 2024; Women & Equalities Committee, 2024). Furthermore, it is recommended that any menstrual health-related policy or law passed includes planning for emergency situations to minimise the disruption of menstrual health provision and support across the UK. This must include the continued provision of free menstrual products, the provision

of menstrual health education and the provision of menstrual health care. It must also include the recognition of menstrual products as ‘essential’ items, as per UNICEF (2020) guidance.

7.9.1.5 Adopting an intersectional approach to address menstrual equity

This study provides numerous examples of how the pandemic exacerbated existing inequalities, through the lens of menstrual health. The discussion situates the analysis within wider pandemic-related research to further demonstrate how such inequalities intersect to create additional barriers for historically minoritised and marginalised women, girls and people who menstruate.

The menstrual advocacy and activism sector has been critiqued for being a predominantly ‘white, middle class, cisgender’ space (Tomlinson, 2023; Weckesser, Randhawa, et al., 2019) and this is indicative of wider structural inequalities around gender, race, sexuality, class and wealth. Within sexual and reproductive health, for example, the disparities around health outcomes for Black women are well documented (Abrahams et al., 2022; Conneely et al., 2023; Howell, 2023; Laster Pirtle & Wright, 2021; Perro et al., 2022; Rosenthal & Lobel, 2020). The need to address this health gap is often included within government policy as a key outcome, a recent example being the Womens Health Strategy for England (2022) which acknowledges health disparities amongst specific groups, including black and Asian women, lesbian and bisexual women, and women living in the most deprived parts of the country. Such acknowledgements are typically vague and lack any clear commitment as to how inequalities will be practically addressed, feeling almost tokenistic in their presentation. Within healthcare, ways to provide more meaningful solutions to tackling inequalities include co-design and inclusion of the affected communities in setting research priorities, designing interventions and structuring support (Coren et al., 2021; Farrington, 2016; Ocloo & Matthews, 2016; Stanek et al., 2023).

It is therefore recommended that efforts to address menstrual health inequality centre the voices and experiences of those that are to be impacted by any decisions made. This is especially important for historically minoritised and marginalised groups. Those impacted must be involved in the decision-making processes, including the design and implementation of policies and strategies to tackle such inequality (Tomlinson, 2025). This approach has been particularly effective with regard to youth engagement and the provision of menstrual health support within schools within the UK (Irise International, 2024; Prime Minister's Office Number 10 Downing Street, 2021), and with patient-designed awareness campaigns (Stanek et al., 2023), providing examples of how impacted groups have influenced service provision in a meaningful, non-tokenistic way.

7.9.2 Future research considerations

Several suggestions for future research considerations have been made throughout this chapter. These build upon the analysis of this current study, to provide additional evidence that addresses gaps in knowledge to strengthen efforts to address menstrual inequality:

1. **Examining the impact of the pandemic on existing free menstrual product provision, to identify barriers and good practice as part of future planning**. This thesis provides insight into barriers and good practice regarding menstrual product provision across Great Britain, however, much of this provision was via non-profit services and not via centralised government schemes (such as DfE Period Products Scheme). To date, the pandemic has not been included within the evaluation of government free menstrual product schemes across the UK. Further research on this would be beneficial as a measure of how any disruption contributed to barriers in service provision. Research into areas of good practice within this context would also be useful to include within future disaster/emergency planning, minimising disruption and ensuring the needs of those who menstruate are met.
2. **Examining the impact of free menstrual product schemes across the UK upon pandemic menstrual health experiences**. The provision of free menstrual products varies widely across parts of the UK, with many areas introducing schemes during the pandemic (e.g. Scotland, Northern Ireland). While this thesis provides insight into this, it comes from the perspective of those providing services. It would therefore be useful to examine how government schemes in place during the pandemic helped those needing support, and the impact that such support had upon their menstrual health and wider health and wellbeing.
3. **Examining the impact of the pandemic on menstrual health education and menstrual health care provision**. This thesis provides insight into how the pandemic impacted the provision and accessibility of menstrual health education and knowledge, and menstrual health care. However, there is still limited research on this. It would be useful to examine any ongoing impact that delays in accessing these types of menstrual health support during the pandemic have had upon menstruation experiences to identify priorities that menstrual inequality efforts should focus on. For example, if menstrual health education within schools was deprioritised during the pandemic, how has this impacted young people's understanding and knowledge of menstruation and has this had any impact on their experiences of accessing menstrual health support?

4. **Ensuring the inclusion and representation of historically minoritised groups within menstrual health research**. Menstrual health research has been criticised for centring the experiences of white, cisgender women (Perro et al., 2022). To ensure better inclusion and representation of historically minoritised groups, research must diversify to de-centre these experiences and voices. This is especially important where menstrual health research evidence informs the development and implementation of menstrual health policies, to ensure that the needs of all menstruators are considered and that menstrual inequality is meaningfully addressed.

7.9.3 Summary

The recommendations made regarding future policy, practise and research considerations complement each other in terms of their shared objectives towards addressing menstrual inequality. The research recommendations contribute to and strengthen the policy recommendations, ensuring that UK policy decisions and implementation are evidence-based and representative of all affected communities. By focusing on the areas outlined within the recommendations while recognising the diversity and intersections of menstrual health experiences, the key elements within Hennegan et al.'s (2021) definition of menstrual health are addressed to ensure greater menstrual equity for women, girls and people who menstruate.

7.10 Conclusion

This thesis has made important contributions to pandemic-related menstrual health research by providing insight into how the Covid-19 pandemic influenced the experiences of those providing and needing to access menstrual health support within the UK. Using critical frameworks throughout all stages of the research, the study examines how existing inequalities intersect with those created by the pandemic, ensuring that the needs of affected communities are at the forefront of the thesis and any subsequent research impact that could lead to meaningful change. The Periods in a Pandemic project has already contributed towards such change, with the findings informing local and national menstrual health policies and recommendations. These are future pathways to impact for this current study, strengthening the thesis' contribution to addressing menstrual health inequalities across the UK. Furthermore, the suggestions as to future policy, practice and research considerations outlined within the discussion chapter provide additional means to further tackle menstrual inequality, creating positive change for those who menstruate.

The thesis adds to the knowledge and evidence base regarding the impact of the pandemic upon menstrual health and period poverty. The analysis demonstrates how the pandemic exacerbated existing health and gender inequalities, creating additional barriers to accessing menstrual health support, as described in both phases of the research. The analysis of phase 2 provides further insight into the experiences of those needing menstrual health support during lockdowns, including what factors influenced health-based decisions such as menstrual management and accessing health care. Combining the experiences of service providers with those who needed menstrual health support during the Covid-19 pandemic is a unique contribution of the study, with other pandemic-related research providing separate accounts.

This study therefore provides a more comprehensive account of how menstrual health was impacted by the pandemic, drawing attention to the similarities and differences in the experiences of service providers and those needing menstrual health support. Furthermore, this study is one of a handful of studies that examine menstrual health experiences during the pandemic. Much of the existing Covid-19 menstrual health related research focuses on the impact of the Covid-19 virus or vaccination upon the menstrual cycle, or menstrual hygiene practice during the pandemic. While this study includes aspects of these, they are not the sole focus of the research. Expanding this research study to include wider elements of menstrual health such as access to products, healthcare and education, in addition to examining menstrual cycle changes attributed to the pandemic, provides a more holistic and in-depth understanding of how the pandemic impacted the menstrual health needs of women and people who menstruate. This allows us to see how physical, social and psychological factors influenced menstrual health experiences during the Covid-19 pandemic.

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APPENDIX A: Phase 1 full ethical approval letter

BIRMINGHAM CITY
University

Faculty of Health, Education & Life Sciences Research Office Seacole Building, 8 Westbourne Road

Birmingham B15 3TN

HELS_Ethics@bcu.ac.uk

04/Aug/2020

Mrs Gemma Williams gemma.williams@bcu.ac.uk

Dear Gemma,

Re: Williams /7567 /R(A) /2020 /Jul /HELS FAEC **-** Periods in a Pandemic: how UK period poverty initiatives are managing with Covid-19-related challenges (phase 1)

Thank you for your application and documentation regarding the above activity. I am pleased to take Chair's Action and approve this activity. Provided that you are granted Permission of Access by relevant parties (meeting requirements as laid out by them), you may begin your activity. I can also confirm that any person participating in the project is covered under the University's insurance arrangements.

Please note that ethics approval only covers your activity as it has been detailed in your ethics application. If you wish to make any changes to the activity, then you must submit an application for approval of the proposed changes.

Examples of changes include (but are not limited to) adding a new study site, a new method of participant recruitment, adding a new method of data collection and/or change of Project Lead.

Please also note that the Health, Education and Life Sciences Faculty Academic Ethics Committee should be notified of any serious adverse effects arising as a result of this activity.

If for any reason the Committee feels that the activity is no longer ethically sound, it reserves the right to withdraw its approval. In the unlikely event of issues arising which would lead to this, you will be consulted.

Keep a copy of this letter along with the corresponding application for your records as evidence of approval.

If you have any queries, please contact HELS_Ethics@bcu.ac.uk I wish you every success with your activity.

Yours Sincerely, Professor Trixie McAree

On behalf of the Health, Education and Life Sciences Faculty Academic Ethics Committee

APPENDIX B: Phase 1 ethics amendment approval letter

BIRMINGHAM CITY
University

Faculty of Health, Education & Life Sciences Research Office Seacole Building, 8 Westbourne Road

Birmingham B15 3TN

HELS_Ethics@bcu.ac.uk

26/Nov/2020

Mrs Gemma Williams gemma.williams@bcu.ac.uk

Dear Gemma,

Re: Williams /#7567 /sub2 /Am /2020 /Nov /HELS FAEC **-** Periods in a Pandemic: how UK period poverty initiatives are managing with Covid-19 related challenges (phase 1)

Thank you for your application for approval of amendments regarding the above study. I am happy to take Chair's Action and approve these amendments. Provided that you are granted Permission of Access by relevant parties (meeting requirements as laid out by them), you may continue your activity.

I can also confirm that any person participating in the project is covered under the University's insurance arrangements.

Please note that ethics approval only covers your activity as it has been detailed in your ethics application. If you wish to make any changes to the activity, then you must submit an application for approval of the proposed changes.

Examples of changes include (but are not limited to) adding a new study site, a new method of participant recruitment, adding a new method of data collection and/or change of Project Lead.

Please also note that the Committee should be notified of any serious adverse effects arising as a result of this activity.

If for any reason the Committee feels that the activity is no longer ethically sound, it reserves the right to withdraw its approval. In the unlikely event of issues arising which would lead to this, you will be consulted.

Keep a copy of this letter along with the corresponding application for your records as evidence of approval.

If you have any queries, please contact HELS_Ethics@bcu.ac.uk I wish you every success with your activity.

Yours Sincerely,

Dr Loukia Tsaprouni

On behalf of the Health, Education and Life Sciences Faculty Academic Ethics Committee

APPENDIX C: Phase 2 full ethical approval letter

BIRMINGHAM CITY
University

Faculty of Health, Education & Life Sciences Research Office Seacole Building, 8 Westbourne Road

Birmingham B15 3TN

HELS_Ethics@bcu.ac.uk

19/Jan/2021

Mrs Gemma Williams gemma.williams@bcu.ac.uk

Dear Gemma,

Re: Williams /#8034 /sub2 /R(B) /2021 /Jan /HELS FAEC **-** Periods in a Pandemic: how UK period poverty initiatives are managing with Covid-19 related challenges (phase 2)

Thank you for your application and documentation regarding the above activity. I am pleased to take Chair's Action and approve this activity. Provided that you are granted Permission of Access by relevant parties (meeting requirements as laid out by them), you may begin your activity. I can also confirm that any person participating in the project is covered under the University's insurance arrangements.

Please note that ethics approval only covers your activity as it has been detailed in your ethics application. If you wish to make any changes to the activity, then you must submit an application for approval of the proposed changes.

Examples of changes include (but are not limited to) adding a new study site, a new method of participant recruitment, adding a new method of data collection and/or change of Project Lead.

Please also note that the Health, Education and Life Sciences Faculty Academic Ethics Committee should be notified of any serious adverse effects arising as a result of this activity.

If for any reason the Committee feels that the activity is no longer ethically sound, it reserves the right to withdraw its approval. In the unlikely event of issues arising which would lead to this, you will be consulted.

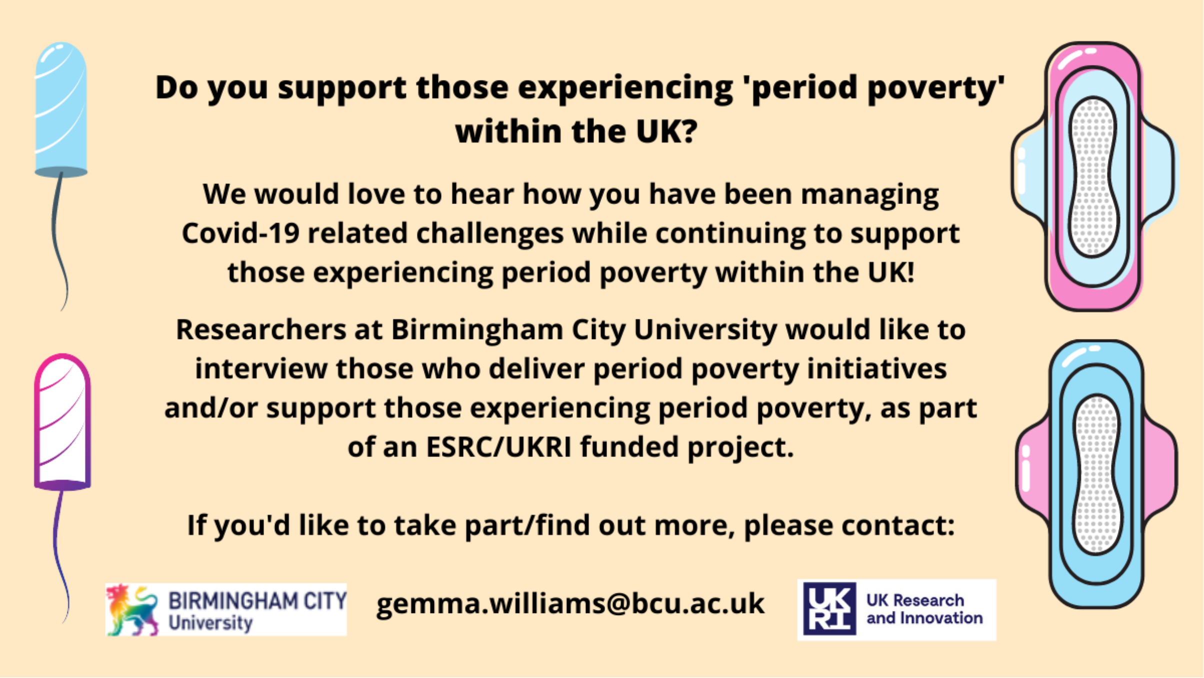
Keep a copy of this letter along with the corresponding application for your records as evidence of approval.

If you have any queries, please contact HELS_Ethics@bcu.ac.uk I wish you every success with your activity.

Yours Sincerely, Professor Joanne Brooke

On behalf of the Health, Education and Life Sciences Faculty Academic Ethics Committee

APPENDIX D: Phase 1 recruitment advert (social media)



Do you support those experiencing 'period poverty' within the UK?

We would love to hear how you have been managing Covid-19 related challenges while continuing to support those experiencing period poverty within the UK!

Researchers at Birmingham City University would like to interview those who deliver period poverty initiatives and/or support those experiencing period poverty, as part of an ESRC/UKRI funded project.

If you'd like to take part/find out more, please contact:

BIRMINGHAM CITY University

gemma.williams@bcu.ac.uk

UKRI UK Research and Innovation

Do you support those experiencing 'period poverty' within the UK?

Researchers at Birmingham City University would love to hear how you have been managing Covid-19 related challenges while continuing to support those experiencing period poverty within the UK, as part of an ESRC/UKRI funded project

If you would like to take part, and be entered into our prize draw to win £50 voucher for your organisation/project, please complete our online survey: https://bcu.onlinesurveys.ac.uk/periods-in-a-pandemic-phase-1

Contact gemma.williams@bcu.ac.uk for further info

BIRMINGHAM CITY University

UKRI UK Research and Innovation

APPENDIX E: Phase 1 Participant Information Sheet

Periods in a Pandemic: how UK period poverty initiatives are managing with Covid-19 related challenges

Research Team: Gemma Williams (Project Lead), Dr Annalise Weckesser, Dr Emma Craddock

We would like to invite you to take part in this qualitative study on how UK based period poverty initiatives and projects are mitigating challenges linked to Covid-19, and how they are continuing to meet the needs of those experiencing period poverty.

Who can take part? Anyone involved in delivering period poverty programmes, or that provides support for those experiencing period poverty, within the UK.

Do I have to take part? It is up to you to decide whether or not to join the study and you are free to withdraw at any time, without giving a reason.

What will happen if I decide to take part? You will be asked to take part in a telephone/online interview that will last approximately 30 minutes, and the interview will be audio-recorded. We can conduct the telephone/online interview at a time that is most convenient to you. We will confirm and record verbal consent (see attached oral consent form) prior to the interview and send you a copy of the consent form for your own record.

What are the possible risks and benefits? We do not anticipate any risks to participants in this study. This study may not directly benefit you personally. Your contribution will be extremely useful in helping to inform current practice, shape policy and develop strategies within the ongoing pandemic crisis (and any future crises), helping to ensure the voices of girls, women and all menstruators are centralised.

How will my anonymity/confidentiality be protected? This project adheres to all current Data Protection Act 2018 guidelines (more details below). All information about you will be handled in confidence. To protect anonymity and confidentiality, audio recordings will be destroyed upon transcription. Transcripts will be anonymised and stored in a secure environment in accordance with Birmingham City University (BCU) Faculty of Health, Education and Life Sciences (HELS) standard operating procedures. In line with current EU General Data Protection Regulations (GDPR) (2018), data containing personal information will be stored securely and separate from the transcripts.

The consent process will allow you to confirm whether you permit the use of your name and your organisation's name to be included in research reports, publications and conference presentations. You can also choose to remain anonymous, if preferred. If you require permission from your line manager, or relevant person within your organisation, prior to taking part; please ensure that you have this in place prior to interview.

What if I want to withdraw from the study after the telephone interview? You are free to withdraw from the study at any time. Due to the nature of this study, you will only be able to withdraw up to the time your interview transcription is analysed.

What if there is a problem? If you have a concern about any aspect of this study, please contact Gemma Williams (gemma.williams@bcu.ac.uk), in the first instance. If you remain concerned or your questions have not been answered, please contact HELS_ethics@bcu.ac.uk .

What will happen to the results of the research study? You will be sent a copy of the final report. The information obtained from this study will be used for reports and publications in medical and health journals and at health and academic conferences.

Who is funding the research? This study is funded by European Social Research Council (ESRC)

Who has reviewed the study? All research undertaken by BCU is reviewed by the HELS Faculty Academic Ethics Committee. This study has been reviewed and given a favourable opinion by the committee.

Data protection and your rights.

BCU is the sponsor for this study. The project co-leads will be using information from you in order to undertake this study and will act as the data controllers for this study. This means that we are responsible for looking after your information and ensuring it is used in accordance with GDPR (2018). We need to manage your information in specific ways in order for the research to be reliable and accurate; your rights to access, change or move your information are limited by this need. To safeguard your rights, we will use the minimum personally identifiable information possible. The researchers will only use your name and preferred contact details (email, phone or mailing address) to contact you about this study. The only people in BCU who will have access to information that identifies you will be people who need to contact you to report the study findings, those who audit the data collection process, and those who manage data storage and archiving.

BCU will retain evidence of your participation in this study (specifically, the consent form) for three years after the project has been completed, this will be in December 2024. This is in accordance with the University's legal obligations and the time you have to raise any issues or concerns with us about your participation in this study. After this period, BCU will securely destroy this information held about you.

You can find out more about how we use your information by contacting the research team, whose details are available at the end of this information sheet. For more information about how the University processes your personal data for research, please see the University Privacy Statement, available here: https://www.bcu.ac.uk/about-us/corporate-information/policies-and-procedures/privacy-notice-for-research-participants

If you have any concerns about how we use or handle your personal data please contact the University's Data Protection Officer:

E: informationmanagement@bcu.ac.uk	T: 0121 331 5288
Address: Data Protection Officer, Information Management Team, Birmingham City University University House, 15 Bartholomew Row, Birmingham, B5 5JU	

You also have the right to complain directly to the Information Commissioner at: Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF (website: http://ico.org.uk).

APPENDIX F: Phase 1 consent form

Periods in a Pandemic: how UK period poverty initiatives are managing with Covid-19 related challenges

Research Team: Gemma Williams (Project Lead), Dr Annalise Weckesser, Dr Emma Craddock

Project Code:

Participant identification number:

	Y/N
I confirm that I have read and understand the participant information sheet dated 29.6.20 for the above named study.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and my legal rights will not be affected.	
I give permission for relevant sections of my data collected during the study to be looked at by individuals from Birmingham City University and from regulatory bodies, where it is relevant to my taking part in this research.	
I understand that personal data about me will be collected for the purposes of the research study including my name and contact details, and that these will be processed in accordance with the participant information sheet (29.6.20).	
I have had the opportunity to consider the information and discuss it with the researchers. I have had any questions answered to my satisfaction.	
I agree to audio recording this telephone/online interview.	
I agree for my name, and my organisation's name, to be used with quotes from my interview in research reports, publications and at conferences	
I agree to the use of anonymised quotes in research reports, publications and at conferences.	
I understand that the transcript of the audio recording will be anonymised and only the researchers will have access to information with my name on.	
I agree to take part in the above study.	

Name of Participant *Date*

Name of Person taking Verbal Consent	*Date*	*Signature of Person taking Verbal Consent*

1 copy to be sent (via preferred contact method); 1 copy for internal records

APPENDIX G: Phase 1 telephone interview guide

Periods in a Pandemic: how UK period poverty initiatives are managing with Covid-19 related challenges (Phase 1)

Interviewer: ________________________ **Participant's ID**: _______________________

Date of Interview: ________________________

Pre Interview Checklist	**X**
Participant confirmed they have read PIS	
Answered participant's questions	
Obtained verbal consent for study	
Obtained verbal consent to audio-record interview	

Background Information

Organisation name:

Location:

Please can you tell me more about the work that you do/services you provide?

Pre-Covid

1. **What did 'normal' provision/services look like before Covid-19 lockdown?**

[Allow participant to respond fully before asking further probe questions]

   a. Who do you usually support? (which groups of people)
   b. What do you provide? (period products, education, other services – what?)
   c. How do you provide services? Directly to people or via a drop-in centre/school/foodbank etc
   d. Do you rely on donations or charitable contributions? How do you get them?
   e. Do you rely on volunteer support to deliver services/support?

Beginning of lockdown to September 2020

2. **Can you tell me how Covid-19 lockdown, from March until September, affected your service provision?**

[Allow participant to respond fully before asking further probe questions]

   a. What had to change?
   b. What sorts of things did you put in place to manage those changes?
   c. Did they work well? Why/why not?

Issues to explore:

- Stockpiling impact and product availability
- Closure of services/schools/churches/food banks etc
- Access to funding/donations/volunteer time
- Changes to communicating with service users or accessing resources

3. **What sorts of things did service users tell you about how Covid lockdown was affecting them?**
4. **How did the needs of those who access your services change?**
   a. Changes in demand and requests for support
   b. Emergence of any new groups needing support
5. **Were you able to support these changes in need? How?**
   a. What worked well
   b. What barriers were there
   c. Did you get any feedback from anyone accessing services? What was it?

<u>Current situation</u>

6. **What does service provision typically look like now?**

[Allow participant to respond fully before asking further probe questions]

   a. Are you in a ‘tier’? Which one?
   b. Who do you support? (which groups of people)
   c. What do you provide? (period products, education, other services – what?)

   d. How do you provide services? Directly to people or via a drop-in centre/school/foodbank etc
   e. Are you relying on donations or charitable contributions? How are you getting them?
   f. Are you relying on volunteer support to deliver services/support? Is it working well?

7. **What are the needs of service users at the moment (post lockdown)?**

Future pandemic considerations

8. Have you received support for period poverty projects, like (organisation), to be able to continue with service provision during the pandemic?
   a. Support from government
   b. Support from elsewhere – who?
   c. Has this support been sufficient?
   d. What type of support is needed?
9. Do you feel that (organisation) is prepared for any further Covid-related issues, like a second wave or further lockdown measures?
10. What would help you to be able to continue to support those experiencing period poverty, within the pandemic?

Any other thoughts/comments/things that you think are important to highlight about period poverty during the pandemic?

Post Interview Checklist	**X**
Upload recording for transcription	
Check transcript and erase recording	
Destroy this form and any written notes	

RECORDER OFF – THANK PARTICIPANT

APPENDIX H: Phase 1 online survey

Periods in a Pandemic: how UK period poverty initiatives are managing with Covid- 19 related challenges (phase 1)

Research Team: Gemma Williams (Project Lead), Dr Annalise Weckesser, Dr Emma Craddock

We would like to invite you to take part in this qualitative study on how UK based period poverty initiatives and projects are mitigating challenges linked to Covid-19, and how they are continuing to meet the needs of those experiencing period poverty.

Who can take part? Anyone involved in delivering period poverty programmes, or that provides support for those experiencing period poverty, within the UK.

What do I have to do if I want to take part? If you would like to take part in the project, please complete the following online survey. The survey is anonymous, so your name will not be linked to your survey responses. By completing the survey, and submitting your response, you have given permission for your anonymous data to be included in this research project.

The survey will take approximately 15 minutes to complete. It includes 'tick box' questions, and ones where you will be given space to write your own answers.

What if I change my mind? If you change your mind while filling in the survey, you can exit at any stage, and your responses will not have been recorded. However, once you submit the survey, it will not be possible to remove your data from the project.

What will happen to my data? Your responses will be kept secure, via the Online Survey software, and will be looked at on secure Birmingham City University computers. Your responses will be combined with others that have completed the survey, and this data may be shared with other researchers at the University. As your responses are anonymous, there are no risks around Data Protection, as we cannot trace your data back to you.

Are there any risks to me? We do not anticipate any risks to participants in this study. This study may not directly benefit you personally. Your contribution will be extremely useful in helping to inform current practice, shape policy and develop strategies within the ongoing pandemic crisis (and any future crises), helping to ensure the voices of girls, women and all people who menstruate are centralised.

Do I get any payment for taking part? At the beginning of the survey, you will be asked if you would like to be entered into a prize draw to win a £50 Amazon voucher for your project/organisation. If you would like to enter into the prize draw, please add your name and email address in the space provided. This information will be kept separate from your survey responses, on secure BCU computers, which only the research team can access.

If you do not submit your survey, you will not be entered into the prize draw.

What will happen to the results of the research study? The information obtained from this study will be used for reports and publications in medical and health journals and at health and academic conferences/events.

Who is funding the research? This study is funded by European Social Research Council (ESRC)

Who has reviewed the study? All research undertaken by BCU is reviewed by the HELS Faculty Academic Ethics Committee. This study has been reviewed and given a favourable opinion by the committee.

Who do I contact if I have any questions?

Please contact Gemma Williams, **gemma.williams@bcu.ac.uk,** if you have any questions about the project. If you remain concerned or your questions have not been answered, please contact HELS_ethics@bcu.ac.uk

If you have any concerns about how we use or handle your personal data please contact the University's Data Protection Officer using the following contact details: **informationmanagement@bcu.ac.uk**; Telephone +44 (0)121 331 5288

Before continuing with the survey, please confirm the following:

1. I confirm that my organisation/project provides support for people experiencing period poverty within the UK ⍰ *Required*

Please select exactly 1 answer(s).

☐ Yes

☐ No

☐ Not sure

2. I am happy for my anonymous responses to be used in any reports, publications, and/or conferences/events ⍰ *Required*

Please select at least 1 answer(s).

☐ Yes

☐ No

3. I am happy to be contacted for a follow up interview as part of the Periods in a Pandemic Project* ⍰ *Required*

Please select at least 1 answer(s).

☐ Yes

☐ No

4. I am interested in finding out more about phase 2 of the Periods in a Pandemic Project, and how my organisation can be involved* ⍰ *Required*

Please select at least 1 answer(s).

☐ Yes

☐ No

5. I would like to be entered into the prize draw to win a £50 Amazon voucher for my project/organisation* ⍰ *Required*

Please select at least 1 answer(s).

☐ Yes

☐ No

6. If you have answered yes any of the asterix* questions, please provide your name, organisation name, and email address:

Page 2: Organisation details

7. Organisation name *Optional*

8. Organisation location *Optional*

9. Our organisation covers: *Optional*

☐ England only
☐ Scotland only
☐ Wales only
☐ Northern Ireland only
☐ UK wide
☐ Other

9.a. If you selected Other, please specify:

☐

10. Do you specifically focus upon supporting those experiencing period poverty within your organisation?

☐ Yes

Optional

☐ No

☐ Don't know

11. Our organisation provides the following support for people experiencing period poverty: *Optional*

☐ Access to period products only

☐ Menstrual health education only

☐ Products and education

☐ Other

11.a If you selected Other, please specify:

☐

12. Our organisation supports (tick all that apply): *Optional*

☐ Adults

☐ Young people

☐ Schools/colleges

☐ Trans and non-binary people who menstruate

☐ Homeless people

☐ Asylum seekers/refugees

☐ Other

13.

14.

12.a If you selected Other, please specify:

15. If you provide period products, how do you distribute them (tick all that apply)? *Optional*

☐ Give directly to those who need them

☐ Give to another organisation/s for distribution

☐ Other

13.a If you selected Other, please specify:

13.b Who do you provide products to (tick all that apply):

☐ Schools Colleges
☐ Homeless shelters
☐ Drop-in centres
☐ Food banks Places
☐ of worship
☐ Domestic abuse shelters
☐
☐ Libraries
☐ Sport/leisure facilities
☐ Other

13.b.1 If you selected Other, please specify:

14. Do you receive donations? *Optional*

☐ Yes - products only

☐ Yes - financial only

☐ Yes - both

☐ No

☐ Other

14.a If you selected Other, please specify:

15. Do you use volunteers to help deliver services? *Optional*

☐ Yes

☐ No

☐ Other

15.a If you selected Other, please specify:

Pre-Covid-19 service provision

16. Please describe how your services usually run (pre-Covid-19 lockdown and social distancing restrictions)

Covid-19 lockdown service provision

17. Did you have to change or adapt any element of service provision, as a result of Covid-19 lockdown and social distancing restrictions? *Optional*

☐ Yes

☐ No

☐ Not sure

18. Please describe how your services had to change and adapt as a result of Covid- 19 lockdown and social distancing restrictions

19. Were your services affected by any of the following (tick all that apply): *Optional*

☐ Stockpiling/hoarding of products

☐ Closure of schools/colleges/universities

☐ Closure of places of worship

☐ Closure of food banks Access

☐ to donations

☐ Access to volunteer support

☐ Other

☐ Not affected

19.a If you selected Other, please specify:

19.a.i If you were affected by any of the above, or answered other, please explain how this impacted upon service delivery

20. Have the needs of service users changed during lockdown? *Optional*

☐ Yes

☐ No

☐ Not sure

20.a Please explain how

☐

21. Do you feel that your organisation has been able to continue to support those experiencing period poverty during lockdown? *Optional*

☐ Yes
☐ No
☐ Not sure

21.a Please explain why

☐

Future service provision

22. What would help you to be able to continue to support those experiencing period poverty, within the current pandemic?

☐

23. Do you feel that your organisation is prepared for any further Covid-related issues, or further lockdown measures?

☐ Yes
☐ No
☐ Not sure

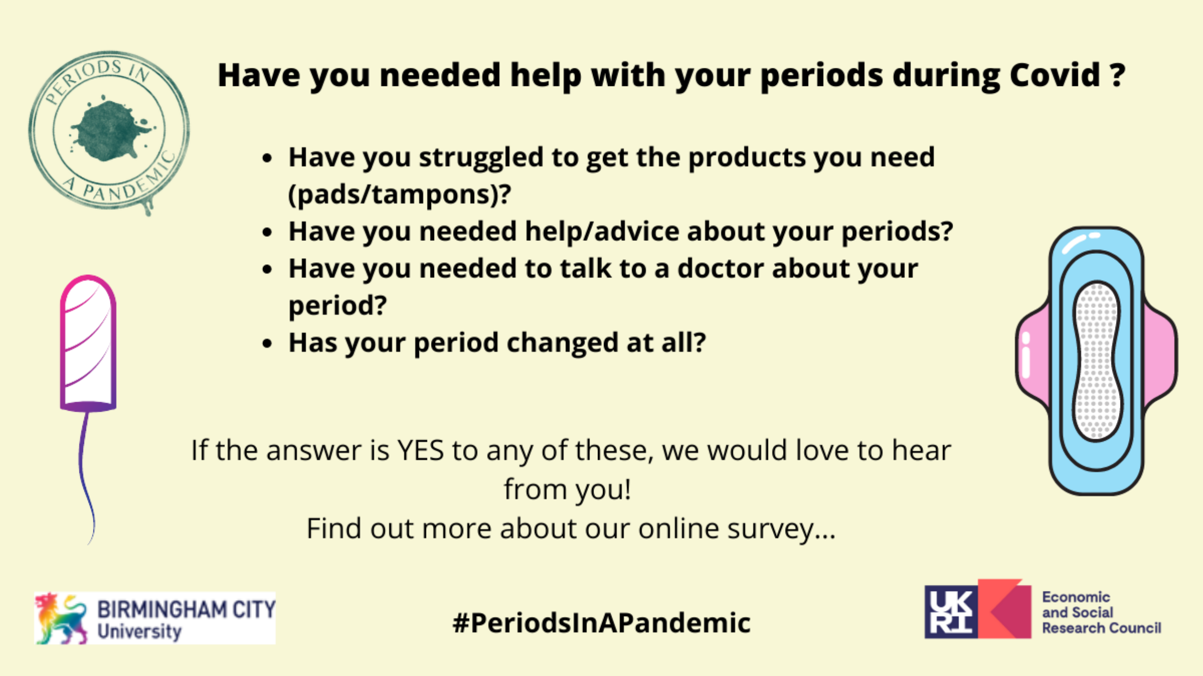
24. Please provide details of any other issues that you think are important to highlight period poverty during the pandemic

☐

Final page

Thank you for your time and for supporting the project! Please stay safe!

APPENDIX I: Phase 2 recruitment advertisements (social media)



PERIODS IN A PANDEMIC

Have you needed help with your periods during Covid ?

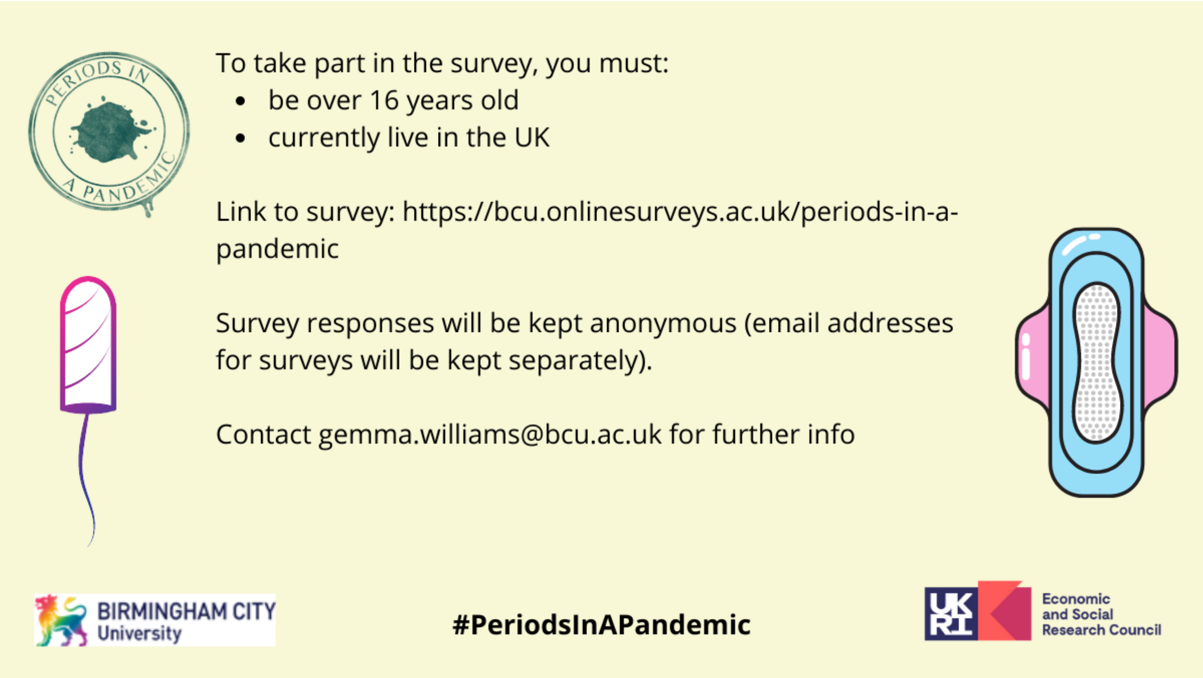
- **Have you struggled to get the products you need (pads/tampons)?**
- **Have you needed help/advice about your periods?**
- **Have you needed to talk to a doctor about your period?**
- **Has your period changed at all?**

If the answer is YES to any of these, we would love to hear from you!
Find out more about our online survey...

BIRMINGHAM CITY University

#PeriodsInAPandemic

UKRI Economic and Social Research Council



PERIODS IN A PANDEMIC

To take part in the survey, you must:

- be over 16 years old
- currently live in the UK

Link to survey: https://bcu.onlinesurveys.ac.uk/periods-in-a-pandemic

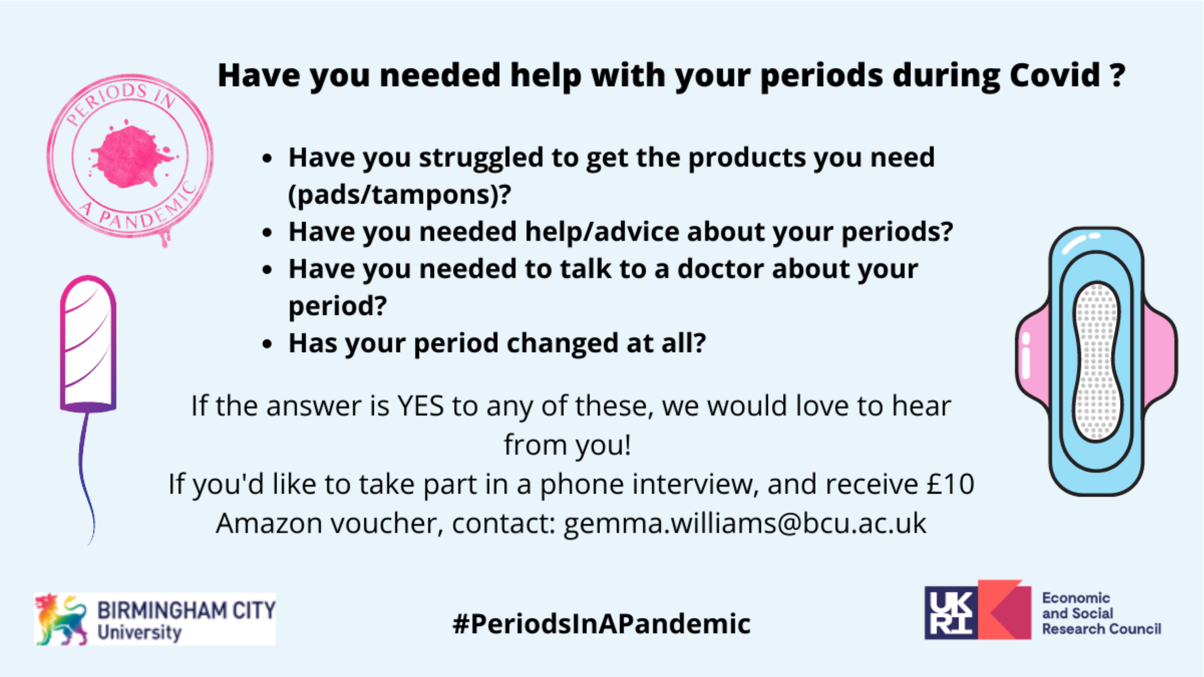
Survey responses will be kept anonymous (email addresses for surveys will be kept separately).

Contact gemma.williams@bcu.ac.uk for further info

BIRMINGHAM CITY University

#PeriodsInAPandemic

UKRI Economic and Social Research Council



PERIODS IN A PANDEMIC

Have you needed help with your periods during Covid ?

- Have you struggled to get the products you need (pads/tampons)?
- Have you needed help/advice about your periods?
- Have you needed to talk to a doctor about your period?
- Has your period changed at all?

If the answer is YES to any of these, we would love to hear from you!
If you'd like to take part in a phone interview, and receive £10 Amazon voucher, contact: gemma.williams@bcu.ac.uk

BIRMINGHAM CITY University

#PeriodsInAPandemic

UKRI Economic and Social Research Council

APPENDIX J: Phase 2 online survey

Periods in a Pandemic

Periods in a Pandemic: how UK period poverty initiatives are managing with Covid-19 related challenges

Research Team: Gemma Williams (Project Lead), Dr Annalise Weckesser, Dr Emma Craddock, Dr Lydia Aston - Birmingham City University

We would like to invite you to take part in our research study, but before you decide to take part, here are some things you need to know...

What are we researching?

We would like to know how UK projects are managing some of the challenges linked to Covid- 19 lockdown and restrictions, and how they are continuing to help people that struggle to afford period products (like pads and tampons) or that need education about periods and/or help with their menstrual health. This is also sometimes called ‘period poverty.’

Why have I been asked to take part?

We’d like to hear about your experiences during the pandemic, and if you've needed help with your periods during lockdown.

What do I have to do if I want to take part?

If you would like to take part in the project, you will need to fill in this survey. The survey is anonymous, so your name will not be linked to your survey responses. By completing the survey, and submitting your response, you have given permission for your anonymous data to be included in this research project.

The survey will take approximately 15 minutes to complete. It includes ‘tick box’ questions, and ones where you will be given space to write your own answers.

What if I change my mind?

If you change your mind while filling in the survey, you can exit at any stage, and your responses will not have been recorded. However, once you submit the survey, it will not be possible to remove your data from the project.

Taking part in the study, or choosing not to take part, will not affect your access to any services that you are currently using.

Are there any risks to me?

We do not anticipate any risks to you. Your feedback will be used as part of a larger study, called ‘Periods in a Pandemic: how UK period poverty initiatives are managing with Covid-19 related challenges’. What you say will be added together with feedback from others across the UK, and that will be used to inform people of how the Covid-19 pandemic has impacted upon people that have experienced period poverty. We might also want to publish this information in a research article, or a book, or tell people about the study on a website or in a presentation. Your name will never be used.

Do I get any payment for taking part?

Due to the high response rate, we are no longer able to provide Amazon vouchers as we have limited funds.

Has anyone checked this is OK?

Yes they have! This study has been checked by Birmingham City University’s Research Ethics Committee, who makes sure that we aren’t doing any harm to people, and that we keep their information safe.

What if there is a problem, or if I have some extra questions?

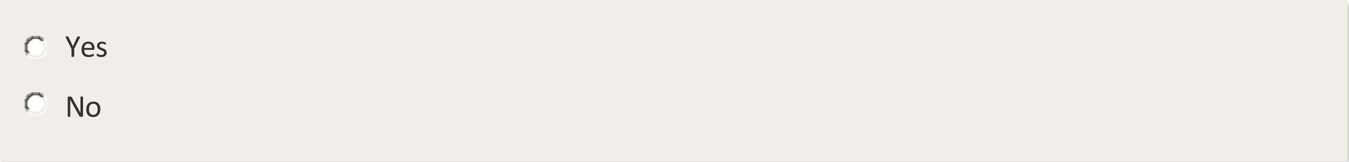
You can contact Gemma if you have any questions about the study or are worried about anything to do with taking part in it. Gemma is leading this research study, and she will be happy to answer your questions. Her email address is gemma.williams@bcu.ac.uk.

You can also email HELS_ethics@bcu.ac.uk if you are not happy with the way that the research has been undertaken, or if we haven’t been able to answer your questions.

Before continuing with the survey, please confirm the following:

I have read the information and confirm that:

1. I am over 16 years old ⍰ *Required*



○ Yes

○ No

2. I would like to receive a £10 Amazon voucher, if funds become available to provide more vouchers *Optional*

○ Yes
○ No

2.a Please provide your email address if you would like to receive a £10 voucher (to protect your anonymity, this information will be kept separate to your survey answers)

Access to period products (pads, tampons etc.)

3. Since Covid and lockdown, have you had any difficulties getting period products (like pads and tampons), or anything else you need for your period?

☐ Yes
☐ No

4. If you experienced difficulties, what were they? (Tick all that apply)

☐ Shops/supermarkets not having period products Not

☐ being able to afford period products

☐ Not having access to period products in my workplace

☐ Not being able to visit shops/supermarkets to buy period products Not

☐ being able to get period products from a support service I use Other

☐

4.a If you selected Other, please specify:

5. If you had difficulties getting the products you needed, what did you do? (Tick all that apply)

☐ I made my own using household items (like toilet roll, old clothes etc) I

☐ made my own reusable pads

☐ I contacted a charity that helps people with their periods I got

☐ some from a food bank

☐ I got some from my family

☐ I got some from my friends

☐ I got some from my workplace I

☐ didn't do anything

☐ Other

5.a If you selected Other, please specify:

☐

6. Before Covid/lockdown, did you ever have difficulties getting period products (like pads and tampons) or anything that you needed for your period?

☐ Yes

☐ No

☐ Other

6.a If you selected Other, please specify:

☐

7. If you had difficulties getting the products you needed *before Covid/lockdown*, what did you do? (Tick all that apply)

☐ I made my own using household items (like toilet roll, old clothes etc)

☐ I made my own reusable pads

☐ I contacted a charity that helps people with their periods

☐ I got some from a food bank

☐ I got some from my family

☐ I got some from my friends

☐ I got some from my workplace

☐ I didn't do anything

☐ Other

7.a If you selected Other, please specify:

8. If you didn't need help getting period products before Covid/lockdown, please tell us why you have needed help during this time (e.g., Did you lose your job/become furloughed? Did you have to shield or self-isolate?)

Help/support with your periods.

9. Where do you usually go to for support with your menstrual health, or if you have questions about your periods? (Tick all that apply)

☐ Family Friends
☐ Doctor/medical person
☐ Online support
☐ Community group
☐ School/University
☐ I don't talk to anyone
☐ Other

9.a If you selected Other, please specify:

9.b What sorts of things have you needed support/advice on (about your menstrual health or periods)?

10. Have you needed support/advice about your periods during Covid/lockdown?

☐ Yes
☐ No
☐ Other

10 a. If you selected Other, please specify:

10 b. What sorts of things have you needed support/advice on during this time (about your menstrual health or periods)?

10 c. If you needed support/advice, did you get the help you needed?

☐ Yes
☐ No
☐ Other

10 c.i. If you selected Other, please specify:

10 c.i.a. If you did not get the support/help that you needed, why was this?

10 c.ii. Where did you get the support/advice that you needed from?

☐ Family

☐ Friends

☐ Online support

☐ Community group

☐ Charity/organisation that helps with periods

☐ School/University

☐ Doctor/medical professional I

☐ haven't talked to anyone

☐ Other

10 c.ii.a. If you selected Other, please specify:

11. If you have needed to talk to a doctor/medical professional about your menstrual health or periods, during Covid/lockdown, did you manage to get an appointment?

☐ Yes - in person appointment

☐ Yes - telephone appointment

☐ Yes - online appointment

☐ No

☐ Other

11 a. If you selected Other, please specify:

☐

11 b. Did the doctor/medical professional give you the support/help you needed?

☐ Yes

☐ No

☐ Other

11 b.i. If you selected Other, please specify:

☐

11 b.ii. If they were able to help you, what sort of help did you get?

11 b.iii. If you did not get the support/help that you needed, why was this?

Your periods during Covid/lockdown

12. Has your period or menstrual cycle changed in any way during Covid/lockdown?

☐ Yes

☐ No

☐ Other

12 a. If you selected Other, please specify:

12 b. If you have experienced changes, what has caused them? (Tick all that apply)

☐ Stress

☐ Having Covid-19

☐ Having the Covid jab/s

☐ I don't know

☐ Other

12 b.i. If you selected Other, please specify:

13. If you've experienced changes to your period or menstrual cycle during Covid/lockdown, please describe them.

14. If you have experienced changes to your period/menstrual cycle, have you had to change how you normally manage your periods?

☐ Yes
☐ No
☐ Other

14 a. If you selected Other, please specify:

14 b. What sorts of things have you had to change?

What would you do in the future?

15. If you needed help with your periods again during the pandemic or if we go back into lockdown, what would you do/who would you go to?

16. Please describe any improvements that you think could be made to support services (e.g., access to period products, access to support/help for your periods)

17. What would you like people to understand more of, about periods during the pandemic?

18. Please add any other comments, or things you'd like to mention, in the space provided.

About you

Please provide as much information about yourself as you feel like. These questions are optional.

19. Which age group describes you?

☐ 16-20

☐ 21-30

☐ 31-40

☐ 41-50

☐ 51-60

20. Please describe your gender

21. Please describe your ethnicity

22. If you identify as 'disabled', please provide details of your disability/disabilities.

23. What is your preferred language to speak in?

24. What part of the UK do you currently live in?

☐ England

☐ Northern Ireland

☐ Scotland

☐ Wales

25. Which best describes you at the moment? (Tick all that apply)

☐ Employed full time

☐ Employed part time

☐ On furlough

☐ Full time student

☐ Part time student

☐ Caregiver (e.g. children/elderly)

☐ Stay at home parent

☐ Not currently employed

☐ Volunteer

☐ Other

25 a. If you selected Other, please specify:

25 b. If you are a full or part-time student, are you a student at Birmingham City University?

☐ Yes

☐ No

26. Do you have any children/dependents?

☐ Yes

☐ No

☐ Other

26 a. If you selected Other, please specify:

26 a.ii If you do, how many do you have?

27. How would you describe your relationship status at the moment? (e.g., single, married, living with partner, in a relationship)

28. Would you be interested in sharing your experiences/story in the future? For example, in future research projects, speaking at an event or as part of an awareness campaign about periods (Tick all that apply)

- ☐ Yes - I would be willing to be interviewed for research
- ☐ Yes - I would be willing to speak at an event
- ☐ Yes - I would be willing to share my experiences for an awareness campaign
- ☐ No
- ☐ Other

28 a. If you selected Other, please specify:

28 b. If you answered 'yes', please provide your preferred contact details in the space provided. These details will be kept separately from your survey responses, to protect your anonymity.

Final page

Thank you for taking part in our survey!

Remember, you can contact Gemma if you have any questions about the study or are worried about anything to do with taking part in it. Gemma is leading this research study, and she will be happy to answer your questions. Her email address is gemma.williams@bcu.ac.uk.

You can also email HELS_ethics@bcu.ac.uk if you are not happy with the way that the research has been undertaken, or if we haven't been able to answer your questions.

#PeriodsInAPandemic

Follow us on Twitter: @PandemicPeriod

APPENDIX K: Phase 2 Participant Information Sheet - interviews

Periods in a Pandemic: how UK period poverty initiatives are managing with Covid-19 related challenges

Research Team: Gemma Williams (Project Lead), Dr Annalise Weckesser, Dr Emma Craddock, Dr Lydia Aston

We would like to invite you to take part in our research study, but before you decide to take part, here are some things you need to know...

What are we researching?

We would like to know how UK projects are managing some of the challenges linked to Covid-19 lockdown and restrictions, and how they are continuing to help people that struggle to afford period products (like pads and tampons) or that need help with their periods. This is also sometimes called 'period poverty'.

Why have I been asked to take part?

We'd like to talk to you to hear about how you've experienced your period during lockdown, and if you've needed any help with things like getting pads/tampons or needed to talk to someone about your periods.

Do I have to take part?

No, you don't! Taking part in the study is completely up to you. If you would like to take part, you will need to sign a form to say that you are happy to take part. You can change your mind if you decide you want to stop taking part, and don't have to give a reason why if you don't want to.

Taking part in the study, or choosing not to take part, will not affect your access to any services that you are currently using.

What will I have to do, if I want to take part?

Taking part will involve a telephone interview, where the person doing the interview will call you. We'll have a chat for about 45 minutes or so, and anything you say will be kept between us. The researcher will only have to tell someone about what we talked about if we have any worries about your safety.

We will also ask you if you are happy for the interview to be recorded – we like to record what you're saying, to make sure we get everything you said and don't miss anything important

We know that talking about periods can be a sensitive subject, and you might feel a bit uncomfortable with some of the questions. There will be some time at the beginning of the interview to ask the researcher some questions about the study and what sorts of things we might end up talking about. If you aren't sure about a question, or don't want to answer it, that's fine – you don't have to. You can also tell us if you want to stop taking part at any time.

Do I get any payment for taking part?

You will be given a £10 Amazon voucher as a 'thank you' for taking part in the study. This will be sent to you via email, so you will need to provide your email address on the consent form. If you would prefer a voucher to be sent to you via post, just let the researcher know.

What happens if I decide I don't want to carry on with the study?

Taking part in the study is completely up to you and you can change your mind if you decide you want to stop taking part, at any time. You don't have to give a reason why if you don't want to. If you change your mind during our chat, just let the researcher know. If you change your mind afterwards, email Gemma Williams to let her know – she is the Project Lead. Gemma's email address is gemma.williams@bcu.ac.uk

What will happen to my information?

Your feedback will be used as part of a larger study, called 'Periods in a Pandemic: how UK period poverty initiatives are managing with Covid-19 related challenges'. What you say will be added together with feedback from others across the UK, and that will be used to inform people of how the Covid-19 pandemic has impacted upon people that have experienced period poverty. We might also want to publish this information in a research article, or a book, or tell people about the study on a website or in a presentation. Your name will never be used in any reports, articles or books and will not be on any websites that mention this study.

We won't share any of your information or what you say with any of the services that you might be currently using.

Has anyone checked this is OK?

Yes, they have! This study has been checked by Birmingham City University's Research Ethics Committee, who makes sure that we aren't doing any harm to people, and that we keep their information safe.

What if there is a problem, or if I have some extra questions?

You can contact Gemma if you have any questions about the study or are worried about anything to do with taking part in it. Gemma is leading this research study, and she will be happy to answer your questions. Her email address is gemma.williams@bcu.ac.uk.

You can also email HELS_ethics@bcu.ac.uk if you are not happy with the way that the research has been undertaken, or if we haven't been able to answer your questions.

APPENDIX L: Phase 2 consent form - interviews

Study Title: Periods in a Pandemic: how UK period poverty initiatives are managing with Covid-19 related challenges

Research Team: Gemma Williams (Project Lead), Dr Annalise Weckesser, Dr Emma Craddock, Dr Lydia Aston

Project Code: *Participant identification number:*

Initial box

I have read the information sheet	
I have been able to talk to one of the researchers about the study, and to ask questions about things I'm not sure about	
I understand I can stop taking part at any time, and don't have to give a reason why	
I understand I can say I don't want to take part in the study after I have taken part and don't have to give a reason why	
I understand that information about me will be kept safe and private, unless the researcher is worried about my safety	
I understand that my name will not be used in any research reports, articles, books, presentation or websites that talk about the study	
I agree to being audio recorded	
I agree to take part in the study.	

_________________________ _________________ ______________________________

Name of Participant *Date* *Signature*

Email address (for voucher) _________________

_________________________ _________________ ______________________________

Name of Researcher *Date* *Signature*

APPENDIX M: Phase 2 telephone interview guide

Periods in a Pandemic: how UK period poverty initiatives are managing with Covid-19 related challenges (Phase 2)

Interviewer: ________________________ **Participant's ID**: _______________________

Date of Interview: ________________________

Pre Interview Checklist	**X**
Participant confirmed they have read PIS	
Answered participant's questions	
Obtained verbal consent for study	
Obtained verbal consent to audio-record interview	

Where do you live at the moment? England/Scotland/Wales/Northern Ireland

1. Since Covid and lockdown, could you tell me about any difficulties you've had with getting things like pads and tampons or anything else you need for your period?
    a. Availability in shops, changes in money/finances or job, shielding, closure of services, quarantine
    b. Did you have difficulties before Covid, or has it started over the past year? (If started during Covid) What changed?
    c. If had pre-Covid difficulties – what did they used to do when needed help?
2. Can you tell me more about what you did when you found it difficult getting things for your period during Covid/lockdown?
    a) Makeshift or 'homemade' replacements – old clothes, toilet roll etc
    b) Did you talk to someone or ask for help?
    c) Where did you go to get help?
    d) What sort of help did you get?
    e) Do you feel like they supported you with what you needed?

3. Where do you usually go to for support with your menstrual health, or if you have questions about your periods?
    a) Doctors, family, support group, internet etc
4. What sorts if things have you needed support or advice about?
5. Have you needed support/advice about your periods over the past year, during lockdown?
    a) What did you need help with?
    b) Where did you go for help?
    c) Was it useful? Why?
    d) If online – what did they think of it? Good and bad points?
6. Have you needed to talk to a doctor or other medical person about your periods, during lockdown?

Did you manage to speak to someone?

    a) What did you talk about?
    b) What type of appointment did you have? In person or telephone/other? If phone/other – what did they think of it?
    c) Did you get the help you needed? What support did they offer?

7. Do you feel like you've been able to get all of the help you have needed for your periods during Covid and lockdown?
    a) If yes, what worked well for you?
    b) If no, what was missing/didn't work well?
8. If you needed help again, what would you do/who would you go to?
9. What sorts of things could be improved to make things better for people that need help with their periods?
10. Is there anything else you'd like to talk about, that's about your periods and Covid lockdown?

Post Interview Checklist	**X**
Upload recording for transcription	
Check transcript and erase recording	
Destroy this form and any written notes	

RECORDER OFF – THANK PARTICIPANT

Chapters 5 and 6 have provided a detailed analysis of the data gathered in each phase of the study, describing the themes generated and discussing the analysis within the context of relevant menstrual health, pandemic-related and wider health inequalities research.

This chapter will summarise the overall study analysis, drawing together analysis of the two phases to illustrate how they address the research questions and study aims. It will compare and situate them within existing pandemic-related menstrual health research and research on wider related factors, including gender inequality and menstrual stigma. The strengths and limitations of the research study will be discussed, examining the study's contribution to research and reflecting upon the researcher's role in generating new knowledge. Finally, it will discuss the implications of the thesis, including implications for policy and practice and future research considerations.

APPENDIX N: Phase 1 - reflexive thematic analysis mapping

Keywords/phrases (examples)	**Initial codes**	**Sub-themes**	**Final theme**
• Products • Increase/rise/more • Demand • Provision • Period poverty • Closure – shops/premises • Essential items/products • Stockpiling • Volunteers • Social distancing • Travel restrictions • Finances – furlough, job loss	• Increase in demand for products • Covid-related measures • Barriers to service provision • Barriers for service users • Financial insecurity/period poverty • Access to volunteers	The need for more menstrual products Recognising menstrual products as essential The increase in 'period poverty' and financial hardship Reduction in volunteer support	***"Overnight we lost all of our locations"*: the pandemic's effect on the accessibility and provision of menstrual products**
• Education • School/college/university • Community groups • Sessions • Training • Remote access • Online access • Digital poverty • Sensitive subject • Pastoral support/care • Safe space • Privacy • Health care • GP service/GP/doctor • Technology/IT	• Access to safe, private spaces • Discussing sensitive subjects • Service user digital needs – digital poverty • Service provider digital needs • Accessing healthcare • Safeguarding/pastoral care • Benefits of online training		***"…we can't talk about these sorts of issues at home via a telephone appointment, it just does not work for us."*: providing menstrual health education and support during the pandemic**
• Adapting • Progress • Challenges • Opportunities	• Changes to service provision • What worked well • New opportunities	Responding to change to meet service user needs	***"It's kind of forced everyone to re-look at the way that we do things."*:**

- Service provision - Systems, processes - Social distancing - Travel restrictions - Lockdowns - Products - Social media - Policy - Period poverty - Awareness	- Progress during the pandemic	Positive progress and new opportunities	**overcoming barriers to continue menstrual health service provision during lockdown**
- Government - Taskforce - Policy - Guidance - Law - Strategy - Funding - Uncertainty - Consistency - Transparency - Concern/anxiety/ worry - Future - Pandemic/Covid-19 - Progress - Priorities - Period poverty	- Future uncertainty - Worries over progress - Pre-pandemic progress - Lack of funding - Inconsistent policies - Pandemic blame - Positive progress		***"We've had to fight so hard…":*** **uncertainties and inconsistencies in menstrual health policies during the pandemic**
- Shame - Embarrassment - Stigma - Period poverty - Poverty - Period dignity - Products - Sensitive/taboo - Inclusion	- Menstrual stigma and shame - Financial stigma - Dual stigma - Language - Menstrual concealment and etiquette		***"If someone has worked up the courage to go to a foodbank, it should just then be really easy to get her period products"*****: menstrual stigma and shame during the pandemic**

APPENDIX O: Phase 2 - reflexive thematic analysis mapping

Keywords/phrases (examples)	**Initial codes (examples)**	**Sub-themes**	**Final theme**
• Stress • Anxiety • Worry • Irregularity • Heavy bleeding • Changes • Symptoms • Menstrual cycle • Periods/menstruation • Understanding • Education/knowledge • Virus/vaccine	• Anxiety over periods • Menstrual cycle changes • Understanding changes • Reasons for menstrual cycle changes •		***"Maybe it's the stress that causes me to have irregular periods"*: trying to understand menstruation during the pandemic**
• Privacy • Health care • GP service/GP/doctor • Hospital • Appointments • Dismissal • Ignored • Problems with access • Products • Stockpiling • Purchasing/buying • Shops • Shielding/vulnerable • Sick • Money/finances	• Accessing healthcare • Feeling dismissed • Financial problems • Covid-related measures • Other problems accessing products	Difficulties getting healthcare – are periods important during a pandemic? Problems getting (menstrual) products	***"During a pandemic, my concerns about my periods seemed frivolous"*: seeking menstrual health support during the pandemic**
• Social distancing • Travel restrictions • Lockdowns • Products • Reusables • Working from home • Pain • Medication • Comfort • Prepared/unprepared • Stockpiling • Toilets • Unclean/dirty • Gross	• Covid-related issues • Menstrual management – products • Menstrual management – pain • Being prepared • Menstrual stigma • Menstrual concealment		***"I've got enough to last about 6 months now"*: managing menstruation during lockdown**

APPENDIX P: List of pre-published works

Craddock, E., Williams, G., & Weckesser, A. (2025). Same shit, different crisis? Feminist activism against period poverty during the Covid-19 pandemic in the UK. *Journal of Poverty and Social Justice*, 1-20. https://doi.org/10.1332/17598273Y2025D000000044

Williams, G., Weckesser, A., & Craddock, E. (2022). *Periods in a Pandemic: how UK period poverty initiatives have mitigated Covid-19 challenges*. https://bcuassets.blob.core.windows.net/docs/periods-in-a-pandemic-final-report-jan2022-132871415463701935.pdf