***Journal of Religion & Society* (JR&S)**
Available Online:
https://islamicreligious.com/index.php/Journal/index
Print ISSN: 3006-1296Online ISSN: 3006-130X
Platform & Workflow by: Open Journal Systems

Cultural Taboos and Women's Reproductive Health: A Sociological Analysis of Menstruation Beliefs

Samina Aziz
PhD Scholar, Department of Sociology, International Islamic University, Islamabad
Saminaaziz124@gmail.com
Dr. Amber Ferdoos
Assistant Professor, Department of sociology, International Islamic University, Islamabad
Amber.ferdoos@gmail.com

ABSTRACT

This paper explores the role of menstrual taboos in influencing the knowledge of women, their day-to-day activities, and their social involvement in different cultural and socioeconomic settings. Based on semi-structured qualitative interviews of 16 to 40 years old women, the results indicate that the process of menstruation is usually enveloped with silence, modesty and stigma. The respondents were found to have a few or false knowledge based on cultural beliefs rather than formal schooling. Menstrual products were available depending on economic status but the stigma was common among groups. Restrictions on religious and social participation were widely practiced and understood as cultural expectations. The study concludes that menstrual taboos continue to limit agency and reinforce gendered norms, highlighting the need for culturally sensitive education, open dialogue, and policy-level interventions to promote menstrual dignity and inclusion.

Keywords: *Menstrual Health, Fertility Beliefs, Infertility Stigma, Cultural Taboos, Reproductive Health, Gender Norms*

Introduction

Biological processes do not only determine menstruation and fertility, but there are social meanings involved in organizing knowledge, behavior and access to care. A sociological perspective helps emphasize that the assigning of shame and secrecy to menstruation, limitations of communication about fertility, and reproduction of health and citizenship inequalities, are cultural taboos and gendered norms shaping both sociology and society. According to Hennegan et al. (2021), menstrual health must be understood as a holistic state of physical, mental, and social well-being throughout a life course, and that the cultural environment of menstruation is a determinant of health as opposed to a peripheral issue.

The recent studies indicate that stigma creates the dirty image of menstrual blood, creates silence, and restricts the activities of women in their day-to-day life, including visiting school, religious experience, and using menstruation products (Akmerman et al., 2024). There is also empirical evidence that stigma decreases disclosure, amplifies psychological distress, and discourages prompt access to healthcare services (Taebi et al., 2021). Equally, infertility

stigma has been observed to be associated with depression and poorer quality of life, which is an expected and avoidable type of social harm (Xie et al., 2023).

Besides, religious authority and customary norms influence the perception of what is acceptable in terms of fertility care and this tends to limit reproductive choice even where there are medical services (Asante-Afari et al., 2025). Without sociologically informed data on the functioning of taboos and beliefs in different contexts, the policy interventions will run a risk of focusing on products and clinical services and affecting norms, gatekeepers, and power relations. Good policy should then deal with the cultural infrastructures according to which reproductive life is organized.

It is within this context that the current research intends to describe how cultural taboos of menstruation and fertility determine women knowledge, identities, and reproductive health behaviors and how these norms can create stigma, delayed help seeking as well as limited access to care in various social settings. This study integrates sociological theory with recent empirical evidence to demonstrate how taboos and belief systems function as upstream determinants of reproductive health. By linking menstrual stigma to constrained social participation and delayed healthcare engagement, and by tracing infertility stigma to mental health harms and reduced service uptake, the analysis identifies the social mechanisms through which cultural norms are translated into patterned health inequities. For policy and programming, the contribution lies in shifting attention beyond product provision and clinic capacity toward norm change, community dialogue, and respectful engagement with religious and customary leaders.

Research Objective

1. To explore that menstrual taboos shape women's knowledge, everyday practices, and social participation across different cultural and socioeconomic contexts

Research Question

2. How do menstrual taboos shape women's knowledge, everyday practices, and social participation across different cultural and socioeconomic contexts?

Review of Literature

Fertility beliefs are more likely to transform a biomedical context into a moralised social condition that is either endorsed or rejected. Women, or their identities and their reproductive choices are organized by these norms which do not simply stipulate their explicit rules, but rather their micro-regulations, which are embedded in the day-to-day life, and are enforced by social surveillance and state legitimacy. In that regard, taboo is a kind of social control that limits agency and participation. The meta-analytic findings prove that infertility stigma is closely related to depressive symptoms and poor quality of life, which means that the psychosocial burden is significant and must be addressed by specific interventions (Xie et al., 2023).

Although there is international support on the importance of menstrual and reproductive health, there is still a heavy hand of taboos and fertility beliefs to limit the independence of women and their ability to seek care and increase their knowledge. Menstrual stigma makes

menstruation appear as a form of pollution, makes it a silent subject, and limits daily practice, thus locking in the shame and misinformation (Åkerman et al., 2024). Such dynamics impede education regarding menstrual cycle literacy, pain, and disorders and postpone clinical evaluation of symptoms related to such conditions as endometriosis, anaemia, and endocrine disorders. Consequently, taboo maintains knowledge gap and delay in diagnosis.

Infertility is still subject to moralization in most areas and in most instances, it is the women who take the brunt of the blame and the social stigma especially in pronatalist societies where religious or customary restrictions define the acceptable means to achieve parenthood. It is not just symbolic but it is a quantifiable type of psychological morbidity. The ethical boundaries that are imposed on assisted reproductive technologies (ART) are often decided upon with the advice of the religious and traditional authorities. As an illustration, in Ghana Christian and Islamic leaders stated that they support ART using the gametes of the couple themselves, but not ART based on third parties; traditional leaders, in their turn, were less receptive to ART in general (Asante-Afari et al., 2025). These religious stances affect the clinic procedures and social acceptance, which has a direct impact on the reproductive choices of women, the direct effect of which has an uneven course of care.

Menstruation is a cultural prescription that is also applied to food consumption, movement, and touch. Ethnographic studies record food taboos and menstrual restrictions, which are explained by the concepts of vulnerability and pollution, and have implications on nutrition, social inclusion, and even self-image, early family negotiations of reproductive processes (Syed Abdullah et al., 2022). Similar processes take place in fertility situations: infertility stigma negatively impacts the mental conditions of individuals, couple relationships, and help-seeking behaviour, especially in women (Taebi et al., 2021).

Religiously grounded power still defines what appears to be allowable forms of fertility care, which frequently restricts reproductive options even in the presence of medical care (Asante-Afari et al., 2025). Survey data on a large scale also indicates that accessibility and socioeconomic status are patterned in the use of safe menstrual materials among adolescent and young women, which further demonstrates the interaction between cultural taboos and affordability and infrastructure (Wasan et al., 2022).

Primary dysmenorrhea is very common among the Pakistani university students, and it is linked with worse health-related quality of life, which indicates that menstrual silence is also translated to untreated pain and loss of daily functioning (Dar et al., 2025). Islamic jurisprudence in Pakistan allows assisted reproduction to be performed exclusively within the marital couple, which influences the acceptability of the community and closes the reproductive avenues of people with infertility (Ahmed et al., 2022). Pakistan is therefore a critical situation wherein stigma, resource scarcity and religious gatekeeping all combine to organize reproductive health opportunities and outcome.

Theoretical Framework

The paper relies on the theory of power, knowledge, and discourse that was developed by Michel Foucault to analyze how knowledge, everyday practices, and social engagement of

women are influenced by menstrual and fertility taboos. Foucault (1978) understood power as not only repressive but as productive by the mean of social institution, norms and discourses, defining what can be known, said and done. Power flows via regimes of knowledge and generates some sense of truth that upholds specific moral and social orders (Foucault, 1980).

In this context, cultural taboos can be interpreted as discursive practices that govern bodies and identities of women in terms of silence, shame, and social control (Sawicki, 2020). Menstrual taboos have been produced using the dominant religious and cultural discourses that establish menstruation as impure, hidden, or contaminated (Bobel, 2019). Such discourses are not just social beliefs; they actually create knowledge practices of this sort that impair free communication and hinder access of women to health information. Knowledge, according to Foucault (1980) is a power that creates subjects and as such, women can internalize the codes of purity and modesty, and engage in self-regulation. However, it is not that menstrual silence and stigma are remnant traditions but rather the result of discursive power within the social and religious framework (Johnston-Robledo & Chrisler, 2020). Taboos serve as disciplinary measures on the day-to-day behavior of women. The limitations of prayer, food preparation, movement and socialization during the time of menstruation are also some of kinds of body discipline that determine the idea of femininity that is acceptable and the maintenance of the patriarchal order (Foucault, 1977; Martin, 2001). These habits go beyond the body to the social arena, where silence and exclusion can be translated into a lack of education, movement, and self-surveillance (Hennegan et al., 2021). Menstrual taboos in the socioeconomic and cultural settings are therefore micro-practices of power that control both body and social presence.

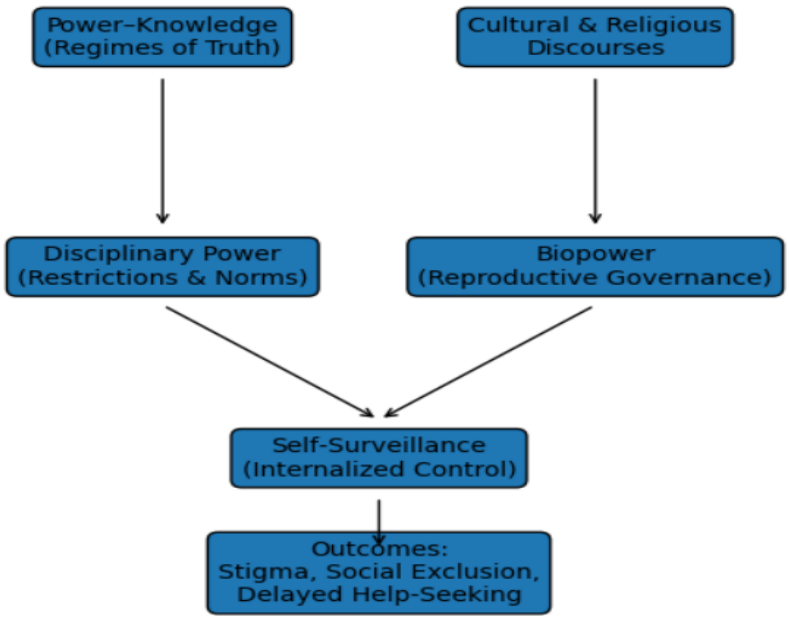

Figure 1 Theoretical Framework

Methodology

The research design of the present study was qualitative research design based on constructivism approach and phenomenology to examine the influence of cultural taboos and religious orientations on reproductive health experiences of women with reference to menstruation and fertility. A qualitative method would be suitable to the discovery of the social meaning and discursive practices that shape the knowledge, behavior, and involvement of women. The sample size included women of reproductive age (16-40 years of age) both urban and rural (urban as well as illiterate). The reason is that they all experience both menstrual and fertility-related taboos. The sample was drawn by using purposive sampling as participant with appropriate experiences and snowball sampling as a supplementary tool which was used to access women in conservative societies.

The semi-structured interviews and focus group discussions were used to gather the data with the help of the open-ended questions on the topic of menstrual restrictions, the fertility expectations, and the role of the religious/community authority. The thematic analysis with references to the Foucault theory of power, knowledge and discourse was used to analyze the data on how women body and choice are regulated by the norms of purity, modesty and morality. The focus was put on the recognition of the trends of discipline, silence and self-regulation in the stories of participants. Ethical concerns were upheld well and the participants gave informed consent; anonymity was respected and the discussions held in a respectful manner to ensure cultural sensitivity.

Data analysis

The empirical findings generated through three focus group discussions (FGDs), each consisting of four women from diverse socioeconomic and cultural backgrounds. The analysis follows the stages of open, axial, and selective coding to develop an integrated thematic framework explaining how menstrual taboos and fertility-related beliefs shape women's knowledge, everyday practices, identities, and reproductive health behaviors.

Demographic Profile of the Respondents

Participant ID	Age (years)	Marital Status	Education Level	Occupation	Household Size	Ethnic/Cultural Background	Residence
P1	19	Single	Intermediate	Student	6	Pashtun	Rural
P2	23	Married	Graduate	Teacher	8	Pashtun	Rural
P3	21	Single	Intermediate	Student	5	Pashtun	Rural
P4	40	Married	Graduate	Homemaker	7	Pashtun	Rural

Table 4.1: Demographic Profile of Participants – FGD 1 (Rural, Pashtun Women)

Interpretation (FGD 1)

The sample of FGD 1 is a group of rural Pashtun women of various ages, i.e. late adolescence to early middle age. The group consists of single students and married women working and living in a rural culture, which is a diversification of the generation. The family sizes are quite large which presupposes joint or extended family systems and this factor is important to determine the daily practice of women and their adherence to cultural norms. Although the environment of education is different, all the participants belong to the rural setting where traditional beliefs and family authority are still influential. This demographic profile offers the essential information on how menstrual knowledge, taboos, and restrictions are passed on to the next generations and supported in the conservative rural environments.

Participant ID	Age (years)	Marital Status	Education Level	Occupation	Household Size	Ethnic/Cultural Background	Residence
P5	22	Single	Graduate	Student	4	Punjabi	Urban
P6	39	Married	Graduate	Office Worker	5	Punjabi	Urban
P7	20	Single	Intermediate	Student	6	Punjabi	Urban
P8	27	Married	Graduate	Teacher	7	Punjabi	Urban

Table 4.2: Demographic Profile of Participants – FGD 2 (Urban, Punjabi Women)

Interpretation (FGD 2)

FGD 2 is a group of urban Punjabi women who are more educated and more exposed to formal jobs and institutionalities. The respondents are young university students and working married people, which represent a blend of new and old adult identities. The size of the household's changes but it is usually smaller as compared to that in the rural areas which indicates a trend toward that of nuclear households. Although the urban dwelling and the lack of lower education level offer more access to information about menstrual health and products, the narratives about the participants show that the cultural taboos and norms regarding menstruation still exist, although they are in more disguised forms. This group demonstrates how urbanization and education can be able to salve, but not completely to destroy menstrual stigma and gendered expectations.

Participant ID	Age (years)	Marital Status	Education Level	Occupation	Household Size	Ethnic/Cultural Background	Residence
P9	18	Single	Intermediate	Student	5	Sindhi	Semi-Urban
P10	38	Married	Graduate	Homemaker	9	Sindhi	Semi-Urban
P11	40	Married	Graduate	Office Worker	6	Sindhi	Semi-Urban
P12	21	Single	Graduate	Student	4	Sindhi	Semi-Urban

Table 4.3: Demographic Profile of Participants – FGD 3 (Semi-Urban, Sindhi Women)

Interpretation (FGD 3)

The participants of FGD 3 are semi-urban Sindhi women who have the features of both rural traditionalism and urban modernity. The age group is between the 18 to 40 women, and they are students, homemakers and salaried employees. The number of households is quite high especially among participants who are married, which means that the extended family remains an important structure. Though the level of education is not too low, the semi-urban area of residence leaves these women in a transitional place where cultural norms and cultural customary values are in conflict with the growing accessibility to education and work. Such population structure makes it possible to make subtle observations of the way menstrual beliefs, fertility perceptions and coping mechanisms are bargained in in-between socio-cultural spaces.

Thematic Analysis

The thematic analysis was done to get a systematic exploration of how menstrual taboos and fertility-related beliefs influence the knowledge of women, their daily lives, social life, and reproductive health behaviour in different cultural and socioeconomic environments. The analysis was based on data obtained by use of three focus group discussions and utilized the inductive approach based on open, axial and selective coding. This has allowed identifying recurring patterns and meanings and relationships in the narratives of participants and has been based on the experience they live in. The themes that arose represent common and context-ually unique realities and how cultural norms, material statuses, and gendered demands interact to form stigma, silence, and limited access to care as well as how women can act and offer agency and change within these frames.

Knowledge and Understanding of Menstruation

In the FGDs, women constantly related a disjointed, partial, or silent knowledge of menstruation when they were young. The concepts that were found included fear, shock, lack of preparation, peer-based learning, and family secrecy. Describing their initial experience of menstruation, most of the subjects described an event of confusion and instant body transformation. People have given an account of how they were not ready since menstruation was not openly talked about in their homes. One of the participants said, I had no idea what was going on; I thought I was hurt; or something wrong had occurred. It had not been explained to anyone before. Another added that her mother had just said it is a part of being a woman but had not told her about the reasons of its occurrence. Even the interactions with mothers, sisters, or cousins were restricted rather often. One of the women stated that they learned more amongst their peers than with their families; home was always hush-hush. This gap in knowledge was more evident especially in the respondents who belonged to lower-income and rural families who reported that menstrual health was not discussed in detail in school. Some of the respondents regarded menstruation as a natural, biological process but still considered it as a source of impurity/dirtiness as a result of culturally inherited beliefs. One of the respondents elaborated, "I understand that scientifically it normal, but internally I believe it is something dirty since that is what we were brought up to think. Such internalized

discourses show that the biomedical knowledge and cultural meanings coexist in an uncomfortable state of cognitive and emotional ambivalence.

This trend is consistent with the Foucault notion of power knowledge that states that power is neither repressive nor concealing but is rather a generator of certain forms of truth and ignorance by hegemonic discourses (Foucault, 1977). Regarding menstruation, cultural practices that define menstrual blood as a taboo create a regime of ignorance, systematic unknowledge that determines what is unspeakable or unacceptable knowledge. This dynamic is depicted in the memories of women learning about periods mostly at the hands of their peer groups and less at the hands of some knowledgeable grown-up: We learned more with friends than with relatives; at home, it was always hushing. It is not some neutral silence but it is constructed by a set of cultural practices which stipulate that menstruation should be discrete, discreet, and morally clean only when it is absent. This silence discourse is symbolic power as referred to by feminist scholars in which social meanings determine the self understanding and body perceptions in individuals. Normativity by Judith Butler emphasizes repetitive norms (what is unsaid and what is said) to create subjects that internalize social expectations so that they can create conforming behaviors despite the discomfort or damage that these expectations cause. With menstrual knowledge, women can rationally understand scientific knowledge of menstruation but at the same time experience a sense of shame or impurity due to the influence of the culture on the inner landscape of sense making. An interviewee described the same tension as follows: I know that scientifically it is normal, but in my heart, I feel that it is something dirty as that is what we were taught when we were growing up. This conflict between embodied knowledge and cultural meaning can be heard in the wider feminist criticism of the way in which a patriarchal discourse practices the female body as a problem or a secret and not a transparent and health related body.

Cultural Taboos, Taboos and Constraining Norms

The cultural taboo was identified as one of the most coherent and probative findings in all FGDs. Findings of FGDs revealed certain taboos concerning religious practices, food taboos, movement restrictions and household interaction provisions. Those who took part in the survey repeatedly referred to menstruation as time to be careful, restrained and secret. This feeling was summarized in one of the responses; we are informed not to pray, not to go to the mosque, not to touch the Quran. Another pattern was food restrictions, as they say, we are not spiritually clean that day. Other women mentioned that they were told not to eat sour foods or take cold drinks as they would make them bleed or become painful. One participant said, "The reason is that my grandmother always used to say, do not eat pickles during your period it will cause the blood to be too much. Although such beliefs were perceived by the participants as superstition, they still engaged in them due to the fact that they were deeply entrenched in the family structure. Results showed intergenerational continuation of menstrual taboos as a key process of supporting these restrictive norms. Once again and again, women stressed the fact that mothers and grandmothers were the guardians and passing on of these beliefs. According to one woman, even when we do not believe in these things, our

elders insist on it thus we undergo it to evade conflict. Societal influence was observed as a supporting factor as well: those women who had broken the norm faced the risk of being called disrespectful or Westernized, and it turned out that it took more than education to dissolve ingrained thoughts. One of the participants commented that it wasn't true and I know that I work in an office and I do not enter the prayer room during periods because this is how we were raised. Such utterances indicate the influence that cultural norms have very strong effects on behaviour in spite of whether one believes it or not.

Everyday Menstrual Practices and Material Choices

Menstrual practices were also influenced by cultural values, financial limitations, and resources among others in addition to personal choice. The most outstanding practices identified by the findings include use of cloth, sanitary pads, often washing and limited movement. Other respondents used cloth because of affordability whereas others used pads although they highlighted that they kept them hidden because they felt ashamed. One of the interviewees said, at home we put pads on men; even the wrapper was making some sound and we were ashamed. Results showed that two major dimensions of the cultural appropriateness and economic affordability were used to determine material choices. Pads were the default in the case of low-income households. Nevertheless, the wearing of cloths was associated with the cultural assumptions according to which reusable materials were more modest. Hygiene practices were dominated by family values and not by biomedical knowledge as one of the participants explained, my mom told me to use cloth since it is more respectful and natural; pads are the choice of modern girls. Some of the women talked about their methods of washing as cleansing rituals. Indicatively, one respondent told me that her mother used to say that you should not take a bath during the cycle, that will clog the blood and you should take it at the end of the cycle, otherwise you will cause disharmony in the house.

Such issues as pain, insufficient privacy, and inadequate accessibility to bathrooms were regularly cited. Women reported problems in schools, work stations, and households, whereby facilities were poor. According to one interviewee, the bathroom in our house is outside, and at times, it is very difficult to keep it clean and clean. This kind of story showed how ordinary practices are formed at the cross-price between economic circumstances, bodily sensation, and cultural demand.

Effect of Menstruation on Social Participation and Mobility

Menstruation was also characterized as a withdrawal, a low level of involvement, and even self-awareness across FGDs. Women focused on not going to school, employment, religious services, and social activities because of pain, stigma, or even a direct prohibition of the family. One of the respondents wrote; when I am in my periods I will not attend any of the gatherings; when someone realizes that I am not myself he/she would make assumptions and this leaves me ashamed. The findings found avoidance behavioural patterns, limited mobility, withdrawal, and mental uneasiness. It was also found that there was a cycle of effects between taboos and patterns beliefs that strengthened behavioural restrictions, and stigma that was

strengthened by the same beliefs. According to one participant, her mother said to her to keep herself indoors in the room and take a nap; no one should see you outside these days. Indicatively, the students mentioned that they found it hard to go to school because of poor hygiene or being afraid of leaking. One of the young respondents explained it as follows, in school in case a stain occurs, everyone gossips; once a girl had it and that memory is still present in all of us. This theme is rather important as it shows that menstruation makes women less active in educational, social, and religious life not because they cannot do anything because of this physical impossibility but due to the cultural rules that dictate withdrawal. These practices are internalized when women do not want to be shamed, and they reaffirm the gender-based standards of purity and modesty.

FGDs proved that menstrual experiences are significantly influenced by socioeconomic status, knowledge and cultural background. The results showed that there were some differences between the points of views: city participants were more exposed to biomedical information, whereas country ones were more conservative. However, in both groups, cultural beliefs were not eradicated. One respondent in a well-educated, urban background, said, "We are aware of it, but we have to adhere to the old ways because we respect it, and the poor households are more strained materially (access to products and privacy). One participant gave an example that, in her village, women cannot even afford pads; they are forced to use cloth and spend more time at home. In the same time, women in middle-class families exhibited more autonomy but nevertheless were governed by the family. This theme shows that menstruation does not have a universal pattern, but is mediated by the intersections of structural forces of class, education, tradition, and gender norms.

Fertility Conceptions and their association with Menstruation

Another major observation in the discussions was the significant conceptual association between menstruation and fertility. A large proportion of the participants thought that menstrual regularity was a direct correlation with the capability of reproduction. According to one respondent, when the periods of a girl are not regular, then people automatically assume that something has gone wrong with her fertility. Others talked of families tracking the cycle of girls to determine suitability in marriage because menstruation is considered as a blessing and cleanliness. Findings revealed that some of the beliefs include period regularity is fertility, menstruation is a window that assesses the reproductive value of the women in society, and shame on fertility issues. This theme was identified as selective coding: Periods, Fertility, Purity, Womanhood: Menstruation as a Cultural Marker of Fertility, Purity, and Womanhood.As one respondent elaborated, people have equated periods and fertility to the extent that any trouble leads them to attribute the problem to an individual rather than the husband. Women reported that they were under pressure to be in the optimum health during their menstrual cycle in order to shun the stigma, examination, or even marital discord.

Women as well related acts of resistance, reinterpretation and change regardless of strong cultural norms. Participants that were younger especially stressed on increased conversation, awareness at school, and access to information online. Peer support, silent compliance,

strategic resistance and private online learning were found to be some coping strategies used by girls today as they respond to different situations and conditions, yet some of these coping styles are not approved by the elders. Women took the problem by adapting behaviour to reduce conflict and privy accumulating new knowledge. The results associated coping mechanisms with generational change, as younger women are less open to norms, whereas older women are not against traditions, just see gradual changes. All participants collectively stated that awareness programs, change in school curriculum, and education at the community level are ways to eliminate the silence. A suggestion of a woman said, that, had girls been conditioned at the right time, there would be less shame and more confidence.

Discussion

In this paper, it has been demonstrated that the experience of menstruation and fertility is highly influenced by cultural norms, which act as power structures to generate a specific body of knowledge and silence that dominates women bodies and experiences. Based on Foucault theory of power, knowledge and discourse the results show that the menstrual stigma and norms of infertility are not merely a manifestation of personal ideas and beliefs; instead, they are constructed in discursive processes that determine what is acceptable knowledge, what should be suppressed and how subjects are disciplined in social arenas. Foucault (1980) hypothesized that power is practiced through the systems of knowledge, which create the truths about social life and bodies, and in the field of reproductive health, its truths can determine not only what women can know about their bodies, but also the way they behave in their everyday life.

A significant observation of this study, which is one of the most obvious observations, is the silence that has dominated the culture of menstruation and fertility knowledge. The initial experiences of menarche were marked with confusion, fear, and disjointed understanding that women experienced in their early lives, and these experiences were usually based on the silence between people as opposed to the formal health education. This experience is consistent with the latest qualitative evidence demonstrating that there is still cultural influence over menstrual experience even in international settings; in Spain, menstruation is still moderately stigmatized, and silence is a persistent phenomenon that prevents open conversations, which adds to a feeling of stigma by association as even the individuals, who talk openly of menstruation, may still be taken to be breaking social norms (Sánchez Lopez et.al, 2025).

The information regarding menstrual processes and reproductive functions is not neutral biomedical information, but a part of the cultural scripts that introduce menstruation as something secret, dirty, or something that cannot be discussed in public. This is consistent with the outcome of studies carried out as per the rest of the world that cultural beliefs often propagate embarrassment and silence where people are unable to seek help or observe proper menstrual hygiene (Hankinson, 2025). Within this sense, power works in discourse to generate subjects who internalize silence and concealment as normal behavioral activities. The fact that women claim that there is no idea what is going on means not only something

that is not known but also the working of power through discourse that has produced a subject matter too delicate or embarrassing to be openly discussed.

Moreover, internalization of silence shows the way in which the disciplinary power works at the individual behavior level. The work of discipline, in the Foucault meaning, is not achieved by physical force, but by the repetitive norms which determine self regulation. The story of the women concealing menstrual items, not talking to members of the male family and not being seen are not merely the result of being told not to do so but also self surveillance in that people watch and control their actions based on the norms that are adopted internally. This policing of the self does not arise out of actively coerced silence of women, but rather out of the repetition of discourse of purity and propriety through social interaction in families, schools, and communities to the extent that it becomes an element of the common sense of how one ought to act. Through this, menstrual silence is represented as discipline; women need not be monitored, they monitor themselves.

The results also bring to light the fact that cultural taboos on menstruation also get translated into social participation restriction. Women reported not going to meetings, places of worship and other social life during menstrual practices that reflect reported practices on menstrual restrictions in the South Asian context where women are often forbidden to enter the temples or attend rituals and experience moderate to severe levels of psychological distress due to the norms (Santosh University Journal of Health Sciences, 2025). Such prohibitions demonstrate the disciplinarity of cultural rules: women do not only revise their mobility and contacts due to a particular prohibition but due to the fact that the absence of participation is already an established norm that is embedded into discourse of purity and decency. These practices impose a moral geography in which some spaces of activities are only accessible to menstruating women and by doing so, these practices strengthen bodily and social boundaries.

Furthermore, the long-held connection between menstruation and impurity and shame even among educated and urban women is a sign that power is circulated through the social institutions and through language practices, which demarcate the discourse of menstruation. The operation of power in relation to institutions and norms as well as the discursive contexts that determine what is acceptable to know, say and do was described by Foucault (1978). In reproductive health, these norms determine women body behavior beyond the confines of individual ignorance into structural control: women avoid engaging in social roles not because they are ignorant of social issues, but because the discursive surrounding constantly determines menstruation as an area of privacy and ethical control.

This controlling aspect can also be seen in the way women associate menstruation and fertility and moral value in men. Women in this study also tended to understand irregular cycles as the sign of lower fertility or failure in society. The concept of biopower of managing life and populations by controlling the norms of health and reproduction by Foucault helps to understand that the discussion of fertility is used to classify bodies and generate normative categories of reproductive fitness. Within the biopower, the bodies of individuals are not only

places in which biological activities take place but are also subjects of regulation whose reproductive activity can be evaluated on the standards of normalcy and deviance. The social compulsion to have regular cycles may thus be seen as a cultural regime not only in the regulation of health practices, but also in the social interpretation of the body of women concerning reproduction and social roles.

The empirical data provided on varying contexts proves the premise that women are socialized based on their normative fertility beliefs. According to recent studies about menstrual stigma and religion, the sociocultural context, including religion and family norms has a huge effect on the form of restriction as well as the resulting shame, meaning that restrictions cause internalized stigma that leads to well being (King et al., 2025). These results overlap with the Foucauldian approach by demonstrating that reproductive norms are socially constructed as opposed to biologically necessary, and by highlighting the discursive character of health norms that are not only the determinations of what is healthy but do not incur social acceptability.

The mental aspects of stigma that are reported in this research are shame, embarrassment, unwillingness to talk about menstrual discomfort are additional opinions of how discourse defines embodied experiences. Foucault believed that power acts through producing subjectivities: individuals realize themselves in relation to norms that are circulated by social language and are practiced in institutions. Therefore, by refusing to talk about pain or discomfort due to their fear of being judged, women are not being personally reticent, but rather are performing the discourse regulations inscribed on their bodies that define what they can and cannot say about menstruation and not face social punishment.

Help seeking behavior is also affected by these discursive processes. Since menstruation is a taboo or shameful topic, most women postpone or evade access to health service, which may complicate the problem of health. Even though this study is not focused on particular clinical studies of the relationship between stigma and delayed diagnosis, there is more general literature of the broader public health that the silence of menstrual issues is related to missed opportunities to diagnose and intervene in menstrual disorders early, indicating that cultural norms do have material health implications, but not social implications (International Journal for Equity in Health, 2025). In this meaning power does not just act in this way by being able to be socially marginalizing, but it is also able to control access to knowledge and services which are determinants of health outcomes.

The fruitful nature of power is also indicated by the multi layered approaches of navigating cultural norms by women through silence, self regulation and selective disclosure. Foucault pointed out that the power does not solely limit, it also gives rise to agency forms that are placed within the norm. Some of the coping mechanisms identified by women in this study include sharing knowledge with other women, having a candid talk, and finding information in the informal networks. The practices are not just a mere rejection of norms but the ways in which subjects negotiate, re-single out and even oppose the dominant discourses internally. These forms of negotiation are reminiscent of the productive nature of power: since discourse

controls what can be done, it also creates practices that create new formations of such boundaries.

The results also indicate that the interventions on menstrual and reproductive health should target the cultural infrastructures of discourse, rather than just offer products or clinical services. How women think, talk and act in relation to their bodies is conditioned by cultural norms. The literature on this topic reviewed in the current research shows that menstrual health education and community involvement, which directly address cultural taboos and promote open discussion, are necessary. By way of illustration, qualitative studies have shown that culturally sensitive menstrual education interventions, including involvement of the local stakeholders, and work around socio cultural barriers are more effective in reducing stigma and increasing menstrual health outcomes (Hankinson, 2025). The theory of power, knowledge and discourse by Foucault is a powerful theory to employ in explaining how cultural meanings are embodied as practices that govern the body of women, restrict social participation, and determine the health behavior. The focus on the ensnaring of social norms, embodiment experience, and reproductive knowledge by emphasizing the need to face the cultural taboos by means of interventions that change not only health services but also discourses that make health and illness in the reproduction process.

Conclusion

This paper has shown that menstruation and fertility in women in Pakistan are not only biological but are deeply colored by social, cultural and religious discourses, which are force processes. Through the Foucault approach of power, knowledge and discourse, the analysis has established that the menstrual and fertility related norms generate knowledge, silence and self-regulation to govern the behavior, participation and access to reproductive health services by the women. Menstrual stigma was demonstrated to create secrecy, shame, and limited movement whereas infertility beliefs brought about moralizing judgments limiting help-seeking and social identity. Notably, these standards are inculcated in the process of self-surveillance, which makes women control their actions to correspond with the culturally approved norms. The paper brings to fore the continuation of cultural taboos within the socioeconomic and educational setting, and the result is that education and economic privilege is not enough to break the established power relations that regulate reproductive health.

The intersectionality of menstrual and fertility experiences highlighted in the findings is that the socioeconomic status, rural-urban place, and educational level come together with the gendered expectations to create differentiated experiences of stigma, constraint, and opportunity. The study also explains the fruitful character of power, in that although norms restrict women, they also produce resistance in minor ways through sharing of knowledge among peers, learning in secret through the internet and even through household negotiation. These approaches imply that initiatives that target reproductive health should be able to embrace cultural and discursive contexts in an attempt to change health behaviors and social participation.

References

Al Sabbah, S., Tantry, A., & Bayliss Pratt, L. (2025). Do perceived social support mitigate the influence of infertility stigma on fertility quality of life? Frontiers in Global Women's Health, 6, Article 1577951. https://doi.org/10.3389/fgwh.2025.1577951

Åkerman, E., Wängborg, A., Persson, M., Sörensdotter, R., & Klingberg Allvin, M. (2024). Navigating menstrual stigma and norms: A qualitative study on young people's menstrual experiences and strategies for improving menstrual health. BMC Public Health, 24, Article 3401. https://doi.org/10.1186/s12889-024-20936-5

Asante Afari, K. (2025). Religious and cultural perspectives on assisted reproductive technology in Ghana: A comparative analysis of traditionalist, Islamic, and Christian beliefs. PLOS Global Public Health, 5(9), e0005240. https://doi.org/10.1371/journal.pgph.0005240

Bobel, C., Winkler, I. T., Fahs, B., Hasson, K. A., Kissling, E. A., & Roberts, T. A. (Eds.). (2020). The Palgrave handbook of critical menstruation studies. Palgrave Macmillan Singapore. https://doi.org/10.1007/978-981-15-0614-7

Dar, M., Khan, A., Shah, S. S., Aleem, A., Jaber, A. A. S., Hussain, M., & Khan, G. M. (2025). Evaluation of health related quality of life of female students suffering from primary dysmenorrhea: Findings of a cross sectional study from Pakistan. Frontiers in Public Health, 13, Article 1467377. https://doi.org/10.3389/fpubh.2025.1467377

García Egea, A., Pujolar Díaz, G., Hüttel, A. B., et al. (2025). Mapping the health outcomes of menstrual inequity: A comprehensive scoping review. Reproductive Health, 22, Article 156. https://doi.org/10.1186/s12978-025-02103-0

Hennegan, J., Shannon, A. K., Rubli, J., Schwab, K. J., & Melendez Torres, G. J. (2019). Women's and girls' experiences of menstruation in low and middle income countries: A systematic review and qualitative metasynthesis. PLOS Medicine, 16(5), e1002803. https://doi.org/10.1371/journal.pmed.1002803

Hennegan, J., Winkler, I., Shannon, A. K., Schwab, K. J., & Melendez Torres, G. J. (2021). Menstrual health: A definition for policy, practice, and research. Sexual and Reproductive Health Matters, 29(1), Article 1911618. https://doi.org/10.1080/26410397.2021.1911618

Jackson, P. L., Saunders, P., Mizzi, S., & Hallam, K. T. (2025). The efficacy of psychological interventions for infertile women: A systematic review and meta-analysis. BMC Women's Health, 25, Article 506. https://doi.org/10.1186/s12905-025-04054-x

Medina Perucha, L., López Jiménez, T., Pujolar Díaz, G., et al. (2024). Menstrual characteristics and associations with sociodemographic factors and self-rated health in Spain: A cross sectional study. BMC Women's Health, 24, 88. https://doi.org/10.1186/s12905-023-02840-z

Sánchez López, S., Barrington, D. J., & Poveda Bautista, R. (2025). Stigma and silence: The menstrual taboo in Spain. International Journal for Equity in Health, 24, Article 278. https://doi.org/10.1186/s12939-025-02630-z

Taebi, M., Kariman, N., Montazeri, A., & Alavi Majd, H. (2021). Infertility stigma: A qualitative study on feelings and experiences of infertile women. International Journal of Fertility & Sterility, 15(3), 189–196. https://doi.org/10.22074/IJFS.2021.139093.1039

Wasan, Y., Baxter, J. B., Rizvi, A., Shaheen, F., Junejo, Q., Abro, M. A., Hussain, A., Ahmed, I., Soofi, S. B., & Bhutta, Z. A. (2022). Practices and predictors of menstrual hygiene management material use among adolescent and young women in rural Pakistan: A cross sectional assessment. Journal of Global Health, 12, 04059. https://doi.org/10.7189/jogh.12.04059

Xie, Y., Ren, Y., Niu, C., Zheng, Y., Yu, P., & Li, L. (2023). The impact of stigma on mental health and quality of life of infertile women: A systematic review. Frontiers in Psychology, 14, Article 1093459. https://doi.org/10.3389/fpsyg.2022.1093459