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"Smile, even though it hurts": A photovoice study exploring the practices, experiences and spaces for menstrual care in Spain

Astrid Boe Hüttel [a,b], Vinita Mahtani-Chugani [c,d,e], Ainhoa Ulibarri-Ochoa [f,g,h], Noemi López-Rey [e,i,j], Rosalba Company-Córdoba [k,l], Andrea García-Egea [a,m], Alejandra Méndez-González [c,d,n], Estíbaliz Gamboa-Moreno [e,o,p], Macarena Chacón-Docampo [q,r], Carmen Rodríguez-Domínguez [s], Bruna Álvarez-Mora [b], Casandra del Pilar González-Hernández [d], Ana Garaikoetxea-Iturriria [t,u], Mª José Fernández-Domínguez [e,v,w,x], Ana Isabel Arcos-Romero [y], Constanza Jacques-Aviñó [a,m,e], María José González-Luis [d], Maialen Berridi-Agirre [z], Celsa Perdiz-Álvarez [j,aa,ab], Cristina Martínez-Bueno [ac,ad,ae], Maria Dolores Marrero-Díaz [d], Uxune Apalategi-Gómez [e,af,ag], Carmen Verde-Diego [j,ah], Irene Gómez-Gómez [y], Roberto Fernández [ai], Sara Domínguez-Salas [aj], Clàudia Díaz [ak], Mª Dolores Martínez-Romero [al], Carme Valls-Llobet [am], Diana Pinzón-Sanabria [an], Anna Sofie Holst [a], Anna Berenguera [a,m,e,ao], Laura Medina-Perucha [a,m,e,*]

[a] Institut Universitari per a la Recerca a l'Atenció Primària Jordi Gol i Gurina (IDIAP Jordi Gol), Gran Vía Corts Catalanes, 587 ático, Barcelona, 08007, Spain
[b] Grup de Recerca AFIN, Departament d'Antropologia Social i Cultural, Universitat Autònoma de Barcelona, Bellaterra (Cerdanyola del Vallès), Plaça Cívica, Bellaterra, Barcelona, 08193, Spain
[c] Unidad de investigación, Nuestra Señora de Candelaria Hospital Universitario, Carretera General del Rosario, 145, Santa Cruz de Tenerife, 38010, Spain
[d] Primary Care Management of Tenerife, Calle de Carmen Monteverde, 45, Santa Cruz de Tenerife, 38004, Spain
[e] Network for Research on Chronicity, Primary Care and Health Promotion (RICAPPS), Spain
[f] Instituto de Investigación Sanitaria Bioaraba, Jose Atxotegi Kalea, Txagorritxu, Vitoria-Gasteiz, Araba, 01009, Spain
[g] Osakidetza-Servicio Vasco de Salud, Organización Sanitaria Integrada Araba, Jose Atxotegi Kalea, Txagorritxu, Vitoria-Gasteiz, Araba, 01009, Spain
[h] Escuela Universitaria de Enfermería de Vitoria-Gasteiz, Euskal Herriko Unibertsitatea, Jose Atxotegi Kalea, Txagorritxu, Vitoria-Gasteiz, Araba, 01009, Spain
[i] Centro de Salud CIS-Milagrosa Lugo, Rúa da Saúde, Lugo, 27004, Spain
[j] Instituto de Investigación Sanitaria Galicia Sur (IISGS), Hospital Álvaro Cunqueiro Bloque técnico, Estrada de Clara Campoamor, 341, Vigo, Pontevedra, 36312, Spain
[k] Departamento de Psicología Evolutiva y de la Educación, Universidad de Sevilla, Calle de Camilo José Cela, s/n, Sevilla, 41018, Spain
[l] Instituto de Biomedicina de Sevilla (IBiS), Calle de Antonio Maura Montaner, Sevilla, 41013, Spain
[m] Universitat Autònoma de Barcelona, Bellaterra (Cerdanyola del Vallès), Plaça Cívica, Bellaterra, Barcelona, 08193, Spain
[n] Fundación Canaria Instituto de Investigación Sanitaria de Canarias (FIISC), Calle Plaza Barranco de la Ballena, Las Palmas de Gran Canaria, Las Palmas, 35012, Spain
[o] Osakidetza-Servicio Vasco de Salud, Instituto de Investigación Sanitaria Biogipuzkoa, Grupo de Atención Primaria, Paseo del Doctor Beguiristain s/n, Donostia San Sebastián, 20014, Spain
[p] Osakidetza-Servicio Vasco de Salud, Subdirección de Asistencia Sanitaria, Unidad de Investigación de Atención Primaria y OSIs de Gipuzkoa, Paseo del Doctor Beguiristain s/n, Donostia San Sebastián, 20014, Spain
[q] Unidad de Investigación en Cuidados del Área Sanitaria de Vigo, Instituto de Investigación Sanitaria Galicia Sur (IISGS), Hospital Álvaro Cunqueiro Bloque técnico, Estrada de Clara Campoamor, 341, Vigo, Pontevedra, 36312, Spain
[r] Grupo de Investigación en Cuidados (INVESTIC), Instituto de Investigación Sanitaria Galicia Sur (IISGS), Hospital Álvaro Cunqueiro Bloque técnico, Estrada de Clara Campoamor, 341, Vigo, Pontevedra, 36312, Spain
[s] Departamento de Psicología Social, Evolutiva y de la Educación, Universidad de Huelva, Avenida de las Fuerzas Armadas, S/N, Huelva, 21007, Spain
[t] Osakidetza- Servicio Vasco de Salud, Organización Sanitaria Integrada Donostialdea, Calle Doctor Begiristain, 117, Donostia San Sebastián, Gipuzkoa, 20080, Spain
[u] Centro salud Alde Zaharra, Aldamar, s/n, Edificio Pescadería, Donostia San Sebastián, 20003, Spain
[v] Grupo I-Saúde, Instituto de Investigación Sanitaria Galicia Sur (IISGS), Hospital Álvaro Cunqueiro Bloque técnico, Estrada de Clara Campoamor, 341, Vigo, Pontevedra, 36312, Spain
[w] Universidad de Santiago de Compostela, Praza do Obradoiro, 0, Santiago de Compostela, A Coruña, 15705, Spain
[x] Servizio Galego de Saude, Complejo administrativo de San Lázaro, s/n, Santiago de Compostela, 15781, Spain

* Corresponding author. Institut de Recerca en Atenció Primària Jordi Gol i Gurina (IDIAPJGol) Gran Via de les Corts Catalanes 587 attic, Barcelona, 08007, Spain.
E-mail address: lmedina@idiapjgol.org (L. Medina-Perucha).

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[y] Departamento de Psicología, Universidad Loyola Andalucía, Avenida de las Universidades 2. C.P. 41740, Dos Hermanas, Sevilla, Spain
[z] Unidad Docente Multiprofesional de Atención Familiar y Comunitaria de Gipuzkoa, Hospital Universitario Donostia, Paseo del Doctor Beguiristain s/n, Donostia, San Sebastián, Gipuzkoa, 20014, Spain
[aa] Área sanitaria de Ourense, Verin e Barco Valdeorras, Spain
[ab] Facultad de ciencias de la educación y del trabajo social, Universidad de Vigo, Vigo, Spain
[ac] Atenció a la salut sexual i reproductiva (ASSIR), Institut Català de la Salut (ICS), Gran Via de les Corts Catalanes, 587, L'Eixample, Barcelona, 08007, Spain
[ad] Sexual and Reproductive Health Care Research Group (GRASSIR), Barcelona, Spain
[ae] Facultat d'Infermeria, Universitat de Barcelona, Gran Via de les Corts Catalanes, 585, L'Eixample, Barcelona, 08007, Spain
[af] Osakidetza-Servicio Vasco de Salud, Organización Sanitaria Integrada Donostialdea, Unidad de Epidemiología Clínica e Investigación, Hospital Universitario Donostia, P° Dr. Beguiristain s/n, Donostia San Sebastián, Gipuzkoa, 20014, Spain
[ag] Osakidetza-Servicio Vasco de Salud, Instituto de Investigación Sanitaria Biogipuzkoa, Grupo de Atención Primaria, Paseo Dr. Begiristain, s/n, Gipuzkoa, 20014, Spain
[ah] Grupo de investigación GETS-IT. Facultad de Educación y Trabajo social. Universidad de Vigo, Campus As Lagoas s/n, Ourense, 32004, Spain
[ai] Servizio Galego de Saude, Servicio de Atención Primaria de Allariz, Rua Oliveira, 6, Allariz, Ourense, 32664, Spain
[aj] Departamento de Psicología Experimental, Universidad de Sevilla, Calle Camilo José Cela, s/n, Sevilla, 41018, Spain
[ak] Centre Jove d'Atenció a les Sexualitats (CJAS), Carrer de la Granja, 19, Gràcia, Barcelona, 08024, Spain
[al] Subdirección General de Atención Primaria, Servicio Gallego de Salud, Spain
[am] Centro de Análisis y Programas Sanitarios (CAPS), Rambla de Santa Monica 10. 1°, Barcelona, 08010, Spain
[an] SomiArte Taller, Educación afectiva y Sexual, Barcelona, Spain
[ao] Departament d'Infermeria, Universitat de Girona, Carrer Emili Grahit, 77, Girona, 17003, Spain

1. Introduction

The menstrual cycle is much more than merely a biological occurrence; it is a social phenomenon that intersect with issues such as patriarchy, ableism, racism, (neo)colonialism and (neo)liberalism, significantly shaping the way it is experienced (Bobel, 2020). Within androcentric societal structures that continue to marginalize menstruating bodies, distressing experiences such as menstrual pain or premenstrual mood fluctuations are frequently normalised, pathologized or minimized, resulting in the lack of (menstrual) health care, insufficient public policies supporting menstrual experiences as well as the medicalization of women and people who menstruate (PWM) (Blázquez Rodríguez, 2021; Wiggleton-Little, 2024).

Research on women and PWM's experiences of distressing menstrual experiences are often situated within a biomedical framework, portraying the menstrual cycle as a physiological process governed by hormonal fluctuations and as the source of both physical and mental suffering and illness (Blázquez Rodríguez, 2021). As an example hereof, the twofold prevalence of anxiety and depression in women compared to men is frequently attributed to oestrogen and other gonadal hormones, while experiences of menstrual pain are dismissed as an expected and inevitable part of having a menstrual cycle (Pujal i Llombart et al., 2020; Mendle et al., 2016; Wiggleton-Little, 2024). Pujal i Llombart et al. (2020) demonstrate, however, that the biomedical model underpinning psychiatric diagnoses, such as anxiety and depression, are not neutral but rather build on and reinforce gender asymmetries by associating traditional feminine traits with irrationality and madness. Similarly, Wiggleton-Little (2024) argues that the consistent dismissal of menstrual pain reflects a patriarchal ideology that frames the female body as inherently inferior and weak.

In this article, we employ the term "menstrual distress" to refer to the range of physical, emotional, and social challenges and distressing experiences associated with the menstrual cycle. By utilizing this concept, we seek to emphasize that menstrual experiences, such as pain or premenstrual emotions, are shaped by the specific context the (menstruating) body is situated within and influence how this pain or emotion is lived, understood and articulated (Ussher, 2008; Wiggleton-Little, 2024). We thus purposefully seek to counteract processes of pathologization of the bodies and minds of women and PWM (Blázquez Rodríguez, 2021; Blázquez Rodríguez & Bolaños Gallardo, 2017), critically reflect upon how women and PWM are expected to express (or suppress) emotions (Boler & Zembylas, 2016) and recognize the diverse expressions of menstrual distress.

Explorations of how women and PWM address such experiences of menstrual distress tends to focus on how they "cope with" or "manage" them (Allyn et al., 2020; Armour et al., 2021; Åkerman et al., 2024). Similarly, the concept of menstrual care is generally reduced to "hygienic menstrual management" in the form of blood collection, washing of the body and pain management (Adika et al., 2013; Bataglioli et al., 2024; Casola et al., 2024; Kristiansen et al., 2024). Some studies include emotional self-awareness and seeking support from family or physicians as part of menstrual care (Casola et al., 2024; Hunter et al., 2022). This approach, however, articulate it as a matter of self-care, emphasizing it as a responsibility of women and PWM. In doing so, it individualizes the burden of alleviating menstrual distress, framing menstruation itself as the problem, rather than addressing the structural factors that create, shape and sustain such menstrual distress in the first place.

Instead, we propose a focus on menstrual care grounded in understandings of care as a multi-directional, relational and interdependent practice that fosters welfare, wellbeing and emotional health, being simultaneously deeply personal and inherently political (Chatzidakis et al., 2020; O'Riordan et al., 2023). Engaging with the concept of menstrual care thus involves looking into the ways in which cultural assumptions, public policies and institutional practices define what care practices are supposed to look like, who is considered to need them and who is expected to perform them (McKearney & Amrith, 2021; O'Riordan et al., 2023). Guided by this conceptualisation, we explore the question: How do women and PWM in Spain experience and make sense of menstrual distress, and how do they navigate, negotiate, and engage in different practices and spaces of care in response to it? By approaching menstrual experiences through the lens of care and moving beyond the hegemonic "management" framework, this study offers an original contribution to the field of critical menstruation studies by providing insights into the gendered, classed and racialised inequities shaping care practices and experiences of menstrual distress.

Against the backdrop of the limited research that critically examines how menstrual distress is structurally exacerbated and how women and PWM navigate, interpret, and respond to it through different care practices, this study aims to explore the practices, experiences and spaces for menstrual care of emotional health in women and PWM who experience menstrual distress in Spain.

2. Methods

The present study is part of the mixed-method research project "Menstrual Health, Mental Health and Quality of Life in Spain" in which five research teams from different regions of Spain are participating: Andalusia, Basque Country, Canary Islands, Catalonia and Galicia. These regions differ significantly in culture, language, and socioeconomic status: Galicia, Catalonia and the Basque Country are bilingual (Spanish and Galician/Catalan/Basque), while Catalonia and the Basque Country have notably more economic resources.

2.1. Epistemological framework

Drawing on a feminist research perspective, critical theory and participatory-action research aimed at exposing power structures that produce inequality and oppression, this study employed the method of Photovoice. The method is carried out as a group activity in various sessions, where participants bring photographs taken prior to the sessions and engage in critical self-reflective enquiry and dialogue of the positive and negative aspects of a situation, community or issue (Kemmis, 2007; Lorenz & Kolb, 2009; Wang, 1999). The participatory aspect of the method consists of participants collaborating in collecting, analysing, and presenting the data alongside the researchers, challenging traditional researcher-informant power hierarchies and avoiding passive forms of representation that may reinforce existing social inequities (Lorenz & Kolb, 2009). As a participatory-action research method, the method aims to not only reveal the lived experiences of social inequities and injustice, but also to foster positive social change by raising awareness of specific issues and communicating them beyond purely academic audiences (Bell, 2015). Given the menstrual stigma and social expectations of concealing menstrual experiences (Wood, 2020), photography can be especially useful, as images elicit interpretations that could otherwise be difficult to articulate (Lorenz & Kolb, 2009). A Photovoice was conducted in parallel in all five regions.

2.2. Recruitment

Participants had to be 18 years or older, experience menstrual distress and have menstruated within the past six months. Recruitment focused on socioeconomically vulnerable areas, reflecting evidence that socioeconomic factors shape menstrual experiences (Medina-Perucha et al., 2024; Pruneda Paz et al., 2024). However, recruitment in Andalusia, Catalonia, and the Canary Islands was challenged and required expansion to other areas. One participant with long-term amenorrhea was included, despite not having menstruated in the previous six months because the research team agreed that her experiences of menstrual distress were still relevant to the study. These inclusion criteria ensured that all participants experienced some form of menstrual distress, while allowing for a diversity in age, gender, racialisation as well as in socioeconomic, migratory and administrative situation.

Participants were recruited through multiple strategies across the different regions, including outreach by healthcare professionals and/or social workers, posters in community spaces, digital dissemination on social media, as well as snowball sampling. In the Basque Country, an NGO supported recruitment, and in Andalusia and Galicia participants were recruited through universities. All potential participants were contacted by phone or email. Recruitment occurred in two phases: April–July 2024 (Basque Country, Catalonia, Galicia) and August-October 2024 (Andalucía, Canary Islands).

The study included 41 participants. 40 identified as cisgender women and one as a non-binary trans person. Ages ranged from 18 to 50, with the majority being between 21 and 26. Over half of the participants had at one point received a menstrual-related diagnosis and 16 experienced economic struggles sometimes, often or always. Characteristics are detailed in Table 1.

2.3. Data collection and analysis

To ensure a shared methodological approach, researchers met in person before conducting the Photovoice to receive a two-day training and discuss key decisions. Biweekly meetings were held throughout recruitment, data collection and analysis to address emerging issues. A researcher facilitated each session, while one or two others observed and took notes.

Each region held six weekly in-person sessions of two-hours duration. Participants attended only the sessions in their own region. Sessions were held in community spaces, healthcare settings or at universities between April-June 2024 (Basque Country, Catalonia, Galicia) and October-December 2024 (Andalusia, Canary Islands). The first session included a photography workshop by an external expert, and verbal and written consent and sociodemographic data were collected. In this first session, participants also developed, in collaboration with the researchers, a question/sentence to guide their photographs. These questions/sentences were unique to each region but aligned with the overall study objective. As an example, the guiding question in Catalonia was: “How do I care for my emotional health during menstrual distress?” Participants were informed of image rights and the need for written consent from identifiable individuals in their photographs.

The following three sessions involved group discussions around the photographs. The discussions were guided by the SHOWeD method: What do we **S**ee here? What is really **H**appening here? How does this relate to **O**ur lives? **W**hy does this situation, concern, or strength **E**xist? What can we **D**o about it? (Wang, 1999). The final two sessions focused on collaborative analysis, where participants grouped previously discussed topics written on post-it notes. This grouping of topics developed into categories, which participants named before assigning their photos to the category they considered best represented each one (Lorenz & Kolb, 2009; Wang, 1999). This resulted in a total of 20 categories across the regions. All sessions were audio recorded. Researchers in each region drafted a summary of the participant-developed categories, gathered participants’ reflections, and presented a preliminary regional analysis to the rest of the research team in two online meetings. The 20 participant-developed categories were then synthesized into four themes by juxtaposing them, comparing similarities and differences in titles and content before coding in Atlas.ti. Many of the regional categories aligned closely, facilitating synthesising the regional categories into overarching themes, with each theme encompassing between four and six of the regionally developed categories. The four overarching themes functioned largely, however not rigidly, as a preestablished coding frame, giving the coding process a relatively structured character. Hereafter, all sessions were coded in Atlas.ti drawing on reflexive, inductive thematic analysis (Braun & Clarke, 2006, 2019, 2023). The initial coding was inductive and textually grounded, with codes generated to closely mirror participants' original statements. These textually specific codes were then grouped together, and sorted into the synthesized themes, aligning as much as possible with how participants had already categorized the concept(s) the statements described. To remain consistent with the analytical process conducted in collaboration with the participants, which the research team considered essential, the coding process differed slightly from the proposed inductive approach by Braun and Clarke (2006). They describe how themes are generated by combining and grouping different codes, rather than working with a predefined coding frame. However, they do not present reflexive thematic analysis as a rigid “recipe following” activity but rather describe it as a fluid approach allowing for flexibility in the enactment of the analytical process. As such, the central aspect of the approach is reflexive engagement with the data and the acknowledgement that the research process and analytical decision-making are inherently interpretive practices (Braun & Clarke, 2019, 2023). Key aspects that accompanied the analytical process. Important reflections are specified in the “Limitations and reflections” section. The synthesized analysis was then presented in an online meeting with researchers and participants from all the regions in order to gather their feedback, comments and reflections. Participants received a €50 supermarket voucher in the final session.

3. Results

The 102 photographs taken by the participants revealed a variety of experiences of menstrual distress and care, which have been organized into the following four analytical categories. For all photos see supplementary material (Supplementary material1).

Table 1
Sociodemographic information of participants.

Participant id	Gender	Age	Country of birth	Sexual orientation	Administrative status	Education	Occupation	Care for dependent people	Economic difficulties	Diagnoses	Use of medical substances
Andalusia											
A1	Woman	27	Spain	Homosexual	Spanish nationality	Postgraduate degree	Employment	No	Often	Iron deficiency	-
A2	Woman	22	Spain	Bisexual	Spanish nationality	Postgraduate degree	Studying	No	Never	-	-
A3	Woman	21	Spain	Bisexual	Spanish nationality	Graduate degree	Studying	No	Never	-	-
A4	Woman	35	Spain	Heterosexual	Spanish nationality	Postgraduate degree	Studying	No	Never	Polycystic ovaries, endometriosis	Hormonal contraceptives
A5	Woman	41	Colombia	Heterosexual	Temporary residency	Postgraduate degree	Employment	No	Almost never	Iron deficiency, uterine fibroids	-
A6	Woman	23	Spain	Heterosexual	Spanish nationality	High school	Studying	Yes	Sometimes	Polycystic ovaries	Hormonal contraceptives
A7	Woman	19	Spain	Bisexual	Spanish nationality	High school	Studying	Yes	Sometimes	-	-
A8	Woman	28	Colombia	Heterosexual	Temporary residency	Postgraduate degree	Employment	No	Often	Premenstrual syndrome	Painkiller, herbal painkiller
A9	Woman	25	Spain	Bisexual	Spanish nationality	Graduate degree	Studying	No	Sometimes	Polycystic ovaries	Hormonal contraceptives, food supplement, benzodiazepine
A10	Woman	24	Spain	Heterosexual	Spanish nationality	High school	Studying	Yes	Never	Premenstrual syndrome, iron deficiency, MTHFR gene mutation, mammary cysts	-
Basque Country											
BC1	Woman	26	Morocco	Bisexual	Permanent residency	High school	Full-time domestic work	Yes	Sometimes	-	-
BC2	Woman	44	Colombia	Heterosexual	No papers/Papers in process	High school	Studying	Yes	Always	-	-
BC3	Woman	27	Spain	Bisexual	Spanish nationality	High school	Employment	No	Often	Anaemia, iron deficiency	-
Bc4	Woman	26	Spain	Heterosexual	Spanish nationality	Graduate degree	Employment	No	Never	Polycystic ovaries	-
BC5	Woman	38	Honduras	Heterosexual	No papers/Papers in process	High school	Employment	Yes	Sometimes	Polycystic ovaries	-
BC6	Woman	29	Colombia	Heterosexual	Temporary residency	High school	Employment	Yes	Sometimes	Polycystic ovaries	-
BC7	Woman	33	Spain	Bisexual	Spanish nationality	High school	Full-time domestic work	Yes	Sometimes	-	-
BC8	Woman	18	United States	Heterosexual	No papers/Papers in process	High school	Studying	No	Almost never	Polycystic ovaries	-
BC9	Woman	41	Morocco	Heterosexual	No papers/Papers in process	High school	Studying	Yes	Often	-	-
Canary Islands											
CI1	Woman	25	Spain	Bisexual	Spanish nationality	High school	Unemployed	No	Never	Anaemia, iron deficiency	-
CI2	Woman	21	Spain	Heterosexual	Spanish nationality	High school	Studying	No	Never	Premenstrual syndrome	-
CI3	Woman	20	Spain	Bisexual	Spanish nationality	High school	Studying	No	Almost never	Anaemia, polycystic ovaries	-
CI4	Woman	21	Spain	Bisexual	Spanish nationality	High school	Studying	No	Never	Anaemia, iron deficiency	-
CI5	Woman	21	Spain	Heterosexual	Spanish nationality	High school	Studying	No	Never	-	-
CI6	Woman	24	Spain	Bisexual	Spanish nationality	Postgraduate degree	Employment	No	Never	Premenstrual syndrome	-
Catalonia											

(*continued on next page*)

Table 1 (*continued*)

Participant id	Gender	Age	Country of birth	Sexual orientation	Administrative status	Education	Occupation	Care for dependent people	Economic difficulties	Diagnoses	Use of medical substances
C1	Woman	28	Spain	Bisexual	Spanish nationality	Postgraduate degree	Employment	No	Almost never	Anaemia, iron deficiency, amenorrhea	-
C2	Woman	32	Spain	Heterosexual	Spanish nationality	Graduate degree	Employment	No	Never	Migraine	CBD
C3	Trans non-binary	25	Spain	Bisexual	Spanish nationality	High school	Employment	No	Sometimes	-	-
C4	Woman	30	Italy	Bisexual	Permanent residency	Graduate degree	Employment	No	Often	Anaemia, iron deficiency, amenorrhea	-
C5	Woman	47	Spain	Bisexual	Spanish nationality	High school	Unemployed	No	Sometimes	Anaemia, iron deficiency	-
C6	Woman	20	Colombia	Heterosexual	Temporary residency	High school	Employment	No	Almost never	Polycystic ovaries	Hormonal contraceptives
C7	Woman	30	Italy	Heterosexual	Permanent residency	Postgraduate degree	Employment	No	Almost never	Polycystic ovaries, endometriosis/adenomyosis	-
C8	Woman	24	Morocco	Heterosexual	Spanish nationality	High school	Studying	Yes	Never	Anaemia, iron deficiency, depression	Antidepressive
C9	Woman	36	Colombia	Heterosexual	No papers/Papers in process	Graduate degree	Employment	No	Sometimes	Polycystic ovaries, endometriosis/Adenomyosis	Hormonal contraceptives
C10	Woman	24	Spain	Bisexual	Spanish nationality	Postgraduate degree	Employment	No	Never	Iron deficiency, migraine	Painkillers
Galicia											
G1	Woman	37	Spain	Heterosexual	Spanish nationality	Graduate degree	Employment	Yes	Never	-	-
G2	Woman	44	Spain	Heterosexual	Spanish nationality	Postgraduate degree	Employment	No	Never	Uterine fibroids, endometrial polyps	-
G3	Woman	21	Spain	Heterosexual	Spanish nationality	High school	Studying	No	Never	-	-
G4	Woman	44	Spain	Heterosexual	Spanish nationality	Graduate degree	Employment	No	Almost never	-	Ibuprofen
G5	Woman	26	Spain	Heterosexual	Spanish nationality	High school	Employment	No	Almost never	Anaemia, iron deficiency uterine fibroids	Hormonal contraceptives
G6	Woman	50	Chile	Bisexual	Spanish nationality	Postgraduate degree	Employment	Yes	Almost never	Polycystic ovaries	-

3.1. *"Smile, even though it hurts": Structural disregard of menstrual distress and care*

This category emerged from the participants accounts of how their need for menstrual care collided with the hectic pace of everyday life.

3.1.1. *Menstrual distress: Embodied and emotional experiences*

The menstrual distress participants described manifested itself both physically and emotionally, often occurring during the premenstrual or menstrual phase. For others, menstrual distress took the form of a constant health concern due to (inexplainable) irregularity or absence of menstruation. Some participants were extremely affected by their menstrual distress, describing it as "horrible", "feeling like shit" and "a curse".

Participants most frequently reported menstrual pain, low energy levels, and discomfort from abundant bleeding as physical distress, while often linking their emotional distress to the premenstrual phase, describing feelings of being "out of control" (Fig. 1) and "not like themselves."

Premenstrual mood changes were often attributed to hormonal fluctuations and described as "premenstrual syndrome" though one participant criticized this explanation as reflecting sexist bias in scientific and popular knowledge. The menstrual experiences the participants shared were not only described as distressing in themselves but also generated feelings of loneliness and isolation.

3.1.2. *Care challenges: Balancing daily demands*

A recurring theme was the tension between experiencing menstrual distress and maintaining everyday life. Participants noted how societal structures are not designed for women and PWM, and they shared how menstrual distress was often dismissed as an illegitimate reason for feeling unwell. Expressing menstrual distress could be interpreted as being "dramatic" or "crazy": "It's already like 'you're crazy' or 'oh, you're angry today—are you getting your period?'" (CI6, 24 years). This disregard of menstrual distress made some participants feel like they had to "push through" (Fig. 2). Participants described how menstrual product advertisements reinforce this by emphasizing that menstruation should not interfere with daily life.

Fig. 2. Rusty tool.
"It's a tool I found in my garden […] It's like the literal need to be functional and having to be productive, but the tool is rusty, and the nail is out and you're going to get splinters. So, it's like, still trying but to a level where you can't.". (A7, 19 years).

For some, this balancing act meant choosing to endure menstrual distress to not be considered "less than" or "weaker" than men and people who do not menstruate (PWNM): "I see it [not taking painkillers] as a way of showing that I am capable … Like to men or to the figures

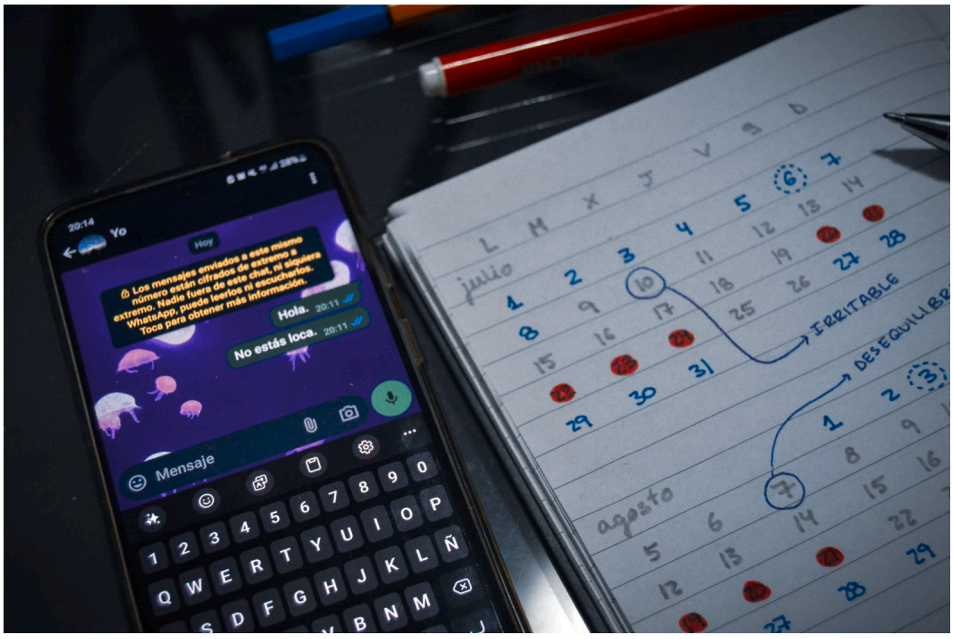

Fig. 1. You are not crazy.
"I get out of control; I perceive reality in a different way […] I used to think "maybe I have some psychological problem". (CI6, 24 years).

that have made me feel that I am not capable, or that I am less, that I have my period or that I am sensitive, delicate, sweet …" (CI3, 20 years). Menstrual care was sometimes secondary to caring for others: "I don't have time to dedicate to myself, […] I eat the chocolate, but I eat it while I'm doing something else, while I'm with my kid. I don't have time to just sit on the sofa" (BC7, 33 years). Financial or administrative insecurity also added challenges to menstrual care: "In my case, I'm irregular, I work informally, as we say, off the books. I can't say, 'I'm not going back to work this week so I can stay at home.' If I did that, my kids wouldn't eat … " (BC5, 38 years).

3.1.3. *Positive aspects: Reframing menstrual distress*

Several participants mentioned positive aspects of having a menstrual cycle. They described how, in opposition to the fatigue, pain and wish for solitude that often characterized menstruation, they felt more energetic, social and beautiful during ovulation. It was mentioned how a regular menstruation was a sign of health, which many participants found reassuring. For some, menstruation was integral to their female identity, making them relate more positively to menstrual distress: "This is part of my feminine identity, and I bless my period, and I integrate it, and it changed the way I see it" (A9, 25 years). Another participant expressed how the cyclical changes in themselves were positive: "How boring life would be without such hormonal changes." (CI6, 24 years). Some participants also mentioned how being more sensitive during certain phases could be something positive, like feeling more creative. For one participant, menstrual care took the shape of intentionally focusing on such positive aspects (Fig. 3).

3.2. *"I didn't know before, because no one had told me": Menstrual education and (self-)knowledge as the basis for menstrual care*

The lack of menstrual education was the most frequently repeated theme. This knowledge gap was understood as a structural issue with harmful consequences for women and PWM, hindering menstrual care.

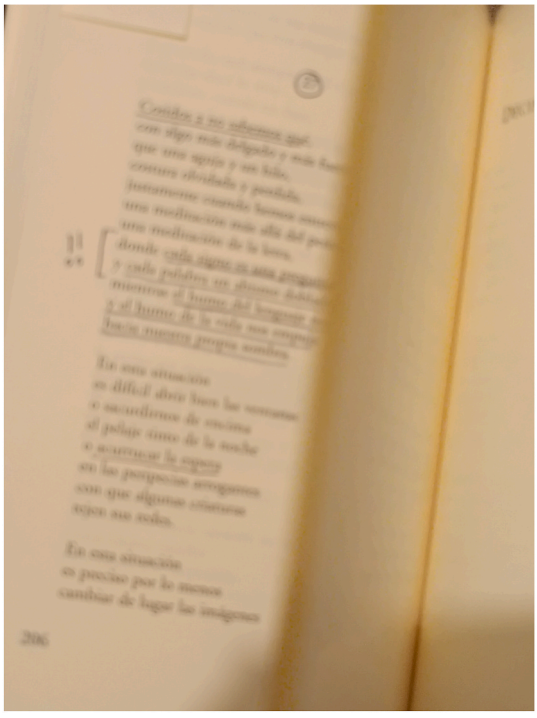

Fig. 3. Poem.
"Taking care of myself is also to explore this part in a positive way, with things like reading poetry. […] It's like everything affects me deeply. I underline everything, I fill it with exclamations.".
(C1, 28 years).

3.2.1. *Knowing oneself: A foundation for menstrual care*

Participants frequently emphasized the importance of understanding their own bodies and menstrual cycles as a prerequisite for menstrual care. However, they described how acquiring self-knowledge was often hindered by limited menstrual information. As a result, many turned to informal sources such as friends or social media: "I think Instagram is a good place, really, because you can find different professionals who talk about things that I've learned over the past few years […] It that has really helped me understand myself." (C2, 32 years).

The participants mentioned how tracking their menstrual cycle was a useful way to understand bodily and emotional changes. This was not only considered key in identifying menstrual care needs but were also experienced as a form of care in itself: Several participants felt reassured when they could attribute certain inexplicable emotional changes to their menstrual cycle: "I know that once my premenstrual syndrome passes, I'll go back to being the [name] I was before. So, I don't mind." (CI6, 24 years). Likewise, participants who had irregular or absent menstruation expressed having difficulties understanding themselves.

Participants reflected upon how menstrual education had changed through generations: "My grandfather, a macho of the time, in a village, my grandmother, a typical woman, works at home, quiet […] Tell me then, in that social context, what information is my mother going to have to later give to her daughter?" (CI4, 21 years). Participants also reflected on how to best pass on menstrual information to their children.

3.2.2. *Sustaining menstrual distress: Gaps in knowledge*

Participants linked the lack of menstrual information to a general lack of research on female health, highlighting it as a discriminatory issue that hindered both menstrual care and female empowerment: "And we don't know anything about periods […] this is a structural issue and it needs to be researched […] research is what opens doors for us and what empowers you." (A2, 22 years). They also criticised menstrual information as narrow and stereotypical, reflecting only specific cycle lengths, bleeding amounts, and cis women's experiences. This silenced other menstrual experiences, leading several participants to question if theirs were "normal." A participant, working as a midwife, expressed how she believed that women and PWM often do not seek information due to such doubts (Fig. 4).

Participants discussed how the lack of menstrual knowledge placed the responsibility on women and PWM to both seek information and educate men and PWNM. One participant criticised this: "It's like a backpack that keeps getting heavier with things we have to do, and how we have to do them, and explain it well, and explain it in such a way, and be empathetic. It's exhausting" (C2, 32 years). She believed instead that menstrual information was an institutional and political responsibility. A non-binary trans participant undergoing hormonal treatment with testosterone mentioned how a lack of menstrual information in his case could be dangerous: "My endocrinologist […] He doesn't know the changes I should be going through […] It's actually very dangerous […] I didn't know that taking testosterone carries a risk." (C3, 25 years).

Many participants described how menstrual care was generally framed as an individual responsibility. Many of them therefore emphasized the importance of including men and PWNM in menstrual education to foster empathy, promote care, and drive structural change (Fig. 5).

3.3. *"This is normal.": Experiences of menstrual care in the healthcare system*

This category encompasses the participants' experiences of seeking menstrual care within the healthcare system. Many recounted not having found neither the answers nor the resolution they were looking for. On the contrary, many described how their interactions with the healthcare system generated more distress.

Fig. 4. Empty consultation room.
"I understand that there isn't much information, because there really isn't any, but it's also true that many women don't go looking for that information either. You get your period, you have a terrible time, and some people just accept it and say, 'well, this is just how it is'." (CI2, 21 years).

3.3.1. *Everything is normal: Dismissal of menstrual distress*

The participants generally perceived the healthcare system as the first place to seek menstrual care. However, several participants shared that when they sought medical consultation, instead of feeling cared for, they were dismissed and received no guidance on how to alleviate their menstrual distress: "You go to the doctor, and they always say, 'This is normal.' […] Everything is normal — but how am I supposed to manage it?" (C5, 47 years). Participants attributed this to medical staff's lack of menstrual knowledge, a general neglect of menstrual distress in an overburdened healthcare system and gender bias in understandings of pain: "Why does it hurt? Because it's normal, because for women, periods are supposed to hurt." (A10, 46 years). Some participants even hesitated to seek medical attention, fearing they would not be taken seriously (Fig. 6).

In some cases, participants described overtly unpleasant and upsetting experiences with healthcare professionals. A participant with long-term amenorrhea described how a doctor had implied that she had invented her symptoms: "She ordered some blood tests for me at first, and since they came back fine, then it just couldn't be. It couldn't be that the blood test was fine, and I still didn't have my period […] The way she was talking to me and how she was treating me—I felt really bad." (C4, 30 years). A few participants had developed a distinct fear of going to the gynaecologist. Nonetheless, some participants also shared positive experiences of receiving care from healthcare professionals. Remarkably, in these accounts feeling cared for were less about resolving menstrual distress, but about feeling understood and taken seriously.

3.3.2. *Barriers in menstrual care: Inaccessibility of the healthcare system*

Migration and administrative irregularity emerged as significant barriers to accessing the healthcare system. Participants who had migrated to Spain had trouble understanding and accessing the healthcare system and felt they had less rights and were uncomfortable making demands: "I feel I can't make the same demands as a I would in my own country in terms of health issues." (A8, 28 years). Participants described gynaecological care as hard to access, requiring repeated insistence and long waiting times. One participant referred to it "as a battle" in which she had to "fight with all her strength". A similar experience was expressed by another participant, who had unexpectedly stopped menstruating. She described having visited several health clinics but was told her case was not urgent enough for a gynaecological consultation. She was instead told to wait five months. This made her feel powerless and caused her a deep concern for her health (Fig. 7).

Participants born in Spain with Spanish citizenship also expressed difficulties accessing public gynaecological services, feeling they constantly had to "push" or "find a way around" the system. This led participants with sufficient financial means to seek menstrual care through private healthcare.

Fig. 5. Crumbled paper.
"Despite feeling bad, like the wrinkled paper and the stairs … Despite feeling bad, we have to keep going. […] Therefore, I think it's important that there should be a solid educational foundation that allows us to give space to be able to stay on that step of time for as long as we need.".
(A9, 25 years).

3.3.3. *A "quick fix": Contraceptives as the solution*

Hormonal contraceptives were often presented to the participants as the only form of menstrual care available within the healthcare system. While some acknowledged that contraceptives had helped reduce their menstrual distress, the majority expressed discomfort taking them or dissatisfaction due to adverse side effects. Some participants felt that contraceptives served as a "quick fix" rather than allowing women and PWM the time for rest: "My problem is that I have polycystic ovaries. The problem I have is that I have a fibroid. […] Well, okay, just suck it up, take the pill and go on." (A5, 41 years). One participant rejected hormonal contraceptives as menstrual care, describing it instead as "medical violence" referring to what she saw as an overmedication of women and PWM. The persistent lack of menstrual care from the healthcare system left several participants unsure where to turn. As a

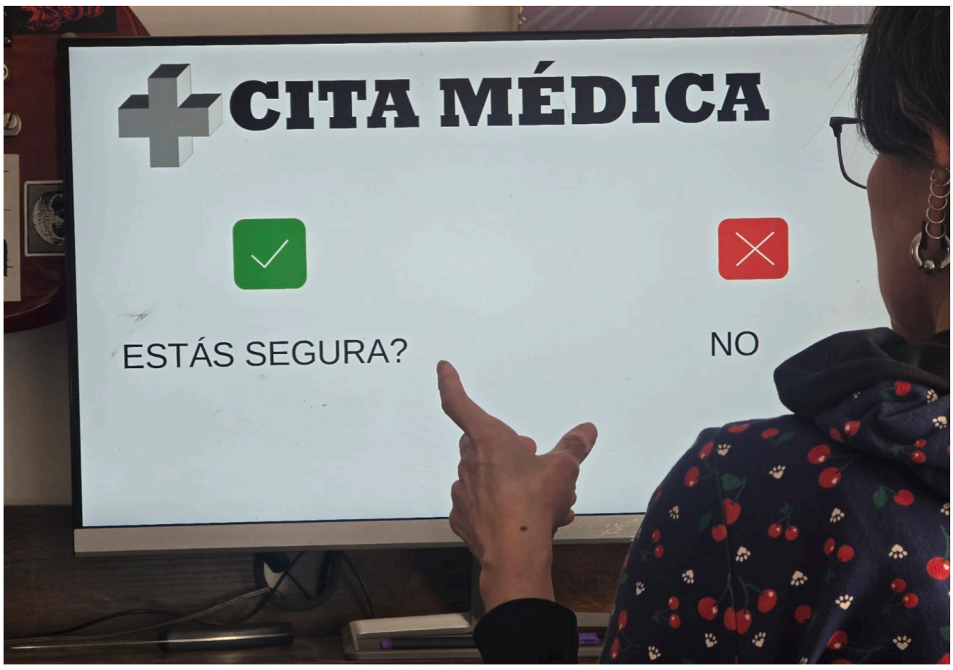

Fig. 6. Booking appointment.
"Sometimes I doubt whether to make an appointment with my doctors because I don't know if they're going to scold me." (G6, 50 years).

Fig. 7. Stormy sea.
"The sea can be very relaxing, but when it looks a little noisy, it can also cause doubts and 'what else is there, in this … big place.' And the uncertainty it causes, right? It caused me a lot of uncertainty." (C6, 20 years).

result, many felt obliged to alleviate their distress on their own or accept living with it and a constant worry about their health.

3.4. "Learning to slow down": Collective and individual care practices

This category covers the various menstrual care practices participants engaged in, usually centred around the premenstrual or menstrual phase.

3.4.1. Resting as care: Slowing down in response to menstrual distress

A vast number of participants took pictures of their bed, themselves in the bed and with certain objects, like books, computers or cups of tea.

These accounts often focused on the need to rest, slow down, and stay at home—a need that frequently emerged from severe menstrual pain, physical fatigue, or feeling sensitive (Fig. 8).

Premenstrual feelings of being more irritable or sensitive than normally meant that for many, menstrual care involved retracting from social interactions. The participants described how this relieved them from dealing with other people but also "protected" others from potential premenstrual outbursts. Participants also described slowing down as leaving the city, emphasizing the emotional and physical wellbeing experienced in nature. Menstrual pain relief also emerged as an important form of menstrual care. Participants described using painkillers, drinking tea and using heat packs. They also mentioned preparing and planning for menstruation and the expected pain as a form of menstrual care. However, some participants felt uncomfortable taking painkillers frequently: "I don't want to take a pill because I don't want to be drugged, but I also don't want to feel unwell, you know?" (A2, 22 years). Many participants felt like they had no other choice than taking painkillers, especially when they did not have the time to rest.

3.4.2. *Being taken care of: Relational forms of menstrual care*

Despite many participants voicing wanting to be alone, others mentioned their relations to other people (Fig. 9) and animals as necessary during times of menstrual distress.

The participants described how relational menstrual care took the shape of other people buying them menstrual products, cooking for them, taking over domestic or caregiving obligations or listening to their experiences of menstrual distress. Two participants mentioned how they used menstrual tracking apps with their partners, facilitating their role in menstrual care: "I have an app to track my period, but he has it too. […] He knows that on those days, maybe I need this soup, or I need something else." (C2, 32 years). Participants also mentioned siblings and children as important figures providing menstrual care.

Fig. 8. Book and headphones.
"What I need is like, to have my book, to rest, to be quiet, to put my headphones on, so that nobody talks to me.".
(A2, 22 years).

Fig. 9. Snail.
"I saw myself in that snail, because during a period that lasts five days, I'm just spotting, and I go slowly, slowly, always leaving something behind. […] And this is my husband's hand. In those moments, sometimes you need a helping hand." (BC5, 38 years).

Some participants described how menstrual care could manifest as a supportive "menstruating sisterhood" alleviating feeling of loneliness. A participant described menstrual care as a way to establish and nurture relations: "I think it [menstruation] can be interpreted in a positive way. An opportunity to care for someone else and to be cared for in return. Throughout the cycles, it ultimately becomes an opportunity to build bonds, to create community and share experiences." (C3, 25 years). Others mentioned how collective support could materialize in the recommendation of gynaecologists or exchange of menstrual products: "There is a kind of unspoken sorority where any woman, whether you know her or not, anyone who menstruates, asks you for some kind of menstrual product, and we immediately give it to each other." (CI3, 30 years). Some participants felt especially disappointed and frustrated when they encountered incomprehension from women and PWM, like bosses, friends, or health professionals, who, by virtue of sharing the menstrual experience, were expected to be more empathetic. One participant however, challenged this perspective, arguing that this demand for empathy placed yet another unjust expectation on women and PWM.

3.4.3. *Menstrual care and privileges: The cost of menstruation*

Participants mentioned how resources such as time, money, flexibility at work etc. shaped menstrual care. Especially the economic aspect of menstruating was often mentioned (Fig. 10).

Many participants expressed that menstrual products were unreasonably expensive. They saw this as an example of the unfair structural neglect of menstrual needs. Some participants noted the lack of information and advertising for reusable products, like cups or menstrual underwear, as they were considered less profitable options for the industry. A participant, for whom nature was an important part of

Fig. 10. Menstrual products.
"I went shopping, and I thought, 'Let's see how much it costs.' And honestly, I was amazed. I mean, six euros? For a box of tampons?" (BC4, 26 years).

menstrual care, reflected on the privilege of accessing nature and fresh air: "I believe that a person, a woman, who breathes clean air and has a healthier environment obviously has much better health and menstrual process […] What are we going to compare it to? […] A polluted city, that's how the poor survive" (BC2, 44 years).

4. Discussion

The testimonies and photographs of the participants reveal not only the multifaceted ways menstrual experiences and care practices take shape in everyday life but furthermore expose the structural inequities that women and PWM continuously have to navigate.

Patriarchal notions of the female body as biologically inferior frame menstruation as the source of illness, consequently normalizing experiences of menstrual distress (Hudson, 2021; Pujal i; Llombart et al., 2020; Ussher, 2011; Wiggleton-Little, 2024). This normalization is further reinforced by the stigma and secrecy surrounding menstruation as well as historical constructions of women and PWM as "emotional" and "hysterical", resulting in the mere mentioning of menstrual distress as potentially transgressing social norms, labelling women and PWM as "dramatic" or "crazy" (Eitze & Reinhardt, 2025; Sánchez-López et al., 2025a). This makes it difficult to recognize and respond to menstrual distress as a potential health issue (Wiggleton-Little, 2024), and made the participants doubt whether their experiences warranted care, rest or medical attention. Their experiences reflect how normalization of menstrual distress is internalized, making women and PWM less likely to seek healthcare and physicians less inclined to investigate underlying causes (Wiggleton-Little, 2024). This discrediting of menstrual distress appeared in several participants' narratives. In cases where participants received menstrual healthcare, it was reduced to hormonal contraceptives, a clear manifestation of the medicalization of the lives of women and PWM (Blázquez Rodríguez & Bolaños Gallardo, 2017;

Sánchez-López, 2025b). Several participants intentionally resisted medicalizing and pathologizing discourses that frame menstruation as marked by suffering and pain (Blázquez Rodríguez & Bolaños Gallardo, 2017; Guilló-Arakistain, 2020). They instead focused on how menstrual care could foster positive introspection, creative expression, and deeper social connection.

Specific emotional experiences were interpreted by the participants through the concept of "premenstrual syndrome", which was especially evident in their descriptions of feeling "out of control" or "not like themselves". Such self-rejection has been conceptualised as experiences disrupting an idealized hegemonic femininity, with feelings of anger or irritability not corresponding to gendered expectations of submission and self-control (Ussher & Perz, 2020). However, interpreting their distress as caused by the menstrual cycle, made certain emotions understandable and justified expressions of "non-feminine" emotions. This provided relief and acceptance, while also resisting perceptions of (premenstrual) women and PWM as mad (Ussher & Perz, 2013). As illustrated in one participant's narrative, she described how she might have been "actually" mad, but by framing her emotional experiences as premenstrual, she negotiates the extent of her own "madness". Identifying emotional distress as related to the menstrual cycle also warranted menstrual care, justifying the need for solitude or rest.

The complications in caring for oneself and others described by the participants have been referred to in the literature as the "crisis of care", in which care is commodified, feminized, racialised and disregarded in political debates, confining it to the private sphere (Chatzidakis et al., 2020; Malherbe, 2020; O'Riordan, 2023). This crisis has been linked to neoliberal politics and capitalism's prioritization of profit over care, devaluing it as unpaid social reproductive labour and sustaining a global burden that disproportionately falls on women, particularly those who are racialised and economically marginalized (Chatzidakis et al., 2020; Hyde et al., 2020; Malherbe, 2020; McKearney & Amrith, 2021). This manifested in tangible ways in the lives of the participants, who mentioned the demand to be constantly "productive" and lack of political interest as key barriers to menstrual care. The participants of the study had to balance several types of unpaid care work, such as caring for children, parents and the home, which also complicated menstrual care.

Participants constantly negotiated which rules of "menstrual etiquette", referring to the social expectations and codes surrounding menstruation, to follow or challenge (Laws, 1990). A negotiation Deniz Kandiyoti (1988) calls "the patriarchal bargain". She describes how this bargain may involve compliance with patriarchal norms in return for security, respect, stability or access to resources (Kandiyoti, 1988). Adhering to social expectations of not attending to menstrual needs was seen as a way to avoid future stress, or to demand respect by showing they were "no less" than men and PWNM. Menstrual agency thus manifested not only as acts of resistance to hegemonic structures, but also as retaining and complying with such norms (Baumann et al., 2025).

The participants' overwhelming demand for more menstrual information, and their emphasis on its importance for menstrual care, reveals the pressing need to promote menstrual education, which has been argued to be essential to overcome menstrual stigma and challenge harmful social structures (Bobel, 2019). Participants repeatedly criticised the severe menstrual knowledge gap in healthcare, educational institutions, workplaces and in society in general; an absence of information which has been attributed to a "wilful ignorance" within androcentric biomedicine (Hudson, 2021). These findings align with those of Sánchez López et al. (2023), who similarly found that women and PWM (as well as men and PWNM) in Spain perceive themselves to have very limited menstrual knowledge, a situation attributed in part to the absence of formal menstrual health education in the country. The participants highlighted how menstrual education was not only crucial for their own (self-)knowledge, but also instrumental in cultivating the interdependency of menstrual care. Beyond limited access to menstrual information, several participants criticized the narrow biomedical representations of the menstrual cycle, which can reinforce existing social norms (García-Egea et al., 2025) and stigmatize or silence non-normative experiences, such as those of trans and gender non-conforming menstruators, irregular cycles, or absent bleeding. Many of the participants felt that they did not live up to menstrunormative representations (Persdotter, 2020), which generated health concerns, doubts and feelings of being less feminine. This reflects prevailing western biomedical constructions that position menstruation as something inherently female, and femaleness as inherently tied to menstruation, denying the diversity of biological materiality, social experience, and their interrelationship (Guilló-Arakistain, 2020). This structural neglect of providing nuanced menstrual education as well as the lack of care from the healthcare system resulted in most of the participants having to search for menstrual information on their own through social networks or online. Online spaces can be important sources of (menstrual) information (Sánchez-López, 2023) and have also been shown to constitute important care networks offering support, especially for people sharing socially invisibilised experiences (Phillips & Rees, 2018), like menstrual distress. However, information obtained online might be inaccurate and shaped by commercial interests, distorting health messages and leading people to make ill-informed decisions (Phillips & Rees, 2018).

The experiences of distress and challenges to care became further exacerbated and manifested in different ways when intersecting with other axes of power such as racism, classism and capitalism (Crenshaw, 1998; Haneman, 2021). Amid increasing privatisation and the exclusion of people in administrative irregularity from public health services in Spain (Hsia & Gil-González, 2021), participants in migratory situations and/or administrative irregularity experienced barriers in accessing healthcare. Such experiences reflect broader, global patterns of institutionalised racism manifesting in reduced access to and lower quality of healthcare for migrants and racialised people (Williams & Mohammed, 2009). Particularly pronounced among racialised women experiencing menstrual distress, as intersecting axes of racism and gender further exacerbate the normalization and silencing of their menstrual experiences (Hoffman et al., 2016). These challenges aggravated experiences of distress by adding feelings of exhaustion, worry and uncertainty.

Menstrual care practices were in a similar manner shaped by intersecting hegemonic structures. Participants with the financial resources sought care within the private healthcare system, used the menstrual products of their preference, took food supplements and attended therapy. However, such care practices were not accessible to everyone, as participants facing socioeconomic vulnerability had fewer economic and temporal resources and had to prioritise menstrual expenses among other costs. Such barriers to menstrual care are not isolated issues, but rather a reflection of how women and PWM in situations of socioeconomic vulnerability are more exposed to menstrual inequities and injustices (Pruneda-Paz, 2025). As an example, for participants in informal employment situations, engaging in menstrual care became secondary to providing the livelihood for themselves and their families. This scarcity of resources can, in turn, restrict access to education, healthcare, income, and is linked to poorer health outcomes, reinforcing barriers to menstrual care among those already vulnerable to menstrual inequities (Holst et al., 2022).

Several scholars have called for the need to place care at the centre of political action and acknowledge it as necessary in every scale of life (Chatzidakis et al., 2020; Malherbe, 2020; O'Riordan et al., 2023). Conducting research through the lens of care asserts it as both a value and a practice, while simultaneously revealing its structural and intersectional nature. Such a perspective is crucial for the development of evidence-based policies and to generate transformative structural change that effectively address and dismantle the systemic inequities embedded within menstrual care practices.

4.1. Limitations and reflections

Participating in a Photovoice requires significant resources such as time, access to a camera or phone, and the confidence and comfort to share personal experiences; potentially excluding already invisibilised experiences such as those of women and PWM in structurally disadvantaged situations. Only one participant did not identify as a cis woman, limiting the inclusion of underrepresented gender diverse perspectives within menstrual research. However, the perspective of this participant was highly valuable and constitutes a significant strength of the study. The sample also skewed younger, abled, and more educated than the general population, potentially due to the considerable resources required by the method. Due to the recruitment strategies focusing on specific neighbourhoods within cities, participants living in more rural settings were excluded, consequently leaving out experiences of menstrual distress and care in such contexts. This constitutes an important gap for future research to explore how urban and rural contexts shape the lived realities of menstrual inequities. Participants that were recruited via healthcare settings and who participated in sessions led by health care professionals may have felt hesitant to share negative experiences with the healthcare system. It is also important to consider the results of the study in light of the research team's positionality, as it consists of relatively privileged, primarily white (however not all), cisgender women from the Global North, whose educational, socioeconomic, and cultural backgrounds may have influenced the interactions with participants, and interpretation of findings. For example, racialised participants may have felt less represented or understood by the research team, and as a result, may have moderated or downplayed experiences of racism. Furthermore, the interpretation of results may have been influenced by Western feminist frameworks, where concepts such as agency often align with Western values of independence and individualism. We have, however, throughout the research process, made continuous efforts to engage in critically reflection on our own positionality and how it may have shaped the study. The method's strengths, and the multicentric design of this study, lie in amplifying diverse perspectives across a wide geographical area, fostering active representation and participation by the study's participants as well as presenting findings creatively beyond academic audiences.

5. Conclusion

This study exposes how women and PWM navigate and negotiate unjust structures that continue to disregard their experiences of menstrual distress. It emerges how menstrual experiences are not only characterised by suffering, but also are moments of care, compassion and connection with oneself, the body, others, nature and animals. By exploring experiences of menstrual distress through the lens of menstrual care, our study contributes with a novel approach to menstrual research, moving beyond hegemonic biomedical and essentialising frameworks. In this way care functions as a critical lens to examine how intersecting power structures produce, shape, and perpetuate menstrual distress. It challenges hegemonic discourses of "menstrual management" that pathologize menstruation and individualize the responsibility for care. By foregrounding the social and political dimensions of menstrual care, the research findings highlight the responsibility of stakeholders to ground their decision-making in the social realties of menstrual inequities. The research further points to an urgent need to address such structural factors and emphasises the necessity for research to approach menstrual experiences through concepts, such as care, that encompass the diversity of menstrual experiences and attend to structural injustices as well as the everyday practices of resilience, negotiation, and meaning making.

CRediT authorship contribution statement

Astrid Boe Hüttel: Writing – original draft, Visualization, Software, Investigation, Formal analysis, Data curation, Conceptualization. **Vinita Mahtani-Chugani:** Writing – review & editing, Resources, Investigation. **Ainhoa Ulibarri-Ochoa:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Noemi López-Rey:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Rosalba Company-Córdoba:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Andrea García-Egea:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Alejandra Méndez-González:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Estíbaliz Gamboa-Moreno:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Macarena Chacón-Docampo:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Carmen Rodríguez-Domínguez:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Bruna Álvarez-Mora:** Writing – review & editing, Supervision, Conceptualization. **Casandra del Pilar González-Hernández:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Ana Garaikoetxea-Iturriria:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Mª José Fernández-Domínguez:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Ana Isabel Arcos-Romero:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Constanza Jacques-Aviñó:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **María José González-Luis:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Maialen Berridi-Agirre:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Celsa Perdiz-Álvarez:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Cristina Martínez-Bueno:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Maria Dolores Marrero-Díaz:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Uxune Apalategi-Gómez:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Carmen Verde-Diego:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Irene Gómez-Gómez:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Roberto Fernández:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Sara Domínguez-Salas:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Clàudia Díaz:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Mª Dolores Martínez-Romero:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Carme Valls-Llobet:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Diana Pinzón-Sanabria:** Writing – review & editing, Investigation, Formal analysis, Conceptualization. **Anna Sofie Holst:** Writing – review & editing, Formal analysis, Conceptualization. **Anna Berenguera:** Writing – review & editing, Funding acquisition, Formal analysis, Conceptualization. **Laura Medina-Perucha:** Writing – review & editing, Supervision, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization.

Data statement

The dataset is available from the corresponding author upon request. To protect participants' anonymity, the datasets are not publicly accessible. All data are securely stored on the servers of Institut Universitari d'Investigació en Atenció Primària (IDIAP Jordi Gol).

Ethical statement

The study was approved by Institut Universitari d'Investigació en Atenció Primària (IDIAP Jordi Gol) on the 11th of January 2023, Ref 22/234-P. All study activities followed ethical guidelines. Participants provided both verbal and written consent. Anonymity and confidentiality were maintained throughout the study. Consent from identifiable people in the images were collected.

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Declaration of competing interest

The authors declare no conflict of interest.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssmqr.2026.100771.

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