GENDER AND CULTURE, A CONSIDERATION OF FACTORS INFLUENCING MENSTRUAL HYGIENE MANAGEMENT AMONG SCHOOL GIRLS IN GHANA; LITERATURE REVIEW

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DECLARATION

Gender and culture. a consideration of Factors Influencing Menstrual Hygiene Management Among School Girls in Ghana: A literature review

A thesis submitted in partial fulfilment of the requirements for the degree of Master of Science in Public Health

By

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Declaration:

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DEDICATION

To my late, beloved mother, Mama Paulina Abanga Atiah, and John Ivan Abotiba, my beloved son, Rev & Mrs Bismark Anongyine Anafo, my Pastor and the wife in Ghana, Pastor & Mrs Joel Owusu Mensah, my pastor and wife in Amsterdam, Solomon Ntim, my good friend, thank you for being my foundation and strong support, always reminding me of the greatest possibilities I can achieve.

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Lastly, I dedicate this thesis to Mama Pualina, my late mother. I am who I am today because of you.

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Table of Contents

LIST OF ABBREVIATIONS

COVID-19: Coronavirus disease 2019

GSS: Ghana Statistical Service

ICPD: International Conference on Population and Development.

MHM: Menstrual Hygiene Management

MOH: Ministry of Health

MOE: Ministry of Education

NGO: Non-Governmental Organization

SRH: Sexual and Reproductive Health

UNESCO: United Nations Educational, Scientific, and Cultural Organization

UNICEF: United Nations Children's Fund

UNDP: United Nations Development Programme

WASH: Water, Sanitation, and Hygiene

WHO: World Health Organization

GLOSSARY

Adolescents: The Ministry of Health [MOH] and Ghana Health Service refer to adolescents as individuals between the ages of 10 and 19 years (1).

Gender: Refers to the roles, behaviors, norms, and relationships that society attributes to women, men, girls, and boys. These expectations vary across cultures and are shaped by social constructs (2).

Menarche: Describes the onset of menstruation, marked by a girl's first menstrual period (3).

Menstruation: A natural biological process involving the monthly discharge of the uterine lining through the vagina, commonly known as a period or menses (1).

Menstrual Health: Defined as a holistic state of physical, mental, and social well-being in connection with the menstrual cycle, beyond just the absence of illness (3).

Menstrual Hygiene Management (MHM): Defined as the use of clean menstrual products that can be changed in private as often as needed during menstruation. It also includes access to soap, water, and appropriate facilities for disposal of used materials (3).

Menstrual Health and Hygiene: UNICEF describes this as a combination of MHM practices and broader systemic influences linking menstruation to health, well-being, gender equality, education, empowerment, equity, and rights (3).

ABSTRACT

Menstrual hygiene management (MHM) remains a critical issue affecting adolescent girls in Ghana. Despite its significance for girls' health, dignity, and school participation, many continue to face challenges related to limited access to menstrual products, poor water, sanitation, and hygiene (WASH) facilities, and persistent socio-cultural taboos that stigmatize menstruation. Although government and non-governmental organization (NGO) interventions have been implemented, they often neglect the influence of cultural norms, gender dynamics, and social context.

This study conducted a literature review to explore the factors influencing MHM among in-school adolescent girls in Ghana. It applied Caruso et al.'s (2021) conceptual framework for monitoring gender equality in WASH, which focuses on four domains: agency, access to resources, gender norms, and institutional structures.

Findings show that girls' agency is severely limited, particularly in school environments where they have little say in WASH-related decisions. Resource disparities between rural and urban areas persist, with many rural schools lacking private, functional latrines and clean water. Gender norms and cultural taboos contribute to menstrual stigma, silence, and absenteeism, while institutional structures often exclude girls from meaningful participation in decision-making. Current interventions, though well-intentioned, rarely address these interconnected barriers.

The study concludes that improving MHM in Ghana requires more than material support; it calls for culturally sensitive, gender-responsive approaches that challenge harmful norms and empower girls as active participants. Recommendations include integrating menstrual education into school curricula, involving community and religious leaders in norm transformation, and ensuring inclusive WASH infrastructure planning that reflects girls' specific needs

Key words: Gender, Culture, Menstrual Hygiene Management, School, Adolescent, Ghana

Word count: 8492

INTRODUCTION

As a nurse who has spent years working closely with communities in Ghana, I have witnessed firsthand the great yet often unspoken challenges adolescent girls face in managing their menstrual health. What hit me the most was not necessarily the physical needs that came with menstruation, but the emotional, social, and psychological burden it takes, especially when shaped by silence, gender disparity, negative cultural norms, and misinformation. My experiences with young girls in clinical and community settings brought to light a similar story each time; menstruation was often shrouded in secrecy, misunderstood, stigmatized, and unsupported.

These experiences had a profound effect on my understanding of the current situation and deeply influenced my decision to explore MHM as a public health concern. While menstruation is a natural part of life, managing it safely and with dignity remains a privilege for many, rather than a right. In Ghana, despite increasing public health attention, MHM continues to be a neglected aspect of adolescent well-being. Even today, far too many girls miss out on accurate age-appropriate information, with their experiences defined more by cultural taboos and norms than by scientific guidance or supportive conversation.

What further complicates this issue in Ghana is the unexpected weight that Ghana's cultural and tribal diversity carries in this discussion. Every community has its own culture, attitude, and practices related to menstruation, all of which play an enormous role in shaping how adolescent girls understand and handle their period. In some cases, these traditions offer direction and a sense of identity. In other instances, they set limits and perpetuate negative stereotypes that isolate girls and undermine their confidence. Sources of menstrual knowledge, whether from schools, parents, peers, or media, vary widely and often leave critical gaps, especially in rural or marginalized settings.

This study is motivated by the desire to understand and further unpack these intersecting influences more deeply. Specifically, by answering the question, how do cultural beliefs and gender influence menstrual hygiene practices or management? And how can we apply this knowledge to promote inclusive, culturally sensitive approaches that empower adolescent girls rather than marginalize them? With the help of my clinical experience and public health training, I hope to contribute meaningfully to this under-researched yet vital area. My goal is not only to document the barriers but to help ignite conversations that shift the narrative toward dignity, knowledge, and equity for all adolescents, no matter where they come from or what they profess to believe.

CHAPTER ONE: BACKGROUND

1.1 Socio-demographic profile

Ghana is a lower-middle-income country in West Africa on the Gulf of Guinea with a population of about 33 million as of 2024 (4). Adolescents aged 10 to 19 years constitute a significant portion of the population, comprising 22%. Among them, females make up approximately 11.3% whereas males at 11.1% of the adolescent population (4,5). Urbanization in Ghana is proceeding rapidly, with more than half (58%) of the population living in urban areas, compared to 43% living in rural areas (4). However, the gaps between urban and rural residents in access to basic social services and economic opportunities are still wide. The national poverty rate is about 23.4%, with rural poverty more prevalent at 39% than in urban areas, which stands at 7% (6). Based on the UNDP 2021 Human Development Report, Ghana's Gender Inequality Index value is 0.531, placing the country 133 out of 170 national rankings, suggesting a persistent inequality between genders in reproductive health, empowerment, and economic participation (7).

Ghana is characterized by cultural and ethnic diversity, with over 100 ethnic groups. Major ethnic groups include the Akan, Mole-Dagbani, Ewe, and Ga-Dangme (8,9). The country operates under a decentralized government structure that often reflects traditional chieftaincy systems and cultural norms, particularly in rural communities (5). Religion plays a significant role in shaping social norms and behaviors; approximately 71% of the population identifies as Christian, 18% as Muslim, and the remainder practice traditional African religions or identify with no religion (5,9). Cultural taboos and religious beliefs often influence gender roles, health-seeking behavior, and attitudes towards menstruation, which can perpetuate stigma and affect menstrual health management (10).

1.2 Macroeconomy

Ghana's economy is heavily reliant on agriculture, mining, and services. Despite sustained economic growth enjoyed by the country for the last ten years, macroeconomic challenges, including inflation, youth unemployment, and income inequality, remain (11). The effect of the COVID-19 pandemic on household income and access to all key services, including health and education, was the last blow to household incomes and livelihoods, especially putting the livelihoods of adolescent girls in rural areas at risk (5).

1.3 Education

Ghana has undoubtedly made strides in getting children into school, but inequity remains. The current adult literacy rate stands at nearly 70% with a significant gender gap in favor of males. Female literacy trails at around 66% in contrast to 74% for male counterparts (12). Primary school completion is at 71%, although secondary school completion drops dramatically, especially for females, to about 34% (13). Barriers like poverty, early marriage, menstrual hygiene challenges, and domestic duties frequently prevent girls from attaining an education (5).

1.4 Water Hygiene and Sanitation

The physical environment, particularly Water, Sanitation, and Hygiene (WASH) infrastructure, remains inadequate in many parts of the country. Access to improved sanitation facilities and safe water sources is uneven, especially in schools. According to UNICEF (2021), only 55% of schools have access to basic water services, and less than 30% have gender-sensitive sanitation facilities. While approximately 62% of schools have toilet facilities and 65% have access to on-site water (14). However, the data does not provide information on the condition or functionality of these facilities. The absence of safe, private, and hygienic spaces for girls during menstruation contributes to school absenteeism and poor menstrual health outcomes (5).

1.5 Health system

Ghana's health system is decentralized, with a mix of public and private providers providing care at the national, regional, and district levels. The MOH is responsible for developing health policies, mobilizing resources for their implementation, and overseeing monitoring and evaluation to enhance population health outcomes (15). The MOH oversees 26 agencies, each tasked with specific mandates to support the health sector's goals and programs. Health service delivery in Ghana is structured across three levels (primary, secondary, and tertiary) with contributions from the government, development partners, civil society organizations, and the private sector (15). However, significant gaps remain in the availability of health facilities, essential logistics, and medical equipment (14,15).

In the 30 years since the ICPD, adolescent healthcare reforms have made strides toward universal primary healthcare coverage, but a critical gap remains, especially in SRH. Most healthcare facilities do not provide adolescent-friendly services, and menstrual health is often neglected as part of the overall SRH agenda (15). Cultural stigma and a lack of provider training lead to little engagement with adolescent girls when it comes to addressing menstruation-related issues, further marginalizing their needs

CHAPTER TWO: PROBLEM STATEMENT, JUSTIFICATION, AND OBJECTIVES

2.1 Problem Statement

MHM is an important aspect of adolescent girls' health, dignity, and educational success (16,17). Safe MHM practices, backed by comprehensive education, improved WASH infrastructure in schools, and access to menstrual products, are essential for promoting adolescent well-being (17). Poor MHM can lead to serious negative health issues, including reproductive and urinary tract infections, chronic conditions, and social stigma. Furthermore, poor MHM contributes to school absenteeism, perpetuates gender inequity, and pollutes the environment through improper disposal of menstrual products (5,18,19). For instance, UNICEF in 2016 reports that about 22% of adolescent girls in Ghana fail to attend school, participate in school activities, or work during their menstrual period (5).

MHM continues to be a significant challenge in Ghana. Even with growing global attention to menstrual health as a crucial public health and gender equity issue, MHM remains inadequately integrated into national health and education policies in Ghana, resulting in limited institutional support for adolescent girls, particularly in schools. Despite increasing awareness of the challenges girls face during menstruation, including stigma, lack of access to sanitary products, and inadequate sanitation facilities, these concerns have not been systematically addressed in government strategies or budget allocations (20, 21). As a result, many girls continue to face barriers to education and social participation during their menstrual periods. Adolescent girls often lack access to accurate and age-appropriate information on menstruation and rely on peers or media, which may perpetuate myths and misinformation (22).

Cultural and gender norms further exacerbate the problem. In most Ghanaian communities, menstruation is handled in silence, shame, and restrictive taboos that stigmatize menstruating girls and limit them from participating in everyday activities, including attending school (10,23). These socio-cultural constraints, alongside poor WASH infrastructure within schools and limited access to menstrual products, contribute to an environment in which effective MHM is challenging (17,23).

While some government and non-governmental organization (NGO)-led interventions have tried to address adolescent girls' menstrual health education and access to sanitary products, these initiatives often fail to take into account the complex cultural and gendered contexts that influence the lives of adolescent girls. Ghana's rich ethnic diversity introduces a wide variety of cultural and

religious practices influencing menstruation-related beliefs and behaviors. Yet, there is a notable paucity of research assessing how these cultural and gender factors specifically and uniquely affect MHM practices for school-going adolescents in various regions of Ghana. Without a nuanced understanding of the cultural and gender dynamics that shape girls' experiences of menstruation, interventions risk being ineffective, culturally inappropriate, or even inadvertently reinforcing stigma and exclusion.

This knowledge gap hinders the development of culturally sensitive, sustainable, and effective MHM interventions. Without a deep appreciation of the intersection between gender, culture, and menstrual hygiene practices, current interventions risk being ineffective or even counterproductive. Thus, this study aims to identify the socio-cultural and gender-based factors that influence menstrual hygiene management among in-school adolescent girls in Ghana. The study findings will inform more inclusive and contextually appropriate strategies to improve menstrual health outcomes and promote gender equity in education and health.

2.2 Justification

MHM is increasingly becoming an important part of the conversation surrounding public health, education, and gender equity (5,16). In Ghana, the interplay between cultural and gender dynamics in influencing MHM practices, especially among in-school adolescent girls, is not adequately understood. Though most relevant literature has focused on individual awareness, attitudes, unmet needs, and menstrual product and MHM resource access, they have shield away from the cultural norms and gender inequities that uphold period poverty (19,24–27). For instance, studies have shown that although awareness of menstruation is relatively high among Ghanaian adolescent girls, comprehensive knowledge about the menstrual cycle, hygiene practices, and reproductive health remains limited, especially in rural and underserved areas (23). In-school girls frequently report anxiety, embarrassment, and misinformation surrounding menstruation, which affects their confidence and participation in school (23).

Arguably, while some multisectoral interventions in Ghana have aimed to improve MHM through product distribution, WASH facility upgrades, and hygiene education, there is limited analysis of whether and how these initiatives address the cultural beliefs, gender norms, and regional dynamics that shape girls' menstrual experiences (28,29). Some of the existing studies provide useful insights but do not comprehensively assess the extent to which current interventions are gender-transformative or culturally responsive (28,29). This presents a critical gap, as the success

and sustainability of MHM interventions depend heavily on their contextual appropriateness and sensitivity to the socio-cultural realities of adolescent girls.

Ghana's socio-cultural landscape is one of the most diverse in Africa, home to over 100 ethnic groups, with varying traditions and practices, making it one of the most vibrant (8). This influence is not a side issue but foundational to how menstruation is perceived, talked about, and dealt with. There remains a scarcity of nuanced, context-specific research that illuminates how these socio-cultural factors intersect with overall barriers to MHM, including resources, girls' agency, and institutional structures that influence the menstrual experiences of adolescent girls. Absent this understanding, even the best and most well-intentioned policies will end up being culturally misaligned and therefore ineffective.

This study is justified in its aim to fill this knowledge gap by examining the factors affecting MHM among in-school adolescents in Ghana, applying a gender and cultural lens. By uncovering the nuanced socio-cultural realities and gendered experiences of menstruating girls, the findings will contribute to the development of more responsive, equitable, and sustainable policies and programs. Ultimately, this study aims to support efforts to promote menstrual dignity, reduce educational disparities, and enhance the overall well-being of adolescent girls across Ghana.

2.3 Objectives

General Objective

To explore the factors influencing MHM among in-school adolescent girls in Ghana through a gender and cultural lens, with the aim of generating evidence-based recommendations for policymakers, school actors, and public health practitioners to improve MHM practices and outcomes.

Specific Objectives

1) To examine the accessibility and adequacy of menstrual hygiene resources to in-school adolescent girls in Ghana
2) To explore girls' ability to participate in decision-making around MHM issues.
3) To analyze multi-level environmental factors influencing MHM practices among in-school adolescent girls.
4) To explore the extent to which existing MHM interventions in Ghana address gender and cultural norms in responding to the lived realities of adolescent girls.

5) To provide contextually appropriate and culturally sensitive recommendations to Ghana policy makers, school actors, and public health practitioners.

CHAPTER THREE: METHODS AND ANALYTICAL FRAMEWORK

3.1 Study Design

To address the objectives stated above, this study utilized a literature review to analyze the available empirical evidence on the influence of gender and cultural factors on MHM among in-school adolescents in Ghana. A literature review was considered appropriate for this study because it enables a comprehensive exploration of the research topic through critical analysis of existing peer-reviewed articles, grey literature, and reports from reputable organizations and government ministries like the MOH and MOE. Additionally, with the limitation of the study period, it would not have been feasible to collect primary data that addresses all these objectives and analyze them thoroughly to give valid and reliable results.

3.2 Conceptual framework

This study used the conceptual framework outlined in Caruso et al. (2021), *"A Conceptual Framework to Inform National and Global Monitoring of Gender Equality in WASH"*. The framework offers a multidimensional and gender-focused approach to understanding inequalities in WASH, which is particularly relevant when examining MHM among adolescent girls in school settings (30).

The framework outlines three core domains: Resources (e.g., access to menstrual materials, WASH infrastructure, and information), Agency (e.g., girls' ability to make informed decisions and take action on their menstrual health), and Multi-level enabling environmental factors (e.g., policies, governance, school practices, and accountability systems). Importantly, these domains are shaped by underlying social and gender norms, which act as cross-cutting influences. Although the framework does not explicitly acknowledge *culture* as a standalone domain, this study integrated cultural beliefs, practices, and taboos within the norms' domain, given their centrality to how menstruation is understood and experienced in the Ghanaian context.

In selecting this framework, other models were considered such as the Social Ecological Model (31), which situates health behavior within layered systems (individual, interpersonal, institutional, community, and policy levels), and the UNICEF MHM in Schools Five-Pillar Strategy (2012), which emphasizes basic physical infrastructure, education, and policy (32). However, these models, while useful, either lacked the explicit gender lens or failed to provide a clear pathway for analyzing power, agency, and social structures together. Caruso et al.'s framework was chosen because it more comprehensively links gender, WASH, and institutional accountability, making it especially well-suited for exploring the gendered dimensions of MHM in schools.

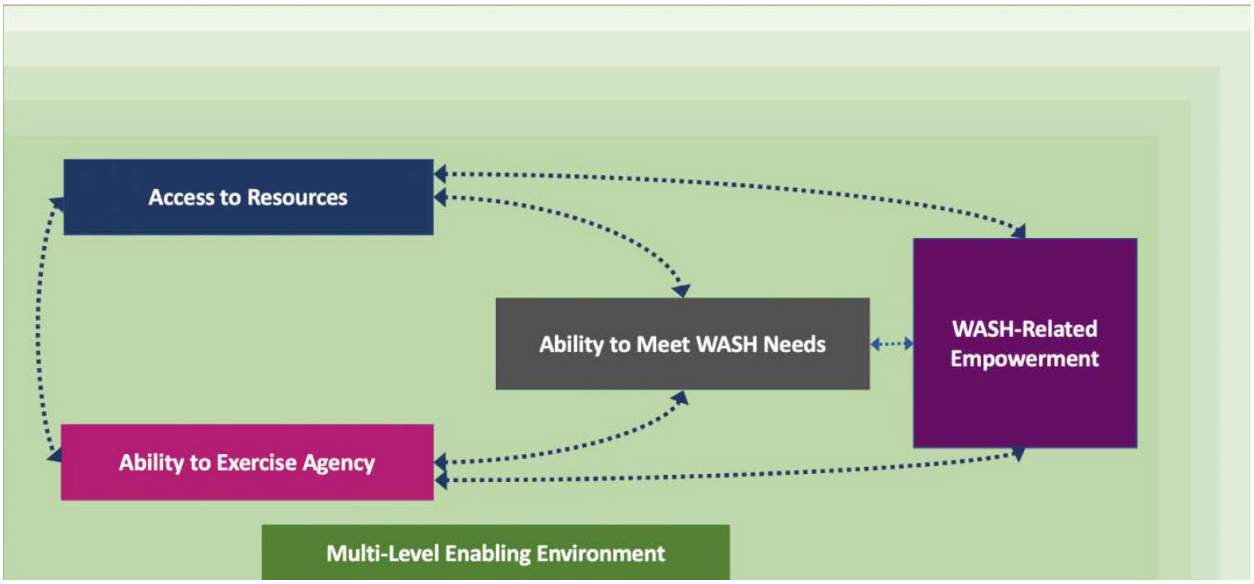

Figure 1: A conceptual framework to inform National and Global Monitoring of Gender Equality in WASH, source: Caruso et al., 2021

Furthermore, the framework's flexibility allows for the incorporation of cultural analysis at the intersection of gender roles, social norms, and menstruation-related stigma. While culture is not treated as an independent domain in the original framework, this study adopts a working definition of culture as *the dynamic set of shared beliefs, practices, values, and symbols through which individuals interpret their experiences and social roles* (33). In this study, culture is primarily situated within the norms' domain, where it shapes how menstruation is understood, experienced, and managed, which in turn might influence adolescent girls' ability to exercise their agency and their access to resources. This recognizes that culture is not static or monolithic, but relational and embedded within structures of power, including gender and institutional (34, 35). This framework informed the literature search strategy and structured the data analysis process and presentation of findings.

3.3 Search Strategy and Keywords

A literature search was conducted to capture relevant published and grey literature on MHM targeting adolescent girls in Ghana. The search included PubMed and Google Scholar databases as well as grey literature from reputable organizations such as UNICEF, WHO, WaterAid, the Ghana Education Service, and the Ministry of Education (MoE). Only literature published in English between 2014 and 2025 was included.

The search strategy employed a combination of keywords and Boolean operators ("AND", "OR") tailored to align with the study's objectives. To ensure broad but targeted retrieval, search terms

(full search word table attached in Appendix 1) were grouped under key thematic areas corresponding to the study objectives:

1. Access and availability of menstrual hygiene materials and enabling environments

Keywords used included *"menstrual products"*, *"sanitary pads"*, *"toilets"*, *"WASH"*, *"income"*, *"finance"*, *"safety"*, *"violence prevention"*, *"information"*, *"knowledge"*, *"social capital"*, *"menstrual kits"*, *"menstrual cup"*. These were combined with population terms like *"adolescents"*, *"in-school girls"*, *"junior high school"*, and *"school"*, and outcome terms such as *"menstrual hygiene management (MHM)"*, *"menstruation"*, and *"menstrual hygiene"*. Contextual filters included *("Ghana" OR "West Africa" OR "Africa")*.

2. Menstrual health and agency (decision-making power and empowerment)

Keywords included *"decision making"*, *"agency"*, *"leadership"*, *"autonomy"*, and *"empowerment*" *, in combination with the same population and outcome terms described above, and the same geographical limits.

3. Multi-level enabling environmental factor for MHM

This theme applied terms such as *"MHM policies"*, *"institutional challenges"*, *"institutional support"*, *"school environment"*, *"structural factors"*, and *"SRHR policies"*, also combined with population, outcome, and location filters as described.

4. Sociocultural and gender influences on MHM

Keywords included *"beliefs"*, *"norms"*, *"culture"*, *"gender"*, *"taboos"*, *"tradition"*, *"stigma"*, *"discrimination"*, and *"gender inequality"*. These were used alongside the standard population, outcome, and regional filters.

To specifically identify interventions to answer the fourth objective, the search was refined by adding terms such as "program", "intervention", "initiative", "implementation", and "evaluation" in combination with the core MHM terms. Titles and abstracts were screened to extract studies and reports that described implemented or evaluated MHM interventions. Priority was given to peer-reviewed articles, policy briefs, implementation evaluations, and program reports published between 2014 and 2025. Only English-language sources were included.

3.4 Data Analysis

Data was extracted using a structured data extraction sheet developed in Microsoft Excel, capturing key information such as study title, author(s), publication year, country, study design, intervention focus (if applicable), target population, and MHM-related outcomes.

Thematic synthesis was guided by a deductive framework based on the four domains outlined by Caruso et al. (2021): Resources, Agency, and Multi-level enabling environment and Norms. Relevant findings were grouped according to these domains and mapped to the specific objectives of the review. Studies discussing material access, facilities, or knowledge were categorized under Resources; those addressing girls' decision-making, voice, or empowerment under Agency; and those focused on policies, school practices, or institutional support under Multi-level enabling environment. Cultural beliefs, taboos, and gendered norms were captured under a cross-cutting 'norms' sub-theme and analyzed in relation to each domain.

CHAPTER FOUR: FINDINGS

Chapter Four of the study presents the literature review findings thematically, categorized by the dimensions of the conceptual framework and objectives.

4.1 Accessibility and Adequacy of Menstrual Hygiene Resources

Three critical resource dimensions emerge from the studies, including access to menstrual products, adequacy of WASH infrastructure, and availability of accurate information.

4.1.1 Access to Menstrual Products

Despite various government and NGO-led initiatives to improve access, most studies report that sanitary pads remain financially inaccessible to many girls, particularly in rural areas. Several school-based surveys show that although a majority of girls prefer disposable sanitary pads, affordability constraints often compel them to alternate with reusable cloths, sometimes within the same menstrual cycle (23, 28, 36). For instance, while more than 65% of girls used pads during their most recent menstruation, up to 17% reverted to cloth when their supplies ran out, often drying them indoors due to privacy concerns, a practice that risks microbial growth due to poor ventilation and limited sunlight exposure (28)

Economic vulnerability, such as lack of pocket money or dependence on unemployed guardians, was strongly associated with poorer menstrual hygiene practices and higher rates of school absenteeism (28, 36, 37). In one large-scale study in northern Ghana, 40% of girls reported missing school during their periods, citing embarrassment and inability to afford pads (38). Although some schools distribute pads sporadically through health outreach or donor programs, coverage is often inconsistent and not scaled nationally (39).

4.1.2 WASH Infrastructure in Schools

A recurring theme across studies is the inadequacy of school WASH infrastructure. Across rural, peri-urban, and even some urban public schools, toilets are often shared, lack doors, soap, water, and safe disposal facilities. In one multi-district survey, less than 40% of schools had functional running water, and fewer than one-third had private changing spaces or bins for used pads (26). Even schools with latrines rarely provided maintenance, and girls reported feelings of shame or fear of leaks due to the absence of soap or water for washing (40).

There is also a clear rural-urban disparity. While peri-urban schools often had better infrastructure, even there, access to soap and waste disposal was not guaranteed. In some cases, girls reported

being forced to use improvised disposal methods or skip school altogether during menstruation due to fear of humiliation (25, 29, 41).

The importance of privacy is frequently underlined in girls' narratives. The lack of secure, gender-sensitive toilets discouraged many from attending school during their periods or forced them to stay in class while experiencing discomfort. This invisibilized their needs within the broader school health agenda (16).

4.1.3 Information and Knowledge about MHM

In addition to material and infrastructural gaps, many girls enter menarche with limited or inaccurate knowledge about menstruation. Studies across multiple regions indicate that although menarche awareness is high, a comprehensive understanding of the menstrual cycle, hygiene practices, and reproductive health is uneven, especially in rural and low-literacy communities (42, 43,44).

Mothers, older sisters, and female teachers were cited as primary sources of information (5,23,42). However, the content and quality of information received are often inadequate or shrouded in euphemisms, reinforcing secrecy and stigma (10). Girls with more educated mothers or access to television/radio were more likely to report accurate knowledge and safer hygiene practices (5,23).

Studies also show that schools are not reliable sources of menstrual education. Even when MHM is included in the curriculum, teachers, especially male ones, may avoid the topic due to cultural discomfort or lack of training (22). As a result, many girls learn through trial and error, peers, or unreliable media, perpetuating fear, confusion, and misconceptions.

4.2 Girls' Agency in WASH and Menstrual Decision-Making

Adolescent girls' ability to exercise agency in managing menstruation and influencing school WASH environments remains limited in Ghana as discussed in detail below.

4.2.1 Limited Expression and Participation in School Governance

Studies show that menstruation remains a culturally sensitive subject, rarely discussed openly within schools, particularly with male teachers. Girls frequently report embarrassment, fear of ridicule, or cultural pressure to remain silent, which limits their ability to request improvements in facilities or access to support (10,23,26). In a national-level survey, fewer than 30% of girls had ever discussed menstruation with a teacher, and many were unaware of mechanisms through which they could report WASH-related concerns or request menstrual support (23). Even where

school structures such as health committees or teacher-student associations existed, these were often adult-led and failed to include adolescent girls in meaningful roles (22).

The discomfort around menstruation is not limited to students. Teachers, especially males, often avoid the topic or treat it with discomfort, further reinforcing taboos. In some schools, menstruation is not addressed in science or health lessons despite its inclusion in the curriculum. This silence compounds stigma and perpetuates misinformation, discouraging girls from voicing their needs (16, 43, 44).

4.2.2 Cultural Norms, Silence, and Stigma as Structural Barriers to Agency

Cultural expectations that menstruation is private, unclean, or polluting play a significant role in limiting girls' agency. Across many regions in Ghana, menstruating girls are still expected to hide their menstrual status and avoid certain public roles or household duties (38,45). These norms are internalized at an early age, making girls hesitant to raise menstruation-related concerns even in supportive school environments.

In practice, this silence limits both the visibility of girls' needs and their ability to contribute to solutions. Even where WASH resources are available, girls may not use them due to fear of being identified as menstruating. Consequently, agency in this context is not just about voice or participation, but also about navigating stigma and controlling how their bodies are perceived within public spaces (38, 45.46)

4.2.3 Emerging Examples of Participatory Models

Despite the prevailing limitations, some recent interventions have successfully introduced platforms for adolescent girls to engage in MHM decision-making and advocacy. In Cape Coast, a programme involving students with visual and hearing impairments provided reusable menstrual kits alongside training in menstrual tracking and hygiene planning. Girls were also supported to participate in school sanitation assessments and share feedback with school leaders. Though small in scale, these activities resulted in reported increases in girls' confidence and willingness to speak up about their needs (47).

Similarly, in the Volta Region, peer-led menstrual clubs and school WASH committees have shown potential to challenge cultural taboos and amplify girls' voices. Girls participating in these programmes took active roles in organizing awareness campaigns, engaging teachers in dialogue about broken latrines, and advocating for soap and pad disposal bins during staff meetings (48,49). Observational data from these initiatives suggest that creating dedicated, girl-centered spaces within schools fosters a more supportive environment for menstrual health governance.

Another example from Accra and Amasaman involved adolescent girls conducting school walk-throughs and developing WASH improvement plans through hygiene clubs. Teachers reported that girls became more vocal in demanding hygiene supplies, and three of six participating schools implemented some of the proposed changes (45). These programmes demonstrate that when girls are given structured opportunities to participate and when adult facilitators are supportive, agency can be nurtured even in culturally constrained settings.

4.3 multi-level enabling environmental factor influencing MHM

The MHM practices in Ghana are significantly shaped by institutional arrangements, policy frameworks, and the broader structural environment within which schools operate. Across the literature, three main issues emerge, including the disconnect between infrastructure and management, limited institutional accountability, and fragmented or underfunded national policies.

4.3.1 Infrastructure Without Management or Sustainability

While efforts to improve school WASH infrastructure have increased, often with donor or NGO support, evidence suggests that such improvements are rarely sustained without clear institutional maintenance plans (26). In a cross-sectional study across multiple basic schools in northern Ghana, it was observed that although latrines had been constructed in over 80% of schools, fewer than half had functional doors, water access, or soap. Furthermore, no schools had sanitary disposal bins or emergency menstrual supplies, and cleaning responsibilities were inconsistently assigned to untrained staff (26)

A multi-site evaluation by the World Bank of a pilot WASH project in Greater Accra demonstrated that infrastructure improvements alone did not result in meaningful changes in girls' school attendance or comfort unless coupled with hygiene education, staff involvement, and dedicated menstrual spaces (50). In some cases, newly installed facilities became nonfunctional within a year due to a lack of maintenance budgets or ownership from school authorities (40).

This trend reflects a broader institutional problem that while infrastructure may be visible and easy to measure, its utility for girls' MHM is compromised by poor governance, lack of recurrent budgeting, and low prioritization of menstrual needs within school operations (39).

4.3.2 Weak Institutional Accountability Mechanisms

Few schools have formal accountability structures in place to ensure that menstrual health needs are adequately addressed. Headteachers and school boards often make resource allocation

decisions without consulting girls or female staff. Teachers may lack guidelines or support to address MHM-related needs, resulting in ad-hoc and inconsistent practices (38)

In some districts, teachers reported using their personal funds to buy pads for girls who lacked them (44). However, this charitable model does not replace the need for institutional commitment. Studies show that schools with designated health focal persons or WASH coordinators who received training were more likely to provide pads, monitor latrine conditions, and integrate menstrual health into school improvement plans (47).

Moreover, while Ghana's Education Strategic Plan (ESP) 2018–2030 includes references to girl-friendly sanitation, these provisions are not adequately monitored or enforced. District Education Offices are understaffed and lack the tools to track WASH compliance across schools (51). The absence of performance indicators or standard operating procedures related to menstrual health management means that even well-intentioned school leaders may overlook these responsibilities.

4.3.3 Fragmented Policy and Low Budget Allocation

At the national level, MHM is addressed across multiple ministries, health, education, gender, and sanitation, but without clear coordination. This fragmentation contributes to policy gaps and limited implementation. For example, while the Ghana Education Service supports health clubs and reproductive health education, no national programme exists to provide menstrual products to all public schools (52)

Only a few metropolitan assemblies, such as Accra and Kumasi, have incorporated MHM into local sanitation plans. Even then, implementation remains weak due to limited financing and lack of technical capacity (53). WaterAid Ghana's policy review in 2021 found that fewer than 20% of district development budgets included specific funding for adolescent girl WASH or MHM programming (54).

Furthermore, national guidelines developed with donor support often remain underutilized at the district level. The 2019 UNICEF-IRC MHM guidelines for schools in Ghana, though well-designed, have not been institutionalized in teacher training colleges or district monitoring systems (55). Without integration into existing government systems, scale-up remains donor-dependent and vulnerable to funding fluctuation

4.4 How Gender and Cultural Norms Influence MHM Practices

Despite increased programming around MHM in Ghana, many interventions remain technically focused and fail to fully engage with the cultural and gendered realities that shape girls' lived experiences. Below evaluates the extent to which MHM interventions have meaningfully addressed gender and cultural norms.

4.4.1 The Internalization of Menstrual Taboos, Silence, and Shame

Menstruation remains culturally taboo across many Ghanaian communities, such as restrictions on cooking or touching food, avoidance of religious activities, exclusion from cultural or social events, being forbidden from fetching water or bathing in the rivers, restriction from interacting with boys or men and fear of menstrual blood with the belief that it is a curse. These are often framed as a subject that should be hidden, controlled, or feared. This norm is reinforced both in homes and schools, where menstruating girls are socialized to be discreet and avoid activities that would reveal their menstrual status (10,23,28). These cultural expectations shape girls' behaviors as many avoid physical activity, remain silent about pain or leakage, and use euphemisms when discussing menstruation (56).

While most MHM interventions acknowledge this stigma, few address it directly. For example, school-based interventions often focus on providing pads or facilities but do not incorporate dialogue around gendered meanings of menstruation or body shame (39). Some programmes distribute products while maintaining silence on gender dynamics, thereby reinforcing the idea that menstruation is a hygiene issue rather than a gender justice concern (45).

The internalization of shame affects help-seeking. Girls who lack products or experience leaks may prefer to stay home rather than risk exposure. In one study, girls reported being teased by boys or disciplined by teachers when they stained their uniforms (29). Without addressing the underlying cultural scripts, even technically adequate MHM interventions risk failing to improve girls' psychosocial well-being.

4.4.2 Shallow Cultural Adaptation, Representation Without Engagement

Several government and NGO-led initiatives claim to be culturally sensitive but fall short of challenging entrenched power structures. Programmes may use local languages or include female facilitators, yet they often stop at tokenistic inclusion without engaging gatekeepers or tackling norms head-on (21).

For example, while some NGOs have included mothers or female elders in menstrual health education sessions, these sessions often focus on hygiene messaging rather than enabling intergenerational conversations about shame or gendered control (43). Similarly, instructional materials may depict culturally appropriate imagery but avoid direct reference to restrictive beliefs or discriminatory practices.

This shallow adaptation has been critiqued by Ghanaian scholars who argue that without addressing the gendered power relations embedded in family, school, and religious institutions, interventions only skim the surface of girls' lived experiences (44). In practice, many girls continue to face conflicting messages: encouraged to stay in school, but expected to hide menstruation, avoid public speaking, or skip school during their periods.

Moreover, the marginalization of girls with disabilities is often overlooked. In many communities, cultural beliefs associate disability with impurity, which can be intensified during menstruation. Only a handful of interventions have specifically addressed how girls with disabilities experience MHM stigma or facility exclusion (47).

4.4.3 Disruptive and Gender-Transformative Approaches

Despite these gaps, a few interventions in Ghana have begun to address gender and cultural norms more intentionally. Notably, some peer-led menstrual health clubs have gone beyond hygiene education to engage students, both girls and boys, in dialogue about stigma, gender roles, and respectful language around menstruation (48).

In the Volta Region, menstrual clubs led by adolescent girls created school-wide campaigns to challenge derogatory myths and reframe menstruation as a normal biological process. Teachers reported reduced teasing, and girls expressed more confidence in using WASH facilities without shame. These clubs also trained female students to engage school authorities on issues such as disposal infrastructure and pad availability (49).

Another promising example comes from Cape Coast, where girls with disabilities were trained to track their cycles and supported to lead school sanitation mapping exercises. This approach not only validated their lived experiences but re-positioned them as knowledge-holders in their schools. In this context, menstruation was linked to voice, autonomy, and inclusion, not merely hygiene (57).

A further innovation was reported in Amasaman, where MHM sessions included fathers and male teachers. Boys participated in role-plays that explored empathy and respectful support for

menstruating peers. Though limited in scale, such activities model a shift away from individual hygiene education toward social norm transformation (58).

These emerging practices suggest that when MHM interventions are co-designed with communities and explicitly aim to shift gender norms, they can begin to dismantle stigma and enhance girls' agency. However, such efforts remain the exception, not the norm. Most programmes still operate within a biomedical or WASH-centric frame, leaving deeper cultural engagement underdeveloped.

4.5 Case Analysis of Selected MHM Interventions in Ghana

To understand the extent to which existing interventions address adolescent girls' lived experiences, including gendered expectations and cultural taboos, this section critically analyses three selected MHM initiatives.

4.5.1 Global Communities Ghana: Inclusive MHM for Girls with Disabilities

This programme targeted adolescent girls with hearing and visual impairments in Cape Coast through a tailored menstrual hygiene intervention that included reusable pads, menstrual tracking tools, and training on menstrual self-care (47). Importantly, the intervention moved beyond product distribution to integrate girls into school sanitation decision-making.

Evaluation reports indicate that girls demonstrated improved confidence and ability to advocate for their needs in school. However, cultural taboos surrounding menstruation and disability remained a significant barrier. While the programme created temporary platforms for engagement, it lacked long-term institutionalization; there were no clear mechanisms for sustaining disability-inclusive WASH planning beyond the project lifecycle (47). While this intervention directly addressed the intersection of menstruation, disability, and exclusion, it had a limitation of a short project cycle and limited uptake into school governance structures.

4.5.2 Hope of Africa Hygiene Clubs (Greater Accra and Amasaman)

Hygiene clubs implemented in six public schools aimed to reduce stigma and promote gender-sensitive WASH practices by training girls to conduct sanitation audits, track their menstrual cycles, and lead peer education sessions (57). Unlike traditional health clubs, these were explicitly designed to disrupt stigma and encourage boys' participation in menstrual discussions.

Teachers reported reduced incidents of teasing and increased openness in classroom discussions about menstruation. Furthermore, three schools adopted menstrual product provision

and installed disposal bins based on girls' advocacy. However, the clubs' dependency on NGO facilitation raises questions about scalability and integration into the Ghana Education Service structure (57). This intervention fostered gender-transformative dialogue and supported peer-led advocacy. However, it heavily relied on external facilitation with uncertain sustainability.

4.5.3 Days for Girls Ghana: Social Enterprise Model

Days for Girls implemented a social enterprise model in the Ashanti and Volta regions, training local women to produce and distribute washable pads, coupled with menstrual health education (59). The intervention not only addressed product access but also aimed to foster economic empowerment and normalize menstruation through community engagement.

However, studies evaluating the initiative noted that while it improved girls' confidence in using reusable products, its impact on broader cultural norms such as silence or shame around menstruation was limited unless accompanied by deeper school or family engagement (59). In some cases, uptake was low due to persistent beliefs that menstruation should remain hidden. This intervention was economically empowering and contextually adapted product design.

CHAPTER FIVE: DISCUSSIONS

5.1 Introduction

This chapter interprets the key findings of the literature review in relation to findings from different contexts. It synthesizes how MHM practices in Ghana address gender and cultural norms, identifies where the literature aligns or departs from existing knowledge, and reflects critically on both methodological and theoretical implications. The discussion is structured around four main insights that emerged from the review, followed by sections on limitations and reflections on the conceptual framework used.

5.2 Discussion of Key Findings

This study reveals the profound influence of gender norms and cultural beliefs on MHM among in-school adolescent girls in Ghana. While infrastructural barriers remain significant, the findings reveal that many of the challenges girls face are rooted in sociocultural constructions of menstruation and in institutional environments that fail to challenge these norms. It showed how gender roles, cultural taboos, and institutional silences shape the design, delivery, and experience of MHM practices.

5.2.1. Menstruation as a Cultural Taboo and Gendered Silence

A central finding of this study is the persistence of menstruation-related stigma, which continues to construct menstruation as a subject of impurity, secrecy, and shame. Across both rural and urban settings, menstruation is treated as a private, almost illicit matter, reinforcing silence and limiting open discussion. This is consistent with research from Ethiopia and Bangladesh, where menstrual shame remains deeply internalized, contributing to school absenteeism, fear, and isolation (67,68).

Despite increased educational outreach, most interventions in Ghana continue to frame menstruation in biomedical or hygienic terms, failing to engage with its symbolic weight in gendered cultural systems. For instance, messages about menstruation in school health programmes rarely challenge the belief that menstruating girls are 'unclean' or that their participation in public life should be restricted during menstruation. This gendered construction of the menstruating body reinforces girls' marginality and perpetuates social norms that compromise their dignity and educational engagement.

By failing to confront these beliefs directly, MHM programmes risk becoming superficial, focusing on pad distribution or facility upgrades without addressing the structural roots of stigma. In contrast, culturally embedded programmes such as Nepal's community dialogue model, which

includes religious leaders and mothers in menstruation awareness, have shown promise in shifting community norms (69). Ghanaian interventions must similarly move beyond hardware to disrupt the gendered silence around menstruation at the household, school, and community levels.

5.2.2. Gendered Inequities in Infrastructure and Access

The unequal distribution of MHM resources across rural and urban schools in Ghana reflects not just economic disparity but gendered neglect in educational policy. While rural schools face more acute shortages of clean water, private changing areas, and disposal mechanisms, even urban schools often fail to provide safe and girl-friendly MHM environments. This is not simply a logistical issue; it speaks to a deeper institutional disregard for girls' bodily needs.

In most school planning processes, sanitation is designed without consultation with girls, and maintenance is delegated to under-resourced staff. This gender blindness in infrastructure design mirrors patterns in other settings like Tanzania and Uganda, where the absence of female voices in WASH planning has led to poorly located latrines, unusable disposal systems, and unsafe spaces (70,71).

Moreover, infrastructure alone does not translate into safe or dignified menstruation if it is not supported by institutional accountability and cultural sensitivity. In many cases, toilets become unsafe due to a lack of maintenance, and disposal systems go unused due to taboos around touching menstrual waste. These breakdowns are not technical failures; they are reflections of gendered and cultural discomfort with menstruating bodies, particularly in public institutions.

5.2.3. Gendered Exclusion from Decision-Making

Another dimension of gendered inequality identified in this study is the exclusion of girls from school-level decision-making about sanitation and health. Although many MHM programmes emphasize individual empowerment through education or peer support, very few offer structural avenues for adolescent girls to influence WASH planning or implementation.

Findings revealed the frustration girls experience when left out of decisions that directly affect their well-being. This absence of voice aligns with findings from Tanzania, Ethiopia, and Nepal, where girls' perspectives are routinely ignored in school governance structures (70,72). Even well-intentioned programmes that aim to increase awareness fail to institutionalize girls' participation, thereby reproducing hierarchical power structures where adult males or external donors define priorities.

By contrast, initiatives in India and Malawi that embedded girls into WASH committees and monitoring roles not only improved infrastructure outcomes but also shifted power dynamics, allowing girls to claim space within traditionally male-dominated school governance (73,74). These models demonstrate the potential of participatory approaches to challenge gendered marginalization and position adolescent girls as agents, not just beneficiaries, of MHM interventions.

5.2.4. Institutional Cultures and the Reproduction of Gender Norms

The study further reveals how institutional cultures within schools often reproduce, rather than resist, harmful gender norms. Teachers, particularly male staff, are frequently reluctant to engage with menstruation-related issues. In some cases, girls reported that they were discouraged from using toilets during class time or reprimanded for hygiene issues without support or understanding. This creates a climate of fear and shame that undermines girls' sense of safety and dignity.

Such responses reflect deeper institutional discomfort with menstruation and a broader failure to normalize it as a routine biological process. Without training and sensitization, school staff, regardless of gender, often perpetuate the very taboos that programmes aim to dismantle. This highlights the need for institutional transformation: policies that not only provide infrastructure but also require training, monitoring, and accountability mechanisms that challenge gender bias and support menstrual equity.

5.2.5. Beyond the Individual: Towards Structural and Cultural Change

Many MHM programmes remain focused on the individual distributing pads, teaching hygiene, or building self-confidence without addressing the structures that shape menstrual experiences. While individual knowledge is important, it is insufficient in the absence of cultural change and institutional reform. As this study shows, girls who are knowledgeable about menstruation still struggle if they lack access to facilities, support from teachers, or safe spaces to change at school.

A transformative approach to MHM in Ghana must therefore be both gender-responsive and culturally grounded. This means engaging traditional leaders, families, and school management in efforts to deconstruct harmful norms. It also requires embedding MHM within broader frameworks of adolescent sexual and reproductive health rights, educational policy, and gender equality commitments at national and district levels.

5.2.6 Case Analysis of Selected MHM Interventions in Other Contexts

Across LMIC, menstrual hygiene interventions have taken diverse forms, shaped by local needs and sociocultural dynamics. From curriculum reforms to community-driven models. In India, the *Kishori Shakti Yojana* integrated menstrual health into school curricula and trained teachers to deliver lessons sensitively, normalizing menstruation and improving girls' knowledge and confidence (60). Similarly, Kenya's National Menstrual Hygiene Management Policy (2019) led to free pad distribution in public schools, especially benefiting girls in marginalized regions by reducing absenteeism (61).

In Tanzania, the Maji Safi Group's participatory approach empowered communities to co-design WASH and MHM activities. Through school health clubs and improved sanitation, the programme fostered acceptance and likely contributed to better school attendance during menstruation (62). Malawi's *Keeping Girls in School* project trained girls to monitor school WASH conditions and report gaps, improving pad supply and challenging stigma through student-led accountability (63).

Kenya's *Inua Dada Foundation* supports local pad production by women's groups and distributes them to low-income girls via schools and clinics, boosting access and women's livelihoods (64). In Nepal, WaterAid's *Breaking the Silence* campaign used theatre and household dialogue to challenge taboos, reducing harmful practices like menstrual isolation (65). Moreover, Rwanda's adolescent-friendly clinics integrated menstrual health into outreach programmes, enhancing girls' help-seeking behaviors and confidence in managing menstruation (66). All these examples demonstrate the value of multi-sectoral, locally grounded interventions in promoting MHM practices and menstrual equity.

5.3 Strengths and Limitations of the Study

One of the key strengths of the reviewed literature is the diversity of geographical coverage, including studies from rural northern Ghana, peri-urban districts, and urban centers like Accra and Kumasi, which paint a broader picture of regional variation in access to WASH services and menstrual products, as well as cultural and gender dynamics.

There is also strength in multiple study designs, utilizing mixed-methods and participatory approaches, which allowed some researchers to combine quantifiable measures of school attendance or facility availability with deeper qualitative insights into girls' lived experiences. There is a recent study engaging girls with disabilities, a group often neglected in earlier MHM research. Moreover, some interventions demonstrate innovation in delivery, such as menstrual clubs,

community-led mapping, and inclusion of boys and men, providing valuable practice-based evidence for future scale-up

Several limitations must be acknowledged. First, the review was limited to peer-reviewed and grey literature published in English between 2014 and 2025. This may have excluded important community-based reports, policy briefs, or local language evaluations. Second, few studies offered long-term outcome data, limiting the ability to assess sustainability or normative shifts over time.

Additionally, there is a notable gap in longitudinal research. Most of the included studies provide snapshots of menstrual practices and attitudes at a single point in time, offering limited understanding of how norms evolve with repeated intervention exposure or how adolescent girls' agency changes over time. The voices of out-of-school girls, girls in humanitarian contexts, and those in informal urban settlements also remain marginal in current literature. Lastly, there is limited cross-study comparability due to variability in age groups, outcome measures, and definitions of 'adequate' hygiene. This inconsistency complicates national-level synthesis and impedes monitoring progress toward Sustainable Development Goal indicators on gender, health, and education.

The majority of the reviewed MHM research in Ghana remains descriptively rich but analytically shallow when it comes to interrogating the structural roots of menstrual inequities. Few studies adopt an explicitly feminist, rights-based, or sociological lens to question why menstruation remains silenced or why institutions fail to prioritize it. Gender is often mentioned as a variable rather than explored as a structural determinant of power, marginalization, and stigma (16,22). Likewise, culture tends to be treated as a static backdrop, a list of restrictive taboos, beliefs, and practices rather than as a dynamic and contested space that girls navigate strategically. For instance, while many studies report that menstruating girls face shame or teasing, fewer unpack the gendered socialization processes or school dynamics that produce and sustain these responses.

Moreover, many studies lacked critical reflexivity, especially around power dynamics in data collection, as none of them were youth/adolescent-led studies; instead, most of the studies that involved adolescents treated them as subjects. As such, the review relied on authors' interpretations, which may not fully reflect girls' lived experiences. Finally, most included studies used cross-sectional designs, making it difficult to trace changes in behavior or institutional responsiveness over time.

5.4 Reflections on the Conceptual Framework

This study utilized the Caruso et al. (2017) WASH-Gender Accountability Framework as its conceptual lens, appreciating its structured approach to examining gender norms, institutional actors, and accountability mechanisms within WASH systems. The framework proved particularly valuable in emphasizing the role of voice, decision-making, and resource distribution as critical domains of analysis relevant to MHM.

However, the application of the framework to the Ghanaian context also had limitations. While it successfully maps institutional and gendered dynamics, it offers limited guidance on how to assess the intersectionality of menstruation-related experiences especially across dimensions such as disability, ethnicity, religion, or socio-economic status. These factors are deeply interwoven with cultural norms that shape stigma, access, and perceptions of menstruation, yet they are insufficiently accounted for in the current structure of the framework.

Moreover, While the framework does address gender norms, it does not clearly focus on cultural beliefs and taboos. In Ghana, these cultural factors play a major role in shaping how menstruation is viewed often leading to silence, shame, and restrictions for girls. Adding a stronger cultural perspective, especially one that reflects local beliefs and practices, would make the framework more useful for understanding these challenges. Future versions of the framework could be improved by including ideas from feminist or intersectional theories, which would help capture the full range of experiences girls face, especially in diverse cultural settings

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This study revealed the persistent and multifaceted challenges that in-school adolescent girls in Ghana face in managing menstruation with dignity, safety, and confidence. While menstruation is a natural and routine biological process, the ability to manage it effectively remains a matter of social privilege shaped by gender norms, economic status, institutional responsiveness, and cultural belief systems. Across the reviewed evidence, it is evident that MHM is not merely a matter of product availability or infrastructure; it is profoundly embedded within the social and cultural fabric that defines girls' identities, freedoms, and sense of worth.

In particular, this review has shown how adolescent girls' experiences are often defined by silence, stigma, and shame. Even in contexts where some facilities or materials exist, many girls struggle with invisibility and marginalization shown by being excluded from decision-making processes and unsupported by teachers, parents, or policy structures. Efforts by government agencies, NGOs, and schools have undoubtedly made progress in raising awareness and introducing MHM-related programming, but most interventions remain surface-level and fragmented. Without challenging the deeper gendered and cultural norms that position menstruation as shameful or polluting, such efforts risk reinforcing the very exclusion they seek to address. Therefore, to ensure the well-being, educational continuity, and personal agency of adolescent girls in Ghana, MHM must be reimagined not just as a technical health issue but as a gender justice imperative, one that also critically engages with cultural norms and promotes inclusive practices.

6.2 Recommendations

6.2.1. For Policymakers: Institutionalize Menstrual Health as a National Priority

a) Integrate Menstrual Health into Education and SRHR Policy Frameworks

Menstrual hygiene should be fully integrated into Ghana's national education, adolescent health, and reproductive health policies. This includes the formal inclusion of menstrual health education in basic and secondary school curricula in the biology subject, complemented by national guidelines for menstrual product provision in schools. Moreover, policy must mandate regular teacher training and set minimum WASH infrastructure standards aligned with gender-responsive norms.

b) Establish Dedicated Budget Lines for MHM in School and Health Sector Plans

Menstrual health programmes cannot thrive without sustained financing. The Ministry of Education and the Ministry of Health should allocate dedicated resources for menstrual product procurement, WASH infrastructure maintenance, and MHM teacher training in annual budgets. These budget lines should be disaggregated by region to prioritize rural and underserved areas.

6.2.2. For School Actors: Create Safe, Inclusive and Supportive Learning Environments

a) Upgrade WASH Infrastructure with Girl-Centred Design

School heads, facility managers, and district education officers must ensure that school toilets are safe, clean, gender-segregated, and equipped with running water, soap, bins for disposal, and private changing areas. Design processes should actively involve adolescent girls in identifying needs and shaping infrastructure plans.

b) Institutionalize Girl Participation in School Governance

Schools should formally establish girl-led WASH clubs or menstrual health committees. These platforms should be empowered to monitor hygiene conditions, advocate for improvements, and engage school leadership with evidence-based feedback.

c) Foster a Positive Menstrual Culture in Schools

School actors, including both male and female teachers, should be equipped to promote open, respectful dialogue around menstruation. Activities like school-wide menstrual hygiene days, storytelling sessions, or mother-daughter clubs can break the culture of silence and shame.

6.2.3. For Public Health Practitioners: Bridge Gaps Between Community Norms and Menstrual Health Programming

a) Support Local Production and Distribution of Menstrual Products

Health-focused NGOs, health promotion officers, and SRHR champions should partner with women-led enterprises to locally produce reusable menstrual products and distribute them through schools and community clinics. Training on usage, cleaning, and disposal should accompany product distribution.

b) Conduct Community-Based Norm-Change Campaigns

Public health actors must work with traditional leaders, religious figures, and local influencers to dismantle harmful menstrual myths. Community dialogues, participatory theatre, and

intergenerational storytelling can encourage empathy and shared responsibility in supporting menstruating girls.

c) Integrate Menstrual Health into Adolescent-Friendly Services

Clinics and school health programmes must offer menstrual education as part of adolescent sexual and reproductive health services. Health workers should be trained to provide accurate, empathetic guidance on menstruation and recognize signs of menstrual distress, such as dysmenorrhea, reproductive infections, or psychosocial stress.

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APPENDIX

Appendix 1: Search table

		Population			Location
(“Menstrual products”) OR (“sanitary pads”) OR (toilets) OR (WASH) OR (income) OR (finance*) OR (safety) OR (violence prevention) OR (information) OR (knowledge) OR (social capital) OR (“Menstrual pad”) OR (“Menstrual cup”) OR (“Menstrual kits”)	AND	(Adolescent) OR (“in school girls”) OR (youths) OR (“Junior high school”) OR (“high school”) OR (School)	AND	(MHM)) OR (“menstrual hygiene management”) OR (Menstruation) OR (“menstrual hygiene”)	(Ghana) OR (West Africa) OR (Africa)
(“decision making”) OR (agency) OR (leadership) OR (autonomy) OR (empower*)	AND	(Adolescent) OR (“in school girls”) OR (youths) OR (“Junior high school”) OR (“high school”) OR (School)	AND	(MHM) OR (“menstrual hygiene management”) OR (Menstruation) OR (“menstrual hygiene”)	(Ghana) OR (West Africa) OR (Africa)
(MHM policies) OR (“institutional challenges”) OR (“Institutional support”) OR (“School environment”) OR (“Structural factors”) OR (“SRHR policies”)	AND	(Adolescent) OR (“in school girls”) OR (youths) OR (“Junior high school”) OR (“high school”) OR (School)	AND	(MHM) OR (“menstrual hygiene management”) OR (Menstruation) OR (“menstrual hygiene”)	(Ghana) OR (West Africa) OR (Africa)
(beliefs) OR (norms) OR (culture) OR (Gender) OR (taboos) OR (tradition) OR (stigma) OR (discrimination) OR (gender inequality)	AND	(Adolescent) OR (“in school girls”) OR (youths) OR (“Junior high school”) OR (“high school”) OR (School)	AND	(MHM)) OR (“menstrual hygiene management”) OR (Menstruation) OR (“menstrual hygiene”)	(Ghana) OR (West Africa) OR (Africa)