

Intergenerational Transmission of Menstrual Shame: A Qualitative Investigation of Parental Influence on Adolescent Menstrual Health Attitudes in Urban Ghana

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Abstract

This qualitative study examined how parents transmit menstrual health attitudes and knowledge to their adolescent daughters in urban Ghana through focus group discussions with 15 parents representing diverse socio-economic backgrounds and educational levels. Thematic analysis revealed four major themes: intergenerational transmission of menstrual shame despite improved hygiene practices, persistent influence of cultural and religious beliefs on menstrual attitudes, notable generational shifts in comfort levels with menstrual discussions, and evolving perspectives on male involvement in menstrual health education. Parents acknowledged transmitting the same shame and discomfort they experienced in their own adolescence, despite possessing better factual knowledge than previous generations. Cultural restrictions preventing menstruating girls from cooking, touching food, or participating in ceremonies remained firmly embedded across socio-economic levels, while religious beliefs imposed additional constraints on worship and spiritual activities. Parents expressed internal conflicts between maintaining traditional practices and adapting to modern health perspectives, using ancestral teachings to legitimize restrictive attitudes. However, parents also recognized that their daughters' generation demonstrates greater openness and comfort with menstrual topics compared to their own upbringing, though many admitted their personal discomfort continues despite intellectual acceptance of menstruation as normal. Educated urban parents increasingly supported teaching boys about menstruation to create supportive environments, while traditional attitudes maintaining menstruation as exclusively female knowledge persisted particularly in less educated populations. These findings illuminate the complex mechanisms through which cultural beliefs persist across generations even as health knowledge improves, highlighting the critical need for family-centered interventions addressing both parents' and daughters' attitudes simultaneously rather than focusing on adolescent education alone.

Keywords: *Adolescent Menstrual Health, Cultural Beliefs, Intergenerational Transmission, Parental Attitudes, Qualitative Research, Urban Ghana.*

Introduction

Menstrual hygiene management (MHM) represents a critical aspect of adolescent reproductive health that extends beyond individual hygiene practices to encompass complex social, cultural, and psychological

dimensions [1-3]. While substantial research has examined knowledge and practice patterns among adolescent girls [4-7], limited investigation has explored the mechanisms through which parents transmit attitudes, beliefs, and behavioral patterns regarding

menstruation to their daughters [15, 29]. The family environment serves as the primary context for initial menstrual health socialization, with parents playing critical roles in shaping how adolescent girls perceive and manage menstruation throughout their reproductive years [1, 15, 29].

In Ghana and across sub-Saharan Africa, menstruation remains subject to cultural taboos, religious restrictions, and social stigma that significantly influence adolescent girls' experiences and management practices [3, 9, 14, 25]. Traditional beliefs about menstrual impurity, contamination, and spiritual effects persist alongside modern health knowledge, creating complex environments where multiple belief systems coexist and compete [9, 14, 25]. Parents navigate these tensions as they guide their daughters through menarche and ongoing menstrual experiences, often transmitting contradictory messages that combine factual health information with culturally embedded attitudes and restrictions [3, 15].

Social Cognitive Theory emphasizes that health behaviors and attitudes develop through observational learning, modeling, and social reinforcement within family and community contexts [1, 15]. Parents serve as primary role models whose own attitudes, behaviors, and communication patterns profoundly influence how adolescent girls conceptualize menstruation and develop management strategies [1, 15]. The intergenerational transmission of menstrual attitudes occurs through both explicit instruction and implicit modeling, with daughters internalizing not only what parents say about menstruation but also how parents behave, what they avoid discussing, and which aspects they treat with shame or discomfort [10, 15, 16, 19].

Despite the recognized importance of parental influence in adolescent health behavior development [15, 29, 30], qualitative research examining parents' perspectives on menstrual health guidance remains limited in sub-Saharan African contexts [3, 9, 25]. Existing studies

have primarily focused on adolescent girls' experiences and perceptions [4-7, 13], with minimal exploration of how parents understand their roles, navigate cultural expectations, experience intergenerational change, and transmit attitudes to the next generation. This gap limits understanding of family-level dynamics that shape menstrual health outcomes and constrains development of effective family-centered interventions [29, 30].

This study addresses this critical gap through in-depth qualitative exploration of parental perspectives on menstrual health guidance in urban Ghana. The research examines how parents perceive their roles in menstrual health education, how they navigate tensions between traditional beliefs and modern health knowledge [14, 17, 25], how they transmit attitudes despite changing generational contexts, and how their own experiences shape the guidance they provide. Understanding these parental perspectives and transmission mechanisms provides essential insights for developing comprehensive interventions that address family-level attitudes and communication patterns rather than focusing exclusively on adolescent education [29, 30].

Materials and Methods

Study Design and Setting

This qualitative study employed focus group discussion methodology to explore parental perspectives on menstrual health guidance in the Greater Accra Region of Ghana [14]. The study was conducted as the qualitative component of a larger sequential explanatory mixed-methods investigation examining knowledge, attitudes, and practices in adolescent menstrual hygiene management. The Greater Accra Region was selected due to its demographic diversity encompassing urban, peri-urban, and semi-urban communities, providing opportunities to examine variations in parental perspectives across different socio-economic and geographic contexts [10, 13, 22].

Participant Selection and Recruitment

Participants were selected using purposive maximum variation sampling strategies designed to ensure representation of diverse parental characteristics, experiences, and perspectives [14]. Selection criteria included having at least one adolescent daughter aged 10-19 years who had experienced menarche, willingness to discuss menstrual health topics openly in group settings, and demographic diversity across educational levels, socio-economic status, residential locations, and family structures. Recruitment occurred through multiple channels including school administrators, community health centers, religious organizations, and community leaders

who identified potential participants meeting the selection criteria.

The final sample comprised 15 parents including 14 mothers and 1 father, reflecting the predominant pattern of mothers serving as primary providers of menstrual health guidance [3, 15]. Participant ages ranged from 38 to 52 years, with educational backgrounds spanning no formal education (n equals 3), primary education (n equals 3), junior high school (n equals 3), senior high school (n equals 4), and tertiary education (n equals 2). Residential locations included urban (n equals 7), peri-urban (n equals 5), and rural areas (n equals 3) (Table 1). All participants provided informed consent and were assured of confidentiality and anonymity in reporting.

Table 1. Participant Demographic Characteristics

Characteristic	Frequency (n=15)
Gender	
Mothers	14
Fathers	1
Education Level	
No Formal Education	3
Primary Education	3
Junior High School	3
Senior High School	4
Tertiary Education	2
Residential Location	
Urban	7
Peri-urban	5
Rural	3

Source: Field Survey (2025)

Data Collection Procedures

Data were collected through three focus group discussions with 4-6 participants each, organized to facilitate comfortable discussion among parents with similar socio-demographic characteristics [14]. Focus groups were conducted in community centers and school facilities providing private, quiet spaces conducive to open discussion. Each focus group discussion lasted 90-120 minutes and was conducted in English with occasional use of local languages when participants preferred

expressing certain concepts in their native tongue.

A semi-structured discussion guide developed based on theoretical frameworks [1, 2] and literature review [3, 9, 14] facilitated exploration of key topics while allowing flexibility to pursue emerging themes. The guide addressed five main areas: parental experiences and attitudes regarding their own menstrual health education and management, current approaches to discussing menstruation with daughters, cultural and religious beliefs

influencing guidance provision [9, 14, 19, 25], challenges and barriers encountered in providing menstrual health education, and perceptions of generational changes in menstrual health attitudes and practices. The research team included trained qualitative researchers experienced in facilitating sensitive health discussions.

All focus group discussions were audio recorded with participant permission and supplemented by detailed field notes documenting nonverbal communication, group dynamics, and contextual observations [14]. Recordings were transcribed verbatim by professional transcriptionists, with transcript accuracy verified through comparison with audio recordings and field notes. Non-English segments were professionally translated to English with back-translation procedures ensuring accuracy and cultural authenticity.

Data Analysis

Qualitative data analysis followed Braun and Clarke's six-phase thematic analysis approach [12] utilizing NVivo 14.0 software to manage and organize data systematically. The analysis process began with data familiarization through repeated reading of transcripts and review of field notes to develop comprehensive understanding of content, patterns, and meanings. Initial coding involved systematic line-by-line analysis identifying meaningful units of data and assigning descriptive codes capturing content and meaning. This process incorporated both deductive codes derived from theoretical frameworks [1, 2] and inductive codes emerging organically from data content [12].

Theme development involved organizing codes into broader conceptual categories capturing patterns of meaning across the dataset [12]. This process included examining relationships between codes, identifying higher-order themes encompassing multiple related codes, and developing thematic maps illustrating connections between themes and

subthemes. Theme review and refinement involved systematic checking of themes against coded data and the entire dataset ensuring themes accurately represented data content and provided coherent distinct analytical categories [12]. Final theme definition involved developing clear names and descriptions capturing essence and scope of each theme while ensuring themes worked together to provide comprehensive understanding of research questions.

Quality assurance followed established criteria for trustworthy qualitative research [13] including prolonged engagement, persistent observation, member checking, audit trails, reflexivity practices, and triangulation across multiple data sources and analytical perspectives. Two researchers independently coded selected transcripts with comparison and discussion of coding decisions ensuring consistency and comprehensiveness in analytical interpretations [13, 14].

Ethical Considerations

Ethical approval was obtained from the Institutional Review Board prior to data collection. All participants provided informed consent after receiving detailed information about study purposes, procedures, potential risks and benefits, confidentiality protections, and rights to withdraw participation at any time without consequences. Participants' identities were protected through use of pseudonyms and demographic descriptors rather than identifying information in reporting findings. Audio recordings and transcripts were stored securely with access limited to the research team.

Results

Thematic analysis of focus group discussions with parents revealed four major themes illuminating the complex mechanisms through which menstrual health attitudes, beliefs, and practices are transmitted across generations in urban Ghana [12]. These themes demonstrate persistent tensions between

traditional cultural beliefs and modern health knowledge [9, 14, 25], revealing how parents simultaneously transmit shame and improved hygiene practices, navigate religious and cultural restrictions, recognize generational shifts while maintaining personal discomfort, and grapple with evolving perspectives on gender inclusivity in menstrual health education [27].

Intergenerational Transmission of Menstrual Shame

The first and most pervasive theme revealed how parents explicitly recognize that they transmit the same feelings of shame and embarrassment about menstruation to their daughters that they experienced in their own adolescence, despite simultaneously teaching improved hygiene practices and factual biological knowledge [1, 15]. This intergenerational transmission occurs through both conscious instruction and unconscious modeling [1, 15, 16], creating contradictions where daughters receive messages that menstruation is natural while simultaneously learning to hide, conceal, and feel embarrassed about their menstrual status.

Parents demonstrated awareness of this transmission pattern through reflective acknowledgment of how their own upbringing shaped current guidance approaches. A 38-year-old mother with no formal education from a rural area articulated this pattern clearly:

"Menstruation is something private and a bit shameful. I was taught this by my mother, and now I see my daughter has learned the same attitude from me. When she started menstruating, I told her this is something women go through but we don't talk about it openly. She has absorbed this lesson. She is very secretive about her period now, just like I am." (38 years, No formal education, Rural)

This transmission manifested through specific behavioral modeling around menstrual

product management and discussion patterns [5, 18]. Parents acknowledged teaching daughters to hide menstrual products, speak in whispers when mentioning menstruation, and maintain secrecy about their menstrual status even within family contexts. A 40-year-old mother with primary education from a rural area explained:

"My daughter feels ashamed when she goes to buy pads at the store. She says she feels like everyone is looking at her and judging her. I understand this feeling because I still feel that way too when I buy pads for myself. Sometimes I send her father to buy them so we don't have to face the shopkeeper. It's just uncomfortable." (40 years, Primary, Rural)

Parents provided detailed descriptions of how they model concealment behaviors that daughters subsequently adopt [1, 15]. A 42-year-old mother with junior high school education from a semi-urban area elaborated:

"Even though pads are just a hygiene product like soap or toothpaste, buying them feels different. When I go to the pharmacy with my daughter, she whispers to me to buy pads instead of speaking out loud. She wraps them quickly and hides them in her bag. I don't correct her because I do the same thing. We both feel embarrassed about it, and I think this is normal for women." (42 years, JHS, Semi-urban)

This transmission pattern persisted even among educated parents who intellectually understood menstruation as a normal biological process [5, 18, 28]. Parents acknowledged contradiction between the facts they taught and the attitudes they modeled, revealing how deeply embedded shame operates independently of biological knowledge. The pattern demonstrated how effective hygiene practices can coexist with persistent shame-based attitudes, with parents successfully

teaching daughters proper hygiene procedures while simultaneously transmitting emotional discomfort and social embarrassment about menstruation.

Cultural and Religious Influences on Menstrual Attitudes

The second major theme highlighted the persistent and powerful influence of cultural and religious beliefs on menstrual attitudes across generations [9, 14, 25], shaping both parents' guidance approaches and daughters' experiences. Parents articulated specific traditional restrictions limiting menstruating girls' activities based on beliefs about menstrual contamination, spiritual impurity, and cultural propriety. These restrictions operated across diverse socio-economic levels and educational backgrounds, though their specific manifestations varied by family context [14, 25].

Cultural restrictions centered primarily on food preparation and consumption practices [9, 14]. A 46-year-old mother with no formal education from a semi-urban area explained traditional prohibitions firmly embedded in family practice:

"In our culture, when my daughter is menstruating, she cannot enter the kitchen or touch food that others will eat. This is our tradition passed down from our ancestors. She knows this rule and follows it without question. During those days, she stays away from the cooking area and eats separately. This is how we respect our culture and maintain purity in our home." (46 years, No formal education, Semi-urban)

Additional cultural restrictions extended to social participation and family ceremonies [9, 14, 25]. A 50-year-old mother with primary education from a rural area described comprehensive activity limitations:

"There are many things my daughter cannot do during her period according

to our customs. She cannot touch newborn babies because the menstrual blood is considered unclean. She cannot participate in family ceremonies or important events. She cannot even sit on certain furniture in the house. These rules may seem strict, but they are our cultural beliefs that have existed for generations." (50 years, Primary, Rural)

Religious beliefs imposed parallel restrictions on worship and spiritual activities, particularly within Islamic and some Christian denominations [9, 25]. A 42-year-old mother with junior high school education from an urban area explained religious teachings about menstrual impurity:

"Our religion teaches that when my daughter is on her period, she cannot pray or enter the mosque. She is considered temporarily impure and cannot participate in religious activities until her menstruation ends and she performs the cleansing ritual. This is not punishment but part of our faith. My daughter understands and accepts these religious rules even though she wishes she could pray with us." (42 years, JHS, Urban)

A 45-year-old mother with secondary education from a peri-urban area elaborated on religious restrictions affecting spiritual participation [9, 25]:

"During menstruation, my daughter cannot touch the Quran or participate in religious studies at the mosque. She must stay home during prayer times on those days. At first, she was confused about why menstruation affects her relationship with God, but I explained this is what our religion teaches. She has accepted it now, though sometimes I see she feels excluded from our spiritual life during those days." (45 years, Secondary, Peri-urban)

Parents expressed internal tensions between maintaining traditional practices and adapting to modern health perspectives [5, 14, 25]. Many acknowledged awareness of alternative viewpoints but felt compelled to preserve ancestral teachings despite potential conflicts with health information. A 48-year-old mother with primary education from a rural area articulated this tension:

"I know times are changing and young people have different ideas about menstruation now. At the health center, they tell us menstruation is natural and girls should not be restricted. But I still follow what my grandmother taught me about keeping girls separate during their period. It's difficult to abandon these teachings even when I hear modern information. Our traditions are important to us." (48 years, Primary, Rural)

Even highly educated parents acknowledged struggling with competing belief systems [15, 25]. A 43-year-old mother with senior high school education from an urban area expressed similar internal conflict:

"I am educated and I understand the scientific facts about menstruation. I know the blood is not really dirty or impure. But at the same time, I was raised with certain beliefs and practices that are hard to let go. So with my daughter, I try to teach her both the modern understanding and the traditional rules. Sometimes these two approaches contradict each other, and I'm not sure which one is right." (43 years, SHS, Urban)

Parents used ancestral teachings and cultural continuity as justification for maintaining restrictive practices despite awareness of alternative perspectives [14, 15]. A 52-year-old mother with no formal education from a rural area emphasized the importance of preserving intergenerational tradition:

"These restrictions on menstruating girls have been practiced in our family for many, many generations. My great-grandmother taught my grandmother, who taught my mother, who taught me. Who am I to break this chain? These traditions exist for a reason, and we must respect them. If we abandon our cultural practices, we lose our identity and connection to our ancestors." (52 years, No formal education, Rural)

Generational Shifts in Comfort and Openness

The third theme revealed notable generational shifts in comfort levels and communication openness regarding menstrual health [5, 18, 21], with parents recognizing that their daughters' generation demonstrates substantially greater ease discussing menstruation compared to their own upbringing. This recognition occurred across educational and socio-economic levels, suggesting widespread awareness of changing social norms around menstrual health discourse. However, parents simultaneously acknowledged that their personal discomfort persists despite intellectual acceptance of these positive changes [15, 16].

Parents observed and often appreciated the increased openness among contemporary adolescents [18, 21]. A 39-year-old mother with senior high school education from an urban area described this generational difference:

"My daughter and her friends talk freely about their periods. They discuss which pads are best, when they started, how they feel during menstruation. They even joke about it sometimes. We could never do that in my time. Menstruation was whispered about in secret, and we were too ashamed to mention it even among ourselves. I see this openness in the young generation and I think it's actually healthy." (39 years, SHS, Urban)

Educational institutions contributed significantly to this generational shift through formal health education curriculum [5,26]. A 40-year-old mother with tertiary education from an urban area noted:

"In school, my daughter learns about menstruation in biology class. Her teachers explain it openly, and the students ask questions freely. This is very different from my experience where no teacher ever mentioned menstruation. The girls learn together with boys about the menstrual cycle. I think this openness helps remove shame and makes menstruation feel more normal for this generation." (40 years, Tertiary, Urban)

Despite recognizing and sometimes appreciating increased openness among youth, many parents admitted their own discomfort continues [15, 16]. A 41-year-old mother with junior high school education from a semi-urban area confessed:

"I try to be open with my daughter about menstruation. I want her to feel comfortable asking me questions. But honestly, I still feel uncomfortable talking about some things. When she asks detailed questions about menstrual blood or her body changes, I feel awkward and don't know how to answer properly. My own upbringing makes it hard for me to discuss these topics naturally." (41 years, JHS, Semi-urban)

A 44-year-old mother with secondary education from a peri-urban area expressed similar struggles between intentions and behaviors [15]:

"Even though I tell my daughter that menstruation is natural and nothing to be ashamed of, I realize my behavior doesn't always match my words. I still hide my own pads, I whisper when talking about periods, and I become uncomfortable when the topic comes up

in public. My daughter notices this contradiction. She sees that I'm not as comfortable as I claim to be." (44 years, Secondary, Peri-urban)

Parents identified a critical gap between cognitive understanding and emotional comfort [15, 16]. A 47-year-old mother with tertiary education from an urban area reflected on this knowledge-attitude disconnect:

"I have read books and attended health talks about menstruation. Intellectually, I understand it's a normal biological process that should not carry shame. But emotionally, I still carry the shame I learned as a girl. So when I teach my daughter, I can give her the right information, but I cannot fully give her the attitude of confidence and openness I want her to have. There is a disconnect between my knowledge and my feelings." (47 years, Tertiary, Urban)

This theme demonstrated that generational change in menstrual attitudes occurs gradually, with knowledge and behavioral patterns shifting more rapidly than deeply embedded emotional responses and comfort levels [15, 18]. Parents recognized their daughters' generation as transitional, experiencing less shame than previous generations while not yet achieving complete comfort and openness. Parents acknowledged their own limitations as role models, understanding that their persistent discomfort constrains their ability to fully support their daughters' development of shame-free menstrual attitudes despite possessing improved knowledge [15, 16].

Changing Gender Perspectives on Menstrual Health

The fourth theme highlighted evolving perspectives on male involvement in menstrual health education [27], revealing substantial variation in attitudes ranging from progressive gender-inclusive approaches to traditional gender-segregated frameworks. These

divergent perspectives correlated strongly with parental education levels and geographic locations, with educated urban parents more likely to support male education while less educated rural parents maintained traditional exclusionary approaches [14, 27].

Progressive parents, particularly those with higher education and urban residence, articulated strong support for educating boys about menstruation [27]. A 45-year-old mother with tertiary education from an urban area explained the rationale for male inclusion:

"I think boys should learn about menstruation in school so they can support their sisters, friends, and future wives. When boys understand what girls go through during menstruation, they become more sympathetic and helpful. My husband knows about menstrual health, and he buys pads for our daughter without embarrassment. I want my sons to be the same way. Menstruation affects half the population, so everyone should understand it." (45 years, Tertiary, Urban)

Another urban mother with senior high school education supported gender-inclusive education based on school experiences [26, 27]:

"In my daughter's school, boys and girls learn about menstruation together in their health education class. I support this approach. Boys need to know that menstruation is natural, not shameful or dirty. When boys are educated, they don't tease girls about periods or make them feel bad. They understand it's just a normal part of life. This creates a more supportive environment for everyone." (42 years, SHS, Urban)

In contrast, traditional attitudes maintaining menstruation as exclusively female knowledge persisted strongly among less educated parents, particularly in rural areas [14, 27]. A 43-year-

old mother with primary education from a rural area firmly stated:

"Menstruation is women's business. Men don't need to know about it. It's not for them to understand or discuss. In our culture, these things stay among women. My husband doesn't know when I am menstruating, and he doesn't need to know when our daughter is menstruating either. This is private female matters that should remain private." (43 years, Primary, Rural)

Another rural mother with no formal education expressed similar exclusionary views [14]:

"Why should boys learn about menstruation? It doesn't concern them. When my daughter started menstruating, I taught her, and my mother helped. Men have no role in this. If we start teaching boys about periods, it will make girls embarrassed and uncomfortable. Some things should stay separate between males and females. This has always been our way, and it should continue." (48 years, No formal education, Rural)

The contrast between progressive and traditional gender perspectives revealed clear patterns related to education and location [14, 26, 27]. A 46-year-old mother with tertiary education from an urban area observed:

"I notice that educated families in urban areas are more open to teaching boys about menstruation, while traditional families in rural areas keep it strictly among women. Education makes a difference in how we think about these things. When you understand the biology and health aspects, you see menstruation differently and you want everyone, including boys, to have accurate information." (46 years, Tertiary, Urban)

This theme demonstrated ongoing transitions in gender norms regarding menstrual health knowledge and support [27]. While traditional gender-segregated approaches remain dominant in many contexts, educated urban populations increasingly embrace gender-inclusive frameworks recognizing male education as beneficial for creating supportive environments and challenging stigma. The persistence of exclusionary attitudes in less educated populations suggests that changing gender norms around menstrual health requires not only health education but broader educational advancement and urbanization processes that shift cultural frameworks [14, 26, 27].

Discussion

This qualitative investigation provides critical insights into the complex mechanisms through which parents transmit menstrual health attitudes, beliefs, and practices to their adolescent daughters in urban Ghana. The findings reveal that intergenerational transmission operates through multiple simultaneous pathways including explicit instruction, behavioral modeling, cultural practice maintenance, and emotional communication, often conveying contradictory messages that combine improved factual knowledge with persistent shame-based attitudes [1, 15, 16, 24].

The intergenerational transmission of menstrual shame despite improved hygiene knowledge represents the most striking and problematic finding. Parents demonstrated remarkable self-awareness about transmitting the same emotional discomfort they experienced yet felt unable to break this pattern despite intellectual understanding of menstruation as normal [15, 16]. This phenomenon aligns with Social Cognitive Theory's emphasis on observational learning and modeling [1], whereby daughters internalize not only explicit teachings but also implicit attitudes conveyed through parents'

behaviors, emotional reactions, and communication patterns. The persistence of shame across generations despite knowledge improvement suggests that attitudinal change requires more than factual education; it necessitates addressing deeply embedded emotional and social conditioning that operates independently of cognitive understanding [2, 15].

The finding that parents successfully teach proper hygiene practices while simultaneously transmitting shame challenges simplistic assumptions about attitude-behavior relationships [2]. This pattern demonstrates that behavioral competence and emotional comfort represent distinct dimensions that do not necessarily develop in parallel. Parents can effectively teach daughters what to do during menstruation while failing to convey that menstruation is nothing to be ashamed of [5, 18]. This disconnect has important implications for intervention design, suggesting that programs must explicitly address attitudinal dimensions rather than assuming that teaching proper practices automatically builds positive attitudes [2, 5].

The persistent influence of cultural and religious beliefs across generations illuminates the power of traditional frameworks in shaping menstrual attitudes despite modernization and health education [9, 14, 25]. The finding that restrictions on food preparation, ceremony participation, and religious activities remain firmly embedded across socio-economic levels challenges assumptions that education automatically displaces traditional beliefs. Instead, the data suggest that traditional and modern belief systems coexist in complex configurations, with educated parents often attempting to honor both frameworks simultaneously despite their contradictions [14, 25].

Parents' use of ancestral teachings to legitimize maintaining restrictive practices reveals how cultural continuity and intergenerational identity operate as powerful

motivators for preserving traditional beliefs even when alternative perspectives become available [14, 15]. The statement that abandoning traditional practices would break intergenerational chains and disconnect families from ancestral heritage demonstrates how menstrual restrictions function not merely as isolated beliefs but as integral components of cultural identity and family continuity. This finding suggests that interventions challenging traditional menstrual restrictions must carefully navigate cultural sensitivity and identity concerns rather than simply dismissing traditional beliefs as superstition [9, 14, 25].

The recognition of generational shifts in comfort and openness provides some optimism about gradual attitudinal change over time [18, 21]. Parents' observations that their daughters' generation demonstrates substantially greater ease discussing menstruation suggests that social norms are evolving, likely driven by formal education [26], peer communication, and broader social changes reducing gendered shame. However, the persistence of parental discomfort despite recognizing these positive changes demonstrates that generational shifts occur slowly and unevenly, with knowledge and behavioral patterns changing more rapidly than deeply embedded emotional responses [15, 16].

The knowledge-attitude disconnect articulated by educated parents particularly highlights the challenge of translating intellectual understanding into emotional comfort [15, 16]. Parents acknowledged possessing scientific knowledge about menstruation as normal biology while simultaneously experiencing persistent shame rooted in childhood socialization. This pattern validates psychological research demonstrating that emotional conditioning established during childhood often persists despite later cognitive learning, requiring specific interventions targeting emotional reconditioning rather than merely providing factual information [2, 15].

The divergent perspectives on male involvement in menstrual health education reveal ongoing negotiations between traditional gender frameworks and emerging inclusive approaches [8, 24, 27]. The strong correlation between education level, geographic location, and support for male education suggests that changing gender norms around menstruation requires not only targeted interventions but broader social transformations including educational advancement and urbanization [14, 26, 27]. The finding that educated urban parents increasingly support male education based on practical benefits including reduced teasing, increased support, and normalized discourse provides compelling rationales for gender-inclusive approaches [27].

However, the persistent exclusionary attitudes among less educated populations demonstrate that traditional gender segregation around menstruation remains deeply embedded in many contexts [14, 27]. The framing of menstruation as women's business that men should not understand reflects broader gender frameworks where certain knowledge domains remain gender-restricted. Challenging these frameworks requires sensitivity to how menstrual education intersects with larger questions of gender roles, family privacy, and cultural authenticity [9, 14].

These findings have critical implications for intervention design [29, 30]. The demonstration that parents transmit shame despite improved knowledge suggests that family-centered interventions must address parents' own attitudes alongside daughters' education. Programs targeting only adolescent girls while ignoring parental attitudes may have limited effectiveness because parents continue modeling shame-based behaviors regardless of what daughters learn in educational settings [15, 29]. Effective interventions should engage both generations simultaneously, helping parents recognize and address their own internalized shame while supporting daughters' development of shame-free attitudes [29, 30].

The persistence of cultural and religious restrictions suggests that interventions must engage with traditional belief systems rather than dismissing them [9, 14, 25]. Culturally sensitive approaches might involve dialogue with religious leaders about interpretations of religious teachings, exploration of cultural practices that honor tradition while promoting health, and respectful discussion of how traditional beliefs can coexist with modern health knowledge. Interventions adopting confrontational approaches that directly challenge cultural identity and ancestral teachings risk backlash and rejection [14, 23, 25].

The generational shift toward greater openness suggests that supporting institutional changes in schools, religious organizations, and community structures can accelerate attitudinal change at population levels [18, 26]. Formal education systems incorporating comprehensive menstrual health education with gender-inclusive approaches appear to contribute substantially to reducing shame and normalizing menstrual discourse [26, 27]. Supporting and expanding such programs while simultaneously engaging parents can create synergistic effects where institutional and family-level changes reinforce each other [29, 30].

Study limitations include the focus on urban and peri-urban contexts limiting generalizability to rural populations where traditional beliefs may be even more firmly embedded [11, 13, 14]. The predominance of mothers in the sample reflects typical family patterns but limits understanding of paternal perspectives on menstrual health guidance [27]. The qualitative design provides rich insights into mechanisms and meanings but cannot quantify the prevalence of different perspectives across broader populations [12, 14]. Future research should examine paternal perspectives [20, 27], include substantial rural samples [13], and employ mixed-methods

approaches combining qualitative depth with quantitative prevalence estimation.

Conclusion

This qualitative investigation reveals that parents transmit complex and often contradictory messages about menstruation to their daughters, combining improved factual knowledge with persistent shame-based attitudes, cultural restrictions, and emotional discomfort [1, 9, 14, 15]. The intergenerational transmission of menstrual shame operates through both explicit instruction and implicit behavioral modeling [1, 15, 16], with parents demonstrating remarkable awareness of perpetuating patterns they experienced while feeling unable to break these cycles despite intellectual understanding. Cultural and religious beliefs continue exerting powerful influence across generations and socio-economic levels [9, 14, 25], with parents using ancestral teachings to legitimize maintaining restrictive practices even as they acknowledge tensions with modern health perspectives. Generational shifts toward greater openness provide optimism about gradual attitudinal change [18, 21], though parental discomfort persists despite recognition of positive changes among youth. Divergent perspectives on male involvement reflect ongoing negotiations between traditional gender frameworks and emerging inclusive approaches [27, 11], with education and urbanization correlating with progressive attitudes. These findings demonstrate that effective interventions must address family-level dynamics and parental attitudes rather than focusing exclusively on adolescent education [29, 30]. Family-centered approaches engaging both parents and daughters simultaneously, addressing internalized shame and cultural beliefs while respecting identity concerns, and supporting institutional changes in schools and communities offer the greatest potential for transforming menstrual health attitudes across

generations in urban Ghana and similar contexts.

Conflict of Interest

The authors declare that there is no conflict of interest regarding the publication of this article.

Ethical Approval

Ethical approval was obtained from the Institutional Review Board prior to data collection. All participants provided informed consent after receiving detailed information about study purposes, procedures, potential risks and benefits, confidentiality protections, and rights to withdraw participation at any time without consequences. Participants' identities were protected through use of pseudonyms and demographic descriptors rather than identifying information in reporting findings. Audio recordings and transcripts were stored securely with access limited to the research team.

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Data Availability

The datasets generated and analysed during the current study are not publicly available due to confidentiality and privacy obligations to the study participants. However, the data that support the findings of this study are available from the corresponding author upon reasonable request.

Author Contributions

All authors contributed equally to this work. All authors have read and approved the final version of the manuscript.

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