Houston Area Model United Nations
Standard Committee

WHO

Chair | Shriya Reddy
Topic A: Addressing Barriers to Menstrual and Reproductive Health Care in Sub-Saharan Africa
Houston Area Model United Nations 51

Chair Letter

Dear Delegates,

Welcome to the 51rst Annual Houston Area Model United Nations Conference. I am so excited to welcome you all and look forward to an engaging and meaningful weekend of discussion and collaboration. My name is Shriya Reddy, and I am honored to serve as your Chair for the World Health Organization committee.

I am a sophomore at the University of Texas at Austin, majoring in Philosophy with a minor in Business, and I am on the pre-law track. Outside of academics, I love spending time with my friends and family, reading and writing, watching shows and movies, and love all things makeup and beauty. I try to implement and enjoy creativity in my daily life!

Model United Nations has been a huge part of my life since high school, and my love for it has only grown over the years. Chairing this committee truly means a lot to me, and I am so excited to help create a welcoming, thoughtful, and collaborative space for all of you.

The topic we will be discussing addresses important global health challenges that require cooperation, empathy, and innovative thinking. I encourage you to approach committee with confidence, curiosity, and an open mind. Some of the best ideas come from working together and learning from one another.

Please do not hesitate to reach out if you have any questions, concerns, or just need support during the conference. I genuinely want this to be a positive and rewarding experience for everyone. I cannot wait to see your ideas and diplomacy in action, and I wish you all the very best of luck this weekend.

Sincerely,

Shriya Reddy

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WHO
Chair | Shriya Reddy
Houston Area Model United Nations 51
February 5-6, 2026

Topic Overview

INTRODUCTION

Menstrual and reproductive health care are fundamental to public health, gender equality, and human dignity. In Sub-Saharan Africa, millions of women and girls continue to face entrenched barriers that prevent reliable access to menstrual products, safe sanitation, reproductive health services, and accurate education. These failures undermine health outcomes, exacerbate gender inequality, limit educational and economic opportunity, and entrench cycles of poverty and marginalization. The effects extend beyond physical health, touching mental well-being, social participation, and community development.

Although progress has been made through national policy reforms and international partnerships, these barriers persist in many forms and require comprehensive, culturally informed, and sustainable interventions to ensure that all women and girls can manage menstruation and access reproductive health care with dignity, confidence, and safety.

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HISTORY

Health systems in Sub-Saharan Africa have been shaped by colonial history and global inequalities. During the colonial period, investment in local health infrastructure was uneven and often prioritized colonial administrative needs over community-oriented care, particularly for women's health and preventive services. Traditional knowledge systems around menstruation and reproductive health were sidelined, contributing to long-lasting gaps in culturally relevant health education.

To guide this process, the UN created the Trusteeship System, which built on the earlier League of Nations Mandate System. Territories placed under UN trusteeship were monitored by the Trusteeship Council, ensuring progress toward independence or free association.

In the decades following independence, many states have struggled to build robust health systems due to economic constraints, political instability, and inequitable resource distribution. Weak infrastructure, shortages of health professionals, and limited investment in reproductive health services have perpetuated inequalities. These structural conditions compound social and cultural barriers, making menstrual health and reproductive care access especially difficult for adolescents, rural populations, and those living in poverty.

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SOCIOECONOMIC AND CULTURAL BARRIERS

Stigma and Social Norms

Deeply rooted cultural beliefs and stigma surrounding menstruation persist across many communities in Sub-Saharan Africa. Menstruation is frequently viewed as unclean or shameful, creating powerful incentives for silence. In contexts where menstruation is not openly discussed, girls and women lack accurate information before menarche, leading to confusion, fear, and shame when menstruation begins. Studies in Uganda, for example, reveal that cultural restrictions associated with menstrual blood and taboos on hygiene practices can negatively impact self-esteem and social participation

Period Poverty and Poverty-Related Vulnerabilities

Period poverty — the inability to afford menstrual products and necessary sanitation — remains widespread. In Zambia, research illustrates that menstrual poverty affects learners in both urban and rural schools, with disparities in product access and associated health risks. In Kenya, a substantial proportion of adolescent girls cannot afford preferred menstrual products, and many lack access to water and soap necessary for proper menstrual management at school. Economic hardship leads some girls to resort to unsafe materials or, in extreme instances, exploitative means to obtain products, further exposing them to physical and social harm.

INFRASTRUCTURE, EDUCATION, AND WASH CHALLENGES

Sanitation and Water Systems

Access to water, sanitation, and hygiene (WASH) facilities is vital for effective menstrual hygiene management. However, recent WHO data show that only about one in ten schools in Sub-Saharan Africa provides menstrual materials or facilities that support private, safe menstruation management. Comprehensive reviews indicate that less than half of schools in rural areas have adequate sanitation facilities, and far fewer offer private spaces for menstrual management.

Schools without reliable water and soap force many girls to miss school during their menstrual periods, which can have cumulative negative effects on educational outcomes.

Educational Gaps

The lack of comprehensive menstrual education exacerbates stigma and misinformation. Many girls reach puberty without prior knowledge of menstruation, impacting their preparedness and mental health. This gap is mirrored in broader reproductive health education, where curricula often emphasize abstinence or omit critical information on contraception, sexually transmitted infections (STIs), and reproductive rights, particularly in adolescent health programs.

REPRODUCTIVE HEALTH SYSTEM CHALLENGES

Reproductive health services in Sub-Saharan Africa are frequently underfunded and understaffed. Rural clinics often lack trained personnel, adolescent-friendly services, or essential supplies, while social stigma deters many young women from seeking care. Barriers such as lack of confidentiality, judgmental attitudes, and restrictive policies further limit access to necessary services including family planning and safe childbirth care. These systemic gaps contribute to persistently high rates of maternal mortality, unintended pregnancy, and preventable reproductive health complications.

POPULATION-SPECIFIC CHALLENGES

Adolescents

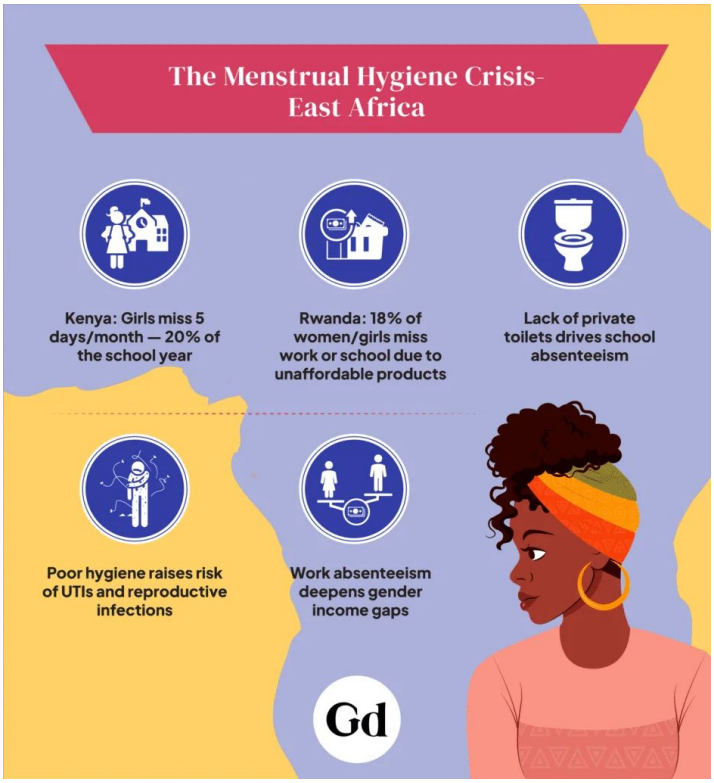
Adolescent girls are particularly disadvantaged by intersecting barriers. Limited menstrual education, school infrastructure deficits, and social stigma contribute to high absenteeism and dropout rates. These educational disruptions reduce future employment opportunities and perpetuate gender disparities in socioeconomic outcomes..

Displaced Populations

Women and girls in refugee or internally displaced person (IDP) settings encounter severe barriers to menstrual and reproductive health care. Research in displacement contexts reveals that lack of access to menstrual products, safe water, and privacy intensifies physical and psychological hardships.

Women with Disabilities

Women with disabilities face multidimensional barriers, including physical inaccessibility of facilities, lack of tailored services, and societal discrimination. These obstacles increase vulnerability to infections and restrict participation in community life, including education and employment.



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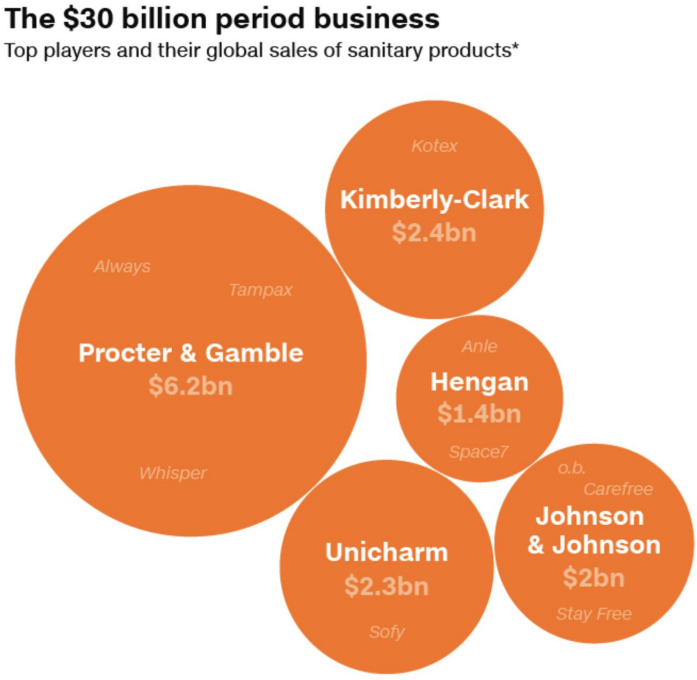
KEY STATISTICS AND RESEARCH FINDINGS

A multilevel analysis across six Sub-Saharan African countries found that more than half of women of reproductive age have an unmet need for menstrual hygiene management, with prevalence highest in Burkina Faso and Ethiopia.

Menstrual hygiene practice among adolescent girls in the region is low, with pooled prevalence of good practices estimated at around 45 percent, undermining health and dignity

Less than one in ten schools in the region provide menstrual materials or private spaces for menstrual hygiene management, significantly limiting girls' ability to attend school during menstruation.

In some countries, lack of menstrual knowledge before first menstruation affects a majority of girls, exacerbating anxiety and stigma.



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ROLE OF THE WORLD HEALTH ORGANIZATION

The World Health Organization plays a central role in addressing menstrual and reproductive health inequities. WHO develops evidence-based guidelines, supports national health policies, and collaborates with governments to integrate menstrual health into broader sexual and reproductive health frameworks. Through technical assistance and partnerships with UNICEF, UNFPA, and civil society organizations, WHO promotes health system strengthening, data collection, and implementation of adolescent-friendly services.

WHO's mandate encompasses advancing universal health coverage that includes menstrual health as a core component, bridging gaps in policy, and providing technical support for WASH improvements, health education, and reproductive health service delivery.

INTERNATIONAL AND REGIONAL RESPONSES

Several international frameworks — including the Sustainable Development Goals — emphasize gender equality, quality education, universal health coverage, and access to clean water and sanitation, all of which intersect with menstrual and reproductive health. Various NGOs, regional partnerships, and national governments have piloted programs to reduce stigma, distribute products, improve school sanitation, and train educators and health workers.

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BLOC ANALYSIS

The issue of menstrual and reproductive health care in Sub-Saharan Africa divides Member States based on levels of economic development, public health priorities, cultural norms, and approaches to international assistance. While most states affirm the importance of gender equality, universal health coverage, and reproductive rights, significant differences remain regarding the role of governments, cultural considerations, funding responsibilities, and the scope of international intervention.

Sub-Saharan African States

Countries within Sub-Saharan Africa emphasize the urgent need to address menstrual and reproductive health barriers as a matter of public health, education, and socioeconomic development. Many governments acknowledge the negative impacts of period poverty, inadequate sanitation, and limited reproductive health services on girls' education and women's health outcomes. However, these states often face financial constraints, limited health infrastructure, shortages of trained health professionals, and competing development priorities. While supportive of international assistance, some governments stress the importance of culturally sensitive approaches that respect local traditions and community norms when addressing menstruation and reproductive health.

Developed and High-Income Countries

High-income Member States, including many in Europe, North America, and parts of East Asia, generally support comprehensive sexual and reproductive health policies, including access to menstrual products, contraception, and education. These countries often advocate for increased funding, data collection, and evidence-based interventions through organizations such as WHO, UNICEF, and UNFPA. Many also promote the framing of menstrual health as a human rights issue. However, debates may arise regarding the scale of financial commitments, the role of private sector partnerships, and how directly international actors should influence domestic health policies in recipient countries.

Countries with Conservative Social or Religious Frameworks

Some Member States prioritize cultural values, religious norms, or traditional family structures when addressing reproductive health. These countries may support improvements in sanitation, maternal health, and basic hygiene while expressing reservations about comprehensive reproductive health education, contraception access for adolescents, or discussions of menstruation that conflict with societal norms. They often emphasize community-led education, parental involvement, and gradual social change rather than externally driven reforms.

International Organizations and Donor-Aligned States

States that closely align with international development agencies and donor frameworks emphasize measurable outcomes, accountability, and integration of menstrual health into broader health and education systems. These countries support standardized indicators, monitoring mechanisms, and data-driven policy design. They often advocate for linking menstrual and reproductive health initiatives to the Sustainable Development Goals, particularly those related to health, education, gender equality, and water and sanitation.

Neutral or Mixed Positions

Some Member States adopt a more cautious stance, supporting general improvements in women's health while avoiding strong positions on culturally sensitive aspects of reproductive health policy. These states may prioritize national sovereignty, non-interference, or broader health system strengthening over issue-specific interventions. Their policies often focus on infrastructure and service delivery rather than social or educational reform.

Delegates should note that these blocs are not rigid. Member States may share overlapping priorities or shift positions based on national context, funding capacity, and public opinion. Innovative solutions and cross-bloc collaboration are encouraged throughout committee debate.

POSSIBLE POLICY RESPONSES

1. Expand national health policies to explicitly include menstrual health and menstrual hygiene management as integral components.
2. Invest in WASH infrastructure in schools and health facilities to ensure privacy, dignity, and hygiene.
3. Strengthen reproductive health services by training providers in adolescent-friendly care and reducing stigmatizing practices.
4. Subsidize or reduce tariffs on menstrual products to improve affordability.
5. Support culturally relevant education campaigns that engage communities, parents, and youth on menstrual and reproductive health.
6. Improve data collection and monitoring to inform policy and program design.

QUESTIONS TO CONSIDER

1. How can Member States address menstrual and reproductive health barriers in a way that improves public health outcomes while respecting cultural diversity and community norms?
2. What role should the World Health Organization play in coordinating international efforts without undermining national sovereignty or local ownership of health systems?
3. Should menstrual health products be classified as essential health items, and how can affordability be ensured without creating long-term dependency on external aid?
4. How can water, sanitation, and hygiene infrastructure be expanded sustainably in schools and health facilities across rural and underserved areas?
5. To what extent should international funding prioritize adolescent-friendly reproductive health services, and how can confidentiality and accessibility be improved for young people?
6. How can better data collection and monitoring strengthen policy design while ensuring ethical standards and respect for privacy?

TOPIC A APPENDIX & SOURCES

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