Alliance for Reproductive Health Rights

BASELINE SURVEY REPORT

PUTTING WOMEN AND GIRLS AT THE CENTRE OF PRIMARY HEALTH CARE (PHC) INITIATIVE

2025

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Executive Summary

Background

Women's empowerment is a crucial global issue, with gender inequalities persisting in many aspects of society, including economic participation and decision-making. The AU Strategy for Gender Equality and Women's Empowerment (2018-2028) emphasizes the importance of equal rights and opportunities for both men and women. However, in Ghana, many women and girls still face significant barriers in accessing quality and timely primary healthcare (PHC). These challenges arise from institutional limitations, including inadequate infrastructure, personnel shortages, financial costs, and a lack of gender-sensitive policies. Additionally, cultural and social constraints limit women's ability to seek healthcare, often requiring permission from spouses or dependents.

Women's healthcare needs in Ghana are often narrowly defined within reproductive, maternal, and sexual health, neglecting broader social and economic factors. Their underrepresentation in health management structures further hinders efforts to address their specific needs. In some regions, women's health outcomes are also affected by inadequate water, sanitation, and governance services. The National Health Policy (2020) prioritizes preventive and promotive healthcare, yet women and girls in marginalized communities continue to face disparities.

Women's voice, agency, and leadership are critical to improving healthcare outcomes. However, disparities in literacy, access to information, geographical barriers, and economic limitations reduce their ability to demand better healthcare services. The existing feedback system in Ghana's health sector is largely supply-driven and fails to adequately incorporate patient perspectives. While Civil Society Organizations (CSOs) engage in policy discussions at the national level, their ability to represent patients' views remains limited.

Ghana has a range of legal, policy, and administrative frameworks for Universal Health Coverage (UHC), including the National Health Insurance Scheme (NHIS), the Public Health Act, and the Community Health Planning Services (CHPS) policy. However, gender equity is not central to these policies, leading to gaps in service delivery. More women than men are enrolled in NHIS (72.6% vs. 64.5%), but this is mainly due to free maternal health services. Many poor women struggle to renew their NHIS cards or afford out-of-pocket expenses for healthcare, making healthcare access inconsistent. Furthermore, the NHIS does not adequately cover essential services like cancer screening and geriatric care.

Policy inconsistencies, such as the non-reimbursement of CHPS-level maternity care, further hinder women's access to comprehensive services.

The Gender Model Family (GMF) approach has emerged as a transformative strategy to address gender inequalities. GMF promotes shared decision-making within families, encouraging both men and women to engage in equitable healthcare and social practices. By fostering gender-sensitive household dynamics, GMF aims to create long-term social change. Training programs under GMF focus on empowering families to challenge traditional norms and adopt equitable behaviors.

The Baseline Study

The baseline study's objectives include assessing women's participation in PHC decision-making, evaluating GMF's knowledge of health-seeking behaviors, identifying feedback mechanisms, and determining frontline health workers' capacity to provide gender-sensitive care. Addressing these issues requires policy reforms, increased women's leadership in healthcare, improved NHIS accessibility, and strengthened feedback systems to ensure that healthcare services effectively meet the needs of women and girls in Ghana. The research was carried out across seven regions in Ghana, focusing on 558 respondents from 279 GMFs, and utilized a quantitative survey methodology to capture comprehensive data.

Key Findings

GENDER DISPARITIES IN DECISION-MAKING

- Household decision-making remains male-dominated, with 82% of respondents identifying men as the primary decision-makers.
- Cultural norms, economic factors, social status, and religious beliefs contribute to power imbalances, affecting women's autonomy in healthcare choices and limiting their ability to seek timely medical care.
- While some families reported joint decision-making, women's influence in household and healthcare decisions remains significantly constrained.

WOMEN'S PARTICIPATION IN COMMUNITY LEADERSHIP AND HEALTH COMMITTEES

- Women's involvement in health committees is significantly low, with only 5.2% of female respondents identified as members, compared to 13.6% of men.
- Awareness of community health committees exists (27.8% among women), but active participation remains limited due to societal norms and lack of empowerment.
- Structural barriers, such as male-dominated leadership structures and lack of supportive policies, further restrict women's leadership roles in community healthcare governance.

Key Findings

HEALTH-SEEKING BEHAVIOR OF GENDER MODEL FAMILIES

- 24.4% of respondents had not visited a health facility within the past year, indicating gaps in healthcare utilization.
- High costs of care (36.5%), lack of essential medicines (22.5%), and long distances to clinics (10.3%) were identified as major barriers to accessing healthcare.
- NHIS enrollment is higher among women (48.7%) than men (41.9%), but many struggle to maintain active cards due to financial constraints, affecting their ability to access free or subsidized services.
- Many households resort to self-medication (10.4%) or traditional healers (2.3%) as their first point of care, highlighting the need for enhanced health education and awareness campaigns.

FEEDBACK AND ACCOUNTABILITY MECHANISMS

- While 82.4% of respondents were aware of NHIS-subsidized services, many still opted for pharmacies or self-medication due to perceived inefficiencies in public healthcare facilities.
- Mechanisms for healthcare feedback exist, but their accessibility and responsiveness need improvement to ensure that community concerns are adequately addressed.
- Women face greater challenges in utilizing feedback mechanisms due to socio-cultural constraints, lack of information, and limited influence in community decision-making processes.
- The study found that families with stronger communication and joint decision-making structures were more likely to participate in accountability systems and demand better healthcare services.

Recommendations

1. Strengthen women's leadership and participation in PHC decision-making through targeted empowerment programs, leadership training, and policy reforms.
2. Improve access to affordable healthcare by addressing NHIS enrollment gaps, reducing out-of-pocket costs, and ensuring the availability of essential medicines at health facilities.
3. Enhance community health education through localized outreach programs to raise awareness about PHC services, NHIS benefits, and the importance of timely medical interventions.

4. Establish more inclusive and responsive feedback and accountability systems to ensure service improvements, with a focus on gender-sensitive approaches that amplify women's voices in healthcare governance.
5. Integrate gender-transformative approaches into national health policies to create an enabling environment for equitable healthcare access and decision-making at all levels.
6. Foster partnerships between government, civil society organizations, and local communities to drive sustainable improvements in primary healthcare service delivery.

CONCLUSION

This study serves as a critical foundation for future interventions aimed at advancing gender equality, strengthening community-based health structures, and improving primary healthcare accessibility for women and girls in Ghana. The findings emphasize the urgent need for systemic reforms and strategic investments in gender-responsive healthcare policies to bridge existing gaps and ensure that women play a central role in shaping health outcomes within their families and communities.

1.0 INTRODUCTION

1.1 Background of the study

Women's empowerment remains among the most enduring social challenges and opportunities worldwide. Gender inequalities are evident in numerous forms across every nation and community (Cocoa Life, 2018). The AU Strategy for Gender Equality and Women's Empowerment 2018-2028 outlines that gender equity is realised when both women and men have equal rights and opportunities in all areas of society, including economic involvement and decision-making, and when the diverse behaviours and aspirations of women and men are equally respected and supported.

Slightly more than half of Ghanaian women and girls, particularly those aged 15 and above, encounter multiple barriers to accessing quality and timely primary healthcare (PHC) in Ghana. These barriers stem from individual, contextual, and institutional factors. On the institutional or supply side, challenges include the adequacy of infrastructure and personnel at the first point of contact/service (FPC), the distance to appropriate facilities, health insurance coverage, and the costs associated with accessing the care they need. PHC policy tends to narrowly interpret women's health needs, focusing primarily on reproductive, maternal, and sexual well-being, while insufficiently addressing the impact of social and economic circumstances and gender differences in policy and program processes. The limited representation of women in health management structures at the community level further hinders the system's responsiveness to the needs of women and girls. On the demand side, women and girls face constraints such as inadequate resources and social support to seek healthcare, often requiring permission from spouses or dependents. Some demand-side issues are linked to their lack of awareness of their rights and their limited ability to advocate for the necessary resources within their families and communities.

While these challenges affect women and girls across the country, those in certain geographical regions and districts experience poorer health service performance. These regions also face challenges in sectors such as water, sanitation, and governance, which have significant implications for women's and girls' health. These complementary sectors are crucial because they align with the preventive and promotive aspects of healthcare delivery prioritized by the National Health Policy (2020). Women's voice, power, agency, and leadership are essential on both the supply and demand sides of Primary Health Care (PHC). Although there are disparities in women's and girls' awareness and exercise of their healthcare rights and entitlements, the situation varies. These disparities are connected to their ability to demand information and assert their rights with providers and local authorities, to negotiate and make the most of available resources within their families and communities, and to take on visible roles in health management structures, particularly at the local level.

Apart from issues of access to formal decision-making spaces, literacy, information availability and comprehension, technology, geographical location, age and economic status may all play a part in the agency of women and girls and impact on their responsiveness (Ghana 2017 Maternal Health Survey Key Findings).

The existing feedback system is largely supply-driven and not easily responsive to clients and other stakeholders. While strategic and policy planning processes at the national level do involve CSOs, there is a limited extent to which these bodies can represent the perspectives of clients/ patients/citizens.

Ghana has a wide range of legal, policy and administrative guidelines relating to UHC, prioritizing PHC and delivering NHIS. While provision has been made for some women-focused services, gender equity is not central to their delivery. Critical instruments including the Public Health Act (Act 851), the Patients' Charter, the UHC Roadmap, the Community Health Planning Services (CHPS) policy and NHIA Act still need to be interpreted, implemented and monitored from a gender-equitable perspective, at both national and local administrative levels and across sectors. There are records of higher registration levels in the NHIS of women than men (72.6% of female residents in the regions indicated above as compared to 64.5% for males). However, this could be due to the provision of free maternal health care. However, women's use of NHIS beyond maternal health; and their needs at different stages of their lives must be analyzed to ascertain whether, in practice, they are able to take full advantage of the facility. Many poor women may be unable to pay renewal fees for their insurance as compared to men. NHIS also does not cover out-of-pocket costs which is a critical consideration for women in the indigent category.

There are other health concerns at the primary care level that women require but are excluded by restrictive categorization, such as access to cancer screening and geriatric care. Some policy inconsistencies also affect the full enjoyment of benefits. While NHIS provides for maternity-related costs, measures such as the non-reimbursement of costs at the CHPS level work against the free maternity health services.

1.2 The GMF Methodology

Over the past 15 years, Gender Transformative Approaches (GTA) have emerged as a way to challenge traditional methods of development. These approaches focus on transforming the power relations and structures that perpetuate gender inequality, aiming to achieve both gender equality and broader development goals. Unlike approaches that solely focus on women's empowerment, GTA involves both women and men in reshaping social-gender relations to be more equitable. The Gender Model Family (GMF) is an example of a gender transformative approach to community mobilization, addressing the unequal power dynamics between women and men. This approach works by establishing role-model families and involving wives, husbands, and children as 'change agents' within their community. The GMF includes a training program designed to help husbands and wives live together in a more just and equitable way, challenging traditional practices within the family unit, which is seen as the foundation for social transformation. This process encourages families to unlearn unequal gender practices and adopt more equitable behaviours.

1.3 Objectives of the study

The primary aim of the baseline study is to establish the factors that inhibit women and girls from utilizing PHC services. participating in leadership and influencing decision-making among GMFs. This will provide a basis for the co-impact project implementation in the key priority areas.

The specific objectives of the baseline survey are:

1. Assess the participation and leadership of women and girls in primary healthcare decision-making
2. Assess the knowledge of the GMF on health-seeking behaviours in the context of PHC
3. Identify feedback and accountability channels available among the GMFs.
4. Determine the level of knowledge of frontline health workers on providing a gender-sensitive health service

2.0 DESK REVIEW OF LITERATURE

2.1 The Concept of Gender Model Family (GMF)

Over the past 15 years, Gender Transformative Approaches (GTA) have evolved to challenge traditional methods of 'doing development.' These approaches aim to change the power relations and systems that perpetuate gender inequality, thereby achieving both gender equality and broader development outcomes. Unlike other approaches to women's empowerment, GTAs engage both men and women in efforts to improve gender relations.

The Gender Model Family (GMF) concept is widely recognized as a prominent example of a gender transformative approach. Originally conceptualized by SEND Ghana in 2001 to implement a livelihood and food security project promoting soybean production to combat malnutrition, the GMF has since expanded its focus. It is now used to promote women's and gender equity issues in governance, water, sanitation, education, and peacebuilding, and to encourage farm families to adopt climate-smart farming practices. The GMF approach addresses the unequal power dynamics between women and men through community mobilization (Kamara and Ayamga, 2020). It operates by establishing model families by engaging wives, husbands, and children as 'change agents' within their communities (SEND West Africa, 2014). The approach is preceded by organizing training programs that empowers husbands and wives to live equitably and justly by challenging traditional gender roles within the household. It views the family as the fundamental unit of social transformation, enabling members to unlearn unequal gender practices.

The theory of change behind the GMF approach is that by creating a locus of transformation at the household level, a ripple effect will occur at the community level, which will be sustained over time (SEND West Africa, 2014). The transformation begins with the individual within the family, where self-reflection is encouraged to challenge and change unequal gender relations. GMFs are accountable to concrete action plans, starting with the equitable sharing of household tasks. As families experience the benefits of these actions, they extend this sharing to decision-making and strategic use of household and productive income and resources. By initiating their own process of critical reflection, these families aim to become role models for others in their communities.

This leads to collective transformation, where a network of community change agents is created. GMFs support one another and continuously recruit new families into the program. With a critical mass of GMFs, gender transformation can extend beyond individual families to entire communities and societies. Over the years, the GMF methodology has been scaled to reach more families. For instance, in the Eastern Corridor, SEND Ghana started with 105 GMFs in 2003, expanding to 1,069 in 2018. The GMF methodology has also been replicated by other development partners, such as Oxfam and RING in Ghana. The 4R Nutrient Stewardship Programme in Ethiopia plans to scale this up to 4,300 families between 2019 and 2024. Families of various income levels, professions, religions, and ethnic groups participate in the GMF program.

Communities in Ghana and Sierra Leone include teachers, health workers, farmers, pastors, traditional leaders, and traders who are GMFs and actively support each other (Kamara and Ayamga, 2020; SEND West Africa, 2014).

2.2 Power Dynamics Among Couples Practicing the Gender Model Family Approach

The concept of power is central to the study of all social relationships in society (Straus & Yodanis, 1995). Power is defined as the ability to influence or change the behaviour of another member within a social system. Wood et al. (2009) noted that power dynamics within intimate partner relationships significantly impact the duration and quality of the relationship, as well as the well-being of the couple and other family members. An unequal distribution of power within intimate relationships can lead to negative outcomes, such as poorer psychological and physical health, particularly for women (Wood et al., 2009). Globally, women are often treated unequally compared to men, with gender inequality rooted in cultural norms that promote male dominance and female subordination (United Nations, 2016). This issue has been a global concern for decades, and many influential international institutions, such as the World Health Organization (WHO), have advocated for research and interventions to address gender-based power imbalances (WHO, 2009). Power dynamics can profoundly affect interpersonal relationships. In strong and healthy relationships, power is generally equal or nearly equal (Bishop, 2011). Partners may not possess the same types of power—one may have more financial resources while the other has more social connections—but influence is often mutual. In balanced relationships, partners work together respectfully, with both having a say in decision-making. According to Kane (2014), a balanced relationship is characterized by power being held equally by both partners, who recognize each other's value, respect each other, and listen to each other's feelings and interests. In GMF couples, every family member has equal rights and is entitled to opportunities for empowerment. In the GMF context, empowerment means that both men and women can jointly take control and improve their lives. Neither the man nor the woman exerts power over the other; instead, they make decisions together and share resources and benefits (SEND West Africa, 2014). In a GMF, anyone in the family can contribute to household chores, run a business, or make financial decisions. All family members should have access to and control over resources, including education, which will help them improve their decision-making and life direction.

2.3. Participation and Leadership of Women and Girls in Primary Healthcare Decision-Making

The participation and leadership of women and girls in primary healthcare (PHC) decision-making are crucial for achieving equitable and effective health outcomes. Historically, women's and girls' voices have often been underrepresented in health policy and decision-making processes, despite their significant role as primary caregivers in families and communities. This review explores the importance of their involvement in PHC decision-making, the barriers they face, and the benefits of inclusive leadership in the healthcare sector.

2.4 Importance of Women's and Girls' Participation in PHC Decision-Making

Women and girls are at the forefront of healthcare in many societies, often responsible for managing the health needs of their families. Their lived experiences and understanding of health issues make their participation in decision-making essential for creating responsive and effective healthcare policies. When women and girls are involved in healthcare leadership, they are more likely to advocate for services that address the unique health needs of women, children, and marginalized groups (World Health Organization, 2019).

Inclusive decision-making processes in PHC ensure that healthcare services are more attuned to the needs of the entire population, leading to better health outcomes. For example, when women are part of health management teams, there is a greater focus on maternal and child health, reproductive health services, and gender-sensitive care, which are critical for reducing morbidity and mortality rates among women and children (UN Women, 2020).

2.5 Barriers to Participation and Leadership

Despite the recognized importance of women's and girls' participation in PHC decision-making, numerous barriers hinder their involvement. Socio-cultural norms and gender stereotypes often limit women's roles to caregiving rather than leadership, reducing their influence in formal decision-making spaces. (George, Mehra, Scott, & Sriram, 2015).In many settings, women may lack the necessary education or professional training to assume leadership roles in healthcare (George, Mehra, Scott, & Sriram, 2015).

Structural barriers within healthcare institutions, such as male-dominated leadership structures and a lack of supportive policies for women's advancement, further exacerbate the underrepresentation of women in decision-making roles. Additionally, women who do hold leadership positions often face challenges such as gender bias, unequal pay, and limited opportunities for career advancement (Buse, Hawkes, & Kapilashrami, 2018).

2.6 Benefits of Women's Leadership in PHC

The inclusion of women and girls in healthcare leadership has numerous benefits. Studies show that diverse leadership teams that include women are more likely to implement policies that are inclusive and equitable, leading to improved health outcomes for all population groups (Miller, 2017). Women's leadership in PHC can also help to address gender-based disparities in access to healthcare services, such as the availability of maternal and reproductive health services (Witter, Govender, & Ravindran, 2017).

Furthermore, when women and girls participate in decision-making processes, there is a greater likelihood that health policies will address issues such as gender-based violence, discrimination in healthcare settings, and the specific health needs of adolescent girls, which are often overlooked in male-dominated decision-making processes (Stamatiou & Stokes, 2020).

Therefore, empowering women and girls to take on leadership roles in primary healthcare decision-making is vital for the development of equitable and effective health systems. By addressing the barriers to their participation and fostering inclusive leadership, healthcare systems can better meet the needs of all individuals, particularly women and girls who have historically been marginalized in healthcare decision-making. This not only improves health outcomes but also contributes to broader goals of gender equality and social justice.

2.7 Factors Influencing the Health-Seeking Behaviors Of Families In Ghana

Health-seeking behaviour refers to the actions individuals and families take to maintain health, prevent illness, and seek treatment for health issues. In Ghana, these behaviours are influenced by a variety of factors, including socio-cultural beliefs, economic conditions, educational levels, and the availability of healthcare services. While the NHIS has made strides in reducing financial barriers, significant challenges remain, particularly in rural areas and among less-educated populations. Addressing these barriers requires targeted interventions that consider the cultural context, improve healthcare accessibility, and promote education on health-related issues.

2.8 Socio-Cultural Influences

In many Ghanaian communities, traditional beliefs and practices play a significant role in health-seeking behaviours. Even though there may be a primary health care facility available in the community, traditional medicine, including the use of herbal remedies and consultation with traditional healers, is widely practised and often preferred for the initial treatment of ailments. Studies indicate that these practices are deeply rooted in cultural beliefs, where illness is sometimes perceived as a spiritual issue rather than a purely medical one (Gyasi, Mensah, & Siaw, 2015). This reliance on traditional medicine can delay the utilization of formal healthcare services, especially for rural families.

2.9 Economic Factors

Economic status is a critical determinant of health-seeking behaviour in Ghana. Families with higher income levels are more likely to access formal healthcare services compared to those with limited financial resources. The cost of healthcare, including transportation to facilities and the price of medication, often acts as a barrier for low-income families (Asenso-Okyere, Anum, Osei-Akoto, & Adukonu, 1998). The introduction of the National Health Insurance Scheme (NHIS) was intended to alleviate some of these financial barriers; however, there remain gaps in coverage and awareness of the benefit packages including the essential services provided, which continue to affect health-seeking behaviours (Alhassan et al., 2016).

2.10 Couples' Level of Education

Another factor that impedes health-seeking behaviour is the educational level of family members, particularly the heads of households, which significantly impacts health-seeking behaviours. According to a study conducted by Bosu et al (2014), higher levels of education are associated with better awareness of health issues and the importance of seeking timely medical care (Bosu, 2014). The emphasizes that individuals who are

educated are more likely to recognize symptoms that require professional medical attention and are more informed about the benefits of utilizing formal healthcare services. Conversely, families with lower educational attainment may rely more on traditional medicine or delay seeking treatment due to a lack of understanding of the health condition (Doku, Neupane, & Doku, 2012).

2.11 Accessibility and Quality of Healthcare Services

Access to healthcare facilities is a major factor influencing health-seeking behaviours. Families living in urban areas typically have better access to healthcare services, including hospitals and clinics, compared to those in rural areas. In rural communities, the distance to healthcare facilities and the quality of available services often determines whether families seek medical help (Gyamfi, 2014). Poor infrastructure, inadequate healthcare personnel, and lack of essential medicines in rural health facilities further discourage formal health-seeking behaviours (Ngugi, 2017).

2.12 Gender Dynamics

Another significant determinant of the health-seeking roles of couples in Ghana is Gender. In a study by Ganle et al (2014), women often manage the health needs of their families in Ghana. Women who are central in managing the health needs of their family may face additional barriers such as needing permission from their husbands to seek care or being unable to afford treatment due to financial dependency (Ganle, Parker, Fitzpatrick, & Otupiri, 2014). Gendered health disparities are particularly pronounced in reproductive health services, where cultural norms and stigma can inhibit women from seeking necessary care. Addressing these barriers requires targeted interventions that consider the special needs of women in planning and implementation of health-related policies and addressing cultural myths.

2.13 Feedback and Accountability Channels Among Gender Model Families (GMFs)

The Gender Model Family (GMF) approach, widely implemented in Ghana, fosters equitable relationships and promotes gender equality within communities by transforming power dynamics at the family level. Central to its success is the feedback and accountability mechanisms that ensure continuous improvement and adherence to the principles of gender equality.

2.14 Feedback Channels among GMF

The GMF approach encourages open communication between family members as a fundamental practice. Regular family meetings are a core feature where all members, including men, women, and children, are encouraged to voice their opinions and concerns. These discussions are designed to be inclusive, ensuring that even the most marginalized voices within the family are heard. According to Kamara et al. (2020), the participatory approach not only strengthens family bonds but also serves as a feedback loop for the continuous assessment of gender dynamics within the household (Kamara & Ayamga, 2020).

Moreover, GMFs engage in community forums such as durbars, women's meetings, support groups etc. where multiple families come together to share experiences and

best practices. These forums provide a platform for families to offer constructive feedback on the implementation of GMF principles and discuss challenges they encounter. The collective nature of these forums fosters a sense of community accountability, where families hold each other to the standards of equality and justice established by the GMF approach (SEND West Africa, 2014).

2.15 Accountability Mechanisms

Accountability within the GMF framework is maintained through several layers of oversight. Firstly, the individual families are accountable to themselves and their community. (Kamara & Ayamga, 2020). This is achieved when each family is tasked to develop an action plan outlining the steps they will take to promote gender equity within their household. The progress of this framework is monitored regularly, with community members (Gender mentors) and facilitators (CBOs) who provide support and guidance where needed (Kamara & Ayamga, 2020).

At the community level, there are structured monitoring and evaluation processes. Community leaders, often trained in the principles of the GMF approach, play a crucial role in overseeing the adherence of families to their commitments. They provide both positive reinforcement for achievements and constructive criticism where improvements are needed. In some cases, families may be required to report on their progress to local authorities or community organizations, adding an additional layer of accountability (SEND West Africa, 2014).

The GMF approach also incorporates external evaluations conducted by partner organizations doing the implementation and other NGOs involved in the program. These evaluations assess the impact of the approach on gender relations and provide feedback on the effectiveness of the accountability mechanisms in place. The findings from these evaluations are used to refine the approach and ensure that it remains responsive to the needs of the families and communities it serves (SEND West Africa, 2014).

The feedback and accountability channels within the GMF approach are designed to be participatory, inclusive, and multi-layered, ensuring that the principles of gender equality are not only promoted but also sustained over time. These mechanisms are essential for the continuous evolution of the GMF approach and its effectiveness in transforming gender dynamics within communities in Ghana.

2.16 Access to Essential Health Services by Gender Model Families (GMFs)

The Gender Model Family (GMF) by design, are positioned to overcome traditional barriers to accessing health services through a gender-responsive framework. In many rural communities, access to health services is often impeded by socio-cultural norms that limit women's autonomy in health-related decision-making. The GMF approach challenges these norms by promoting joint decision-making within households, where both men and women actively participate in decisions related to health care (Kamara & Ayamga, 2020).

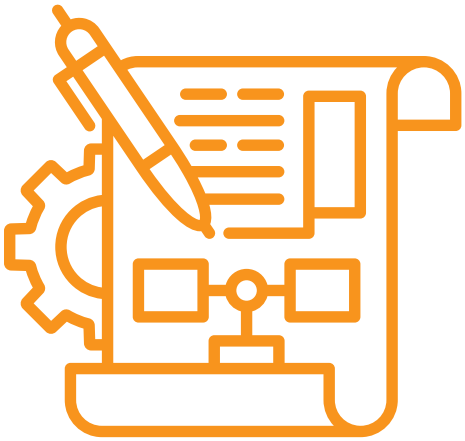
Research indicates that GMFs are more likely to utilize preventive health services such as immunizations, maternal health care, and regular health check-ups. This is attributed to the GMF training programs that emphasize the importance of these services and encourage equitable health-seeking behaviours among all family members (SEND West Africa, 2014). The approach also promotes the use of community health workers (CHWs) who serve as a bridge between the community and the formal health system, facilitating access to health services for GMFs, particularly in remote areas (Atinga et al., 2012).

2.17 Measures Needed to Support GMF Implementation

To further enhance the access of GMFs to essential health services, several support measures are necessary. Firstly, capacity building for community health workers is crucial. CHWs need to be adequately trained in the principles of the GMF approach and equipped with the skills to address gender-specific health needs. This training should include components on cultural sensitivity, gender equity, and community mobilization strategies (Alhassan et al., 2016).

Secondly, strengthening the health infrastructure in GMF-implementing communities is essential. Many rural areas face challenges such as inadequate health facilities, shortages of medical supplies, and limited transportation options. Addressing these infrastructural gaps would significantly improve the ability of GMFs to access necessary health services (Kamara & Ayamga, 2020). Thirdly, integrating GMF principles into national health policies can provide a more supportive environment for the approach. By aligning GMF objectives with broader health sector goals, such as those outlined in Ghana's National Health Policy, the government can ensure that GMFs receive the institutional backing needed for sustainability. This integration would also facilitate the allocation of resources and support for GMF activities at the community level (SEND West Africa, 2014).

Finally, monitoring and evaluation mechanisms are vital for the ongoing success of the GMF approach. Regular assessments of the health outcomes of GMFs can provide valuable feedback on the effectiveness of the approach and highlight areas for improvement. These evaluations should include both quantitative and qualitative data to capture the full impact of the GMF approach on health service access (Atinga et al., 2012).



3.0 METHODOLOGY

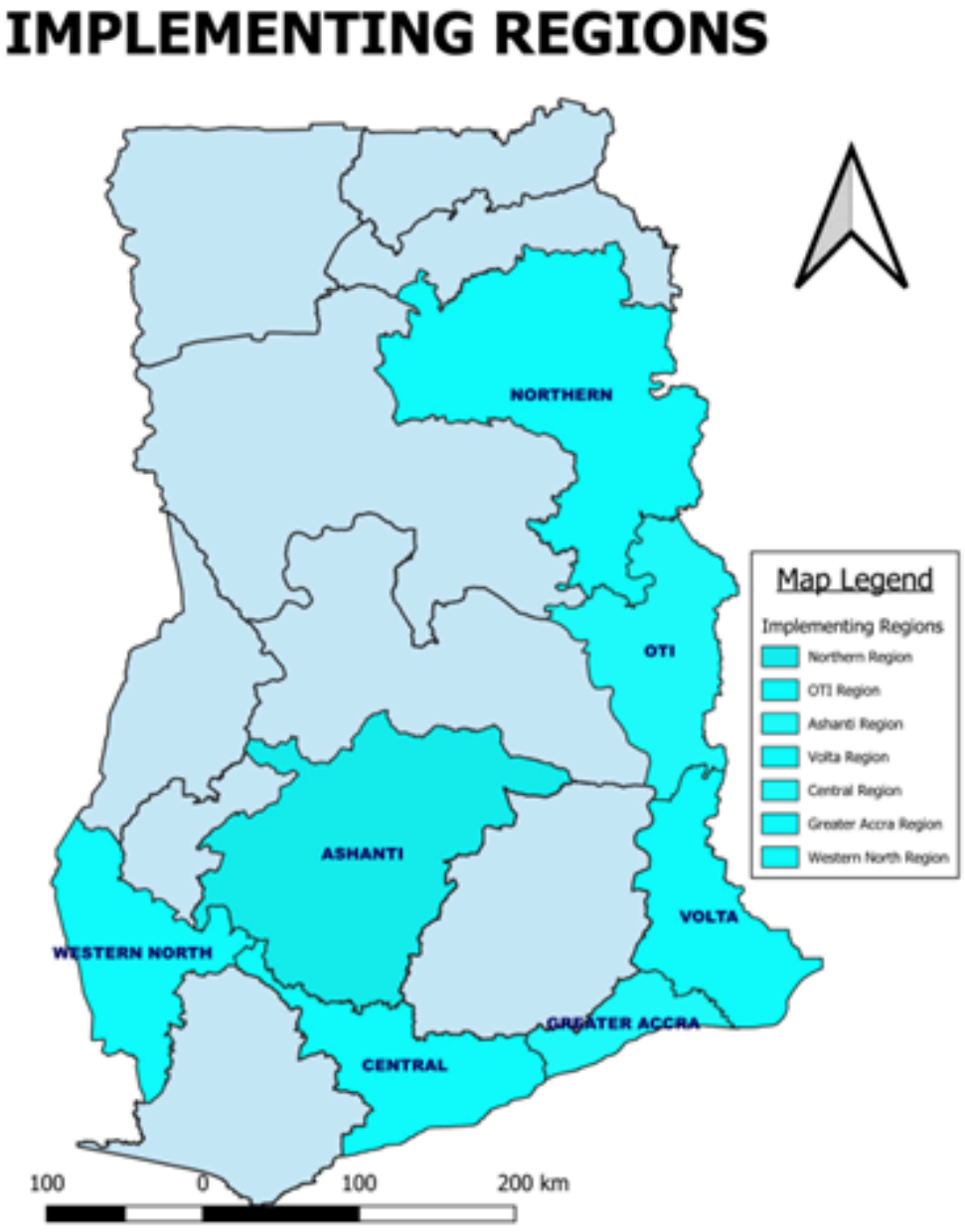
3.1 Research design

This assessment adopted a survey approach, based on a quantitative research design. This involved quantitative methods in data collection and analysis. The survey approach was chosen as best suited for this assessment because it allowed us to reach out to a significant proportion of households within the project-implemented districts. Using quantitative methods provides the assessment with rich data sources for the baseline. This survey will use a cross-sectional approach to collect the data. Levin (2006) summarised cross-sectional studies as providing snapshots of the outcome of the intended study.

3.2 Geographic locations and sampling procedure

This baseline study will be implemented in all seven regions of Ghana—i.e., Greater Accra, Volta, Oti, Western, Northern, Ashanti, and Central regions—targeting 276 gender model family couples. Figure 1 shows the location of the sample respondents.

3.2.1 Study Area



3.3 Sampling

The sampling for the quantitative data will be computed using Slovin's formula as shown by equation 1 given that the population (N) of the study is determined as 900

$$n = \frac{N}{(1+(e2 * N))}$$

where n is the sample size,

N is the population, and

e is the margin of error at 0.05.

The N is the total number of women and men (900) who will benefit from the project.

Therefore, the sample is estimated as:

$$n = \frac{N = 900}{(1+(e2 * N))}$$

n= 276.9

The minimum sample required for adequate representation, therefore, is 276.9 GMF. This was adjusted to 279 GMF to allow for proportionate distribution among the eighteen districts within the seven regions where the data will be collected.

The sample size was further distributed proportionately by the number of districts in the regions as shown below. An average of 31 couples were selected from regions with two districts (31 females and 31 males) while in regions with four districts, 62 couples were selected (62 females and 62 males) – resulting in 279 couples (558 respondents) from all the eighteen districts selected from the 7 regions.

Region	Districts	Sample	Distribution of Sample Size	Communities (5 cmt per dist.)	GMF (10 GMF per cmt)	# of couples		Total
						Women	Men	
Ashanti Region	2	276	2/18*279=31	10	100	31	31	62
Central Region	4	276	4/18*279=62	20	200	62	62	124
Greater Accra	2	276	2/18*279=31	10	100	31	31	62
Northern Region	4	276	4/18*279=62	20	200	62	62	124
Oti region	2	276	2/18*279=31	10	100	31	31	62
Volta Region	2	276	2/18*279=31	10	100	31	31	62
Western Region	2	276	2/18*279=31	10	100	31	31	62
Total	18		279	90	900	279	279	558

3.4 Sampling of Communities

The sample of GMF couples comprising females and males was drawn randomly from the selected project communities in the implemented districts in Ghana. In each of the eighteen Municipal and District Assemblies-(MDAs) that were sampled for the Co-impact project baseline survey, the selection of the survey communities was proportionately determined.

3.5 Sampling of females and males

The procedure for sampling was initiated with a list of GMF couples' populations in the sampled communities. The sampling frame from each region was obtained from CBOs under the alliance in the various regions. Using the simple random sampling technique based on the proportional-to-size approach, the sample of females and males was identified. The proportional-to-size approach considered the gender and age dimensions of the GMF couples' population. The sampling of respondents was done at the community level.

3.6 Baseline survey instruments

The design of the data collection instruments by the Alliance for Health Rights (AHeR) Secretariat was guided by the objectives of the Co-Impact Project. The instruments included individual surveys using questionnaires. The data collection instruments were designed and reviewed by the AHeR Secretariat with input from SEND Ghana. The data (questionnaire) will be collected using a mobile phone data collection application (kobo collect) to collect and manage the data. This ensured high data validity, accuracy and timeliness in the submission of the report.

3.7 Data collection procedure

A day training workshop, including the pretesting of instruments, was organized for the research assistants (Community-Based Organisations (CBOs)) as well as the field supervisors (AHeR Secretariat/SEND Ghana) for the survey. The research assistants were drawn from partners in the implementing Districts. Each field staff was assigned to the specific district he/she represents and was centrally monitored by the field supervisor based on the data transmitted. The training was facilitated by the lead of the study from the AHeR Secretariat. The training covered issues such as an overview of the Co-impact project, baseline survey objectives, contents of the baseline instruments, translation of baseline instruments into local dialects, use of the electronic data collection software, data transmission, ethics in research, roles of field staff, and anticipated challenges and how to resolve them. The pretesting of the survey instruments was conducted in the Agona East and Swedru districts in the Central and Volta Regions. The field officers commenced the data collection activities concurrently in all the districts in the Regions in the southern belt (Volta, Oti, Greater Accra, Central, and Western), to be followed by the regions in the Northern Belt (Northern and Ashanti regions).

Field Officers administering questionnaires in the community

3.8 Data Cleaning, Analysis and Reporting

The collected data undergo cleaning to ensure accurate analysis, enabling evidence-based descriptions of the current realities. Data was analyzed using R statistical software and presented through descriptive statistics, including frequencies, percentages, means, and cross-tabulations, as well as statistical tests for differences in means. The unit of analysis will focus on project beneficiaries and implementing partners, with data disaggregated by region, district, community, and respondents' demographic characteristics.

3.9 Ethical Issues and Clearance

Participants in this baseline survey were assured that their responses would remain anonymous and confidential. Personal identifiers were not used in any reports; instead, pseudonyms were employed where necessary. To further safeguard confidentiality, all data files are password-protected and shared exclusively with ARHR, field staff (CBOs), and SEND Ghana. Additionally, informed consent was obtained from all participants before administering the questionnaire. Staff who did not give their consent to the study were not recruited.

4.0 EMPIRICAL FINDINGS FROM THE STUDY

This section outlines the findings from the baseline study concerning the stated objectives. Data from the target areas on specific topics are presented using tables, graphs, and maps. The findings reflect the conditions in the districts and communities where data collection was conducted.

4.1 Demography

A total of 558 respondents participated in this baseline study, comprising 279 males and 279 females from the GMFs. The respondents had an average age of 33 ± 5 years. As shown in Table 1 below, the majority (48.4%) of respondents had attained primary education, while only 5.9% had tertiary education. These findings highlight a gap in educational progression, with most respondents unable to advance beyond primary education. Additionally, a significant proportion (25.8%) of respondents had no formal education, with females constituting the majority of this group, accounting for 15.8% of the total respondents without formal education.

4.1.2 Educational Status of the Respondent

Table 1: Percentage of educational status of the respondent

	Female		Male	
	Freq	%	Freq.	%
Primary	148	26.5	122	21.9
No formal	88	15.8	56	10
Secondary	36	6.5	75	13.4
Tertiary	7	1.2	26	4.7
Total	279	50.0	279	50.0

Source: Baseline data 2024

4.1.3 Regional distribution of educational status

Table 2 below presents the regional distribution of the respondents' educational status. This offers a localized insight into the educational patterns among the respondents. The findings reveal regional disparities in the levels of educational attainment. The majority of respondents with no formal education (11.8%) are from the Northern Region, emphasizing the need for tailored health education approaches in these communities. The Central Region recorded the highest proportion (13.3%) of respondents with primary-level education, while the Ashanti Region had the highest percentage of respondents with secondary-level education. Notably, only a small proportion (2.2%) of GMFs in the Northern Region reported attaining tertiary-level education.

Table 2: Regional distribution of educational status

	No Formal	Primary	Secondary	Tertiary
Ashanti Region	0.5	4.3	5.2	1.1
Central Region	3.9	13.3	4.1	0.9
Greater Accra Region	2.2	6.6	2	0.4
Northern Region	11.8	4.7	3.6	2.2
Oti Region	1.3	7	2.2	0.7
Volta Region	2.7	5.7	2.3	0.4
Western North Region	3.4	6.8	0.5	0.4
Total	25.8	48.4	19.9	6.1

Source: Baseline data 2024

4.1.4 Disability status of the respondents

The study assessed respondents' disability status to ensure that the program considers their specific needs. As illustrated in Figure 1, the majority, 98% of respondents reported no known disabilities, with females comprising the larger proportion (49.8%) of this group. Conversely, most respondents with a known disability were male, representing 1.8% of the total population with disabilities. Among the reported cases, four respondents were physically challenged, two were deaf, two were visually impaired, three had osteoarthritis, one had a stroke, and one had myopia.

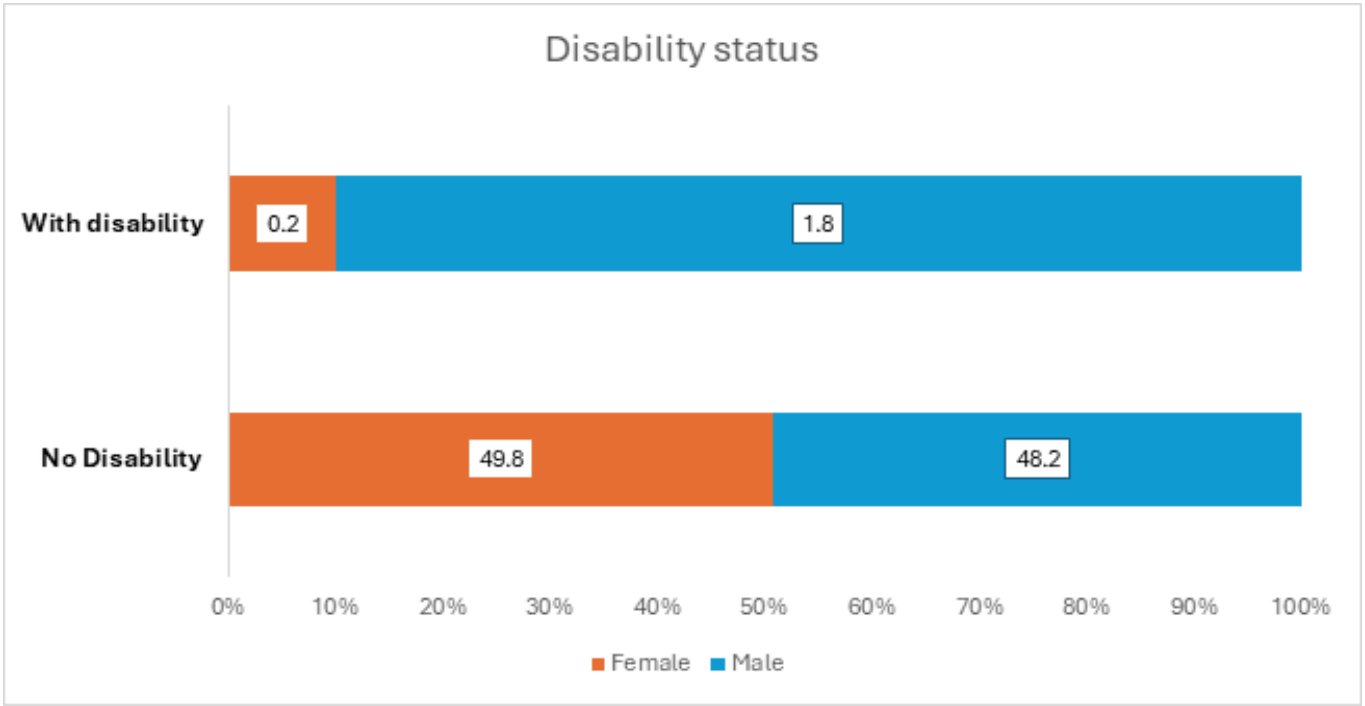


Figure 1: Disability status of the respondents

4.1.5 Gender distribution of Household heads among the GMF

In our traditional settings, as discussed in the literature, men are typically regarded as the heads of households in our communities. However, data from Table 3 below reveal nuanced perspectives when respondents were asked about their roles within their families. The majority of women indicated that they are not the head of their household, with only 1.4% of men reporting the same. Conversely, 48.6% of men identified as the head of their household, while 6.8% of women also reported being the household head.

These findings, in line with previous studies, suggest that the traditional notion of men being solely responsible as household heads may not fully reflect reality. This evolving dynamic provides opportunities for women to play a more active role in family decision-making, particularly in accessing primary healthcare services.

Table 3: Gender distribution of household heads among the GMF

	Female		Male	
Response	Freq	%	Freq	%
No	241	43.2	8	1.4
Yes	38	6.8	271	48.6
Total	279	50	279	50

Source: Baseline data 2024

4.1.6 Decision-making among GMF

Table 4 summarizes findings on household decision-making dynamics. Traditionally, men have been regarded as the primary breadwinners and decision-makers within families, while women have been associated with nurturing, caregiving, and managing household responsibilities. As societal norms evolve and gender roles become less rigid, the distribution of decision-making responsibilities within households has become more fluid. Nevertheless, the results from Table 4, based on pooled data, reveal that a significant majority 82.1% of both men and women still view husbands as the primary decision-makers in their households. Additionally, 16% of respondents indicated that decision-making power is shared equally between men and women in the family, while only a small proportion believed that women have greater decision-making authority. This aligns with traditional cultural norms in the country, where men are often assigned primary leadership roles within households. Consequently, this dynamic can limit women's ability to influence critical family decisions, including those related to their own health and well-being.

Table 4: Who has more decision-making power-pooled

Response	Freq	%
Men	458	82.08
Equal for men and women	90	16.13
Women	10	1.79
Total	**558**	**100**

Source: Baseline data 2024

4.1.7 Regional Distribution of Decision-making Power among Couples

Figure 2 below illustrates the regional distribution of power among couples in the seven implementing regions. The majority (96%) of respondents indicated that in the Northern region, men hold the highest decision-making power, while 4% believe decision-making is shared equally between men and women. Notably, none of the respondents indicated that women have decision-making power in the Northern and Oti regions. Across all regions, men consistently held the highest decision-making authority, while women had minimal influence over household decisions. This trend may be attributed to traditional and social constructs that position men as the heads of households.

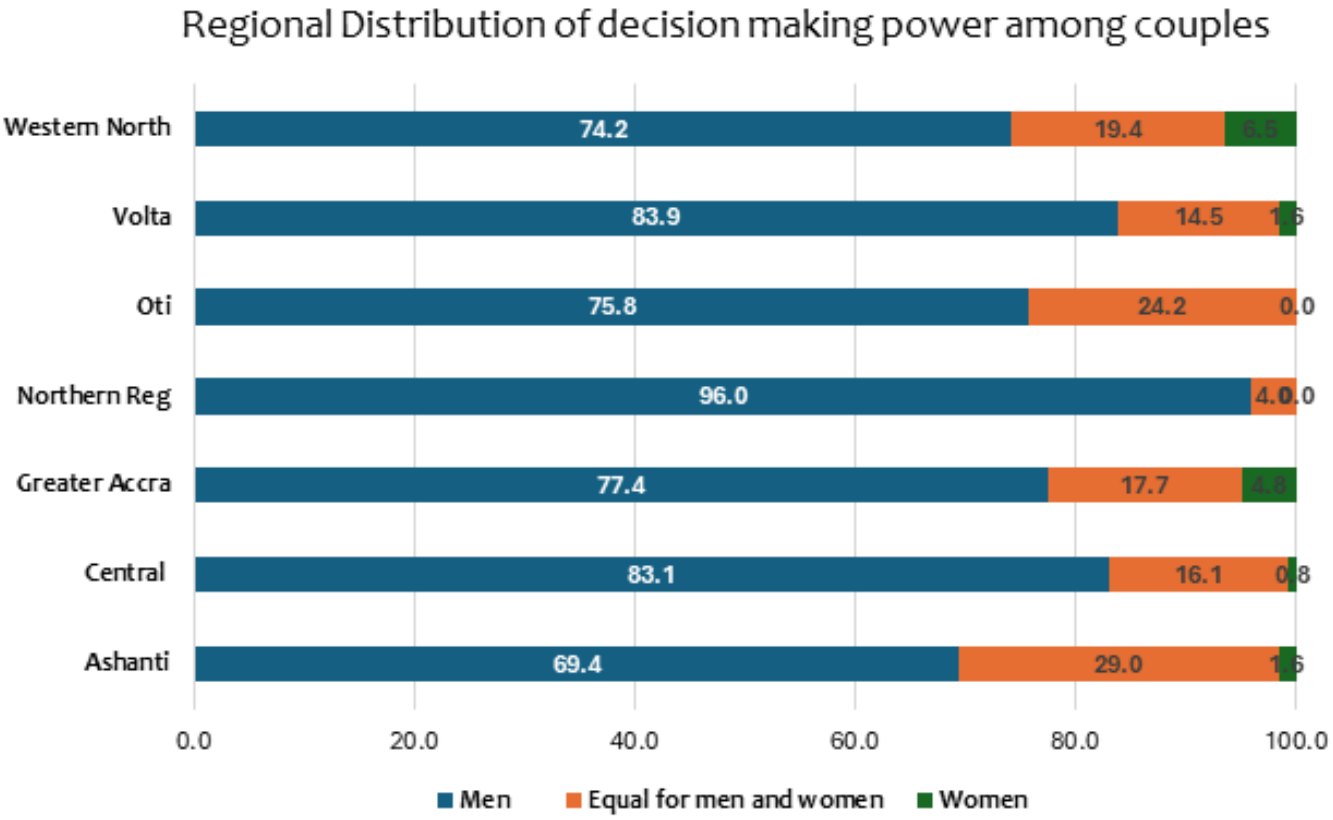


Figure 2: Who has more decision-making power-pooled

4.1.7.2 Major Decision-making among the Couples

Figure 3 provides an overview of who holds primary responsibility for making major family decisions. The findings show that the majority of respondents (59.8%) identified husbands as the key decision-makers within the family. Additionally, 36.3% believed that decision-making is a shared responsibility between men and women. Notably, the study highlights the unique role of children in family decision-making in certain cases. This is attributed to the financial support often provided by older children, which positions them as key stakeholders who are consulted before significant family decisions are made.

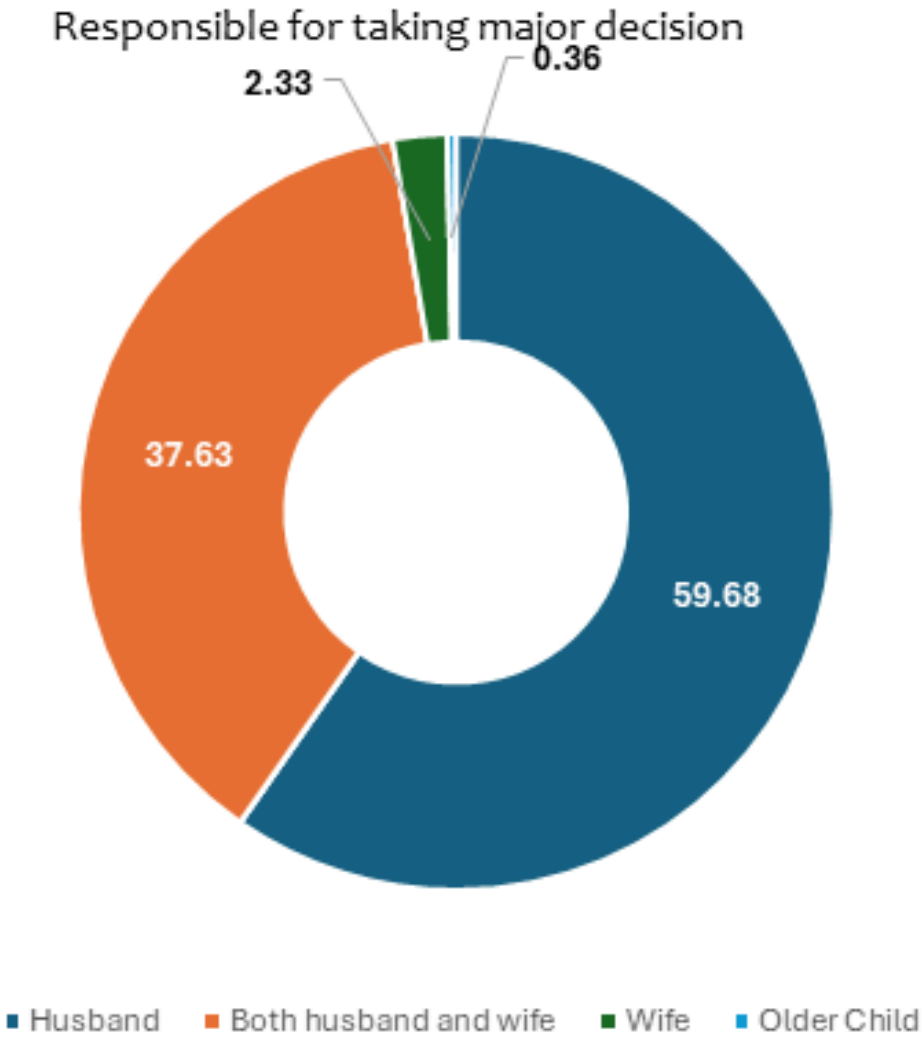


Figure 3: Responsible for making a major decision

4.1.8 Deliberation on issues before making decisions

The respondents were explicitly asked whether couples deliberate on issues before making family decisions. As shown in Table 5, a majority (51.6%) indicated that they always engage in discussions before reaching a consensus. This approach allows women to contribute to household matters, including those affecting their health. However, 44.1% of respondents noted that while some level of deliberation occurs, it is limited to certain issues, restricting women from fully participating in leadership roles at home and diminishing their influence in household decision-making. Additionally, a small minority (4.3%) reported that no deliberation takes place in their households. In such cases, decision-making is solely the man's responsibility, with women entirely excluded from consultations under all circumstances.

Table 5: Deliberation on issues

Response	Freq	%
Yes, in all issues	288	51.6
Yes, for some issues	246	44.1
Not at all	24	4.3
Total	**558**	**100**

Source: Baseline data 2024

4.1.9 Contributions to the differences in power among GMF

The distribution of power within families varies across communities, tribes, cultures, and individual households. Various societal factors contribute to these differences. For instance, in some families, the older spouse—whether male or female—is automatically accorded respect and authority to lead the household. In other cases, cultural norms dictate that power is ascribed to a particular gender. During our interactions with families for this study, it was observed that individuals who attain new social statuses, such as becoming a chief or assembly member, experience a shift in their household dynamics. This elevated status often grants them decision-making authority, which can significantly impact family dynamics, including health-seeking behaviour. Conversely, some individuals may prevent their partners from taking on community leadership roles to maintain a sense of equality at home.

Figure 4 illustrates respondents' perspectives on the primary contributors to power differences within families. The majority (21.4%) identified cultural norms as the key determinant of power dynamics, followed by age differences (19.4%), income levels (17.9%), certain religious practices (14%), and educational status (9.9%). Understanding these dynamics is crucial for improving the uptake of primary healthcare services, as partners must be mindful of these power structures to foster equitable decision-making and promote better health outcomes.

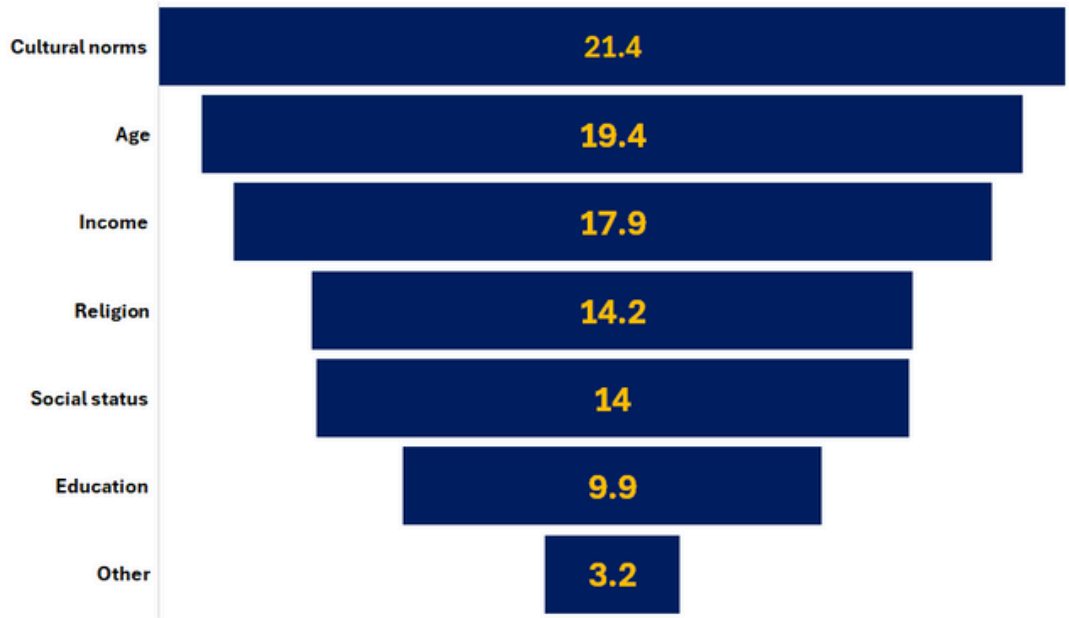


Figure 4: Percentage of contribution to the difference in power

4.1.10 Regional distribution of contributions of power among GMF

Figure 5 below indicates the regional distribution of power among GMF. In the Northern, Western North, and Ashanti regions, cultural norms were the most significant factor influencing household power. In contrast, income played the dominant role in the Central and Oti regions. In the Volta region, social status was the key determinant, whereas in the Greater Accra region, age was the primary influence. This highlights the regional variations in factors that shape power dynamics.

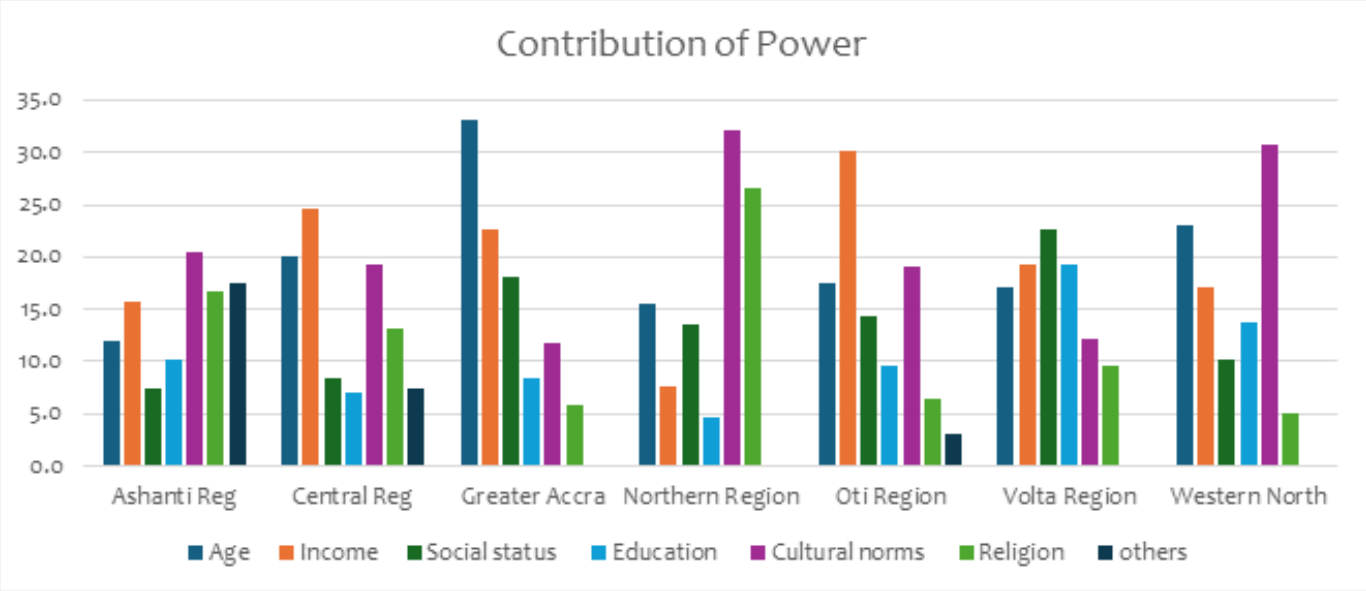


Figure 5: Regional distribution of contributions of power among GMF

4.1.11 Decision-making on specific socioeconomic issues

As outlined in the earlier subsections, while couples may deliberate on decisions, final authority typically rests with men. This section delves into specific decisions across key social and economic areas. Table 6 illustrates the decision-making trends in these domains. The findings reveal that both men (27.8%) and women (25.8%) contribute to decisions on the type of economic activity to pursue. However, 41% of respondents indicated that men predominantly make the final decisions in this area.

The results reinforce the notion that men hold significant authority over decisions related to the use of economic resources, household income allocation, family size, and birth spacing. Additionally, respondents noted that even decisions regarding the use of family planning methods often require male authorization, despite Ghana's reproductive health policy stating that women do not need male approval to exercise their reproductive health rights. Alarmingly, only 7% of men believe that women should have control over their reproductive health, highlighting a substantial gender disparity in this regard.

On household matters such as meal planning, the study found that only 10% of men believe women should have the sole authority to decide what to cook. Interestingly, in some cases, children play a role in these decisions, likely due to their financial contributions to the household. This dynamic allows children to influence meal choices on occasion.

The study also found that men are the primary decision-makers regarding participation in health committees, although some decisions are made jointly by both partners. This suggests that women often lack the autonomy to join community health committees without their male partners' approval. Discussions with female respondents revealed that, without their partner's consent, women may have to participate in such activities covertly, limiting their ability to contribute to community health initiatives.

Despite some areas of joint decision-making—such as the use of economic resources, household income, meal choices, family size, birth spacing, and family planning, the findings highlight persistent gendered disparities that limit women's agency in both household and community-level decisions.

	Economic activity		Economic resource		use of household income		What to cook		No. of children		Birth Spacing		use of FP		Visit Clinic		Reg. With NHIS		education of children		Asso. To belong		Participation in health comt	
	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M
Both	25.8	27.8	22.8	25.3	27.4	31.4	26.2	28	32.8	36.4	30.5	36.2	27.4	33.3	30.3	33.7	21.5	24.9	26	28.1	27.2	31	28.1	31.2
Children	0	0.2	0.2	0	0	0	0.9	1.8	0	0	0	0	0.2	0	0	0.2	0.0	0.4	0.0	0	0.0	0	0.0	0.2
Men	20.8	20.3	22.6	23.8	19.7	16.8	10.2	9.9	13.1	11.8	11.8	9.3	12.4	9.9	12.2	10.2	23.8	22.9	20.4	20.3	19.4	16.1	18.5	17
Women	3.4	1.7	4.5	0.9	2.9	1.8	12.7	10.3	4.1	1.8	7.7	4.5	10.0	6.8	7.5	5.9	4.7	1.8	3.6	1.6	3.4	2.9	3.4	1.6

Table 6: Decision-making on specific socioeconomic issues

4.1.12 Should women be allowed to make an independent decision

The respondents were explicitly asked whether women should be allowed to make independent decisions. As shown in Figure 6, the majority of both males (43.7%) and females (44.1%) stated that women should not have the autonomy to make decisions on any matters. This highlights the persistent restrictions women face, particularly in areas such as the use and control of household resources, childcare, and income allocation. Notably, even a significant proportion of women (44.1%) share the belief that they should not independently make decisions. This mindset can be attributed to social and cultural conditioning, where women are often trained to be submissive to men, leading many to view independent decision-making as inappropriate within the context of marriage, even on matters affecting their health.

However, 30.5% of men believe that women should be allowed to make independent decisions on specific matters, though fewer than 27% of women support this idea. Additionally, 29.4% of female respondents think women should be granted the autonomy to make decisions on all matters. These findings suggest that, while there is a prevailing perception that men resist granting women complete decision-making freedom, the reality is more nuanced, with some openness to change evident among both genders.

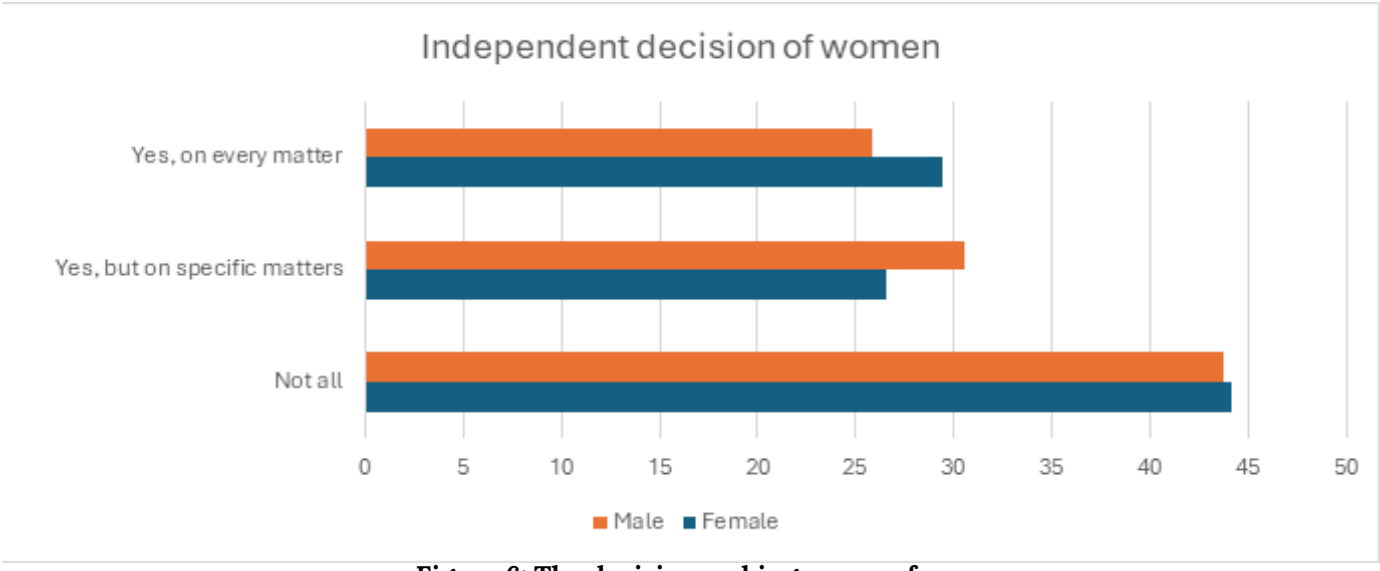


Figure 6: The decision making power of women

4.1.13 Topics unable to discuss with a partner

Table 7 highlights the topics couples find challenging to discuss with their partners. The majority of respondents (41.7%) reported difficulties discussing sexual and reproductive health issues, including family planning, sexually transmitted infections, and related matters. A smaller proportion (13.8%) indicated challenges in discussing the sharing of household chores. Additionally, a significant percentage of the respondents (25.0%) found it difficult to talk about community management, leadership, and participation with their partners. Furthermore, 19.5% of respondents expressed difficulty in discussing resource control and decision-making within the household. These findings suggest that a notable proportion of couples struggle to communicate openly on certain critical topics. This underscores the need for targeted health education initiatives that focus on promoting open dialogue and understanding around these sensitive issues, particularly within the household setting.

Table 7: Topics unable to discuss with a partner

	Freq	%
Sexual and Reproductive Issues (family planning, fertility etc)	308	41.7
Sharing housework	102	13.8
Control Resources and Decision Making	144	19.5
Community mgt leadership participants	185	25.0

Source: Baseline data 2024

4.2.0 Assessing Women's Participation in Community Leadership

4.2.1 Members of the Health Committee

The participation and leadership of women and girls in primary healthcare (PHC) decision-making are essential for achieving equitable and effective health outcomes. Despite their critical roles as primary caregivers within families and communities, women's and girls' voices have historically been underrepresented in health policy and decision-making processes.

As shown in Table 8, only 5.2% of women were identified as members of health committees in their communities, compared to 13.6% of men. This disparity highlights a significant underrepresentation of women in these committees, limiting their ability to contribute to discussions and decisions regarding their own health and that of their families. Addressing this imbalance is crucial to ensuring inclusive and representative healthcare decision-making processes.

Table 8: Membership of the health committee

Response	Female	Male
No	44.8	36.4
Yes	5.2	13.6

Source: Baseline data 2024

4.2.2 Gender Model Family's Awareness of Health Committees

Respondents were asked explicitly about their awareness of the existence of community health committees, extending beyond those integral to the Primary Health Care (PHC) concept. As presented in Table 9, a majority (31.4%) of men reported being aware of some health committees, compared to 27.8% of women. Notably, while the proportion of women aware of these committees was relatively appreciable, this awareness did not translate into their active participation.

The findings suggest that men are often prioritized for leadership roles within these committees, potentially due to traditional gender norms and perceptions about leadership in the community. Addressing this gap requires intentional efforts to promote women's participation and leadership in health committees, ensuring a more inclusive and equitable approach to community health governance.

Table 9: Percentage of GMF awareness of health committee

Response	Female	Male
Not aware of the health committee	22.2	18.6
Awareness of Health committees	27.8	31.4

Source: Baseline data 2024

4.2.3 Gender Model Family's Participation in Health Volunteerism

Community Health Volunteers play a crucial role in supporting healthcare providers through community mobilization and education. In some areas, these volunteers also assist with tasks such as drug distribution and tracing individuals who default on health treatments. However, the findings reveal that women are significantly underrepresented in these roles, with only 5.2% serving as community health volunteers compared to 10.4% of men.

Overall, participation in health volunteerism is notably low, with only 15.6% of respondents indicating involvement, while a vast majority (84.4%) reported not participating as health volunteers. This low engagement underscores the need for strategies to increase community involvement in health volunteerism, with a particular focus on encouraging women's participation to ensure a more inclusive and representative approach to community health initiatives.

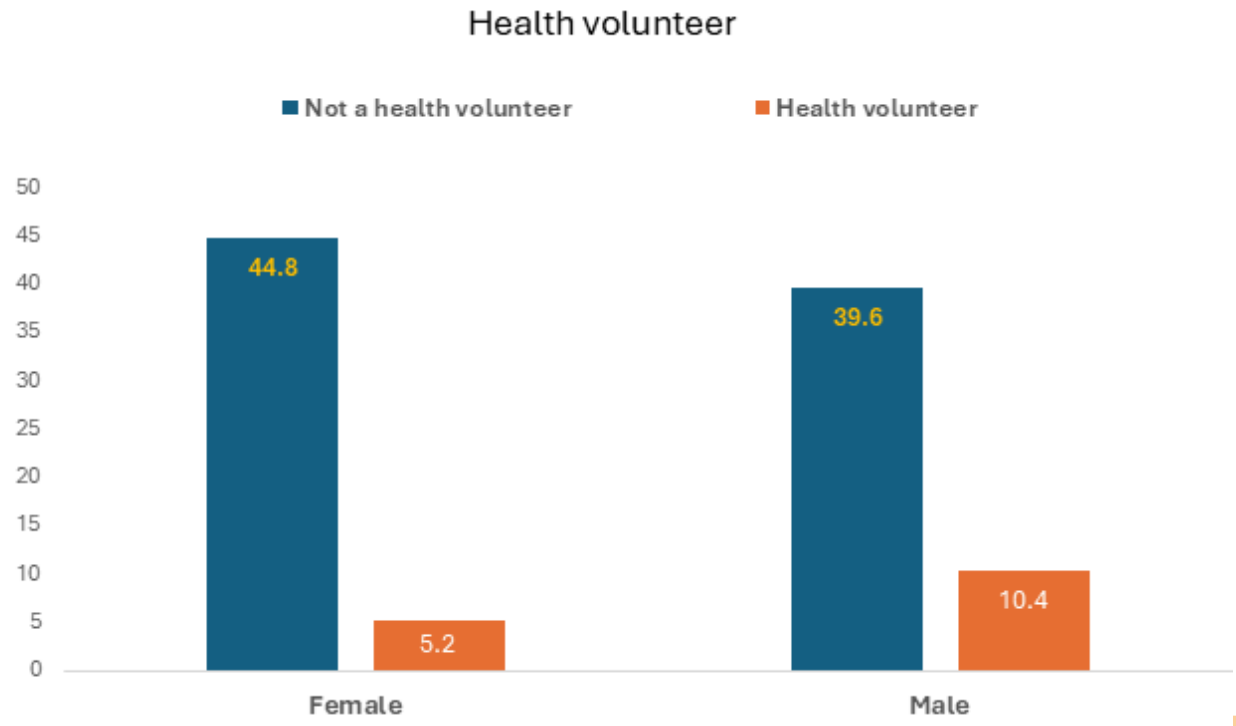


Figure 7: GMF participating in health volunteerism

4.2.4 Women's Assessment of Men's Support to Primary Health Care Services

Women were assessed on the level of support they received from their husbands in various health activities, with the results presented in Figure 8. Regarding antenatal care (ANC) services, over 34% of women reported that their husbands often accompanied them, while 10.5% stated that their husbands rarely did so. For postnatal care (PNC) services, 29% of women indicated that their husbands often accompanied them, whereas close to 26% revealed that their husbands had never done so.

Notably, more than half (52.9%) of the women expressed that their husbands always accompanied them during delivery, which is commendable. However, 14.1% of women reported that their husbands had never accompanied them for delivery. Strikingly, 64.9% of husbands had never accompanied their wives for family planning services, suggesting potential contention or disagreement among couples regarding family planning decisions, as many men may not support their wives' participation in such services.

Lastly, a significant proportion of women indicated that their husbands always accompanied them to the hospital when they were ill, with over 33% of husbands providing this support. Nonetheless, 13.8% of men had never accompanied their wives to the hospital, highlighting gaps in spousal support for healthcare services.

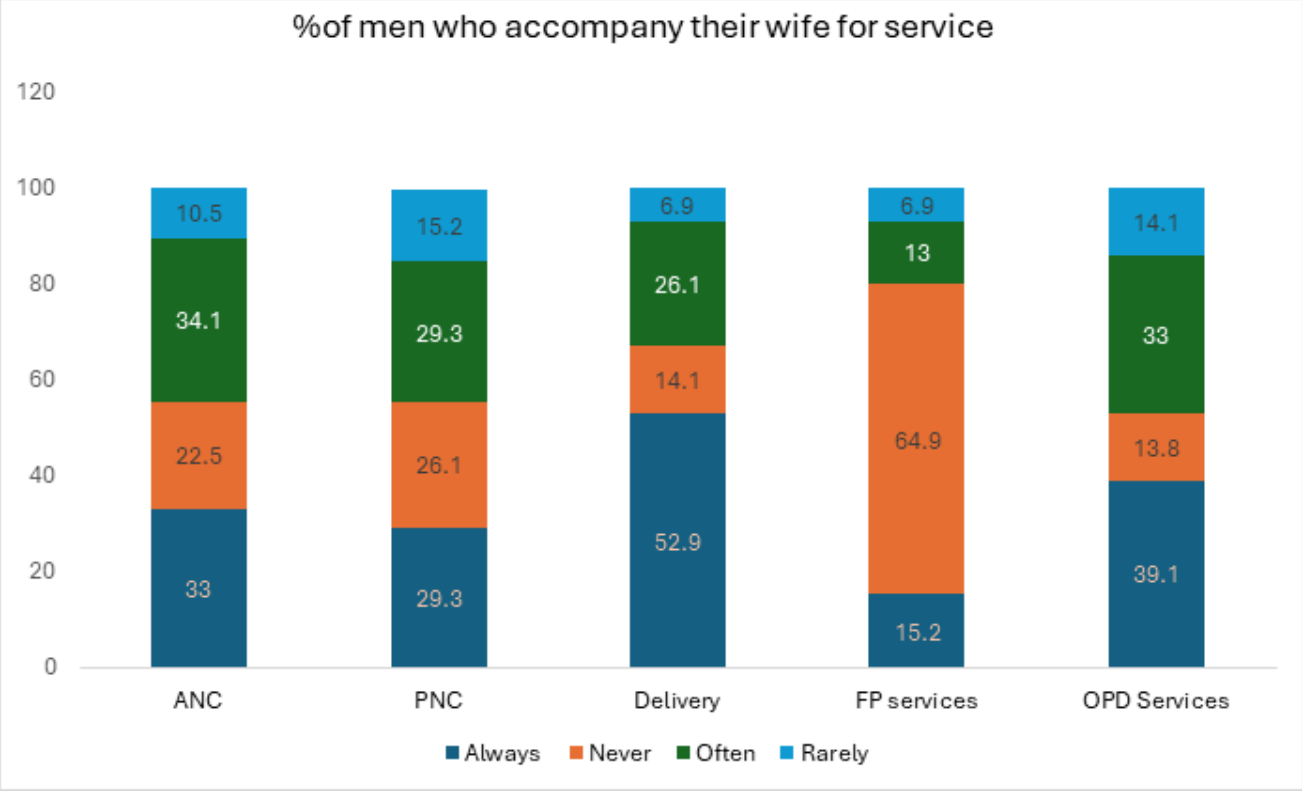


Figure 8: Percentage of women's assessment of men's support to PHC services

4.3.0 Assessing Health-seeking Behaviour of the Gender Module Families

4.3.1 Frequency of facility visits by couples

Health-seeking behaviour encompasses the actions individuals and families take to maintain their health, prevent illness, and seek treatment for health-related concerns. Figure 9 illustrates respondents' frequency of visits to health facilities within the year. Nearly half of the respondents reported visiting a health facility 1 to 2 times during the year, while a smaller proportion (16.9%) indicated making 3 to 4 visits. Notably, 24.4% of the respondents had not visited a health facility at all at the time of the study. These findings highlight variability in health-seeking behaviour, suggesting potential barriers or differing health needs among the population.

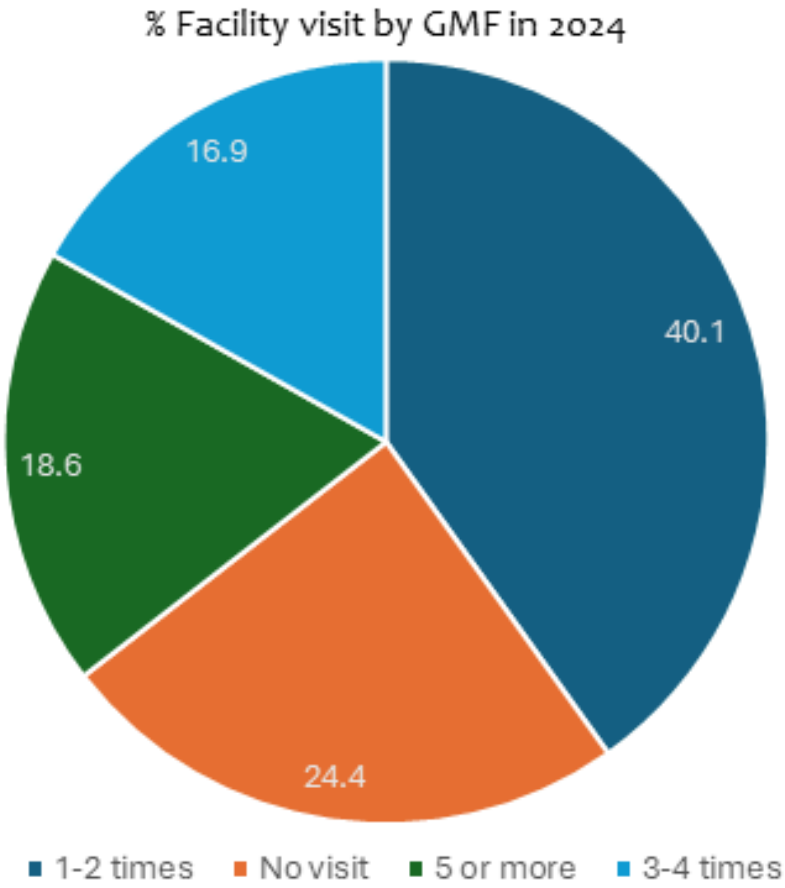


Figure 9: Frequency of facility visit by respondent

4.3.2 Seeking Medical Care When You or a Family Member is Sick

Respondents were also asked whether they seek medical care when they or a family member fall ill. The majority of couples reported that they sometimes seek medical care under such circumstances. Additionally, over 42% of couples indicated that they always seek medical care when they or a family member is sick.

Notably, almost 2% of couples stated they had never sought medical care when ill. This could be attributed to religious beliefs or a preference for alternative medicine, as they may rely on these avenues instead of conventional healthcare services. These findings highlight the influence of personal beliefs and cultural practices on health-seeking behaviour.

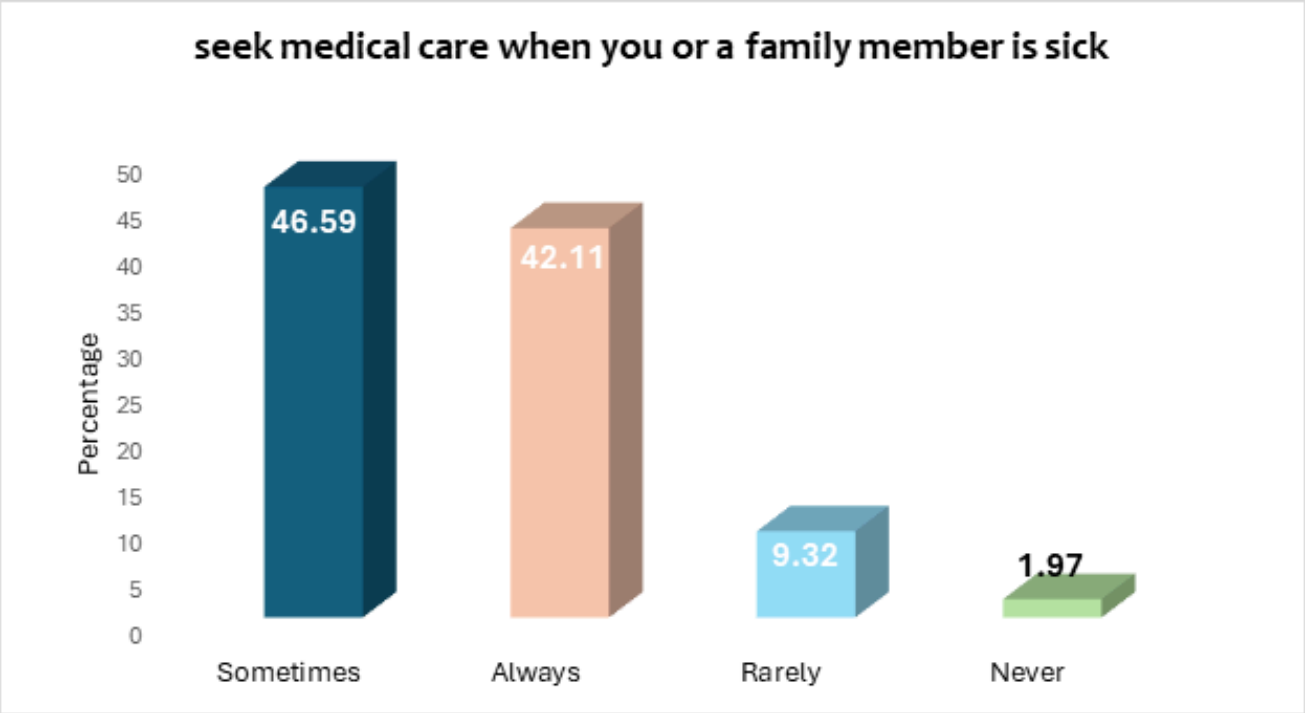


Figure 10: Seek medical care when you or a family member is sick

4.3.3 Urgency of couples seeking health care after noticing signs and symptoms

Table 10 provides insights into couples' urgency and responsiveness in seeking health care at their primary healthcare centres. Respondents were explicitly asked about how promptly they seek care upon noticing signs or symptoms of an illness.

Nearly half (45%) of the respondents reported seeking health care immediately after observing symptoms. Additionally, 31% indicated they would seek care a few days after experiencing symptoms. However, 17.6% stated they would only seek health care when the illness becomes serious, while 6.6% admitted they would delay seeking care for a week or longer after the onset of symptoms.

These findings underscore the varying levels of urgency in health-seeking behaviour, emphasizing the need for targeted health education to encourage prompt care-seeking practices.

Table 10: Urgency of couples seeking health care

Response	Frq.	pct
Immediately	251	45.0
After a few days	172	30.8
Only when the illness gets serious	98	17.6
After a week or more	37	6.6
Total	558	100

Source: Baseline data 2024

4.3.4 Couples' understanding of the services provided by the primary healthcare facilities

Research suggests that when community members are aware of the services offered by their primary healthcare providers, they are more likely to utilize these services, despite other barriers to access. Nearly half (49.8%) of the couples surveyed reported having a fairly good understanding of some key services provided at their community health facility. This suggests that a significant proportion of community members might not seek care at their local facility due to uncertainty about the range of services available.

Additionally, 40% of respondents indicated that they have a very good understanding of the services offered, while a small proportion (3%) admitted to having no understanding of the services provided at all. These findings highlight the importance of community education and awareness campaigns to improve service utilization and healthcare access.

Table 11: Couples understanding of the services offered by the healthcare facilities

Response	freq	pct
Fairly well	278	49.82
Very well	195	34.95
Not very well	68	12.19
Not at all	17	3.05
Total	558	100

Source: Baseline data 2024

4.3.5 Respondent's first point of care.

The respondents were asked where they first seek medical care when they fall ill. The majority indicated they would seek care at the local clinic or CHPS compound, while 2.3% reported consulting traditional healers. Notably, almost 15% of respondents stated they would first seek care at the local pharmacy instead of visiting their primary clinic, which is not considered an ideal option. Additionally, nearly 11% of respondents would go directly to the hospital rather than their community clinic, and over 10% reported self-medicating at home. These choices may be influenced by several factors, including satisfaction with services at the primary clinic, NHIS enrollment status, high service costs, availability of essential medications, and other considerations.

Table 12: Respondents' first point of care

Response	Freq	pct
Local clinic/primary health care Centre	344	61.7
Pharmacy	83	14.9
Hospital	59	10.6
Self-medication at home	58	10.4
Traditional healer	13	2.3
other	1	0.2

Source: Baseline data 2024

4.3.6 Respondents' satisfaction with services they received at their primary clinic

Table 13 presents respondents' satisfaction with services received at their primary care center, specifically the CHPS compound, which serves as the primary healthcare facility under Ghana Health Service structures. According to the data, over half of the respondents (52.5%) reported being satisfied with the services provided at the facility. Additionally, nearly a third of the respondents (32%) expressed feeling very satisfied with the care they received. However, 2.9% of respondents indicated dissatisfaction with the services, highlighting a small but notable area for improvement in the delivery service.

Table 13: Respondents' satisfaction with services

Response	Freq	%
Satisfied	293	52.5
Very satisfied	181	32.4
Neutral	68	12.2
Dissatisfied	16	2.9

Source: Baseline data 2024

4.3.7 NHIS enrollment, activation and Health-saving practices of GMF

We also assessed respondents' enrollment, activation, and health-saving practices. From the data presented, 41.9% of male respondents and 48.7% of female respondents reported being enrolled in the National Health Insurance Scheme (NHIS) and currently possessing an NHIS card. Notably, more females than males were enrolled, with 8.1% of men reporting they did not have NHIS cards. Among the female respondents enrolled in NHIS, 37.2% had active cards, compared to 32.2% of men with active cards.

Interestingly, a higher percentage of women (16.6%) had inactive cards compared to men (14%). This disparity might be attributed to the challenges women face in renewing their cards compared to their male counterparts. Additionally, a significant proportion of respondents—31.0% of females and 16.5% of males—indicated that women are primarily responsible for keeping the NHIS cards. Lastly, the findings revealed that most respondents do not set aside savings specifically for their health needs. Among those who do, a higher proportion of men reported saving for health-related expenses compared to women. This underscores a potential gap in financial preparedness for healthcare, with women being particularly disadvantaged in this regard. Addressing this disparity could be crucial for improving healthcare access and outcomes.

Table 14: NHIS enrollment, activation and health saving practices

Response	Female(%)	Male(%)
Respondent With NHIS card		
Without NHIS	1.3	8.1
With NHIS	48.7	41.9
Status of NHIS card		
Not Active	16.0	15.6
Active	34.0	34.4
Who keeps the NHIS card		
Both Father/mother	12.0	14.8
Father	7.0	18.7
Mother	31.0	16.5
Save for Health Needs		
Do not save	29.9	30.3
Save for Health Needs	20.1	19.7

Source: Baseline data 2024

4.3.8 Respondents' awareness of free or subsidized services by NHIS

Table 15 highlights respondents' awareness of the NHIS-subsidized services provided at health facilities. An overwhelming majority (82.4%) of the respondents indicated they are aware that NHIS covers free services at the point of care.

However, despite this awareness, many respondents do not prioritize health facility visits as their first choice when seeking care. This discrepancy underscores the need to investigate the underlying reasons for this behaviour. Potential factors could include indirect costs, perceptions of service quality, availability of medicines, or other systemic barriers affecting healthcare utilization.

Addressing these barriers will be essential to maximize the utilization of NHIS-subsidized services and improve health-seeking behaviour among community members.

Table 15: Knowledge of respondents on the NHIS package

Response	frq	%
Yes	460	82.4
No	98	17.6
Total	558	100

Source: Baseline data 2024

4.3.9 Challenges faced by GMF accessing health service

Table 16 outlines the challenges couples face in accessing healthcare at the primary level. The most significant barrier identified is the high cost of care (36.5%). Although many families have active health insurance, they reported being charged exorbitant fees when seeking care. This could explain why some respondents opt to seek care at pharmacies or other sources when they first notice signs of illness.

Additionally, over 23% of respondents indicated that the unavailability of essential medicines is a critical factor affecting their access to healthcare facilities. Many participants mentioned that basic drugs are often unavailable at health facilities, forcing providers to write prescriptions for medicines to be purchased at pharmacies, which imposes a considerable financial burden.

Other challenges highlighted include distance to the clinic (10.3%), long waiting times (8.5%), poor attitudes of health staff (6.7%), lack of transportation to health facilities (6%), and cultural or religious reasons (2.3%). These factors contribute to barriers in accessing timely and affordable healthcare.

Table 16: Challenges faced by GMF's accessing health service

Response	Freq	pct
High cost of care	336	36.5
Lack of available medicines	207	22.5
Distance to clinic	95	10.3
Long waiting times	78	8.5
Other	66	7.2
Poor attitude of health staff	62	6.7
Lack of transport	55	6
Cultural or religious reasons	21	2.3
Total	**558**	**100**

Source: Baseline data 2024

4.3.10 Factors that will encourage families to seek medical care

The couples in Figure 11 expressed that reducing costs (62%) at health facilities is the primary factor that would encourage them to seek care. Additionally, nearly 24% of respondents mentioned that improved service quality would motivate them to utilize these facilities.

Other suggestions included increased health education on available services (7.4%), shorter waiting times (2.7%), and better transportation options for referrals and other purposes (2.0%).

To address these concerns effectively, the project should prioritize these key areas. Specifically, reducing financial barriers, enhancing service delivery, and raising awareness about available services could significantly improve access and utilization of healthcare facilities, particularly for women and girls.

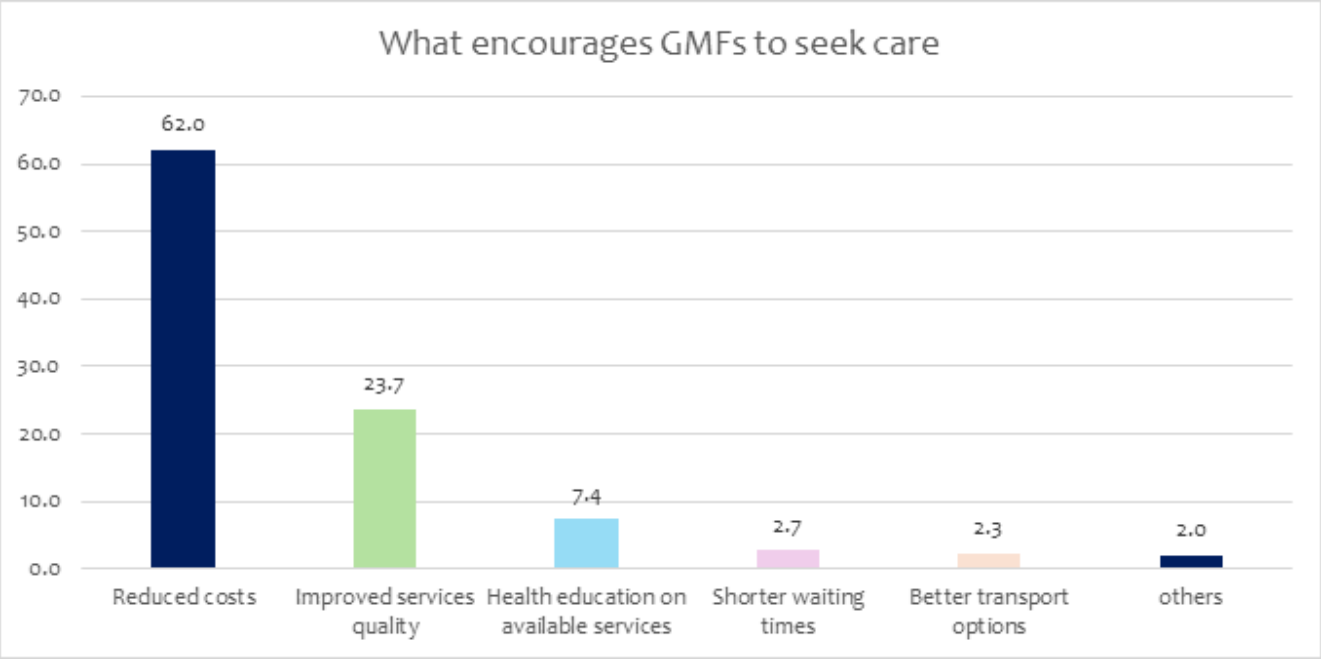


Figure 11: Factors that will encourage families to seek medical care

4.3.11 Client receiving information on their health rights at the facility

Figure 12 illustrates the GMF's assessment of the rights-oriented information they received during their visits to health facilities. Respondents from the Ashanti (43.5%), Central (57.3%), Western North (71.0%), and Oti (43.5%) regions reported that they always received information about their rights as clients during their visits. However, in the Ashanti region, 37.1% indicated that they had never received any rights-related information, a trend also observed in the Central region, where 29.8% reported the same. Additionally, 74.2% of respondents from the Volta region stated that they sometimes received such information, along with 50% in the Volta region, 43.5% in the Greater Accra region, and 24.2% in the Northern region. It would be beneficial for health staff to integrate rights-based education into their interactions with clients, empowering them to demand accountability when seeking healthcare services.

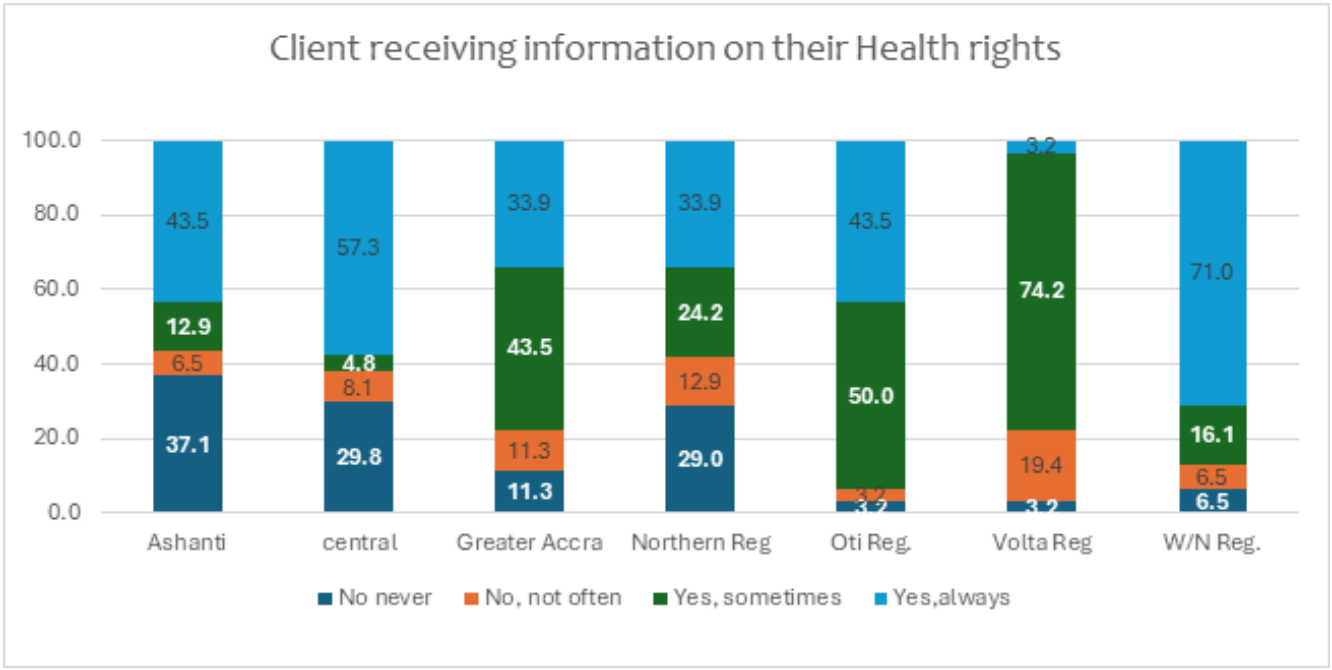


Figure 12: Client receiving information on their health rights

4.3.12 Couples Assessment of respected medical care at the health facilities

Client rights must always be upheld when they seek healthcare at any level. Ensuring respectful and dignified care encourages clients to fully disclose their health concerns and receive the appropriate services as guaranteed by the Constitution of the Republic of Ghana.

As illustrated in Figure 13, a significant number of Gender Model Families (GMFs) in the Ashanti, Central, Greater Accra, Western North, and Oti regions reported that their health rights are consistently respected when accessing primary healthcare services. However, in the Volta region, more than half of the GMFs indicated that their rights are only sometimes respected, a trend also observed in the Oti region (where nearly 55% of couples reported the same) and the Greater Accra region (over 45.2%).

Additionally, some couples in the Ashanti, Volta, Northern, Greater Accra, and Central regions noted that they do not frequently receive these rights-based services from healthcare providers.

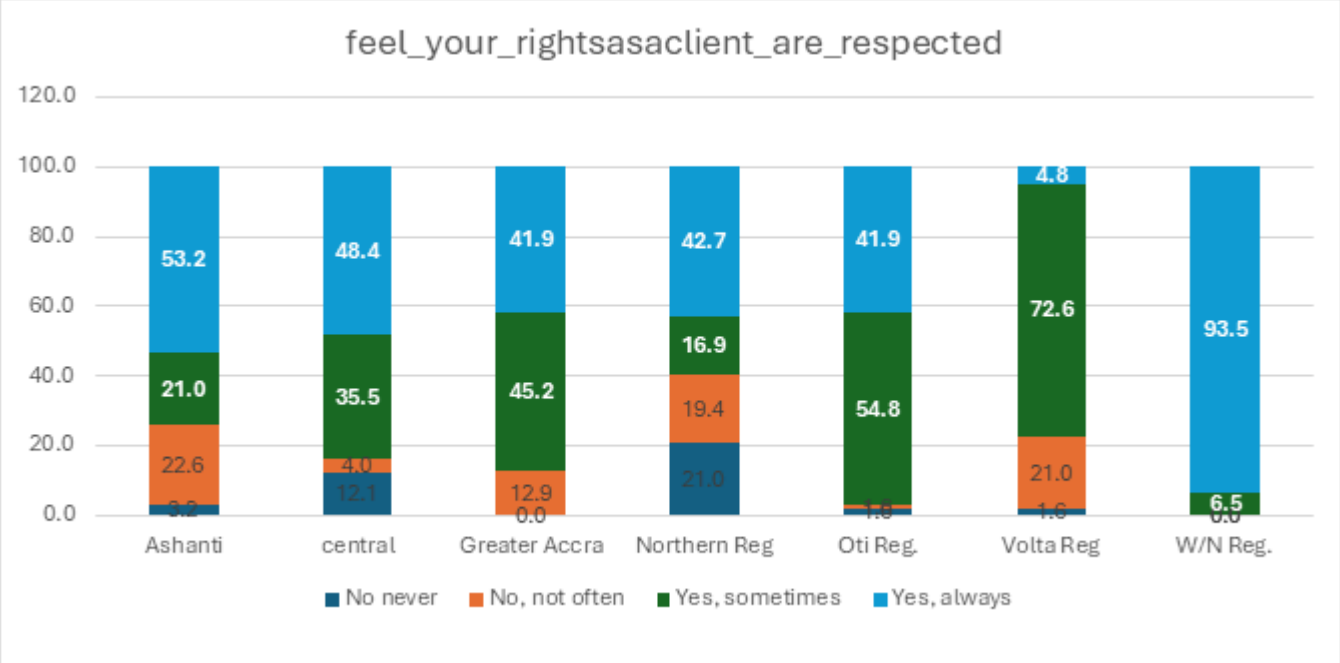


Figure 13: Couples assessment of respected medical care at the health facilities

4.4.0 To assess the availability and utilization of feedback and accountability mechanisms among GMFs.

4.4.1 GMF's awareness of feedback and accountability mechanisms

Feedback and accountability mechanisms are crucial for expressing dissatisfaction with services and ensuring that healthcare delivery adheres to standards, including privacy, confidentiality, and other ethical principles. The table below illustrates the Gender Model Families' (GMF) awareness of the feedback and accountability mechanisms available and accessible to them.

The majority of males (29.6%) and females (23.1%) reported being aware of these mechanisms in their community. However, a significant proportion of females (19.2%) indicated they were unaware of such mechanisms, compared to 12.5% of males who

reported the same. Additionally, 7.7% of females and 7.9% of males stated they were unsure about the existence of feedback and accountability mechanisms.

This highlights a gap in awareness, particularly among females, which may affect their ability to voice concerns or ensure accountability in healthcare services.

Table 17: GMF's awareness of feedback and accountability mechanisms

Response	Female	Male	Total
Yes	23.1	29.6	52.7
No	19.2	12.5	31.7
Not Sure	7.7	7.9	15.6
Total	**50**	**50**	**10**

Source: Baseline data 2024

4.4.2 Knowledge of the Platforms through which feedback is given

Feedback in the context of this study includes clients expressing their satisfaction, suggestions or giving a complaint on the services they have received from the frontline healthcare providers in the community. Respondents were asked about their knowledge of some of the feedback mechanisms available. The first mechanism the majority (56.9%) of the respondents mentioned was verbal feedback to the health care workers. They said they usually give direct feedback to the healthcare worker on services they are happy or unhappy with. Furthermore, they also know that through the community health committee and the leaders of the community, they can give feedback to the healthcare workers and also hold them accountable. Others include phone calls (14.7%) and finally suggestion boxes (6.5%) which they hardly use.

Table 18: Knowledge of the platforms through which feedback is given

Response	Freq	%
Verbal feedback to HCW	194	56.9
C.H.C/leaders	75	21.9
Phone calls	50	14.7
Suggestion box	22	6.5
Total	341	100

Source: Baseline data 2024

4.4.3 Source of information about feedback mechanisms

Regarding the sources of knowledge about feedback and accountability mechanisms, the majority of respondents indicated that they received their information from community leaders. Health workers were identified as the second most common source of information, accounting for 21%. Approximately 17% of respondents reported

learning about these mechanisms from other sources, while 16% gained this knowledge during community outreaches.

Additionally, some respondents mentioned that community members or posters at health facilities and within the community provided information. Unfortunately, sources such as community information centers and community radio were not mentioned, likely due to the nature of the local settings. This highlights potential gaps in leveraging accessible media for disseminating information about feedback and accountability mechanisms.

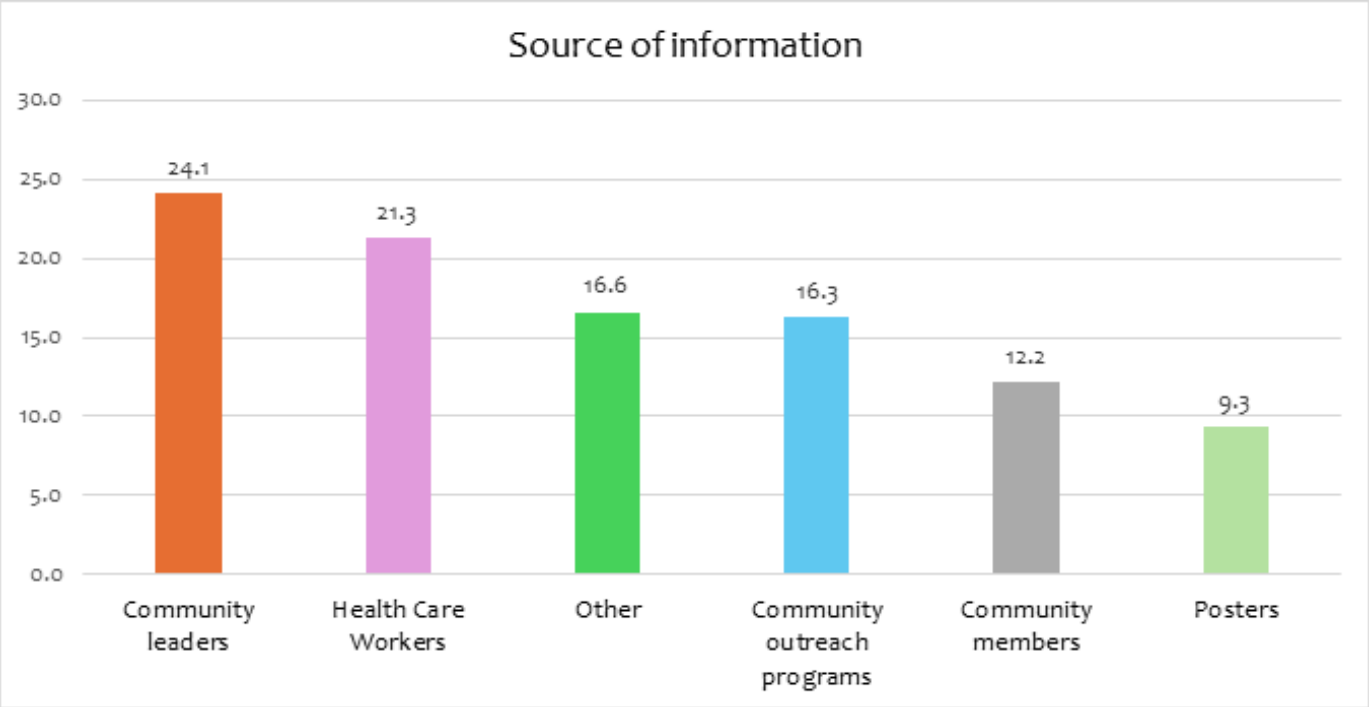


Figure 14: Sources of information

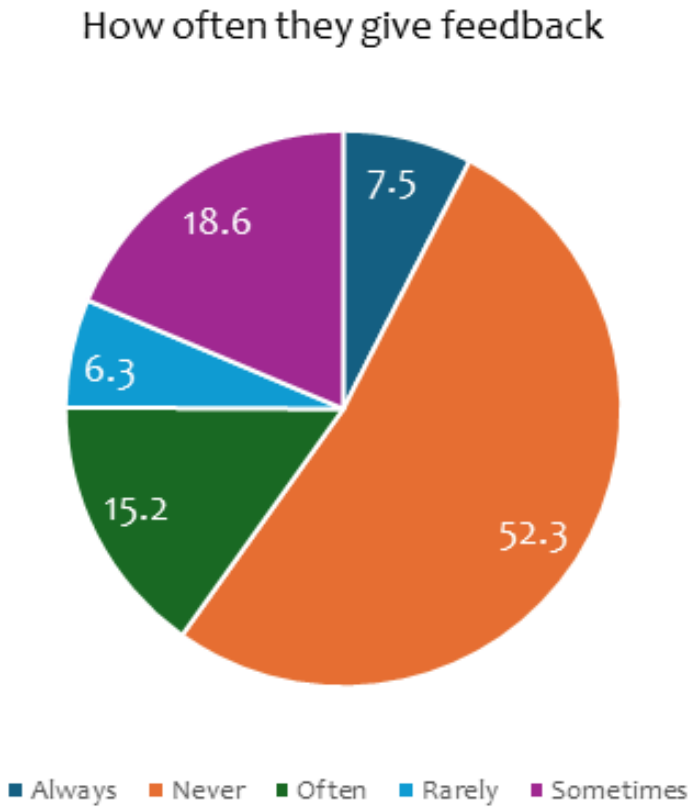
4.4.4 Utilization of Feedback and Accountability Mechanism

Figure 15 highlights respondents' frequency of providing feedback to healthcare authorities regarding the services they receive. Over half of the respondents indicated that they had never provided feedback on the services received. Additionally, 18.6% mentioned that they sometimes give feedback after accessing health facilities, while 15.2% reported always providing feedback after visiting their care provider.

Furthermore, 7.5% of respondents indicated that they often give feedback, and 6.3% stated that they rarely share their feedback with healthcare providers.

These findings suggest a general lack of engagement in providing feedback, which may limit opportunities for service improvement and addressing client concerns effectively.

Figure 15: Utilization of feedback and accountability mechanisms



4.4.5 Provision of Feedback (Satisfaction/complaint/ suggestion) on services provided by frontline health staff

Couples were asked explicitly whether they had ever expressed satisfaction or lodged complaints about the services received at health facilities. More than half (57.4%) of the respondents reported never having done so. Among those who had not provided feedback, the majority were women (30.5%) compared to men (26.9%). This disparity could be attributed to societal norms and gender dynamics within communities, where women may lack the confidence or opportunity to voice their concerns due to fear of victimization or denial of services.

Consequently, many women might choose to relay their feedback to their husbands or refrain from sharing it altogether. Nonetheless, 23% of men across the communities reported having given feedback, while 19.5% of women had also expressed their opinions or complaints, indicating a growing willingness among women to participate in feedback processes despite prevailing barriers.

Table 19: GMFs who have given feedback on the services they received

Response	Female	Male	Total
No	30.5	26.9	57.4
Yes	19.5	23.1	42.6

Source: Baseline data 2024

4.4.6 How long did it take the authorities to respond

Every client who provides feedback or expresses satisfaction with service provision expects a prompt response to their concerns. From the table below, respondents were asked if they received any response to the feedback or complaints, they had provided regarding the services they received.

The findings revealed that more than half (60.4%) of the respondents did not receive any response to their complaints. On the other hand, 22% of the respondents reported receiving an immediate response, while 5.4% indicated that it took up to a month before the authorities responded to their feedback. These results highlight significant gaps in the responsiveness of the feedback and accountability mechanisms, which could impact on clients' trust and willingness to engage in such processes.

Table 20: Duration of the response after feedback

Response	%
No response	60.4
Immediately	22.0
Within a week	12.2
within a month	5.4

Source: Baseline data 2024

4.4.7 GMFs assessment of improvements in service delivery after their complaint

From Table 21 below, couples who had previously lodged complaints or expressed satisfaction were asked whether they observed any changes following their feedback. The majority (56.3%) of respondents, both men and women, reported noticing significant improvements after their complaints. Meanwhile, 32.8% observed only minor improvements, and 10.9% stated that they did not notice any improvement following their feedback to the authorities. These findings suggest that while many complaints lead to positive changes, there is room for enhancing responsiveness and ensuring more impactful outcomes.

Table 21: Improvement after complaint or suggestion

Response	%
Yes, significant improvements	56.3
Yes, but only minor improvements	32.8
No improvements	10.9

Source: Baseline data 2024

4.4.8 Informed about action taken on your complaint or suggestion

The majority (79.4%) of couples, both male and female, informed the researchers that they had received information regarding the actions taken by authorities to address their complaints. However, 21% of couples reported not receiving any feedback about the actions taken, even when measures were implemented. This indicates a gap in communication, as the specific strategies used to address the issues were not shared with the complainants.

Table 22: Informed about action taken on your complaint or suggestion

Response	%
Did not receive information about action taken on the complaint	20.6
Received information about action taken on a complaint	79.4

Source: Baseline data 2024

4.4.9 GMF's satisfaction with the feedback process

The process or medium for giving feedback can sometimes be challenging and frustrating, particularly depending on the education level of the person providing the feedback. It is worth noting that the majority of respondents who gave feedback expressed satisfaction with the process. Additionally, 31.9% of respondents reported being very satisfied, while about 10.1% were neutral, stating they were neither satisfied nor dissatisfied with the process. A small proportion, 1.7% and 0.8%, indicated being dissatisfied and very dissatisfied, respectively, with the feedback process.

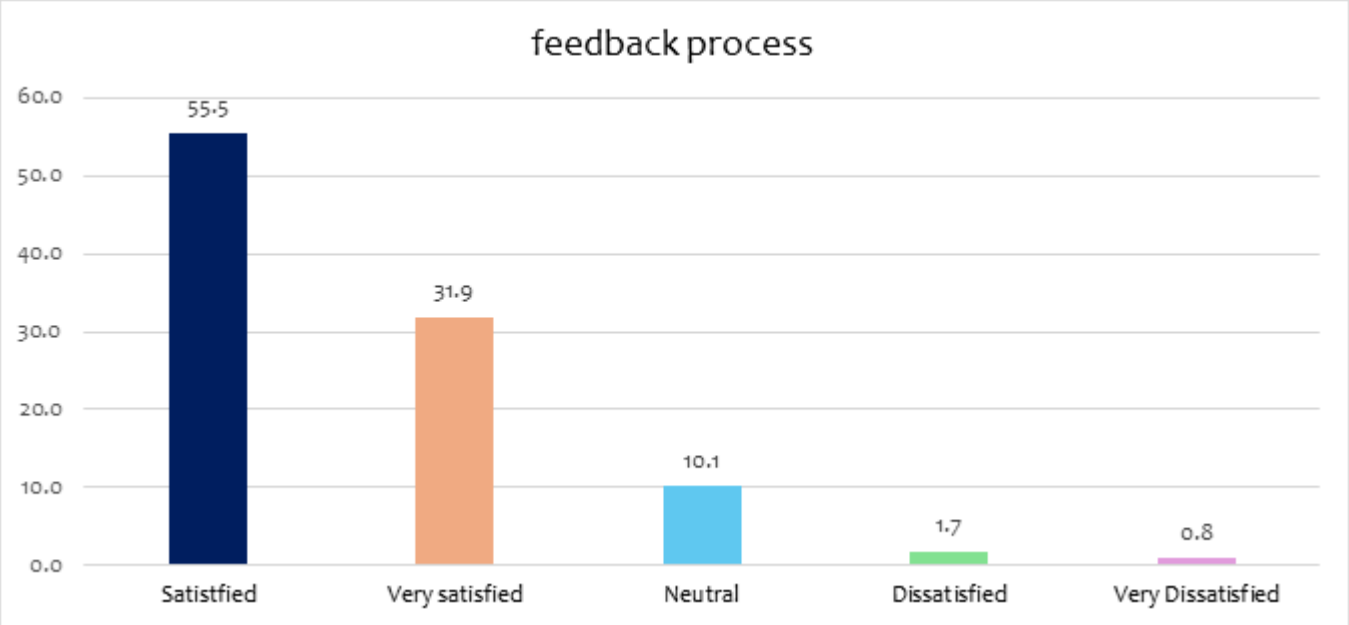


Figure 16: GMF's satisfaction with the feedback process

4.4.10 Challenges when trying to provide feedback

Key challenges inhibiting respondents from providing feedback include a lack of knowledge on how to give feedback (21.8%) and fear of being treated poorly (15.7%). Many clients prefer to withhold complaints, fearing negative treatment if action is taken against the frontline provider. Additionally, 11.9% of respondents indicated the absence of a clear system for submitting feedback, while 11.5% noted concerns about the lack of anonymity, as the identity of the person providing feedback could be revealed. Other barriers include the lengthy process (9.3%) and skepticism about the effectiveness of their feedback, with 7.6% believing it would not result in any meaningful change.

Table 23: Challenges when trying to provide feedback

Response	Percentage
others	22.2
Don't know how to provide feedback	21.8
Fear of being treated poorly	15.7
No clear system for giving feedback	11.9
feedback is not anonymous	11.5
it takes too much time	9.3
I don't believe my feedback will make a difference	7.6

Source: Baseline data 2024

4.4.11 What encourages the GMFs to utilize feedback and accountability Mechanisms

On factors that would encourage GMFs to use feedback and accountability mechanisms, the majority indicated that better awareness of how to provide feedback would significantly motivate them to utilize these services. This underscores the importance of educating and creating awareness about existing mechanisms within the communities. Additionally, less than 24% of respondents highlighted the assurance that feedback would lead to tangible improvements as a key motivating factor. Meanwhile, 21.2% of respondents emphasized the need for faster responses after submitting complaints, and almost 20% expressed a preference for anonymous feedback options.

Table 24: Factors that encourage the GMF to use the feedback and accountability mechanism

Response	Percentage
Better awareness of how to give feedback	30.8
Assurance feedback leads to improvements	23.6
Faster response to feedback	21.2
Anonymous feedback options	19.7
Others	4.7

Source: Baseline data 2024

4.4.12 Suggestions to Improve Accountability and Feedback Mechanisms

Lastly, regarding ways to improve accountability and feedback mechanisms, the majority of respondents emphasized the need for more information about existing feedback and accountability channels. Additionally, 23.3% of respondents advocated greater involvement of community members in the process, while 21.1% stressed that authorities should take their feedback more seriously. Over 20% suggested that responses to feedback should be faster, and some couples recommended introducing more anonymous methods for providing feedback. A small proportion (1%) proposed other ways to enhance the system.

Table 25: Suggestions to improve accountability and feedback mechanisms

Response	Percentage
Provide more information on feedback channels	24.9
Involve community members	23.3
Ensure feedback is taken seriously	21.1
Ensure faster responses to feedback	20.1
Provide more anonymous ways to give feedback	9.6
Others	1.0

ource: Baseline data 2024

4.5.0 knowledge of frontline health workers on providing responsive and gender-sensitive health service

4.5.1 Number of health facilities in the communities

A good number of the communities visited for the survey had at least a health facility that served the people in and around the catchment area. It was noted that most of the communities selected under the Oti region were without a health facility, however, zones are demarcated for nurses to provide basic services on a regular basis. From the study, over 92% of the communities had at least one health facility operational while 4% of the communities visited had 2 facilities serving the area. We also noted that 2% of the communities that took part in the study had 3 health facilities with 2% of the communities having 4 health facilities.

4.5.2 Composition of Health Providers

According to the CHPS policy, a CHPS compound is supposed to have three key healthcare workers as a full complement of the staff for the facility. The frontline health professionals at the various health facilities include Community health nurses, Registered General Nurses, Midwives, enrolled nurses and Registered Community Nurses. Almost 58% of the facilities had the full composition of health care providers (CHN, Midwives, Enrolled Nurses) per the CHPS policy while 42% had one or two of the frontline health staff (RGN, RCN, MID, EN). Though these numbers are huge, however, most of them are unable to provide the services due to infrastructural challenges, logistics challenges and lack of essential medicine supplied from the regional medical stores.

4.5.3 Frontline Staff Who Received Gender Training

The study also assesses the knowledge of the frontline health professionals on gender, and we asked them if they have received training in gender. Over 87% of the respondents indicated that they have not received any training on Gender while a few (13%) of them had received some form of training in gender. The table below illustrates the region, organization that conducted the training and the venue of the training.

Table 26: Table of staff who had training in gender

Region	District	Facility	Organization or institution	Venue
Central	Agona West	Nyamedam CHPS zone	Young and Lonely Foundation (YLF)	Pentecost church in the community
Central	Agona West	Kwaman CHPS	Young and Lonely Foundation (YLF)	At the community centre
Greater Accra	Shia Osudoku	Duffor health facility	NGO	Accra poly hospital
Western North	Bodi	Denchemuasue CHPS	RuDeF	Denchemuasue
Western North	Bodi	Datano CHPS	RuDeF	Datano CHPS
Northern	Nanumba North	Dangbe CHPS	Catholic Relief Service	Health Directorate
Northern	Yendi	Yendi Health Center	Ghana Health Service	Yendi

Source: Baseline data 2024

4.5.4 Knowledge of Frontline Health Workers on Right-Oriented Services

The respondents' understanding of rights-oriented services was evaluated. A majority (62%) of healthcare workers reported having a fair understanding of rights-oriented services, while 38% indicated they had no knowledge in this area. Examples of rights-oriented services mentioned by respondents included confidentiality, the right to privacy, fidelity, integrity, the right to choice, and the right to healthcare, among others.

4.5.5 Proportion of Women on the Community Health Management

The study further revealed that 44% of the facilities had one female representative on the Community Health Management Committee (CHMC), 34% had at least two women, and 22% had three or more women serving on the committee.

4.5.6 Facilities without a woman volunteer

The study also identified that 25% of the facilities or communities lacked even a single health volunteer to support the activities of health professionals. Additionally, over 32% of the facilities had at least one woman serving as a volunteer, while 22.6% had two women, and another 22.6% had three or more women serving as volunteers, as illustrated in the table below.

Table 27: Communities without a woman volunteer

Region	District	Facility
Volta region	Adaklu	Torda CHPS
Central Region	Gomoa	Asebu/Pomadze CHPS Compound
	Agona West	Kojo Armah CHPS
Greater Accra Region	Shia Osudoku	Natriku CHPS
Oti Region	Guan	Likpe Bala Health Centre.
Western Region	Bodi	Kama CHPS
		Datano CHPS
Northern Region	Tamale Metro	Duuyin CHPS
		Lahagu CHPS
		Bamvim CHPS
	Nanumba North	Dangbe CHPS
		Salnayiii CHIPs
	Savelugu	KULDANALI CHPS

Source: Baseline data 2024

4.5.7 Facilities with Referral Register

Referral is a critical process in healthcare delivery, and evidence of client referrals is typically documented in a referral register. These registers or booklets contain all the necessary information to ensure continuity and progress in treatment at the next health facility. As shown in the table below, 74% of the facilities had a referral register available, while 26% did not have this essential resource.

Table 28: Referral Register

response	freq	pct
Yes	39	74
No	14	26

Source: Baseline data 2024

4.5.8 Availability of Community Emergency Transport Systems (CETs)

Evidence from the survey indicated that the majority of the communities do not have a community emergency System in place which is an integral part of the CHPS implementation to improve the referral system and encourage clients to accept referrals. It was revealed that 62% of the respondents had no CETs in place to support the referral system. Also, just 38% of the facilities indicated that they have CETs in place. We didn't ask if the CETs are functional and are serving its purposes in the community.

4.5.9 Facilities providing 24hrs Service.

The majority of facilities reported providing 24-hour services to people within their catchment areas, while 20.8% indicated they do not offer round-the-clock services. Further discussions with some facility revealed that, although the policy mandates 24-hour service delivery, several challenges hinder its full implementation. Key factors include a lack of accommodation, inadequate security, and insufficient health staff, which collectively undermine the ability to provide uninterrupted services.

4.6 Area's facilities need support for community education

Table 29 below provides a list of facilities that have clearly outlined the areas where they require support for health education. A few facilities also identified areas where they need support with logistics and resources; however, these were not included in the report as they fall outside the scope of the objectives. Community-based organizations are encouraged to collaborate with these facilities to provide the necessary educational support, aiming to improve service uptake and participation in public health activities within the communities.

Table 29: List of facilities and areas they will need support for community education

Facilities	Area of advocacy support
Asebu/Pomadze CHPS Compound	Maternal Health.
Kortsrala CHPS	Home delivery and self-medication
Keyime CHPS	Home delivery, Self-meditation, Importance of immunization, Family planning
Nyamedam chip zone	Early reporting to the facility, Adhering to referrals
OKANTA CHPS	Infection prevention
Likpe Agbozume chips.	Family Planning, Importance for Referral, Teenage Pregnancy, Importance orNIHS.
Likpe Polyclinic	Child welfare, Adolescent health.
Asato Chps	STI
Akwettey CHPS	Patronizing the facility, adhering to referrals, birth preparedness
Gomoa Mangoase Health Centre	Reproductive Health
Amuzudeve CHPS	Personal hygiene, Dangers of self-meditation, Home delivery
Torda CHPS	Malaria prevention, Cholera, Hypertension and diabetes, Utilization of NHIS
Adaklu Kodzobi CHPS	Family planning, sanitation, iron supplement
Msnuso Chps	Family Planning and Teenage Pregnancy
Eguafo Chps	Language Translation
Assin Kumasi Chps	Family planning, diabetes, BP
Kwaman chips	Motivation for home visiting and Some materials to support school Education system
Boubai Health Centre	Education on family planning, child welfare, and early report for ANC
MIM - PIPIE CHPS compound	Maternity
Lahagu CHPS	Family Planning
Antokrom CHPS	ANC, General OPD,RCH
Kama CHPS	Family planning
Kwasuo CHPS	ANC services, PNC services, Child Welfare Clinic Delivery services, Family planning services
Duuyin CHPS	Out Reach, Family Planning, Childbirth (Delivery)
Juo CHPS	Immunization
Denchemuasue CHPS	CWC
Gbangbalga Chips	CWC (Child Welfare Clinic) OPD
Lekpongunor chps	Wellness Clinic
Prampram Polyclinic	Advocacy
OLD NINGO Health Centre	Family planning, Antenatal, CWC, Delivery, ART
Datano CHPS	CWC
Dangbe CHPS	Family planning, ANC Registration
Bamvim CHPS	OPD, Child Labour (Deliveries), CWC Services, Mental health
Yendi Health Center	ANC, CWC (child welfare clinic), Family planning
Salnayili CHIPs	Family planning, ANC registration, PNC registration

5.0 RECOMMENDATIONS

1. Conduct targeted community awareness campaigns, particularly for women, to enhance understanding of feedback and accountability mechanisms in healthcare services.
2. Leverage accessible media channels such as community radio, information centers, and local meetings to educate the public on how to provide feedback.
3. Facilitate periodic community dialogues between health service providers and residents to address concerns and improve accountability in healthcare delivery.
4. Develop structured training programs for healthcare workers and community leaders on the importance of patient feedback and its role in service improvement.
5. Expand capacity-building programs on rights-oriented healthcare services to equip health workers with the necessary knowledge and skills for patient-centered care.
6. Integrate gender training into the professional development programs of frontline healthcare workers to bridge the current knowledge gap.
7. Advocate for policies that require a minimum representation of women in Community Health Management Committees (CHMC) to ensure gender-balanced decision-making.
8. Strengthen community engagement efforts to encourage more women to take up leadership roles in health management and governance structures.
9. Provide mentorship and leadership training for female community members to enhance their confidence and ability to contribute meaningfully to health governance.
10. Establish partnerships between healthcare facilities and community-based organizations (CBOs) to strengthen public health activities and improve service uptake.
11. There should be targeted health education initiatives that focus on promoting open dialogue and understanding around sensitive issues, particularly among couples and within the household setting.
12. Strengthen gender-transformative training for couples to promote equitable decision-making.
13. Encourage male partners to support women's participation in leadership and household decision-making ensuring inclusive and representative healthcare decision-making processes.
14. Promote education on the benefits of timely healthcare access.
15. Enhance awareness campaigns on existing feedback mechanisms.
16. Strengthen community structures to facilitate dialogue between patients and providers.
17. Encourage women to actively participate in giving feedback without fear of victimization.
18. Community Education on health volunteerism, with a particular focus on encouraging women's participation to ensure a more inclusive and representative approach to community health initiatives.

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