Alliance for Reproductive Health Rights

ADDRESSING HOUSEHOLD DECISION-MAKING INEQUALITIES AMONG COUPLES IN GHANA

POLICY BRIEF, 2025

Executive Summary

- In over 82% of households surveyed, husbands are still regarded as the primary decision-makers.
- Cultural norms, age differences, and income levels are major contributors to power disparities within couples.
- Limited decision-making power for women negatively impacts their autonomy, particularly in health-related decisions.
- Empowering women to participate equally in household and community decisions can improve family well-being and healthcare uptake.
- ARHR calls for culturally sensitive but progressive reforms to promote gender equitable decision-making in households.

Introduction

Power imbalances in household decision-making persist as a significant barrier to achieving gender equality and improving women's health in Ghana.

Despite growing awareness and advocacy, most households still reflect traditional norms that position men as dominant figures in decision-making. These dynamics restrict women's autonomy, especially in accessing and utilizing healthcare services.

Background

ARHR conducted a baseline survey in 18 districts, across 9 regions in Ghana. The survey involved 556 respondents (primarily couples) and investigated gender dynamics in household decision-making.

Findings underscore that societal norms and status-based hierarchies still heavily influence how power is distributed in homes. This has far-reaching implications for primary healthcare utilization, reproductive health, and family welfare.

Decision-Making Trends

- 82.1% of respondents stated that men are the primary decision-makers. Only 16% reported shared decision-making, and a negligible number believed women held more authority

- In the Northern and Oti regions, no respondent said women have any decision-making power. Cultural norms dominate the Northern, Western North, and Ashanti regions, while income and age play bigger roles in other regions.

- Men are the dominant voices in economic activity decisions (41%) and resource allocation. Even in reproductive health where national policy supports female autonomy only 7% of men believe women should independently decide.

- While 51.6% of couples deliberate before decisions, 44.1% do so selectively, often excluding women from key matters. In 4.3% of households, women are entirely excluded from discussions.

Drivers of Power Differences

- Cultural norms – 21.4%
- Age differences – 19.4%
- Income levels – 17.9%
- Religious practices – 14%
- Educational status – 9.9%

These disparities are not just domestic issues they spill into community spaces, undermining women's participation in health committees and leadership roles.

Policy Options

- Community Dialogues: Use culturally-sensitive education and outreach to reshape norms.
- Legislative Reforms & Local Enforcement: Mandate equitable participation of both spouses in health-related decisions, especially in family planning and healthcare access.
- Integrate gender roles and power-sharing conversations into CHPS compounds, community meetings, and faith-based platforms.
- Develop and roll out household-level toolkits for shared decision-making with a focus on healthcare, family planning, and income use.
- Sensitize chiefs, assembly members, and religious leaders to champion gender-equitable decision-making practices.
- Expand male-inclusive SRHR and primary healthcare education to foster shared responsibility at home

Conclusion

Power dynamics within Ghanaian households are deeply influenced by cultural norms and social structures that often marginalize women. Changing this status quo is not only a matter of rights, but a strategic step toward better health outcomes, improved child welfare, and stronger communities.

By promoting shared decision-making and dismantling systemic barriers, we can create more balanced households and healthier societies.

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