SEND GHANA

REPORT

UNEQUAL RISK: SGBV AMONG YOUTH AND PERSONS WITH DISABILITIES

Building Inclusive Policies and Protection for All in Ghana

POWER TO CHOOSE | OXFAM | In partnership with Canada | WILDAF GHANA | SEND GHANA | norsaac | PARDA

OCTOBER, 2025

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Acknowledgement

We express our gratitude to our funders (Global Affairs Canada) through Oxfam in Ghana and our co-implementing partners: Norsaac, Women in Law and Development in Africa (WiLDAF), Planned Parenthood Association of Ghana (PPAG), and Participatory Action for Rural Development Alternatives (PARDA) for their valuable support.

We are thankful to our community stakeholders, including parents, teachers, community leaders, the Ghana Federation for Disability Organization and their members across the study district, and the young people, for providing us with relevant information that contributed to the successful completion of the study.

We also want to express our profound appreciation to our project principals, the Power to Choose young women, and youth groups who led this research from the development of data collection instruments to data collection and the preparation of this report.

List of Abbreviations

CEDAW - Convention on the Elimination of All Forms of Discrimination Against Women.

CHRAJ - Commission on Human Rights and Administrative Justice.

DHS-Demographic and Health Survey.

DOVVSU- Domestic Violence and Victim Support Unit.

DVF - Domestic Violence Fund.

FMG - Female Genital Mutilation.

GBV - Gender-Based Violence.

GDHS - Ghana Demographic and Health Survey.

IPV- Intimate Partner Violence

NGOs - Non-Governmental Organizations.

PNDCL - Provisional National Defence Council Law.

PHC-Population and Housing Census.

PTSD - Post Traumatic Stress Disorder

SGBV - Sexual and Gender-Based Violence.

SRHR - Sexual and Reproductive Health and Rights

SHR- Sexual Health and Reproductive.

SRS - Simple Random Sampling.

STIs - Sexually Transmitted Infections

UNCRPD - United Nations Convention on the Rights of Persons with Disabilities.

UNFPA - United Nations Population Fund.

UNW - United Nation Women.

UN-United Nation

WHO - World Health Organization.

Executive Summary

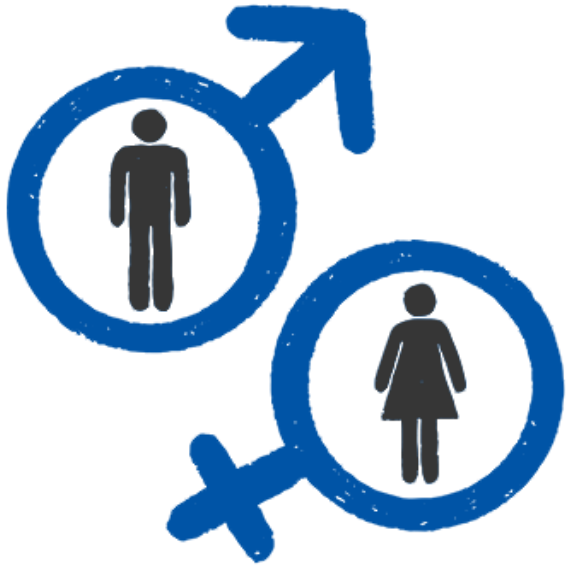
Globally, there is a concerning statistic that nearly one in three women and girls will experience physical or sexual violence at some point in their lives. In Ghana, Sexual and Gender-Based Violence (SGBV) is a deeply entrenched issue, particularly impacting young people and especially those with disabilities. This study examined the prevalence and consequences of SGBV, as well as evaluating the availability and effectiveness of support systems for survivors.

A cross-sectional survey was conducted in twenty-nine (29) communities selected from the Power to Choose project, covering six districts—three from Northern Ghana and three from Southern Ghana. The districts chosen are Savelugu, Sagnarigu, and West Mamprusi in Northern Ghana, and Ashaiman, Awutu Senya East and Cape Coast in the South. In total, 1,204 respondents aged 10 and older participated in the survey, which included 933 (77.5%) young people and 271 (22.5%) persons with disabilities (PWDs).

The findings indicate a significant prevalence of SGBV, with 84% of respondents reporting that they have either experienced, witnessed, or heard about such violence. More than half (54.3%) attribute its occurrence to harmful social norms. The most common perpetrators are household members (34.2%), and homes are the primary locations where SGBV happens (65%). The implications of SGBV on victims are extensive, affecting their mental, social, economic, and physical health. Psychological impacts are the most frequently reported (37.3%), followed by sexual issues (20.5%) and reproductive health concerns (15.1%), with 38.2% experiencing depression. Many victims also reported a decline in emotional well-being, academic performance, and social participation. Accessing support services is particularly challenging for PWDs, with main barriers including lack of confidentiality, stigma, inadequate services and financial limitations. Only 18.9% of respondents rated the available

services as very effective, and nearly half of PWDs were unaware of existing support systems. Traditional leaders were identified as the most frequently consulted sources of support.

The study recommends strengthening multi-sectoral collaboration to promote community awareness and prevent SGBV in all settings. Educational efforts should focus on youth, traditional leaders, and other influential figures to challenge harmful social norms and raise awareness of survivors' rights and available services. The establishment of a confidential digital referral system is also advised to facilitate reporting and tracking of cases, ensuring survivors—especially young people and PWDs—can access crucial support. Additionally, survivor-centered reintegration programs should be developed in partnership with social protection initiatives such as LEAP and NHIS to reduce economic dependence. The Domestic Violence and Victims Support Unit (DOVVSU) is encouraged to leverage modern technology and mobile outreach to expand access to shelters and support services in remote areas, helping to prevent further victimization.



1.0 INTRODUCTION

Sexual and Gender-Based Violence (SGBV), commonly referred to as violence against women and girls includes any harm inflicted on an individual or group due to their actual or perceived sex, sexual orientation, or gender identity. This issue is widespread and deeply rooted, affecting people of all ages, cultures, and socio-economic backgrounds. SGBV manifests in various forms, including violence against women and girls, Intimate Partner Violence (IPV), child marriage, forced marriage, Female Genital Mutilation (FGM), forced pregnancy, human trafficking among others. SGBV is a significant violation of human rights that affects both men and women. The prevalence of SGBV is often exacerbated by a culture of silence and denial, which exists in both private and public contexts.

Globally, a concerning statistic indicates that approximately one in three women and girls will experience physical or sexual violence at some point in their lives . The prevalence of IPV among adolescent girls is particularly alarming, with 25% (or one in four) of those aged 15-19, who have ever been married or in a relationship, having experienced IPV. In 2023, at least 51,100 women lost their lives to femicide (homicide targeted at women), with more than half of these murders committed by intimate partners or family members .

According to UN Women's 2022 report, nearly 30% of women in Ghana will face sexual violence at some point in their lives, with 25% experiencing physical or sexual violence from an intimate partner. The 2022 Demographic and Health Survey Report indicates that one-third (33%) of Ghanaian women aged 15-49 have suffered physical violence, while 61% of partnered women reported controlling behavior. Furthermore, 36% experienced emotional, physical, or sexual violence, with 28% of these cases occurring in the past year . PWDs also face discrimination and exclusion, being equally or more likely to experience SGBV compared to their non-disabled peers, often encountering multiple perpetrators and prolonged periods of abuse . This situation can severely impact their quality of life and overall well-being, limiting their access to political, cultural, educational, and economic opportunities.

In Ghana, various efforts have been made to address SGBV, including the establishment of institutional and legal frameworks such as the National Strategic Plan for GBV, the National Strategy for Addressing Adolescent Pregnancy (2024-2029), the National Domestic Violence Act of 2007 (Act 732), and the Affirmative Action (Gender Equity) Act 2024, among others. However, challenges such as limited funding, poor institutional coordination, and inadequate monitoring and feedback systems continue to undermine the effectiveness of these policies in addressing SGBV. This study aims to assess SGBV among youth

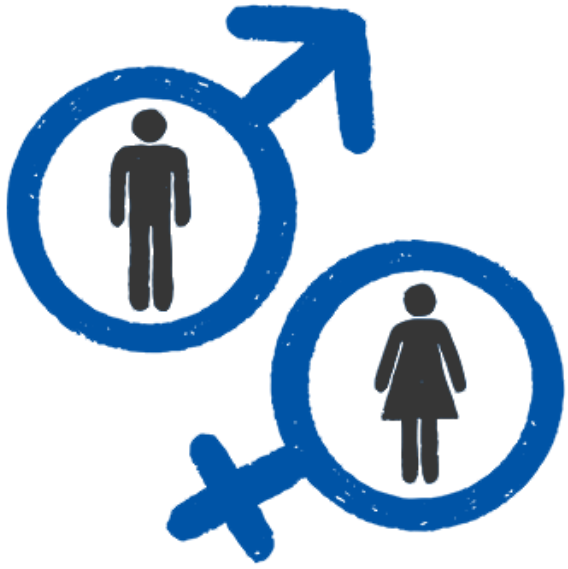
and young PWDs, focusing specifically on prevalence rates, impact on survivors and their families, and available support systems for those affected.

1.2 Study Objective

Overall, this research assessed the prevalence of SGBV among youth and young PWDs in Ghana.

The specific objectives were:

1. Assess the prevalence of SGBV among youth and young PWDs.
2. Examine the impact of SGBV on survivors and their families.
3. Evaluate the availability of support systems for survivors



2.0 METHODOLOGY

2.1 Study Design and Area

The study employed a cross-sectional design to collect data from both PWDs and those without disabilities at a single point in time. It was conducted in the Power to Choose (P2C) project operational areas. Twenty-nine (29) communities were purposefully selected from six (6) districts-three each from Southern Ghana (Cape Coast municipal, Ashaiman municipal, Awutu Senya East) and three from Northern Ghana (Sagnarigu, Savelugu, and West Mamprusi). A proportional distribution was used to allocate the sample sizes among the respective communities. Further details are presented in Table 1.

Table 1: Breakdown of P2C districts selected for the study

Region	District	Frequency
Northern	Sagnarigu	231
	Savelugu	220
North-East	West Mamprusi	194
Central	Awutu Senya-East	171
	Cape Coast	224
Greater Accra	Ashaiman	164

Source: Field Data, 2025

2.2 Sampling Techniques

Twenty-nine (29) communities were purposefully sampled from the six project districts for the Power to Choose Project. Simple Random Sampling and Snowballing techniques were then applied to select respondents without disabilities and those with disabilities, respectively. The simple random technique was adopted to ensure that differences and unique characteristics, including age, gender, race, educational status, and migrant status, are adequately represented in the sample. Snowball sampling was used to access hard-to-reach or hidden populations by leveraging referrals from initial participants, which helped build trust and identify others within the same group. It also improves efficiency by using existing social networks to quickly expand the sample when no formal list or database of the target population exists.

2.4 Data Collection Procedure

Data collection was primarily conducted by P2C youth groups in six (6) project districts. Before the data collection process, the enumerators followed community entry protocols and sought permission from local leaders, including Imams and Chiefs, to engage with interviewees. A training session was held for the enumerators focusing on data collection ethics and protocols, understanding the questionnaire, and engaging respectfully and sensitively with PWDs. Additionally, focal persons for disabilities in each district were involved to support the data collectors, either by mobilizing their members or by providing interpreters. A pilot data collection exercise was carried out to assess the validity and reliability of the questionnaire. To guarantee data quality and integrity, an electronic consent form was provided to respondents, and only those who agreed to participate were interviewed.

Young SRHR Advocates engaging respondents during data collection

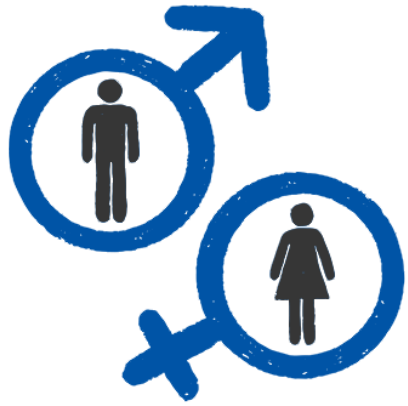
Young SRHR Advocates engaging respondents during data collection

2.5 Survey Instruments (Questionnaire)

A cross-sectional survey was used to obtain data for the study. A structured survey instrument was designed and reviewed by the Ghana Federation of Disability Organization (GFD) to ensure that, it is disability sensitive. The tool was uploaded onto a Kobo Collect toolbox and administered by the enumerators to elicit relevant information from the different categories of respondents. The questionnaire was organised into separate sections; Section I focused on the demographic characteristics of the respondents. Section II examines the prevalence of SGBV among youth and PWDs. Section III investigated the effect of SGBV among survivors and their families, and Section IV evaluated the availability and effectiveness of support systems for survivors of SGBV in the study areas.

2.6 Pre-Testing of Instruments

The survey instruments were pre-tested in non-sampled communities in Cape Coast, Sagnarigu, Savelugu, Awutu Senya East and West Mamprusi districts in a pilot exercise. The pilot survey provided an opportunity to determine response rate, difficult/ambiguous questions and average time spent on each respondent. Lessons learnt from the pilot survey was used to review and update the questionnaire and data collection strategies and techniques.



3.0 DATA ANALYSIS

The data was analysed using Excel and STATA statistical software, version 15.0. Descriptive statistics was the primary approach for the analysis. This presents the data in frequencies (freq.), percentages (percent), maximum and minimum values.

3.1 Results and Discussions
3.1 Summary Descriptive Statistics of Respondents

Table 2 presents the demographic characteristics of the respondents. A total of 1,204 individuals were interviewed, comprising 798 females (66.3%) and 406 males (33.7%). Majority of respondents, (37.1%), falls within the 15-19 age group, followed by 27.1% in the 20-24 age group. Those aged 10-14 represent 20.3% of the sample, while the 25 and older group makes up the remaining 15.5%. Together, individuals aged 15-24 account for 64.2% of the total sample, indicating a significant representation of young adults.

Regarding educational status, 597 respondents (49.6%) completed basic education, followed by 281 (23.3%) who completed Senior High School, 156 (13.0%) had no formal education, and 123 (10.2%) had attained tertiary education. Additionally, 3.9% reported having completed other forms of education. This indicates that most of the respondents have acquired some level of formal education. In terms of occupational status, a significant proportion of the respondents, 696 (57.8%), were students, while 198 (16.4%) were unemployed. Those working in the informal sector numbered 266 (22.1%), and only 44 respondents (3.7%) were gainfully employed in the formal sector.

Table 2: Demographic Characteristics of Respondents

Variable	Category	Frequency	Percent (%)
Sex	Female	798	66.3
	Male	406	33.7
Age	10-14	244	20.3
	15-19	447	37.1
	20-24	326	27.1
	25+	187	15.5

Source: Field Data, 2025

Variable	Category	Frequency	Percent (%)
Education	Basic level	597	49.6
	No formal education	156	13.0
	SHS	281	23.3
	Tertiary	123	10.2
	Vocational	43	3.6
	Other, specify	4	0.3
Occupation	Formal worker	44	3.7
	Informal worker	266	22.1
	Student	696	57.8
	Unemployed	198	16.4
Marital Status	Divorced	16	1.3
	Married	218	18.1
	Never married	955	79.3
	Separated	9	0.7
	Other, specify	6	0.5

Source: Field Data, 2025

Variable	Category	Frequency	Percent (%)
Religion	Christian	481	40.0
	Islam	703	58.4
	No Religion	12	1.0
	Traditional	8	0.7

Source: Field Data, 2025

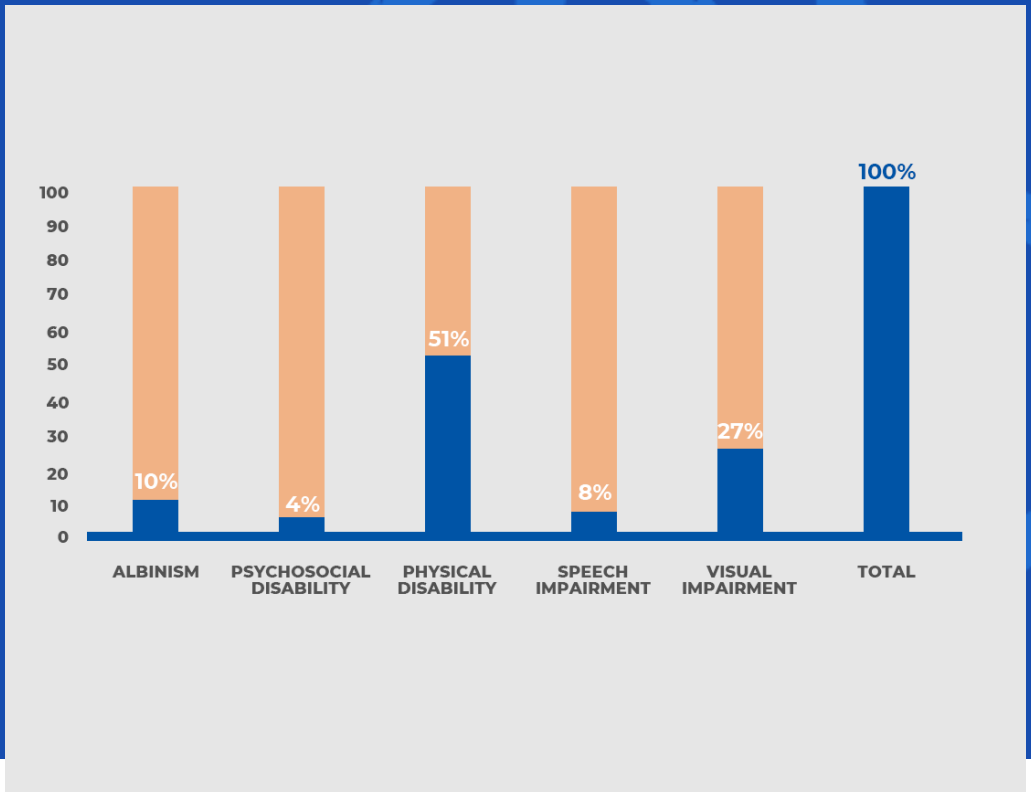
Marital Status

With regards to the marital status of respondents, a total of 955 (79.3%) are single. Respondents who are married constitute 218 (18.1%), divorced 16 (1.3%), and those engaging in other forms of relationship represent 16 (11%). This finding suggests that a significant proportion of the study population are single, with marital unions (married, divorced, separated) representing less than a quarter of the total sample. In addition, a significant proportion of respondents 703(58.4%) practice Islam religion, Christians 481(40.0%) traditional believers 8 (0.7%), and those who hold other faiths 12 (1.0%).

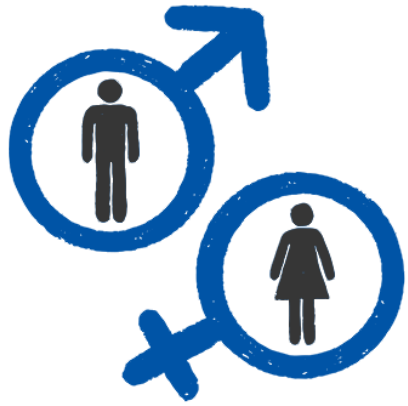
3.2 Disability Types

Figure 1 presents the different forms of disability among the sampled population. The data shows that physical disability constitute (51%), visual impairment (27%), albinism (10.%), and speech impairment being the least (8%). The remaining 11 other cases include psychosocial disability. Further details are illustrated in the figure below

Figure 1: Type of Disability



Source: Field data, 2025



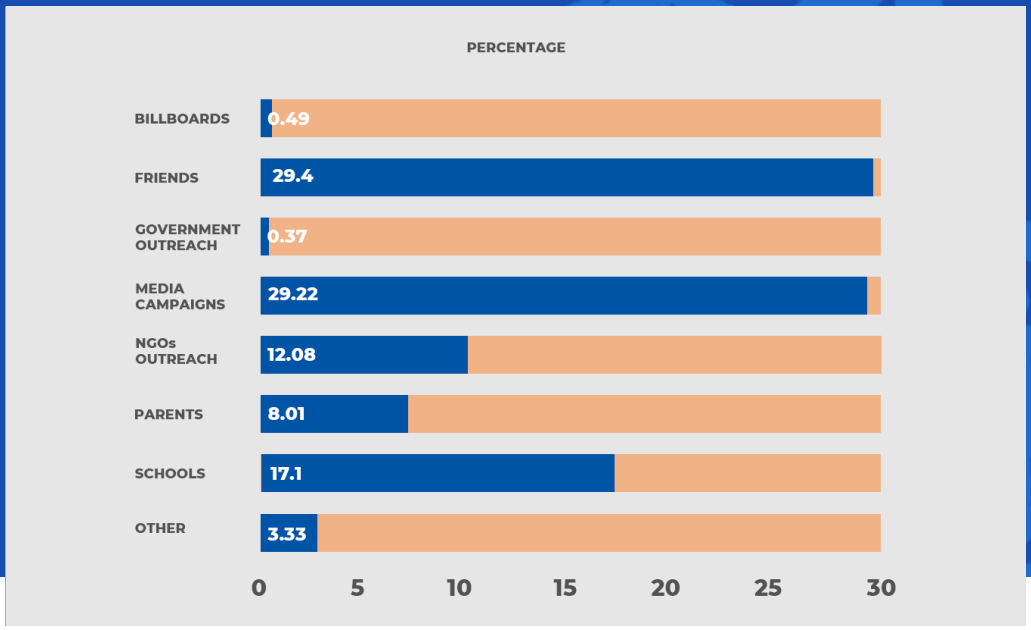
4.0 PREVALENCE OF SEXUAL AND GENDER-BASED VIOLENCE (SGBV)

4.1 Access to SGBV information

Access to information is essential for increasing knowledge and understanding of SGBV-related issues, enabling informed decision-making. An analysis of respondents' awareness and sources of information about SGBV shows that, as illustrated in Figure 2, friends (29.4%) and the media (29.2%) were the primary sources through which respondents learned about SGBV. This aligns with Adomako Ampofo's (2008) research, which highlights the strong influence of peers on young people's understanding and behavior regarding Gender-Based Violence (GBV). Media outreach (29.2%) ranked a close second, emphasizing the importance of targeted information campaigns for vulnerable groups. Schools (17.1%) also play an important role, underscoring

the need to incorporate SGBV education into school curricula. In contrast, parents (8.0%) and government institutions were among the least significant sources of information about SGBV.

Figure 2: Sources of information on SGBV

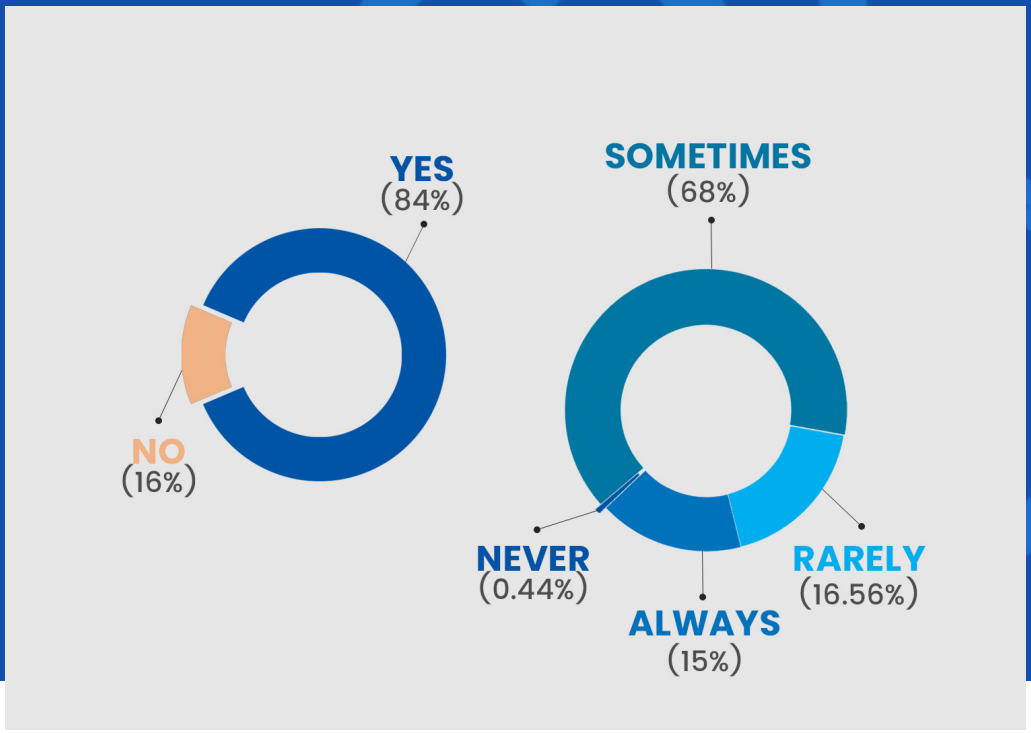


Source: Field Data, 2025

4.2 Prevalence of SGBV

We examine the prevalence of SGBV by considering three clear categories: individuals who report experiencing SGBV themselves, individuals who have witnessed incidents of SGBV, and individuals who have learned about SGBV cases from various sources. This is illustrated in figure 3. Approximately 84% of respondents reported having experienced, witnessed, or heard about SGBV. According to the 2022 Ghana Demographic and Health Survey (GDHS), 14% of women aged between 15-49 reported having experienced sexual violence at some point in their lives.

Figure 3: Prevalence of SGBV and Frequency of Occurence



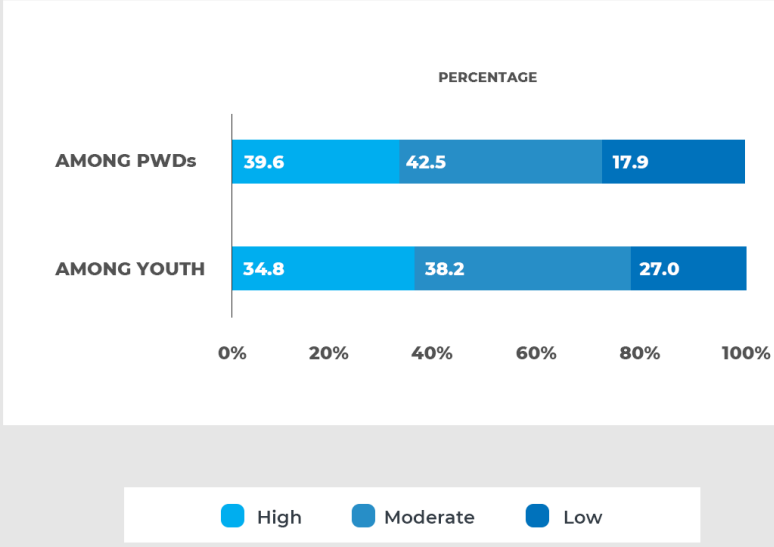
***Source*: Field Data, 2025**

Osei et al. (2020) reported that traditional gender norms, peer pressure, and limited access to education on the rights of the individual account for the low knowledge and exposure to abuses. Societal attitudes often blame victims rather than perpetrators, and this usually discourages survivors, particularly young women, from reporting incidents (Amoah, 2019). Similarly, Tenkorang et al. (2013) found that GBV are common among youth and PWDs in Ghana. Among those who have experienced, witnessed, or heard of SGBV, 68% reported that it occurs occasionally, while 15% indicated that it happens regularly, suggesting a persistent nature to the issue.

4.3 Scale-Based Assessment (1–3) of SGBV Among Youth and PWDs

The prevalence of SGBV was further evaluated using a scale of 1 to 3: a score of 1 indicates high prevalence, 2 indicates moderate prevalence, and 3 represents a low prevalence. According to Figure 4, out of a total of 811 respondents, 603 individuals (comprising 321 people without disabilities and 282 PWDs reported that SGBV is highly prevalent in their communities).

Figure 4: Scale-Based Assessment (1–3) of SGBV Among Youth and PWDs



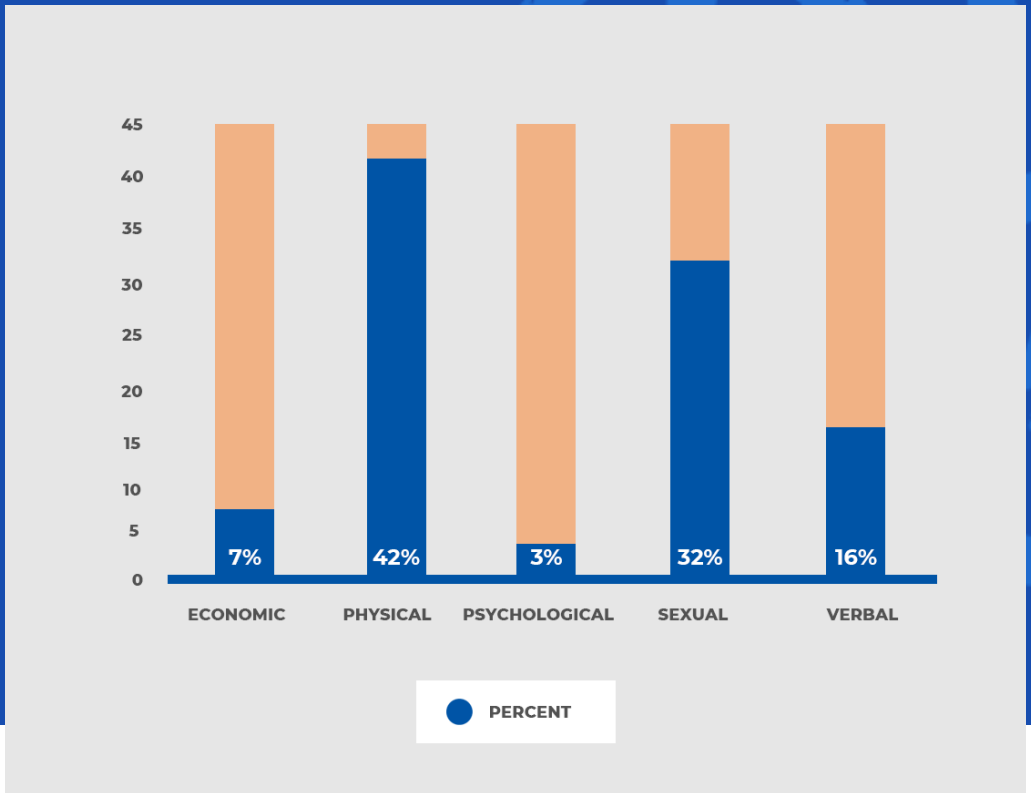
Source: Field Data, 2025

A total of 655 respondents reported that SGBV occurs at a moderate level, while 364 indicated low occurrences. Notably, the majority of those who reported low occurrences (219 individuals) were PWDs. This suggests that SGBV is perceived as a significant and ongoing issue within the studied communities. Although the severity of SGBV may vary across different cases, it is prevalent enough to require targeted interventions. Additionally, the fact that many PWDs perceive SGBV as low may indicate potential underreporting, a lack of awareness, or social isolation among this group. As highlighted by Human Rights Watch and the World Health Organisation (WHO), many individuals with disabilities face obstacles in reporting abuse due to fear, stigma, and inaccessible support services.

4.4 Exposure to SGBV among Youth and PWDs

Figure 5 shows that among youth and PWDs, physical violence is the most frequently reported form of SGBV (42%), followed by sexual violence (32%), verbal abuse (16%), economic abuse (7%), and psychological abuse (3%). Research indicates that individuals with disabilities face higher rates of sexual violence than their non-disabled peers (Dunn, 2019), and that physical abuse is often perpetrated by intimate partners or family members, commonly co-occurs with other forms of SGBV (Ghana Statistical Service, 2018). These findings underscore the multifaceted nature of SGBV and the vulnerability of these groups.

Figure 5: Forms of SGBV Exposure by Youths and PWDs



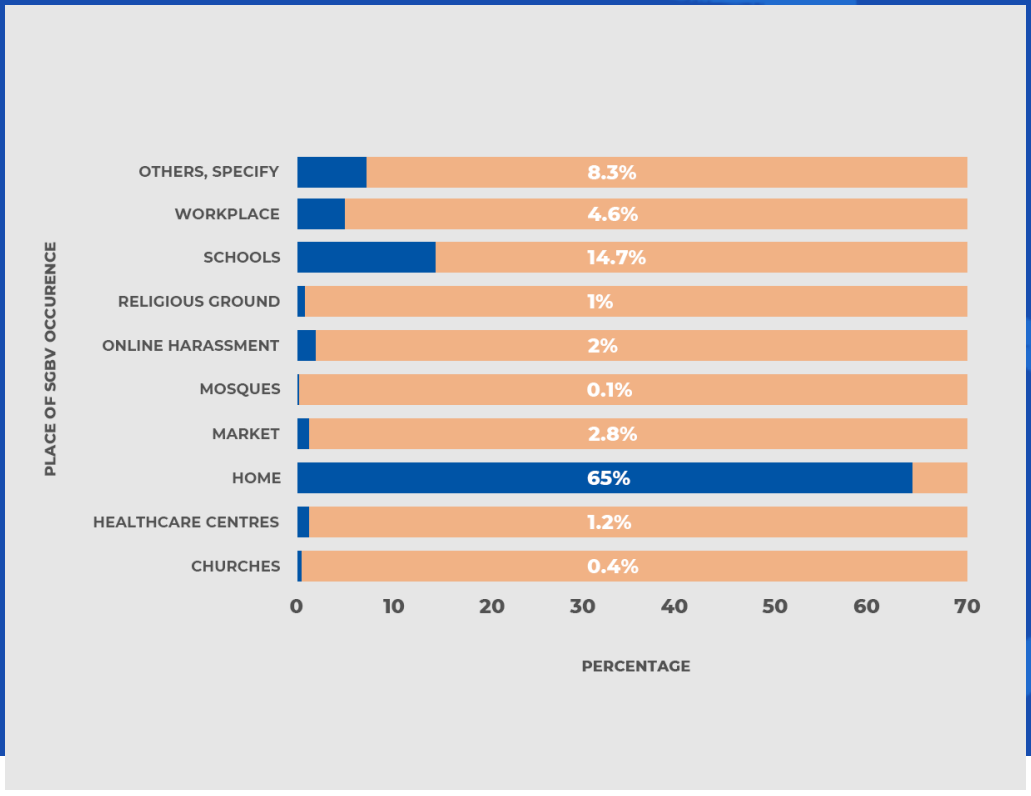
Source: Field Data, 2025

Physical and sexual violence account for over 73% of reported SGBV cases with many victims under 18 years (Ghana Health Service, 2019). In contrast, only 3% of the 1,204 respondents identified psychological violence or emotional abuse. This low rate likely reflects limited awareness of psychological violence among youth and PWDs. Often dismissed as "just words," psychological and emotional violence such as insults, rejection, or belittlement typically occurs in places such as schools, homes, and marketplaces, and these can have a profound negative effect on the mental health of the victims.

4.5 Places where SGBV occur

Figure 6 shows that most incidents of SGBV occur at home (65.0%) and in schools (14.7%). This raises concerns about student safety and the risk of abuse by peers or staff members. Incidents in workplaces account for 4.6% of reported cases, indicating potential harassment, abuse of power, and issues related to workplace safety. The least places where SGBV occurs is religious settings (churches and mosques) accounting for 0.4%, mosques 0.1% respectively.

Figure 6: Common places where SGBV occurs

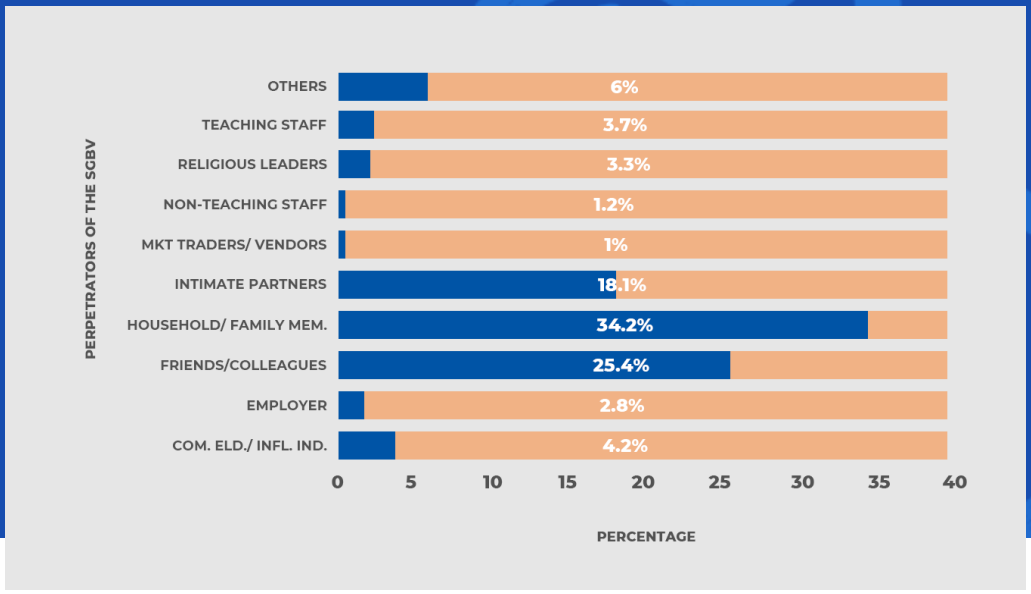


Source: Field Data, 2025

4.6 Perpetrators of SGBV

Figure 7 shows that, out of the 811 reported cases, household and family members 277 (34.2%) were the most common perpetrators of SGBV and abuse. The second category of perpetrators of SGBV that was identified is friends and colleagues 206 (25.4%). Intimate partners were responsible for 18.1% of cases, highlighting the prevalence of sexual violence in intimate relationships. Additionally, individuals in trusted positions such as community elders, religious leaders, employers and teachers were also reported as perpetrators. Alo et al. (2023) reported similar results in the Northern Region of Ghana that individuals within one's social or professional network are now the exploiters and perpetrators of SGBV. Additionally, Compton et al. (2024) and Author-Holmes et al. (2025) found that homes that hitherto served as safe havens are now the breeding place of violence and abuse against women and girls.

Figure 7: Perpetrators of SGBV

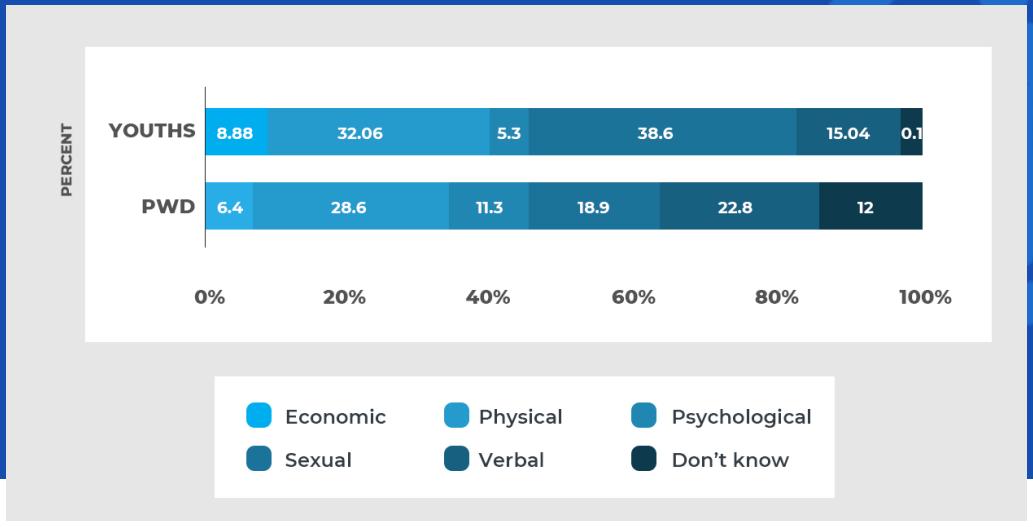


Source: Field Data, 2025

4.7 Type of SGBV Experienced by Respondents

From Figure 8, physical violence is the most common form of abuse experienced by both PWDs (28.6%) and persons with no disabilities (32.06%). Physical violence includes acts such as hitting (punching, slapping, or striking with objects), burning (with fire, hot objects, or chemicals), beating (repeated or severe hitting). The findings suggest that PWDs may be particularly vulnerable due to challenges in self-defence or in reporting abuses. Supporting this, Codina & Pereda (2022) found that 39.9% of women with disabilities have experienced sexual violence, and Plummer & Findley (2012) noted PWDs are four times more likely to face sexual assault than nondisabled women. Verbal abuse involving insults, threats, and degrading language was reported by 185 (22.6%) of PWDs, making it the second most common form of violence they experience, compared to 122 (15.04%) among the nondisabled.

Figure 8: Type of SGBV experienced by youths and PWDs



Source: Field Data, 2025

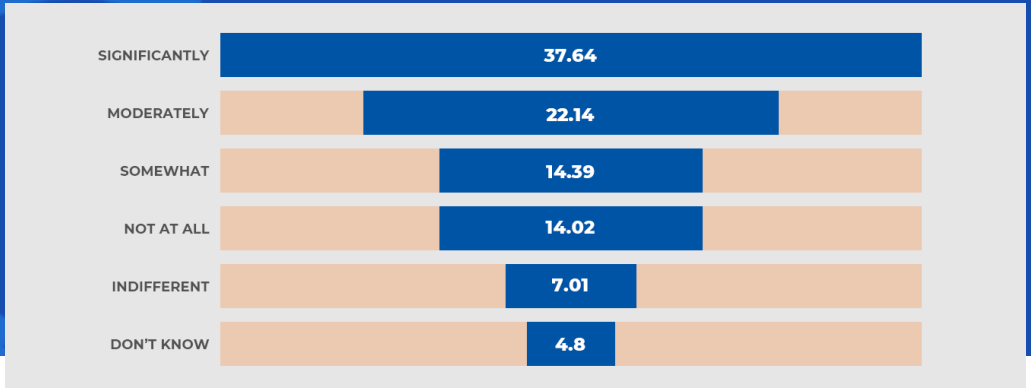
Though, less visible than physical violence, verbal abuse can lead to long-term emotional trauma, psychological harm, social isolation, and lower self-esteem, with data showing it is more prevalent among PWDs. Despite that economic and psychological violence were the least forms of violence experienced by respondents as shown in the figure above, these cases have deep and lasting effects on survivors.

4.8 Vulnerability to SGBV

The study further evaluated whether having a disability increases vulnerability to SGBV. Respondents with various disabilities were asked to share their perspectives to assess the perceived connection between disability and vulnerability to abuse. Results show that 74.17% of individuals with disabilities reported feeling vulnerable to SGBV because of their circumstances. This underscores disability as a significant risk factor and highlights systemic disadvantages, including inadequate support for these groups. Research indicates this problem is particularly severe among visually impaired individuals, who often underreport incidents (Azumah et al., 2019).

4.9 The extent to which one's condition is exposed to SGBV

Figure 9: PWDs Vulnerability to SGBV

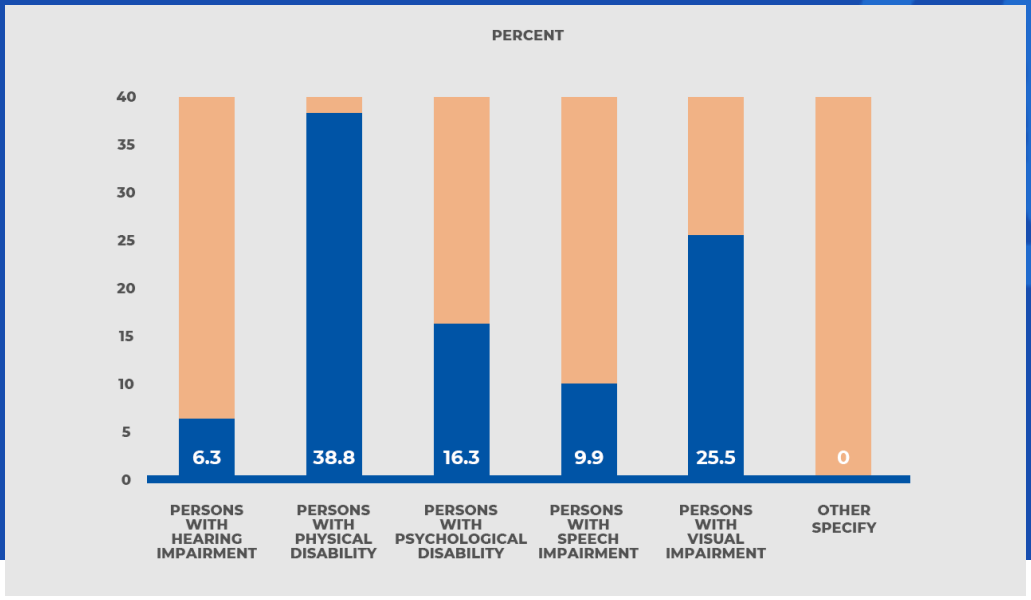


Source: Field Data, 2025

4.10 Forms of disability and related vulnerability

Figure 10 illustrates that individuals with physical disabilities face the highest risk of vulnerability to SGBV, at 38.8%. This is closely followed by those with visual impairments, who face a vulnerability rate of 25.5%. Hearing impairment presents the lowest level of vulnerability among these groups. These findings are consistent with existing research indicating that people with physical disabilities and those who are visually impaired are at a heightened risk of SGBV. For example, Jones et al. (2012) found that individuals with physical disabilities are particularly vulnerable due to their increased dependence on caregivers. Similarly, visually impaired women are at risk of severe consequences from SGBV, including higher rates of suicide, physical injury, marital breakdown, and reproductive health issues (Azumah, 2019).

Figure 10: Category of PWDs and vulnerability to SGBV

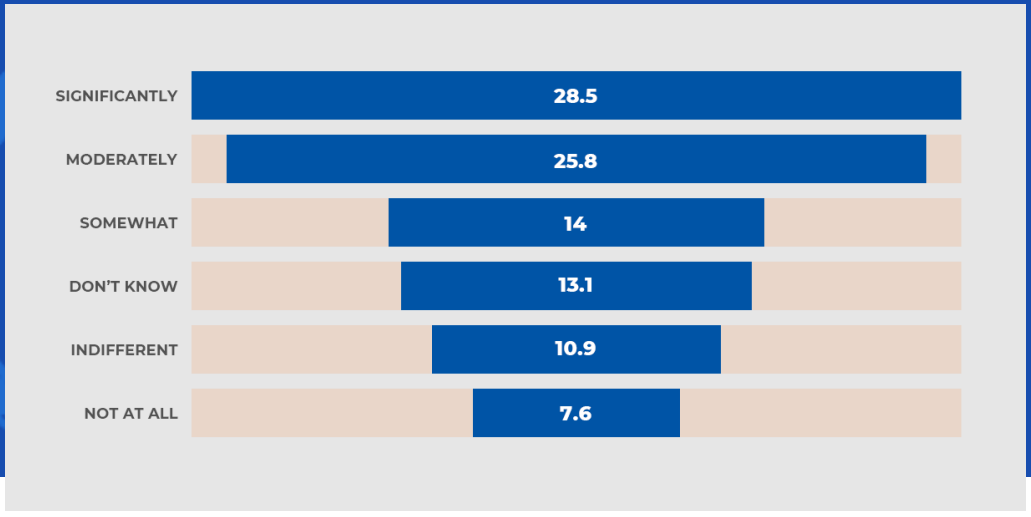


Source: Field Data, 2025

4.11 Contribution of Societal Norms to SGBV

The study assessed the extent to which social norms contribute to the occurrence of SGBV. According to the Figure 11, over half of the respondents (68.3%) believe that social norms play a role in SGBV, with 28.5% indicating a "significant" contribution. Notably, 10.9% of respondents are indifferent, and 13.1% are uncertain, suggesting possible disengagement or lack of awareness. Only 7.6% reported that norms don't contribute to SGBV. Research indicates that societal norms contribute to the increasing prevalence of SGBV. The UNFPA (2023) report identifies harmful social norms, such as patriarchal masculinity and sexual entitlement, as key drivers behind the under-reporting and persistence of intimate partner violence (IPV). Furthermore, societal norms regarding women's sexual purity and male authority also play a significant role in perpetuating violence against women and girls (Perrin et al., 2019; Yount et al., 2018).

Figure 11: Societal Norms Contribute to the Occurrence Of SGBV.



Source: Field Data, 2025

4.12 Forms of societal norms and practices that promote SGBV

As seen in Table 3 below, early and forced marriage was reported as the most (19.3%) common norm that fuels SGBV with the highest frequency in Savelugu. The findings also indicated that the prevalence of forced marriage among young girls is also influenced by cultural norms, poverty, and gender inequality in rural areas. The second most frequently cited societal norm affecting SGBV is the adherence to traditional gender roles and expectations, which accounted for (17.3%) of reported cases. The highest occurrences of this issue were observed in Cape Coast and Sagnarigu. The strict enforcement of gender roles reinforces the subjugation of women and girls, limiting their economic and social independence.

Table 3: Forms of societal norms and practices that promote SGBV

Norms and Practices	Ashaiman	Awutu Senya	Cape Coast	Sagnarigu	Savelugu	West Mamprusi	Total
Bride price/ dowry	0	6	15	13	9	9	52
Early & forced marriage	32	33	41	41	51	35	233
Female genital mutilation	14	10	16	4	4	5	53
Gender roles & expectations.	21	5	51	53	41	37	208
Patriarchy	18	15	44	85	18	21	201
Virginity tests	10	1	7	5	4	6	33

Source: Field Data, 2025

Norms and Practices	Ashaiman	Awutu Senya	Cape Coast	Sagnarigu	Savelugu	West Mamprusi	Total
Widowhood rites	8	3	5	6	8	12	42
Witchcraft accusation	12	57	14	7	61	15	166
None of the above	32	23	27	17	22	53	174
Other, specify	17	18	4	0	2	1	42

Source: Field Data, 2025

Patriarchy and male dominance were identified as significant contributors accounting to 16.7% of the research population with Sagnarigu witnessing the highest frequency. These patriarchal structures often hinder women's access to education, employment, and leadership positions, making them more susceptible to domestic violence and economic dependency.

Witchcraft accusations continue to be a significant human rights issue in Ghana. Out of 166 reported cases, Savelugu accounted for 61 (37%) of the highest occurrences, while Awutu Senya recorded 57 (34%). Women, particularly elderly widows, are the most frequently targeted, often facing violence, banishment, or even lynching. Although such accusations are outlawed under Section 315A of Ghana's Criminal Code Act 29, enforcement remains weak. Government efforts to dismantle alleged witch camps and reintegrate the alleged witches lack sufficient community engagement and awareness initiatives.

Virginity tests represent one of the least socially accepted norms contributing to SGBV, with the highest reported incidence in Ashaiman, and the least in Awutu Senya East. A significant portion of respondents, 174 (14.4%), indicated that none of the societal norms listed contribute to SGBV. This suggests either a lack of awareness regarding how these norms promote SGBV or that certain harmful practices have become socially normalized.

4.13 Knowledge of the rights of PWDs

The Table 4 below reveals gaps in public awareness regarding the rights of PWDs. A significant proportion of respondents 246 (20.4%) reported having no knowledge about the rights of PWDs at all. Among those aware, the most recognized right was the right to education 303 (25.2%), followed by the right to equality and non-discrimination 225 (18.7%) and the right to health 99 (8.2%). Less commonly known rights included access to justice and legal aid 30 (2.5%) and right to privacy and confidentiality 25 (2.1%).

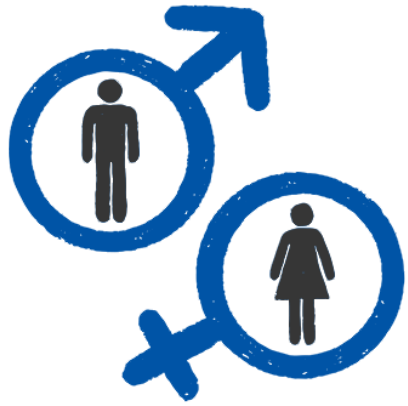
Table 4: Knowledge of the rights of PWDs

Rights	Frequency	Percent
Access to justice and legal aid	30	2.5
Freedom from stigma and discrimination	62	5.1
Protection from GBV	50	4.2
Right to accessibility	42	3.5
Right to education	303	25.2
Right to employment	43	3.6
Right to equality and non-discrimination	225	18.7

Source: Field Data, 2025

Rights	Frequency	Percent
Right to health	99	8.2
Right to privacy and confidentiality	25	2.1
Right to protection from exploitation and violence	55	4.6
Not at all	246	20.4
Others, Specify	24	2.0
Total	1204	100.0

Source: Field Data, 2025

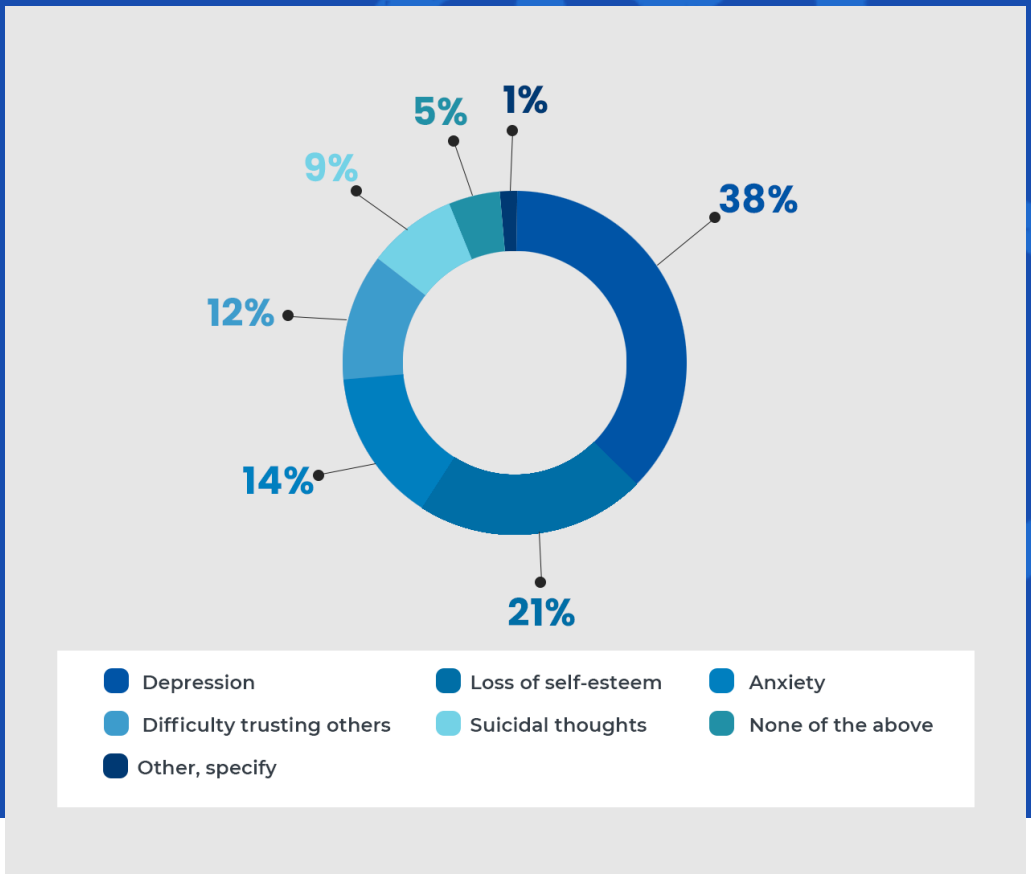


5.0 EFFECT OF SGBV ON SURVIVORS AND THEIR FAMILIES

SGBV has far-reaching consequences that extend beyond the immediate experience of the survivors. It does not only affect the physical and psychological well-being of survivors but also places a significant emotional, social, and economic burden on their families and communities.

In the context of this section, the focus was to discuss the perceived effects of SGBV on survivors. The study revealed that depression is the most common psychological effect of SGBV, affecting 38% of respondents. Loss of self-esteem (21%), anxiety (14%), trust issues (12%), and suicidal thoughts (9%) were also reported. Together, this highlights the deep emotional distress many survivors face along with the mental health effects they endure.

Figure 12: Effects of SGBV on survivors and their families



Source: Field Data, 2024

A small percentage of survivors (5%) reported having no side effects, while 1.5% noted other issues. This suggests that nearly all survivors have experienced some level of emotional or psychological trauma. This conclusion is supported by Tenkorang (2021), who found that survivors of SGBV are more likely to develop severe depression due to trauma and social stigma. Alongside the effects of SGBV, respondents also indicated that SGBV significantly impacts their mental and emotional well-being, academic or job performance, and participation in social activities as discussed below.

5.1 Extent of Effect on Mental/Emotional Well-Being, Academic Performance, and Participation in Social Activities

Respondents were asked to rate the effects of SGBV on the psychosocial well-being, academic performance, and social participation of survivors. Table 5 shows that 424 respondents reported significant effects on their mental and emotional well-being, while 302 reported moderate effects, 135 reported somewhat noticeable effects, and 92 experienced no impact. These results align with WHO (2021), which found that survivors often experience psychological trauma such as anxiety, depression, and post-traumatic stress disorder (PTSD). The high number reporting significant and moderate effects reinforces global evidence that SGBV often results in emotional instability and long-term mental health challenges (WHO, 2021; UNFPA, 2019). A similar trend is observed in academic and job performance: 432 respondents believe SGBV has a significant impact on survivors, while 114 consider the impact to be moderate.

A 2016 Ghana Health Service report confirmed that SGBV increases school absenteeism and reduces workplace productivity, leading to lower educational attainment and diminished income potential (UN Women, 2022). In this survey, 423 respondents reported that SGBV significantly affects social participation, while 290 noted a moderate impact. These findings are consistent with prior research indicating that survivors frequently withdraw from social interactions due to shame or societal rejection (Human Rights Watch, 2021; Amnesty International, 2020; Adjah & Agbemafle, 2016). Because social participation is critical for recovery, such disruptions can intensify emotional trauma and delay healing.

Table 5: Rating of the effect of SGBV

	Mental and Emotional Well-being	Academic or Job Performance	Survivors Social Participation
Significantly	424	432	423
Moderately	302	114	290
Somewhat	135	123	133
Indifferent	102	90	102
Don't know	81	81	86
Not at all	92	92	102

Source: Field Data, 2025

5.2 Effect of SGBV on the Economic Situation of Survivors and their Families

The most reported consequence of SGBV is increased dependency on family members, with 354 respondents (31.2%) citing this issue (see Table 6). Following closely is increased medical costs, reported by (17.5%) of respondents. This suggests that survivors of SGBV frequently find it challenging to regain their financial independence, often relying on relatives for fundamental needs such as shelter, food, and healthcare. Such dependency can exacerbate the situation, particularly if the abuser is also the caretaker. The mention of increased medical expenses also highlights the physical and psychological effects of SGBV.

Other significant impacts include forced relocation, reported by (16.2%), and loss of income, affecting (16.1%) of respondents, emphasizing the disruptions experienced by survivors of SGBV. These findings align with the research of Tenkorang (2021) and Alvarado et al. (2018), which demonstrated that SGBV often leads to enduring health and economic hardships. Although the Domestic Violence Victim Support Fund (DVF) was established to support survivors with essentials like shelter and medical care, persistent underfunding has limited its reach and effectiveness.

Table 6: Effect of SGBV on the economic situation of survivors and their families

Economic Effect	Frequency	Percent
Forced relocation	184	16.2
Increased dependency on family members	354	31.2
Increased medical costs	199	17.5
Loss of income	183	16.1
None of the above	191	16.8
Other, specify	25	2.2
Total	1,136	100

Source: Field Data, 2025

5.3 Long-Term Health Effects on Survivors of SGBV

Psychological problems (37.3%) are the most reported long-term effects among survivors of SGBV (see Table 7). The finding underscores the severe mental health (e.g., anxiety, depression, and PTSD toll of such experiences. A report by the WHO revealed that nearly one in three women globally has endured sexual violence, often with enduring mental health consequences.

Table 7: Long-Term Health Effects on Survivors of SGBV

Health Effects	Frequency	Percent
Chronic pain	60	9.7
Long term impairment	67	10.8
Psychological problems	230	37.3
Reproductive health problems	93	15.1
Sexual health problems	126	20.5
None of the above	33	5.4
Other, specify	7	1.1
Total	616	100

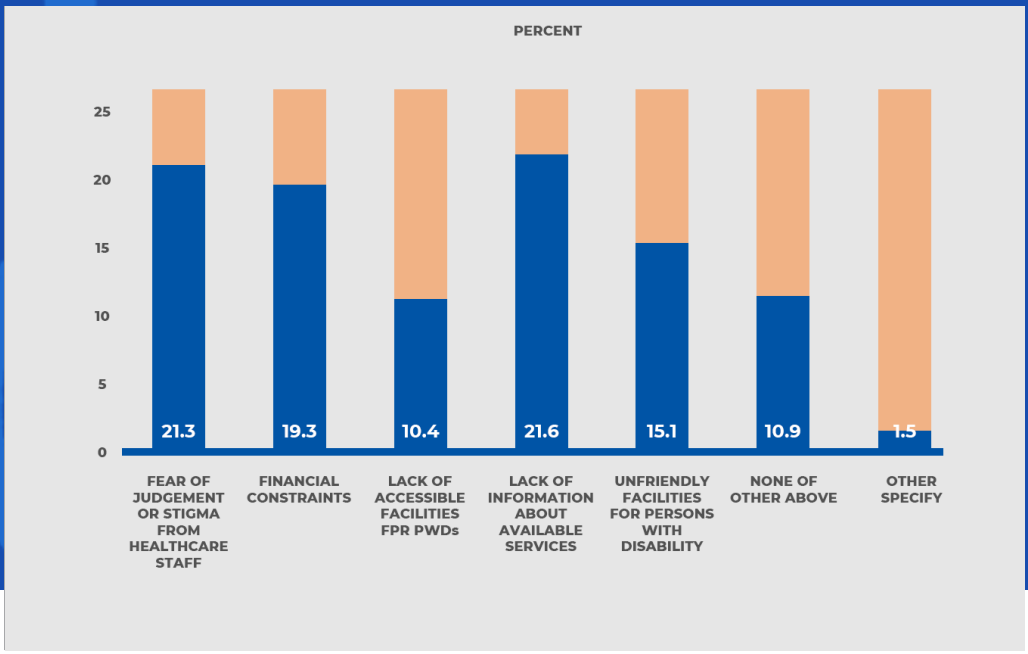
Source*: *Field Data, 2025

Following psychological impacts of SGBV, sexual health issues (20.5%) and reproductive health problems (15.1%) are also frequently reported, raising serious concerns about survivors' bodily autonomy and reproductive well-being. Some studies indicate a higher likelihood of childbirth complications, including fistula, caesarean sections among SGBV survivors (Cherepanov, 2021). Long-term impairment (10.8%) and Chronic pain (9.7%) also reflect significant, though less frequently reported physical consequences. Meanwhile, 5.4% of respondents reported no lasting effects, and 1.1% identified other impacts not listed.

5.4 Barriers to accessing SRHR Services

Figure 13 illustrates the key barriers that prevent survivors from accessing Sexual and Reproductive Health and Rights (SRHR) services. The most reported barrier is a lack of information about available services, cited by 21.6% of respondents. Youth and individuals with disabilities often experience significant gaps in awareness, leaving many marginalized groups without the necessary knowledge or guidance to access essential health services (Guttmacher Institute, 2021). The second most common barrier to receiving care is the fear of judgment from healthcare providers, reported by 21.3% of participants. Many survivors avoid seeking services due to anticipated stigma, blame, or negative attitudes from providers. The WHO (2022) underscores the impact of healthcare provider attitudes on whether survivors of SGBV feel safe accessing healthcare. In some instances, healthcare staff intentionally delay services for young clients as a form of punishment or deterrence. Such unprofessional behaviours, particularly toward vulnerable groups like SGBV survivors, further discourages them from seeking the support they need.

Figure 13: Barriers to Accessing SRHR Services



Source*: *Field Data, 2025

Additionally, financial constraints, (reported by 19.3%) also posed a significant barrier for SGBV victims. Many survivors face difficulties covering medical treatment, transportation, and other health-related costs, especially if they've lost income or become financially dependent due to the abuse. Tenkorang (2021) reported that poor access to financial resources affects access to healthcare services by SGBV survivors. Also, physical and systemic inaccessibility was a major concern for PWDs. A combined 25.5% of respondents pointed to either unfriendly (15.1%) or inaccessible (10.4%) health facilities as barriers. According to Human Rights Watch (2020), many health facilities have inadequate infrastructure and trained personnel, including interpreters needed to effectively serve the survivors and PWDs.

5.5 Impact of SGBV on Reproductive Health of survivors

The study uncovered SRHR issues among respondents resulting from SGBV. The data shows that approximately 369 respondents reported that unwanted pregnancy is the major effects of SGBV with Savelugu recording the highest. Stoeckl et al., (2012) and Ahinkorah, (2021) reported that intimate partner violence is significantly associated with unwanted pregnancies and pregnancy loss. Similarly, a multi-country analysis in sub-Saharan Africa found that women with a history of sexual violence had increased risks of mistimed and unwanted pregnancies (Ahinkorah et al. 2020; Arthur-Holmes, 2023). Amoakohene, (2004) further reported that SGBV particularly rape, often leads to unintended pregnancies.

Table 8: Impact of SGBV on Survivors Reproductive Health

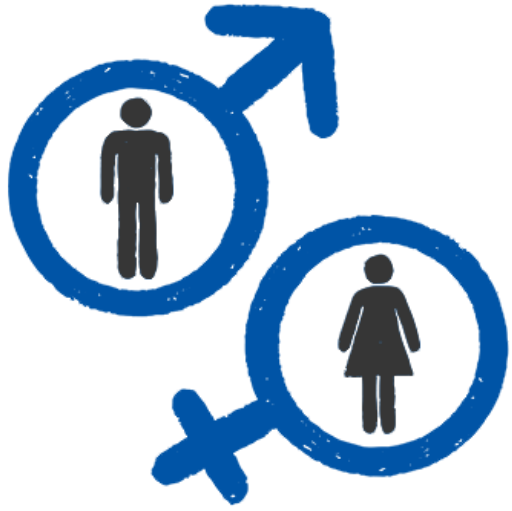
SRHR issues SGBV lead	Ashaiman	Awutu S.	Cape	Sagnarigu	Savelugu	West Mam.	Total
Unwanted pregnancy	42	61	61	59	85	61	369
Early/Forced marriage	12	10	14	19	31	21	107
Lack of access to contraceptives	3	5	10	13	4	9	44
Loss of life	20	13	25	17	13	13	101
School drop-out	28	20	33	30	42	24	177
STI	44	41	54	54	26	12	231
Don't know	15	19	22	34	18	42	150

Source: Field Data, 2025

SRHR issues SGBV lead	Ashaiman	Awutu S.	Cape	Sagnarigu	Savelugu	West Mam.	Total
None of the above	0	0	4	0	0	8	12
Other, specify	0	2	1	5	1	4	13

Source: Field Data, 2025

Sexually transmitted infections (STIs) are the second most reported impact of SGBV (231 cases), with the highest response from Cape Coast (54) and Sagnarigu (54). The WHO reported that women who have experienced violence are at a higher risk of contracting STIs, including HIV (WHO, 2016; Taylor et al., 2017). This increased vulnerability is often due to forced unprotected intercourse and the inability to negotiate safe sexual practices. School drop-out is another significant consequence, with 177 cases reported. The Guttmacher Institute noted that early marriage and unintended pregnancies, often resulting from SGBV, can lead to girls discontinuing their education . The problem of school dropouts shows the connection between GBV and education, as survivors are often forced to drop out of school because of the physical, financial, or social stigma related to violence (Pool et al., 2014).



6.0 SUPPORT SYSTEMS FOR SGBV SURVIVORS

6.1 Availability of Support Systems for Survivors of SGBV

Support systems are a comprehensive network of services, structures, and resources designed to provide survivors with the emotional, physical, legal, social, and economic assistance they need to recover, seek justice, and rebuild their lives. Following the passage of the DVA, 2007 (Act 732), the state is mandated to provide support systems for survivors of any form of abuse. Ghana is also a signatory to several international conventions such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Maputo Protocol

(Article 4) among others that obligate the state to provide support systems for survivors. This section sought the views of respondents regarding the availability of support system for survivors of SGBV.

6.2 Awareness of the Availability of Support Systems

Table 9: Awareness of support systems among youths and PWDs

	Disability Status		
Awareness	**No**	**Yes**	**Total**
No	407 (43.6%)	118 (43.5%)	525
Yes	526 (56.4%)	153 (56.5%)	679
Total	933 (77.5%)	271 (22.5%)	1,204 (100%)

Source: Field Data, 2025

The data illustrates the relationship between respondents' awareness of support systems and disability status. As seen in table 9, out of a total of 1,204 respondents, 271 (22.5%) identified as PWDs, while 933 (77.5%) identified as Persons without disabilities. Among the PWDs, only 153 (56.5%) reported being aware of support systems, while 118 (43.5%) indicated that they were not aware. In contrast, among those without disabilities, 526 (56.4%) were aware of support systems, while 407 (43.6%) were not.

Despite awareness levels being nearly the same for both groups, the data reveal that almost half of PWDs remain unaware of the support systems available to them. This is particularly concerning given that PWDs are more vulnerable to SGBV and often face additional barriers in accessing support systems. Research has shown that PWDs frequently encounter gaps in information, limited access to accessible communication formats, and issues related to stigma and discrimination when seeking help. According to a report by UNFPA (2018), PWDs are often excluded from health promotion campaigns, and many facilities do not accommodate their special needs. Similarly, the WHO, (2021) reports that access to information and services related to support systems for PWDs remains significantly lower due to systemic barriers, which further heightens their risk of abuse and negatively impacts their health outcomes.

6.3 Source of information on the Support Systems

Table 10 presents the distribution of respondents based on their source of information regarding awareness of support systems. Among the 679 individuals who were aware of support systems, the most common source was the media (TV, radio, newspapers, and social media), cited by 35.9% of respondents. This was followed by schools, which accounted for 24.9%, and friends or family members, reported by 16.2%.

Table 10: Source of information on the Support Systems

Source of information on Support Systems	Frequency	Percent
Friends/Family	110	16.2
Government Agencies	35	5.2
Health Care Workers	30	4.4
Media (TV, Radio, Newspapers, social media)	244	35.9
Religious gatherings	21	3.1
School	169	24.9
Workshops/Events	51	7.5
Other, specify	19	2.8
Total	679	100.

Source: Field Data, 2025

Other notable sources included workshops or events (7.5%), government agencies (5.2%), health care workers (4.4%), religious gatherings (3.1%), and other unspecified sources (2.8%). These findings highlight the significant role of mass media and educational institutions in disseminating information about available support systems, while more formal or institutional sources like government agencies and healthcare workers were less commonly reported.

6.4 Availability of support services for SGBV survivors

An assessment of support services for survivors of SGBV from the Table 11 below revealed that traditional and religious networks are the most frequently reported sources of assistance, comprising 26.36% of responses, particularly in the West Mamprusi district. This reliance on traditional and religious institutions highlights their crucial role, especially in contexts where formal services may be mistrusted or hard to access. As noted by Koenig (2009), these institutions often provide accessible and trusted avenues for community support, particularly in low-resource settings. Similarly, Nyamekye (2014) suggest that traditional leaders and religious figures are often the first point of contact for support in many African societies due to their perceived moral authority and closeness to community members. Evidence also suggests that faith-based networks, along with village leaders, play a vital role in assisting survivors of SGBV by offering advocacy, financial aid for legal proceedings, and psychosocial counselling. They also mediate disputes, manage traditional courts, refer cases to the police, and promote awareness campaigns to combat SGBV within their communities.

Legal services were utilized by 22.53% of respondents, with higher usage observed in urbanized areas such as Cape Coast and Ashaiman. This suggests a greater awareness of legal aid in these regions compared to peri-urban and rural communities. Access to legal support is vital for addressing gender-based violence and discrimination, particularly for marginalized populations, including women and individuals with disabilities (WHO, 2013; Kemp et al., 2018). However, many vulnerable groups face challenges in accessing these services due to costs, lack of awareness, and other factors. Similarly, access to healthcare services for survivors, including adolescents and individuals with disabilities, is hindered by costs, the distance to facilities, and the discriminatory attitudes of service providers.

In terms of counselling and psychological services, only 8.1% of respondents reported accessing them, despite an increasing need for mental health support. This low percentage may be attributed to stigma, a lack of mental health literacy campaigns, and the limited availability of trained professionals. Patel et al. (2018) point out that "in many low- and middle-income countries, mental health care remains underfunded, under-resourced, and stigmatized, making it a neglected area of public health." While financial assistance (3.24%) and shelters or safe houses (1.18%) are among the least accessed forms of support, it is concerning that 6.04% of respondents reported having no access to any listed support services, particularly in Ashaiman, Awutu Senya East, and West Mamprusi. Although further investigation was not conducted to understand the reasons behind these gaps, the UNFPA (2020) report notes that such issues often stem from geographic isolation, stigma, inadequate information, and institutional weaknesses. This reflects social exclusion and systemic neglect, highlighting the need for inclusive support systems that ensure no one is left behind.

Table 11: Support Systems accessed by survivors of SGBV

Support Systems accessed	Frequency	Percent
Counselling/ psychological services	55	8.1
Financial assistance	22	3.24
Healthcare service	137	20.18
NGOs	82	12.08
Shelter/safe house	8	1.18
Traditional and Religious authorities	179	26.36

Source: Field Data, 2025

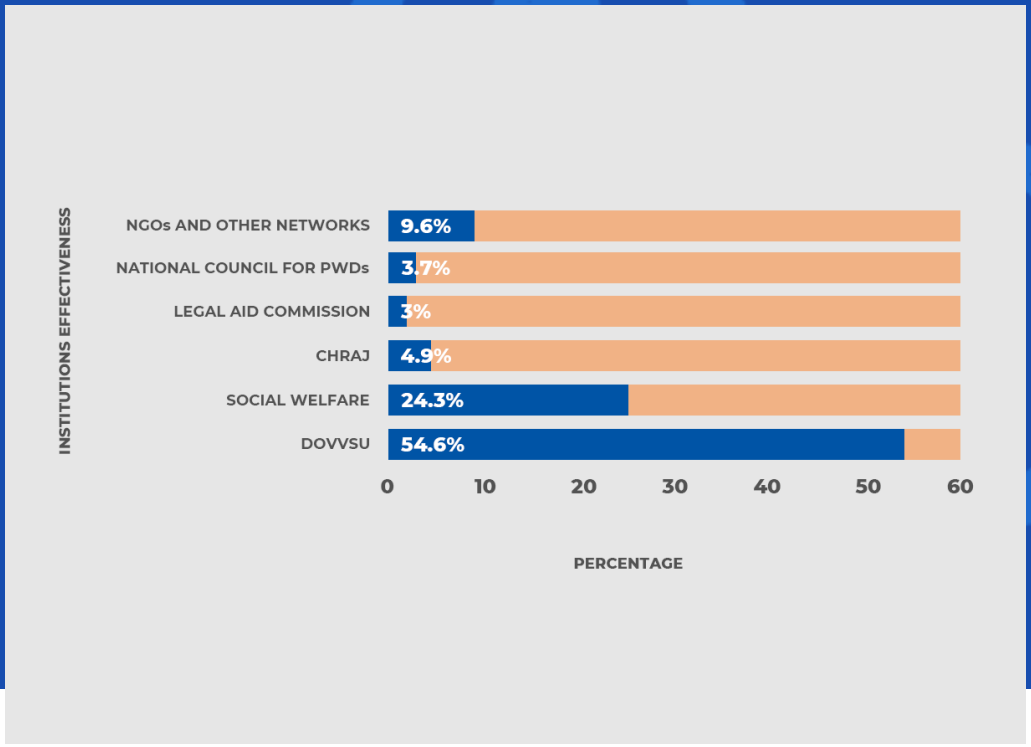
Support Systems accessed	Frequency	Percent
Legal services	153	22.53
None of the above	41	6.04
Other, specify	2	0.29
Total	679	100

Source: Field Data, 2025

6.5 Institutional support systems for SGBV

Alongside gathering respondents' opinions on the availability of various support services such as healthcare, counselling, and financial assistance, participants were asked to share their experiences in accessing and utilizing support systems, specifically focusing on the roles of various institutions. The results indicate that the Domestic Violence and Victims Support Unit (DOVVSU) of the Ghana Police Service is the most frequently accessed support institution, accounting for 54.6% of cases. This finding aligns with the research by Kaburi & Kaburi (2023), which stated that DOVVSU is the main point of contact for survivors seeking to report abuse. Other possible explanations for this trend may include heightened awareness, the institution's presence across the country, and its legal obligations. DOVVSU is tasked with receiving and addressing complaints, conducting investigations, providing temporary shelter, and referring victims to necessary medical, legal, and counselling services. Furthermore, DOVVSU works in collaboration with institutions like the Department of Social Welfare to ensure comprehensive support for victims.

Figure 14: Institutional support systems for SGBV



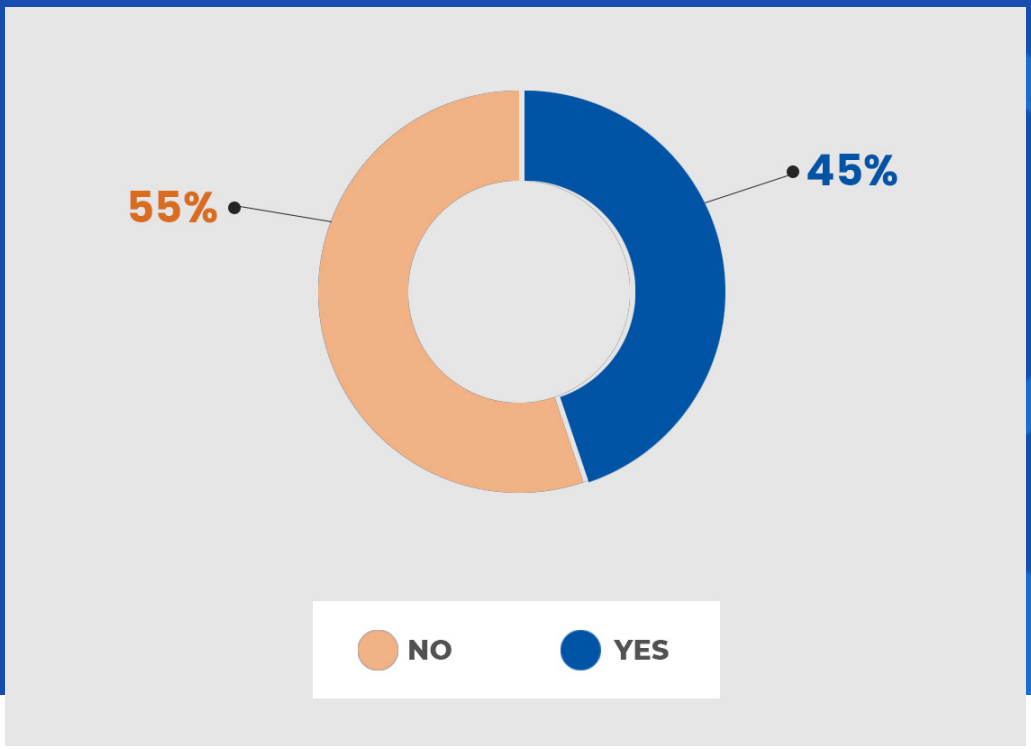
***Source:** Field Data, 2025*

A baseline study report from 2022 reveals that DOVVSU recorded 31.9% of violent cases against women, underscoring its vital role for survivors of SGBV seeking assistance (CHRAJ, 2022). The research also underscores the important function of Social Welfare in aiding survivors, though it often struggles to provide thorough assistance, particularly in rural areas, due to resource constraints (Kaburi & Kaburi, 2023). Other institutions, such as the CHRAJ (4.9%), the Legal Aid Commission (3.0%), and the National Council for Persons with Disabilities (3.7%), are less often accessed.

6.6 Barriers in accessing support services

The data indicates that nearly half (45%) of respondents reported facing barriers in accessing available services. Although no inquiries were conducted to explore the reasons why over half of the respondents reported facing no barriers, potential explanations may include improved accessibility to local services, more effective publicity, or services that are better suited to meet the needs of the community.

Figure 15: Respondents faced barriers in accessing support services



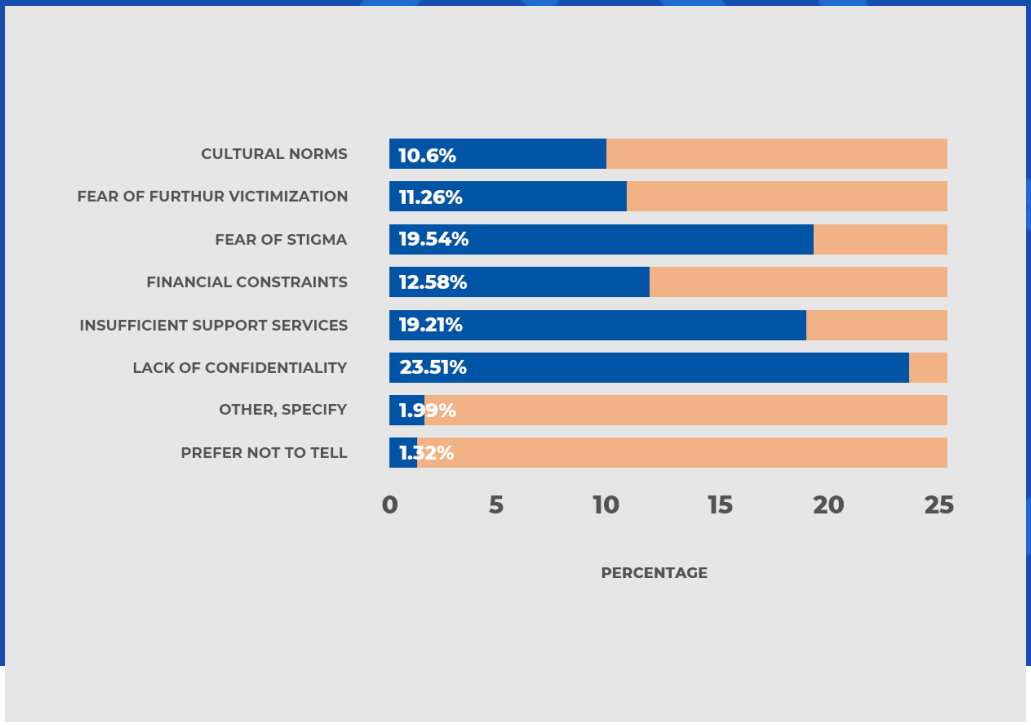
Source: Field Data, 2025

6.7 Challenges in accessing support services

Several key barriers continue to hinder individuals from accessing vital support services, as revealed by the study. Foremost among these is the lack of confidentiality, cited by 23.51% of the research population. Concerns about personal information being exposed create a significant trust deficit, discouraging individuals from seeking help and exacerbating stigma or fear of further victimization. Confidentiality is fundamental to effective support service delivery, as it forms the basis of trust between service providers and users (Amon et al., 2019). Closely linked to these concerns is the fear of stigma and discrimination (19.54%). Many individuals, particularly from marginalized communities, worry about being judged or ostracized if their personal struggles become public. This aligns with the notion that social stigma is a powerful deterrent to accessing mental health and social services (Corrigan, 2016).

Another pressing issue is the inadequacy of support services, reported by 19.21% of participants. This reflects broader systemic issues, including limited resources, poor service integration, and funding shortfalls. When services are scarce or poorly coordinated, individuals are less likely to find the help they need (Banks et al., 2017). Financial constraints also pose a significant barrier (12.58%). Many individuals are unable to afford support services, particularly when faced with out-of-pocket costs or indirect expenses such as transportation. This economic burden disproportionately affects those from low-income backgrounds, further limiting their access to care.

Figure 16: Barriers in Accessing SGBV support systems



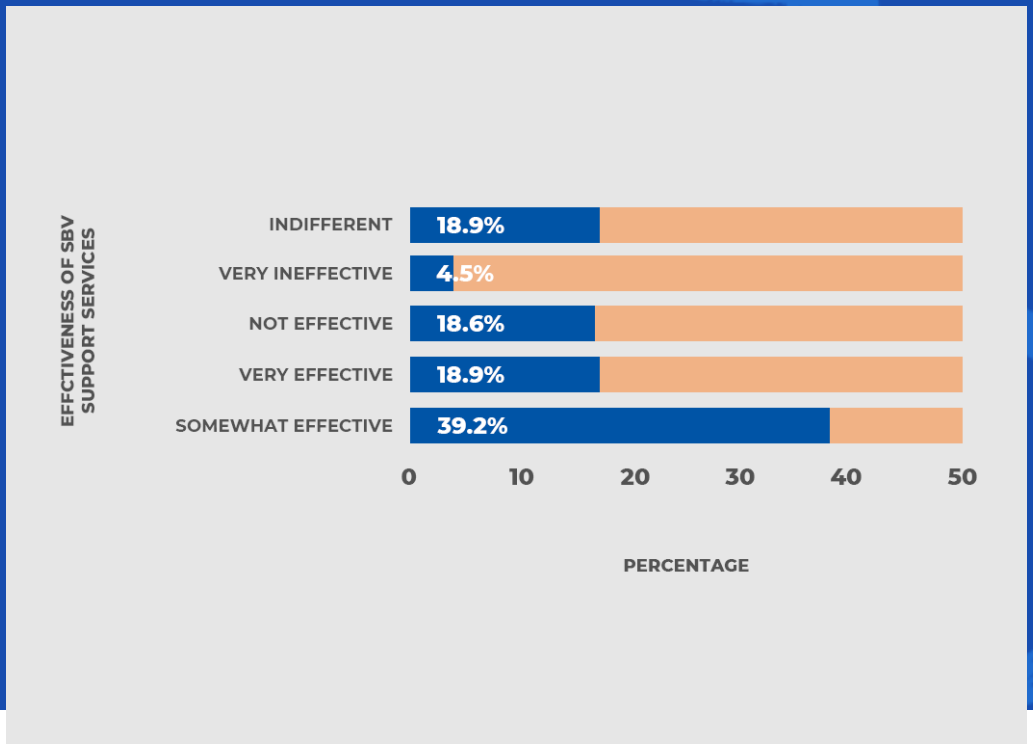
Source: Field Data, 2025

Additionally, fear of further victimization (11.26%) remains a deterrent, especially among those with past experiences of abuse or exploitation. Concerns about retaliation or repeated harm may lead many to avoid engaging with support systems. Cultural norms continue to influence help-seeking behaviours of people in many underserved communities. In some communities, traditional beliefs discourage individuals, particularly women and marginalized groups, from using formal services, instead promoting reliance on family or community support structures. While culturally rooted, such norms can limit access to comprehensive care and exacerbate the conditions of survivors (Awuah-Nyamekye, 2014).

6.8 Effectiveness of SGBV Support Systems in Ghana

Respondents had mixed opinions about the effectiveness of support services. The study revealed that overall, 39.2% of respondents rated support services as “somewhat effective”, while 18.9% rated them as “very effective. Eighteen point six (18.6%) of respondents rated the services as ‘‘poorly’’, with less than 5% of respondents rating services “not effective, and “very ineffective.”

Figure 17: Effectiveness of SGBV Support Services

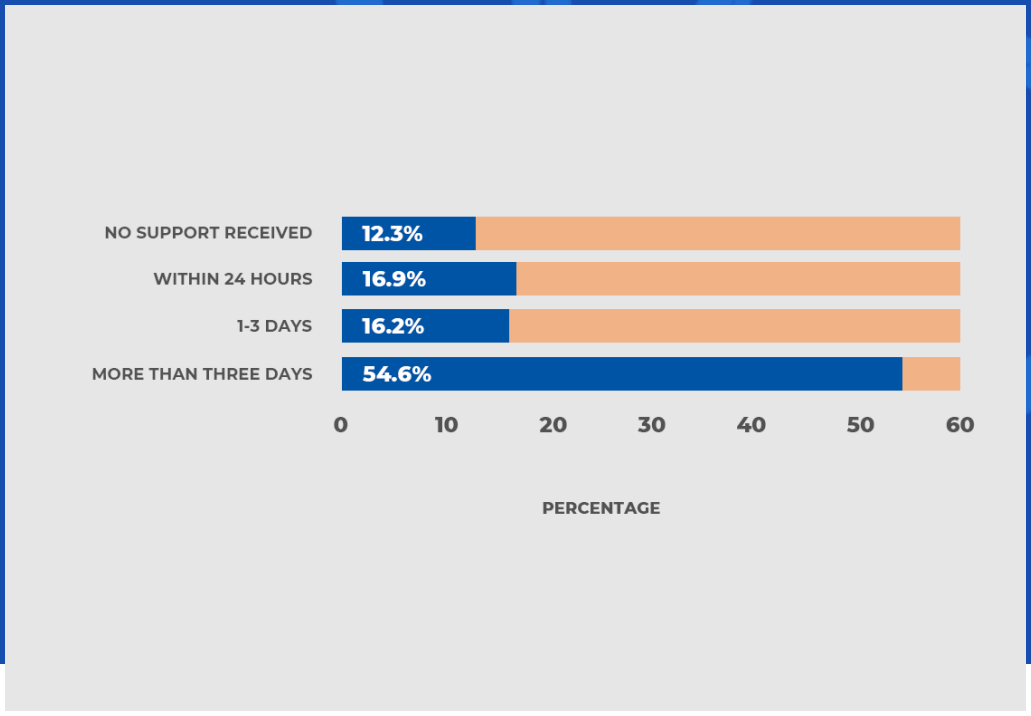


Source: Filed Data, 2025

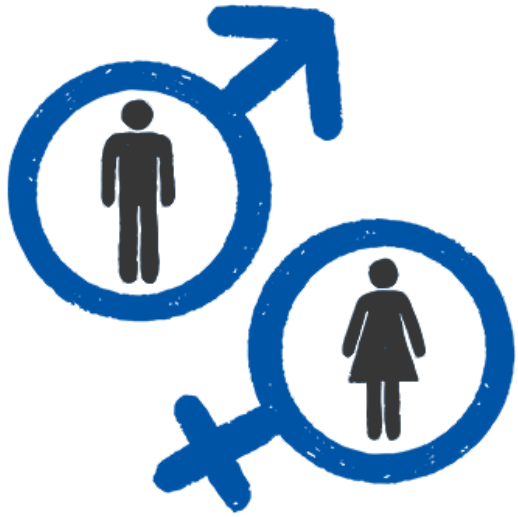
6.9 Timeliness of Support Services for SGBV Survivors

The data presented in Figure 18 indicates that a substantial majority (54.6%) of survivors experienced delays exceeding three days in accessing essential support services, such as legal aid, medical care, or counselling. Furthermore, 12.3% of survivors did not receive any assistance, highlighting significant gaps in responsiveness of support systems. Only 16.2% of survivors received help within 1 to 3 days (quickly), while a marginally higher 16.9% received assistance within 24 hours (very quickly), demonstrating the overall inefficiency of rapid-response services. Delays in providing services to survivors of SGBV can have serious and lasting effects. These delays often worsen psychological trauma, increasing the risk of post-traumatic stress disorder . Nonetheless, there are efforts underway to enhance support services for SGBV survivors. The Ministry of Gender, Children, and Social Protection (MoGCSP) has organized training workshops to equip service providers from health, social, police, and justice sectors with the skills needed for coordinated and timely assistance (MoGCSP, 2023). However, despite these initiatives, there are still delays, indicating challenges that extend beyond the capacity of service providers. According to Cannon et al. (2020), these delays in receiving timely care are largely due to a shortage of trained healthcare professionals and insufficient resources. The study further points out that inadequate counselling services and a lack of awareness about available support contribute to these delays (Ibid).

Figure 18: Timeliness of Support Services for SGBV Survivors in Ghana



Source: Field Data, 2024

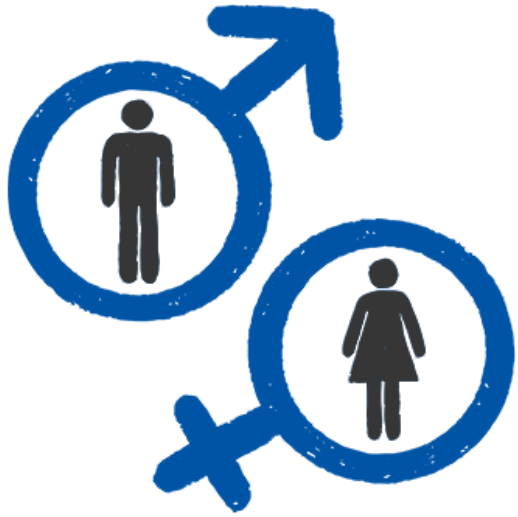


7.0 CONCLUSION

The research examined the prevalence of SGBV among youth and individuals with disabilities in Ghana, focusing on its impact on survivors and their families, as well as the availability and effectiveness of support systems. The findings indicated a rising trend in SGBV incidents within the studied population, particularly among people with physical disabilities. Alarmingly, most of these incidents occurred in homes, traditionally viewed as safe spaces. Among the youth, sexual violence was identified as the most common form, while individuals with disabilities were more frequently subjected to physical violence. Social norms, including early and forced marriages, were highlighted as significant contributors to SGBV.

The research also highlighted the long-term effects of SGBV on survivors and their families, which included psychological distress, lower academic performance, social isolation, and increased economic dependency. Survivors also face the risk of experiencing lasting health issues, such as depression and unintended pregnancies. A variety of support systems exist, including both traditional and formal institutional structures. Most participants reported being aware of these support systems, with the media serving as the primary source of information. However, nearly half of the individuals living with disabilities remained unaware of their existence. Traditional support systems were seen as the most accessible and effective, while the DOVVSU emerged as the most reached out to institution for survivor support services.

Overall, these findings emphasize the urgent need for enhanced awareness, improved protection mechanisms, and strengthened support systems, both traditional and institutional, to combat the escalating impact of SGBV among youth and PWDs in Ghana.



8.0 RECOMMENDATIONS

01

It is imperative to strengthen multi-sectoral collaboration to effectively prevent and combat SGBV everywhere. The Departments of Social Welfare and Community Development, the National Commission for Civic Education, and CHRAJ should enhance and intensify an inclusive community-based sensitization campaigns and educational initiatives on SGBV in schools and communities. These campaigns must target the youth, PWDs, opinion leaders, and religious and traditional authorities, addressing harmful social norms and promoting a comprehensive understanding of survivors' rights and the support services available to them.

02

The Ministry of Education and the Ghana Education Service should establish safe and confidential reporting mechanisms and operate "Social Welfare Fronts" in all basic educational institutions. These units would handle SGBV cases within school environments and provide psychosocial support services, including guidance and counselling by trained staff to address trauma and refer survivors for additional assistance. The Ministry should also consider approving the Reproductive Health Education guidelines for schools to make SRH information available to young people across the country.

03

In addition to supporting awareness campaigns on SGBV, the media and Civil society should champion advocacy for the inclusion of survivors who are socially excluded, stigmatised, and ostracised into the Livelihood Empowerment Against Poverty (LEAP) program and the National Health Insurance Scheme (NHIS). This initiative is essential not only for facilitating the reintegration of survivors into society but also for improving their access to livelihoods and critical healthcare services.

04

The MoGCSP should spearhead the development and strengthening of comprehensive National Safeguarding Policy (NSP) that addresses SGBV across all levels, including the prevention and response to sexual harassment at the workplace, schools, marketplaces, churches etc. The absence of a centralized NSP create opportunities for perpetrators to commit acts of violence with limited accountability. Therefore, it is essential for MoGCSP to develop a comprehensive NSP and ensure its effective integration and implementation across all public and private institutions.

05

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06

It is crucial to establish stronger local support systems to ensure that survivors receive comprehensive and culturally appropriate care. Civil society should collaborate closely with social welfare departments and traditional authorities to create community watch groups. These groups can serve as reliable and confidential channels for survivors to report incidents that occur in schools, homes, and public spaces, allowing them to seek help without fear of victimization. Additionally, these groups should be trained in basic skills to actively support the economic and social reintegration of survivors, prioritizing their safety and well-being, especially for PWDs.

07

The Ministry of Health and the Ghana Health Service should work to improve training and resources for healthcare personnel to better manage cases of SGBV. It is crucial that all frontline personnel are equipped to address the needs of individuals with disabilities in a respectful, knowledgeable, and inclusive manner. Given that survivors frequently experience long-term health challenges such as reproductive, sexual, and psychological issues, it is important to establish accessible facilities to provide timely support.

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