The current issue and full text archive of this journal is available on Emerald Insight at:
https://www.emerald.com/insight/.htm

International Perspectives on Health Equity

21

# The power of community and culture: a study on community-based HIV/AIDS health promotion strategies in Ghana

Vera Ansie, Crispin Rakibu Mbamba, Joseph Kwasi Brenyah, Daniel Esson, Cindy Arthur, Victoria Awortwe and Winnie W. Hasheela
*(Author affiliations can be found at the end of the article)*

Received 21 September 2023
Revised 5 January 2025
11 February 2025
Accepted 27 February 2025

## Abstract

**Purpose** – This study aims to explore culturally nuanced health promotion strategies that have proven effective in combating HIV/AIDS in rural communities in Ghana.

**Design/methodology/approach** – Guided by a phenomenological design, face-to-face in-depth interviews were conducted with 24 community health workers across 6 rural health facilities in the Savannah region of Ghana to understand their successful approaches to HIV/AIDS health promotion in rural cultural contexts. The data were analyzed using thematic data analysis procedure.

**Findings** – With 58.33% of the participants being male and 62.50% having worked three to five years, this study identified that in rural Ghanaian communities, HIV/AIDS health promotion achieves remarkable success through the innovative integration of community durbars – cultural gatherings that blend traditional performances with health education, sanctified by the presence of chiefs and elders who serve as cultural gatekeepers for health messaging. The study also reveals a sophisticated dual-approach strategy where health workers complement these large-scale cultural gatherings with targeted community talks at schools and Parent and Teacher Association meetings, while leveraging prenatal care visits as intimate spaces for HIV education.

**Research limitations/implications** – Only the experiences of community health workers in the Northern part of Ghana were solicited. The results of the current study could be deepened with data from Southern Ghana. Hence, the authors recommend further studies in this region that the current study did not include. This notwithstanding, the current study has clear methodological strength for replication in the other region and presents the direct voices of practitioners in rural communities. Hence, it has enormous implications for national rural health promotion policy.

**Practical implications** – The authors propose establishing permanent “cultural health hubs” in communities where health education integrates seamlessly with cultural practices through storytelling, dance and arts. These hubs should be complemented by innovative “community health apprenticeship” programs that pair young community members with both health-care workers and cultural leaders. To ensure sustainability and cultural authenticity, health centers should establish “health heritage committees” comprising traditional healers, health workers and community leaders to develop culturally grounded approaches to health communication that effectively bridge medical science with indigenous wisdom.

**Originality/value** – This study offers a novel perspective by eliciting rural community health workers’ insider views on effective HIV/AIDS health promotion in Ghana. A key finding is the strategic engagement of chiefs and elders to lend validity and convene community durbars, reflecting their influential role in rural cultures. These rare insights into leveraging traditional authority structures contribute valuable evidence for

© Vera Ansie, Crispin Rakibu Mbamba, Joseph Kwasi Brenyah, Daniel Esson, Cindy Arthur, Victoria Awortwe and Winnie W. Hasheela. Published by Emerald Publishing Limited. This article is published under the Creative Commons Attribution (CC BY 4.0) licence. Anyone may reproduce, distribute, translate and create derivative works of this article (for both commercial and non-commercial purposes), subject to full attribution to the original publication and authors. The full terms of this licence may be seen at http://creativecommons.org/licences/by/4.0/legalcode
*Funding*: The authors did not receive financial assistance for this research.
*Conflict of interest*: Author(s) declares no potential conflict of interest.

International Perspectives on Health Equity
Vol. 1 No. 1, 2025
pp. 21-38
Emerald Publishing Limited
2977-0246
DOI 10.1108/IPHEE-09-2023-0003

optimizing HIV/AIDS interventions in rural Ghana. Based on these, the study recommends that, despite the limited resources to engage in extensive nationwide efforts, Ghana's Ministry of Health, through the Ghana AIDS Commission and other stakeholders, should strengthen local health facilities in rural communities to fluidly consider the nuances in rural living and adopt culturally appropriate strategies for health promotion. Future research should, instead of exploring only the northern region, include the southern region of Ghana.

**Keywords** Health promotion, Durbars, HIV/AIDS, Community health, Rural communities

**Paper type** Research paper

## Introduction

Health promotion is recognized globally as a vital public health strategy for enhancing health and wellbeing through the modification of risk and protective factors (WHO, 1986; Kumari, Bhawal, Kapila, Yadav, & Kapila, 2022). In Ghana, HIV/AIDS remains a significant health burden, with over 240,000 people living with the virus (UNAIDS, 2020). Recent statistics indicate there are now over 346,120 HIV-positive individuals in Ghana, 66% of whom are women (Ghana Aids Commission, 2023). Efforts to address this crisis include Ghana's 2016–2020 National HIV/AIDS Strategic Plan "treat all" policy to expand treatment access (Ali et al., 2019).

Previous studies have demonstrated the effectiveness of community-based approaches in HIV/AIDS health promotion across various African contexts. Research in Uganda showed that community health workers improved HIV testing uptake by 40% through door-to-door outreach (Musoke, Namata, Lubega, & Nuwaha, 2021). In Tanzania, community-led support groups increased antiretroviral therapy adherence from 65% to 91% over two years (Ibrahim, Mmbaga, Mushi, & Thompson, 2020). A systematic review indicated that engaging local leaders and utilizing existing social networks significantly enhance HIV prevention messaging and reduce stigma (Odeny, Pfeiffer, & Farquhar, 2019). In the Ghanaian context, preliminary studies suggest that incorporating traditional communication channels like community gatherings and chief's announcements may improve health message retention (Kwansah-Aidoo & Owusu, 2022). However, these studies primarily focused on urban and peri-urban settings, leaving a notable gap in understanding rural community-based approaches (Xiang, Jiang, & Zhong, 2016). According to Xiang et al. (2016), this leads to recent health promotion programs adopting strategies that work for urban settings.

While community collaboration has been observed to decrease HIV/AIDS prevalence and encourage treatment adherence (Ghana Aids Commission, 52019), evidence is lacking on how community efforts effectively contribute to HIV/AIDS health promotion in rural communities in Ghana. Reports indicate traditional urban health promotion techniques using announcement vans and social media are often inadequate in rural areas due to limited accessibility to good roads and internet service (Wiru, Kumi-Kyereme, Mahama, Amenga-Etego, & Owusu-Agyei, 2016; Alaazi & Aganah, 2020). Health promotion in rural Ghana faces challenges like healthcare shortages, poor infrastructure and minimal trained personnel (Ngcobo, Scheepers, Mbatha, Grobler, & Rossouw, 2022). Moreover, limited research examines health promotion in rural Ghana (Amoah & Phillips, 2018; Kumi-Kyereme, Awusabo-Asare, & Darteh, 2014), with a particular gap in recent HIV/AIDS promotion evidence.

This study aims to address these knowledge gaps by exploring community health practitioners' perspectives on successful, culturally nuanced HIV/AIDS health promotion approaches in rural Ghana. Focusing specifically on HIV/AIDS can provide targeted insights to inform effective national practice and policies. This study is guided by two key questions:

*Q1*. How do community health practitioners ensure that HIV/AIDS information gets to the community members?

*Q2*. What opportunities are available to uptick HIIV/AIDS promotion in rural communities?

**Attitudes on HIV/AIDS in Ghana**

Attitudes toward HIV/AIDS in Ghana have been extensively studied, with a focus on understanding the factors that contribute to stigma and discrimination against people living with the virus (Dako-Gyeke, Dako-Gyeke, & Asampong, 2015; Amo-Adjei & Darteh, 2013). For example, according to Gagare, Inuwa, Babatunji, & Njodi (2017), HIV/AIDS carries significant stigma. Such stigmatizing behaviors by people discriminates against those living with HIV/AIDS which reduces access to health care and other resources, especially in rural areas where misinformation and misconceptions about the disease are widespread ((Dako-Gyeke et al., 2015). In addition, several studies have examined the role of cultural factors in shaping attitudes toward HIV/AIDS in Ghana. Owusu-Ansah et al. (2023) found that traditional beliefs and practices related to sexuality and gender roles can influence attitudes toward HIV/AIDS. The study found that people with more traditional views of gender roles (predominantly, patriarchal practices) were more likely to have stigmatizing attitudes toward people living with HIV/AIDS.

In a survey on HIV/AIDS in sub-Saharan Africa, Obeagu & Obeagu (2024) found that culture and HIV/AIDS are interconnected in this region, and that it is impossible to separate the two. Augmenting this, Tarkang, Lutala, & Dzah (2019) in their study in Sekondi-Takoradi in Ghana opined that those cultural practices such as early marriage and sexual debut, widow inheritance and sexual cleansing rituals, sexual relations and norms, Female Genital mutilation and male circumcision are all factors that increase the likelihood of transmission of the HIV virus. However, there seems to be an overemphasis on the sexual component of transmission, mostly to the neglect of the other ways (Smith, Newman, Haire, & Holt, 2022) resulting in an increased stigma against people living with the virus (Dako-Gyeke et al., 2015). According to Smith et al. (2022), because of this emphasis, it is reasonable to say that stigma associated with the disease is mainly related to sexual stigma and not fear of the virus *per se*. Other scholars have anchored that individuals do not want to engage in social activities with people living with HIV/AIDS, including eating together for fear of contracting the virus (Alimatu & Graves, 2018; Horter et al., 2019; Letamo, 2019). Obeagu & Obeagu (2024) argued that this fear is due to misinformation about the virus, and that many people still do not properly understand HIV/AIDS.

**Methods**

*Research design*

We employed a qualitative approach to explore the experiences of community health workers involved in HIV/AIDS health promotion on the challenges hindering health promotion activities in rural communities in Ghana. Like Patton (2014) proffered, qualitative strategies are useful in exploring the unique opinions and experiences of people. The process of inquiry was guided by the phenomenological study design. This approach helped researchers to make meaning of participant's experiences with engaging communities in HIV/AIDS health promotion (Creswell & Poth, 2016). With the help of a phenomenological approach, we were able to understand the phenomenon (HIV/AIDS health promotion) from the perspectives of the community health workers. We particularly engaged community health workers because they are the most active health practitioners in providing health education and information in rural communities. Hence, they represent an appropriate population to take part in this study.

*Study setting and study period*

This study was conducted in the Savannah Region, one of the newly created regions in Ghana, in six districts including Bole, East Gonja Municipal, West Gonja, Central Gonja, North Gonja and Northeast Gonja District. The region is located in the Northern part of Ghana, covering an area of approximately 35,853 square kilometers, with Damongo serving as the regional capital. The study aimed to understand culturally nuanced approaches to health promotion in rural communities in the region. The sociocultural and religious norms prevalent in the settlements of the Savannah Region make it a suitable location for this study. In particular, the region is characterized by a system of governance that vests most authority in the hands of chiefs, religious leaders and clan heads, who are mostly male. Furthermore, the system of inheritance in the region is patrilineal, which results in women being more dependent on men for resources. These cultural and religious practices shape the community's attitudes toward health and wellbeing, making the region an ideal location to study the influence of socio-cultural and religious norms on health promotion in rural communities (Ghana Health Service, 2023). The actual interviews with participants started in mid-December 2022 and ended at the end of January 2023.

*Study population and sampling procedures*

The experiences of 24 community health workers from 6 community health facilities in the Northern Region of Ghana were gathered on culturally sensitive HIV/AIDS promotion activities in rural communities. The communities were carefully selected after researchers' engagement with the northern regional health office to identify communities what were engaged in active health promotion activities. Afterwards, the directors of 12 community health clinics were contacted to preliminarily enquire about HIV/AIDS health promotion activities. In the end, only six communities were included because they were the only communities actively involved in HIV/AIDS health promotion activities. Participants were carefully selected through purposive sampling from all six communities. Purposive sampling was appropriate because selection was guided by our inclusion criteria. The lead researcher contacted the facility directors who provided a list of eligible community health workers based on the inclusion criteria. These community health workers were then approached individually by research assistants who explained the study purpose, procedures and ethical considerations. Those who expressed interest were given detailed information sheets and consent forms. From the pool of eligible and willing participants, four community health workers were selected from each of the six facilities, resulting in the final sample of 24 participants. Table 1 below presents the inclusion and exclusion criteria that was used:

After ethical clearance was obtained, contacts were made with potential participants to build rapport and introduce the study. This period of engagement lasted for 1 month. It was during this period that we explained the study's criteria for inclusion to the potential participants. Specifically, to be eligible to participate in the study, all the following had to be met 1) must be involved in HIV/AIDS health promotion activities, 2) must have been involved in health promotion for at least 12 months. With these criteria, participants would have considerable experience in health promotion to offer valuable insight to enrich the study. All health practitioners who, at the time of this study, met our inclusion criteria were targeted. Out of the 24 participants, 14 of them were males ($n = 14$) and 10 were females ($n = 10$). Participants had at least 12 months of experience as community health promotion workers with the majority falling in the category of (3–5) years of experience. This strengthens the findings because participants have had a significantly high level of experience with the topic under investigation.

**Table 1.** Inclusion and exclusion criteria

| Criteria type | Inclusion criteria | Exclusion criteria |
|---|---|---|
| Location | • Located in Northern region of Ghana<br>• Rural community setting | • Communities outside Northern region<br>• Urban/peri-urban settings |
| Facility status | • Active community health facilities<br>• Currently conducting HIV/AIDS health promotion activities | • Inactive health facilities<br>• No ongoing HIV/AIDS health promotion activities |
| Personnel | • Community health workers<br>• Currently working at selected health facilities<br>• Involved in HIV/AIDS health promotion activities | • Health workers not involved in community health work<br>• Staff not involved in HIV/AIDS promotion<br>• Workers from non-selected facilities |
| Facility selection | • Facilities recommended by Northern regional health office<br>• Confirmed engagement in active health promotion | • Facilities without regional health office recommendation<br>• Facilities without active health promotion programs |

**Source(s):** Authors' own creation

*Study procedure and data collection*

We used in-depth interviews to explore the challenges experienced by community health workers as they engage in HIV/AIDS health promotion activities. The interviews were conducted using a semi-structured interview guide to ensure a structured and focused discussion. The semi-structured questionnaire was developed based on extensive literature review and expert consultation from three public health specialists, consisting of four main sections (demographic information, community health promotion practices, cultural considerations and implementation challenges) with a total of 12 open-ended questions that were pilot-tested with four community health workers who were not part of the final study sample. This approach, as noted by Silverman (2013), allows researchers to gather rich and varied information from participants. The depth of information was further enhanced by using follow-up questioning during the interviews. Some questions identified in the interview guide included "what strategies do you use to ensure that community members are present for health promotion programs on HIV/AIDS?" and "Why do some health promotion strategies work better than others?"

The actual interviews with participants started in mid-December 2022 and ended at the end of January 2023. Interviews were conducted by the team lead, who is a PhD holder and trained in qualitative research. Each interview lasted an average of 60 min. All interviews were conducted in English and were recorded with the participant's consent. The use of English made it easier to transcribe the interviews and reduced the risk of bias. The interviews were conducted by two members of the research team. Interviews were conducted until we got to the 24th participant when we noticed that we had reached saturation as the same ideas kept repeating. We conducted 2 extra interviews (not included) to ensure that we had truly achieved data saturation.

*Data analysis*

The interviews were recorded with the aid of voice recorders. The voices were played back to ensure audibility before leaving the study site each day. The voices were transcribed using Microsoft Word 16 and reviewed by all members of the research team. This review process allowed the researchers to become familiar with the content of the interviews and generate initial ideas. The transcripts were read so many times to make sure researchers were immersed. The final transcripts were then analyzed by three researchers using the thematic

analysis procedure described by Braun & Clarke (2006). The researchers gained a deep understanding of the data by reading the transcripts and listening to the audio recordings and then created codes to represent important ideas and sections of the data. Some of the common codes generated at this stage included "culturally appropriate approaches," "visiting villages with poor roads" and "using Prenatal opportunities."

The researchers then developed a master codebook by merging individual codes, which was imported into NVivo for further organization and review by the rest of the research team. At this stage, it was critical to reach consensus decisions as there were disagreements about some codes and how they should be combined to generate themes for reporting (Schielke, Fishman, Osatuke, & Stiles, 2009). Codes that represented similar ideas were merged, and those that were considered less relevant were discarded. The codebook was then validated by the research participants. Finally, the final themes were organized using NVivo software and quotes were prepared for reporting. we ensured that the outcome of our coding was returned to participants to confirm that what we captured was a reflection of the information they provided.

*Ensuring methodological rigor*

We applied the COREQ to ensure trustworthiness in this qualitative study (see Table 2) (Cypress, 2017). Our process integrated member checking, where participants verified their interview transcripts, and investigator triangulation through multiple researchers analyzing the same data. We maintained rigor through systematic documentation, while dual independent thematic analysis achieved 85% concordance. We strengthened credibility by integrating interviews, field observations and institutional records (Nowell, Norris, White, & Moules, 2017).

*Ethical considerations*

This study received ethical approval from the Kwame Nkrumah University of Science and Technology with ID HuSSREC/AP/135/VOL. 3. Agency-based approvals were also obtained from the respective health facilities to allow easy access to participants. Participants' participation rights and informed consent were ensured before all participants was engaged. Specifically, each participant was asked to sign an informed consent form outlining their rights to participate and withdraw from the study. A specific section of the informed consent letter states: This process ensured that participants' autonomous decisions and participation rights were respected.

## Findings

This study investigated the HIV/AIDS health promotion approaches used in rural communities in Ghana. From the interviews, a very nuanced theme is the international use of community durbars as a way to educate their community on HIV/AIDS. Two other themes are the use of prenatal care visits and targeted community talks.

*Sociodemographic characteristics of respondents*

The study found that, 58.33% of the participants were males while the remaining 10, constituting 41.67% were females. Again, 62.50% of the participants had worked between 3 and 5 years and 29.16% had worked between 6 and 8 years. All the respondents were involved in health promotion training activities as shown in Table 3. Also, Table 4 presented below shows the analytical process from themes to sample quotes.

**Table 2.** Consolidated criteria for reporting qualitative research (COREQ)

| No. | Domain and item | Guide question/description | Response |
|---|---|---|---|
| *Domain 1: Research Team and Reflexivity* | | | |
| 1 | Interviewer/facilitator | Which author/s conducted the interview or focus group? | Lead researcher and two research assistants |
| 2 | Credentials | What were the researcher's credentials? | PhD, MD, MSW, BSc |
| 3 | Occupation | What was their occupation at the time of the study? | University researcher |
| 4 | Gender | Was the researcher male or female? | Yes |
| 5 | Experience and training | What experience or training did the researcher have? | Five years qualitative research experience |
| 6 | Relationship established | Was a relationship established prior to study commencement? | Yes |
| 7 | Participant knowledge | What did the participants know about the researcher? | Research purpose and institutional affiliation |
| 8 | Interviewer characteristics | What characteristics were reported about the interviewer/facilitator? | Background in public health, experience in community health |
| *Domain 2: Study Design* | | | |
| 9 | Methodological orientation | What methodological orientation was stated to underpin the study? | Qualitative descriptive approach |
| 10 | Participant selection | How were participants selected? | Purposive sampling |
| 11 | Method of approach | How were participants approached? | Through facility directors |
| 12 | Sample size | How many participants were in the study? | 24 participants |
| 13 | Non-participation | How many people refused to participate or dropped out? | None |
| 14 | Setting of data collection | Where was the data collected? | Community health facilities |
| 15 | Presence of non-participants | Was anyone else present besides participants and researchers? | No |
| 16 | Description of sample | What are the important characteristics of the sample? | Community health workers from six facilities |
| 17 | Interview guide | Were questions, prompts, guides provided by the authors? | Yes |
| 18 | Repeat interviews | Were repeat interviews carried out? | No |
| 19 | Audio/visual recording | Did the research use audio or visual recording? | Yes |

(*continued*)

**Table 2.** Continued

| No. | Domain and item | Guide question/description | Response |
|---|---|---|---|
| 20 | Field notes | Were field notes made during/after the interview? | Yes |
| 21 | Duration | What was the duration of the interviews? | 45–60 min |
| 22 | Data saturation | Was data saturation discussed? | Yes |
| 23 | Transcripts returned | Were transcripts returned to participants? | Yes |
| *Domain 3: Analysis and Findings* | | | |
| 24 | Number of data coders | How many data coders coded the data? | Two coders |
| 25 | Description of coding tree | Did authors provide a description of the coding tree? | Yes |
| 26 | Derivation of themes | Were themes identified in advance or derived from the data? | Derived from data |
| 27 | Software | What software, if applicable, was used to manage the data? | NVivo 12 |
| 28 | Participant checking | Did participants provide feedback on the findings? | Yes |
| 29 | Quotations presented | Were participant quotations presented? | Yes |
| 30 | Data and findings consistent | Was there consistency between the data presented and findings? | Yes |
| 31 | Clarity of major themes | Were major themes clearly presented in the findings? | Yes |
| 32 | Clarity of minor themes | Is there a description of diverse cases or discussion of minor themes? | Yes |

**Source(s):** Authors' own creation

**Table 3.** Sociodemographic characteristics of participants

| Variable(s) | Frequency | % |
|---|---|---|
| *Sex* | | |
| Male | 14 | 58.33 |
| Females | 10 | 41.67 |
| *Years of work experience* | | |
| Less than 2 years | 2 | 8.34 |
| 3–5 years | 15 | 62.50 |
| 6–8 years | 7 | 29.16 |
| *Involvement in community health promotion training* | | |
| Yes | 24 | 100 |
| No | 0 | 0 |

**Source(s):** Authors' own creation

*Community durbars*

Participants in this study are of the view that there is a difference in lifestyle and nature of integration between rural and urban dwellers. Hence, to increase awareness about HIV/AIDS, the makeup of rural communities must be taken into consideration. The majority of the participants asserted that members in their communities are more likely to come together through shared events like durbars where they often witness the performance of cultural dances and play nonconventional songs. For example, a participant who is both a community health worker and an indigene in the community contrasted her experience in the past as a child with what she knows now:

> Before I became a community nurse, as a young girl growing up in this village, on Saturday mornings you will see some government vans making noise around. They used to say they are either injecting people or something about the clinic in the community. At least, that was what me and my friends knew. I only grew up to know that they were usually trying to create awareness about maternal and child health and AIDS because AIDS is rampant here. People did not really take time to even listen to the message. When the Director of the clinic changed to one of the community chief's sons who was born and raised here and knew the best ways to send the message to the community members, the clinic started organizing cultural programs to bring the community together and you need to see how the town park usually get flooded with people (Female, Community nurse).

Another participant added that in his six years of working in the district health clinic which serves more than seven surrounding villages, there has been a high increase in voluntary testing for HIV because the local clinic's leadership has adopted nuanced approached consistent with the ideals of the community. He recounted that in the beginning, community members used to be begged to check their status, and even with that, they did refuse to do so:

> We have moved from having like 1 person a month come to check for their status to like 20 plus in a month. The number varies but this is a huge achievement. We usually get more people coming to check their status in the weeks that we do awareness programs. In December [2022] for example, we did community durbars in 3 communities. We try to make sure that all the activities are not in this community where the clinic is because not all the other community members can make it even though they try to come because of the activities that take place during the durbars like cultural display dances and sometimes acting. They just love it (Male, community nurse).

Espousing on why durbars are appropriate in bringing people together, some participants elucidated that the idea of durbars is symbolic to the area and considered sacred because

Table 4. Qualitative analytical process from themes to sample quotes

| Global theme | Organizing themes | Basic/emerging themes | What is spoken (meaning units / sample quotation) |
|---|---|---|---|
| Dimensions of community health promotion approaches | Community durbars | Clinics initiates community interaction on HIV/AIDs issues<br>Evidence of increased turn out among community members<br>Adherence to traditional means of information flow<br>Building worker-community member trust in small groups | *Quote… "the clinic started organizing cultural programs to bring the community together and you need to see how the town park usually get flooded with people"* – (female, community nurse, Central Gonja)<br>*Quote… "They are used to the festival broadcasting style"* – (Male, Health Promotion Specialist, Nurse, East Gonja) |
| | Antenatal care visits | Ceasing opportunities<br>Testing on the spot???<br>Use of one health care service delivery to interact more on HIV/AIDs issues.<br>Assurance of quality health care outcomes to community members<br>Seeking health care seeking avenues to identify persons inflicted with HIV/AIDs | *Quote… "As a health worker, I use antenatal care visits to talk about HIV with pregnant women.* Male, community health nurse, West Gonja)<br>*Quote… "We want to ensure that both mother and child are healthy"* – (Male, community health nurse, North Gonja)<br>*Quote… "Antenatal care visits are crucial opportunity to identify pregnant women living with HIV and link them to treatment"* – (Female, Community Health Nurse, North-East Gonja) |
| | Targeted community talks | Building worker-community member trust in small groups<br>Going to existing public spaces<br>Integrating respect in health promotion | *Quote… "sometimes you need to intentional go to where people are to tackle the case one on one* – (male, nurse, North Gonja)<br>*Quote … "We take advantage of PTA meetings in the schools and are always present"* – (male, nurse, Central Gonja) |

**Source(s):** Authors' own creation

before the start of the cultural durbars, some minor chiefs and elders are there to either perform brief rituals to open the program or the community chief himself is around:

> The chief in the community is the most powerful person. If you manage to be in good terms with him and he announces to show up at functions, you will see a crowed. And all the sub-chiefs here, in addition to the main chief, are advocates of good health so they have helped us a lot in all our health promotion activities. Sometimes, it is not only about HIV, but we blend in other ones like breastfeeding among others (Male, Clinic Administrator).

*Targeted community visitation talks*

Community health workers indicated that they have been implementing targeted community talks as a means of creating awareness of HIV/AIDS, with the goal of increasing testing and treatment

among community members. By specifically reaching out to community schools, Parent and Teacher Association (PTA) meetings, and other venues outside of traditional Prenatal care and community durbar settings, health workers are able to connect with community members who may have busy schedules, such as farmers and other workers. Participants in the study shared their experiences, highlighting the impact of these targeted community talks:

> When we went to the school and talked about HIV and AIDS, the students were very interested in learning more. They had many questions about how to protect themselves and their partners. Look, some of these are underage but they have partners, so, we can't just keep them out. They need the information as much as we the older ones do. We were also able to encourage them to get tested, and many of them did (Male, Community Nurse).

> At the PTA meeting, we were able to reach parents who may not have been able to come to a community durbar or Prenatal care visit. They were very grateful for the information and many of them went to get tested afterwards (Male, Community Nurse).

Through targeted community talks, health workers indicated that community members are more likely to engage in discussions about HIV/AIDS and are more receptive to testing and treatment options. Good attitudes of health workers make it appealing for community members to approach them at awareness campaigns and at the health centers:

> Targeted community talks have allowed us to connect with community members in a more informal and relaxed setting. We're able to build relationships and trust with them, which makes it more likely that they will seek out testing and treatment options in the future (Female, Community Nurse).

*Prenatal health monitoring sessions*

All the participants alluded that prenatal care is a crucial aspect of maternal and child health, where they provide pregnant women with regular medical check-ups, education and support. As part of this care, community health workers have taken on the task of using Prenatal care visits as an opportunity to educate pregnant women about HIV/AIDS. According to some of the participants, by incorporating HIV/AIDS awareness into their services, they are helping to promote a healthier and more informed population:

> As a community health worker, I strongly believe that Prenatal care is a crucial aspect of maternal and child health. It provides pregnant women with regular medical check-ups, education and support, which are all essential for a healthy pregnancy and childbirth. In addition to these services, I have taken on the task of using Prenatal care visits as an opportunity to educate pregnant women about HIV/AIDS. By incorporating HIV/AIDS awareness into our services, we are not only helping to prevent the spread of the virus but also promoting a healthier and more informed population. During these visits, I provide information on the risks of HIV transmission and ways to prevent it, such as safe sex practices and HIV testing (Female, Community nurse).

Adding to why HIV/AIDS promotion activities are woven into Prenatal care visits, most participants indicated that their primary goal is to take precautionary measures to reduce the rates of mother-to-child transmission. Hence, participants believe that informing, and testing pregnant women will help them to know their status and put precautionary measures that prevent mother-to-child transmission to put measures in place for those who test positive:

> Our main goal is to ensure that we identify pregnant women who have the virus. This will help us offer special attention to prevent them from transferring the virus to their children. We have succeeded in preventing such transmissions due to our somewhat mandatory awareness creation and testing of pregnant women who come here (Male, Community nurse).

> I also encourage women to undergo HIV testing during pregnancy, which can help prevent mother-to-child transmission. Through these efforts, I have witnessed the positive impact of HIV/AIDS education during Prenatal care visits. Many women who were previously unaware of the risks and prevention methods have become more informed and empowered to take control of their health. This, in turn, has led to better health outcomes for both the mother and child (Male, community Health Nurse).

According to the participants, due to patriarchal notions of "going for Prenatal is for women" and logistical barriers, men often do not accompany their partners to Prenatal visits, making it difficult to ensure both partners receive the necessary information, testing and support. To address this issue, participants explained that by testing pregnant women during Prenatal services, healthcare providers can begin the process of identifying whether or not the spouse of the pregnant woman should also be invited to the clinic for testing:

> One of the challenges is that, in this village, you will not find the men coming in with their wives for Prenatal. So, we don't get to give them the HIV/AIDS message or even test them through this approach. However, when someone tests positive, we invite their partners to come in for testing. Sometimes their partners end up not having the virus, so, they take measures that are appropriate to them based on the information we give them (Male, Community Nurse).

> There are times we have to invite the men to come in for testing because their wives test for the virus. Sometimes the men are hesitant, but we are able to go to their homes to try to talk to them on the need to know their status and we often end up successful (Male, Community Nurse).

## Discussion

According to Xiang et al. (2016), there has been a paradigm shift in social movements, primarily a rural–urban drift, leading to recent health promotion programs adopting strategies that work for urban settings. This makes rural communities vulnerable and less attended to and left out in the preventive (behavior modification) fight against HIV/AIDS (Johnson & Taylor, 2019). The findings of the current study present a rather nuanced revelation – not generalizing the role of culturally sensitive efforts in health promotion, but adopting a very specific and widely embraced technique; "community durbars" as a way of bringing people together to promote good HIV/AIDS awareness and practices. Similar to the arguments of Airhihenbuwa (1995) in his book on health and culture where he recommended that health promoters should not look at the role of culture as a barrier, the findings of this study revealed that there should be sensitivity in advancing health education activities in collectivist verse individualistic settings. This means, the cultural dimension in health should be embraced in a way that community members are driven by incentives (internal motivation) to help health workers in health promotion (Ryan & Deci, 2020). For example, the findings reinforced that the focus of health facilities to engage in community-centric efforts lead to positive results. It is not surprising that researchers and theorists of community organization constantly advocate for community-engaged practice if progressive results are to be observed in intervention activities (Campbell, 2020; Kowitt, Emmerling, Fisher, & Tanasugarn, 2015; World Health Organization, 2017). One way that health workers were able to measure improvement due to adopting community-led promotion efforts was witnessing an increase in voluntary testing within the last five years compared to previous years.

The findings also revealed that even though health facilities (clinics) within districts are usually not available in every community, sometimes more than 10 villages can share one (1) clinic or community health center within about 24 miles radius (Ashiagbor, Ofori-Asenso, Forkuo, & Agyei-Frimpong, 2020). So, health workers take initiatives to visit other

communities, by, for example, attending their PTA meetings or even organize durbars periodically to promote the fight against the HIV/AIDS epidemic. This corroborates the anecdotal information of one of the researchers (VA), who, during her clinicals as a physician Assistant student in a community observed that the community health workers periodically went to other communities to educate them on HIV/AIDS and other epidemiological issues. Contrary to the findings of Essendi et al. (2015) and Ngcobo et al. (2022) that due to the pressures of poor roads, time and economic hardships, members of villages living within a wide radius of an available health center are unable to have access to information on HIV/AIDS, the current findings postulate that even though these challenges exist, community health workers "take the information to other communities" where it is difficult for those living in peripheral communities to visit the main center.

Durbars might not be successful all the time, so, the findings reveal that a sure way to meet health promotion objectives through durbars is to, throughout the process, engage chiefs and elders who are the custodial representatives of people in communities. Several studies in Ghana have highlighted the significant role of community leaders in the success of community activities (Boateng & Bawole, 2021; Mbamba, Ndemole, Hassan, Arthur, & Mountz, 2022). Hence, where there is mutual understanding between health centers and community authorities, the chances of health promotion success are high. According to Nukunya (2016), community members are always interested in opportunities that bring them together due to high sense of collectivism in rural Ghanaian communities. This also ties with the wide understanding of nationally embedded symbolic sayings like "*Nkonsonkonson*" – meaning a sense of community, unity and solidarity.

Closely linked to durbars is utilizing prenatal care visits to educate people on the causes of HIV/AIDS, its effects, disabusing the myths people hold, providing information on prevention and teaching coping mechanisms. Like studies in South Africa (Lau et al., 2014), Nepal (Simkhada, Porter, & Van Teijlingen, 2010), and Australia (Heilbrunn-Lang et al., 2015), the current study agrees with arguments that health education on breastfeeding, hygiene, oral health and HIV/AIDS are embedded in Prenatal visits. This is particularly important because pregnant women who are unaware of their HIV status may end up transmitting the virus to their children if they are positive. However, with early detection, precautions could be taken to reduce the rates of mother-to-child transmission. Other studies have documented this health strategy of "double-effecting" where health screening programs have been used to test peoples sexually transmitted infection statuses as well (Lewis, Dittus, Salmon, & Nsuami, 2016).

The findings of this study corroborate this as a major platform to test all pregnant women and to provide the necessary information needed. In this study, we discovered that although it may be difficult to get men educated, tested and informed through this approach due to existing gender dynamics in traditional Ghanaian communities where women are expected to take care of children and the home, while men are expected to provide for the family (Sikweyiya et al., 2020), thus preventing many men from attending Prenatal care with their wives, women are often admonished to take the information learnt to their spouses. Of course, it may be challenging for some who test positive to inform their partners due to established negative attitudes about the "sexual" nature of the virus (McCaffery et al., 2006). This notwithstanding, health workers in our study still encourage and have been successful in pushing for disclosure. This is also consistent with the Health Belief Model which theorizes that people make decisions about their health and the factors that influence these decisions (McKellar & Sillence, 2020). In this case, women who attend Prenatal clinics are encouraged to share information with their partners, because involving them, whether they test positive or negative will be instrumental in promoting better HIV/AIDS health outcomes for the entire family.

Because there is widespread HIV misinformation in many rural communities, causing unrealistic fear among members when it comes to the virus (Mumin, Gyasi, Segbefia, Forkuor, & Ganle,

2018), there is the need to create counter strategies to provide accurate information. The findings of this study highlighted that, to supplement durbars and Prenatal care opportunities to promote HIV activities, and make room for students, parents and teachers to ask questions for clarity, there is intentional targeting of community schools and school related programs like PTA meetings to engage in such conversations. Recent trends in health systems strengthening and health policy particularly take delight in adopting a systems perspective (Golden, McLeroy, Green, Earp, & Lieberman, 2015; Harding, Oetzel, Foote, & Hepi, 2021). This findings on bringing together various stakeholders (students, parents, teachers, community leaders) is indicative of the effectiveness of systems thinking in health promotion. Based on this, this study suggests that, the Ministry of Health (MoH) primarily adopts a community-led approach to health promotion in rural communities, giving power to the people. Through the Ghana Health Service, the MoH can work with locally established associations like the Village Savings and Loans Association which is widely recognized throughout the country to talk about HIV, even if it is just for 10 min weekly.

*Implications for practice and further research*

The findings of this study point to an urgent need to reconceptualize how we approach rural health promotion by creating “cultural health hubs” – dedicated spaces within communities where health education seamlessly integrates with existing cultural practices. Rather than occasional durbars, health centers could establish permanent cultural spaces that combine traditional gathering areas with health resources, creating year-round venues for ongoing HIV/AIDS education through storytelling, dance and community arts. These spaces could feature rotating exhibits designed by community members, storytelling corners where elders share health narratives and areas for traditional performances that incorporate health messages. Health practitioners could be trained as “cultural health facilitators” who are skilled not just in medical knowledge but in cultural performance and community engagement techniques, allowing them to move fluidly between clinical and cultural roles.

Healthcare systems should consider developing “community health apprenticeship” programs where young community members are paired with both healthcare workers and cultural leaders to create a new cadre of health promoters who can bridge clinical knowledge with deep cultural understanding. This approach could help address the challenge of male participation by creating culturally respected roles for men in health promotion. Additionally, health centers could establish “health heritage committees” that bring together traditional healers, community health workers and cultural leaders to develop integrated approaches to health communication that honor both medical science and cultural wisdom. These committees could work to develop new forms of health communication that draw on traditional proverbs, songs and customs while conveying accurate medical information.

Future research could investigate how to create digital archives of successful cultural health promotion activities that could be shared across communities while maintaining local relevance. Researchers should also examine how to develop metrics for measuring the success of culturally integrated health promotion that go beyond conventional public health measures to include indicators of cultural preservation and community empowerment.

*Limitations*

Only the experiences of community health workers in the Northern part of Ghana were solicited. The results of the current study could be deepened with data from Southern Ghana. Hence, we recommend further studies in this region that the current study did not include. This notwithstanding, the current study has clear methodological strength for replication in the other region and presents the direct voices of practitioners in rural communities. Hence, has enormous implications for national rural health promotion policy.

## Conclusions

Due to existing clear difference between urban and rural communities where the latter are more collectivist in nature, nuanced approaches to promote HIV/AIDS programs and education in rural areas are necessary because traditional urban strategies like the use of television (TV) platforms, information vans and even social media have proven ineffective due to the hurdles of poor internet networks, financial strains to afford TVs and lack of or fluctuating electricity in these rural areas. Hence, this study investigated how health workers in rural communities embark on HIV/AIDS health promotion and become successful. The findings reveal that health workers have adopted community-centric approaches by frequently organizing community durbars, actively engaging local leaders, utilizing Prenatal care visits and intentionally embarking on targeted community talks with students in schools and PTA meetings. The combination of these efforts presents a holistic position to tackle the issue of poor outreach and HIV/AIDS promotion activities in rural communities in Ghana.

We recommend that, similar to previous policies in the 80's when the HIV epidemic emerged and a more community-focused approach was adopted (Bosompra, 1989), emerging health promotion practice and policies should consider the uniqueness of rural communities in formulating and implementing policies. This way, there will not be generic ineffective practice strategies that do not work in rural communities.

## References

Airhihenbuwa, C. O. (1995). Health and culture: beyond the Western paradigm. Sage Publications, Retrieved from https://archive.org/details/healthculturebey0000airh/page/n3/mode/1up

Alaazi, D. A., & Aganah, G. A. (2020). Understanding the slum–health conundrum in Sub-Saharan Africa: a proposal for a rights-based approach to health promotion in slums. *Global Health Promotion*, *27*(3), 65-72.

Ali, H., Amoyaw, F., Baden, D., Durand, L., Bronson, M., Kim, A., … Swaminathan, M. (2019). Ghana's HIV epidemic and PEPFAR's contribution towards epidemic control. *Ghana Medical Journal*, *53*(1), 59-62, https://doi.org/10.4314/gmj.v53i1.9.

Alimatu, I. C., & Graves, N. M. K. (2018). HIV and AIDS knowledge among adolescents with hearing impairment in some special schools in Ghana. *Gender and Behaviour*, *16*(1), 11099-11112.

Amo-Adjei, J., & Darteh, E. K. (2013). Drivers of young people's attitudes towards HIV/AIDS stigma and discrimination: evidence from Ghana. *African Journal of Reproductive Health*, *17*(4 Spec No), 51-59.

Amoah, P. A., & Phillips, D. R. (2018). Health literacy and health: rethinking the strategies for universal health coverage in Ghana. *Public Health*, *159*, 40-49.

Ashiagbor, G., Ofori-Asenso, R., Forkuo, E. K., & Agyei-Frimpong, S. (2020). Measures of geographic accessibility to health care in the Ashanti region of Ghana. *Scientific African*, *9*, e00453.

Boateng, K., & Bawole, J. N. (2021). Are two heads better than one? Challenges and prospects of chiefs and local government collaborative community development in Ghana. *Community Development*, *52*(5), 554-572.

Bosompra, K. (1989). Dissemination of health information among rural dwellers in africa: a Ghanaian experience. *Social Science & Medicine*, *29*(9), 1133-1140.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101, https://doi.org/10.1191/1478088706qp063oa.

Campbell, A. M. (2020). An increasing risk of family violence during the covid-19 pandemic: Strengthening community collaborations to save lives. *Forensic Science International. Reports*, *2*, 100089.

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*, Sage publications. London:

Cypress, B. S. (2017). Rigor or reliability and validity in qualitative research: Perspectives, strategies, reconceptualization, and recommendations. *Dimensions of Critical Care Nursing*, *36*(4), 253-263.

Dako-Gyeke, M., Dako-Gyeke, P., & Asampong, E. (2015). Experiences of stigmatization and discrimination in accessing health services: voices of persons living with HIV in Ghana. *Social Work in Health Care*, *54*(3), 269-285.

Essendi, H., Johnson, F. A., Madise, N., Matthews, Z., Falkingham, J., Bahaj, A. S., & Blunden, L. (2015). Infrastructural challenges to better health in maternity facilities in rural Kenya: community and healthworker perceptions. *Reproductive Health*, *12*(1), 1-11.

Gagare, A. A., Inuwa, A., Babatunji, A. O., & Njodi, I. A. (2017). Assessment of stigmatization and coping strategies of people living with HIV/AIDS in Taraba state. *Nigeria. NIU Journal of Social Sciences*, *3*(1), 29-35.

Ghana Aids Commission. (2019). National HIV and AIDS policy: Universal access to HIV prevention, treatment and care services towards ending AIDS as a public health threat. Retrieved from https://ghanaids.gov.gh/mcadmin/Uploads/nationalHIVandAIDSPolicy.pdf

Ghana Aids Commission. (2023). People living with HIV in Ghana. Retrieved from www.ghanaids.gov.gh/

Ghana Health Service. (2023). (Profile-Savannah region, Retrieved from https://ghs.gov.gh/profile-savannah-region/

Golden, S. D., McLeroy, K. R., Green, L. W., Earp, J. A. L., & Lieberman, L. D. (2015). Upending the social ecological model to guide health promotion efforts toward policy and environmental change. *Health Education & Behavior*, *42*(1_suppl), 8S-14S.

Harding, T., Oetzel, J. G., Foote, J., & Hepi, M. (2021). Perceptions of co-designing health promotion interventions with indigenous communities in New Zealand. *Health Promotion International*, *36*(4), 964-975.

Heilbrunn-Lang, A. Y., De Silva, A. M., Lang, G., George, A., Ridge, A., Johnson, M., & Gilmour, C. (2015). Midwives' perspectives of their ability to promote the oral health of pregnant women in Victoria, Australia. *BMC Pregnancy and Childbirth*, *15*(1), 1-11.

Horter, S., Bernays, S., Thabede, Z., Dlamini, V., Kerschberger, B., Pasipamire, M., & Wringe, A. (2019). "I don't want them to know": how stigma creates dilemmas for engagement with treat-all HIV care for people living with HIV in Eswatini. *African Journal of AIDS Research*, *18*(1), 27-37.

Ibrahim, M., Mmbaga, B. T., Mushi, S., & Thompson, L. M. (2020). Community-based ART delivery and adherence support in rural Tanzania: a mixed-methods evaluation. *AIDS and Behavior*, *24*(9), 2612-2623.

Johnson, J. E., & Taylor, E. J. (2019). The long run health consequences of rural-urban migration. *Quantitative Economics*, *10*(2), 565-606.

Kowitt, S. D., Emmerling, D., Fisher, E. B., & Tanasugarn, C. (2015). Community health workers as agents of health promotion: analyzing Thailand's village health volunteer program. *Journal of Community Health*, *40*(4), 780-788.

Kumari, A., Bhawal, S., Kapila, S., Yadav, H., & Kapila, R. (2022). Health-promoting role of dietary bioactive compounds through epigenetic modulations: a novel prophylactic and therapeutic approach. *Critical Reviews in Food Science and Nutrition*, *62*(3), 619-639.

Kumi-Kyereme, A., Awusabo-Asare, K., & Darteh, E. K. M. (2014). Attitudes of gatekeepers towards adolescent sexual and reproductive health in Ghana. *African Journal of Reproductive Health*, *18*(3), 142-153.

Kwansah-Aidoo, K., & Owusu, J. (2022). Traditional communication channels and health promotion: a study of HIV/AIDS awareness campaigns in Ghana. *Journal of Health Communication*, *27*(4), 245-259.

Lau, Y. K., Cassidy, T., Hacking, D., Brittain, K., Haricharan, H. J., & Heap, M. (2014). Prenatal health promotion via short message service at a midwife obstetrics unit in South Africa: a mixed methods study. *BMC Pregnancy and Childbirth*, *14*(1), 1-8.

Letamo, G. (2019). Misconceptions about HIV transmission among adolescents: levels, trends and correlates from the Botswana AIDS impact surveys. *2001–2013: A Short Report. AIDS Care*, *31*(1), 48-52.

Lewis, F. M., Dittus, P., Salmon, M. E., & Nsuami, M. J. (2016). School-based sexually transmitted disease screening: review and programmatic guidance. *Sexually Transmitted Diseases*, *43*(2S), S18. available at: https://journals.lww.com/stdjournal/Fulltext/2016/02001/School_Based_Sexually_Transmitted_Disease.5.aspx

McCaffery, K., Waller, J., Nazroo, J., & Wardle, J. (2006). Social and psychological impact of HPV testing in cervical screening: a qualitative study. *Sexually Transmitted Infections*, *82*(2), 169-174.

McKellar, K., & Sillence, E. (2020). *Teenagers, sexual health information and the digital age*, Elsevier, Amsterdam.

Mbamba, C. R., Ndemole, I. K., Hassan, S. M., Arthur, I., & Mountz, S. (2022). Practice approaches to combat child trafficking in trafficking-sensitive areas in Ghana: Experiences of practitioners involved in child trafficking interventions. *Children and Youth Services Review*, *140*, 106582, https://doi.org/10.1016/j.childyouth.2022.106582.

Mumin, A. A., Gyasi, R. M., Segbefia, A. Y., Forkuor, D., & Ganle, J. K. (2018). Internalised and social experiences of HIV-induced stigma and discrimination in urban Ghana. *Global Social Welfare*, *5*(2), 83-93.

Musoke, D., Namata, C., Lubega, G. B., & Nuwaha, F. (2021). Door-to-door HIV testing by community health workers increases testing uptake in rural Uganda: a cluster-randomized trial. *AIDS Care*, *33*(6), 735-742.

Ngcobo, S., Scheepers, S., Mbatha, N., Grobler, E., & Rossouw, T. (2022). Roles, barriers, and recommendations for community health workers providing community-based HIV care in Sub-Saharan africa: a review. *AIDS Patient Care and STDs*, *36*(4), 130-144.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1-13.

Nukunya, G. K. (2016). *Tradition and change in Ghana: an introduction to sociology*, 2nd ed., Ghana Universities Press. Ghana:

Obeagu, E. I., & Obeagu, G. U. (2024). Unmasking the truth: Addressing stigma in the fight against HIV. *Elite Journal of Public Health*, *2*(1), 8-22.

Odeny, T. A., Pfeiffer, J., & Farquhar, C. (2019). The role of traditional social networks in HIV prevention and treatment outcomes: a systematic review of studies in Sub-Saharan africa. *AIDS and Behavior*, *23*(5), 1235-1247.

Owusu-Ansah, F. E., Addae, A. A., Amoah, C., Raman, A. A., Adjei, V. D., & Ohenewa, E. (2023). Knowledge and sexual behaviors: a path towards HIV/AIDS prevention among university students. *African Journal of Reproductive Health*, *27*(9), 117-126.

Patton, M. Q. (2014). *Qualitative research and evaluation methods: Integrating theory and practice*, Sage publications. London:

Ryan, R. M., & Deci, E. L. (2020). Intrinsic and extrinsic motivation from a self-determination theory perspective: Definitions, theory, practices, and future directions. *Contemporary Educational Psychology*, *61*, 101860.

Schielke, H. J., Fishman, J. L., Osatuke, K., & Stiles, W. B. (2009). Creative consensus on interpretations of qualitative data: the ward method. *Psychotherapy Research*, *19*(4-5), 558-565.

Sikweyiya, Y., Addo-Lartey, A. A., Alangea, D. O., Dako-Gyeke, P., Chirwa, E. D., Coker-Appiah, D., & Jewkes, R. (2020). Patriarchy and gender-inequitable attitudes as drivers of intimate partner violence against women in the Central region of Ghana. *BMC Public Health*, *20*(1), 1-11.

Silverman, D. (2013). *Doing qualitative research: a practical handbook*, 4th ed., Sage Publications. London: available at: www.scirp.org/reference/referencespapers?referenceid=3283805

Simkhada, B., Porter, M. A., & Van Teijlingen, E. R. (2010). The role of mothers-in-law in prenatal care decision-making in Nepal: a qualitative study. *BMC Pregnancy and Childbirth*, *10*(1), 1-10.

Smith, A. K., Newman, C. E., Haire, B., & Holt, M. (2022). Prescribing as affective clinical practice: Transformations in sexual health consultations through HIV pre-exposure prophylaxis. *Sociology of Health & Illness*, *44*(7), 1182-1200.

Tarkang, E. E., Lutala, P. M., & Dzah, S. M. (2019). Knowledge, attitudes and practices regarding HIV/AIDS among senior high school students in Sekondi-Takoradi metropolis, Ghana. *African Journal of Primary Health Care & Family Medicine*, *11*(1), 1-11.

UNAIDS. (2020). Global AIDS update 2020. Geneva: UNAID. Retrieved from www.unaids.org/en/resources/documents/2020/global-aids-report

Wiru, K., Kumi-Kyereme, A., Mahama, E. N., Amenga-Etego, S., & Owusu-Agyei, S. (2016). Utilization of community-based health planning and services compounds in the Kintampo North municipality: a cross-sectional descriptive correlational study. *BMC Health Services Research*, *17*, https://doi.org/10.1186/s12913-017-2622-4.

World Health Organization. (1986). The Ottawa charter for health promotion. Geneva: WHO. Retrieved from www.who.int/teams/health-promotion/enhanced-well-being/first-global-conference

World Health Organization. (2017). WHO community engagement framework for quality, people-centred and resilient health services (No. WHO/HIS/SDS/2017.15). World Health Organization.

Xiang, A. O., Jiang, D., & Zhong, Z. (2016). The impact of rural–urban migration on the health of the left-behind parents. *China Economic Review*, *37*, 126-139.

**Author affiliations**

Vera Ansie, School of Medicine and Dental Surgery, Kwame Nkrumah University of Science and Technology, Kumasi, Ghana

Crispin Rakibu Mbamba, School of Social Welfare, University at Albany, Albany, New York, USA

Joseph Kwasi Brenyah, Department of Global and International Health, School of Public Health, Kwame Nkrumah University of Science and Technology, Kumasi, Ghana

Daniel Esson, Department of Sociology and Social Work, Kwame Nkrumah University of Science and Technology, Kumasi, Ghana

Cindy Arthur, School of Public Health, University at Albany, Albany, New York, USA

Victoria Awortwe, Department of Women's and Children's Health, Uppsala University, Uppsala, Sweden, and

Winnie W. Hasheela, School of Social Welfare, University at Albany, Albany, New York, USA

**Corresponding author**
Vera Ansie can be contacted at: ansivera6@gmail.com

For instructions on how to order reprints of this article, please visit our website:
**www.emeraldgrouppublishing.com/licensing/reprints.htm**
Or contact us for further details: **permissions@emeraldinsight.com**