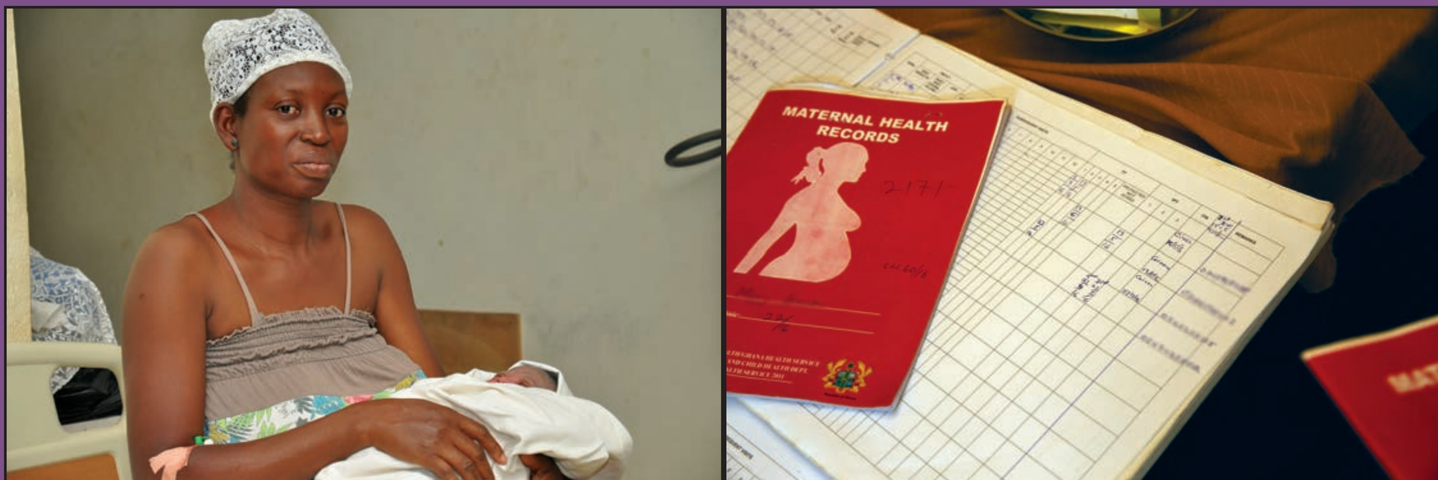
2017 Ghana Maternal Health Survey

Research Policy Briefs



2017 Ghana Maternal Health Survey (GMHS)

Research Policy Briefs

The 2017 Ghana Maternal Health Survey (2017 GMHS) was implemented by the Ghana Statistical Service (GSS) and the Ghana Health Service (GHS) from 15 June through 12 October 2017. The funding for the 2017 GMHS was provided by the Government of Ghana, the United States Agency for International Development (USAID), the European Union (EU) delegation to Ghana, and the United Nations Population Fund (UNFPA). ICF provided technical assistance through The DHS Program, a USAID-funded project providing support and technical assistance in the implementation of population and health surveys in countries worldwide.

The views expressed are those of the authors and do not necessarily reflect the views of USAID or the United States Government.

Document Production: Sally Zweimueller

Additional information about the 2017 GMHS may be obtained from the Ghana Statistical Service, Head Office, P.O. Box GP 1098, Accra, Ghana; Telephone: +233-302-682-661/+233-302-663-578; Fax: +233-302-664-301; Email: info@statsghana.gov.gh.

Information about The DHS Program may be obtained from ICF, 530 Gaither Road, Suite 500, Rockville, MD 20850, USA; Telephone: +1-301-407-6500; Fax: +1-301-407-6501; E-mail: info@DHSprogram.com; Internet: www.DHSprogram.com.

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Introduction

These four research policy briefs rely largely on the findings of the nationally representative 2017 Ghana Maternal Health Survey (GMHS). This report is the product of the GMHS Analysis and Policy Brief Writing Workshop held in Big Ada, Ghana from 16-23 May 2019. The purpose of the workshop was 1) to build the capacity of workshop participants to understand and use the 2017 GMHS dataset, and 2) to support participants in writing a policy brief using the results of data analysis performed in the workshop. The workshop included training on Stata.

A total of 13 participants were divided into four teams. Each team agreed on a topic of interest, conducted the analysis, and wrote a policy brief with relevant findings and recommendations. Each brief reflects the views of the team members that organized and wrote the brief. The first brief focuses on early antenatal care, the second and third briefs concentrate on access to skilled care and facility delivery, and the final brief presents information about health insurance coverage among women with disabilities. These briefs are intended to inform maternal health policy in Ghana by bridging the gap between research and policy, and ultimately practice.

About the 2017 Ghana Maternal Health Survey

Sample: 26,324 households nationwide; 25,062 women age 15-49

Implementing Agency: Ghana Statistical Service

Funding: Government of Ghana through the Ministry of Health (MOH) and by United States Agency for International Development (USAID), the European Union (EU) delegation to Ghana, and the United Nations Population Fund (UNFPA)

Data Collection: June through October 2017

Research Policy Brief	Authors	Organisations
Demographic Disparities in Early Antenatal Care	Dr. Solomon K. Gumanga	Tamale Teaching Hospital, Ministry of Health
	Rejoice Bansa	Ghana Health Service
	Vivian Ofori-Dankwah	Ghana Health Service
	Nicholas Nyagblornu	Ministry of Health
Access to Skilled Care: Pregnant Women in Rural Ghana	Dr. Helen Akaba	Ghana Health Service
	Michael Tetteh Sottie	Ghana Health Service
	Anyinau Sumaila	Ministry of Health
Access to Skilled Care: When Problems Arise during Childbirth	Gladys Brew	Ghana Health Service
	Dr. John Abenyeri	Ghana Health Service
	Dieudonnee Ankamah	Ghana Statistical Service
Health Insurance Coverage for Women Living with Disability in Ghana	Dr. Eric Lartey Quarshie	Komfo Anokye Teaching Hospital
	Dr. Mary Eyram Ashinyo	Ghana Health Service
	Michael Opoku Acheampong	Ghana Statistical Service
Workshop facilitators	Courtney Allen	The DHS Program, ICF
	Lindsay Mallick	The DHS Program, Avenir Health
	Joshua Amo-Adjei	University of Cape Coast, Ghana

Executive Summary

Antenatal care (ANC) is the health care and education given to a pregnant woman by skilled health care professionals in order to ensure the best health conditions for both mother and baby from conception to onset of labour. Pregnant women should attend their first ANC visit within the first trimester; yet 1 in 3 pregnant women in Ghana attend their first ANC visit after the first trimester. The purpose of this brief is to understand **demographic disparities** affecting early ANC among women age 15-49 and recommend appropriate interventions. The brief demonstrates that women in lower wealth quintiles are less likely to receive ANC within the first trimester than women in higher wealth quintiles. This brief recommends 1) implementing **instant National Health Insurance Scheme (NHIS) registration** for pregnant women and 2) investing in health promotion that focuses on early ANC visits.

Introduction

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Antenatal care includes a package of services to monitor maternal and foetal health. Early ANC visits provide the opportunity to monitor any risks before delivery and for the timely management and intervention of complications during pregnancy, thereby preventing direct and indirect maternal deaths. Anemia, for example, a leading indirect cause of maternal deaths in Ghana, can be resolved with early initiation and daily consumption of iron and folic acid tablets during pregnancy. Nevertheless, data from the routine health information system—the District Health Information Management System (DHIS2)—indicates that the prevalence of anemia was 35% in 2018 among women at least 36 weeks pregnant in Ghana, highlighting the need to increase early and regular attendance of ANC during pregnancy.

The World Health Organization (WHO) recommends eight antenatal care visits for all pregnant women before delivery. Additionally, the Ghana National Safe Motherhood Protocol recommends that all pregnant women make their first ANC visit within the first 12 weeks of gestation (hereafter, early ANC) and attend at least eight ANC visits before delivery. The Ministry of Health's (MoH) Health Sector Medium Term Development Plan (2018-2021) sets a target of at least 80% of pregnant women attending early ANC visits.

Yet many pregnant women still initiate ANC after the first trimester and fail to achieve the recommended number of ANC visits. Household wealth is shown to significantly influence the use of ANC services in Ghana. Adequate use of ANC services remains challenging as affordability is still a problem to some pregnant women within the lowest wealth quintiles.[1] Even though ANC is free under the National Health Insurance Scheme, in practice, many women pay out of pocket due to financial challenges of the Scheme.

1 Arthur, E. "Wealth and antenatal care use; implications for maternal health care in Ghana." Health Economics Review. 2012. 12(14):1-8. Doi:10.1186/2191-1991-2-14.

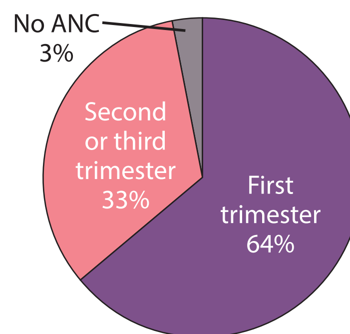
Interventions aimed at removing existing barriers to achieve desired maternal health outcomes include ANC outreach service delivery, regular home visits, task sharing in midwifery, and redeployment of midwives to Community-based Health Planning Services (CHPS) compounds. Key policy interventions, such as the free maternal health care policy, have not sufficiently bridged existing demographic disparities in access to ANC services[2], and poorer women are more likely to receive ANC from unskilled than skilled providers.[3]

Key Findings

Evidence from the 2017 Ghana Maternal Health Survey (GMHS) indicates that although attending at least one ANC visit is nearly universal (only 2% of women did not attend ANC during their last pregnancy), at least one-third of women age 15-49 report late into the second or third trimester for ANC services[4] (**Figure 1**).

Figure 1. Timing of First ANC Visit

Percent distribution of women age 15-49 who had a live birth or stillbirth in the 5 years before the survey



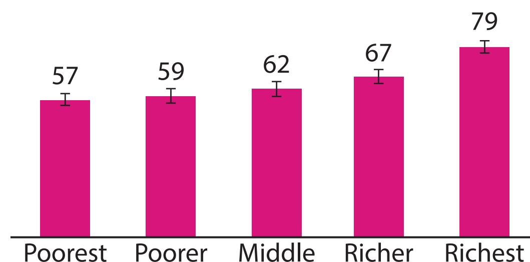
Note: No ANC includes missing and don't know responses.

Further, 89% of women who had a live birth or stillbirth in the five years preceding the survey attended four or more ANC visits during their pregnancy; 43% attended at least 8 visits. Despite the policy of free maternal health care, 45% of women who received ANC at a public facility were asked to make payments for ANC services.

Women in higher wealth quintiles are significantly more likely to receive early ANC compared with women in lower wealth quintiles; 79% of women from the highest wealth quintile received early ANC, while only 57% of the poorest women attended early ANC (**Figure 2**).

Figure 2. Early First ANC Visit by Wealth Quintile

Percent of women age 15-49 who had a live birth of stillbirth in the 5 years before the survey



2 Ganle, J.K., M. Parker, R. Fitzpatrick, and E. Otupori. "Inequalities in accessibility to and utilisation of maternal health services in Ghana after user-fee exemptions a descriptive study". International Journal Equity Health. 2014. 13(89): 2-19. Doi:10.1186/s12939-014-0089.

3 Dickson, K.S., E.K.M. Dartey, A. Kumi-Kyereme. "Providers of antenatal services in Ghana: evidence from Ghana demographic and health surveys 1988-2014". BMC Health Services Research. 2017. 17(1):203. Doi:10.1186/s12913-017-2145-2.

4 Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF. 2018. Ghana Maternal Health Survey 2017. Accra, Ghana: GSS, GHS, and ICF.

Conclusions and Recommendations for Policies and Programmes

Findings from the 2017 GMHS show current interventions to address late first ANC visits have not yielded the targeted outcome of 80% of pregnant women receiving early ANC. It is recommended that the NHIS, the MoH, and health service delivery agencies implement the following interventions:

1. Instant NHIS Registration for Pregnant Women

Implement health facility-based instant NHIS registration for all pregnant women who attend ANC. The prospect of accelerated NHIS card acquisition combined with ANC services on the spot will attract women, especially those within the lower wealth quintiles, to seek early ANC care within the first trimester. We recommend this policy be enacted within the last quarter of 2020.

2. Strengthen Health Promotion Activities

Strengthen health promotion activities aimed at achieving early initiation of ANC by targeting potential pregnant women and their male partners, community groups, mother support groups, and other social groups. Health educational topics by Agencies of the MoH, National Commission on Civic Education (NCCE), and non-governmental organisations (NGOs) within the health sector should focus on the benefits of early ANC visits, availability of instant NHIS registration for pregnant women at the health facilities, and free maternal health care. Community-level health promotion activities are cost-effective strategies that have been demonstrated to increase the use of maternal health care services.[5,6,7]

DISPARITIES AMONG WOMEN WHO RECEIVE EARLY ANC

- **Pregnant women in lower wealth quintile are significantly less likely to receive early ANC, compared to wealthier women.**
- **Instant NHIS registration and community-level health promotional activities are cost-effective strategies to increase the use of maternal health care services.**

5 Turan, J. M., Tesfagiorghis, M., & Polan, M. L. (2011). Evaluation of a community intervention for promotion of safe motherhood in Eritrea. Journal of midwifery & women's health, 56(1), 8–17. doi:10.1111/j.1542-2011.2010.00001.x.

6 Findley, S. E. et al. (2015) 'Reinvigorating Health Systems and Community-Based Services to Improve Maternal Health Outcomes: Case Study From Northern Nigeria', Journal of Primary Care & Community Health, pp. 88–99. doi: 10.1177/2150131914549383.

7 Brazier, E., Andrzejewski, C., Perkins, M.E., Themmen, E.M., Knight, R.J. and Bassane, B., 2009. Improving poor women's access to maternity care: Findings from a primary care intervention in Burkina Faso. Social science & medicine, 69(5), pp.682-690.

Access to Skilled Care: Pregnant Women in Rural Ghana

Executive Summary

In Ghana, 1 in 5 women deliver at home, while overall maternal mortality still looms high. This brief identifies geographic areas where home births are most common, presents the reasons why women deliver at home, and proposes feasible policy solutions that will address the barriers to delivering at a health facility.

Data from the 2017 Ghana Maternal Health Survey (GMHS) show that twice as many women (nearly 50%) in rural areas of the Northern and Volta regions of Ghana deliver at home compared with the national average (21%). **The major reasons for home deliveries include transportation challenges, lack of money, the baby coming earlier than expected, and the facility being too far.** This brief offers the following recommendations to improve barriers to accessing facilities: 1) a **One District–One Ambulance** for use by pregnant women; 2) **transportation vouchers for pregnant women**; 3) **support from transport unions**, such as the Ghana Private Road Transport Union (GPRTU) and the Progressive Transport Owners Association (PROTOA), to transport women in labour to health facilities; and 4) **inclusion of midwives** at Community-based Health Planning Services (CHPS) compounds.

Introduction

According to the 2017 GMHS, the maternal mortality ratio in Ghana remains unacceptably high: 310 deaths per 100,000 live births.[1] Although Ghana has now attained a middle-income status, maternal mortality is still one of the highest in this income bracket. Delivering at a health facility with a skilled birth attendant allows a pregnant woman to receive emergency care when complications arise and can help save the lives of both baby and mother.[2] Nonetheless, 21% of women deliver at home in Ghana.[1]

© 2011 UNFPA, Men encouraged to be in the labour ward while wives give birth at Dodowa Hospital

Sri Lanka, a lower-middle income country like Ghana, has a low maternal mortality ratio, 30 deaths per 100,000 live births.[3] The difference is striking when compared with other nearby lower middle-income countries like India and Bangladesh, where maternal mortality rates remain high, at 174 deaths and 178 deaths per 100,000 live births, respectively. Sri Lanka has reduced their maternal mortality by enacting policies to enable access to and increase the use of health facilities for delivery by increasing the number of facilities, training midwives and nurses, and developing roads and emergency transportation systems.[4]

1 Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF. 2018. Ghana Maternal Health Survey 2017. Accra, Ghana: GSS, GHS, and ICF.

2 World Health Organization. Making pregnancy safer: the critical role of the skilled attendant. A joint statement by WHO, ICM and FIGO. Geneva: World Health Organization; 2004.

3 World Health Organization, UNICEF, UNFPA, World Bank, United Nations Population Division. Trends in Maternal Mortality: 1990–2015: Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Geneva: World Health Organization; 2015.

4 Haththotuwa, R., Senanayake, L., Senarath, U. and Attygalle, D., 2012. Models of care that have reduced maternal mortality and morbidity in Sri Lanka. International Journal of Gynecology & Obstetrics, 119(S1).

Key Findings

Analysis of the 2017 GMHS shows that in all regions of Ghana, pregnant women are still delivering at home. Additionally:

- In every region, rural women are more likely to deliver at home than urban women (**Figure 1**).
- In Northern and Volta regions, home deliveries are twice as high in rural areas compared with urban areas.
- In the Northern region, 49% of rural women deliver at home, compared to 18% of urban women.
- In the Volta region, 45% of rural women deliver at home, compared to 22% of urban women.
- Among rural women, the major reasons given for home deliveries include (**Figure 2**):
  - ○ Transportation challenges (28%)
  - ○ The baby came earlier than expected (23%)
  - ○ Health facility is too far (16%)
  - ○ Lack of money (14%)

Figure 1. Home Deliveries by Region and Residence

Percent of most recent live births or stillbirths in the 5 years before the survey

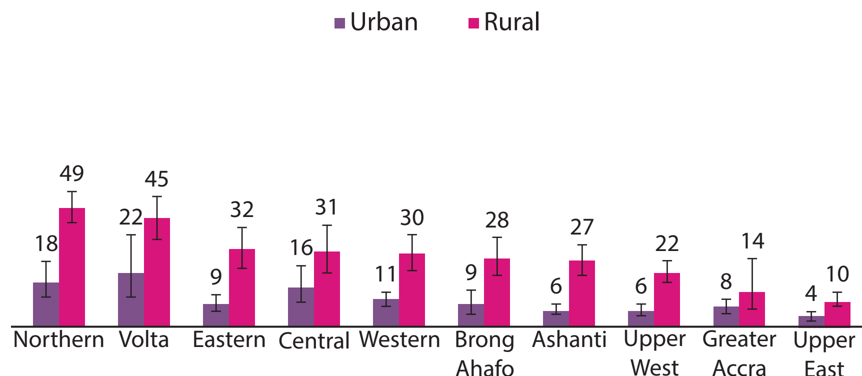
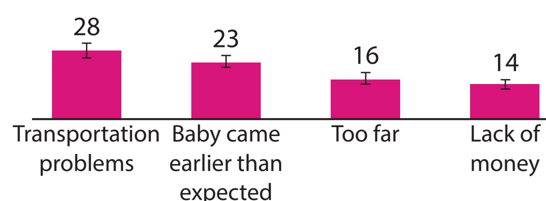


Figure 2. Reasons for Delivering at Home among Rural Women

Percent of rural women age 15-49 with a live birth or stillbirth in the 5 years before the survey who did not deliver in a health facility



Note: Women may have mentioned more than one reason.

From Data to Action: Conclusions and Implications for Policies and Programmes

As shown in the 2017 GMHS, home deliveries are more common in rural settings than urban settings, with the highest proportions of home delivery in the Northern and Volta regions. The major reasons women gave for delivering at home are indicative of a core barrier–a lack of access to health facilities for delivery. Several countries have documented success in reducing access barriers through a health systems approach that involves communities, installation and improvement of health facilities, and implementation of an emergency transportation and transportation voucher scheme.[5,6]

5 Conlon, C.M., Serbanescu, F., Marum, L., Healey, J., LaBrecque, J., Hobson, R., Levitt, M., Kekitiinwa, A., Picho, B., Soud, F. and Spigel, L., 2019. Saving Mothers, Giving Life: it takes a system to save a mother. Global Health: Science and Practice, 7(Supplement 1), pp.S6-S26.

6 Singh, S., Doyle, P., Campbell, O.M., Rao, G.V.R. and Murthy, G.V.S., 2016. Transport of pregnant women and obstetric emergencies in India: an analysis of the '108' ambulance service system data. BMC pregnancy and childbirth, 16(1), p.318.

In line with the Ghana Health Service's (GHS) recommendations,[7] we propose the following interventions, which can be driven by the Government of Ghana or by public-private partnerships.

1. One District–One Ambulance: An Evidence-based Solution

One ambulance allocated to each district in the rural Northern and Volta regions by the year 2021 solely for the use of pregnant women. Treatment can begin for a pregnant woman while in transit.

2. Transportation Vouchers: Incentivizing the Use of Multiple Services with One Programme

Disbursement of transportation coupons, financed by the government or in public-private partnerships, that cover women's transportation costs to the health facility for delivery for all pregnant women in the rural areas of Northern and Volta regions. Distribution of the vouchers will take place during antenatal care visits, which may also incentivize women to seek care.

3. Transport Union Support: A Cost-effective Approach

Each District Assembly within Northern and Volta regions will encourage local transport unions such as the GPRTU to offer subsidized transportation services to transport women in labour to health facilities.

Since most transport union members are men, to gain support and adoption of this policy, advocates can package this practice as men's contribution and social responsibility to reduce maternal deaths of their wives, mothers, and daughters. This has no cost for transport unions and can bring profit.

4. Installation of Additional Health Facilities: A Stepwise Approach to Saving Lives

Each district should have two CHPS compounds by 2021 with at least one midwife who can communicate with health centres and district hospitals closest to each compound. The health centres can serve as the critical link between CHPS and district hospitals. The long-term goal is to have at least one emergency obstetric care operating theatre in at least one district hospital in each district.

HOME DELIVERIES IN NORTHERN AND VOLTA REGIONS

Rural areas of the Northern and Volta regions of Ghana have the highest prevalence of home deliveries, most likely due to transportation challenges.

This brief calls for:

- **One District-One Ambulance for pregnant women**
- **Transportation vouchers**
- **Transport Union support to help with transporting women in labour to health facilities**
- **More CHPS compounds and emergency operating theatres**

7 Ghana Health Services. Improve Maternal Health Care. http://www.ghanahealthservice.org/maternal-health.php. Accessed June 20, 2019.

Access to Skilled Care: When Problems Arise during Childbirth

Executive Summary

Maternal health is one focal area of Sustainable Development Goal (SDG) 3: Good Health and Well-Being. One of the global SDG targets is to reduce the maternal mortality ratio (MMR) to fewer than 70 women dying in pregnancy and childbirth per 100,000 live births. However, Ghana's MMR is four times as high as the global SDG target, currently 310 deaths per 100,000 live births.[1] Improving access to skilled delivery care at the time of childbirth and in the event of a complication during childbirth is critical to avoid maternal deaths. This brief presents evidence that women who deliver at home are not getting the care they need even when complications arise during delivery. This brief suggests interventions such as establishing **community-based emergency transport systems and maternity waiting homes near district hospitals** for very hard-to-reach communities are vital to saving lives and achieving the SDG target.

Introduction

The availability of skilled delivery care at the time of birth is key to the timely management of any problems that may arise during childbirth. Delivery assistance by a skilled provider such as a doctor, nurse, midwife, or community health officer has increased over the last decade in Ghana from 55% in 2007 to 79% in 2017.[1] Interventions such as the free maternity care policy introduced in 2008 by the National Health Insurance Scheme (NHIS) contributed to this increase by addressing financial barriers to care. However, many geographic barriers to skilled delivery assistance persist, and although Community-based Health Planning and Services (CHPS) compounds aim to provide basic maternity services in remote areas, these facilities are not intended to provide delivery services.

© 2014 UNFPA, Labour ward in Tamale District Hospital

Transportation provides a vital link from the home to a health facility, where problems that arise during childbirth can be effectively managed. The national ambulance system functions in transporting people with emergencies, though financial challenges remain in vehicle upkeep and management. Additionally, maternity waiting homes—lodging near health facilities where women can reside toward the end of their pregnancies—have been found to increase health facility utilization in countries with similar context and geographic barriers to accessing health care.[2,3,4]

1 Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF. 2018. "Ghana Maternal Health Survey 2017". Accra, Ghana: GSS, GHS, and ICF.
2 Singh K, Speizer I, Kim ET, Lemani C, Phoya A. "Reaching vulnerable women through maternity waiting homes in Malawi." International Journal of Gynecology & Obstetrics. 2017. 136 (1): 91-97.
3 Bayu Begashaw Bekele & Aline Umubyeyi. "Maternity Waiting homes and skilled delivery in Ethiopia: Review of strategy and implementation to drive sustainable development goals". Medical Practice and Review. 2018. 9(3):19-26.
4 Henry, E.G., Semrau, K., Hamer, D.H influence of quality maternity waiting homes on utilization of facilities for delivery in rural Zambia." Reproductive Health Journal. 2017. 14: 68. https://doi.org/10.1186/s12978-017-0328-z.

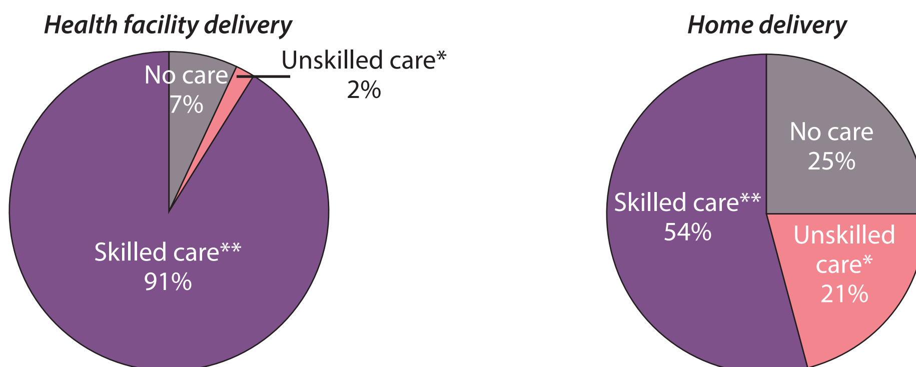
Key Findings

One in five women in Ghana experienced a problem during delivery according to the 2017 Ghana Maternal Health Survey (GMHS). Among all women who encountered problems during childbirth, the survey found that nine in ten (91%) sought some form of care for the complication, whether from a skilled (provided by a doctor, nurse, midwife, or community health officer or nurse) or unskilled provider.

Further analysis of the GMHS reveals that while nearly all women (91%) who delivered at a health facility sought skilled care for their problems during delivery, only half of women (54%) who delivered at home sought skilled care for problems during delivery (**Figure 1**).

Figure 1. Type of Care Sought for Problems Encountered during Delivery by Place of Delivery

Percent distribution of women with a live birth or stillbirth in the 5 years before the survey who encountered a problem during delivery

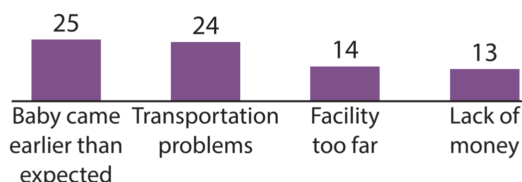


**Unskilled care includes providers other than a doctor, nurse, midwife, or community health officer*
***Skilled care includes providers such as a doctor, nurse, midwife, or community health officer*

The survey found that among women with a live birth or stillbirth in the 5 years before the survey who did not deliver in a facility, the four most common reasons for delivering at home are the baby came earlier than expected (25%), transportation problems (24%), distance to the facility was too far (14%), and lack of money (13%) (**Figure 2**).

Figure 2. Reasons for Delivering at Home

Percent of women with a live birth or stillbirth in the 5 years before the survey who did not deliver in a health facility



Note: Women may have mentioned more than one reason.

From Data to Action: Conclusions and Implications for Policies and Programmes

Women who deliver in a health facility are more likely to get skilled care for problems during childbirth than women who deliver at home. Because home births are risky due to problems that can arise during childbirth, it is critical that women deliver in a facility to receive skilled care. Commonly cited reasons for not delivering in a health facility could be remedied with the availability of transportation to a facility.

In view of these findings, the following solutions are proposed:

1. Strengthen Emergency Transportation Options

All CHPS Zones should have community-based emergency transport as part of the formal referral system. This emergency transport should be linked to the National Ambulance system. Community engagement would be critical in creating community-based transport systems that have local buy-in and support to ensure they are ready and available when emergencies arise.

2. Ensure Lasting Infrastructure for National Ambulances

The National Health Insurance Authority should manage the maintenance costs for national ambulances by the end of 2020.

3. Establish Maternity Waiting Homes and Counseling on Proximity to Delivery Facilities

District Assemblies should establish maternity waiting homes near a district hospital for women in hard-to-reach communities by the year 2025. These would allow women to reside near the district hospital towards the end of their pregnancies, reducing barriers to accessing skilled delivery assistance.

Counseling and public education should encourage pregnant women who live far from delivery facilities to use Maternity Waiting Homes and, in the absence of Maternity Waiting Homes, reside with friends or relations living closer to facilities as their expected delivery dates draw near.

SKILLED DELIVERY CARE FOR THE HARD-TO-REACH

- **Only 54% of women who deliver at home receive skilled care for problems that occur during childbirth.**
- **The establishment of Community-based Emergency Transport and Maternity Waiting Homes can help address challenges for hard-to-reach women.**

Health Insurance Coverage for Women Living with Disability in Ghana

Executive Summary

Health disparities between **persons with disabilities (PWD)** and those without persist in Ghana despite efforts to achieve health for all by 2030. One globally recognised strategy to address accessibility problems of vulnerable people is a **publicly funded health insurance programme**. This brief aims to illuminate the differences in health insurance coverage between Ghanaian women age 15-49 with disabilities and women without disabilities. Data are drawn from the 2**017 Ghana Maternal Health Survey (GMHS)** and analysed descriptively. Women with disabilities more often lack health insurance coverage, compared to women without a disability. A step towards bridging the health insurance gap between PWD and the rest of the population is to require expansion of the exemption criteria.

Introduction

Globally, people living with disabilities experience health and health care inequities due to financial and other socioeconomic barriers.[1] Disability is defined as having a lot of difficulty or inability to function in at least one domain such as seeing, hearing, communicating, remembering or concentrating, walking or climbing steps, and washing all over or dressing.[2]

The quest to achieve the *Health for All* agenda is driven by an inclusivity strategy where *no one is left behind*. Women of reproductive age with disabilities in developing countries face multiple challenges in accessing health services.[3]

Ghana has a strong legal framework that protects the health of citizens, with particular interest in vulnerable and marginalized populations. For instance, in 2006, Ghana passed the Disability Law (Act 715), which ensures the enforcement of the provisions in Article 29 of the 1992 constitution of the country.[4] This law includes provisions that PWD should have unhindered access to public places, education, employment, free general and specialist medical care, and transportation among others. Still, 13 years after the law was passed, most of the provisions in the law have yet to be implemented.

The most pragmatic approach to ensuring the provision of free medical care for PWD is to ensure their enrolment in the National Health Insurance Scheme (NHIS). Ghana's health insurance law provides exemptions for certain categories of people such as pregnant women, children under 5, the very poor, and the elderly. PWD who are likely to be poor are not captured under these exemptions.

1 Iezzoni, LI (2011). Eliminating health and healthcare disparities among the growing population of people with disabilities. Health Affairs 30 (10), 1947-1954.

2 Madans, J. H., Loeb, M. E., & Altman, B. M. (2011). Measuring disability and monitoring the UN Convention on the Rights of Persons with Disabilities: the work of the Washington Group on Disability Statistics. BMC public health, 11 Suppl 4(Suppl 4), S4. doi:10.1186/1471-2458-11-S4-S4.

3 Ganle, J. K., Otupiri, E., Obeng, B., Edusie, A. K., Ankomah, A., & Adanu, R. (2016). Challenges women with disability face in accessing and using maternal healthcare services in Ghana: a qualitative study. PloS one, 11(6), e0158361.

4 The Republic of Ghana 2006. Persons' with Disability Act, 2006 (Act 715). Accra, Ghana.

As part of efforts to accelerate the provision of health services to PWD, this brief aims to answer two interrelated questions with secondary analysis of the 2017 GMHS.

1. **How does health insurance coverage among PWD compare to persons without disabilities?**
2. **Does household wealth affect insurance coverage among PWD?**

Key Findings

- One in ten Ghanaian women aged 15-49 years have a disability.
- Only four in ten women with disabilities are insured (**Figure 1**).
    - Women with disabilities are less likely to have health insurance (42%) than women without disabilities (47%).
- Women with disabilities in the poorest wealth quintile are the least insured of all (**Figure 2**).
    - There is a gross 23 percentage difference in insurance coverage between women with disabilities from the poorest households (33%) and women with disabilities from the wealthiest households (56%).

Women with disabilities are less often insured than non-disabled women. Women with disabilities in the poorest households are the least insured of all.

Figure 1. Health Insurance Coverage by Disability Status

Percent of women age 15-49 with health insurance coverage

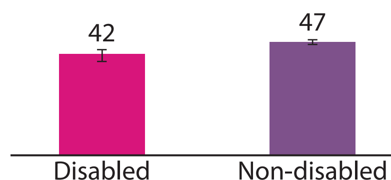
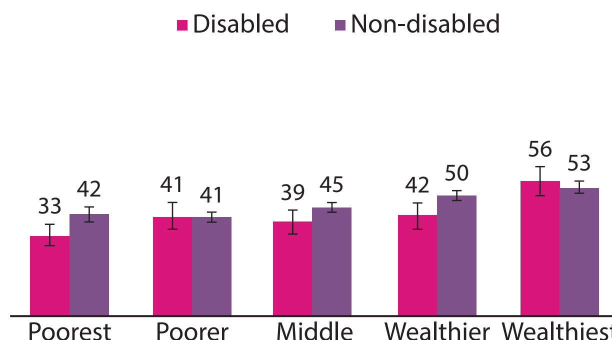


Figure 2. Health Insurance Coverage by Wealth and Disability Status

Percent of women age 15-49 with health insurance coverage



From Data to Action: Conclusions and Implications for Policies and Programmes

This brief shows differences in health insurance coverage between women with disabilities and women without disabilities. Disabled women in the poorest households are less likely to have insurance coverage than wealthier women, both with or without disabilities. It is recommended that:

1. Insurance Exemptions to Include PWD

The Government of Ghana should expand the exemption criteria for health insurance registration to include PWD in accordance with the Disability Law (Act 715) by 2020. An exemption may enhance insurance coverage for PWD.

2. Online and Mobile Registration

To facilitate registration, the NHIS should develop an online registration system and deploy mobile registration vans to register PWD in hard-to-reach communities.

Transportation is a key obstacle to accessing health services among PWD.[5] An exemption policy complemented by online registration and mobile registration at the community level can propel enrolment into the insurance scheme among PWD.

3. Wealth Creation Opportunities

Together with development partners, the Government of Ghana can enhance wealth creation and employment prospects of PWD to reduce their financial dependence on the government.

Entrepreneurial education is a pragmatic step towards wealth creation efforts for PWD,[6] thereby reducing their exclusive reliance on national incentives and support.

INSURANCE FOR THE MOST DISADVANTAGED: THE DISABLED AND DISABLED POOR

This brief calls for:

- **Insurance exemptions for persons with disabilities**
- **Online and mobile registration for insurance for persons with disabilities in communities**
- **Wealth creation and employment assistance for persons with disabilities**

5 Badu, E., Opoku, M. P., Appiah, S. C. Y., & Agyei-Okyere, E. (2015). Financial access to healthcare among persons with disabilities in the Kumasi Metropolis, Ghana. MPhil Dissertation, KNUST, Ghana.

6 Dakung, R. J., Orobia, L., Munene, J. C., & Balunywa, W. (2017). The role of entrepreneurship education in shaping entrepreneurial action of disabled students in Nigeria. Journal of Small Business & Entrepreneurship, 29(4), 293-311.