World Health Organization

hrp

Universal health coverage for sexual and reproductive health in Ghana

Evidence brief

Evidence and policy implications

Key messages

- This brief highlights evidence from a case study of Ghana that critically examines the progress in national measures, experiences and implementation to achieve universal access to various sexual and reproductive health (SRH) services. Three tracers of this are discussed: pregnancy and delivery, gender-based violence (GBV), and safe abortion/post-abortion care. Although Ghana has made considerable progress towards universal health coverage (UHC), there are gaps in prioritization, resource allocation and access in these areas.
- Maternal health has always been considered a high priority by the Government of Ghana, with pregnancy and safe delivery services provided through both public and private sectors and covered under the free maternal health care programme. However, issues remain, such as with the distance to facilities, social/cultural factors and the quality of maternal health care services.
- To fulfil its international obligations, Ghana has made significant progress towards protecting the women and children who are worst affected by GBV. Progress is, however, hampered by a lack of reliable GBV data, poor knowledge and/or training of health care workers and inadequate coordination among state agencies dealing with different aspects of GBV.
- Prioritization of, and access to safe abortion and post-abortion care is challenged by political will plus wider contextual factors. Key policy implications include: using evidence-based political prioritization; reorganizing scopes of practice to expand access to critical SRH services and optimize service delivery; establishing legislative mandates and a clear governance and accountability framework for SRH; and dedicating resources to support and sustain implementation.

Introduction

Many countries have committed to investing in SRH over the last few years. However, progress has been slow due to weak political commitment and leadership, inadequate resources, cultural and legal barriers, and gender and health systems challenges *(1,2)*. This is even more pronounced in low-income countries where funding for SRH services, which is largely donor-driven, is dwindling *(3)*. Responsibility for improving SRH ultimately lies with national leaders, who are striving to develop long-term strategies to ensure sustainable access to comprehensive SRH services *(4–6)*. In Ghana, access to SRH services is a fundamental human right

enshrined in the 1992 Constitution. Since the early 1990s, Ghana has taken steps to ensure that it is a high priority by implementing interventions, policies, laws and programmes aimed at expanding access to SRH services. Key among them are:

- the Community-based Health Planning and Services programme
- the free maternal and child health policy under the National Health Insurance Scheme
- the Domestic Violence Act 2007
- the National Gender and Children Policy.

For decades, maternal and child health has remained a higher priority for the Government of Ghana than other SRH services. Some achievements in the protection of women's rights include the criminalization of harmful traditional practices under the Criminal Code (Amendment) Act 1994 and the passage of the Human Trafficking Act in 2005. In spite of progress towards universal access to the full range of SRH services in Ghana, efforts are being impeded by structural, administrative and stakeholder processes in relation to the prioritization, planning and implementation of SRH programmes and activities in the country.

About this evidence brief

The aim of integrating SRH services into UHC is to ensure individuals, including those who are disadvantaged and marginalized, receive quality, rights-based, non-discriminatory services without experiencing financial hardship. This evidence brief provides an understanding of Ghana's progress towards integrating SRH services into UHC. Particular consideration is given to the political, socioeconomic and cultural contexts that have influenced these services, and how these factors have affected population and service coverage and financial risk. This evidence brief arises from an in-depth study on Ghana involving key stakeholders, including government agencies, multilateral organizations and nongovernmental organizations.

Findings from the government's approach to integrating SRH into UHC

Maternal health: a national emergency

Maternal health has always been considered a high-priority issue by the Government of Ghana *(7)*. Several internationally recommended interventions (such as the Universal Declaration of Human Rights and the International Conference on Population and Development) and local initiatives have been implemented by the Ministry of Health, the Ghana Health Service and partners to promote maternal health *(8,9)*. Although maternal mortality remains high, it has reduced significantly in the past three decades, from 740 per 100 000 live births in 1990 to 451 in 2008 *(10)*. In 2017 there were 310 maternal deaths per 100 000 live births *(11)*. Despite this, Ghana failed to meet Millennium Development Goals 4 and 5 regarding reduction in child and maternal mortality by the end of 2015 *(12)*. In response, the Government of Ghana has instituted a number of innovative interventions over the past two decades to address the high maternal mortality, including *(13)*:

- the Safe Motherhood Programme
- Community-based Health Planning and Services
- User Fees Exemption for Delivery
- National Health Insurance Scheme
- the Millennium Development Goal 5 acceleration framework.

Maternal mortality was declared a national emergency by the Minister of Health and a maternal mortality conference was held in July 2008, attended by representatives from Ghana and overseas *(14)*. This led in that year to the introduction of the free maternal health care policy, which was largely seen as a politically driven initiative *(10)*. Stakeholders included individuals from the Ministry of Health, the Ghana Health Service, the Christian Health Association of Ghana and the National Health Insurance Scheme, who worked together to produce these guidelines *(15)*. The guidelines specified who was eligible for free health care (all pregnant women and newborns up to 3-months old) and details of the benefits package (that is, all health services normally provided within the National Health Insurance Scheme package falling

within the year, beginning from the presentation of a pregnant woman to a health care facility *(10)*). Since 2008, this policy has contributed to an increase in National Health Insurance Scheme enrolment and improvement in health care delivery *(16,17)*.

The Safe Motherhood Programme arose from a task force, supported and operationalized by the government, to reduce morbidity and mortality, and to improve the availability and quality of maternal health services. The broad initiative included programmes addressing demand and supply interventions, such as training health care workers and improving facilities *(18)*. For example, increased training facilities led to a greater level of enrolment of midwives, enabling the Ministry of Health to place more trained midwives in Community-based Health Planning and Services zones, which have the lowest level of health care provision at the community level.

Despite these policies, implementation and health outcomes have been mixed. There remain some significant challenges to ensuring universal access to maternal health care. For instance, according to the most recent maternal health survey conducted in Ghana, there is a disparity in the number of women receiving at least four antenatal care visits, between those who live rurally (83%) and those living in urban areas (92%). The level of skilled attendance at birth is also lower (60%) in rural areas compared with urban areas (90%). Also, nearly all pregnant women from the most wealthy households (98%) made at least four antenatal care visits, whereas only 76% of pregnant women from the poorest households did so. Only 47% of deliveries in the poorest households had a skilled attendant at birth, compared with 97% of deliveries in the richest households. Furthermore, 29% of newborns in the richest households receive postnatal care within two days of birth, but only 25% among the poorest households do *(19)*.

Distance from, and journey time to the nearest facility are perceived as barriers to seeking care. Infrastructure, laboratory tests, drugs and supplies, equipment, water, electricity and emergency transport have also been cited as either being inadequate or unavailable in many of the lower-level facilities (Community-Based Health Planning and Services compounds) *(16)*.

While the direct cost of service delivery is nil, there remain some indirect costs related to antenatal care and delivery, which limit the use of hospital-based midwifery and obstetric care. Emergency referral has been recognized as a challenge. To address this, the local government initiative, "One constituency 1m USD" has provided each of the 275 constituencies in Ghana with an ambulance. In spite of an increase in skilled health care workers, supply of equipment, improved logistics, staff accommodation, transportation and ambulance services, poor quality of care continues to persist. Women are also reluctant to give birth in health facilities due to the poor quality of care experienced in the past at health facilities in Ghana *(17)*.

Gender-based violence

GBV has received some attention, but not to the same degree as maternal health. The media, civil society and nongovernmental organizations raising awareness of GBV have been vociferous in highlighting the issue and ensuring that offenders are brought to account by the law. The Ministry of Gender, Children and Social Protection is responsible for coordinating and ensuring gender equality and for the social protection and development (physical, mental and educational) of children, vulnerable and excluded people, and people living with disability. Steps have been taken to safeguard citizens' constitutionally protected rights to live free from violence. For example, in 1998, the Ghana Police Service established a women and juveniles unit, which resulted in increased reports of violence against both women and children. In 2007, the Domestic Violence Act (Act 732) was passed.

GBV is not prioritized as highly as other components of SRH, despite these legal provisions. Socioeconomic inequalities and gender norms continue to create an atmosphere in which GBV is tolerated. Female (and male) victims are unlikely to report incidents of GBV, and there is little public outcry, and therefore less incentive for policy-makers and programmers to prioritize the issue. There is also a lack of quality data on the gravity of the situation, and perpetrators are not being brought to account by law enforcement agencies *(20)*.

Safe abortion

Although Ghana has relatively broad abortion laws, complications as a result of unsafe abortions are the leading cause of maternal mortality for young women (under 19 years) and the second leading cause of maternal mortality for all women of reproductive age *(21,22)*. This is despite the aim for safe abortion, performed by a qualified health care provider, being part of the reproductive health strategy since 2003. Abortion is currently a criminal offence regulated by Section 58 of the Criminal Code (Act 646) *(23)* but Section 2 of this law states that:[1]

> "It is not an offence under subsection (1) of this section if an abortion or a miscarriage is caused in any of the following circumstances by a registered medical practitioner specialising in gynaecology or any other registered medical practitioner in a Government hospital or in a private hospital or clinic registered under the Private Hospitals and Maternity Homes Act, 1958 (No. 9) or in a place approved for the purpose by legislative instrument made by the Secretary."

Those circumstances include pregnancies resulting from rape, those that would cause injury to the woman or fetus malformation.

The Ghana Health Service promotes post-abortion care within its facilities, through the development of guidelines and policies built into the country's reproductive health framework. In 2003, reproductive health policies and guidelines explicitly stated that comprehensive abortion care should be provided by trained health care professionals with midwifery skills (that is, midwives and medical assistants). To ensure that legal abortions are provided safely, the Ghana Health Service and Ministry of Health developed protocols for the provision of safe abortion. These guidelines were adopted in 2006 and:

- outlined the components of comprehensive abortion care, including counselling and the provision of contraceptives;
- defined mental health conditions that could qualify a patient for an abortion;
- called for expansion of the provider base by authorizing midwives and nurses with midwifery skills to perform first-trimester procedures.

The comprehensive abortion care policy was revised in 2012 *(24)* to include task-sharing for abortion care services at various levels of the health system, including the community, sub-district, district, regional and teaching hospitals. Although Ghana has made significant strides in expanding the cadres of providers for abortion care, ensuring access to services is still a challenge, as midwives are not present in most primary care facilities. In addition, abortion services are not covered under the National Health Insurance Scheme, and there is no regulation of fees for such services, which can often be too high for care seekers.

Medical abortion is increasingly considered as an alternative to surgical abortion in Ghana *(25)* and this is reflected in the latest "Comprehensive abortion care services standards and protocols" *(26)*, which were published and disseminated in 2021. The revised policy also includes a pathway for self-care management of medical abortion. Despite these impressive policy developments, recent research suggests that there is poor knowledge among women about the legal grounds on which abortion is permitted *(27)*. There are also social, cultural and religious factors that delay and affect the provision and demand for abortion care services *(28)*.

1 Section 58 – Abortion or Miscarriage.
(1) Subject to the provisions of subsection (2) of this section – (a) any woman who with intent to cause abortion or miscarriage administers to herself or consents to be administered to her any poison, drug or other noxious thing or uses any instrument or other means whatsoever; or (b) any person who – (i) administers to a woman any poison, drug or other noxious thing or uses any instrument or any other means whatsoever with the intent to cause abortion or miscarriage, whether or not that the woman is pregnant or has given her consent; (ii) induces a woman to cause or consent to causing abortion or miscarriage; (iii) aids and abets a woman to cause abortion or miscarriage; (iv) attempts to cause abortion or miscarriage; or (v) supplies or procures any poison, drug, instrument or other thing knowing that it is intended to be used or employed to cause abortion or miscarriage, shall be guilty of an offence and liable on conviction to imprisonment for a term not exceeding five years.
(2) It is not an offence under subsection (1) of this section if an abortion or a miscarriage is caused in any of the following circumstances by a registered medical practitioner specialising in gynaecology or any other registered medical practitioner in a Government hospital or in a private hospital or clinic registered under the Private Hospitals and Maternity Homes Act, 1958 (No. 9) or in a place approved for the purpose by legislative instrument made by the Secretary:
(a) where the pregnancy is the result of rape, defilement of a female idiot or incest and the abortion or miscarriage is requested by the victim or her next of kin or the person in loco parentis, if she lacks the capacity to make such request; (b) where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health and such woman consents to it or if she lacks the capacity to give such consent it is given on her behalf by her next of kin or the person in loco parentis; or (c) where there is substantial risk that if the child were born, it may suffer from, or later develop, a serious physical abnormality or disease.

Policy Implications

Ghana has made substantial progress in the integration of SRH services into UHC. However, critical challenges remain, including: inadequate funding, non-inclusion of comprehensive SRH services within the health benefits package and hidden/indirect charges for pregnancy and delivery services. Other issues include poor supervision, maldistribution of logistics and health personnel *(29)*, fragmentation of support services for GBV victims across agencies, and sociocultural/religious attitudes affecting SRH service delivery and utilization *(28)*. These issues are being addressed by the Government of Ghana at a policy level; the recent National Health Strategic Plan is committed to "resilient health systems" with high-quality services, irrespective of the patient's ability to pay *(9)*. Also, the latest reproductive, maternal, newborn, child, adolescent health and nutrition plan centres particularly on increasing access to primary health services *(30)*.

Actions at policy level

- **Improve stakeholder participation in policy formulation and implementation:** Create an enabling environment for the participation of communities, including marginalized and vulnerable groups, by regularly evaluating policy dialogue mechanisms. Communities should be included in local health governance, community engagement and monitoring to allow greater involvement.
- **Use evidence-based political prioritization:** A concerted effort is required to highlight issues of poor access to SRH services, using the available evidence. Education and training institutions need to scale up sustainable training of the health care workforce with competencies in SRH to respond to current and future needs. This will require the development of evidence-based workforce policies and strategies.
- **Reorganize scopes of practice to expand access to critical SRH services and optimize service delivery:** The capacity of national regulatory authorities ought to be strengthened to regulate health professional practice, in both the public and private sectors, including the development of professional bodies and models of care that advance comprehensive integrated SRH services.
- **Establish legislative mandates and a clear governance and accountability framework** for SRH and dedicate resources to support and sustain implementation: Annual and semi-annual national review meetings of stakeholders are necessary to improve SRH programmes, and to increase awareness of concurrent activities, the milestones reached and any gaps where attention may be needed.
- **Develop a national master plan for SRH integration within UHC:** The government needs to make a concerted effort to address financial, logistical and health worker shortages and maldistribution through a rigorous planning process. This may be best achieved through a national master plan for SRH integration within UHC, which could address issues such as expanding the health benefit package and long-term funding strategies.
- **Further the research into the implementation of comprehensive abortion policy:** Do targeted research to understand the recent abortion policy implementation, implications for service delivery, providers' perceptions (and receptivity) and users' experiences.
- **Commit to fostering strong and resilient health systems:** Strengthen the health system at its most critical point of service delivery in line with the principles of primary health care.