

RESULTS BRIEF: 13 NOVEMBER 2025

WOMEN-FRIENDLY, QUALITY REPRODUCTIVE AND MATERNAL CARE IN GHANA:

FINDINGS FROM THE SERVICE DELIVERY INDICATORS HEALTH SURVEY



KEY TAKEAWAYS

Reproductive and maternal health services are predominantly used by women and girls. In Ghana, these services are expanding, but key gaps in access and quality continue to shortchange women's needs, choices, and rights with regard to antenatal care, maternity care, and family planning. Provider counseling is often incomplete, and maternity services and lifesaving commodities are less available at community-level facilities and in the public sector. Inadequate infrastructure, including water, electricity, and toilets, further undermines safe and respectful care. Women's access to and choice of family planning services and methods is constrained by limited service, provider, and commodity availability. Preventive and protective services, such as cancer screening and gender-based violence screening and care, are scarce, leaving major gaps in women's right to comprehensive health. Finally, women face significant out-of-pocket costs, particularly at district and non-public facilities, compounding inequities in access. To achieve women-friendly care, it is important that Ghana expand service readiness in public sector and community facilities and strengthen women's access to affordable, respectful, and responsive health services.



MOTIVATION

The maternal mortality rate in Ghana declined from 472 per 100,000 live births in 2000 to 234 in 2020¹, and modern contraceptive use among married women increased from 13 percent in 1998² to 27.8 percent in 2022³. Despite this progress, **large numbers of women and girls in Ghana still risk their lives and health during pregnancy and have unintended pregnancies**. For poor, rural, and disadvantaged women in particular, distance and cost barriers remain, and frequently, the lack of quality, women-friendly services is a demotivating factor for women in seeking services. Facilities can struggle with logistical and infrastructure constraints as well as staff, funds, and commodity shortages that make it difficult to deliver high quality services that meet women's needs and preferences.

Ghana is committed to improving the quality of reproductive and maternal health services and outcomes under its national health sector development plan⁴ and advancing women-friendly, respectful maternal and reproductive health services through its national health sector gender policy and action plan⁵. An assessment of key indicators on service readiness, including women's experiences of care, is critically important in directing policy and programmatic action to strengthen services so that women and girls are well served by the health system.

¹ World Bank Group. Maternal mortality ratio (modeled estimate, per 100,000 live births) - Ghana. 2025. <https://data.worldbank.org/indicator/SH.STA.MMRT?locations=GH>

² ICF Macro. Trends in Demographic, Family Planning, and Health Indicators in Ghana, 1960-2008: Trend Analysis of Demographic and Health Surveys Data. ICF Macro; 2010.

³ Ghana Statistical Service & ICF. Ghana Demographic and Health Survey. GSS and ICF; 2022.

⁴ Ghana Ministry of Health. Health Sector Medium Term Development Plan 2022-2025; 2021.

⁵ Ghana Ministry of Health. National Health Sector Gender Policy; 2024. <https://www.moh.gov.gh/policy-documents/>



SDI HEALTH SURVEY

In 2024, the Ghana Service Delivery Indicators (SDI) Health Survey included assessments at 500 health care facilities, including public and non-public facilities, and interviews with 1,227 health care providers and with 2,409 patients at these facilities. The sampling design used facility tier for stratification, and the results are not only nationally representative but also representative of facility tiers (community, sub-district and district) that provide primary health care in Ghana. Among surveyed facilities, 157 were in the community tier, 207 were in the sub-district tier, and 136 were in the district tier. This brief also presents results disaggregated by facility ownership – public (n = 358) versus non-public (n=142).⁶ This study was not designed to find a clear difference between public and non-public facilities. Therefore, any comparisons made should be viewed carefully.

The survey collected information on the availability of inputs such as supplies and infrastructure; competencies, trainings, and satisfaction of health care providers; and the experience and satisfaction of patients receiving care. The analysis in this brief examines these indicators from a gender lens to assess the extent to which maternal and reproductive health services are offering women quality care and meeting their needs and rights.

The complete Survey Report is available online. Further information on the methods, results, and limitations is available in the full report.

KEY MESSAGE 1

WOMEN ARE LIMITED IN THEIR ACCESS TO AND EXPERIENCE OF QUALITY ANTENATAL CARE DESPITE HIGH COVERAGE LEVELS

Ghana has made tremendous progress in achieving a national ANC4 coverage rate of 87.6 percent.⁷ However, **ANC services were not always conveniently accessible to women, and facilities frequently lacked providers with recent training, essential commodities, and equipment.**

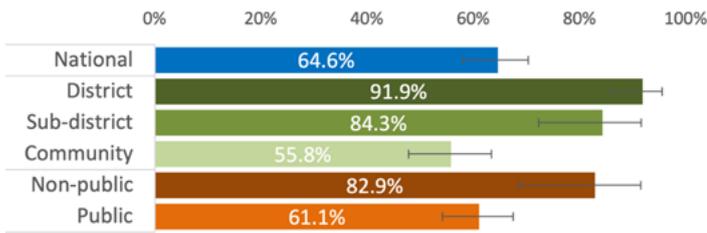
Moreover, women often did not get the full antenatal care in line with the required standards or their right to information and counselling.

- Women's access to facilities offering ANC services was particularly limited at the community level (55.8 percent) but higher at the district level (91.9 percent) (figure 1). Access was also lower in public facilities (61.1 percent) compared to non-public facilities (82.9 percent). Thus, women may have to travel longer or pay more to get basic antenatal care. Limited integration into primary/community care platforms may be preventing women from receiving early and sufficient antenatal care.
- In many cases, women did not get access to a provider with recent training in antenatal care. About half of the facilities offering ANC had at least one provider with recent ANC training (figure 2). Availability of providers with updated training was much lower at the community level (44.2 percent) compared to the district level (74.2 percent). Additionally, while the availability in public facilities was reported at 51.4 percent compared to 68.4 percent in non-public facilities, the sample size was insufficient to definitively assess the statistical significance of this difference.ⁱ

⁶ Public facilities include Ghana Health Service and Ministry of Health facilities. Non-public facilities include Christian Health Association of Ghana (CHAG), Mines, Other faith based, private, and quasi-governmental facilities.

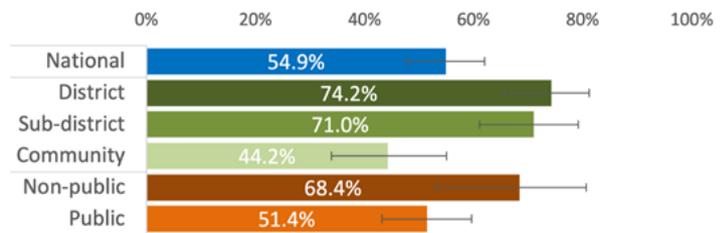
⁷ Ghana Statistical Service & ICF. Ghana Demographic and Health Survey. GSS and ICF; 2022.

Figure 1. **Proportion of facilities offering ANC services (N=500)**



Note: Error bars represent the 95% confidence interval

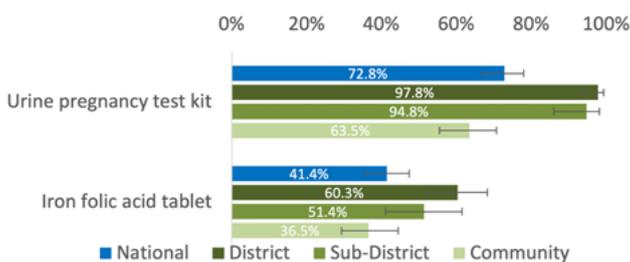
Figure 2. **Proportion of facilities offering ANC services with provider trained in ANC in the past 2 years (N=408)**



A significant share of facilities were short on essential commodities and equipment important for women’s needs.

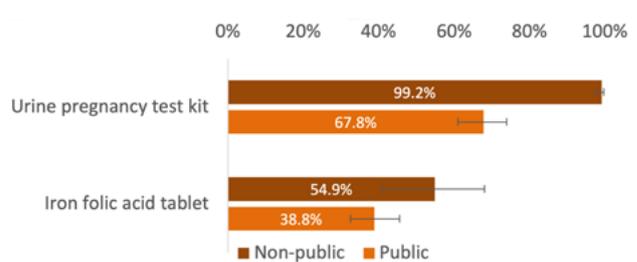
Nationally, less than three-fourths of facilities had pregnancy test kits available, and only four in ten had unexpired iron folic acid (IFA) tablets available (figure 3). Shortages of women-specific commodities and equipment were most common where women most often sought care—at community level facilities and public facilities. For example, pregnancy tests were available in less than two-thirds of community level facilities compared to almost universally at district level facilities. They were similarly short at public versus non-public facilities (figure 4). The availability of IFA tablets, on the other hand, was limited even at the district level (60.3 percent) and fell to 36.5 percent at the community level. Availability of IFA tablets was higher at non-public facilities (54.9 percent) compared to public facilities (38.8%), but this survey was not powered to detect if there is a statistically significant difference.

Figure 3. **Availability of key commodities for ANC by facility type (N=500)**



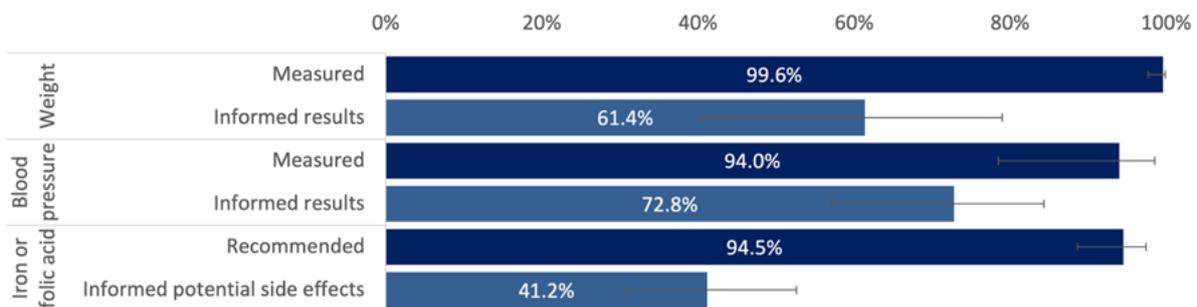
Note: Error bars represent the 95% confidence interval

Figure 4. **Availability of key commodities for ANC by facility ownership (N=500)**



Women reported gaps in receiving essential ANC services. Only four in ten women over 20 weeks pregnant reported receiving the five essential ANC services that they should have received by that stage. **Even as women get basic checkups and recommendations, they were not provided with vital information and options.** Nearly all women had their weight and blood pressure checked, but far fewer were informed of the results (61.4 percent and 72.8 percent, respectively) (figure 5). The gap between IFA tablet recommendations (94.5 percent) and information on their side effects (41.2 percent) was even more stark.

Figure 5. **Proportion of women who were provided care and informed of results and potential side effects (N=216)**



Note: Error bars represent the 95% confidence interval

Data on counselling during ANC highlights missed opportunities on important dimensions for women’s comfort and understanding such as pain management and common pregnancy-related symptoms (58.4 percent) even as coverage for some dimensions such as advice on diet (92.2 percent), pregnancy danger signs (87.2 percent), and physical activity (79.0 percent) was relatively high.

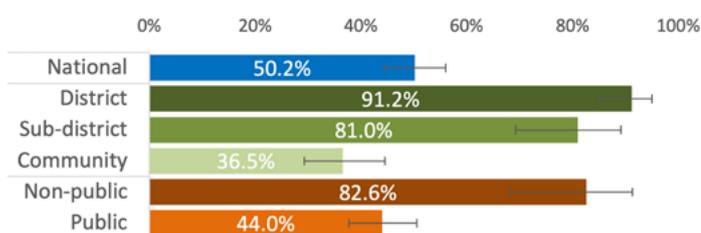
KEY MESSAGE 2

WOMEN DID NOT FULLY BENEFIT FROM THE CONVENIENCE AND LOW COST OF LOCAL AND PUBLIC SECTOR FACILITIES FOR THE NORMAL DELIVERY OF THEIR BABIES BECAUSE OF LACK OF INFRASTRUCTURE, QUALIFIED PROVIDERS, EQUIPMENT, COMMODITIES, AND RESPECTFUL CARE FEATURES

Ghana has achieved a high rate of 86.4 percent institutional deliveries.⁸ **As basic maternity servicesⁱⁱ** are concentrated in district, subdistrict, and non-public facilities, women have to overcome distance and cost barriers even for the normal delivery of their babies.

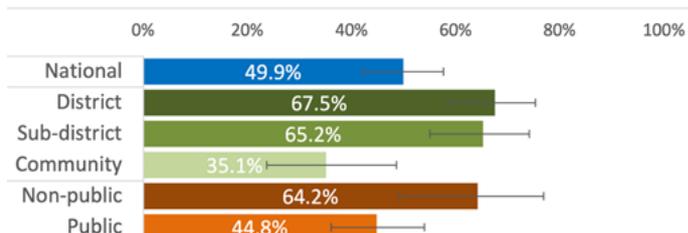
Furthermore, a lack of well-qualified providers, supplies, and privacy in local and public facilities for basic maternity care also channels women to district level and non-public facilities for normal deliveries. Women could access basic maternity services at only about one-third of community level facilities but at over 90 percent of district facilities (figure 6). A similar gap exists between public (44.0 percent) and non-public (82.6 percent) facilities. Poor, rural and remote women may incur greater costs, time burdens, and risks in getting care. However, **even for normal deliveries at higher level and non-public facilities, women may not necessarily get services from a recently trained provider.** Only two-thirds of district level and non-public facilities had at least one provider trained in maternity care in the last two years (figure 7). This is true for only one-third of community level facilities and one-half of public facilities.

Figure 6. **Proportion of facilities offering maternity services (N=500)**



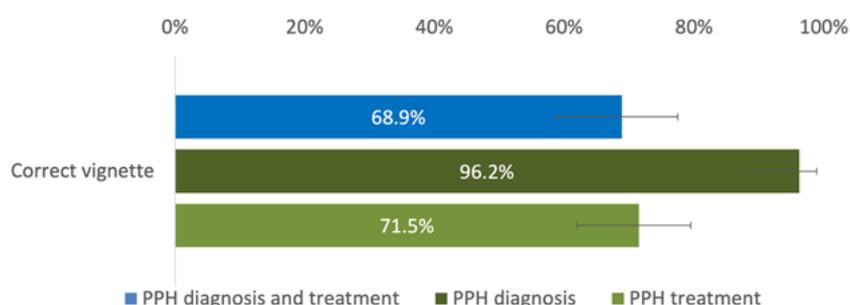
Note: Error bars represent the 95% confidence interval

Figure 7. **Proportion of facilities offering maternity services with provider trained in maternity care in the past 2 years (N=374)**



In a clinical vignette simulation⁹, midwives, who are central to maternal care, **almost universally demonstrated the ability to correctly diagnose postpartum hemorrhage**, but only seven in ten demonstrated **capacity to treat it or do both**. These findings reveal **gaps in provider competency and training** that hinder timely, lifesaving care for women (figure 8).

Figure 8. **Correct vignette PPH diagnosis and treatment among midwives (N=298)**



Note: Error bars represent the 95% confidence interval

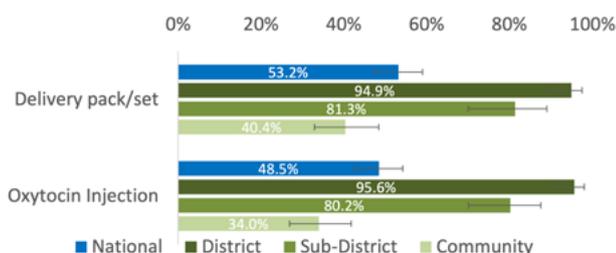
⁸ Ghana Statistical Service & ICF. Ghana Demographic and Health Survey. GSS and ICF; 2022.

⁹ A clinical vignette is a clinical case simulation wherein one enumerator presents a clinical case and acts as the patient, and the other enumerator records the provider's questions and actions. The provider, who is aware that this is a clinical competency assessment, asks questions of the patient enumerator, who provides standardized responses on patient presentation and history. The provider then diagnoses the case and proposes treatment and follow-up. The providers are then evaluated on whether they provided the correct diagnosis and treatment.

A positive factor, however, was that **among facilities offering normal delivery services, most (89.3 percent) were open 24 hours a day, 7 days a week** for delivery care, regardless of location or ownership.

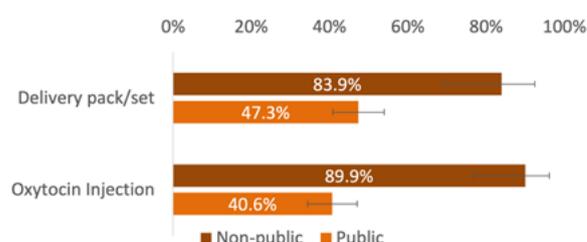
At the same time, women’s access to services with basic maternity equipment and commodities was much better at district and non-public facilities. Delivery packs and oxytocin, for example, were almost universally available in district facilities, and were largely available in non-public facilities (83.9 percent and 89.9 percent respectively) (figure 9; figure 10). But only 40.4 percent of community facilities had delivery packs, and only 34.0 percent had oxytocin. Similarly, less than half of public facilities had delivery packs, and only four in ten had oxytocin.

Figure 9. **Availability of key commodities and equipment for maternity services by facility type (N=500)**



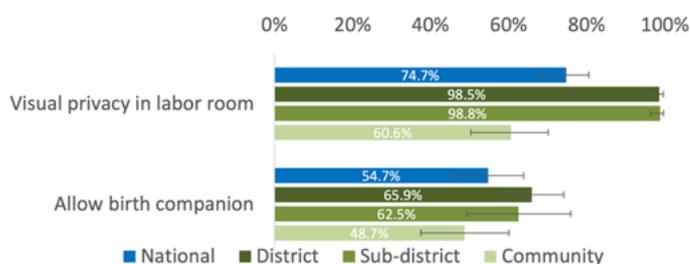
Note: Error bars represent the 95% confidence interval

Figure 10. **Availability of key commodities and equipment for maternity services by facility ownership (N=500)**



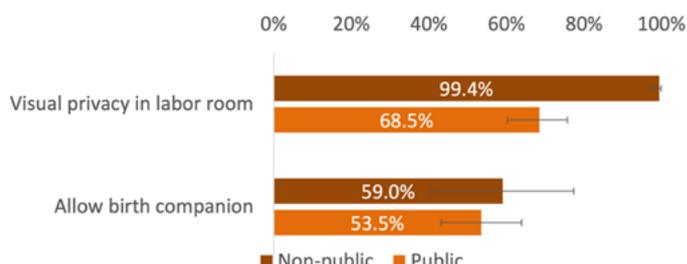
Privacy is a core component of respectful maternity care, and while district level facilities nearly universally provide privacy for women during childbirth, community-level facilities lag significantly behind (98.5 percent versus 60.6 percent), with a similar contrast between non-public (99.4 percent) and public (68.5 percent) facilities (figure 11; figure 12). Another important feature of respectful care, the option to have a companion (e.g., partner, family member, friend) during childbirth, was limited across all facility types (54.7 percent), with district level facilities still more likely to provide this women-friendly option (65.9 percent) than community level facilities (48.7 percent).

Figure 11. **Women’s experience of privacy (N=422) and support (N=402) by facility level**



Note: Error bars represent the 95% confidence interval

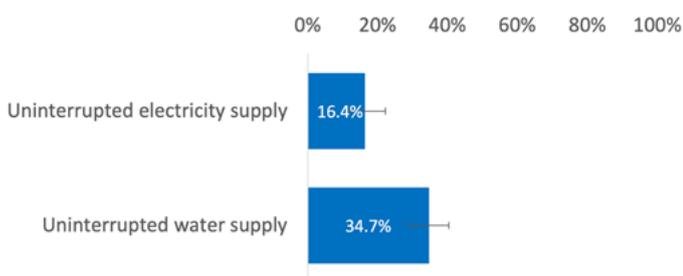
Figure 12. **Women’s experience of privacy (N=422) and support (N=402) by facility ownership**



Women were frequently delivering their babies in facilities without functioning and uninterrupted electricity and water supply. Nationally, only 16.4 percent of facilities reported a functioning and uninterrupted electricity supply during the survey period, and only 34.7 percent had uninterrupted water supply (figure 13). Power shortages directly undermine safe deliveries, emergency procedures, and storage of lifesaving commodities, while water supply is critical for safe care and women’s needs, especially during delivery.

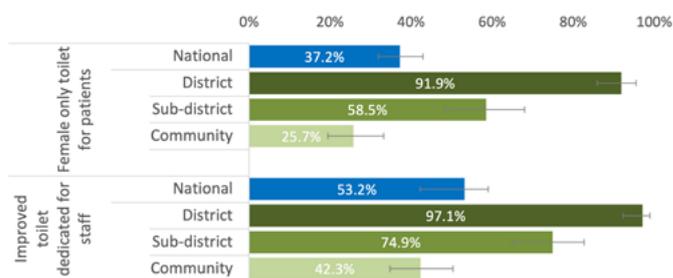
Most facilities lacked toilets to serve women’s basic needs and protect their dignity and safety as patients and as providers, with the gap most pronounced in lower-level facilities. Nationally, only a little over one-third of facilities had a separate female-only toilet for patients, and only half had an improved toilet dedicated for staff, with district-level facilities performing better on both types in comparison with community-level facilities (figure 14). Regardless of health care service, access to clean, functional toilets is an essential need for women as patients and as worker; it is an especially critical need for maternal and reproductive health care.

Figure 13. **Proportion of facilities that have uninterrupted electricity and water supply (N=500)**



Note: Error bars represent the 95% confidence interval

Figure 14. **Proportion of facilities that have at least one female-only toilet for patients and an improved toilet dedicated for staff (N=500)**



KEY MESSAGE 3

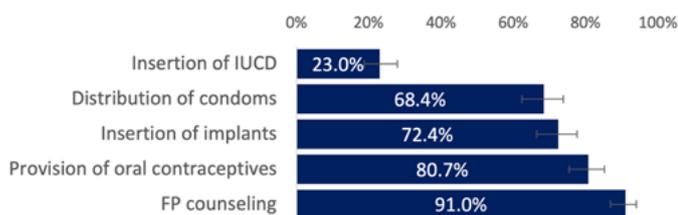
WOMEN'S ACCESS TO AND CHOICE OF FAMILY PLANNING SERVICES AND METHODS WAS LIMITED, WITH SERVICE, PROVIDER, AND COMMODITY AVAILABILITY CONSTRAINING THEIR OPTIONS

Ghana's modern contraceptive prevalence rate has been stagnant at 27.8 percent, and only 49.5 percent of women 15-49 have their demand for family planning satisfied by modern methods.¹⁰ A significant share of facilities stated that they offered family planning counseling and long and short-term methods, but a shortage of recently trained providers and commodities limits women's actual access and choice.

Even as community-level facilities offered women more accessible family planning services at similar rates as higher level facilities, they faced greater constraints on provider and commodity availability.

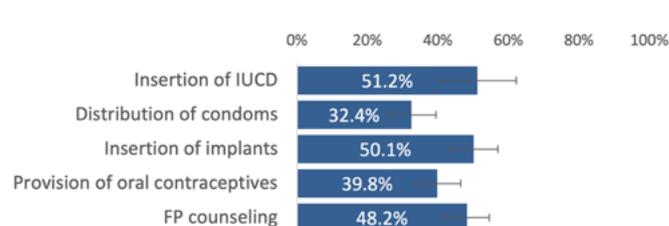
- Most facilities (91.0 percent) indicated that they offer family planning counseling, but a smaller share offers short-term methods such as oral pills (80.7 percent) or condoms (68.4 percent) (figure 15)ⁱⁱⁱ. Implants, the most common long-term method was offered by 72.4 percent of facilities whereas IUDs are offered by a small minority of facilities (23.0 percent).
- Across the board, however, there was a shortage of recently trained providers who could effectively serve women with specific family planning services and methods. For long term methods (implants and IUCDs), about half the facilities offering the services had recently trained providers; for counselling it was only 48.2 percent, and for short term methods (condoms and oral pills) the rates were even lower (32.4 percent and 39.8 percent, respectively) (figure 16).

Figure 15. **Proportion of facilities offering FP services (N=500)**



Note: Error bars represent the 95% confidence interval

Figure 16. **Proportion of facilities offering FP services with provider trained in the past 2 years¹¹**

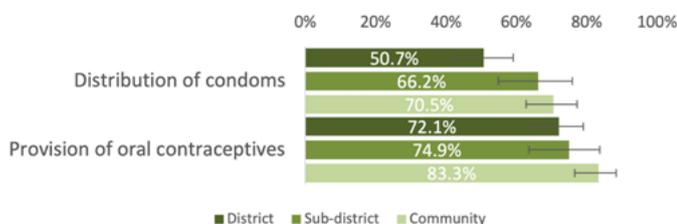


¹⁰ Ghana Statistical Service & ICF. Ghana Demographic and Health Survey. GSS and ICF; 2022.

¹¹ Insertion of IUCD (N=202); Distribution of condoms (N=345); Insertion of implants (N=389); Provision of oral contraceptives (N=406); FP counseling (N=452).

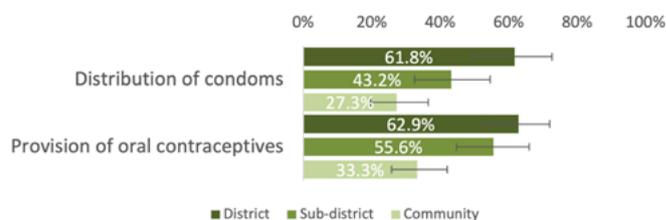
Community level facilities were challenged in offering quality services through short term methods to women despite offering these services at higher rates compared to district level facilities. Although 70.5 percent of community facilities offered condoms and 83.3 percent offered oral pills compared to 50.7 percent and 72.1 percent of district facilities, respectively, community facilities were especially short of recently trained providers (27.3 percent for condoms and 33.3 percent for pills) compared to district facilities (61.8 percent for condoms and 62.9 percent for pills) (figure 17; figure 18). It is important to note that even district level facilities were short on recently trained providers in these methods.

Figure 17. **Proportion of facilities offering FP services (N=500)**



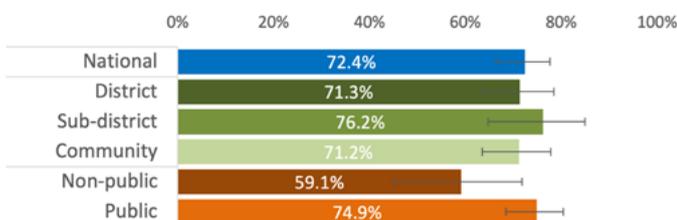
Note: Error bars represent the 95% confidence interval

Figure 18. **Proportion of facilities offering FP services with provider trained in the past 2 years**



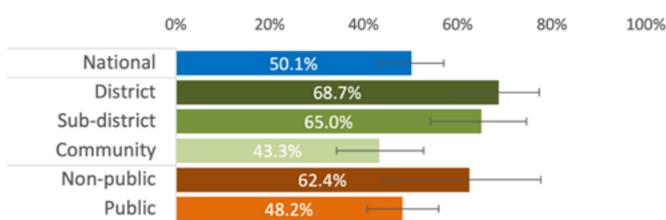
For long term methods as well, women risk getting poor quality of service because of the lack of recently trained providers, especially at community and public facilities. For example, seven in ten district and community level facilities offered the insertion of implants, but while 68.7 percent of district level facilities had recently trained providers, this is the case for only 43.3 percent of community facilities (figure 19; figure 20). **While women had better access to implant services at public facilities, they were more likely to be served by a recently trained provider at non-public facilities.**

Figure 19. **Proportion of facilities offering insertion of implants (N=500)**



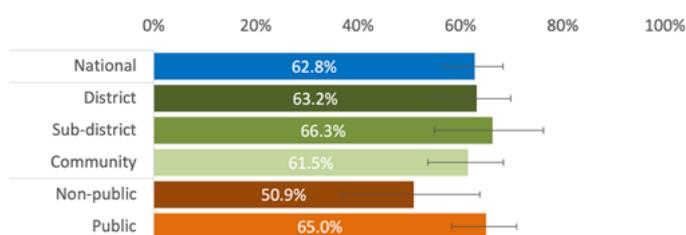
Note: Error bars represent the 95% confidence interval

Figure 20. **Proportion of facilities offering insertion of implants with provider trained in the past 2 years (N=389)**



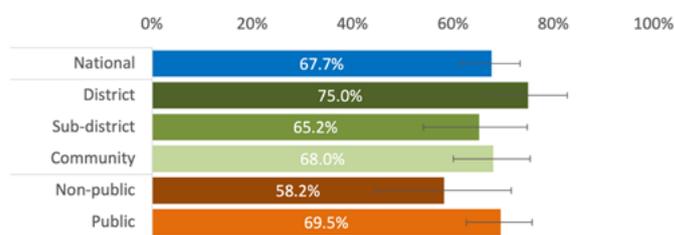
Women may not get the method of their choice due to commodity shortages across all types of facilities. For example, only two-thirds of community and district level facilities providing condoms had them available on the day of the survey (figure 21). The shortage was more acute in non-public facilities (50.9 percent) compared to public facilities (65.0 percent). The Depo-Provera injectable was available on the day of the survey at three-fourths of district facilities and two-thirds of community facilities (figure 22). Again, non-public facilities fared worse (58.2 percent) compared to the public sector (69.5 percent).

Figure 21. **Condoms available on day of survey (N=500)**



Note: Error bars represent the 95% confidence interval

Figure 22. **Depo-Provera available on day of survey (N=500)**



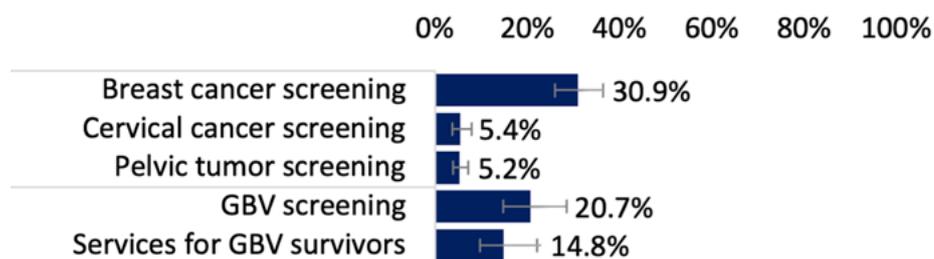
KEY MESSAGE 4

ESSENTIAL PREVENTIVE AND PROTECTIVE REPRODUCTIVE HEALTH SERVICES FOR WOMEN, SUCH AS FOR BREAST CANCER OR GENDER-BASED VIOLENCE (GBV), WERE VERY LIMITED

Women’s reproductive health needs beyond ANC, maternity, and family planning remain underserved. Preventive and protective services were scarce—only 30.9 percent of facilities offer breast cancer screening, and only 5.4 percent of facilities offered cervical cancer screening, and 5.2 percent offer pelvic tumor screening. GBV screening is offered by only 20.7 percent of facilities, while only 14.8 percent of facilities offered services to GBV survivor—limiting women’s rights to timely detection and services (figure 23).

Data also shows that access to GBV services was inequitable. According to local guidelines, GBV screening and services are only provided at district-level facilities, meaning the national percentages reflect availability solely among these higher-level facilities. Women seeking care at community-level facilities had no access to these services at all and may face insurmountable barriers to seeking specialized care. Even at the district level where services are permitted, just 50–60 percent of facilities had trained providers, further constraining quality and women’s ability to realize their health rights.

Figure 23. **Proportion of facilities offering women’s cancer prevention and GBV services (N=500)**



Note: Error bars represent the 95% confidence interval

KEY MESSAGE 5

WHILE HIGHER-LEVEL AND NON-PUBLIC FACILITIES OFFER BETTER SERVICE AVAILABILITY AND READINESS, WOMEN SEEKING CARE AT THESE FACILITIES FACE HIGHER COSTS

Ghana covers 56 percent of its population as active members of the National Health Insurance scheme.¹²

Despite insurance coverage, women incur out of pocket costs at every type of facility for a range of services, from consultation fees, laboratory tests, medicines, to travel costs.

Women’s out of pocket costs are substantially higher at district level and non-public facilities, with travel being the highest cost factor, possibly linked to the lack of adequately equipped local facilities.

- **Medicines and transportation are the largest out of pocket cost driver for women seeking health care.** At the district level, more than half of women paid for medicines and three-fourths paid for transportation costs, but a significant proportion incurred these costs even at the community level (27.5 percent and 35.3 percent respectively) (figure 24).
- **Public facilities are not cost free for women.** Four out of ten women seeking care at public facilities paid for medicines while six out of ten women paid for medicines at non-public facilities (figure 25). The high share of women paying out of pocket for non-emergency travel to health facilities – 56.5 percent of those seeking care at public facilities and 68.3 percent for non-public facilities—may discourage them from seeking needed care.
- **A higher proportion of women paid for consultation fees (24.2 percent) and laboratory tests (41.5 percent) at district level than at community level facilities (9.2 percent and 3.1 percent respectively)** (figure 24). Similarly, one-fourth of women paid for consultation fees and four in ten for laboratory tests at non-public facilities, compared to only 15.8 percent and 31.0 percent respectively for each of these services at public facilities (figure 25).

Figure 24. **Proportion of women reporting out of pocket costs by facility level (N=1,807)**

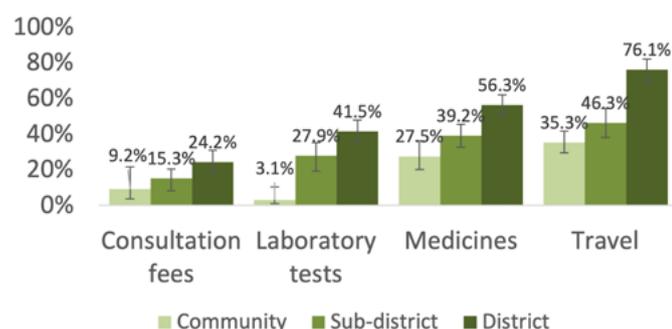
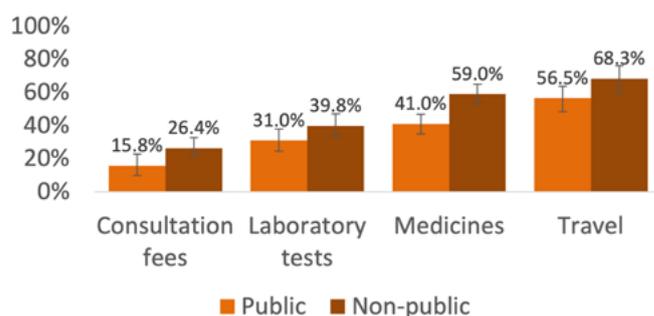


Figure 25. **Proportion of women reporting out of pocket costs by facility ownership (N=1,807)**



Note: Error bars represent the 95% confidence interval

¹² Ghana National Health Insurance Scheme. NHIA CEO Underscores NHIS as Backbone of Networks of Practice, UHC. September 15, 2025. Accessed September 29, 2025. <https://nhis.gov.gh/News/nhia-ceo-underscores-nhis-as-backbone-of-networks-of-practice%2C-uhc--5896>

PHC STRENGTHENING STRATEGIES

FOR WOMEN-FRIENDLY RESPECTFUL MATERNAL AND REPRODUCTIVE CARE

By continuing to strengthen key elements of service availability and readiness, Ghana's health system can make services more accessible and affordable for women and meet their essential needs. Special attention is required in meeting clinical standards and expertise, and in providing compassionate care and respecting women's privacy and rights.



BETTER QUALITY ANC

Improve ANC quality and communication: Ensure all facilities have qualified providers and provide essential ANC services, tests, and commodities. Strengthen communication, especially sharing test results and counselling in line with women's concerns, so women can make informed decisions.



RESPECTFUL MATERNITY CARE

Expand lifesaving services at community level and ensure respectful, women-friendly maternity care: Prioritize reliable access to obstetric medicines like oxytocin, essential supplies, and maternity services at community facilities and improve the supply chain to better serve the community level and the public sector. Guarantee privacy and the option of a birth companion in all facilities. Upgrade basic infrastructure (female-only toilets, reliable electricity and water) and strengthen availability of trained providers.

EXPANDED CHOICE



Strengthen family planning service quality and method choice, especially at the community level: Ensure all facilities provide an adequate mix of long and short-term modern contraceptive methods. Expand provider training, particularly at community and public sector facilities, to improve women's informed choice and access to a broader method mix.

COMPREHENSIVE WOMEN'S SERVICES



Strengthen women's access to preventive and protective reproductive and women's health services: Integrate breast and cervical cancer screening and GBV screening, response, and referral protocols into community-level health care. This would expand coverage and reduce inequities in access.

LOWER COSTS



Strengthen readiness and expand services to reduce women's out of pocket costs: Improve commodity availability and local service options to reduce the high level of out-of-pocket costs women incur for medicines and transportation.

ⁱ Facilities reporting at least one provider receiving in-service training in the past two years are only those facilities reporting that they were able to offer the given service in the three months prior to the survey.

ⁱⁱ The SDI survey questions refer to "normal delivery" but as the term "delivery" is increasingly considered not representing women-centered care (women are "giving birth", providers are "delivering"), we also use the term "basic maternity" care or services.

ⁱⁱⁱ The SDI survey did not collect information on the service offered or trained provider availability for injectable contraceptives.