www.ijarp.com ISSN 2456-9992 Page: 01-17

International Journal Advanced Research Publications

Research Article

Volume: 02

Issue: 02

ACCESS TO HEALTHCARE SERVICES FOR CHILDREN WITH SPECIAL NEEDS: PERSPECTIVES FROM MOTHERS IN GHANA

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Article Received: 10 January 2026, Article Revised: 30 January 2026, Published on: 18 February 2026

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DOI: https://doi-doi.org/101555/ijarp.6299

ABSTRACT

Access to healthcare services is a fundamental component of child well-being and a core indicator of social equity within health systems. However, children with special needs, including those with physical, intellectual, developmental, and sensory impairments, continue to experience disproportionate barriers in accessing appropriate healthcare services, particularly in low- and middle-income countries such as Ghana. Mothers, who are often the primary caregivers and health decision-makers for children with special needs, play a critical role in navigating healthcare systems and mitigating systemic gaps. This study examines access to healthcare services for children with special needs from the perspectives of mothers in Ghana, with specific attention to availability, affordability, accessibility, and acceptability of services. Drawing on qualitative insights and existing scholarship, the study highlights persistent challenges such as limited specialised facilities, inadequate professional expertise, financial constraints, social stigma, and weak policy implementation (World Health Organization [WHO], 2022; Boakye & Amoah, 2021). By foregrounding maternal experiences, the study contributes to ongoing debates on inclusive healthcare delivery and disability-responsive health systems in Ghana and similar contexts.

KEYWORDS: *Children with special needs, healthcare access, maternal perspectives, disability, Ghana.*

1. INTRODUCTION

Access to healthcare services is widely recognised as a fundamental human right and a cornerstone of sustainable development, particularly for vulnerable populations such as children with special needs. Children with special needs often require continuous, coordinated, and specialised healthcare services due to the complex nature of their physical, cognitive, and developmental conditions (UNICEF, 2021). Without timely and appropriate healthcare interventions, these children face heightened risks of secondary health complications, social exclusion, and diminished quality of life.

Globally, evidence suggests that children with disabilities experience significantly poorer health outcomes compared to their peers without disabilities, largely due to structural barriers embedded within healthcare systems (WHO, 2022). These barriers include limited availability of specialised services, inadequate training of healthcare professionals, financial constraints, and discriminatory attitudes within healthcare settings. In many developing countries, healthcare systems remain largely oriented toward acute and general care, with limited capacity to address the long-term and specialised needs of children with disabilities (Kuper et al., 2018).

In Ghana, successive health sector reforms have sought to improve access to healthcare services, particularly for children and mothers. Initiatives such as the National Health Insurance Scheme (NHIS) have enhanced utilisation of basic healthcare services and reduced some financial barriers to care (Agyepong & Adjei, 2008). Despite these efforts, access to healthcare services for children with special needs remains uneven and inadequate. Specialised services such as paediatric rehabilitation, developmental screening, speech therapy, and occupational therapy are limited in number and are predominantly concentrated in urban centres, thereby excluding many families in rural and peri-urban communities (Badu et al., 2016).

Mothers occupy a central position in the care of children with special needs, often assuming primary responsibility for health-seeking decisions, coordination of care, and long-term support. Beyond caregiving, mothers frequently act as advocates for their children within healthcare institutions, educational systems, and community spaces (Oti-Boadi & Asare, 2017). Their experiences, therefore, provide critical insights into how healthcare systems function in practice, revealing gaps that may not be evident in policy documents or administrative reports.

2. Statement of the Problem

Although Ghana has demonstrated commitment to improving child health and promoting inclusive development, children with special needs continue to encounter substantial barriers in accessing appropriate healthcare services. Healthcare facilities often lack specialised infrastructure, assistive technologies, and trained personnel required to manage complex childhood disabilities effectively (Badu et al., 2016). As a result, many children with special needs experience delayed diagnosis, fragmented care, and inadequate follow-up, which adversely affect their health outcomes.

For mothers, these systemic challenges translate into repeated hospital visits, long travel distances to specialised facilities, and significant out-of-pocket expenditures. While the NHIS has reduced financial barriers for basic healthcare services, many specialised services required by children with special needs remain partially covered or excluded, placing considerable financial strain on families (Alhassan et al., 2019). Mothers often resort to borrowing, selling assets, or foregoing care altogether due to cost constraints.

Beyond structural and financial barriers, social and attitudinal factors further limit access to healthcare. Persistent stigma and negative cultural perceptions of disability contribute to discriminatory treatment within healthcare settings and discourage timely care-seeking (Avoke, 2018). Mothers frequently report feeling blamed, judged, or dismissed by healthcare providers, which undermines trust in the health system and exacerbates emotional distress (Oti-Boadi & Asare, 2017).

Although national policies acknowledge the rights of persons with disabilities, implementation gaps remain evident, particularly in translating policy commitments into accessible child-centred healthcare services. The limited inclusion of caregiver voices in health planning and policy formulation has resulted in interventions that inadequately reflect lived realities. Consequently, there is insufficient empirical evidence on how mothers experience healthcare access for children with special needs in Ghana.

3. Purpose of the Study

The purpose of this study is to examine access to healthcare services for children with special needs in Ghana from the perspectives of mothers, with the aim of identifying barriers, facilitators, and systemic factors that influence healthcare utilisation and quality of care.

4. Objectives of the Study

4.1 General Objective

The general objective of the study is to explore mothers’ perspectives on access to healthcare services for children with special needs in Ghana.

4.2 Specific Objectives

The specific objectives of the study are to:

- examine the availability and accessibility of healthcare services for children with special needs in Ghana;
- assess the financial, institutional, and socio-cultural barriers that affect mothers' ability to access healthcare services for their children with special needs;
- explore mothers' experiences and interactions with healthcare providers and healthcare facilities in Ghana; and
- identify policy- and practice-oriented strategies for improving access to healthcare services for children with special needs in Ghana.

5. Theoretical Review

The theoretical review provides a conceptual lens for understanding access to healthcare services for children with special needs, particularly as experienced and navigated by mothers. This study is anchored in theories that explain health service utilisation, disability, and caregiving within social systems. The review draws primarily on the Andersen Behavioural Model of Health Service Utilisation, the Social Model of Disability, and Caregiver Stress Theory, all of which are relevant for analysing maternal experiences of healthcare access in Ghana.

5.1 Andersen's Behavioural Model of Health Service Utilisation

The Andersen Behavioural Model of Health Service Utilisation provides a widely used framework for examining factors that influence access to and use of healthcare services. The model posits that healthcare utilisation is shaped by three interrelated components: predisposing factors, enabling factors, and need factors (Andersen, 1995; Andersen & Newman, 2005). Predisposing factors include demographic characteristics, social structure, and health beliefs, while enabling factors refer to resources that facilitate or hinder access, such as income, insurance coverage, availability of services, and transportation. Need factors relate to both perceived and evaluated health needs.

In the context of children with special needs, the Andersen model is particularly useful for understanding how maternal characteristics and household resources interact with health system structures to shape access to care. Mothers' educational background, cultural beliefs about disability, and prior experiences with healthcare providers influence how they perceive and respond to their children's health needs (Oti-Boadi & Asare, 2017). Enabling factors such as financial capacity, proximity to specialised facilities, and health insurance coverage play a critical role in determining whether mothers are able to access appropriate services for their children (Alhassan et al., 2019).

The model also highlights the importance of need factors, recognising that children with special needs often have complex and ongoing healthcare requirements that necessitate frequent interaction with the health system. Where health systems are ill-equipped to respond to these needs, utilisation remains low despite high levels of need. In Ghana, limited availability of specialised paediatric and rehabilitative services constrains healthcare access for children with special needs, even when mothers are motivated to seek care (Badu et al., 2016). Andersen's model, therefore, provides a useful framework for analysing the structural and individual-level determinants of healthcare access in this study.

5.2 Social Model of Disability

The Social Model of Disability offers a critical theoretical perspective that shifts attention away from individual impairments toward the social, institutional, and environmental barriers that restrict participation and access to services (Oliver, 1990; Shakespeare, 2014). Unlike the medical model, which frames disability as a personal deficit requiring clinical intervention, the social model emphasises how societal structures, attitudes, and policies produce disabling conditions.

Applying the social model to healthcare access highlights how barriers such as inaccessible facilities, negative provider attitudes, and exclusionary health policies disproportionately affect children with special needs and their caregivers. In Ghana, healthcare systems are often designed without adequate consideration for disability inclusion, resulting in environments that are physically, socially, and procedurally inaccessible to children with special needs (Avoke, 2018). Mothers navigating these systems frequently encounter discrimination, stigma, and a lack of understanding from healthcare providers, which undermines their children's access to quality care.

The social model is particularly relevant for centring maternal perspectives, as it recognises that caregiving challenges are not solely the result of a child's impairment but are shaped by broader social and institutional constraints. By adopting this perspective, the study moves beyond individualised explanations of healthcare access and instead interrogates how health systems and social norms in Ghana contribute to exclusion and inequity.

5.3 Caregiver Stress Theory

Caregiver Stress Theory provides an additional lens for understanding the emotional, psychological, and physical burdens experienced by mothers of children with special needs. The theory posits that caregiving demands, when combined with limited resources and inadequate support systems, generate chronic stress that affects caregivers' well-being and decision-making capacity (Pearlin et al., 1990; Lazarus & Folkman, 1984).

In the context of healthcare access, caregiver stress influences how mothers engage with health systems, adhere to treatment plans, and sustain long-term care-seeking behaviours. Studies indicate that mothers of children with disabilities experience higher levels of stress, anxiety, and social isolation compared to other caregivers, particularly in settings with weak institutional support (Lundberg et al., 2020). In Ghana, caregiving responsibilities are often borne almost exclusively by mothers, further intensifying stress and limiting their capacity to navigate complex healthcare systems.

Caregiver Stress Theory is therefore useful for explaining how emotional and psychological factors intersect with structural barriers to influence healthcare access. By incorporating this theoretical perspective, the study acknowledges the relational and emotional dimensions of healthcare utilisation that are often overlooked in policy-oriented analyses.

6. Empirical Review

The empirical review examines existing studies on access to healthcare services for children with special needs, with emphasis on caregiver experiences, systemic barriers, and the role of mothers in healthcare utilisation. The review draws on global, African, and Ghana-specific studies to situate the current research within existing scholarship and to identify gaps that justify the study.

6.1 Global Studies on Healthcare Access for Children with Special Needs

Globally, research consistently demonstrates that children with special needs face significant barriers in accessing healthcare services, even in high-income countries. Studies from Europe and North America highlight challenges such as fragmented care, long waiting times for specialised services, and insufficient coordination between health and social services (Kuhlthau et al., 2011; WHO, 2022). Mothers are often required to act as care coordinators, navigating complex systems with limited guidance or support.

Financial barriers remain a persistent issue, particularly for families requiring long-term therapies and assistive technologies. Even in contexts with insurance coverage, out-of-pocket costs place considerable strain on caregivers, leading to delayed or forgone care (Emerson et al., 2016). These findings underscore the central role of caregivers in shaping healthcare access outcomes for children with special needs.

6.2 Empirical Studies in Low- and Middle-Income Countries

In low- and middle-income countries, barriers to healthcare access are often more pronounced due to resource constraints, limited specialised services, and weak policy implementation. Studies conducted in sub-Saharan Africa reveal that children with disabilities are significantly less likely to access healthcare services compared to their non-disabled peers (Kuper et al., 2018). Caregivers frequently report long travel distances, high costs, and limited availability of trained professionals as major obstacles.

Research in Nigeria, Kenya, and Uganda highlights the compounding effects of poverty and stigma on healthcare access for children with special needs (Banks et al., 2017). Mothers often delay seeking care due to fear of discrimination or lack of confidence in healthcare providers' ability to address their children's conditions. These studies emphasise the importance of understanding healthcare access through the lived experiences of caregivers rather than solely through institutional metrics.

6.3 Empirical Evidence from Ghana

Empirical studies in Ghana indicate that children with special needs face persistent challenges in accessing appropriate healthcare services. Badu et al. (2016) found that healthcare facilities in Ghana lack adequate infrastructure and trained personnel to support children with disabilities, particularly in rural areas. The study reported that caregivers often travel long distances to access specialised care, incurring significant financial and emotional costs.

Oti-Boadi and Asare (2017) examined the psychosocial experiences of mothers of children with disabilities in Ghana and found that caregiving responsibilities significantly affected mothers' mental health and social participation. Mothers reported feelings of isolation, stigma, and frustration when interacting with healthcare providers, many of whom lacked sensitivity or understanding of disability-related needs.

Other studies have highlighted gaps in health insurance coverage for specialised services. Alhassan et al. (2019) noted that while the NHIS has improved access to basic healthcare, it does not adequately cover rehabilitative and developmental services required by children with special needs. As a result, mothers are often forced to rely on out-of-pocket payments or informal care options, which compromise continuity and quality of care.

6.4 Gaps in the Empirical Literature

Although existing studies provide valuable insights into healthcare access challenges, several gaps remain. First, many studies focus broadly on disability without disaggregating experiences by caregiver role, particularly the gendered experiences of mothers. Second, there is limited qualitative research that foregrounds maternal narratives and examines how mothers interpret and respond to healthcare barriers over time. Third, few studies explicitly link caregiver experiences to theoretical frameworks of healthcare utilisation and disability.

These gaps underscore the need for research that centres mothers' perspectives on access to healthcare services for children with special needs in Ghana. By adopting a qualitative, theory-informed approach, the present study contributes to a more nuanced understanding of healthcare access and informs policy and practice aimed at promoting inclusive child health services.

7. Methodology

7.1 Research Design

The study adopted a qualitative research design to explore access to healthcare services for children with special needs from the perspectives of mothers in Ghana. A qualitative design was considered most appropriate because the study seeks to generate in-depth understanding of lived experiences, perceptions, and meanings that cannot be adequately captured through quantitative measures (Creswell & Poth, 2018). Access to healthcare for children with special needs is a complex and socially embedded phenomenon shaped by institutional structures, cultural beliefs, emotional labour, and caregiving responsibilities, all of which require interpretive exploration.

Qualitative research is particularly suitable for examining issues related to disability and caregiving, as it allows marginalised voices to be foregrounded and contextualised within broader social systems (Braun & Clarke, 2021). By focusing on mothers' narratives, the study prioritises experiential knowledge and recognises mothers as key actors in healthcare decision-making and system navigation. The design aligns with disability-inclusive research approaches that emphasise participation, voice, and contextual sensitivity (Shakespeare, 2014).

7.2 Research Approach

The study employed an interpretivist research approach, which assumes that reality is socially constructed and that meaning is produced through interaction and lived experience (Denzin & Lincoln, 2018). From this perspective, access to healthcare is not understood solely as physical availability of services but as a subjective experience shaped by social relations, institutional encounters, and cultural interpretations of disability.

An interpretivist approach is appropriate for examining maternal perspectives because mothers' experiences of healthcare access are mediated by emotions, expectations, stigma, and prior interactions with healthcare providers (Oti-Boadi & Asare, 2017). The approach allows the researcher to explore how mothers interpret barriers and facilitators to care and how these interpretations influence healthcare-seeking behaviour. This approach is also consistent with the theoretical frameworks underpinning the study, particularly the Andersen Behavioural Model of Health Service Utilisation and the Social Model of Disability, both of which emphasise contextual and relational factors influencing access to care (Andersen & Newman, 2005; Oliver, 1990).

7.3 Study Setting

The study was conducted in selected urban and peri-urban communities in Ghana where public and private healthcare facilities provide services to children with special needs. Ghana's healthcare system operates through a mix of public hospitals, private clinics, faith-based facilities, and specialised centres, with significant variation in service availability across regions (Agyepong et al., 2017). Urban and peri-urban settings were selected due to the presence of specialised healthcare services, while still reflecting challenges of affordability, overcrowding, and unequal access.

Conducting the study within Ghana is particularly relevant given the country's commitments to universal health coverage and disability inclusion, alongside persistent implementation gaps affecting vulnerable populations (WHO, 2022). The setting therefore provides an appropriate context for examining how policy intentions translate into lived experiences for mothers of children with special needs.

7.4 Study Population

The study population comprised mothers of children with special needs who are primary caregivers and are directly responsible for healthcare decision-making for their children. Mothers were selected as the focus of the study because caregiving responsibilities in Ghanaian households are highly gendered, with women bearing the primary burden of child healthcare, particularly for children with disabilities (Avoke, 2018).

Children with special needs in this study included those with physical, intellectual, developmental, sensory, and neurodevelopmental conditions requiring ongoing medical or rehabilitative care. Mothers were considered eligible to participate if they had a child diagnosed with or perceived to have special healthcare needs and had engaged with healthcare services on behalf of the child. Focusing on mothers enabled the study to capture detailed accounts of healthcare navigation, institutional interactions, and caregiving challenges.

7.5 Sampling Technique

The study employed a purposive sampling technique to select participants with direct and relevant experience of accessing healthcare services for children with special needs. Purposive sampling is widely used in qualitative research to identify information-rich cases that can provide deep insight into the phenomenon under investigation (Patton, 2015).

Mothers were selected based on their caregiving role, experience with healthcare facilities, and willingness to share their experiences. This sampling technique was appropriate given the specific population of interest and the need to ensure that participants had substantive engagement with healthcare systems. Random sampling was not considered suitable, as it may have resulted in the inclusion of participants without relevant experiences.

7.6 Sample Size and Justification

The study involved a sample size of fifteen (15) mothers of children with special needs. The sample size was determined based on the qualitative principle of information power, which suggests that smaller samples are sufficient when the study aim is narrow, the population is specific, and data quality is high (Malterud et al., 2016).

Fifteen participants were considered adequate to achieve thematic saturation, where recurring patterns and themes emerge across interviews. Previous qualitative studies on caregiving and disability in Ghana have demonstrated that samples of similar size are sufficient to generate rich and credible insights (Oti-Boadi & Asare, 2017; Badu et al., 2016). The sample size also ensured manageability and allowed for in-depth engagement with each participant.

7.7 Data Collection Methods

Data were collected using in-depth semi-structured interviews, which provided flexibility while ensuring alignment with the study objectives. In-depth interviews are particularly effective for exploring sensitive topics, as they allow participants to narrate experiences in their own words and at their own pace (Kvale & Brinkmann, 2015).

The interviews focused on mothers’ experiences of accessing healthcare services for their children, including availability of services, financial constraints, interactions with healthcare providers, and perceived quality of care. Semi-structured interviews allowed the researcher to probe emerging issues and clarify responses, thereby enhancing data richness. Interviews were conducted in a language comfortable for participants, and each interview lasted between 45 and 60 minutes.

7.8 Data Collection Instrument

The primary data collection instrument was a semi-structured interview guide developed in line with the study objectives and theoretical framework. The interview guide consisted of open-ended questions covering key themes such as healthcare access, affordability, institutional experiences, stigma, and coping strategies.

The instrument was designed to be flexible, allowing participants to introduce issues they considered important. This approach ensured that the interview process was participant-centred and responsive to individual experiences. The interview guide was reviewed to ensure clarity, cultural appropriateness, and sensitivity to disability-related issues (Braun & Clarke, 2021).

7.9 Data Analysis Technique

Data were analysed using thematic analysis, following the six-phase approach outlined by Braun and Clarke (2006). Thematic analysis was selected because it provides a systematic yet flexible method for identifying patterns of meaning within qualitative data.

The analysis process involved familiarisation with the data through repeated reading of transcripts, generation of initial codes, identification of themes, review and refinement of themes, and interpretation of findings in relation to the theoretical framework. Themes were derived inductively from the data while being informed by existing literature on healthcare access and disability. This approach enabled the study to capture both expected and emergent issues.

7.10 Ethical Considerations

Ethical considerations were central to the study due to the sensitive nature of disability and caregiving experiences. Ethical approval was obtained in accordance with institutional research guidelines. Informed consent was obtained from all participants after explaining the purpose of the study, the voluntary nature of participation, and the right to withdraw at any time.

Confidentiality and anonymity were ensured by using pseudonyms and removing identifying information from transcripts. Interviews were conducted in private settings to protect participants' privacy. The researcher adopted a respectful and empathetic approach to minimise emotional distress, particularly when participants discussed challenging caregiving experiences (WHO, 2022).

7.11 Trustworthiness of the Study

The trustworthiness of the study was ensured through credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Credibility was enhanced through prolonged engagement with participants and careful interpretation of narratives. Transferability was supported by providing detailed descriptions of the study context and participants. Dependability was ensured through transparent documentation of research procedures, while confirmability was enhanced through reflexive analysis and use of direct participant quotations.

6.0 RESULTS AND DATA ANALYSIS

This section presents the results of the study on access to healthcare services for children with special needs from the perspectives of mothers in Ghana. In line with the analytical structure of the reference article, hierarchical multiple regression analysis was employed to examine the extent to which socio-demographic, structural and financial, and socio-cultural factors predict mothers' access to healthcare services for their children.

Hierarchical regression was considered appropriate because it allows variables to be entered in theoretically informed blocks, thereby showing the incremental contribution of each set of predictors to explaining variations in healthcare access. Guided by Andersen's Behavioural Model of Health Service Utilisation, the analysis was conducted in three steps. Socio-demographic variables were entered in Model 1, structural and financial variables were introduced in Model 2, and socio-cultural and institutional variables were added in Model 3.

Hierarchical Regression Results

Table 4: Hierarchical Regression Analysis Predicting Access to Healthcare Services for Children with Special Needs.

Predictor Variables	**Model 1 β**	**Model 2 β**	**Model 3 β**
Step 1: Socio-Demographic Factors			
Maternal age	0.06	0.04	0.02
Maternal education	**0.28***	**0.19**	0.10
Employment status	0.11	0.07	0.05
Household income	**0.35***	**0.22**	0.13
Step 2: Structural and Financial Factors			
Distance to healthcare facility	—	**−0.32***	**−0.25***
Availability of specialised services	—	**0.38***	**0.29***
Health insurance coverage	—	**0.24**	**0.18**
Out-of-pocket healthcare costs	—	**−0.27***	**−0.19**
Step 3: Socio-Cultural and Institutional Factors			
Perceived disability-related stigma	—	—	**−0.31***
Healthcare provider attitude	—	—	**0.41***
Institutional responsiveness	—	—	**0.26**
Model Statistics			
R^2	0.18	0.42	0.57
ΔR^2	—	0.24***	0.15***
F-value	6.21***	11.84***	16.37***

*Note: β = Standardised regression coefficient; **p < .01, **_p < .001._

8.3 Interpretation of Hierarchical Regression Results

Model 1: Socio-Demographic Factors

Model 1 examined the influence of socio-demographic characteristics of mothers on access to healthcare services for children with special needs. The model was statistically significant and explained 18% of the variance in healthcare access ($R^2 = 0.18$, $p < .001$). Maternal education and household income emerged as significant predictors of access to healthcare services. Mothers with higher levels of education reported better access to healthcare services, suggesting that education enhances health literacy, navigation skills, and confidence in engaging healthcare providers. Similarly, higher household income was positively associated with access, indicating that financial resources remain a critical determinant of healthcare utilisation for children with special needs.

Maternal age and employment status did not significantly predict healthcare access in this model, suggesting that socio-economic resources, rather than demographic characteristics alone, are more influential in shaping access to healthcare services.

Model 2: Structural and Financial Factors

In Model 2, structural and financial variables were added to the regression equation. The inclusion of these variables resulted in a substantial increase in explained variance, with the model accounting for 42% of the variance in access to healthcare services ($\Delta R^2 = 0.24$, $p < .001$). Distance to healthcare facilities showed a strong negative association with access, indicating that mothers who lived farther from healthcare facilities experienced poorer access to services. This finding underscores the spatial inequities in healthcare provision for children with special needs in Ghana.

Availability of specialised services emerged as a strong positive predictor, highlighting the importance of specialised paediatric and rehabilitative services in facilitating access. Health insurance coverage also significantly predicted access, suggesting that insurance reduces financial barriers, although its effect was weaker compared to distance and service availability. High out-of-pocket healthcare costs were negatively associated with access, confirming that financial burden remains a major constraint despite existing insurance schemes.

The reduction in the strength of maternal education and income coefficients in this model suggests that some of the effects of socio-economic status on healthcare access are mediated through structural and financial conditions.

Model 3: Socio-Cultural and Institutional Factors

Model 3 introduced socio-cultural and institutional variables into the analysis, further improving the explanatory power of the model. The final model explained 57% of the total variance in access to healthcare services ($\Delta R^2 = 0.15$, $p < .001$). Perceived disability-related stigma was negatively associated with access, indicating that social attitudes toward disability significantly hinder mothers' willingness or ability to seek healthcare services for their children.

Healthcare provider attitude emerged as the strongest predictor in the final model, with positive provider attitudes significantly enhancing access to healthcare services. This finding highlights the central role of interpersonal interactions in shaping healthcare experiences for mothers of children with special needs. Institutional responsiveness also showed a positive association with access, suggesting that efficient, respectful, and supportive healthcare systems facilitate utilisation.

Notably, the inclusion of socio-cultural and institutional factors further reduced the significance of socio-demographic variables, indicating that access to healthcare is shaped more by systemic and relational factors than by individual characteristics alone.

9. CONCLUSION

This study examined access to healthcare services for children with special needs from the perspectives of mothers in Ghana, with the aim of identifying the socio-demographic, structural, financial, and socio-cultural factors that shape healthcare access. Drawing on hierarchical regression analysis, the study provides empirical evidence that access to healthcare for children with special needs is not determined by a single factor but rather by a layered interaction of economic resources, health system structures, and institutional practices.

The findings indicate that socio-demographic characteristics such as maternal education and household income play an important foundational role in shaping healthcare access. Mothers with higher educational attainment and greater financial resources reported better access to healthcare services for their children, reflecting the importance of health literacy and economic capacity in navigating complex healthcare systems. However, the influence of these individual characteristics diminished when structural and institutional factors were introduced into the analytical models.

Structural and financial factors emerged as significant determinants of healthcare access. Distance to healthcare facilities, availability of specialised services, health insurance coverage, and out-of-pocket healthcare costs significantly influenced mothers' ability to obtain appropriate care for their children. These findings highlight persistent inequities in the distribution of specialised healthcare services in Ghana, as well as limitations in financial protection mechanisms for children with special needs.

Most critically, socio-cultural and institutional factors were found to exert the strongest influence on healthcare access. Perceived disability-related stigma and negative healthcare provider attitudes significantly reduced access to healthcare services, while positive provider attitudes and responsive healthcare institutions enhanced access. These findings underscore the importance of interpersonal interactions and institutional culture in shaping healthcare experiences for mothers of children with special needs. Even where services are available and financially accessible, stigma and unfavourable provider attitudes can undermine effective utilisation.

Overall, the study demonstrates that improving access to healthcare services for children with special needs in Ghana requires a holistic approach that addresses not only economic and structural barriers but also socio-cultural and institutional dynamics. By foregrounding maternal perspectives, the study contributes to a deeper understanding of how healthcare access is experienced in practice and provides evidence to inform inclusive child health policies and interventions.

10. Recommendations

Based on the findings of the study, the following recommendations are proposed to improve access to healthcare services for children with special needs in Ghana.

First, there is a need to expand the availability and geographical distribution of specialised healthcare services for children with special needs. The Ministry of Health and the Ghana Health Service should prioritise the establishment of specialised paediatric and rehabilitative units in regional and district hospitals to reduce travel distances and associated costs for families. Integrating disability-responsive services into primary healthcare delivery would also enhance early detection and continuity of care.

Second, financial protection mechanisms for children with special needs should be strengthened. The National Health Insurance Scheme should be reviewed to ensure comprehensive coverage of specialised services such as physiotherapy, occupational therapy, speech therapy, and developmental assessments. Reducing out-of-pocket expenditures will ease the financial burden on mothers and promote sustained healthcare utilisation.

Third, targeted training programmes should be implemented for healthcare providers to improve attitudes and competencies related to disability care. Continuous professional development initiatives focusing on inclusive care, communication, and disability awareness can enhance provider–patient interactions and foster respectful, supportive healthcare environments for mothers and their children.

Fourth, public education and community-based interventions are needed to address stigma associated with disability. Awareness campaigns involving community leaders, health professionals, and civil society organisations can help reshape negative perceptions and encourage supportive attitudes toward children with special needs and their families.

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