



POLICY BRIEF GENDER, SOCIAL INCLUSION AND HEALTH IN GHANA

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1.0 INTRODUCTION

“A healthy population is not only an asset by itself, but also facilitates sustained poverty reduction and socio-economic growth.” (GSGDA, 2010-2013, page 100)

This Policy Brief on Gender Equality, Social Inclusion (GESI) and Health was commissioned by STAR Ghana. The brief is to support STAR-Ghana in addressing Grant Partners (GPs) GESI constraints and serve as reference material for them and other stakeholders. This will strengthen GPs GESI programming and engagement through targeted advocacy. The document provides a brief on key gender and social inclusion legal instruments and policies as well as outlines some critical issues which have implications for programmes, targeting and advocacy.

Gender equality as used in this brief refers to: *“the absence of discrimination on the basis of gender in opportunities, in the allocation of resources or benefits, or in access to services. It is the full and equal exercise by men and women of their human rights.”* **Social inclusion here means** two things. First, the making ‘rules of the game’ more fair i.e. *the removal of institutional barriers and the enhancement of incentives to increase the access of diverse individuals and groups to development opportunities.* These barriers may be formal or they may be informal. (STAR Ghana GESI Strategy Document)

Promotion of gender and social inclusion in the health sector means eliminating inequalities between men and women which are unnecessary, avoidable and, therefore, unjust and ensuring an all inclusive provision of health services for all especially the most vulnerable in society. Inequalities can affect the health status and survival of men and women and especially the vulnerable that must be included in all aspects of programming. Achieving gender equity and social inclusion in health also means addressing the different abilities of women and men to afford health services. Gender roles and unequal gender relations interact with other social and economic variables, resulting in different and sometimes inequitable patterns of exposure to health risk, and in differential access to and utilization of health information, care and services.

The importance of gender to the attainment of particularly the MDGs is crucial. Eight time-bound and quantifiable targets were adopted in September 2000 after a UN Declaration by 189 countries. The targets aim to halve the proportion of people living below the poverty line, improve access to education, promote gender equality, improve maternal and child health, ensure environmental sustainability and promote global partnership between developed and developing countries. The global approach to health and development is increasingly influenced by these MDG goals 3, 4, 5 and 6 with implications on the attainment of all the MDGs for males, females, children and the most vulnerable in society:

- Goal 3: Promote gender equality and empower women.
- Goal 4: Reduce child mortality - A healthy mother is considered to be the first step towards a healthy child.
- Goal 5: Improve maternal health - The highest proportion of women's ill health burden is related to their reproductive role.
- Goal 6: Combat HIV/AIDS, tuberculosis, malaria and other diseases. Two of the MDG goals with direct health and gender implications on national programming are goals 3 and 5.

2.0 LEGAL AND INSTITUTIONAL FRAMEWORK FOR PROMOTING GENDER AND SOCIAL INCLUSION

It is important to be familiar with the international, regional and national legal instruments and frameworks that support the promotion of gender and social inclusion in health and the importance of addressing critical issues in sector programming. At the international, regional and national level, the following conventions and legal frameworks are very informative in ensuring that GESI issues are mainstreamed into national health sector programming.

2.1 International and Regional Conventions and Policies

At the international level there are many conventions and laws which influence the promotion and formulation of gender equality and social inclusion with implications on health programme. Some of these are:

- The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW (1979). Ghana ratified CEDAW on 2 January 1986. Ghana since 1991 has presented reports on CEDAW which always include health issues.
- The Convention on the Rights of The Child (CRC) 1990;
- The World Conference on Human Rights (June 1993, Vienna) stated that women's human rights are an indivisible part of universal human rights;
- The International Conference on Population and Development (ICPD, September 1994, Cairo) recognised reproductive health and rights and the centrality of women to population and development programs. Since then, policy shifts that focus on both the productive and reproductive roles of women have occurred;
- The World Summit for Social Development (March 1995, Copenhagen) underlined the necessity of including women in efforts to reduce poverty, unemployment and in shaping integrated societies;
- The Second United Nations Conference on Human Settlements (Habitat II, June 1996, Istanbul) adopted a global plan and declaration setting out policy guidelines and Government commitments to improving living conditions in urban and rural settlements and acknowledged the gender aspects of access to housing; and,
- Declaration of the Millennium Development Goals (MDGs) (2000): human security and sustained development.
- Beijing PFA (1995), Beijing +5 (2000) Report, and Beijing+10 (2005) Report
- Commonwealth Gender Policy & Plan of Action

At the regional level the following conventions are very relevant to programming:

- African Charter on Human and People's Rights which came into force in 1986 – Ghana ratified on 24th January 1989. There is now a Protocol that focuses on Women and some of the things that inhibit the development of women – harmful cultural practices etc. which are gender-based violence – Ghana is yet to ratify the Protocol.
- Cairo Programme of Action on Population and Development (ICPD)
- ECOWAS Gender Policy (March 2004)
- AU – NEPAD (July 2001) Gender Equality Objective 5
- AU - Solemn Declaration on Gender Equality (SDGE) (July 2004)

2.2 National Instruments and Policies

Some of the legislations and policies include:- The 1960 Criminal Code (Act 29); 1992 National Constitution Article 28; Children's Act 1998 Act 560/LI 1705 " Regulations on children's Act; Criminal Code Amendment Act 1998 (Act 554); Juvenile Justice Act 2003 (Act 653); The Human Trafficking Act 2005 (Act 694); Ghana HIV/AIDS Strategic Framework 2001 -2005; National Monitoring and Evaluation Plan for HIV/AIDS in Ghana 2001 / 2005; National HIV/AIDS and Sexually Transmitted Infection (STI) Policy, 2004 Adolescent Reproductive Health Policy, 2000; Criminal Code (Amendment) Act, 1993 (Act 458) and other amendments in 1994 (Act 484) and 1998 (Act 544); Revised National Population Policy, 1994; National Disability Policy.

Ghana also promulgated the Children's Act, (Act 568) which raised the legal age for marriage to 18 years, and adopted the Policy Guidelines on Affirmative Action, which makes provision for 30% representation by women on all policy making bodies. Under the Constitution, a Commission on Human Rights and Administrative Justice (CHRAJ) was established in 1993. This Commission has been actively investigating complaints of violations of fundamental human rights and freedoms. The following legislative provisions enhance this positive development:

- The 1992 National Constitution: - Chapter Five of the 1992 Constitution of Ghana makes provision for the equitable engagement of both women and men, and embodies the need to focus on redressing existing imbalances;
- Section 2.8 of Ghana's National Population Policy (revised, 1994) states "in view of the woman's central role in production and reproduction, her importance both as an agent and beneficiary of socio-economic development and change cannot be overemphasized". In addition, section 5.6 of the Population Policy argues that "women play an important role in the socio-economic development of the country";
- The Decentralization policy seeks to bring participation in decision making and development closer to communities, and provides a window of opportunity for addressing specific economic and socio-cultural imbalances at the district level through specific support for both men and women equitably, to facilitate human development; and,
- Establishment of a fully-fledged Ministry of Women and Children's Affairs (MOWAC) in 2001, with the same responsibilities as the NCWD and an added focus on facilitating the creation of an enabling environment for gender equity and women's empowerment. Similarly, the efforts of MOWAC will be complemented by the activities of several NGOs, including those of women and civil society in partnership with multi-lateral and bi-lateral development agencies.

In compliance with Article 35 (6) (b) of the 1992 Constitution, which requires the state to take appropriate measures to achieve reasonable gender and regional balance in recruitment and appointment to public offices, the Government issued a policy guideline on Affirmative Action (AA) to encourage women's participation in decision-making . The formulation of the Affirmative Action (AA) policy by government after Beijing assured 40% representation of women at all levels of governance, on Public Boards, Commissions, Councils, Committees and Official Bodies including Cabinet and the Council of State.

2.3 Ghana Shared Growth and Development Agenda (GSGDA), 2010-2013

The GSGDA asserts that even though the health status of Ghanaians has generally improved over the years, there are persistent policy-related issues that need to be addressed. These include: large gaps in access to health care between urban and rural as well as the rich and poor; absence of an appropriate legal framework for the health sector; high infant and maternal mortality; high morbidity and mortality

from communicable diseases such as malaria, HIV and tuberculosis; increasing prevalence of non-communicable diseases with high disability and mortality e.g. cancers, cardiovascular diseases; threats of epidemic prone diseases and diseases of pandemic potential such as influenza; and low level of overall health expenditure and inadequate social protection. Others are: inadequate and unequal distribution of health infrastructure; limited access to health facilities especially by deprived communities; inequitable distribution of workers at different levels of services delivery; inadequate staff numbers; low morale and motivation of health workers; inadequate support /facilitative supervision; high attrition rate of health workers, weak performance management systems; limited training capacity to meet increasing numbers into the training institutions; and inadequate collaboration between MOH and Ministry of Education training institutions; lack of integration of traditional medicine practice into the existing healthcare system; inadequate mental health services; as well as weak governance and accountability.

To improve access to quality health care, the policy objectives are to: bridge equity gaps in access to health care and nutrition services; improve governance and strengthen efficiency in health service delivery, including medical emergencies; improve access to quality Maternal and Child Health services; intensify prevention and control of non-communicable and communicable diseases (malaria, HIV and AIDS/STI/TB); promote healthy lifestyle as well as strengthen Mental Health service delivery and make health services youth friendly at all levels. It is clear that these policies focus has implications and is closely linked to the numerous GESI issues in health.

2.4 Ghana Health Service Act 256, 19196

The Legal framework of the operation of the Ghana Health Service (GHS) is mandated by Act 525 of 1996 as required by the 1992 constitution. GHS operates at the national, regional, district, sub-district and community levels. Each level has a team of health workers called the Sub-district Health Management Team, (SDHMT) or District Health Management Team (DHMT) or Regional Health Management Team (RHMT) headed by the head of the level (BMC). The existing structures within the Ghana Health Service shall be responsible for the implementation of gender concerns at all levels of service delivery. The various levels of the Ghana Health Service shall also collaborate with all Ministries, Departments and Agencies (MDAs) and other collaborating partners, including NGOs, Civil Societies, traditional rulers, and District Assemblies to implement gender issues.

2.5 National Health Policy (2008)

The Health Policy of 2008 reiterates the mission of the Ministry of Health as to contribute to socio-economic development and wealth creation by promoting health and vitality, ensuring access to quality health, population and nutrition services for all people living in Ghana and promoting the development of a local health industry. This mission puts the concept of health beyond the confines of curative care to other socio-economic determinants of health. The majority of conditions leading to out-patient attendance at clinics in Ghana are malaria, diarrhea, upper respiratory tract infection, skin disease, accidents, hypertension, eye infection, pregnancy-related conditions.

Over 90% of these diseases and conditions could easily be prevented if appropriate environmental and lifestyle measures were to be taken. The programmes and projects of the Ministry of Health to date, however, have focused on curative care, leading to failures of the Ministry to make a significant impact in the development of promotive and preventive health to the benefit of its people. The policy presents health in its broadest sense as a multi-sectoral programme focusing on the physical, social, economic,

and spiritual dimensions which can bring total health to individuals, their families and communities. This is where programming on GESI becomes crucial in responding to the health of the populace.

The policy clearly sets out the paradigm shift from curative action to health promotion and the prevention of ill-health. The policy argues that a healthy population can only be achieved if there are: improvements in environmental hygiene and sanitation proper housing and town planning provision of safe water provision of safe food and nutrition encouragement of regular physical exercise improvements in personal hygiene immunization of mothers and children prevention of injuries in our work places prevention of road accidents practising of safe sex. The disease profile and mortality patterns of the country are directly linked to these factors. This document sets out the policy measures which will lead to actions promoting healthy lifestyle and environment. It provides an institutional framework for the implementation of the policy measures. It also defines the health industry in terms of the business entities that will provide the needed manpower, material and financial resources for the health sector, and analyzes the institutional framework for mobilizing all sector-wide resources for health development. The policy document therefore provides a new direction in the development of health in this country, and will serve as the basis for the development of our health sector priorities and planning. The policy document therefore provides a new direction in the development of health in this country, and will serve as the basis for the development of our health sector priorities and planning.

2.6 Persons with Disability Act (2006)

In 2006, after four years of remaining in a draft, Ghana passed the Persons with Disability Act (PDA). Advocates like the Ghana Federation of the Disabled (GFD) were instrumental in getting the bill passed into law. The PDA builds on the country's 1992 constitution, which has eight provisions guaranteeing the rights of the disabled. A year after passing the act, Ghana signed but has not ratified the Convention for the Rights of Persons with Disabilities, which also supports the PDA. The PDA ostensibly delivers social, cultural and civil rights to the country's disabled. An umbrella provision guarantees dignity in social, political, cultural, recreational, and creative pursuits. Subsequent provisions promise job training, employment, an accessible built environment, accessible transportation, free healthcare, protection from discrimination, and a National Council on Persons with Disability (NCPD). A 10-year transition period was built into the law.

2.7 The Health Sector Gender Policy

As far back as 1999 the MoH sought to respond to the growing concerns about gender neutrality, and undertook a situational analysis of gender issues within the sector culminating in the document "Promoting Gender Equity in Health, A Framework for Action". This document highlighted some of the gender issues in the health sector and also proposed a framework for action to address them. The Ministry of Health subsequently developed the draft Health Sector Gender Policy in 2003. The Draft Gender Policy sought to recognize the ways in which gender relations, roles, responsibilities, access and control of resources impact on women and men's health. In 2008 the Health Sector Policy was finalized and launched with support from its stakeholders and is currently under implementation. The goal of the policy is to contribute to better health for both women and men, through health research, policies and programmes which give due attention to gender considerations and promote equity and equality between women and men. The policy is to help position the MoH to use strategies that will help to analyze and prioritize gender issues in planning, implementation, monitoring and evaluation of policies, programmes, projects and research in order to achieve the broad objectives.

The policy seeks to provide strategic direction towards addressing key gender issues identified in the health sector including general access to health care for men and women, gender and life expectancy, sexual and reproductive health, gender and HIV/AIDS, sexual and gender based violence, gender and mental health, traditional and cultural practices and its implications on the health seeking behaviours of males and females, gender issues on health, nutritional health and some of the emerging trends and issues with gender and health Implications.

2.8 The Domestic Violence Act (DVA) 2007, Act 732

The DVA was passed by Parliament on 21st February, 2007 and enacted as law on 3rd May, 2007 with Presidential assent. The Domestic Violence Act provides the long awaited legal environment to empower various actors and professionals to deal more effectively with the problem of domestic violence. The diverse experiences of victims of domestic violence require that systems develop individualized responses to meet victim needs while conforming to best practice. The effects/consequences of domestic violence on the victims and society at large are far too serious to be left unchecked. Domestic violence denies victims and survivors their fundamental rights and undermines human development goals. The health consequences on abused women and the negative psychological and emotional impact on children compromise their well being and undermine development.

2.9 The National Health Insurance Act

This was launched in 2005 as mandated by The National Health Insurance Act 650 (2004) A Legislative Instrument, LI 809 has also been passed to provide operational and administrative guidelines for its implementation. The scheme was initiated to address the problem of financial barriers to health care posed by the 'Cash and Carry System' which requires out-of-pocket payment for health care at the point of service delivery.

2.10 National Population Policy (revised, 1994)

Section 2.8 of Ghana's National Population Policy (revised, 1994) states: "in view of the woman's central role in production and reproduction, her importance both as an agent and beneficiary of socio-economic development and change cannot be over emphasised". In addition, section 5.6 of the Population Policy argues that "women play an important role in the socio-economic development of the country". The Decentralisation policy seeks to bring participation in decision making and development closer to communities, and provides a window of opportunity for addressing specific economic and socio-cultural imbalances at the district level through specific support for both men and women equitably, to facilitate human development.

2.11 Mental Health Bill (MHB)

In 2004, the MHB was drafted. Seven years later, it has yet to be passed, placing it in the neglected ranks of other potentially emancipatory laws, like the Right to Information Bill, itself in limbo for almost ten years. The current Mental Health Act dates back to 1972 and focuses on centralised, institutional care, permitting decades of involuntary confinement. The draft MHB, developed in partnership with WHO, proposes the creation of a Mental Health Service that would operate at the level of primary health care and focus on community delivery. District and regional services would also be established to deliver prevention, treatment, care, rehabilitation, and counselling. The government would have access to private sector facilities, which is what the prayer camps are considered. The draft sets out parameters for voluntary and involuntary treatment, including standards for food, bedding, sanitation, staff qualifications, and essential medicines. It has further clauses protecting at-risk groups like women and

children. Human rights are also addressed, with clauses articulating privacy and autonomy, access to medical records, access to personal money for in-patients, and access to employment and education.

2.12 Health Sector Legislations and Policies

The Health Sector has many legislation, policies and procedures as well as key developments guidelines which takes its position from international and national aid architecture. These are as reflected in the following – the Ghana Health Services and Teaching Hospitals Act 525, 1996; the National Health Insurance Act 650, 2003; the Financial Administration Act 654, 2003; and Regulations 2004; the Accounting, Treasury and Financial Rules and Regulations; the sector annual Planning Guidelines; the Paris Declaration on Aid Effectiveness; the Accra Agenda for Action; the Ghana Aid Policy; the Ghana Harmonisation Action Plan (G-HAP); the Ghana Joint Assistance Strategy (G-JAS) and the sector Aide Memoire.

2.13 National Gender Machinery

Ghana became one of the first member nations to establish a women’s machinery in 1975: the National Council on Women and Development (NCWD) became the country’s highest policy-making body. Its mandate included coordination of the government-wide efforts at promoting women’s issues, providing policy advise to Government on all issues relating to women, facilitating the integration of women’s issues in the national development process at all levels, building alliances among women organizations and development partners and reporting on their status periodically.

The Ministry for Gender, Children and Social Protection (MoGCSP) which was formerly known as the Ministry of Women and Children’s Affairs (MOWAC) was established by the President, John Dramani Mahama by Executive Instrument 1, 2013 (E1, 2013) and comprise of the Department of Gender, Department of Children and the Department of Social Protection. The new Ministry would have oversight of the Disability Council and would take steps to integrate fully “our challenged brothers and sisters in the mainstream of national life. The mandate of the MoGCSP is to ensure gender equality through the mainstreaming of gender considerations.

It is also to promote the welfare and protection of children and also empower the vulnerable, excluded, the aged and persons with disabilities by social protection interventions to contribute to national development. The formulation of gender and child specific development policies, guidelines, advocacy tools strategies and plans for implementation by Ministries, Departments and Agencies (MDAs), District Assemblies, Private Sector Agencies, NGOs, civil Society Groups, and other Development partners. The role of the MoGCSP includes: Prepare National Development plan and programmes for women and children in which all the desired objectives and functions of the Ministry are programmed for implementation. The ministry is also mandated in ensuring that development programmes for women and children are effectively implemented, through continuous monitoring and evaluation of the implementation process, making sure stipulated objectives are fulfilled.

3.0 PROGRAMMES AND PLANS

The health Sector has many ongoing plans and programmes with direct and indirect implications on GESI promotion. It is imperative that sector partners and players in the development of their supportive Programmes take cognizance of the current health objectives.

3.1 Planning Around Sector Objectives and Targets

Currently the sector plans around its five sector objectives which are as following:

- Health objective 1: Bridging equity gaps in access to health care and nutrition services, and ensure sustainable financing arrangement that protect the poor
- Health objective2: Improve governance of the health system
- Health objective3: Improve access to quality maternal, neonatal, child and adolescent services
The coverage of pregnant women, who received at least four antenatal care visits, continued the previous four year's positive trend and increased slightly to 71.3%. Central and Upper East Region had the highest coverage of about 90%, while only 60% of pregnant women! In Upper West and Eastern Region received four or more antenatal visits.
- Health objective 4: Intensify prevention and control of communicable and non-communicable diseases and promote healthy lifestyles
- Health objective 5: Strengthen institutional care, including mental health service delivery.

3.2 Sector Planning with Implications on Gender and Social Inclusion

Two governmental agencies are responsible for national development planning; the Ministry of Finance and Economic Planning (MFEP) and the National Development Planning Commission (NDPC). The NDPC is charged with the preparation of a national land-use plan. Environmental and land management has to be seen in the context of national development plans including the development of PRSPs. Also two main planning documents have implications on gender equality GESI and the health sector. These are the Sector Medium Term Development Plan (SMTDP) the Common Management Arrangements (CMA). Under the guidance of the National Development Planning Commission (NDPC), the Ministry of Health together with other MDAs prepared a new Sector Medium Term Development Plan 2010-2013 (SMTDP), which replaced the 5year Programme of Work (POW III).

The SMTDP aligned with the overall National Medium-Term Development Policy Framework (2010-2013) which has been developed with a view to improving the living standards of people living in Ghana. SMTDP sets out the direction for the sector for the next four years in terms of policy and key implementation strategies.

The CMA focuses on the collaboration arrangements which need to be in place in the sector for the policies outlined in the SMTDP to be successfully implemented. CMA III will support implementation of the Sector Medium-Term Development Plan. The CMA is guided by the numerous sector legislations and Acts.

3.3 National Health Insurance Scheme

One Ghana's major attempts at addressing social inclusion in the health system are considered at the introduction of the National Health Insurance Scheme. (NHIS). The National Health Insurance was initiated to address the problem of financial barriers to health care posed by the 'Cash and Carry System' which requires out-of-pocket payment for health care at the point of service delivery. The National Health Insurance Act (2004), Act 650, has been enacted and a Legislative instrument, LI 809, has also been passed to provide operational and administrative guidelines for its implementation. A Ministerial Oversight Committee has been formed. A National Health Insurance Council is in place. District Mutual Health Insurance Schemes (DMHIS) serve as vehicles for delivering pro-poor policy to the underprivileged segment of society. Currently a minimum benefit package covers about 95% of diseases in Ghana. Some of the diseases covered are malaria, diarrhoea, upper respiratory tract infections, skin diseases, tuberculosis, asthma and hypertension

3.4 Malaria Control Programme (NMCP)

According to the Malaria Operational Plan (FY 2013), Ghana became a US President's Malaria Initiative (PMI) country in December 2007. Malaria is endemic and perennial in all parts of the country, with seasonal variations that are more pronounced in the north.

The Ghana Health Services (GHS) began large-scale implementation of Artemisinin-based combination therapy (ACTs) and Intermittent preventive treatment of pregnant women (IPTp) in 2008 and has progressed rapidly with the scale up of interventions with support from PMI and other partners.

The 2011 Multiple Indicator Cluster Survey has provided data on point prevalence of parasitemia as well as information on trends in malaria control interventions. In FY 2013 PMI will continue to support all four prevention and treatment interventions and prioritize procurement of RDTs and pediatric formulations of ACTs; support for large scale prevention activities in regions with relatively high population and high.

3.5 HIV/AIDS Programme.

The Ghana HIV/AIDS Control Programme adopts a gender mainstreaming approach due to the feminization of infections with more women than men being affected and impacted on. The Ghana AIDS Commission Act, 2002 is an ACT to establish a Commission to formulate a national HIV/AIDS policy; to develop programmes for the implementation of the policy and direct and co-ordinate the programmes and activities in the fight against HIV/AIDS and to provide for related purpose. The object of the Commission is to formulate HIV/AIDS policy and direct and co- ordinate national activities in the fight against HIV/AIDS. The Commission is mandated to:

- Formulate comprehensive policies and strategies and establish programme priorities;
- Provide high level advocacy for HIV/AIDS prevention and control;
- Provide effective leadership in the national planning , supervision and support of the HIV/AIDS programmes;
- Expand and co-ordinate the national response to the HIV/AIDS;
- Mobilize, control and manage resources available for the achievement of its object and monitor their allocation and utilization;
- Foster linkages among stakeholder;

- Promote issues relating to research, documentation and dissemination on HIV/AIDS; and
- Monitor and evaluate HIV/AIDS programme.

3.6 Gender Budgeting

Gender Responsive Budgeting is a kind of budget that prioritizes income and expenditure such that specific needs of women, men, girls and boys are met equally. Its focus is to analyse any form of public expenditure, or method of raising revenue from the perspective of gender and identify the implications for women and girls as compared to men and boys. It is a means of ensuring that budgets are accountable to both girls and boys, women and men, rich or poor. Ghana officially introduced Gender Responsive Budgeting into its budgeting process in 2007 when approval was sought by a Ministers Cabinet Memo dated 9/10/07: 'Request for approval and adoption of Gender Responsive Budgeting Guidelines' and this was approved by Cabinet through a response memo dated 8/11/07: ' Gender Responsive Budget Guidelines'. From December 2007 to date various efforts are ongoing towards national adoption of GRB into the budgeting process. The mandated ministries to oversee GRB are the Ministry of Finance and Economic Planning (MOFEP) and the Ministry of Women and Children's Affairs (MOWAC) with collaboration from National Development Planning Commission and all sector ministries. The first phase of implementing The GRB process for Ghana is to be overseen by MOFEP, MOWAC and the NDPC. The sector players were very clear from the onset of the benefits that GRB could derive for Ghana in line with the accepted international value of GRB. These were to:

- Ensure that Government commitment to gender equality moves beyond lip-service
- Reduce gender disparities can lead to improved macro economic performance
- Expose how girls and boys, men and women fare differently under existing revenue and expenditure patterns, thereby providing Government the opportunity to understand and appreciate how various social groups respond to development policy change differently over time.
- Support Government to understand the need to adjust its priorities and resource allocation in line with its commitment to achieving gender equality and the MDGs for Ghana.
- Allow demonstration of development accountability to Ghanaians by ensuring that Government budget reach the people who need it most: particularly rural poor women who generally are least able to meet their needs fully without outside assistance.
- Prevent the perpetuation of inequality in society and allows democratic participation in development and equitable sharing of the benefits of growth and development.

Clearly GRB is considered as a key tool in the fight against poverty, especially women's poverty and a means to strengthen governance and promote development of the entire nation not just a part through improved development outcomes. In the 2008 – 2010 GoG Budget Guidelines and Statement, Page 251 committed itself to 'enhancing is gender programmes by out a step by step approach to Gender Budgeting and Piloting it in 3 Key Ministries, Departments and Agencies. The phase one of the Ghana GRB involved the Ministries of Food and Agriculture (MOFA), Education (MOE) and Health (MOH).

Initial Stakeholder sensitization seminar was held in December 2007. This was followed by a 10 member Technical Steering Committee of MOWAC, MOFEP, NDPC, MOH, MOE and MOFA and a GRB Road Map was developed. Subsequently representatives of the key MDAs received trainings and a set of 3 training manuals and tool kits developed to guide the pilot agencies with support from the UNDP, UNFPA and UNIFEM (Now UN Women).

From 2009 – 2012 Budget Guidelines/Circular enjoins all ministries to gather sex disaggregated data as part of preparation towards the subsequent rolling out of GRB. Piloting of GRB in three selected ministries – agriculture, education and health is supposed to be ongoing but with clear challenges.

3.7 Monitoring Instruments and Strategies

A Holistic Assessment of the health sector programme of work is undertaken yearly using a collaborative stakeholder approach. For instance the assessment uncovered that institutional Maternal Mortality Ratio (IMMR) increased from 190/100,000 in 2010 to 211/100,000 in 2011. The IMMR however improved for some regions, with decrease especially in Western Region whilst it increased for Greater Accra.

The Multiple Index Cluster Survey (MICS), Demographic and Health Surveys (DHS) and the Ghana Living Standards Surveys (GLSS) provide the continuum of data that Ghana needs for monitoring the impact of health sector interventions as well as progress towards national policies and the MDG targets to make the necessary policy and programmatic adjustments. These are also very good documents for reference by STAR Ghana and its partners in monitoring their individual and corporate contribution towards the achievements of key health and social indicators.

5.0 RESPONDING TO SECTOR LEGAL INSTRUMENTS THROUGH GRANT PARTNERS

Current support to Grant Partners by STAR Ghana truly reflects some relevant response to the many sector legal instruments and goals. The Achievements of Grant Partners in terms of Gender and Social Inclusion are clustered around the three dimensions of STAR-Ghana's GESI strategy – **Gender, Disability and Geographical/Spatial Exclusion**.

Relevance of STAR Ghana supported projects with their Grant Partners can be strategically viewed in relation to their response to international, regional and national legal instruments. For instance under the health call, ABANTU for development's project on *Enhancing Gender and Social Responsiveness of the NHIS: The Case of the Female Porters and Senior Citizens*, responds directly to the CEDAW as well as the Health Sector Gender Policy. This project targets two of the most vulnerable groups in accessing health care and seeks to directly meet their health needs through the elimination of financial barriers and challenges in accessing healthcare.

Another important response towards the implementation of the Mental Act of 2010 is the ongoing Mental Health projects by Basic Needs Ghana and the Brong Ahafo Network of NGOs (BONGO), all Grant Partners under the health call. These NGOs are implementing projects which are directed to aspects of the call for a national, regional and local response to the needs of all mentally ill citizens of Ghana. These projects do not only respond to the Mental Act, but has critical implication on national legislative processes in Ghana. The Basic Needs project for instance has one of its main objectives supporting efforts at having a Legislative Instrument (LI) in place for effective implementation of the new Mental Health Law of Ghana as well as an enhanced access to community mental health services improve for poor men, women, boys and girls with mental illness or epilepsy in deprived and hard to reach areas. This touches on all the three elements of gender and social inclusion.

The need to meet Ghana's goals on the MDGs continue to demand for better programming and planning and Grant Partners are responding by the development and implementation of innovative projects with clear policy implications. The Center for Health and Social Services (CHSS) in their *Transforming Community Health Systems (CHPS) for Universal Coverage In Maternal And Child Health seeks to* Rapidly expand Community Health Programme and Systems (CHPS) from 3.3% service coverage to 30% in three years and improve the efficiency from the current 36% to 70% through policy transformation for Universal Coverage in Maternal and Child Health Service. Their project also seeks to review the existing CHPS policy as implemented, introduce and validated a new conceptual framework to promote quality and performance efficiency in delivering maternal and child health in two CHPS zones by ensuring gender and social inclusion services and provide evidence-based CHPS policy and guidelines proposed and adopted.

Clearly these examples of supported projects as given above, demonstrate commitment of STAR Ghana and Grant Partners towards the implementation of some related sector policies and frameworks with gender and social inclusion implications. A clear understanding of these will enhance such commitment.

6.0 CONCLUSIONS AND RECFOMMENDATIONS

Ghana's health sector is well positioned to implement programs in a holistic manner to ensure the promotion of gender and social inclusion in its health delivery. There is also enough empirical evidence at all levels to confirm the differential health needs of males and females at all ages including children and persons with disability This is because there exist a plethora of legal and institutional frameworks, policies, strategies and plans which provides the foundation for all such gender and vulnerability issues to be addressed.

6.1 Summary of Gender and Social Inclusion Issues in Health

There are many socio-economic issues that has implications on gender and social inclusion in health and these can be summed up as:

- Geographical access (locations and remoteness of access);
- Financial access (ability to afford health services and poverty);
- Operating hours not suitable for some patients (males and females);
- Lack of gender sensitivity by some health workers (the impatience of formal health providers is reported to compare unfavourably with the attitude of traditional healers);
- Long waiting times for patients and carers;
- Lack of gender sensitive infrastructure and privacy guidelines for women and persons with disability;
- Limited presence of particularly male staff at Out Patient Departments to address male concerns
- Limited presence of sign language interpreters;
- Lack of privacy/confidentiality in the handling of medical conditions at health centres
- Stigmatization of HIV/AIDS patients and relations;
- Lack of basic health information including reproductive health information for boys and girls
- Lack of community involvement in provision of health;
- Cultural/traditional practices and beliefs which hinders health seeking behaviours for men and women and provision of health services for children; and
- Accessibility of health facilities for persons with disability and psychiatric needs for men and women.

6.2 Conclusions

To a large extent, socio-cultural factors are the basis for the disadvantaged situation of particularly women in many sectors. The socialisation processes that influence the roles of boys and girls, men and women in society have not changed dramatically over the decade. Existing gaps in the legal framework that limit the opportunities of women and persons with disability to participate in public decision-making on an equitable basis seems to be the major challenge to gender mainstreaming in Ghana. Lack of effective engagement with men and persons with disability continues to be a major gap in gender and social inclusion mainstreaming efforts in Ghana. Gender and social inclusion issues are continually being trivialized as "women's and vulnerable issues". The lack of capacity for formulating and implementing guidelines for integrating and social inclusion into human resource policies and management practices is a constraint. The same constraint affects the development of performance indicators as well as targets for change.

An issue calling for deeper analysis is to what extent gender mainstreaming is an integral part of crucial health sector processes such as policy dialogue, strategy development, programming and implementation - or treated as a separate issue. Of particular interest is to see what role GESI mainstreaming is playing in harmonised and aligned frameworks.

6.3 General Recommendations

It would be a fair assumption that succeeding with gender mainstreaming in the health sector due to the complexity of issues would require updated and well positioned expertise in the mainstreaming *process* as well as the cross-cutting *issues* to be mainstreamed. This kind of expertise may or may not be present in the focal points appointed of the health sector for each of the critical issue, and this will need to be further explored. General recommendations proposed for consideration are:

- Support the formulation of appropriate gender related policies geared towards accelerating the achievement GESI and sustaining the gains attained so far.
- Facilitate inter-sectoral collaboration to bring together relevant agencies and CBOs who are implementing pro-poor and GESI programmes as a means for harmonizing their interventions to increase coverage and enhance impact of health delivery in Ghana.
- Assist and strengthen CBOs, MDAs and MMDAs to monitor interventions at national, regional district as well as grass-roots levels to assess the impact of targeted GESI interventions at achieving the international, regional and national policies and goals including the MDGs.

6.4 Specific Recommendations for STAR Ghana Grant Partners

- a. Position all programmes and projects appropriately into the legal instruments, policies and plans they respond to, and be explicit on the aspects of those instruments to which project outputs and expected outcomes are targeted;
- b. Systematic compilation of all gender issues as relates to programme or project;
- c. Consistent sex disaggregation of all programme / project information;
- d. Analysis and dissemination of gender disaggregated statistics on all aspects of programme / project information;
- e. Progressive building of capacities in gender mainstreaming and analysis;
- f. Gender reporting detailing out gender gaps and achievements and strategies for redress and
- g. Continuous training and capacity building in gender mainstreaming and analysis and social inclusion.

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