NATIONAL HEALTH SECTOR GENDER POLICY

OCTOBER 2024

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ACKNOWLEDGMENTS

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The revision of the National Health Sector Gender Policy (NHSGP) has been made possible through the collaborative effort of the Ministry of Health, its Agencies, Development Partners, and all other relevant stakeholders.

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The Ministry also appreciates the immediate past leadership of Hon. Kwaku Agyeman-Manu and his two (2) deputies: Hon. Tina Mensa (MP), and Hon. Alhaji Mahama Asei Seini (MP) under whose regime the policy review process started.

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FOREWORD

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The policy seeks to emphasize the impact of gender inequality on human development and healthcare-seeking behaviour. It acknowledges the pivotal role of gender in global development, aligning with the 2030 Sustainable Development Goals Agenda.

Ghana's 1992 Constitution recognizes gender concerns as crucial to national development. It guarantees gender equality and freedom of women and men, girls and boys from discrimination based on social or economic status amongst others. Consequently, at the national level, the Ministry of Gender, Children and Social Protection (MOGCSP) has also revised its National Gender Policy 2015 in 2024 with a focus on mainstreaming gender into the country's national development process.

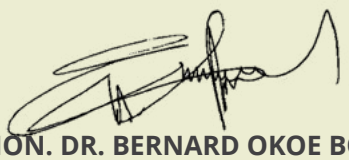
In response to these, the Ministry of Health (MoH) and its key stakeholders, including Development Partners, have collaboratively revised the 2009 National Health Sector Gender Policy (NHSGP) with the under-listed four (4) objectives:

1. **To improve gender responsiveness of health systems for enhanced quality of care.**
2. **To strengthen leadership, coordination, and collaboration for gender mainstreaming in health.**
3. **To address socio-economic and cultural barriers that underlie gender inequalities in health.**
4. **To ensure sustainable financing for gender mainstreaming in health**

Drawing on global, regional, sub-regional, and national frameworks, the revised NHSGP-2024 seeks to prioritize the prompt delivery of gender-sensitive healthcare services throughout the health sector. It is built on the principles of person-centeredness, equity for vulnerable populations, collaborative efforts, and quality improvement.

This document emphasizes the need for a collective effort to fortify gender-related aspects in healthcare delivery to ensure a healthier population and contribute to national development goals. As the Minister, I will ensure effective dissemination of the document to all relevant stakeholders. I encourage all stakeholders to widely disseminate same, include relevant areas of the policy into your annual workplans and make budgetary allocations to ensure the implementation of the plan.

Finally, I call for effective collaboration among all stakeholders to support the implementation of the revised NHSGP.



HON. DR. BERNARD OKOE BOYE
MINISTER FOR HEALTH

LIST OF **ABBREVIATIONS**

AFOG	Africa Federation of Obstetrics and Gynaecologists
AfDB	African Development Bank
AU	African Union
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CDC	Centres for Disease Control
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHNs	Community Health Nurse(s)
CHPS	Community Health Planning Services
CHWs	Community Health Workers
CMDs	Common Mental Disorders
CPMR	Center for Plant Medicine Research
CSOs	Civil Society Organisation(s)
DPs	Development Partners
EmONC	Emergency Obstetric and Neonatal Care
FBOs	Faith-Based Organisation(s)
FCs	Focal Persons
FGM	Female Genital Mutilation
FP	Family Planning
GAC	Ghana Aids Commission
GAQHI	Ghana Association of Quasi-Government Health Institutions
GCNM	Ghana College of Nurses and Midwives
GDHS	Ghana Demographic and Health Survey
GFLHS	Ghana Family Life and Health Survey
GHS	Ghana Health Service
GMHS	Ghana Maternal Health Survey
GOG	Government of Ghana
HeFRA	Health Facilities Regulatory Agency
HIV	Human-Immunodeficiency Virus
HSGP	Health Sector Gender Policy
HSWG	Health Sector Working Group
IALC	Inter-Agency Leadership Committee
ILO	International Labour Organization
KNUST	Kwame Nkrumah University of Science and Technology

LM	Lead Ministry
MDAs	Ministries, Departments and Agencies
MDFP	Millennium Development Framework Programme
MDGs	Millenium Development Goals
MMDAs	Metropolitan, Municipal, and District Assemblies
MNCHP	Maternal, Newborn, and Child Health Promotion
MCHNIP	Maternal and Child Health and Nutrition Improvement Project
MOFA	Ministry of Food and Agriculture
MOH	Ministry of Health
MOI	Ministry of Information
NCCE	National Commission for Civic Education
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organisation(s)
NHIS	National Health Insurance Service
NHSGP	National Health Sector Gender Policy
NTDs	Non-Tropical Diseases
OSH	Occupational Safety and Health
PLHIVs	People Living with Human immune-deficiency Viruses
PPP	Public-Private Partnerships
PWDs	Persons with Disabilities
RMNCAHN	Reproductive, Maternal, Newborn, Child & Adolescent Health and Nutrition
SBCC	Social and Behavioural Change Communication
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TAM	Traditional and Alternative Medicine
TAMD	Traditional and Alternative Medicine Directorate
TB	Tuberculosis
TBA	Traditional Birth Attendants
TM	Traditional Medicines
TMPC	Traditional Medicine Practice Council
TQMH	Tetteh Quarshie Memorial Hospital
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

Contents

GLOSSARY OF TERMS

Affirmative Action Policy: These are measures to promote gender equality and enhance women's representation in decision-making positions.

Gender Inequality: The imbalance in power, resources, and options that disadvantages women, girls, men, and boys.

Gender Mainstreaming: The process of assessing the implications for women, girls, men, and boys of any planned action, including legislation, policies, or programmes, in all areas, and at all levels. It is a strategy for making women's, girls' as well as men's, and boy's concerns and experiences an integral dimension of the design, implementation, monitoring, and evaluation of policies and programmes to promote gender equality.

Gender Responsiveness: Intentionally taking gender inequality considerations to affect the design, implementation, and results of programmes and policies.

Gender-based violence (GBV): An umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between females and males. The nature and extent of specific types of GBV vary across cultures, countries, and regions. Examples include sexual violence/sexual exploitation or abuse and, domestic violence, trafficking, harmful traditional practices such as female genital mutilation, honour killings, and widow inheritance.

Gender-responsive healthcare: Healthcare that is responsive to the knowledge and understanding of the differences, inequalities, and varying needs of women and men and girls and boys. Everyone has the right to access effective care that is responsive to their differing needs.

Reproductive rights: Reproductive rights include the rights of all individuals and couples to decide freely and responsibly the number, spacing, and timing of their children, and to have the information and means to do so. These are essential for all people, married and unmarried, including adolescents and youth.

Differential Needs: Differential needs refer to the recognition that women, men, girls and boys have distinct needs, experiences and challenges due to their different social roles, responsibilities and access to resources. These differences often arise from societal norms, cultural practices and economic conditions that affect the health and lives of individuals based on their gender.

CHAPTER 1

INTRODUCTION

1.1 BACKGROUND

Gender equality is a critical pillar of the global 2030 Sustainable Development Agenda. The central place of gender equality within the Sustainable Development Goals (SDGs) reflects the growing political commitment of governments to address gender inequality. In 2021, the global community through the Generation Equality Forum, reaffirmed its commitment to gender equality and actions to accelerate progress towards achieving the SDGs, as well as the unfinished agenda of the Beijing Platform for Action on women's health, rights, and empowerment.

In Ghana, the 1992 Constitution recognizes that addressing gender inequality is key to national development. Article 17 of the Constitution forbids all forms of discrimination based on gender, and Clause 17(4) permits affirmative action to end discrimination. This has led to the ratification of several international conventions, treaties, and declarations by the Government of Ghana (GoG). Some of these include the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social, and Cultural Rights (ICESCR), the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), and the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa (Maputo Protocol, 2003). These commitments have significantly influenced the development of various tools and legal frameworks to promote gender equality and address gender-based discrimination. These tools and frameworks encompass legislative measures, policies, and programmes aimed at advancing women's rights, enhancing their participation in decision-making processes, and combating gender-based violence.

Recognizing that gender inequality influences population vulnerabilities, risk exposure, health outcomes, and service delivery, the Ministry of Health developed and launched the first National Health Sector Gender Policy (NHSGP) in 2009. This landmark policy identified critical gender inequities affecting health that needed to be addressed.

The Ministry of Health and its key stakeholders in 2023 evaluated the NHSGP after over a decade of providing strategic direction, to assess the performance of the policy implementation and identify gaps, challenges and opportunities for improving gender equity within the health sector. The evaluation revealed that a significant proportion of stakeholders, particularly the agencies of the MoH felt that the NHSGP was relevant to their core mandates but poorly disseminated. Other challenges included: the lack of commitment towards the policy, inadequate budgetary allocation, absence of gender focal persons, low technical capacity at the institutional level, and weak stakeholder engagement. These impacted the overall implementation of the policy.

To address the above challenges, some strategies were recommended for the revised National Health Sector Gender Policy. These include awareness and sensitization, capacity building, development of agency integrated implementation plan, and resourcing of the Gender Desk at the MoH to effectively

coordinate the implementation of the revised policy, appointment of gender-focal persons across Agencies, and establishment of a National Steering Committee to support the implementation and tracking of the policy.

1.2 SITUATIONAL ANALYSIS

The situational analysis is based on key gender issues for health in Ghana that were identified during the review process and through a review of other strategic national and global policy frameworks including the National Gender Policy 2015, the National Health Policy (2020), the Universal Health Coverage Roadmap (2020), and the 2022-2025 Health Sector Medium Term Development Plan.

1.2.1 HEALTH PRIORITY AREAS

Historically and as a continued concern, maternal and child health along with communicable diseases dominate health concerns in Ghana, both for the population and for the health systems. This is evident across different age, gender, location, and socio-economic status groups. Maternal and neonatal health conditions remain a challenge, especially in rural areas and among poor women. Children are primarily impacted by communicable diseases, with malaria being prevalent and the burden of care falling mostly on mothers. However, increasingly, non-communicable diseases (NCDs) such as hypertension, cardiovascular diseases, cancers, diabetes, and mental health disorders are growing in prevalence, and their differential impact by gender is not always well understood.

The COVID-19 experience and the recent outbreak of other infectious diseases such as Mpox, and Marburg, and the renewed threat of communicable diseases in the form of pandemics are major disruptions to the health systems. For instance, access to maternal care and family planning services can be negatively impacted. Men's risk of disease, health seeking behaviour and attitude toward health solutions such as vaccines, for example, is also impacted by crises and pandemics.

There is a need to ensure that the health system is gender-responsive in dealing with current, emerging, and re-emerging diseases if the range of gender inequality considerations in health are to be addressed. The following section provides information related to the health context and key gender-relevant factors are outlined where appropriate.

1.2.1.1 Maternal, Neonatal, Infant, and Child Health

Ghana has made significant strides in maternal and child healthcare services over the past decades by developing and implementing several high-level policy initiatives. However, with a fertility rate of 3.9 in 2022 (GDHS, 2022), women in Ghana have a significant need for high-quality maternal, neonatal, infant, and child health services. There have been modest gains in the mortality rates and ratios over the years. At 310 per 100,000 women, the maternal mortality ratio in the country remains considerably higher than desirable. Similarly, stunting among children under 5 at 17.5% in 2022 remained unchanged since 2017. There has been progress, however, with the under-5 mortality rate declining from 56 in 2017 to 40 in 2022, and the neonatal mortality rate declining from 27 to 17 during the same period. Similarly, institutional deliveries of births/skilled providers have increased from 78% in 2017 to 85.4% in 2022, and the percentage of women who had four or more antenatal care (ANC) visits decreased from 89.3% in 2017 to 88% in 2022 (https://data.gffportal.org/country/ghana; GDHS, 2022).

At the same time, women who are poor, less educated, younger, or living in rural areas continue to have poorer maternal health outcomes as they are less likely to have their babies survive. Only 51% of women in the poorest quintile had assistance from a skilled provider during delivery, whereas 98% of the richest quintile women delivered with a skilled provider (https://data.gffportal.org/country/ghana; GDHS, 2022). Similarly, children in rural areas, those from lower-income or less educated families are less likely to be fully vaccinated compared to their counterparts (GDHS, 2022). For example, by 2020, while 92% of children in the richest quintile had the measles vaccine, this was the case for 86% of the children in the poorest quintile (https://www.countdown2030.org/wp-content/uploads/2020/09/Ghana-MICS-2017.pdf).

1.2.1.2 Nutrition and Food Security

Food insecurity can result in diminished nutritional quality of food eaten by both adults and children in households leading to malnutrition. The rate of exclusive breastfeeding for under 6 months declined from 63% in 2008 to 53% in 2022 (GDHS-2022). For exclusive breastfeeding, rural mothers practice exclusive breastfeeding more than urban - 55.5% for rural and urban - 48.9%.

Young boys (aged 6-59 months) face higher rates of anaemia, stunting, wasting, and underweight conditions compared to girls. In 2022, 51.7% of boys aged 6-59 months had anaemia, while 46.2% of girls in the same age group were affected. Additionally, boys under 5 showed higher percentages of stunting, underweight, and wasting compared to girls of the same age. Pregnant women are more prone to anaemia than non-pregnant women (51% vs. 40%), emphasizing the necessity for iron supplementation during pregnancy.

1.2.1.3 Reproductive Health and Family Planning

High fertility rates are a major cause of high maternal and child mortality and can create a range of health and economic burdens for women and girls while closing doors to many opportunities. In Ghana, the fertility rate has remained significantly unchanged since 2008 when it was 4.0, and the DHS 2022 shows it at 3.9. If women were to continue to have children at the current rate, even urban women would have 3.2 children during their lifetime whereas rural women would have 4.8 children during their lifetime. Access to contraception is an important right for women, increasing their life options while also protecting their health from maternal death and morbidity. It is a key strategic lever for development because it empowers women, improves investments in children, and ultimately contributes to poverty reduction. However, there continues to be a significant unmet need for family planning in Ghana, with only 28% of women using modern methods in 2022 compared to 23% in 2018 (Ghana DHS 2022). Traditional method use during this period increased from 5% to 9%. Injectables and implants are the top family planning methods used by women in Ghana, followed by the oral pill, with these three methods accounting for

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70% of modern contraceptive use among women (GDHS, 2022).

Teenage pregnancy continues to be a problem with 15.2% percent of 15–19-year-old girls reporting having ever been pregnant. 31% of girls this age also have the highest unmet need for family planning than of any age group. Two out of three unmarried sexually active girls and more than half of married adolescent girls report that they want to stop or delay childbearing but are not using any method of contraception.

Girls in the poorest wealth quintile are five times more likely to give birth before the age of 20 than those in the richest (UNICEF, 2022). Most adolescents (72%) do not use condoms during intercourse, with boys reporting condom use more often than girls (UNICEF, 2022). Most people obtain contraception from privately owned pharmacies, suggesting the important need for private-sector collaboration in promoting reproductive health among women, men, and especially adolescents.

Young women in particular face difficulties accessing safe abortion and post-abortion care. Among 1039 Ghanaian women aged 15-24 surveyed in 2018, over half who had an abortion went to informal providers. Of those who had an abortion, about a third experienced complications, and 40% of those who experienced complications did not receive treatment (Keogh et al., 2021).

1.2.1.4 Communicable Diseases

There are national-level programmes that seek to reduce or eliminate Malaria, AIDS/STI, Tuberculosis, and other tropical diseases. Ghana continues to have a high burden of communicable diseases, including HIV, TB, malaria, and hepatitis B despite the significant contribution of health sector players including Civil Society Organizations (CSOs). In 2020, an estimated two-thirds of new HIV infections were among women and girls. The prevalence is even more alarming among young women aged 15-24, accounting for four-fifths of new HIV infections in this group (Ghana AIDS Commission, 2020). Condom use remains low because women and girls often have limited negotiation power in sexual relationships. Knowledge gaps are evident among adolescents aged 15-19, with less educated girls particularly unlikely to access relevant information on HIV prevention. On the other hand, HIV testing rates are lower among men (GDHS, 2022), posing challenges in identifying and addressing the overall prevalence of the virus in the population. As of 2020, one in five new HIV infections is among children through mother-to-child transmission (Ghana AIDS Commission, 2020).

Malaria remains a leading cause of morbidity and mortality, particularly among pregnant women and children under five, accounting for 20% of all outpatient visits and 22% of all hospital admissions in Ghana (Ministry of Health/Ghana Health Service 2023). Overall, women have a higher burden of malaria than men due to gender norms and roles. The poor are also disproportionately impacted by malaria, as they are often unable to afford preventive measures and treatment.

Hepatitis B prevalence remains high in Ghana, with estimated prevalence rates ranging from 12.3% to 14.4% (Efua et al. 2023). Evidence suggests that hepatitis B infections could be 2-4 times higher among healthcare workers compared to the general population (Efua et al. 2023). Gains have been made in screening for hepatitis B among pregnant women. Recent data show that the percentage of pregnant women screened for hepatitis B surface antigen by the time of delivery rose from 87.2% in 2017 to 94.3% in 2020 (Nartey et al 2020). Currently, patients are paying out-of-pocket for antiviral treatment for Hepatitis B, which poses a financial barrier to such treatment, especially for women who have more limited finances.

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TB remains a major public health problem in Ghana despite progress made in combating the disease over the years. The incidence of TB was 136 cases per 100,000 in 2021. The mortality rate of TB cases (all forms, excluding HIV co-infection) has declined slightly since 2016, going from 37 to 36 per 100,000 population in 2022 (WHO, 2023). Gender norms and roles, including types of male employment and higher mobility among men, are seen as contributing to a higher incidence of TB among men than women. In 2022, the total number of new and relapse cases was 16, 510, 67% of which were among men ≥15 years (WHO, 2024).

1.2.1.5 Non-Communicable Diseases

As life expectancy has increased, so have NCD risk factors such as tobacco use, harmful alcohol use, physical inactivity, and unhealthy diets (Boakye et al. 2023). In Ghana, 45% of all deaths are now due to non-communicable diseases (NCDs), but the capacity to address NCDs in primary healthcare remains limited though efforts are being made (WHO, 2022, WHO 2023). Cardiovascular diseases and diabetes contribute the largest NCD burden). In response to these challenges, Ghana in 2022 developed and launched a national policy on non-communicable diseases, the National Alcohol Policy, and others to accelerate progress towards prevention and control of NCDs.

Recent data show that overall, the odds of developing an NCD are higher in women than men (Boakye et al. 2023), in large part due to higher rates of hypertension (male 16%; female 28%) and obesity (male 30%; female 42%) among women. A critical area of concern is pregnancy-induced non-communicable diseases which put women at higher risk of developing or exacerbating pre-existing risks of gestational diabetes mellitus (GDM), gestational hypertension and preeclampsia, postpartum depression, and other mental health disorders. At the same time, the mortality rate across four major NCDs (cardiovascular disease, chronic respiratory disease, cancer, and diabetes) in 2021 was higher in males at 750 per 100,000, compared to 563 per 100,000 in females (WHO 2023).

1.2.1.6 Mental Health and Suicide

Following the Mental Health Act 2012, the MoH has demonstrated support for decentralisation and service integration in mental health care. However, adequate diagnosis and care provision remains a major challenge given the range of services that the primary health care system needs to provide, and especially the limited number of trained providers on mental health. Despite the NHIS benefit package funding procurement of some psychotropic medications, availability and out-of-pocket expenses also continue to pose challenges. It is estimated that 10% of Ghanaians have common mental health conditions, while 1–3% have severe mental health conditions such as schizophrenia, but only 2% of such persons will receive treatment (Ayuurebobi Ae-Ngibise et al. 2023).

Traditional gender norms, societal stigma, and limited access to gender-sensitive mental health services contribute to gender disparities. Men face challenges expressing vulnerability due to societal expectations, while gender-based violence is a major factor contributing to mental health issues among women.

Ghana has made progress in reducing suicide rates. Until March 2023, suicide was criminalized in Ghana and those who attempted it were prosecuted. In 2021, suicide ranked as the fourth-leading cause for those aged 15–29 years in both sexes, but male rates of reported suicide are higher with increasing age than for women (Adoboi et al 2024).

1.2.1.7 Gender-Based Violence

Gender-based violence, including rape, child sexual abuse, sexual harassment, domestic violence, and female genital mutilation have psychosocial effects. Several institutions support the elimination of and protection of victims of gender-based violence including the Domestic Violence Secretariat and Department of Social Welfare (both of the MOGCSP), the Domestic Violence and Victim Support Unit (DOVVSU) of the Ghana Police, and Gender-based Violence Courts. Also, the Commission on Human Rights and Administrative Justice (CHRAJ) safeguards human rights and investigates human rights abuses. Recent data from the Ghana DHS, 2022 revealed that 36% of reproductive-age women reported having experienced at least one form of domestic violence. There are surprisingly few differences by economic status, with 33% of the poorest women and 32% of the wealthiest having experienced intimate partner violence in the last 12 months preceding a 2016 study on national prevalence rates by the Ghana Statistical Service (Ghana Statistical Service, 2016). Similarly, differences by age and rural-urban residence are small, with urban women and older women more likely to have experienced intimate partner violence in the last 12 months preceding the above study.

Gender-based violence negatively impacts women's health and that of their children in multiple ways. For example, one study shows that Ghanaian women who had suffered abuse were 40% more likely to report being ill in the previous month than those who had not. (Alvarado et al 2018). Another study found a high prevalence of domestic violence during pregnancy, especially concerning emotional abuse, with the risk being highest among women who were younger, pregnant for the first time, and had partners who consumed alcohol. The abuse was then associated with poorer delivery experience, including late booking, gestational hypertension, cephalopelvic disproportion, and fetal distress (Thompson et al 2023).

Intimate partner violence is a significant threat to HIV prevention efforts as women and girls facing abuse within relationships may be coerced into unprotected sex, significantly increasing their risk of contracting HIV. The prevalence of sexual violence among women living with HIV in certain regions of Ghana is alarmingly high, with 61% experiencing physical violence, 80% experiencing

emotional violence, and 51% experiencing sexual violence. These rates suggest the need to screen for gender-based violence during HIV testing and treatment and emphasize the need for comprehensive support systems (Tenkorang et al., 2023).

1.2.2 GENDER RESPONSIVENESS OF HEALTH SYSTEMS

There are multiple components to the health system, including service delivery, human resources for health, health financing, governance, medicine and supplies, and data and information systems. The Ghanaian context within each component is discussed below.

1.2.2.1 Health Financing

Gender equitable health financing considers that the type of health systems and services for which health sector investments are prioritized serve the potentially disproportionate needs of women, men, adolescents, and children. For example, women bear the exclusive burden of maternal health, and the disproportionate burden of reproductive health and HIV/AIDS should be considered in assessing whether these areas are especially poorly financed. Gender equitable health financing also considers making equitable investments in both male and female personnel, as well as in infrastructure, innovations, medicine, and technology that do not disadvantage women and keep their needs in mind.

Other important gender equitable financing considerations in the health sector are insurance access and utilization, as well as the burden of out-of-pocket payments or forgone care on women and men. In Ghana, the National Health Insurance Scheme (NHIS) has been successful in increasing its active membership to 17.2 million, representing 54.5% of the population. NHIS data show that active membership is more heavily female (59%) than male (41%) with this ratio consistent over the last five years (2018-2022). It is not clear if this gender disparity is because women find the benefits package more useful for their own and their children's health needs which are generally higher than for men. It is yet to be investigated if men find the package less relevant to them or gender norms prevent them from considering the need for health insurance, or if they are seeking higher-quality private health insurance.

There are surprisingly few differences by economic status, with **33% of the poorest women** and **32% of the wealthiest having experienced intimate partner violence** in the last 12 months preceding a 2016 study on **national prevalence rates by the Ghana Statistical Service** (Ghana Statistical Service, 2016).

There is considerable evidence that health insurance beneficiaries are not immune from unofficial co-payments or are geared to higher-cost services. Studies show, for example, that anywhere from 41% to 71% of Ghanaian women pay out of pocket for health services, drugs, and, in particular, childbirth (Ekholuenetale et al., 2024; Dalaba et al., 2022).

1.2.2.2 Human Resources For Health

Ghana has many of the well-known gender disparities in its health workforce common to many countries. The country has considerably increased the production of its health workforce resulting in an increased density of physicians, nurses, and midwives from 1.07 per 1000 population in 2005 to 2.65 per 1000 population in 2017 (Asamani 2021). Available data shows that there is a higher concentration of men at the top of the health profession compared to women. In 2022, there were 62,643 professional nurses and community health workers (mostly female) on the government payroll system, compared to 5,350 medical doctors (mostly male). Overall, it is estimated that 67% of Ghanaian health workers are women, while 33% are men (2023 MoH Holistic Assessment Report).

Despite the crucial role that women play in delivering health services, they are underrepresented in health sector leadership

at the district, regional, and national levels. There are different gender challenges for men and women, which should be considered in the deployment of health workers particularly to remote or rural locations where the need for trained providers is the greatest. Women workers often have more safety, domestic, and child or spouse-related concerns than male workers. Women healthcare workers are also particularly vulnerable to verbal abuse, sexual harassment and assault, and physical attacks from patients and community members. Moreover, the menace of sexual harassment and bullying from superiors and co-workers is also a concern.

1.2.2.3 Health System Governance

Gender-equitable health system governance involves considering how male and female workers, supervisors, and administrators are recruited, trained, motivated, paid, promoted, and supported. It considers what roles and decision-making they have in the public and private sectors. It also considers how policies and regulations in the health sector will impact male and female clients and their equal right to quality care. For example, certain types of accreditation or empanelment of facilities or providers works may especially expose women with less money, decision-making, and transportation to fraudulent or untrained providers for critical services or compel them into unnecessary treatments such as cesarean sections.

Decision-making and leadership are also part of health system governance. Like many health systems around the world, gender disparities exist in the leadership of the Ghana health system. Evidence from the Ghana health sector suggests that women form a fraction of the people occupying top leadership positions. Across the agencies under the Ministry of Health, women constitute an average of 25% of senior leadership. This suggests that the representation of women in positions of leadership and decision-making in the Ghana health sector is limited.

1.2.2.4 Health Information Systems

Healthcare data is collected and managed across multiple systems and sectors all of which need to be more deliberately considered on how best to collect, report, process, and use data concerning gender equality in healthcare and health systems. Gender data are not limited to sex-disaggregated data, but also include female and male-specific data, on health issues and areas where women's and girls' as well as men's and boys' needs and choices are particularly at stake. For example, concerning quality of care, entitlements, or costs on maternal and reproductive health. Gender data also include data on health systems for example on gender-equitable human resources or gender-responsive infrastructure (for example, female washrooms and privacy).

Most of the main data collection and reporting systems in the Ghana health system currently collect at least some, even if limited data on useful gender indicators. Many of them stay within the system and are not reported or used. Systems that can better report and utilize existing gender indicators include the District Health Information Management System-2 (DHIMS-2; the Human Resource Information System (HRIS), the Logistics Management System (LMIS), and the National Health Insurance Information Systems (NHIA). Certainly, these systems present considerable potential for further improving their collection, reporting, and use of better gender indicators and analysis. (Health Information System Strategic Plan 2022-25). Additionally, as the Ministry of Health and its Service Delivery Agencies are rolling out the Lightwave Information Management System (LHIMS) for the electronic management of patient medical records, laboratory services, patient engagement, and other services, there is huge potential for generating and using high-quality gender data in areas such as patient-client interaction and quality of care.

1.2.2.5 Service Delivery

Improved quality of service readiness and delivery, especially in primary health care, is already a high priority for the MoH. This effort could readily address the gender dimension of service improvement by considering how the gender-specific needs, preferences, and rights of both women and men, girls and boys can be best addressed.

For example, meeting women's maternal and reproductive health care needs would mean addressing gaps in the availability of emergency obstetric and newborn care. In 2022, 17% of district hospitals and 49% of other general

hospitals did not offer all 7 basic emergency obstetric and newborn care (BEMONC) signal functions (MoH et al, 2023). Similarly, given the challenge women in particular face with distances and transportation, the lack of emergency transport systems for obstetric care is a significant constraint to saving women's lives. Only 32% of health facilities in Ghana have access to an emergency transport system, with primary-level facilities having the least access.

In addition to the availability of maternal health services, gender-sensitive and respectful maternity care is also crucial. In a WHO-led study in Ghana, researchers conducting observations at health facilities found that 32% of women experienced physical abuse, verbal abuse, or stigma or discrimination during childbirth (Bohren et al., 2019). Very few health facilities (12%) currently offer services for survivors of rape, sexual or intimate partner violence.

Generally, there is poor health-seeking behaviour among men and boys attributable to gender norms and roles. Sexual reproductive health rights (SRHR) interventions often overlook men and boys further exacerbating the gender gap in the responsibility for sexual and reproductive health for this population (BMJ Global Health, 2020).

Few health facilities offer services for common cancers among men, women, girls, and boys. In 2022, only 15%, 7%, and 5% of health facilities offered any services, including screening, for breast, cervical, and prostate cancers, respectively (Ministry of Health et al, 2023).

1.2.2.6 Medical Products and Supplies

The availability of medical products and supplies that both women and men need and prefer for their health care needs is also a matter of gender equality in health care. For women's health, life-saving maternal health supplies (oxytocin injection, misoprostol tablets, and magnesium sulphate injection) must be available during delivery which is currently the case at only 58% of health facilities.

Similarly, the availability of multiple methods of contraception is critical for women and men to exercise their reproductive rights and choices. Among health facilities that provided family planning services, 79%, 69% and 32% had implants, oral contraceptives, and intrauterine devices, respectively. Stock-outs for emergency contraception were high, with 84% of health facilities reporting a stock-out for emergency contraception over the past three months, compared to 28% for implants (Ministry of Health et al, 2023).

1.2.2.7 Access to Health Services

Access to health services remains a barrier for many groups within Ghana, especially for the poor, physically challenged, women and girls who face a range of distance, transportation, cost, information, and administrative barriers to accessing care. For example, the state of the road network between the home and health facilities is a key determinant of equitable geographical access to health services.

Using geographical access to maternal health services as a proxy, Gething et al. (2012) estimated that the distance time for about half of Ghanaian women to the nearest health facilities offering comprehensive obstetric care is two or more hours. Moreover, the findings of a study by Dotse-Gborgbortsi et al. (2022) on geographic analysis of reported and modeled proximity to maternal health services in Ghana have suggested that women reporting distance challenges in accessing healthcare had significantly longer travel times to the nearest health facility.

Poverty was also noted to significantly increase the odds of reporting challenges with distance. In contrast, living in urban areas and being registered with health insurance reduced the odds of reporting distance challenges. Women with a skilled attendant at birth, four or more skilled antenatal appointments, and timely skilled postnatal care had shorter travel times to the nearest health facility.

1.2.2.8 Traditional and Alternative Medicine

In Ghana, about 80% of the population uses some form of Traditional and Alternative Medicine (TAM). Mainstreaming traditional and alternative medicine as complementary to orthodox medicine is currently ongoing. The Integration Policy which started in 2011 has presently Herbal Medicine Units in 60 selected government hospitals, superintended by

Medical Herbalists. These primary Healthcare Practitioners are trained by the Kwame Nkrumah University of Science and Technology (KNUST), Tetteh Quarshie Memorial Hospital (TQMH), and the Centre for Plants Medicine Research (CPMR). The Centre for Plant Medicine Research (CPMR) leads innovative research in herbal products. The regulation and oversight of traditional medicine practitioners fall under the purview of the Directorate of Traditional Medicine (TAMD) at the Ministry of Health and the Traditional Medicine Practice Council (TMPC), which ensures that policies and standards are upheld within the sector.

Research has shown that there are gender differences in the use of traditional and Alternative medicine (TAM) in Ghana. For instance, studies have shown that women are more likely to use traditional and alternative medicines than men. TAM among women is also linked to their roles in managing household health and their greater involvement in community health practices (Gyasi et al. 2017). These studies suggest a gendered pattern in health-seeking behaviour, highlighting the importance of considering gender when designing and implementing health policies and programmes related to traditional and alternative medicines and underscoring the need for targeted policies to address diverse healthcare needs.

1.2.3 LEADERSHIP, COLLABORATION, AND COORDINATION FOR GENDER MAINSTREAMING IN HEALTH

Gender mainstreaming in the health sector involves considering the relevance of gender inequalities in designing and implementing health programmes, policies, and projects. The aim is to address the differential needs, priorities, and realities of women, men, girls, and boys, and especially mitigate the disadvantage women and girls face due to gender inequality. The starting point for leadership and collaboration for gender mainstreaming in health begins with the different agencies and departments in the health sector. The health sector leaders must recognize that addressing gender inequalities is essential for the sector to fulfill its mandate and achieve success in improving health outcomes. Rather than everyone trying to do everything on gender all the time, each agency and department needs to carve out its specific role, contribution, and accountability while at the same time recognizing connection and dependencies with other agencies and departments.

Coordination and collaboration are also important across other healthcare actors such as the private sector, donors, and civil society organizations who can help foster both technical support and innovation on gender mainstreaming while also sharing the burden of responsibility in moving forward priority initiatives.

Collaboration with other sectors such as transportation, education, or social protection is also critical for addressing some of the gender barriers related to service access, quality healthcare professionals, or reducing financial barriers that women and girls in particular face.

1.2.4 SOCIO-ECONOMIC AND CULTURAL BARRIERS THAT UNDERLIE GENDER INEQUALITIES IN HEALTH

Despite supportive legal and policy frameworks, such as the Constitution, Criminal and Other Offences Act (1960), Children's Act (1998), and the National Gender Policy (2023), gender inequalities in Ghana persist due to economic and social barriers amongst others. There are deep-rooted cultural and gender norms, patriarchal power structures, socialisation processes, and socioeconomic factors that work together to perpetuate gender inequities in the healthcare system. Unequal power dynamics limit women's autonomy and control over their health, while the patriarchal structure of Ghanaian society reinforces the notion that men should have authority and control over women, including in matters of health.

The health sector cannot substantially change the underlying socio-economic and cultural barriers that underlie gender inequalities in health, but it can consider them in designing services, hiring and training providers, developing cost structure and payment options, improving insurance systems, locating facilities, and deploying transport options. For example, recognising that women have less control over money compared to men should mean that cost and payment options are designed with

affordability for women in mind. Similarly, recognising that men are frequently the decision-makers, and women have less access to information means undertaking health awareness campaigns to target both in different ways.

Recognising that early marriage and pregnancy among adolescent girls are prevalent in rural areas means paying special attention to reproductive and maternal services for this age group. Also identifying that masculine norms lead men to avoid seeking lower-level care which results in higher costs and over-burdened secondary and tertiary facilities means undertaking campaigns to make preventive care especially attractive for men. Recognizing women's childcare responsibilities means that they are more likely to seek health care for children, but face travel challenges and time constraints means potentially considering mobile services for women and children's health.

1.2.5 SUSTAINABLE HEALTH FINANCING FOR GENDER MAINSTREAMING

National and sub-national health budgets should play a crucial role in translating government commitments into practical policies and programmes that benefit women, girls, men, and boys. However, there is usually limited budget allocation for gender mainstreaming activities from the national and sub-national budgets. Resourcing these budgets should consider the various sources of revenue for the Ghana health sector, including government allocation, health insurance, Internally Generated Fund (IGF), and donor support (bilateral and multilateral). As the Ghana health sector is increasingly reliant on domestic resources rather than donor assistance for financing health sector expenditures, it will be especially important to align gender equality considerations in planning and spending domestic funds.

One key approach for ensuring sustainable financing for gender mainstreaming in health is gender-responsive budgeting. The approach involves analysis of the differential impacts of public expenditure and revenue policy on women and girls, and men and boys. This approach strives for a fair distribution of resources for everyone.

1.3 SCOPE OF THE POLICY

This policy seeks to ensure gender equality in health for women, men, girls, and boys throughout their lives. It shall guide the health sector and other relevant stakeholders in programme design and implementation.

1.4 POLICY REVIEW PROCESS

The Policy was reviewed under the stewardship of the Minister for Health. The review process was under the chairmanship of the Chief Director of the Ministry of Health. The day-to-day work was done by a consultant with the support of a Technical Working Group led by the Director of PPMED, MoH.

An evidence-based participatory process was used to develop the National Health Sector Gender Policy. Important gender issues for health in Ghana were identified through a review of relevant national policies and strategies, including the National Gender Policy (2023), the National Health Policy (2020), the Universal Health Coverage Roadmap (2020), and the 2022-2025 Health Sector Medium Term Development Plan.

The process started with an evaluation of the 2009 NHSGP using a structured questionnaire (RE-AIM) conceptual model. This was administered to all MoH agencies and some selected development partners. The assessment was complemented by a rapid literature review. The revised draft National Health Sector Gender Policy was subjected to stakeholder consultations and validation after which feedback was incorporated into the document by the task team. The final document was submitted to the Honourable Minister of Health for approval.

CHAPTER 2

POLICY CONTEXT AND FRAMEWORK

INTRODUCTION

The revised National Health Sector Gender Policy Framework acknowledges several global, regional, and national compacts and frameworks that seek to support the health sector's vision of ensuring a healthy population for national development.

2.1 GLOBAL CONTEXT

S/N	DOCUMENT	CONTENT
GLOBAL		
1.	**Sustainable Development Goals (SDGs)**	**Goal 3:** Ensure healthy lives and promote well-being for all at all ages to achieve universal health coverage, provide safe and effective vaccines to all, and undertake supporting research. **Goal 5:** This specifically addresses gender equality and aims to achieve gender equality and empower all women and girls. This includes targets such as ending all forms of discrimination, eliminating violence against women and girls, ensuring equal participation and opportunities, and more.
2.	**The United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)**	This was adopted in 1979 by the United Nations General Assembly. It defines what constitutes discrimination against women and sets up an agenda for national action to end such discrimination.
3.	**The Beijing Declaration and Platform for Action**	This was adopted at the UN's 4th World Conference on Women and it seeks to advance women's rights covering 12 critical areas of concern, including women and poverty, education, health, violence against women, and more.
4.	**UN Security Council Resolution 1325 on Women, Peace, and Security adopted in 2000**	This Resolution calls for the inclusion of women in all aspects of peace and security efforts and recognises the disproportionate impact of conflict on women and girls.
5.	**WHO Gender in Health and Development Policy (2007) Endorsed at the 60th WHA**	This calls for the mainstreaming of gender throughout WHO to better support Member States in achieving goals of gender equality and health equity.

S/N	DOCUMENT	CONTENT
6.	**UNICEF's Gender Action Plan**	This specifies how the global Strategic Plan (2022-2025) will advance gender equality, from before birth through adolescence. It also includes plans and targets related to maternal health and nutrition including HIV AIDs testing, prevention counseling, and care.
7.	**2018 Astana Kazakhstan Declarations**	This declaration by Heads of State and Governments, Ministers, and representatives of countries at the Global Conference on Primary Health Care seeks to promote people-centered, gender-sensitive approaches in all national policies and strategies.
8.	**Guidelines for Gender Mainstreaming in Occupational Safety and Health**	This seeks to integrate gender issues into the analyses, formulation, and monitoring of policies, programmes, and preventive measures to reduce inequalities between men, women in occupational safety and health.
AFRICA REGION		
9.	**AU Agenda 2063: The Africa We Want**	Africa's blueprint and master plan for transforming Africa into the global powerhouse of the future. It is the continent's strategic framework that aims to deliver on its goal for inclusive and sustainable development. (Where no child, woman or man is left behind or excluded based on gender).
10.	**The African Health Strategy (2016-2030)**	The strategy adopts and promotes a paradigm shift in addressing public health threats from natural and man-made disasters including building national, regional, and continental capacity to address disasters.
11.	**The Africa Health Transformation Agenda (2015–2020)**	It provides a vision for universal health coverage and is the strategic framework that will guide WHO's contribution to the emerging sustainable development platform in Africa.

2.2 NATIONAL POLICY CONTEXT

This Policy derives inspiration from ***Articles: 17 (1) and (2)*** of the 1992 Constitution. More specifically, the provisions place responsibility on duty bearers to ensure gender equality and freedoms of women and men, girls, and boys, from discrimination in all its forms. **Chapter 5 of the Constitution** expressly guarantees several fundamental human rights, spanning from ownership of property, property rights of spouses, economic and education rights including affirmative action for women's rights and empowerment. The right to health is also derived from ***Chapter 6 of The Directive Principles of State Policy*** which outlines the economic, social, cultural, and development rights, and the duty of government to reduce inequalities in development and foster societal well-being.

Other national documents and frameworks included the following:

- The National Development Perspective Framework (2024-2057)
- The Coordinated Programme of Economic and Social Development Policies (2017-2024).
- National Gender Policy 2015 (Revised in 2024)
- Consolidated Institutional Gender Action Plans for the Public Services Commission and Selected Entities (2023)
- National Health Policy 2020 (NHP, 2020)
- Health Sector Medium Term Development Plan (HSMTDP-2022-2025)
- Universal Health Coverage Roadmap for Ghana (2020-2030)
- Free Maternal Healthcare Policy under the 2008 NHIS Policy
- Free Antenatal Care Policy under the 2008 NHIS Policy

- The Labour Act, 2003 (Act 651)
- The Intestate Succession Law, 1985 (PNDC Law 111)
- Domestic Violence Act, 2007 (Act 732)
- Human Trafficking Act, 2006 (Act 697)
- National Social Protection Policy (2015)
- l Persons with Disability Act,2006 (Act 715)
- Ageing Policy (2010)
- National Nutrition Policy (2013-2017)
- Mental Health Act, 2012 (Act 846)
- National HIV and AIDS Policy (2019)
- Specialist Health Training and Plant Medicine Act, 2011 (Act 833)
- Policy Guidelines on Traditional Medicine Development (2005) and
- Affirmative Action (Gender Equity) Act, 2024

2.3 VISION AND GOAL

2.3.1 VISION

A healthy population for national development.

2.3.2 GOAL

The Policy seeks to address gender inequalities in health to promote, restore, and maintain good health for women, men, girls, and boys living in Ghana. The policy will help to position the MoH to develop and implement gender-responsive policies, strategies, and programmes through the prioritisation of gender issues in planning, budgeting, implementation, monitoring, and evaluation.

2.4 CORE VALUES AND GUIDING PRINCIPLES

The following core values and principles will guide the implementation of this policy:

- **Timeliness:** The Policy places a premium on prompt response to all types of gender-sensitive healthcare services across the health sector.
- **Client-centeredness:** The Policy will respond to the unique requirements of identified groups such as specialized populations and the vulnerable particularly children, adolescents, women, men and the aged as well as mental health issues.
- **Inclusiveness:** The Policy aims to ensure that all individuals regardless of gender have equal access to healthcare services and resources. It recognizes the unique needs and challenges faced by women, men, girls and boys, and strives to address these disparities through targeted interventions without discrimination.
- **Citizen's involvement and accountability:** Healthcare managers and policymakers are required to involve the citizenry in the planning and execution of interventions that improve their health status and receive feedback from healthcare workers.
- **Equity:** The Policy will ensure that the plans, interventions, and health-related resources required to meet the needs of the population will be prioritized where necessary. There is a fair distribution of health facilities, and no person will be unfairly discriminated against in terms of access to services.
- **Partnerships and collaboration:** The Policy seeks to build sustainable partnerships and harmonized agendas among government institutions (MDAs), private sector players, and all other relevant stakeholders including development partners to scale up health service delivery for long-term gender mainstreaming.
- **Quality:** Healthcare services delivered are of a high standard, effective, safe, prompt, centered on the patient's needs, and given in a timely fashion.
- **Evidence-Based Decision:** The Policy will focus on the collection, analysis, dissemination, and utilization of data to enhance policy development and promote evidence-based decision-making for designing effective interventions in gender.

CHAPTER 3

POLICY OBJECTIVES AND STRATEGIES

POLICY OBJECTIVES

To achieve the goal of the National Health Sector Gender Policy to promote, restore and maintain good health for all people living in Ghana, the MoH will pursue the following policy objectives which are intended to address health-related gender issues in an integrated approach for improved healthcare outcomes: The four objectives are:

1. **To improve gender responsiveness of health systems for enhanced quality of care.**
2. **To strengthen leadership, coordination, and collaboration for gender mainstreaming in health.**
3. **To address socio-economic and cultural barriers that underlie gender inequalities in health.**
4. **To ensure sustainable financing for gender mainstreaming in health.**

3.1 OBJECTIVE 1: TO IMPROVE GENDER RESPONSIVENESS IN THE HEALTH SYSTEM FOR ENHANCED QUALITY OF CARE

To improve gender responsiveness in the health system, gender must be mainstreamed across the different health system components, including service delivery, human resources for health, health financing, governance, medicine and supplies, and data and information systems. The following policy actions will be undertaken to improve gender responsiveness of the health system in Ghana.

Strategies

1. Improve service readiness and delivery to be responsive to women's and girls' as well as men's and boy's needs, choices, and decision-making, keeping in mind the specific disadvantage women and girls face due to gender inequality.
2. Provide timely and appropriate gender-responsive healthcare interventions across health programme areas.
3. Address gender disparities in the health workforce, paying special attention to the disadvantages and challenges faced by female health workers.
4. Strengthen the existing governance structure and supervision systems to prioritize gender-related health issues.
5. Empower women to take up decision-making and leadership roles in the health sector.
6. Develop a review system for medicine and supply procurement with women's and men's differential needs in mind.
7. Increase female and male NHIS enrollment and utilization rates and improve the benefits package to meet the health needs of especially women but also men.

8. Improve health sector data and information systems to more effectively generate and use gender-related data for informed decision-making.

3.2 OBJECTIVE 2: TO STRENGTHEN LEADERSHIP, COORDINATION, AND COLLABORATION FOR GENDER MAINSTREAMING IN HEALTH

To effectively mainstream gender in health, effective leadership and collaboration within the health sector agencies and departments is needed as well as across key sectors, and partners including the private sector, donors, and non-governmental organizations. The following policy actions will be undertaken to strengthen leadership and collaboration for gender mainstreaming in health.

Strategies

1. Establish collaborative, coordination, and accountability mechanisms within health sector agencies and departments to address gender-related issues in health.
2. Establish coordination mechanisms with internal and external partners including key sectors, donors, the private sector, and civil society to address gender-related issues in health.

3.3. OBJECTIVE 3: TO ADDRESS SOCIO-ECONOMIC AND CULTURAL BARRIERS THAT UNDERLIE GENDER INEQUALITIES IN HEALTH

To improve health outcomes for women, men, girls, and boys, the socioeconomic and cultural barriers that underlie gender inequalities can be addressed by the health sector through gender-responsive services, systems, and communications. The following policy actions will be undertaken to address socio-economic and cultural barriers that underlie gender inequalities in health.

To effectively mainstream **gender in health, effective leadership and collaboration** within the health sector agencies and departments is needed as well as across key sectors.

Strategies

1. Ensure deliberate consideration of socio-economic and cultural barriers underlying gender inequalities in the design and delivery of health services.
2. Develop health sector outreach and communications specifically tailored to reach women and girls, and men and boys, and to address gender-related biases.
3. Strengthen women's participation at the community level in the design and implementation of health programmes.
4. Ensure community participation towards the reduction of harmful socio-cultural practices that impact the health of women and girls
5. Encourage women to participate in decision-making about their health at the household level.

3.4 OBJECTIVE 4: TO ENSURE SUSTAINABLE FINANCING FOR GENDER MAINSTREAMING IN HEALTH

To mainstream gender into health policies, strategies, and programmes and implement the

policy actions under Objectives 1-3, a two-track financing approach will be required:

1. For each agency and department to ensure that the gender equality priorities within their purview are financed with their regular and special project budgets; and
2. For targeted high-priority gender equality initiatives to be launched with special financing that supports multiple agencies and departments.

The following policy actions will be undertaken to ensure sustainable financing for gender mainstreaming in health.

Strategies

1. Allocate, and spend some core level of MOH dedicated funds for high priority action items in the gender policy that cannot be readily integrated into existing budgets and work plans.
2. Undertake an agency and departmental financial review to assess which current activities can be effectively repurposed and strengthened concerning gender equality with existing resources.
3. Advocate for additional GoG funding for gender mainstreaming in health.
4. Engage development partners for start-up financing for targeted, high priority gender equality initiatives.
5. Assess budgeting for gender action activities against gender responsive budgeting methodology to recommend improvements.

CHAPTER 4

POLICY IMPLEMENTATION ARRANGEMENTS AND PLAN

POLICY IMPLEMENTATION ARRANGEMENTS

The implementation arrangement for this Policy is designed to ensure that there is effective coordination, collaboration, advocacy, and harmonization among all stakeholders during the implementation process. Overarching coordination shall be led by the Ministry of Health with support from agencies, partners, and other key stakeholders. Below are the identified roles and responsibilities of major partners and collaborators:

4.1 MINISTRY OF HEALTH HEADQUARTERS

The Ministry of Health and its relevant agencies including the private sector shall deliver the necessary interventions to ensure the successful implementation of the gender policy. The Ministry of Health shall collaborate with its key implementing stakeholders to prepare an integrated operational plan. This plan shall be informed by the policy goal, objectives, strategies, and outcomes and will support the development of gender programmes and activities based on the mandates, functions, and jurisdiction of the implementing stakeholders. This plan will guide all implementing institutions to avoid duplication during implementation. The operational plan is expected to be both inward and outward-looking.

The Ministry of Health shall:

1. Ensure the overall implementation of this Policy.
2. Disseminate this Policy to relevant stakeholders at all levels.
3. Work with agencies to design and disseminate standard gender tools including implementation guidelines.
4. Provide technical assistance and build capacity to strengthen gender mainstreaming at all levels.
5. Coordinate the activities of Gender Focal Points in all the agencies of the Ministry.
6. Undertake overall performance monitoring and evaluation of the Policy.
7. Ensure the availability of financial, human, and other resources for the effective implementation of the policy.
8. Lead intersectoral collaborations required for the effective implementation of the strategies in the policy and action plan.

4.2 MOH AGENCY IMPLEMENTING INSTITUTIONS

i. Tertiary and Psychiatric Hospitals

These hospitals will be responsible for ensuring sound referral clinical practice, community outreaches, teaching and research that takes into consideration the peculiar needs of men, women, girls and boys.

ii. Regulatory/Statutory Bodies

These regulatory bodies e.g. Nurses and Midwives Council, Medical and Dental Council, Private Hospitals, and Maternity Homes Boards, etc shall be responsible for regulating the health care providers and practice in areas that touch on human rights and medical ethics. They shall also enforce standards and protocols that ensure that the disparities in the provision of health care to men, women, girls, and boys are minimized.

iii. Health Training Institutions

All training institutions including Nursing Training Colleges, and Post-Graduate Training Colleges such as the Ghana Colleges of Physicians and Surgeons, and Nursing and Midwifery shall create an enabling environment for the training of their students taking into consideration gender matters and implement interventions that address gender gaps in the training of the health workforce.

iv. Health Service

This service is the largest executing/ implementing agency operating mostly at the Regional, District, and Sub-district levels and shall be responsible for delivering gender-responsive interventions and services to men, women, girls and boys.

v. National Level

All directorates under the MoH Headquarters, as well as Headquarters of the GHS, CHAG Secretariat, GAQHI and Ahmadiyya Mission shall interpret the policy and provide guidelines to the sub-national levels.

vi. National Ambulance Service

The mandate of the National Ambulance Service is to provide comprehensive pre-hospital emergency medical care to all people living in Ghana. In addition, the Service is required to provide transportation of patients from one health facility to another, during referrals. The National Ambulance Service shall collaborate with other institutions of the state and the private sector to provide emergency medical response services to women, girls, boys, and men.

vii. Civil Society and Faith-Based Organizations

The Ministry of Health will partner with all the relevant civil society organizations that have a stake in health service delivery on issues stated in the policy.

viii. Private Sector

The Ministry of Health will collaborate with all relevant health institutions (i.e. private for-profit, non-profit, quasi-government health-providing institutions) to ensure that they are guided by the tenets of this policy and report on gender disaggregated service delivery data.

ix. Development Partners

The Ministry of Health will collaborate with all development partners to support the achievement of the policy goals and objectives, including but not limited to the provision of technical assistance and financial support for improving gender mainstreaming. Programmes and interventions of development partners should be informed by and directly supportive of the policy objectives and outcomes.

4.3 MINISTRIES, DEPARTMENTS AND AGENCIES

The Ministry of Health will collaborate with other Ministries, Departments, and Agencies whose mandates directly or indirectly lie at the intersection of gender, health, and development and lead the needed intersectoral collaboration for effective implementation of the policy. These

MDAs will be responsible for the implementation of strategies and interventions in their respective institutions that are gender-sensitive and will promote improved health for all.

i. Ministry of Women, Children and Social Protection

As the Ministry with oversight responsibility for women and children affairs, MoH shall collaborate with MOGCSP to promote the following:

- Women's participation and empowerment
- Women's access to credit and productive resources
- Promotion of women's and children's health and rights

ii. Ministry of Education

MoH shall advocate for the review of school curricula to include gender issues as well as work with the Girls' Education Unit of the ministry to intensify girl child education.

iii. Ministry of Food and Agriculture

Household food security and nutrition are essential for ensuring the health of individuals and families. Concerning improving the nutritional status of women and girls, the prime collaborator shall be the Nutrition Unit of the Ministry of Health.

iv. Ministry of Justice and Attorney General and Ministry of Interior

The Ministry of Health shall collaborate with MOJ, Ministry of Interior, and other enforcement agencies (CHRAJ, Police etc) to curb gender-related violence. Specifically, MoH shall work with the Domestic Violence and Victim Support Unit (DOVVSU) to ensure the rights of women, men, girls and boys are protected.

v. Ministry of Local Government, Decentralisation and Rural Development

The ministry will collaborate with the local government structures, to be precise the Regional Coordinating Councils, Metropolitan, Municipal and District Assemblies, Communities – traditional and religious authorities, to promote women's rights including their health and that of their families.

MDAs will be responsible for the implementation of **strategies and interventions** in their respective institutions.

vi. Ministry of Finance

The Ministry of Finance has overall responsibility for resource mobilization and allocation and therefore will be expected to play a key role in ensuring adequate budgetary allocation for the implementation of the policy.

vii. Ministry of Employment and Labour Relations

The Ministry of Employment and Labour Relations (MELR) is the agency responsible for identifying and meeting the needs of vulnerable groups in society and protecting their rights. MoH shall work in collaboration with MELR to coordinate and monitor efforts aimed at reducing gender-related social vulnerability.

viii. National Development Planning Commission (NDPC)

The National Development Planning Commission is responsible for coordinating the national planning process including the Sustainable Development Goals. The MOH will collaborate with the NDPC in the development of various national development frameworks.

ix. Public Services Commission and Office of the Head of the Civil Service

The Public Services Commission and the Office of the Head of the Civil Service (OHCS), which have

overall responsibility for setting guidelines for public sector organizations and the civil service including the MDAs shall ensure that these entities mainstream gender in their operations including assurances of the highest standards of employee health and well-being.

4.4 GENDER FOCAL PERSONS

For the successful implementation of this policy, the Ministry shall work through its sector agencies, The Gender Focal Desk at the MOH under the leadership of the Director, Policy Planning Monitoring and Evaluation Directorate will ensure the smooth implementation of this policy. Additionally, there shall be the appointment of an institutional Gender Focal Persons to support the implementation of the policy and its action plan.

4.5 RESOURCE MOBILISATION

Mobilizing the requisite resources is key to the successful implementation of the policy. These include financial and human resources as well as materials/logistics. It shall be the responsibility of the MoH to mobilize resources from both local entities, the private sector and international organizations to implement the strategies. Financing options will include but not limited to:

1. GoG Budgetary Support
2. Internally Generated Funds
3. Development Partner(s) Support
4. Corporate Bodies
5. Civil Society Organizations
6. Non-Governmental Organizations
7. Public-Private Partnerships (PPP) and
8. Others

4.6 ROLES AND RESPONSIBILITY MATRIX

The following roles and responsibility matrix is indicative of what will be included within the Gender Policy Action Plan. The Gender Policy Action Plan will identify key stakeholders and responsibilities for each strategy.

Strategies	Responsibility	
	Lead MDA	Collaborators
Objective 1: To improve gender responsiveness of health systems for enhanced quality of care.		
1. Improve service readiness and service delivery to be responsive to women's and girls' as well as men's and boy's needs, choices, and decision-making, keeping in mind the specific disadvantage women and girls face due to gender inequality.	**Lead:** MoH **Co-Lead:** Service delivery Institutions	Agencies within MoH/DPs/ MDAs, CSOs, Private sector
2. Provide timely and appropriate gender-responsive healthcare interventions across health programme areas.	**Lead:** MoH **Co-Lead:** Service delivery Institutions	Agencies within MoH/DPs/ MDAs, CSOs, Private sector
3. Address gender disparities in the health workforce, paying special attention to the disadvantages and challenges faced by health workers.	**Lead:** MoH **Co-Lead:** Service delivery Institutions	Agencies within MoH/DPs/ MDAs, CSOs, Private sector
4. Strengthen the existing governance structure and supervision systems to prioritize gender-related health issues.	**Lead:** MoH **Co-Lead:** Service delivery Institutions	Agencies within MoH/DPs/ MDAs, CSOs, Private sector
5. Empower women to take up decision-making and leadership roles in the health sector.	**Lead:** MoH **Co-Lead:** All MoH Agencies	Agencies within MoH/DPs/ MDAs, CSOs, Private sector

Strategies	Responsibility	
	Lead MDA	Collaborators
6. Develop a review system for medicine and supply procurement with women's and men's differential needs in mind.	**Lead:** MoH **Co-Lead:** All MoH Agencies	Agencies within MoH/DPs/ MDAs, CSOs, Private sector
7. Increase female and male NHIS enrollment utilisation and benefit package to meet the health needs of especially women, but also men.	**Lead:** MoH **Co-Lead:** NHIA	Agencies within MoH/DPs/ MDAs, CSOs, Private sector
8. Improve health sector data and information systems to more effectively generate and use gender-related data for informed decision-making.	**Lead:** MoH **Co-Lead:** All MoH Agencies	Agencies within MoH/DPs/ MDAs, CSOs, Private sector
Objective 2: To strengthen leadership, coordination, and collaboration for gender mainstreaming in health.		
1. Establish collaborative, coordination, and accountability mechanisms within health sector agencies and departments to address gender-related issues in health.	**Lead:** MoH **Co-Lead:** All MoH Agencies	Agencies within MoH/DPs/ MDAs, CSOs, Private sector
2. Establish coordination mechanisms with internal and external partners including key sectors, donors, the private sector, and civil society to address gender-related issues in health.	**Lead:** MoH **Co-Lead:** All MoH Agencies	Agencies within MoH/DPs/ MDAs, CSOs, Private sector
Objective 3: To address socio-economic and cultural barriers that underlie gender inequalities in health.		
1. Ensure deliberate consideration of socio-economic and cultural barriers underlying gender inequalities in the design and delivery of health services.	**Lead:** MoH **Co-Lead:** MLGRD/ Traditional Leaders	Agencies within MoH/DPs/ MDAs, CSOs, Private sector/ NCCE/Traditional Leaders
2. Develop health sector outreach and communications specifically tailored to reach women and girls, and men and boys, and to address gender-related biases.	**Lead:** MoH **Co-Lead:** Service Delivery Institutions	Agencies within MoH/DPs/ MDAs, CSOs, Private sector/ NCCE/Traditional Leaders
3. Strengthen women's participation at the community level in the design and implementation of health programmes.	**Lead:** MoH **Co-Lead:** MLGRD/ Traditional Leaders	Agencies within MoH/DPs/ MDAs, CSOs, Private sector/ NCCE/Traditional Leaders
4. Ensure community participation toward the reduction of harmful socio-cultural practices that impact the health of women and girls.	**Lead:** MoH **Co-Lead:** MLGRD/ Traditional Leaders	Agencies within MoH/DPs/ MDAs, CSOs, Private sector/ NCCE/Traditional Leaders
5. Encourage women to participate in health decision-making about their health at the household level.	**Lead:** MoH **Co-Lead:** MLGRD/ Traditional Leaders	Agencies within MoH/DPs/ MDAs, CSOs, Private sector/ NCCE/Traditional Leaders
Objective 4: To ensure sustainable health financing for gender mainstreaming in health.		
1. Allocate, and spend some core level of MOH dedicated funds for high priority action items in the gender policy that cannot be readily integrated into existing budgets and work plans.	**Lead:** MoH	
2. Undertake an agency and departmental financial review to assess which current activities can be effectively repurposed and strengthened concerning gender equality with existing resources.	**Lead:** MoH **Co-Lead:** MoH and its Agencies	Agencies within MoH/DPs/ MDAs, CSOs, Private sector
3. Advocate for additional GoG funding for gender mainstreaming in health.	**Lead:** MoH **Co-Lead:** MoF/PSCH	Agencies within MoH/DPs/ MDAs, CSOs, Private sector
4. Engage development partners for start-up financing for gender mainstreaming targeted initiatives.	**Lead:** MoH **Co-Lead:** DPs	Agencies within MoH/DPs/ MDAs, CSOs, Private sector
5. Assess budgeting for gender action activities against gender-responsive budgeting to recommend improvements.	**Lead**: MoH **Co-Lead:** MoF/PSCH	Agencies within MoH/DPs/ MDAs, CSOs, Private sector

CHAPTER 5

MONITORING AND EVALUATION

INTRODUCTION

The monitoring of the policy will be routine and continuous (quarterly, half-yearly, and annually) with an impact evaluation at the end-term. The agreed set of indicators and reporting formats shall be spelled out in the implementation framework. Monitoring will be the direct responsibility of the Ministry of Health with the support of relevant stakeholders.

Strategies for monitoring and evaluation will be considered pertinent actions in the implementation of this policy. Result frameworks on each policy commitment detailing outputs, outcomes, impacts, and key actions shall be developed to facilitate the annual national health sector gender policy performance review.

5.1 AIMS AND EXPECTATIONS FOR THE M&E FUNCTIONS

Monitoring and evaluation will aim at:

- Supporting research and studies whose findings and conclusions could be used to enhance stakeholders' understandings of gender equality generally and more specifically as they apply to the health sector.
- Supporting accountability to the health sector's commitments and strategic actions in the institutional gender policy and action plan.
- Assisting stakeholders in operationalising the NHSGP to generate gender-sensitive indicators for measuring the performance of the sector.
- Supporting the development and generation of gender-sensitive indicators at the individual, departmental, programme, facility, and organisation-wide levels.
- Emphasising effective participation of all staff of the MOH and health agencies in activities as a means of holding institutional leaders accountable for the delivery of the goals and objectives of this policy.
- Facilitating coordination and system-wide assessment of the impact of gender mainstreaming initiatives and activities for compliance with policy strategies.

- Ascertaining levels of efficient and judicious use of resources, behavioural and value changes occurring over time.
- Documenting experiences and voices of women, men, boys, and girls of gender equality matters in their access to the healthcare services they need for survival, growth, and development.
- Developing and institutionalising gender management information systems for the health sector to achieve reporting on the health and well-being of women and men, girls and boys in society.
- Assessing the adequacy of resources and budget allocation to units, programmes, and interventions for health care and health services delivery.

The monitoring and evaluation strategies when developed shall fit into the implementation cycle which will be matched to the processes and the measures of each core component of policy commitment to determine its effectiveness, efficiency, economy, and equity compliance. This will be done for:

- Quarterly updates from the human resource department.
- Half-yearly monitoring and quality assurance visits from the Gender Unit officials, and
- Annual performance review and learning sessions as part of the periodic policy review and institutional capability assessments.

CHAPTER 6

COMMUNICATION AND POLICY DISSEMINATION PLAN

INTRODUCTION

Communication and dissemination of the policy will form a major component of the National Health Sector Gender Policy implementation to motivate and inspire all implementing institutions to achieve the desired objectives. The dissemination plan will ensure that the key stakeholders and partners understand the tenets of the document and get their buy-in. It will further create awareness, empower the population as well as generate population interest in the Policy.

6.1 STRUCTURES FOR DISSEMINATION

The communication plan will be activated within the existing structures of MoH as outlined in the Common Management Arrangement (CMA). The following existing systems and structures shall therefore be leveraged for the dissemination of the Policy:

- The Inter-Agency Leadership Committee (IALC)
- The Health Sector Working Group (HSWG) meetings.
- Business Management Meetings and Sector conferences
- Annual Health Summit
- Decentralised Level Dialogue
- Annual Policy Dialogue and
- Others.

Activities that will be undertaken as part of the dissemination strategy after the national launch include regional and institutional dissemination sessions, training of Gender Desk Officers/ Focal Persons and engagements with CSOs, Private Sector, Professional groups within the Health Sector and other MMDAs. The Ministry of Information (MoI), the Office of the Head of Civil Service, the National Commission for Civic Education (NCCE), and the Information Services Department will further play a key role during the policy dissemination process.

6.2 AUDIENCE

- Ministry of Health and its Agencies
- Ministries, Departments, and Agencies
- Metropolitan, Municipal and District Assemblies
- Civil Society and Non-State Actors
- Development Partners
- Parliamentary Select Committee on Health
- The coalition of NGOs/CSOs in Health
- House of Chiefs
- Faith-based Organisations
- Media and
- Others.

6.3 OBJECTIVES

The objectives of the communication strategy are to:

- Seek ownership and buy-in from all stakeholders for smooth implementation of the Policy.
- Inform and assure the public of the government's commitment to achieving Universal Health Coverage through gender mainstreaming at all levels.
- Sensitize stakeholders on their roles and responsibilities.
- Sensitize stakeholders on the institutional and implementation arrangement of the Policy and
- Others.

Appendix 1: MONITORING AND EVALUATION FRAMEWORK

The following monitoring and evaluation framework is indicative of what will be included within the Gender Policy Implementation Plan. The Gender Policy Implementation Plan will identify key indicators related to health strategy.

Objective 1: To Improve Gender Responsiveness in the Health System for Enhanced Quality of Care

Strategy	Indicator	Baseline	Target	Timeline	Means of Verification	Lead	Co-lead
1. Improve service readiness and service delivery to be responsive to women's and girls' as well as men's and boy's needs, choices, and decision-making, keeping in mind the specific disadvantage women & girls face due to gender inequality.	Percentage of current guidelines, protocols and tools that are successfully modified for gender responsiveness	TBD	50% 100%	2026 2027	PPMED Records (PPMED annual audit may be required)	MOH	
	Percentage of modified guidelines, protocols and tools that are adopted system-wide.	TBD	50% 100%	2027 2028	PPMED Records (PPMED annual audit may be required)	MOH	
	Percent of health care facilities that have women friendly infrastructure as measured by the 5 indicators below: 1. Clean functional female washrooms 2. Labour room privacy 3. Presence of female provider 4. No stock out on obstetric medicines 5. No stock-out on at least two short-term and one long-term reversible family planning method.	TBD	50% 75%	2028 2030	DHIMS2 and/ or Health Facility Assessment	GHS	Other service delivery agencies
	Percentage of providers trained on respectful and friendly care to women and adolescent girls	TBD	40% 75%	2028 2030	DHIMS2 and/or HFA	GHS	Other service delivery agencies
	Percentage of providers with training on male sexual health and hypertension	TBD	40% 75%	2028 2030	DHIMS2 and/or HFA	GHS	Other service delivery agencies

Strategy	Indicator	Baseline	Target	Timeline	Means of Verification	Lead	Co-lead
	Number of high priority initiatives that have gender responsive plans	TBD	1-2 high priority initiatives	Annually	Policy/ planning documents of the initiatives	Health service delivery agencies	Other agencies
	Percentage of district level budget spent on gender related activities	TBD	10% or more	Annually	District level expenditure reports	Health service delivery agencies	Other agencies
2. Provide timely and appropriate gender-responsive healthcare interventions across health programme areas.	Average waiting time for core services for women and adolescent girls (family planning, obstetrics, HIV and STI screening and treatment)	TBD	30 minutes or less at 50% facilities 30 minutes or less at 75% of facilities	2028 2030	Surveys	GHS	Health service agencies
	Average waiting time for core services for men and boys (screening and treatment for HIV, STIs, tuberculosis, hypertension, and diabetes)	TBD	30 minutes or less at 50 % facilities 30 minutes or less at 75% of facilities	2028 2030	Surveys	GHS	Health service agencies
	Percentage increase in the number of adolescent girls aged 19 and below who received family planning methods and counselling from trained facility and community health workers	TBD	15% increase from baseline 30% increase from baseline	2028 2030	DHIMS2	GHS	Health service agencies
	Percent of primary level health facilities that provide breast cancer screening services	13%	30% 50%	2028 2030	Health Facility Assessment	GHS	Health service agencies
	Percent of secondary and tertiary level health facilities that provide cervical cancer screening services.	27%	35% 40%	2028 2030	Health Facility Assessment	GHS	Health service agencies

Strategy	Indicator	Baseline	Target	Timeline	Means of Verification	Lead	Co-lead
	Percent of secondary and tertiary level health facilities that provide prostate cancer screening services.	20%	25% 30%	2028 2030	Health Facility Assessment		
3. Address gender disparities in the health workforce, paying special attention to the disadvantages and challenges faced by health workers.	Percentage of women among health workers who get educational opportunities to upgrade their qualifications	TBD	At least 50%	2030	HR data	GHS	Health service agencies
	Percentage of women among health workers who get study leave to upgrade their education.	TBD	At least 50%	2030	HR data	GHS	Health service agencies
	Percentage of community health workers promoted to higher level jobs	TBD	7%	Annually	HR data	GHS	Health service agencies
	Percentage increase in allowances for nurses posted to rural areas	TBD	10%	Annually		GHS	Health service agencies
	Percentage of agencies that have agency-specific versions of the Civil Service Sexual Harassment Policy	TBD	25% 50%	2026 2027	Sexual harassment policy documents	GHS	Health service agencies
	Percentage of agencies that have begun implementing their versions of the Civil Service Sexual Harassment Policy	TBD	25% 50%	2027 2028	Agency reports	GHS	Health service agencies
	Percentage of agencies that have evaluated the implementation of their versions of the Civil Service Sexual Harassment Policy	TBD	25% 50%	2029 2030	Agency reports	GHS	Health service agencies

Strategy	Indicator	Baseline	Target	Timeline	Means of Verification	Lead	Co-lead
4. Strengthen the existing governance structure and supervision systems to prioritize gender-related health issues.	Number of managers & directors trained on gender equity-related action items and gender-responsive performance management	TBD	50 managers & directors	Annually		Health agencies	
	Number of gender equity related action items on improving gender equity in each agency's (a) work plan and (b) management processes that are prioritized, budgeted for, and acted upon each year	TBD	At least 2 gender equity related action items	Annually	Annual workplans of health agencies in conjunction with reporting form that PPMED provides and monitors annually	Health agencies	
5. Empower women to take up decision-making and leadership roles in the health sector	Percentage of participants in leadership training programmes who are middle-grade women staff (managers)	TBD	60%	Annually	HR training reports	MOH	Health agencies
	Percentage of leaders (managers, deputy directors, and directors) in the health sector who are women	TBD	25% 35% 50%	2026 2030 2035	HR records	MOH	Health Agencies
6. Develop a review system for medicine and supply procurement with women's and men's differential needs in mind	Assessment of medicines and supplies classified by male/ females needs undertaken	N/A	Assessment undertaken	2025	Annual reports from medicine and supply procurement agency	MOH	
	Expert meeting called to review assessment and propose a design for a review system on medicine and supply procurement that adequately addresses male/female differential needs.	N/A	Expert meeting on assessment of making medicine supply system gender responsive held	2026	Annual reports from medicine and supply procurement agency	MOH	
	Review system tested, launched and in place for at least 2 years		System in place for 2 years	2029	Annual reports from medicine and supply procurement agency	MOH	

Strategy	Indicator	Baseline	Target	Timeline	Means of Verification	Lead	Co-lead
7. Increase female and male NHIS enrollment and utilization rates and improve the benefit package to meet the health needs of especially women but also men.	A study on NHIS coverage and access, identifying gender related health utilization, costs and forgone care undertaken and assessing ideal female/ male ratio for NHIS package, enrollment, and utilization.	N/A	1 study	2026	Study report	MOH	NHIA
	High-level stakeholder meeting held to discuss and agree on the solutions to the disparities identified from the study.	N/A	Meeting held and solutions identified	2027	Meeting notes	MOH	NHIA
	Proposals/solutions to improve quality and access for men and women implemented	N/A	Proposal/solutions implemented	2028		MOH	NHIA
	NHIS benefits package, enrollment and utilization is assessed to see if they are adequately meeting the health needs of women and girls in particular, but also men and boys	N/A	Assessment conducted and benefits package revised	2027	Assessment report	MOH	
	Number of districts in which the gender-responsive improved benefits package is rolled out as a pilot	Current package as of 2025	5 districts 20 districts	2028 2030	NHIA data on improved gender responsive NHIA package, enrollment, and utilization processes	MOH	
8. Improve health sector data and information systems to more effectively generate and use gender-related data for informed decision-making	Number of core gender indicators tracked through the District Health Information Management System	TBD	30-40 gender indicators	2027	DHIMS2		

Strategy	Indicator	Baseline	Target	Timeline	Means of Verification	Lead	Co-lead
	Number of gender indicators collected by the Human Resource Information System, Logistics Management Information System, National Health Insurance Agency, respectively.	TBD	5–10 gender indicators	2027	HRIS, LMIS, NHIA	MOH	
	Number of gender indicators regularly included in data dashboards, quarterly policy reports or the six-month review of health sector progress by Health Minister	TBD	5-10 gender indicators	2027	National dashboard or policy report review	MOH	
	Number of gender indicators included in data dashboards or progress reports for district level health performance review by District Health Officers.	TBD	10–15 gender indicators	2027	District dashboard or progress report review	MOH	
	Number of District Health Officers and statistics staff in districts trained on health sector gender data and use	TBD	40–50 District Health Officers and statistics staff	Annually		MOH	
	Number of Department Heads within the MOH and other health agencies trained on gender data and use	TBD	40-50 Department Heads	Annually		MOH	

Objective 2: Strengthen Leadership, Coordination, and Collaboration for Gender Mainstreaming in Health

Strategy	Indicator	Baseline	Target	Timeline	Means of Verification	Lead	Co-lead
1. Establish collaborative, coordination, and accountability mechanisms within health sector agencies and departments to address gender-related issues in health	Senior level technical gender lead appointed and supported with human and financial resources as well as backing by MOH leadership.	N/A	1 senior level technical gender lead	2025		MOH	
	Percentage of agencies that have a gender desk officer with a revised remit, training, and reporting lines	N/A	50% 100%	2026 2028	Health agency reports or records	MOH	Health agencies
	Action plan progress report developed and presented at MOH's highest level coordination body	N/A	1 report	Annually	Action plan progress report	Senior gender lead	
	Mapping report produced with identified priority areas for gender integration in key health sector policy implementation and gaps	N/A	1 report	2025	Mapping report	MOH	
	Alignment between Gender Action Plan activities and at least 2 key mainstream health policy implementation efforts.	N/A	Alignment with at least 2 key mainstream health policy implementation efforts	2027	Ministry records or reports	MOH	
2. Establish coordination mechanisms with internal and external partners including key sectors, donors, the private sector, and civil society to address gender-related issues in health.	Number of key health sector platform meetings where gender integration is on the agenda	TBD	2 meetings	Annually	Meeting agenda and minutes	MOH	
	MOH, MOGCSP, OHCS, led convening held to prioritize the two most critical cross-sectoral actions for women and girls' health.	N/A	2 cross-sectoral actions	Annually	Convening meeting minutes	MOH	

Objective 3: Address Socio-Economic and Cultural Barriers that Underlie Gender Inequalities in Health

Strategy	Indicator	Baseline	Target	Timeline	Means of Verification	Lead	Co-lead
1. Ensure deliberate consideration of socio-economic and cultural barriers underlying gender inequalities in the design and delivery of health services.	A study consolidating existing data to highlight the 5 most critical socio-economic and cultural barriers that prevent women and girls from accessing healthcare – and the 5 most critical barriers for men and boys – completed	N/A	1 study	2026	Study	MOH	Health Agencies
	MOH-led convening held and action plan developed for overcoming gender barriers through improved service delivery and behaviour change communication (BCC).	N/A	1 action plan	2027	Convening minutes and action plan	MOH	Health Agencies
2. Develop health sector outreach and communications specifically tailored to reach women and girls, and men and boys, and to address gender-related biases.	Number of behaviour change communication campaigns targeted at women	TBD	1 campaign	Annually	Communications Department records	MOH	Health Agencies
	Number of behaviour change communication campaigns targeted at men	TBD	1 campaign	Annually	Communications Department records	MOH	Health Agencies
	Number of behaviour change communication campaigns targeted at adolescent girls	TBD	1 campaign	Annually	Communications Department records	MOH	Health Agencies
	Number of behaviour change communication campaigns targeted at adolescent boys	TBD	1 campaign	Annually	Communications Department records	MOH	Health Agencies
3. Strengthen women's participation at the community level in design and implementation of health programmes	Gender balance assessment report of community participation mechanisms is completed	N/A	1 assessment report	2025	Report	GHS	
	All community participation mechanisms guidelines target a gender balance of 50/50 female and male.	TBD	All guidelines	2026	Community participation mechanism guidelines	GHS	

Strategy	Indicator	Baseline	Target	Timeline	Means of Verification	Lead	Co-lead
	Percentage of sub-districts in which women comprise at least 50% of participants of community participation mechanisms (e.g. community scorecards, community health management committees (CHMC), community health action plan process)	TBD	50% of subdistricts 80% of subdistricts	2028 2030	Annual progress reports	GHS	
4. Ensure community participation towards the reduction of harmful socio-cultural practices that impact the health of women and girls.	Number of collaborations with or support efforts to community organizations to reduce and eliminate harmful socio-cultural practices that negatively impact the health of women and girls	TBD	2 collaborations/ support efforts	Annually	Reports of Gender Desk Officers	MOH	Health Agencies
	Number of case study reports evaluating programmes implemented by community-based organizations to address and eliminate harmful socio-cultural practices that impact the health of women and girls	TBD	1 case study report	Annually	Case study report	MOH	Health Agencies
5. Encourage women to participate in decision-making about their health at the household level.	Number of community-based organisation initiatives supported/ collaborated with to improve women's and adolescent girls' decision-making on reproductive and maternal care access and choice	TBD	2 initiatives	Annually	Reports of Gender Desk Officers	MOH	Health Agencies
	Number of case study reports evaluating programs to promote women and adolescent girls' autonomy and decision-making on reproductive and maternal care access and choice.	TBD	1 case study report	Annually	Case study report	MOH	Health Agencies

Objective 4: Ensure Sustainable Financing for Gender Mainstreaming in Health

Strategy	Indicator	Baseline	Target	Timeline	Means of Verification	Lead	Co-lead
1. Allocate, and spend some core level of MOH dedicated funds for high priority action items in the gender policy that cannot be readily integrated into existing budgets and work plans.	Assessment of priority activities in Gender Action Plan to identify which require dedicated funding because they are core investments that cannot be integrated into existing plans and activities	N/A	Assessment completed	Annually	Assessment report	MOH	
	Budget and spending plan for select high priority gender activities requiring dedicated spending	N/A	Budget and spending plan completed	Annually	Budget and spending plan	MOH	
	Dedicated spending on core gender activities at not more than 5-10% of spending on gender activities through integration into regular activities and budgets	N/A	Not more than 5-10%	Annually	Financial department records	MOH	
2. Undertake an agency and departmental financial review to assess which current activities can be effectively repurposed and strengthened concerning gender equality with existing resources.	Number of health agencies that conduct financial review to repurpose existing activities and funds for gender equality priorities	N/A	3-5 health agencies	2026	Financial review reports	MOH	
	Number of agencies/ departments that repurpose existing activities and associated budgets to advance gender equality efforts in health.	N/A	3-5 health agencies/ departments	2027	Financial department records	MOH	
3. Advocate for additional Government of Ghana funding for gender mainstreaming in health	Percentage of government budgetary allocation to MOH used for gender mainstreaming activities	TBD	5% 7%	2028 2030	Financial department records	MOH	
4. Engage development partners for start-up financing for targeted, high-priority gender equality initiatives.	Number of multi-agency targeted initiatives on gender equality that have startup funding.	N/A	1 initiative 2 initiatives	2026 2028	Financial department records	MOH	
5. Assess budgeting for gender action activities against gender-responsive budgeting methodology to recommend improvements	Report on assessment of budgeting for gender action plan activities against gender responsive budgeting methodology completed.	N/A	1 report	2028	Report	MOH	
	Dissemination meeting/ consultation with key decision-makers and stakeholders held to present recommendations.	N/A	1 meeting/ consultation	2028	Meeting minutes	MOH	

Appendix 2: LIST OF CONTRIBUTORS/STAKEHOLDERS

S/N	Name	Designation/Organization
Strategic Leadership		
1.	Hon. Dr. Bernard Okoe Boye	Minister for Health
2.	Hon. Alexander Akwasi Acquah (MP)	Dep. Minister for Health
3.	Hon. Adelaide Ntim (MP)	Dep. Minister for Health
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REFERENCES

Abt Associates. (2019). Sources of Family Planning: Ghana. https://shopsplusproject.org/sites/default/files/resources/Sources%20of%20Family%20Planning%20in%20Ghana.pdf

Adoboi F, Mohammed A, Duodu PA, Aboagye RG, Seidu AA, Wongnaah FG, et al. (2014). Sex-related inequalities in crude and age-standardized suicide rates: trends in Ghana from 2000 to 2019. BMC Public Health. Apr 17;24:1070.

Alvarado G, Fenny AP, Dakey S, Mueller JL, O'Brien-Milne L, Crentsil AO, et al. (2018). The health-related impacts and costs of violence against women and girls on survivors, households and communities in Ghana. J Public Health Afr. Oct 1;9(2):860.

Amoah, P. A. (2018). Social participation, health literacy, and health and well-being: A cross-sectional study in Ghana. SSM - Population Health, 4, 263-270. https://doi.org/10.1016/j.ssmph.2018.02.005 PMID:29854910

Amoah, P. A., & Phillips, D. R. (2018). Health literacy and health: Rethinking the strategies for universal health coverage in Ghana. Public Health, 159, 40-49. https://doi.org/10.1016/j.puhe.2018.03.002 PMID:29729490.

Ansu-Yeboah, E., Edusei, A., & Gulis, G. (2019). Comprehensive health literacy among undergraduates: A Ghanaian University-based cross-sectional study. Health Literacy Research and Practice, 3(4), e227-e237. https://doi.org/10.3928/24748307-20190903-01.

Boakye H, Atabila A, Hinneh T, Ackah M, Ojo-Benys F, Bello AI. (2023). The prevalence and determinants of non-communicable diseases among Ghanaian adults: A survey at a secondary healthcare level. PloS One;18(2):e0281310.

Boamah Mensah A. B. et al., (2022). Breast cancer screening pathways in Ghana: Applying an Exploratory Single Case Study Analysis. Heliyon 8: Available from: https://doi.org/10.1016/j.heliyon.2022.e11413.

Boah, M., Kpordoxah, M. R., & Adokiya, M. N. (2021). Self-reported gender differentials in the knowledge of tuberculosis transmission and curative possibility using national representative data in Ghana. PLoS ONE, 16(7 June). https://doi.org/10.1371/journal.pone.0254499.

Bohren, M. A., Mehrtash, H., Fawole, B., Maung, T. M., Balde, M. D., Maya, E., Thwin, S. S., Aderoba, A. K., Vogel, J. P., Irinyenikan, T. A., Adeyanju, A. O., Mon, N. O., Adu-Bonsaffoh, K., Landoulsi, S., Guure, C., Adanu, R., Diallo, B. A., Gülmezoglu, A. M., Soumah, A. M., … Tunçalp, Ö. (2019). How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys. The Lancet, 394(10210), 1750–1763. https://doi.org/10.1016/S0140-6736(19)31992-0.

Dotse-Gborgbortsi W, Nilsen K, Ofosu A, Matthews Z, Tejedor-Garavito N, Wright J, et al.

(2022). Distance is “a big problem”: a geographic analysis of reported and modelled proximity to maternal health services in Ghana. BMC Pregnancy Childbirth. Aug 31;22(1):672.

Droogenbroeck, V. F., Spruyt, B. & Keppens, G. (2018). Gender differences in mental health problems among adolescents and the role of social support: results from the Belgian health interview surveys 2008 and 2013. BMC Psychiatry 18, 6. https://doi.org/10.1186/s12888-018-1591-4.

Efua SDV, Adwoa WD, Armah D.(2023). Seroprevalence of Hepatitis B virus infection and associated factors among health care workers in Southern Ghana. IJID Reg. Jan 20;6:84–9.

Gardner F. (2021). Sex and Gender. Sex, Power, Control. 78 (Suppl 1):134–50.

Gething PW, Johnson FA, Frempong-Ainguah F, Nyarko P, Baschieri A, Aboagye P, et al. (2012). Geographical access to care at birth in Ghana: a barrier to safe motherhood. BMC Public Health. Nov 16;12:991.

Ghana National Gender Policy (2016).

Ghana National Health Policy (2009).

Ghana Report on Beijing +25.

Ghana AIDS Commission. (2020). National and Sub-National HIV and AIDS Estimates and Projections 2020 Report. www.ghanaids.gov.gh.

Ghana Statistical Service, Ghana Health Service, & ICF International. (2015). Ghana Demographic and Health Survey 2014. Accra, Ghana: GSS, GHS, and ICF.

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

Ghana Statistical Service, & ICF. (2023). Ghana Demographic and Health Survey 2022: Key Indicators Report. Accra, Ghana: GSS and ICF.

Gyasi, Razak Mohammed & Abass, Kabila. (2018). Sexual risk behavior and uptake of HIV counseling and testing among youth in Metropolitan Kumasi, Ghana. Journal of HIV/AIDS & Social Services, 17.2.

Institute of Development Studies, Ghana Statistical Services, & Associates. (2016). Domestic Violence in Ghana: Incidence, Attitudes, Determinants and Consequences. Available from: https://opendocs.ids.ac.uk/opendocs/handle/20.500.12413/12168.

Keogh, S. C., Otupiri, E., Castillo, P. W., Li, N. W., Apenkwa, J., & Polis, C. B. (2021). Contraceptive and abortion practices of young Ghanaian women aged 15–24: evidence from a nationally representative survey. Reproductive Health, 18(1). https://doi.org/10.1186/s12978-021-01189-6.

Laryea, D. O., Awuah, B., Amoako, Y. A., Osei-Bonsu, E., Dogbe, J., Larsen-Reindorf, R., Ansong, D., Yeboah-Awudzi, K., Oppong, J. K., Konney, T. O., Boadu, K. O., Nguah, S. B., Titiloye, N. A., Frimpong, N. O., Awittor, F. K., & Martin, I. K. (2014). Cancer incidence in Ghana, 2012: Evidence from a population-based cancer registry. BMC Cancer, 14(1). https://doi.org/10.1186/1471-2407-14-362.

Latunji, O.O. and Akinyemi, O.O. (2018) Factors Influencing Health-Seeking Behaviour among Civil Servants in Ibadan, Nigeria. Annals of Ibadan Postgraduate Medicine, 16, 52-60.

Mainstreaming in Occupational Safety and Health [Internet]. (2013). Available from: www.ilo.org/safework.

Ministry of Food and Agriculture, Ghana Statistical Service, World Food Program, & Food and Agriculture Organisation. (2020). 2020 Comprehensive Food Security and Vulnerability Analysis (CFSVA) - Ghana.

Ministry of Health. (2009). Health Sector Gender Policy.

Ministry of Health. (2011). Human Resources for Health Country Profile.

Ministry of Health/ Ghana Health Service. (2023). National Malaria Elimination Strategic Plan (NMESP) of Ghana: 2024-2028. Available at: https://ghs.gov.gh/wp-content/uploads/2023/12/NMEP-STRATEGIC%20PLAN%202024-2028.pdf.

Ministry of Health, Ghana Health Service, & World Health Organization. (2023). Ghana Harmonized Health Facility Assessment 2022-2023.

Nartey, Y. A., Okine, R., Seake-Kwawu, A., Ghartey, G., Asamoah, Y. K., Senya, K., Duah, A., Owusu-Ofori, A., Amugsi, J., Suglo, D., Bampoh, S. A., Hiebert, L., Njuguna, H., Ward, J. W., Plymoth, A., Roberts, L. R., Bockarie, A. S., Awuku, Y. A., & Obiri-Yeboah, D. (2022). A nationwide cross-sectional review of in-hospital hepatitis B virus testing and disease burden estimation in Ghana, 2016 - 2021. BMC Public Health, 22(1). https://doi.org/10.1186/s12889-022-14618-3.

Nartey YA, Okine R, Seake-Kwawu A, Ghartey G, Asamoah YK, Senya K, et al. (2022). A nationwide cross-sectional review of in-hospital hepatitis B virus testing and disease burden estimation in Ghana, 2016 - 2021. BMC Public Health. Nov 23;22(1):2149.

National Development Planning Commission and UN Ghana. Ghana Millennium Development Goals: 2015 Report, 2015. https://www.gh.undp.org/content/ghana/en/home/library/poverty/2015-ghanamillennium-development-goals-report.html.

Oduro, A. R., Francke, J., Ansah, P., Jackson, E. F., Wak, G., Phillips, J. F., Haykin, L. A., Azongo, D., Bawah, A. A., Welaga, P., Hodgson, A., Aborigo, R., & Heller, D. J. (2022). Social and demographic correlates of cardiovascular mortality in the Kassena-Nankana districts of Ghana: A verbal post-mortem analysis. International Journal of Epidemiology, 51(2). https://doi.org/10.1093/ije/dyab244.

Pons-Duran, C. et al., (2019). Inequalities in sub-Saharan African women's and girls' health opportunities and outcomes: evidence from the Demographic and Health Surveys. Journal of Global Health Vol 9(1): 1-11.

Available from: www.jogh.org • doi: 10.7189/jogh.09.010410.

Republic of Ghana, Ministry of Health (MOH). Health Sector Gender Policy, 2009.

Rwanda's National Gender Policy (2018).

Seidu, A.A. (2020). Using Anderson's Model of Health Service Utilization to Assess the Use of HIV Testing Services by Sexually Active Men in Ghana. Front Public Health 2020: doi: 10.3389/fpubh.2020.00512. eCollection 2020.

Sorrentino E, Vona R, Monterosso D, Giammariolis AM. (2016) Gender issues on occupational safety and health. 52(2):190–7. Available from: https://pubmed.ncbi.nlm.nih.gov/27364393/.

Tenkorang, E. Y., Owusu, A. Y., Zaami, M., Langmagne, S., & Gyan, S. (2023). Intimate Partner Violence and Health Outcomes Among Women Living With HIV/AIDS in Ghana: A Cross-Sectional Study. Health Education and Behavior, 50(3). https://doi.org/10.1177/10901981231152425.

Trades Union Congress. Gender in occupational safety and health. 2017;16. Available from: https://www.tuc.org.uk/sites/default/files/GenderHS2017.pdf.

UNICEF. (2022) The Situation of Adolescents in Ghana. Available from: https://www.unicef.org/ghana/reports/situation-adolescents-ghana.

Wharton-Smith, A, Rassi, C, Batisso, E et al., (2019) Gender-related factors affecting health seeking for neglected tropical diseases: findings from a qualitative study in Ethiopia. PLOS Neglected Tropical Diseases, 13 (12). e0007840. ISSN 1935-2727.

Vidal-Alaball, J., Acosta-Roja, R., Hernández, N. P., Luque, U. S., Morrison, D., Pérez, S. N., & Seguí, F. L. (2020). Telemedicine in the face of the COVID-19 pandemic. Atencion primaria, 52(6), 418-422.

World Health Organization. (2018). WHO recommendations: intrapartum care for a positive childbirth experience. BMC Pregnancy and Childbirth.

World Health Organization. (2022). Beating noncommunicable diseases through primary healthcare. Available at: https://www.afro.who.int/countries/ghana/news/beating-noncommunicable-diseases-through-primary-healthcare.

World Health Organization. (2023). Country Disease Outlook Ghana. Available at: https://www.afro.who.int/sites/default/files/2023-08/Ghana.pdf.

World Health Organization. (2024). Tuberculosis profile: Ghana. Available at: https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&entity_pe=%22country%22&iso2=%22GH%22&lan=%22EN%22.